

STAY SAFE MN

Minnesota COVID-19 Vaccine Equity Partnership with MN Council of Health Plans & Minnesota Association of County Health Plans Summary Report

DATA FROM START OF PARTNERSHIP TO AUGUST 24, 2021

Executive Summary

Partnership purpose. To immunize for impact, the Minnesota Department of Health (MDH) and Department of Human Services (DHS), in close partnership with eight of Minnesota's managed care organizations, coordinated and shared resources to help and connect more Minnesotans from communities hardest hit by COVID-19 to lifesaving vaccines. The purpose of the partnership is for health plans to drive equitable outcomes among their members by prioritizing outreach efforts to those who live in high social vulnerability index (SVI) areas (e.g., SVI quartile 1) and those enrolled in Minnesota Health Care Programs. This innovative partnership started by providing information on members' vaccination status and SVI ZIP code area to assist plans in proactive outreach to members with reliable information on vaccination and help in accessing the COVID-19 vaccine.

Partnership approaches. A primary component of the partnership is sharing information and messaging across agencies. Sharing SVI information about health plan members allowed for the alignment of focused outreach and messaging to populations living within SVI quartile 1 ZIP codes throughout the state. SVI was selected as a vaccine equity metric in part to help prioritize Black, Indigenous and other communities of color (BIPOC) disproportionately impacted by COVID-19, facing vaccine disparities. Health plans' Medicaid members were also noted to be experiencing vaccination disparities and so were prioritized early. Health plans also collaborated with community organizations to help deliver consistent messaging through trusted messengers. They also set up internal processes that emphasized the "no wrong door" approach, where all members would hear the same message about vaccines and health plans would also help their family members get vaccinated, regardless of their family members' health plan.

Partnership results. Overall health plans reported a greater percentage of their outreach for their eligible members living in SVI quartile 1 ZIP codes for a variety of demographics: race/ethnicity, age, and geography. Over 640,000 outreach attempts were made to reach members living in SVI quartile 1, with mass phone calls and texting being the top method of outreach. Health plans were successful in decreasing vaccine access barriers for their members through scheduling transportation and interpreter services for members' vaccine appointments, promoting a variety of ways to receive the vaccine (such as mobile vaccination sites and drive-through clinics), and helping to dispel vaccine misinformation.

The partnership also fostered increased trust between health plans and a variety of sectors, such as community organizations as well as state and local public health. This trust grew through sharing information, vaccine messaging, and problem-solving mutual issues to collectively accomplish the goal of vaccinating Minnesotans. Over the first four months, the percentage of health plan members living in SVI quartile 1 with at least one vaccine dose increased by 55%, compared to a 30% increase of all Minnesotans living in SVI quartile 1 with at least one vaccine dose during a similar time period. While no direct link can be made to the impact of this partnership on vaccination rates, these results suggest that the partnership's outreach work was one of several contributing factors to improving the rate of at least one dose of COVID-19 vaccination among Minnesotans in high SVI ZIP code areas.

Partnership barriers. Health plan outreach to members in historically disadvantaged communities did present some barriers. About 20% of all contact information for members living in SVI quartile 1 was incorrect. When health plans were able to reach members, vaccine hesitancy and COVID-19 "fatigue" were commonly reported. Health plan staff themselves also reported COVID-19 and compassion fatigue, particularly during the most recent two months, when trying to encourage members to receive a vaccine due to the continual distrust and resistance they encountered. Systemic racism and politicization of COVID-19 also presented challenges in reaching out to members. Therefore finding a balance between providing timely and accurate information on COVID-19 and maintaining members trust became an additional challenge due to factors outside of the partnership's control.

Partnership next steps. Moving forward MDH, DHS, and health plans will continue to work together to provide information and facilitate access regarding COVID-19 vaccine boosters and vaccination for children less than 12 years old. There is interest in messaging around other COVID-19 resources like testing and treatments (e.g., monoclonal antibodies) as well as continuing this model of collaborative problem solving to address statewide health-related issues. Future areas that have been proposed include health equity, social determinants of health, mental and physical health, and climate change.

