High-risk outreach playbook (vaccinations)

January 2021

Abstract

The COVID-19 pandemic is a sentinel event for CareOregon. It has required quick action to determine an approach to proactively outreach and provide necessary supports to members who may be at highest risk of complication, including death, if exposed to the virus. To prepare for possible future events similar to this pandemic, a guide for how to approach outreach to highest risk members is warranted.

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Project description

Project name	COVID-19 high-risk member outreach for vaccinations
Summary	COVID-19 vaccine dissemination has created urgency to connect with members who need the vaccine. Though all members are at risk of poor outcomes related to COVID-19 and deserve access to the COVID-19 vaccine, there are members at increased risk or hospitalization and death due to disproportionate effects of COVID-19 on health outcomes. This disproportionate effect could be due to health disparities related to race, ethnicity or language, age, underlying chronic condition. In addition, there are members who may need additional supports to access the vaccine due to geographical barriers and transportation, disability, language, culture, behavioral health conditions etc…The project will use REAL-D data and risk stratification to identify members who will benefit from prioritized outreach or supports related to accessing the COVID vaccine. An equity lens should be used to support this work. An example of an equity tool kit can be found in Appendix E
Scope	Phase IA: Readiness Phase IB: Data creation Phase II: Communication with partners Phase III: Implementation Phase IV: Evaluation
Deliverables	Our primary and most important objective is that all members who are at greater risk due to health disparities and/or health decline receive support, education and navigation to secure the vaccine. We realize due to health disparities and greater risk for medical complication we must conduct special outreach to support members.
Definition of done	When teams have connected with all members who are at risk or teams have made several attempts to engage the member.

Success criteria	• Go-live mid-February • 90% of high-risk members receive vaccinations • Members and staff report a positive experience
Sponsor	Jonathan Weedman
Business owners	PHPMS

Evaluation

The first step in the high-risk outreach process is to identify how you will evaluate the outreach effort.

Data elements to track:

- Utilization for cohorts identified pre- and post-engagement
    - Primary care provider
    - Pharmacy: Medication refills or those converted to 90=day fills
    - Inpatient and emergency department use
    - Behavioral health engagement
- Comparison between those who were reached and received the vaccine vs. those who did not
- Vaccination rate

How to collect data for evaluation:

- ALERT information
- Collective data
- GSI assessment data
- Call tracking
- Claims information for physical health, behavioral health and pharmacy
- Authorization data
- Input from staff and providers doing outreach

Given the claims lag, it is recommended that you have a variety of sources for tracking beyond claims information. Claims can be used for longer-term outcomes, but real-time data sources should be considered.

Project governance structure

The following project structure will be in place for the phases of the project. Meeting functions and purpose are clearly defined, and roles and responsibilities are identified.

Meeting	Cadence	Purpose	Attendees
Steering committee	Two to three times during the course of the project and dependent on progress. Should include a closing session for lessons learned.	To provide clear strategic direction and oversite of project objectives.	• CPCCO, JCC medical directors • VP Pharmacy • VP Population Health
Centralized operations meeting	Weekly until implementation, and then as needed.	Operationalize strategic vision, organize data sets, create communication strategies, problem solve barriers.	• PHPMs • Population Health analyst • Director of Population Health • Member and Provider Customer Service • Community health managers
Team huddles	Weekly once implementation begins and through the end of the project.	Problem solve with team members and pivot as needed.	• RCT managers and/or supervisors • Team members • PHPMs

Roles and responsibilities

Role	Function
VP Population Health	• Convene steering committee • Sponsor overall project • Report regularly to CMO and MDs • Eliminate barriers as identified

	• Support director of Population Health
Director of Population Health	• Convene centralized operations meeting • Support PHPMs regarding cross-regional needs • Support Population Health analyst and informatics team • Be the central point of contact for alignment • Problem solve barriers or escalate to VP Population Health
PMPMs	• Facilitate operationalization of outreach with RCT managers • Provide outreach lists to teams • Provide consultation on regional customization and workflows • Deliver partner toolkits • Solve regional barriers or escalate to director of Population Health
Regional community health leads	• Provide guidance and technical support to CBOs • Regularly check in with CBO partners and make adjustments as needed • Escalate any issues to PHPMs
RCT managers/supervisors	• Operationalize the outreach efforts with teams • Facilitate weekly team huddles • Problem solve for immediate needs • Escalate barriers to PHPMs
Medical directors (physical and behavioral health)	• Provide strategic clinical direction and consultation • Provide clinical criteria for data set
Clinical integration directors	• Provide integration and alignment across regional LOB and teams • Provide direction and consultation to RCT managers regarding operations
Population Health analyst	• Provide high-risk outreach list based on MD clinical criteria • Determine best mechanism for list deployment • Provide data expertise and lens
Data and triage integration manager	• Work with GSI to create needed assessments and templates • Provide direction on data capture into the system for optimal output • Provide ongoing reporting out of the record • Build and monitor cohorts within Collective

Communication pathways

Clinical/Publich Health Procedure

Communication with clinic partners and public health partners — or those doing the outreach as an extension of the team — should occur as soon as possible.

1. Alert clinic or community partners about the situation, describe the work, desired outcomes, target populations, technical support provided, and assess for capacity and desire to do the work themselves.
2. Esablish Letter of Agreements (LOA) between Public Health or other entities if needed for ease of data sharing and partnership
3. Determine which partners have capacity and a willingness to engage in this work, and identify a point of contact for coordination.
4. Create toolkit for outreach work (see appendix A).
5. Schedule partner check-ins at reasonable cadences.
6. Determine the report-back mechanism: How will partners report their progress?
7. Provide updated data regarding vaccination rate to clinic.

CBO Procedure

Communication with CBO partners, particularly those that are culturally specific, should happen quickly to determine their ability and willingness to reach out to members about getting the vaccine, vaccine hesitancy and other navigation needs.

1. Alert CBO partners about the situation, describe the work, desired outcomes, target populations, funding, and technical support provided.
2. Schedule partner check-ins at reasonable cadences.
3. Determine report-back mechanism and provide updated data regarding vaccination completions.
4. Reach out to CBOs and provide them with basic health plan navigation training and a toolkit for accessing health-related service funds.
5. Be sure that all materials are translated into the appropriate language.
6. Work closely with interpreter services and augment current contracts. Consider whether interpreter services should reach out to subpopulations.
7. Leverage existing funds, such as community benefit, to target support to CBOs or communities of color.
8. Prioritize outreach to communities that experience disparities.

Member Procedure

As soon as possible, members should receive written communication about this outreach effort. Guidelines for the letter are:

1. The letter should be meaningful and written in plain language (See Appendix B). It should use CDC and OHA information to supply education about vaccinations.

2. Determine what number should be listed on the letter for members to call: Customer Service, RCT?
3. If possible, the letter should be translated in the appropriate language.
4. The letter should be sent before outreach begins, both to avoid cold calling and as proper TIC practice.

For all partners, who receive member lists the "Yours, Mine and Ours" model should be used:

- Yours: What is the clinic or community partner's work to complete and which members should receive that outreach. Examples may include members who are engaged with the PCO and have seen them at least once in the last 12 months.
- Mine: What is the health plan's role and which members should they reach out to. This has included members who have no PCP visit in the last 12 months or members who do not have an open behavioral health authorization.
- Ours: The subset of members who need support from both the clinic and the health plan. For COVID, this largely played out naturally as members who needed additional support from one or both parties were identified.

When the data subset is routed to the correct outreach partner, information should be exchanged in Excel format and emailed securely to the correct person. Ideally, in the future, self-serve data dashboards with member lists would be available for clinics to access and download on their own.

GSI assessments will need to be built depending on the workflow and desired outreach outcome (see Appendix C). These should begin as soon as possible to provide ample opportunity for GSI to build the assessment. Depending on the time period, a manual version can be used until the assessment is functional.