Background

From the start of Minnesota's COVID-19 vaccination effort Governor Tim Walz and Lt. Governor Peggy Flanagan repeatedly stressed the need to "immunize for impact." Immunizing for impact requires measurement of success not only by how fast and how many Minnesotans are vaccinated but also by how the state reaches communities at highest risk for COVID-19 and who have already been hardest hit by all aspects of the pandemic.

Minnesota's managed care organizations have often found innovative ways to support their members' and communities' health. As the Minnesota Department of Health (MDH) and Department of Human Services (DHS) looked to expand access and decrease barriers to COVID-19 vaccination, they proposed a partnership with managed care plans that currently serve Minnesotans on Medicaid. The goal was to leverage existing work with statewide coordination to help get more Minnesotans from disadvantaged communities connected to these lifesaving vaccines.

One approach MDH has taken to address equity in the state's COVID-19 vaccination campaign has been using place-based strategies to allocate vaccine doses that incorporate a metric of community need.¹⁻⁴ The Centers for Disease Control and Prevention's (CDC) social vulnerability index (SVI) uses 15 indicators grouped into four themes that comprise an overall SVI measure. High SVI communities generally have higher rates of poverty, crowded housing, racial/ethnic minorities, and lack of access to transportation when compared to low SVI communities.⁵ SVI has been used by MDH and local public health agencies before and during the COVID-19 pandemic to calculate a weighted allocation of funding for pandemic/disaster preparedness and COVID-19 response efforts. The SVI is also recommended by the National Academies of Sciences, Engineering, and Medicine for prioritizing places in equitable vaccine distribution.⁶

Additionally, counties with higher SVI scores have been shown to be at increased risk for COVID-19 outbreaks, particularly those with a higher percentage of racial and ethnic minority residents, high-density housing structures, and crowded housing units.⁷ Given the concerning rise of COVID-19 variants, focused allocation using this metric was proposed in order to: 1) help achieve more equitable distribution of COVID-19 vaccines; and 2) decrease the likelihood of future outbreaks among communities already hit the hardest.

Using the CDC's SVI, MDH ranked the ZIP code areas of the state and divide them into quartiles based on their SVI score. These quartiles are used to compare the vaccination rates of Minnesotans based on vulnerability and disproportionate impact of COVID-19, which in turn helps guide outreach and facilitation of identifying and addressing barriers for Minnesotans starting with those living in communities hardest hit by COVID-19. Using SVI ZIP code quartiles, MDH discovered that although Minnesotans living in high-SVI ZIP codes represent 29% of Minnesota's population, in May of 2021 they represented 32% of Minnesota's COVID-19 cases, 39% of hospitalizations and 38% of deaths.⁸ When looking at share of administered doses, Minnesotans living in high-SVI areas initially had the highest share (due to seniors living in congregate care settings and Tribal nations who were largely in or near high-SVI areas, vaccinating at high rates). However, by February that had notably shifted and by the start of this partnership (May 1, 2021) the percent of eligible Minnesotans living in high-SVI ZIP codes who had received at least 1 dose of the COVID-19 vaccine was 56% compared to 58.9% for the statewide average and 65% among Minnesotans in low-SVI ZIP codes.

SVI was also found to overlap to some degree with Medicaid enrollment. Forty-three percent of Minnesotans who were enrolled in Medicaid in May 2021 lived in a high-SVI ZIP code area. A study published in 2017 detailed how Minnesota Health Care Program (MHCP) enrollees have historically reported and experienced barriers to care and utilization.⁹ Given what we know about the communities DHS serves, the structural and societal barriers MHCP enrollees face in accessing care, and the disparities we have already seen in COVID-19 vaccine rates, it was critical that the contracted organizations DHS partners with be engaged and assisted in taking steps to not only mitigate further inequities in access but continue to build a more just and community-driven approach to health.