- All internal and, if possible, external team members should use the assessment created.
- The assessment should incorporate the needs of both physical and behavioral health.
- The assessment is centrally built, although the workflows for its usage may be customized by region.

Process for generating the letter is as follows:

1. Draft letter and send to Brand Marketing and Communications for review.
2. Obtain OHA approval or, based on the circumstance, receive permission from the CareOregon legal team to bypass this process.
3. Inform all member-facing teams about the letter and provide talking points in case a member calls in reference to the letter (i.e., for Customer Service).

Data creation

Criteria for the outreach population is set by medical directors and other leaders. This criteria is used by the Population Health analyst to create the outreach list data set. When at all possible, physical and behavioral health data should be combined for ease of operations and in the spirit of integration. Due to the claims lag, Collective should be leveraged for current data as well as pharmacy claims.

The data template should include the following elements:

- Name
- DOB
- Phone number
- Address/location
- DMAP
- Race/ethnicity
- Language
- Assigned PCP
- Vaccination received and from where

Physical health	Behavioral health
Individuals who are older than 65 years old, or Ages 16-64 with any high-risk chronic conditions (defined above), or Had dialysis or treatment for cancer in the last year, or Has a frailty marker	• High-risk diagnoses defined below, and/or • Anorexia nervosa • Bipolar • Schizophrenia • Depression • Panic disorder • SUD (with or without MAT) • Recent fill of Clozaril • Suicide attempt or overdose event, and/or • Any ED visits related to behavioral healthy, or a Unity IP visit
Social/cultural Health	
Ages 16-64 and also: • Houseless (if that data can be captured) • American Indian/Alaska native population • Black population • Hispanic/Latino • Pacific Islander	

This general criteria was then broken down into priority areas, depending on regional volume:

Example: Physical health

Priority 1
All people who are 80 and older: • Those who have chronic conditions or high-risk race/ethnicity below for should be considered the highest priority for outreach. • Those with a behavioral health condition should be considered for guided outreach.
Priority 2
All people who are 65 and older: • Those who have chronic conditions or high-risk race/ethnicity below for should be considered the highest priority for outreach.

• Those with a behavioral health condition should be considered for guided outreach.
Ages 16-64 who are: (** will need specific culturally/community informed outreach plan) ** Those with a behavioral health condition should be considered for guided outreach. • American Indian/Alaska native population • Black population • Hispanic/Latino • Pacific Islander
Ages 16-64 with chronic condition: • Those who have chronic conditions or high-risk race/ethnicity below for should be considered the highest priority for outreach. • Those with a behavioral health condition should be considered for guided outreach.
Ages 16-64 with behavioral health condition only: • This can help with guided outreach.
Priority 3
Ages 16-64 with no chronic conditions, behavioral conditions or other high-risk social/cultural concerns.

Supply issues and mitigation

During pandemics or worldwide incidents, it is important to consider what members might need, including issues and mitigation strategies. Items to consider that were evident during COVID-19 were:

- Technology: Smart phones for members to engage in telehealth were greatly limited.
    - Mitigation: Created HRSF bulk purchasing policy and purchased phones in small batches by hand by going store to store.
- PPE: Not only is PPE a factor for medical personnel, but members also lacked available materials for protection.
    - Mitigation:
        - Supply mask protocol and usage from CDC.
- DME: Many members needed urgent DME or DME-like equipment, including blood pressure cuffs and scales.
    - Mitigation:
        - Leveraged our other source of funding with OCF to purchase these items for members, because it was a quicker process.
        - Created a bulk purchasing process with DME providers for blood pressure cuffs, so providers could send to members with hypertension.
- Food: Food insecurity was exacerbated by the pandemic.
    - Mitigation:
        - Mom's Meals contract expanded for meal delivery.
        - Tighter partnership with the Oregon Food Bank and other food resources.
        - Expanded NEMT benefit to provide transportation to food resources.
- Household items: Members identified a need for regular household items, especially items for children (including diapers).
    - Mitigation:
        - Used OCF funds to purchase these items.
- Information: Members needed accurate information, which should be prepared in advance. Items to include:
    - Vaccine information
    - Vaccination hesitancy
    - Resources: Food, transportation, housing
    - Health education information: Leverage Health Wise Partnership
    - COVID-19-specific information: Current spread, risk profile, ways to protect, testing
    - Pharmacy information
    - How to connect to the provider and what was allowed

Partnership considerations

There are numerous partnerships to consider when performing this outreach, each of which might contribute different functions toward the overall outcome. Some partnerships to consider are:

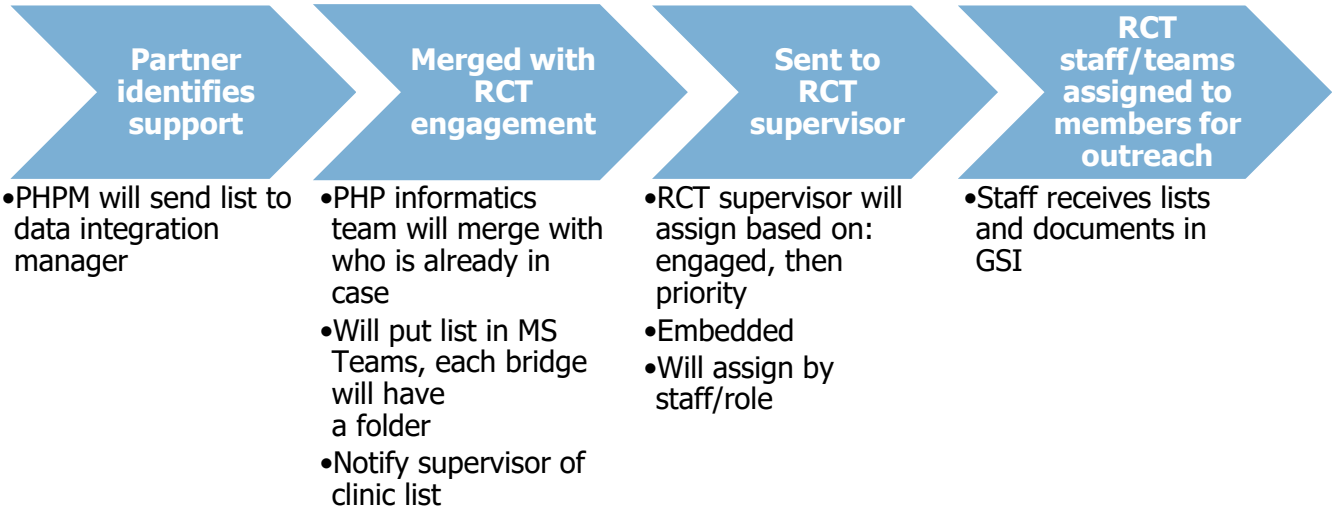
- Community-based organizations: Members might not be engaged at the health plan nor the primary care clinic, but they might be engaged in a community-based organization. Many CBOs are culturally specific and can be excellent partners for connecting across health disparities
- Clinic partners: During the initial stages of the pandemic, clinic staff were available to make outbound calls given the lack of traffic in the clinic. This partnership was very beneficial for member outreach. RCT took over for clinics that were not able to provide outreach.
- Health systems: Hospitals and larger health systems have access to vaccinations and efforts should be coordinated with these entities.
- Pharmacies: Retail pharmacies are likely to play a role in vaccination dissemination. This should be explored and used as a resource.
- Specialty mental health: Although it meant new work for them, many local mental health clinics were willing to reach out to members.
- Public health: Direct linkage with public health is ideal when addressing issues such as COVID-19. A tight partnership between their work (setting up emergency shelters, hotels, etc.) and the care coordination staff is an important area of consideration. Also, we should partner with public health on any funding they provide to CBOs, so we can coordinate more effectively with CBOs on engagement to various populations.

In addition to external partners, this work was highly successful in considering internal teams as part of the expanded RCT.

- HEDIS nurses were highly valuable in this work. They are highly skilled clinicians, excellent at triage and happy to engage with members directly.
- Panel coordinators are ideal partners, as they are familiar with clinic systems and routinely engage members in their care.
- Pharmacy provided outreach and consultation.
- Connect to Care made outreach attempts with the low acuity population.

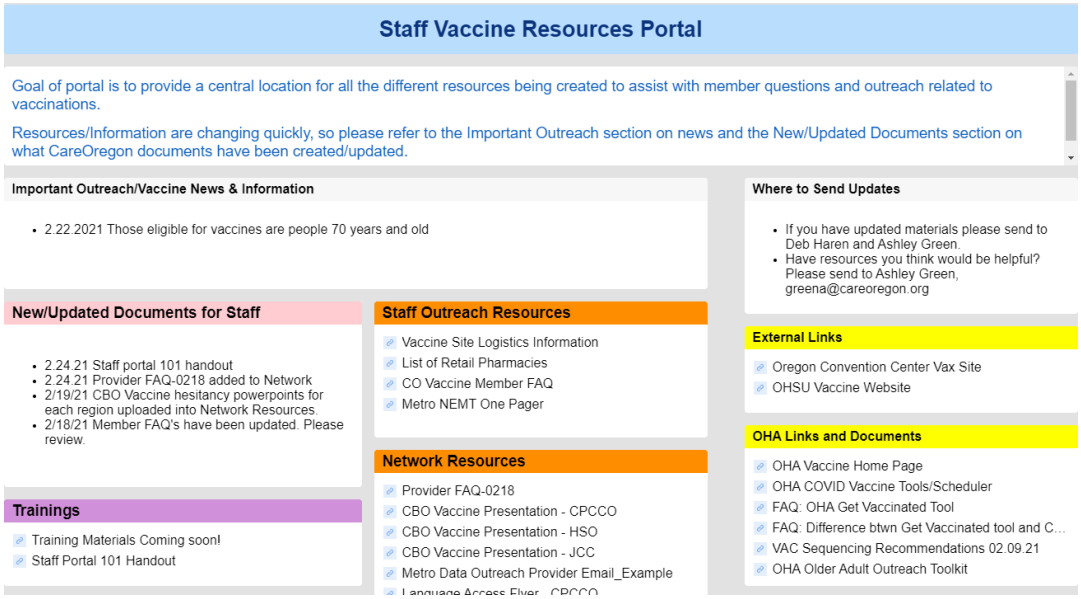
Workflow

The workflow was created by the regions. All regions should use the same template for assessment and gather the same information. However, how they make calls can vary. The metro area, in particular, should be considered unique due to its size and complexity. Below is an example of the process for the metro area**:**



Training

Training staff is a vital part of this process. Although time can be a factor, staff need comprehensive training in order to produce the best results. Using technology to assist in this process is important. Consider building a centralized portal for information and training documents that can be updated as needed (screen shot below).



Elements to include in the portal:

- New/Updated Documents for Staff
- Trainings
- Job Aids and Workflows
- Staff Outreach Resources
- Network Resources
- External Links
- OHA links and Documents

Consider using a slide deck to train on workflow and record the training with the MS Teams recording feature. A short video example demonstrating a member call could be beneficial and can be reviewed later, if needed. Training features should include:

- How to use the high-risk member list.
- How to identify user information outside of the care coordination platform, such as using Collective to find more current contact information.
- Demonstration and guidance on how to use the care coordination platform (see Appendix D for job aid).

- How to engage members in a conversational assessment that allows members to feel connected rather than just answering survey questions.

- How to access resources, specifically those related to social risk.
- Training on the vaccine, how to address vaccine hesitancy, and use MI to support members.
- Escalation pathway for barriers and issues.

Appendix A

Provider toolkit

Physical health email example:

Dear clinic partner,

We hope you are doing well with the many changes and challenges in these unprecedented times!

In an effort to support you in taking care of your vulnerable patient population, CareOregon has put together a list of patients who are at a higher risk for severe illness from COVID-19. We would like to support you in any way we can to proactively reach out to those at greatest risk, ensure they know how to reduce the likelihood of infection with COVID-19, and make sure have all they need to manage their health while physically distancing — many also will need extra support for the social isolation that can come with distance.

At the bottom of this email is more detailed information about the criteria and data included in the attached member list. We recognize you may already be doing outreach and we hope this list can supplement your current efforts.

We understand that your capacity may be limited, and CareOregon wants to be able to support you through this process. Please reply to this email by (INSERT DATE) with what capacity your clinic has to do outreach:

Option 1: We have capacity to reach out to the entire list (engaged and unengaged members).

Option 2: We have capacity to reach out to engaged members only and need assistance reaching out to unengaged members (unengaged is defined as not having a PCP visit within the last 24 months).

Option 3: We have the capacity to reach out to some of the priority populations but may not be able to get through all priority levels with current staffing. (Please be specific. See the attached list for relative numbers by level.)

Option 4: We do not have the capacity to do any outreach and need assistance.

High-risk criteria is defined by the criteria below, and the data set is from claims and the Johns Hopkins ACG risk tool:

- Individuals who are older than 59, or
- Have three or more chronic conditions, or
- Have any of these pre-existing medical conditions: CHF, IscHD, hypertension, HIV, had a transplant, chronic liver disease, asthma, COPD, diabetes, or
- Had dialysis or treatment for cancer in the last year, or

- Has a frailty marker (defined by ACG, in data dictionary in Excel).

Priority populations within the list:

Your high-risk list may have a lot of members in it, so we added additional prioritization flags that may assist you in further refining how and to whom you reach out.

Example: Physical health

Priority 1
All people who are 75 and older: • Those who have chronic conditions or high-risk race/ethnicity below for should be considered the highest priority for outreach. • Those with a behavioral health condition should be considered for guided outreach.
Priority 2
All people who are 65 and older • Those who have chronic conditions or high-risk race/ethnicity below for should be considered the highest priority for outreach. • Those with a behavioral health condition should be considered for guided outreach.
Ages 16-64 who are: (** will need specific culturally/community informed outreach plan) ** Those who have chronic conditions or high-risk race/ethnicity below for should be considered the highest priority for outreach. ** Those with a behavioral health condition should be considered for guided outreach. • American Indian/Alaska native population • Black population • Hispanic/Latino • Pacific Islander
Ages 16-64 with chronic condition: • Those who have chronic conditions or high-risk race/ethnicity below for should be considered the highest priority for outreach. • Those with a behavioral health condition should be considered for guided outreach.
Ages 16-64 with behavioral health condition only: • This can help with guided outreach.

Priority 3
Ages 16-64 with no chronic conditions, behavioral conditions or other high-risk social/cultural concerns.

Excel sheet elements:

- If there are multiple clinics, each site has its own tab as well as a master tab with all clinics on the same sheet.
- The highlighted members are the ones who are unengaged (have not seen PCP in the last 24 months).
- Priority Grouping tab: This lists each clinic and how many members are assigned to each priority area above.
- There are additional variables by which you can sort the list. Definitions are all listed in the data dictionary. Examples include sorting by language, address, how many ED visits they had in the last year, etc.
- Data dictionary: We use the Johns Hopkins ACG. Some definitions reference the ACG technical guide. If you would like a copy of the guide, please let us know and we will send it to you.