Minnesota COVID-19 vaccine equity partnership

Purpose and goals

We know that many factors play into someone's decision to get the COVID-19 vaccine. Even if someone wants the vaccine, they need to trust and be able to communicate with the organization administering the vaccine, have transportation to get to the vaccination clinic, and have the time away from work or family obligations.

Health plans play an important role in helping Minnesotans at increased disadvantage due to structural inequity navigate their decision to get vaccinated. They provide coverage for about 75% of Minnesotans on Medicaid and have the ability to use data, care coordination, and outreach in a way that supports community health. However, they largely rely on medical claims data to guide their efforts and this has several limitations in responding to a pandemic. Claims data generally lags by several months, which prohibits a more rapid assessment and response of member needs during a pandemic and particularly in regards to vaccination. Plans can have data sharing agreements with state and local public health agencies, but that has been inconsistent nationally among plans serving Medicaid enrollees.⁹

The goal/purpose of this partnership was for health plans to reach and support their members' health, prioritizing those who live in high SVI areas (e.g., SVI quartile 1) and those enrolled in Minnesota Health Care Programs, by proactively providing information on vaccination and assistance in accessing the COVID-19 vaccine.

To accomplish this, a bi-directional flow of information was set up between health plans and the State of Minnesota. This level of data exchange and collaboration between health plans, state health and Medicaid agencies is novel and aims to set a national example of what is possible with a shared purpose and goal.

How the partnership worked

Health plans joined the partnership during the months of April and May 2021. In partnership with MDH and DHS, health plans serving the Medicaid population received updated data on their members' immunization status every two weeks from the Minnesota Immunization Information Connection (MIIC), Minnesota's immunization information system. They also received a map and file of all of Minnesota's ZIP codes stratified by SVI quartile and weekly data on immunization rates across the state by ZIP code. Health plans used this information to identify and reach out to members who had yet to receive a COVID-19 vaccine. Members were prioritized initially on Medicaid enrollment then broadened to focus on which SVI quartile they lived in with members living in high SVI ZIP codes receiving the most initial outreach. After prioritizing by SVI quartiles and Medicaid enrollment, health plans could use their own sub-prioritization method to reach out to members and were encouraged to include communities that have experienced a high burden of COVID-19 disease and impact. Health plans used MDH/DHS approved messaging about vaccine safety and efficacy and frequently asked questions on all outreach. DHS created a rapid approval process by which plans could create specific messages for their members to encourage vaccination through a multitude of formats, including phone calls, text messaging, post cards, billboards, emails, and other forms of member outreach. During individual phone outreach attempts, health plan staff directly scheduled vaccination appointments, assessed the need for additional services like transportation or interpreters, and coordinated further care as needed. MDH/DHS provided support and materials to health plans and tracked information regarding the project, as well as met on a regular basis with health plans to discuss successes and challenges with the partnership.

For more information on the evaluation methods and analysis, see Appendix 1.

Participating health plans

The [Minnesota Council of Health Plans \(https://mnhealthplans.org/\)](https://mnhealthplans.org/) and the [Minnesota Association of County Health Plans \(http://www.machp.org/\)](http://www.machp.org/) worked collaboratively with their member health plans in developing and implementing special member vaccination outreach efforts aimed at helping those experiencing unique barriers and challenges get vaccinated against COVID-19. This unique collaboration brought together organizations serving Minnesotans from all areas of the state and those on public and commercial plans. Participating plans varied in size, scope, and types of products they manage. Each of the plans that serve Minnesota Health Care Program enrollees participated in the program.

There were eight participating health plans:

- [Blue Cross and Blue Shield of Minnesota \(https://www.bluecrossmn.com/\)](https://www.bluecrossmn.com/)
- [HealthPartners \(https://www.healthpartners.com/\)](https://www.healthpartners.com/)
- [Hennepin Health \(https://hennepinhealth.org/\)](https://hennepinhealth.org/)
- [Itasca Medical Care \(http://www.imcare.org/\)](http://www.imcare.org/)
- [Medica \(https://www.medica.com/\)](https://www.medica.com/)
- [PrimeWest Health \(http://www.primewest.org/\)](http://www.primewest.org/)
- [South Country Health Alliance \(https://mnscha.org/\)](https://mnscha.org/)
- [Ucare \(https://www.ucare.org/\)](https://www.ucare.org/)

Increasing vaccination rates

The state of Minnesota and health plans saw increases in the number of Minnesotans who received at least one dose of the COVID-19 vaccine during the partnership. From the start of the partnership through the end of August 2021, there was a 55% and 43% increase in percentage of members living in SVI quartile 1 ZIP codes and quartiles 2-4 ZIP codes, respectively, with at least one dose of vaccine. While no direct link can be made to the impact of this partnership on vaccination rates, these results suggest that the partnership’s outreach work was one of several contributing factors to improving the rate of at least one dose of COVID-19 vaccine among Minnesotans in high SVI ZIP code areas.

During a similar time period (between May and August 2021), overall in Minnesota, there was a 28.9% and 24.0% increase in percentage of people living in SVI quartile 1 ZIP codes and quartiles 2-4 ZIP codes, respectively, with at least one dose of vaccine.

During this time, MDH used SVI ZIP code quartiles to prioritize community vaccination and mobile vaccination events, set a vaccine equity administration goal for vaccinating partners focused on quartile 1 SVI ZIP codes and, in addition to county health departments and businesses, ran several vaccine incentive programs.

Figure 1. Percentage change of percent of eligible health plan members (ages 12 +) with at least 1 vaccine dose by SVI ZIP code quartile between the start of the partnership (April/May) to August 24, 2021

Since the start of the partnership to Aug 24, 2021, there was a **55.3%** increase in the overall percentage of members with at least 1 vaccine dose living in Q1.

Since the start of the partnership to Aug 24, 2021, there was a **43.3%** increase in the overall percentage of members with at least 1 dose living in Q2-4.

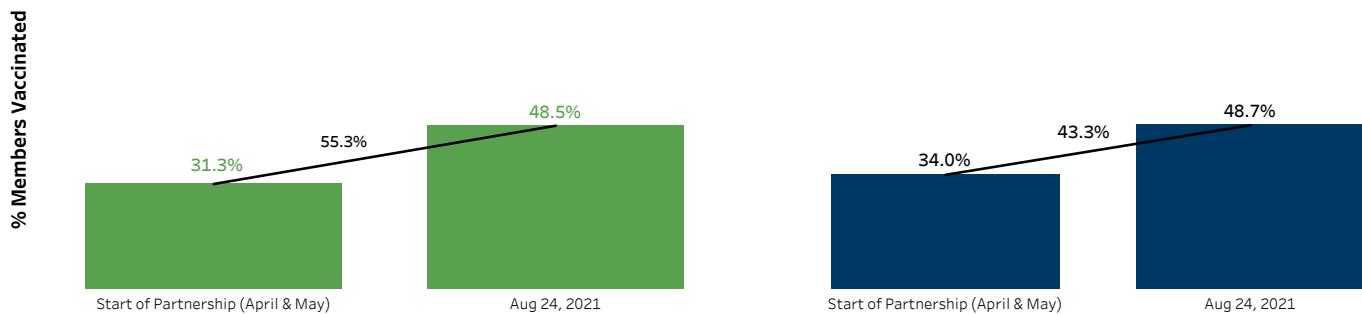
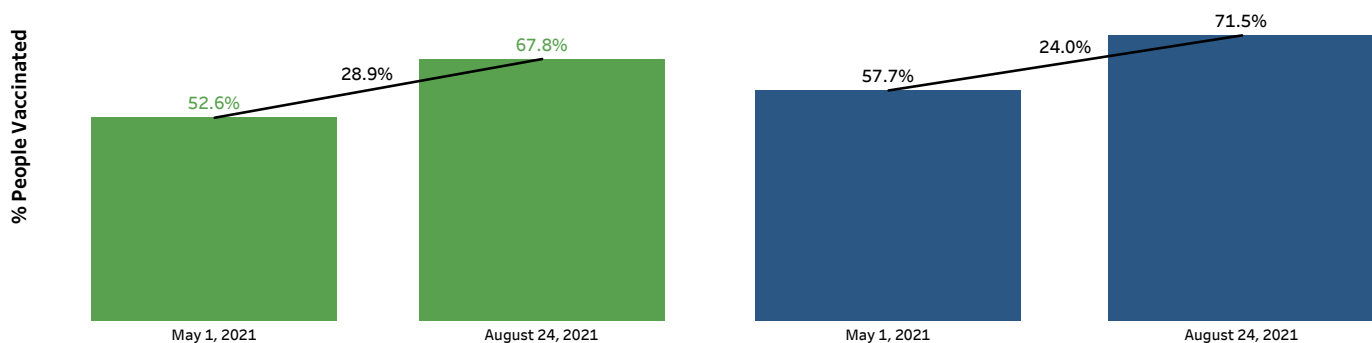