Concurrent CareOregon outreach plans:

- CareOregon pharmacy is currently reaching out to members who are unengaged and on high-risk medications. In the Excel document, this column/variable is called "Pharmacy Outreach Flag," in case you want to use it for your engaged population.
- CareOregon will also create a behavioral health-specific high-risk member list that specialty behavioral health will receive, which uses different criteria and may have some overlap. However, we see both entities reaching out as a good thing and will be encouraging coordination with primary care.

Suggested strategies and resources:

- Key people on the care team who could assist with outreach:
    - Medical assistants
    - RNs or LPNs
    - Clinical pharmacists
    - Community health workers
    - Panel coordinators
    - Health resiliency specialists
    - Behavioral health clinicians (BHC)
    - Care coordinators

- Call patients to check in, ask about needs, connect to services and note that they may receive calls from multiple service providers all wrapping around them to ensure their health and well-being.
- Attached is an outreach assessment script that our teams intend to use. Feel free to use it and make it your own, if you don't already have one. The goal is to elicit the patient's ability to get their needs met without unnecessarily going to places where they might risk exposure.
- Offer a telehealth visit with PCP/clinical pharmacist/BHC/RN.
- Mail a blood pressure cuff to patient for home monitoring.
- Help the patient get medications for 90 days and/or mailed to their home. Attached is a one-pager on pharmacy direct mail, delivery and curbside pick-up options.
- Assure that each caller is equipped with resources to anticipate the member's needs prior to the call. Examples of this include:
    - Mail-order pharmacy information
    - NEMT (life sustaining only)
    - Food insecurity
    - Telehealth information and scheduling assistance (primary care, medical specialist, mental health provider, substance use treatment, or urgent care)
    - ED utilization education (make sure the patient has the clinic's phone number and knows about after-hours availability)
    - Flex funds and how to request health-related services
        - All COVID-related needs will be reviewed through a rapid health-related services approval process.

You can contact CareOregon for additional support like care coordination assistance for behavioral health needs (mental health or substance use disorder treatment), DME support such as respiratory equipment or diabetes supplies, other health care benefit barriers, or any other issues you are unable to help the patient navigate. Please reach out to your regional care team for assistance:

Regional care team	Region/clinic system	Phone number
Steel	Washington County	503-416-3727
Abernethy	Clackamas County	503-416-3729
St. Johns	Multnomah County: West of I-205	503-416-3726
Tilikum	Multnomah County: East of I-205	503-416-1770
Sellwood	Maternal child health, pediatric clinic,	503-416-3768
General/Unassigned	No RCT assignment or unknown	503-416-3731

Refer to the CareOregon Provider COVID-19 webpage for resources and telehealth guides, which are updated weekly.

Our innovation specialists are also available to assist with developing workflows for outreach for various members of the care team if you want help making this list actionable. Contact Alicia Simshauser at simshausera@careoregon.org and Niki Bannister at bannistera@careoregon.org for assistance. We appreciate the work you are doing to help our members and our community during these unprecedented times. Please know that we are here to support you however we can.

Behavioral health email example:

Thank you for participating in reaching out to our members who are at high risk for behavioral health-related challenges. Below are the next steps and resources. If you have any concerns about this approach, please let us know. We are attaching a pre-recorded webinar highlighting our process for determining the high-risk criteria, development of tiers, and other helpful information. Below, we have also described the tiers and what information is included in the member list Excel sheets.

Link to the webinar highlighting our process for determining our high-risk list criteria and reviewing the member list Excel document with explanations: Click here.

Next steps:

1. Please review your high-risk list. If you have already been doing outreach, please compare lists to see which people you may still have the opportunity to reach out to.
    a. If, after reviewing the list, you determine you need additional outreach support, please follow up with Ashley Green. She will work with you to see what other supports can be offered.
        1. Due to 42 CFR Part 2, if you are providing SUD treatment we will not be able to provide outreach support. However, please let Ashley know if you are unable still to do outreach for tracking purposes.
    b. CareOregon may be able to connect you with medical students from OHSU to assist in making outreach calls if additional support at your own agency would be beneficial. Please contact Amy Shea Reyes if you would like to pursue that option.
2. Several resources for outreach are attached to this email:
    a. Outreach script/template: Attached is an example with questions and resources. This is meant as a resource; you do not have to use it. Feel free to adjust or change the script to fit your system and the resources you have to offer.
    b. Pharmacy Resource Guide: This is mentioned in the script. It lists the pharmacies that have direct mail, delivery, and curbside pick-up options.
    c. COVID-19 member resource navigation: Resources for you on who to contact at CareOregon regarding different topics (pharmacy, DME, NEMT, etc.) and links to where you can find information on our website.

High-risk member list/attachment:

- Attached is the list of members we have in our system who have an open authorization with your organization.
- There are at least two tabs on the Excel sheet.
    - Tab 1 is an overview of how many members are in each tier (four tiers total).
    - Tab 2 is the entire member list.

- There are also additional data points that you may find useful:
    - Priority 1 grouping: This is a variable we created to help focus on communities of color and/or English language learners. It is focused on these populations in tiers 1-3 only. This variable will allow you to further filter and focus on those communities we know are experiencing disparities.
    - PCP assigned: Lets you know who the member is assigned to in our system for primary care. Special note: For members enrolled in non-CareOregon physical health plans, we may not have the most updated information. Always check with the patient if you are connecting them to their primary care provider.
    - Medical list: These are members who were on the physical health high-risk list who would be at risk of having complications if exposed to COVID-19. They may have received outreach from primary care and/or CareOregon. Even so, we still see outreach from behavioral health
      as important.

Again, thank you for partnering in supporting our members. Please do not hesitate to reach out if you have any questions or need further support.

Member resource navigation

COVID-19 member resource navigation

Created April 2, 2020

Pharmacy

- Members can get a 90-day supply of medications and fill prescriptions early, if needed. Please consider how much supply is truly necessary to ensure medication shortages are kept to a minimum.
- Prior authorizations have been temporarily removed for formulary medications.
- The following chain pharmacies will mail prescriptions at no cost to the patient: Albertsons (Sav-On), Fred Meyer, Rite Aid, Safeway and Walmart.
- Members have access to mail-order pharmacy benefits through OptumRx and OHSU.
- To sign up, visit careoregon.org/providers/covid-19

DME/supplies

- For questions regarding DME, please see careoregon.org/providers/support/policies-and-forms

Non-emergent medical transportation (NEMT)

- NEMT brokers are still operating and providing rides for essential life-sustaining medical services. To arrange transportation for a patient, please contact Ride to Care:
    - 503-416-3955
    - Toll-free: 855-321-4899
    - TTY 711

Telehealth visits

- Telehealth guidance is available on the provider COVID-19 website: careoregon.org/providers/covid-19
- CareOregon wants to make sure that interpretation needs continue being met.
- Clinics can schedule a telephonic interpreter through Linguava, Passport to Languages or by calling CareOregon Provider Customer Service at 503-416-4100, option 3.

Care coordination and essential needs

- The regional care team can provide support with the following:
    - Connecting your patient to food, transportation, telehealth visit technology resources and other essential needs.
    - Support with hospital discharges and transitions of care for COVID-related concerns.
- Contact your specific regional care team: Metro RCT phone numbers
- Email: ccreferral@careoregon.org
- Community resources:
    - 211
    - OHSU social resource list (Google document updated daily by OHSU)

Substance use/relapse prevention

- Patients may be at high risk for return to substance use or overdose at this time. Please consider providing naloxone if appropriate.
- Online recovery meetings are available for patients. See unityrecovery.org/telerecovery-guide and oregonrecovers.org/resources/ for resources.

CareOregon is updating our provider webpages with network-wide updates, information and reference material. Webpages will be updated at least weekly, and more often as circumstances require. careoregon.org/providers/covid-19

Pharmacy resources

Pharmacy direct mail, delivery and curbside pick-up options

Updated April 2, 2020

Note: Information is gathered as of the date above and is subject to change.
Note: For mailed prescriptions please allow seven to ten days for delivery. Confirm that the member has

at least a ten-day supply of medication on hand. If not, please pursue an alternative (i.e., curbside pick-up or delivery).

Major chain pharmacies across Oregon

Albertson's (Sav-On)

All have the ability to mail medications. Please call the specific store to make sure their location can mail. There is no cost to the member. Curbside pick-up may be available upon request.

Safeway

All have the ability to mail medications. Please call the specific store to make sure their location can do mail. There is no cost to the member. Curbside pick-up may be available upon request.

Costco

No mail order, delivery or curbside pick-up available.

Fred Meyer

They will mail out medications to members upon request at no charge to the member. Please confirm with their specific pharmacy location. Curbside pick-up may be available upon request in stores without walk-up windows.

Rite-Aid

All have the ability to mail medications. Please confirm with the specific store to make sure their location can mail. There is no cost to the member. Curbside pick-up may be available upon request at stores without drive-through options.

Walmart

They will mail out medications to members. Please confirm with the specific pharmacy location. There is no cost to the member. Curbside pick-up may be available upon request.

Appendix B

Member outreach letter sample (English)

<<First and Last Name>>

<<Address 1>>

<<Address 2>>

<<City, State, Zip Code>>

<<Month, day, year>>

Primary care provider: [Name]

Primary care provider phone number: [XXX-XXX-XXXX]

Regional Care Team: [Name]

Regional Care Team phone number: [XXX-XXX-XXXX]

Dear <<Member first and last names>>,

We will be calling you to check in and see how things are going. We want to make sure you have what you need during this time. We have a care team here to support you and connect you to resources. Please read this letter and expect our call. If for some reason we cannot reach you please feel free to call us if you need any support.

CareOregon knows you may have many questions about COVID-19 (also known as coronavirus). We want to help you learn how to prepare and access your benefits. Health care providers are working hard to keep seeing patients, and your health is important to them. Here are some things to know:

- If you have symptoms of COVID-19, call your primary care provider (PCP). Symptoms include fever, cough and shortness of breath. Your PCP can give you next steps, including how to get tested.
- Who can get tested? Right now, providers are working with public health leaders to see whether or not people need to be tested. This depends on the situation and the symptoms present.
- When possible, stay at home and practice social distancing. This is the most effective way to help prevent the spread of COVID-19.
- About current appointments:
    - Your providers may cancel or postpone non-urgent appointments. They may also arrange a phone or video appointment. To protect you and to protect health care workers, the Oregon

Health Authority (OHA) and the Governor's office are asking people not to go to providers' offices, urgent care clinics or the hospital.
    - You may be able to set up a phone or online video call with your provider. Many PCPs and mental health providers are using these methods to meet with patients. Mental health appointments and many physical health needs can be met this way. Call your provider to learn more.
    - If you need help getting equipment for phone or video visits with your providers, such as internet or data for your cell phone, we may be able to help. Contact your Regional Care Team to learn more.
    - For mental health and substance use treatment services, please contact your provider about how to get your needed support. Many providers are now holding appointments by phone or video. If you don't have a mental health or substance use provider and would like to, contact us and we'll help you get started. There are also support and crisis lines you can call:
        - Clackamas County: 503-655-8585
        - Multnomah County: 503-988-4888
        - Washington County: 503-291-9111
    - Most elective procedures are being postponed. However, permission for these is being extended until Jan. 1, 2021.
    - You still have access to our network. None of your benefits have changed. We are still here to ensure that your physical, dental and mental health care needs are met.
- Pharmacy updates:
    - Extra medicine: If you need extra medicine, you can get it. You can extend your prescription to 90 days' worth of medicine or fill your prescription early. Call your pharmacy if you need to refill early or fill for 90 days at a time.
    - Mail order: You can have your medicine sent to you by a mail-order pharmacy. Call Customer Service to learn more. You can also call your local pharmacy, as they may offer home delivery service. Note: Please make sure your pharmacy is in our network before using this service.
    - Extensions: If you have an approved pre-authorization that expires before the end of the year, the expiration date will be extended by six months. You don't need to do anything — it is automatic if you qualify.
- Medical equipment needs:
    - If you use supplies like syringes, lancets or test strips, or other items like oxygen or a CPAP, do you have enough? We can help you get the supplies you need so you don't have to leave your home.
- Interpreter access:
    - If you speak a language other than English, we can help you get access to an interpreter. Call Customer Service at 800-224-4840 to connect to an interpreter for phone or video visits.
- Rides:
    - You can still get rides for vital needs, like dialysis, infusions and more. Due to COVID-19, access to rides may be limited. Call Ride to Care at 855-321-4899 to learn more.
- Food and other items:

- If you need help with food or other basics, call your Regional Care Team. Our care team will work with you to see how we can help.

Thank you,

[RCT phone number and sign off]

OHP-HSO-20-437

Appendix C

GSI assessment

Member name:		Member DMAP #:	
Date:		Screener name:	

Pharmacy and medication access

1. Are you currently taking any medications?	
2. Are you out of any medications? If NO, (a) how many days of medication do you have left?	
3. Do you need any assistance getting refills? a. Would you like to get your medications delivered to where you live? i. Offer to call the member's pharmacy to request a mailing, delivery or curbside pick-up of needed medications. ii. Please see list of pharmacies offering mail, delivery or curbside pick-up. **If the member's pharmacy does not offer these services,*	
Updated pharmacy benefits: • 90-day supply availability for most medications, if needed. ○ This excludes psychiatric/mental health medications, which are limited to a 34-day supply. • Access to mail-order pharmacy through OPTUMRx or OHSU. • Early refill options for most medications.	Provider Customer Service will route calls to pharmacy. 503-416-4100, option 3 *List of pharmacies offering mail, delivery or curbside pick-up attached

DME/supplies

4. Do you currently use any medical supplies – like syringes, lancets or test strips? Or do you have other equipment like nebulizers or a CPAP machine?	
5. Do you have enough supplies? If NO, (a) how many days of supplies do you have left?	
6. How do you plan to get more when you run out? a. Do you know the name of the company you get your supplies from? b. Do you need any help getting more supplies?	
Additional information on DME and supplies: Depending on the company where they get their supplies, they may be able to get them supplies a little earlier.	**For questions or help with DME or supply related concerns, contact:** Provider Customer Service

Social health

7. Are there any essential items or food that you are running low on?	
8. Do you have any housing concerns?	
9. Do you have any other needs in your family we could help with? **Childcare, internet access, data for cell phones, etc*	
Additional information on food and other essential needs: All COVID-related needs will be reviewed through a rapid health-related services approval process. The HRS form is located HERE.	**For questions regarding food and other essential needs, contact:** Contact your Regional Care Team Metro RCT phone numbers ccreferral@careoregon.org

Transportation needs

10. Do you have any transportation concerns? **Issues with getting to required lab draws, infusions, dialysis appointments, etc*	
Additional information on NEMT services: NEMT brokers are limiting rides to essential life- sustaining services during this time.	For questions on NEMT, contact: Ride to Care 503-416-3955 Toll-free: 855-321-4899 or TTY 711

Brief crisis assessment (if appropriate)

11. How are you feeling? Are you feeling lonely, anxious, upset or fearful? a. Other concerns?	
Additional behavioral health resources: If a member is in crisis, please connect them to the appropriate crisis team: • Multnomah County ○ 503-988-4888 ○ TTY: 711 ○ Multnomah County Crisis Services • Clackamas County ○ 503-655-8585 ○ Clackamas County Crisis Services • Washington County ○ 503-291-9111 ○ TTY: 711 ○ Washington County Crisis Services • Online recovery meetings are available for patients. See unityrecovery.org/telerecovery- guide and oregonrecovers.org/resources/ for resources.	**For additional behavioral health support, contact:** *Please do not transfer members in crisis to the RCT. Connect them to the appropriate crisis team. See information in the left column. Contact your Regional Care Team Metro RCT phone numbers ccreferral@careoregon.org

12. Many providers are doing phone and video visits to keep you safe at home and still get the care you need a. Do you know how to contact your primary care doctor? b. If you see a specialist, do you know how to reach them? **Providers are still offering in-person visits on a case- by-case basis. Members should call their provider to receive*	
13. Do you have the technology to do a phone or video visit, such as a cell phone or computer with audio or webcam?	
Health-related services update: All COVID-related needs will be reviewed through a rapid health-related services approval process. The HRS form is located HERE.	**For additional support related to health-related services, contact:** Contact your Regional Care Team Metro RCT phone numbers ccreferral@careoregon.org

Telehealth visit capabilities

COVID-19 education

Before you go, I want to make sure you are aware of the things you can do to reduce the risk of getting COVID-19 or the coronavirus and to reduce the risk to others:

- Most people who get COVID-19 have mild symptoms, which can include a cough and fever that lasts for a few days.
- We know people over 60 years of age — or those who have certain chronic conditions, like lung or heart problem or diabetes, or those who take certain drugs that suppress your immune system — are at increased risking of having more serious symptoms.

It's important to know how the virus spreads so you can take steps to protect yourself and others:

- The virus spreads from person to person, which can happen when people are in close contact with one another.
- The virus can also spread through respiratory droplets produced when an infected person coughs or sneezes.

Here are things you can do to protect yourself and others:

- Use the inside of your elbow to cover your cough or sneeze and wash your hands afterwards.
- Avoid crowds and stay home as much as possible.
- Avoid contact with people who are sick.
- Keep some distance (at least six feet) between yourself and others.
- Clean your hands often.
    - You can do this by washing your hands with soap and water for at least 20 seconds, especially after being in a public place or after coughing, sneezing or blowing your nose.
    - If you use hand sanitizer, it needs to contain at least 60% alcohol. Be sure to cover all surfaces of your hands and rub them together until they feel dry.
- Avoid touching your face, including your eyes, nose and mouth.

If you are feeling sick, you should stay home as much as possible and avoid close contact with others. If you think you need medical care, it is a good idea to call your doctor first, as long as you are not having severe symptoms, like trouble breathing.

- Your doctor may be able to do a virtual health visit either by phone or video (if available) so you don't have to go to the clinic to get health care.

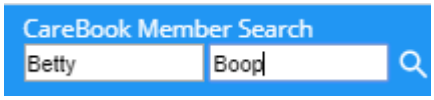
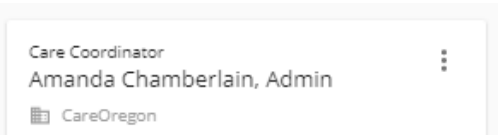
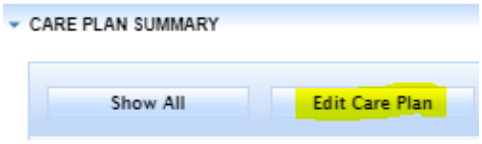
Appendix D

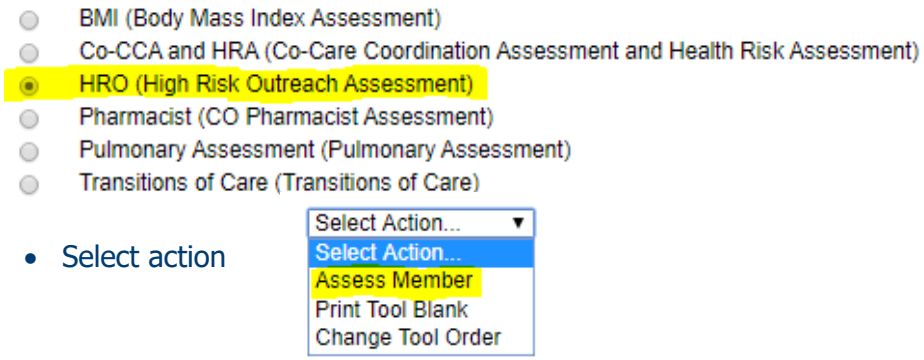
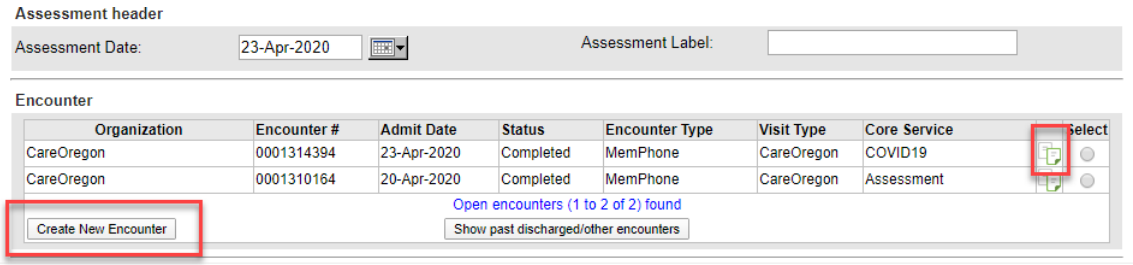
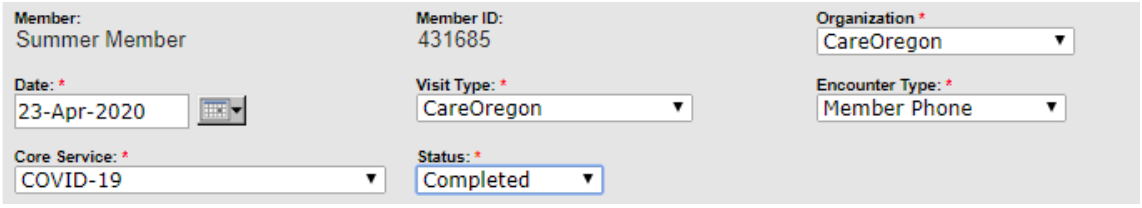
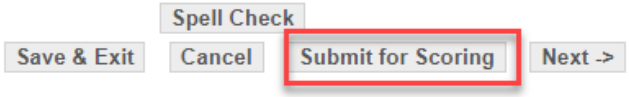
Population Health partnerships COVID-19 outreach job aid

Purpose: Documenting COVID- 19 outreach

Who (by title or role, not person): All Care Oregon staff

When: Doing outreach to identified members at high risk of contracting COVID 19

Steps	Action
1.	Search member in GSI: Using the CareBook Member Search 
2.	Enrollment information: • Click Add/Edit Programs • Go to Care Team tab • Does the member have a care team, anyone that is not a Provider? (Yes or No)  ○ If Yes – Call identified staff for handoff (no need to reach out or document) ○ If No – Open Care Plan
3.	Open Care Plan: • Click Edit Care Plan 
4.	Creating an Assessment • Click Assessments • Select: New 

Steps	Action
	• Select: High Risk Outreach Assessment  • Select action
5.	Copy an existing encounter by clicking the paper next to the encounter and Update or Create New Encounter if one does not exist.  Click Create New Encounter  • Save • Click Continue
6.	Finish the assessment and click Submit for Scoring to complete the assessment. 

(Quick guides and other referral documents are saved to the GSI/RCT job aids on the regional care

team site under topic "COVID-19 Outreach Documents": oneco.careoregon.org/sites/php/gsi/jobaids/Forms/AllItems.aspx. A printable version of the member assessment is located here.

Appendix E

Equity Tool Kit

Columbia Pacific CCO™
Part of the CareOregon Family

COVID19 Vaccine Equity Toolkit

Strategic approaches to support equitable vaccine distribution

Overview

The COVID19 pandemic has shone a light on the deeply ingrained disparities, inequities, and systemic and institutionalized racism within our healthcare system. We know that Black, Indigenous, and People of Color (BIPOC) have been disproportionately impacted by the pandemic in a myriad of ways, from higher infection and mortality rates to economically. As such, we have an opportunity, and responsibility, to center those most impacted in our COVID19 vaccine response.

On January 28, 2021 the Oregon Vaccine Advisory Committee (VAC) released its vaccine sequencing recommendations in an effort to "center equity in all vaccine sequencing discussions and help OHA reach its strategic goal to eliminate health inequities by 2030" (VAC, 2021). The VAC recommended vaccine distribution efforts "include working with trusted community partners including community-based organizations, faith leaders and trusted entities where people feel comfortable" (VAC, 2021).

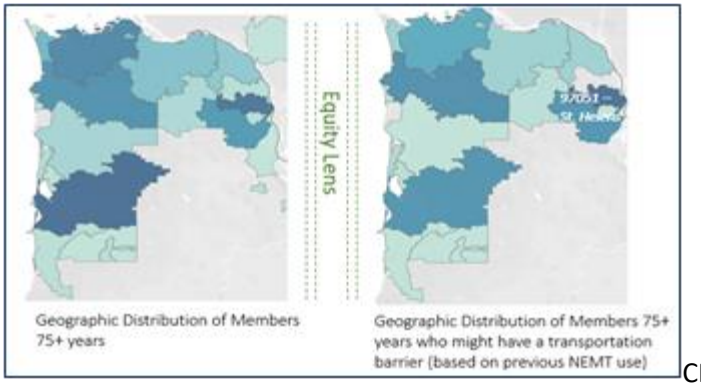
This Toolkit was put together with the aim of providing resources to support equitable vaccine distribution and decision-making with the hope of furthering the VAC recommendations. The rest of this toolkit includes strategies to consider, a list of adversely impacted subpopulations, and information on additional supports that the Columbia Pacific CCO can provide.

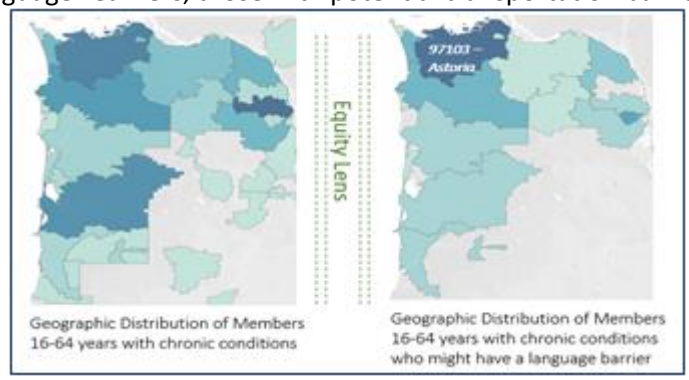
The Oregon COVID-19 Vaccine Advisory Committee (VAC) Recommendation Statement can be found HERE.

Strategies to Support Equitable Vaccine Distribution

Strategy #1. Use Data to understand where subpopulations that are adversely impacted by COVID19 are located to help inform where vaccine events might be held and strategic partnerships with CBOs would be a value add

Key Things to Consider

- 

CPCCO has a COVID Vaccine Data Dashboard that can be used in various ways, such as:
    1. Generating targeted lists of CPCCO members for outreach and vaccine appointment scheduling based on various indicators (ex. OHA eligible groups, BIPOC populations, English Language Learners, those with potential transportation barriers, etc.)
    2. 

Data to support ongoing vaccine distribution tracking and process improvement review to identify opportunities for addressing vaccination gaps among subpopulations
    3. Data exploration to identify targeted opportunities for outreach and/or vaccine events or approaches, see visual for examples.

To get more information on data-related opportunities, contact: Keshia Bigler, biglerk@careoregon.org

Strategy #2. Use the CPCCO Equity Lens Tool to guide decision making and ensure vaccination efforts are equity informed.

Columbia Pacific CCO Equity Lens

S – **Stop**, name the decision, policy or project at hand, make time to reflect.

T – **Think**, ask questions, seek different perspectives, embrace complexity.

O – **Observe** thoughts, feelings, assumptions, dominant culture tendencies.

(i.e. urgency, either/or thinking, perfectionism, worship of the written word, etc.)

P – **Proceed**, communicate with consistency and transparency.

Before making any decisions, advancing work, or resolving issues, did we STOP and consider the following?

1. What inequities and disparities exist among which groups? Which inequities does the work aim to eliminate?

2. How does the work engage other sectors for solutions? What institutional and structural barriers exist?

3. Who is most impacted by the work? How were those communities meaningfully engaged from the beginning?

Deepening Analysis and Accountability

Use the questions below to guide further examination for moving decisions, work, or resolutions toward justice, equity, diversity and inclusion (JEDI).

4. How does the work:
    a. Contribute to racial justice?
    b. Identify and redress past injustices and inequities?
    c. Differ from the current status or status quo?
    d. Support individuals in reaching their full potential.
    e. Support equitable distribution of resources and power?

5. Which sources of inequity does the work address? (race/racism, ethnicity, language, economic status, social class, religion, age, disability, gender, gender identity, sexual orientation or other socially determined circumstance).

6. How will the impact on equity be weighed and monitored? How will accountability be kept as it is meaningful to impacted communities?

Adapted from Public Health Advisory Board (PHAB) Health equity review policy and procedure, September 2020; Mindfulness Northwest, The STOP Practice handout, content by Elisha Goldstein, Ph.D.; White Supremacy Culture, Tema Okun (2001)

Strategy #3. Explore targeted Partnerships with Community-Based Organizations (CBOs) and/or community leaders to host/sponsor vaccination events for targeted subpopulations

What could this look like?

- Holding a vaccine event at local Catholic church to support Hispanic/Latinx populations
- Working with local farms on Sauvie Island to support Hispanic/Latinx populations

Key Things to Consider

- Identifying sites and community leaders for hosting vaccine events (i.e. workplace, Consejo Hispano)
- Organizing transportation for event
- Coordinate interpretation services for event
- Develop process for scheduling people for event
- Communications and materials specific to targeted population

Vaccine Hesitancy & Confidence

We know that there are several factors that contribute to vaccine hesitancy and low uptake, such as concerns around safety, perceived individual threat of the COVID-19 virus, religious and/or moral concerns, fear or anxiety, distrust and skepticism, and "hassle factors" like vaccine clinic locations, wait times, paperwork, and the impact of social determinants of health.

We also recognize some of these concerns are driven by a history of institutional and systemic racism within the health care system against BIPOC Communities. BIPOC subpopulations have been used as subjects of unethical experiments (i.e., Tuskegee syphilis experiment; involuntary sterilization of American Indian women; Puerto Rican women given experimental birth control pills without being told they were part of a clinical trial) and continue to receive unequitable treatment in present day. The realities of this have been evidenced by the disproportionate impact COVID-19 has had on non-dominant, marginalized, and BIPOC communities.

Community Based Organizations, culturally and linguistically specific organizations or groups, and churches are key partners in vaccination efforts as they have established trusted relationships with various communities of people. Including representatives from these organizations and key community leaders in vaccine planning groups and conversations is essential if we are to ensure equitable vaccine distribution. Robust community engagement is key to improving vaccine confidence and uptake across all communities and subpopulations.

Resources to Support CBOs, Culturally and Linguistically Specific Organizations, and Other Community Leaders

- Training Video: COVID-19 Vaccine Confidence Training - https://vimeo.com/518754976/d0dcadaab8
  - 40-minute video with information on vaccine safety and how to address vaccine hesitancy
- Multnomah County COVID Vaccine Informational Handouts – available HERE
  - Available in a variety of languages
- OHA COVID-19 Vaccine: Social Media Cards – available HERE
  - We know many communities use different social apps to share and obtain information, like Facebook or WhatsApp

- Kaiser Family Foundation (KFF) Article on Growing Gaps in COVID-19 Vaccinations among Hispanic People – Published Feb 22, 2021 - available HERE
    - Highlights important considerations when planning vaccine events for the Hispanic and Latinx community

Strategy #4. Develop and implement a robust transportation assistance plan for vaccine events

Key Things to Consider

- Partner with local transportation brokerage to develop workflows to provide transportation assistance for CCO and non-CCO members
- Explore potential partnership with CC Rider in alignment with vaccine events
- Explore partnership with school district to use buses to support socially distanced transportation in alignment with vaccine events

For Questions related to NW Rides Transportation Assistance, Contact Cathy Bond:

Strategy #5. Ensure interpretation services are available at vaccine events and all materials are translated into key languages

Language Access Tips for COVID-19 Vaccine Events

One in five people in the United States speak a language other than English at home, and 41% of these individuals, or 25.1 million people, are considered limited English proficient (LEP). As we grapple with how to accommodate the needs of LEP patients, as well as patients who are deaf or hard of hearing, it's important to consider prioritizing patient language access in COVID-19 vaccination planning as it is so important and how we do this work equitability.

Numerous federal laws require meaningful language access for federally funded healthcare providers (Civil Rights Act, ACA 1157, etc.). Not doing so is discriminatory and illegal.

- **Spreading the Word**
    - Provide high quality, accurate and timely translations of vaccine site related information into commonly used languages in the community, based on community demographics. Share this information for with culturally specific organizations, allow for input.
    - Plan for the increased need for accessible and multilingual messaging and communications through available ethnic media outlets, wireless emergency communications, and use of virtual townhalls for coordinated communications. Consider connecting with connecting with people/messengers who live, work, and worship in the same community (if possible).
    - Include information on how to obtain translated documents on all communications. Including something easy to find in common languages that states where to find information in that language.
    - Consider a more targeted outreach – including door knocking, visits to front-line workers at their place of employment, streamlined registration sites– are needed to overcome misinformation and educate communities. Partnering with Community Based Organizations that could assist once equipped with information and scheduling tools from healthcare organizations.
- **During Vaccination Event:**
    - Provide qualified interpreters at vaccination sites or by telephone for commonly used languages. All vaccine staff should know how to get an interpreter when needed. Consider booking interpreters to be present at event to support, CCOs can pay for this service.

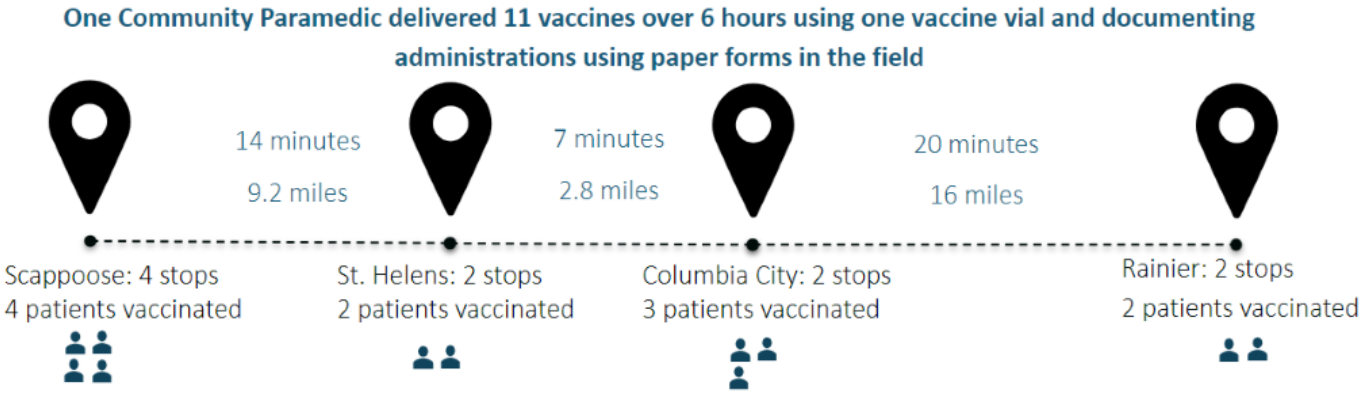
- Use of a family member, friend, or minor is strongly discouraged due to potential issues regarding competency, confidentiality, or conflict of interest. You as a provider are liable for misinformation or adverse events that happen due to language.
- If you have staff that are providing services in language, please ensure they have been tested for competency. Federal law requires qualified staff.
- Ensure signage is translated. Include signage that notes the available for free interpretation.

For questions or more information related to interpretation services, contact
Maranda Varsik, varsikm@careoregon.org

Strategy #6. Organize and implement a mobile vaccine event to support targeted subpopulations who may experience challenges or barriers in traveling to an event

What could this look like?

The OHA EMS Office has issued an emergency scope of practice change that allows all levels of emergency medical services (EMS) providers to do vaccinations to increase the number of vaccine providers. Partnering with an existing Community Paramedicine or Mobile Integrated Health (MIH) program in your region to support mobile COVID-19 vaccine distribution to serve targeted populations and reduce barriers. Example of a real-world mobile vaccine effort:



Key Considerations

- Community Paramedic (or vaccine provider) and the person doing patient outreaching to schedule vaccine appointments have an established communication process
- Ensure the person calling patients and scheduling for home-delivered vaccines sets clear expectations up front
  - Ex. Level of PPE that will be used, scheduling appt window vs. specific time, who to contact with questions, overview of process and what to expect
- When scheduling, appts should be windows of time and not specific times
  - Ex. 1-3pm (appointment window) vs. 2:45pm (appointment time)
  - This allows for any extenuating variables that could impact delivery timeline
- Strategically plan the travel route around geographic clusters of scheduled patients (in groups of 11, if possible)
  - If there are larger cluster of patients in one city or municipality, you could feasibly vaccinate more patients (estimate max 20-22 vaccines distributed in one 6-hour window)
- Have a plan to document vaccine administration

    - Use paper forms to document in the field and document in ALERT afterwards to streamline processes
    - If the goal is to document in ALERT in the field, in real time, then there should be two person teams to support and maintain timeline
- Plan for each stop taking ~30 minutes, including 15-minute post-vaccine observation period
    - Some patients may require 30 minutes observation pending pre-screening and risk level
    - Pre-screening ahead of time as you are able may help to identify higher risk patients and allow for proactive planning and route development
- One vaccine vial has 11 doses in it, once the vial is opened all vaccines must be delivered within 6 hours (vaccine expires after 6 hours of being opened)

Mobile Vaccination – Helpful Resources:

- OHA COVID19 Vaccine Screening and Consent Form
- OHA COVID19 Vaccine Administration Form
- Vaccine Record Card
- All materials are available in multiple languages, linked here

To get more information or for questions on mobile vaccination opportunities, contact: Keshia Bigler, biglerk@careoregon.org

CPCCO Community Engagement Team Support

The CPCCO team can support existing vaccine planning groups to provide additional insight into opportunities to lead with equity and/or connect county planning groups with targeted Community-Based Organizations (CBOs), work sites, community leaders, and other organizations who serve specific subpopulations and have established strong, trusting relationships.

Contact: Nancy Knopf, Director Community Health Partnerships, knopfn@careoregon.org

References

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Williams SE. What are the factors that contribute to parental vaccine-hesitancy and what can we do about it? Hum Vaccin Immunother. 2014;10(9):2584-96. doi: 10.4161/hv.28596. Epub 2014 Nov 13. PMID: 25483505; PMCID: PMC4977453.