Figure 2. Percentage change of percent of all eligible Minnesotans (age 12+) with at least 1 vaccine dose by SVI ZIP code quartile between the start of the May 1, 2021, to August 24, 2021

Between May 1st and August 24th, 2021 there was a **28.9%** increase in the overall percentage of people with at least 1 vaccine dose living in Q1.

Between May 1st and August 24th, 2021 there was a **24.0%** increase in the overall percentage of first dose people with at least 1 dose living in Q2-Q4.



More information about the plans can be found in Appendix 2.

Messaging and reaching members

Sharing information to identify members and tracking progress

A major benefit of the partnership was that it facilitated the sharing of information between state agencies and health plans, so that health plans were able to identify unvaccinated members to contact. State agencies were able to provide vaccination status and SVI quartile to health plans so that health plans were able to match that information with their members. MDH also provided a list of local independent pharmacies as well as a list of community based organizations that they had or were currently contracting with to reach focus communities as COVID Community Coordinators (<https://www.health.state.mn.us/communities/equity/funding/ccc.html>) or COVID-19 Contractors for Diverse Media Messaging and Community Outreach (<https://www.health.state.mn.us/communities/equity/funding/covidcontracts.html>). This allowed health plans to make decisions on where to have vaccination clinics, target efforts, expand community connections, seek collaborations, and focus outreach to unvaccinated members in areas of high disadvantage and increased risk for severe COVID-19 disease.

Alignment on the SVI zip codes of greatest focus and on key messages with DHS, MDH and other health plans helped us by delivering a concerted outreach to these communities. – Health Plan

The data provided through this partnership has been an important contributor to the targeting of direct and mass outreach to members regarding the COVID-19 vaccine. – Health Plan

This provided confidence in the information we were providing especially as information was changing rapidly. –Health Plan

Health plans also reported on progress of their outreach efforts to the state. MDH summarized this information and presented it back to the health plans to facilitate discussion on how the partnership was going and if it needed to be adjusted. This also encouraged several health plans to develop their own internal dashboards to set goals and measure progress.

Health plans also co-created messages that and shared information back to MDH. Blue Cross and Blue Shield of Minnesota initially worked with MDH and DHS to launch a two to three week pilot where Blue Cross navigated the process of setting up the MIIC data exchange, co-created the initial call center scripts and FAQ before MDH and DHS rolled it out to the rest of the partnership. Plans also shared information about homebound members that MDH used to help connect homebound people with local public health agencies doing home-based immunization.

Messaging to reach members

Developing messages to communicate with members takes time and resources. Through this partnership, messages, communication toolkits, and resources were quickly developed by MDH/DHS and quickly shared with health plans. Not only did this help with message development, but it also increased health plans' confidence that they were providing up-to-date information and allowed them to quickly pivot. Health plan employees were excited to reach out to members. Health plans used this messaging statewide, enabling members across Minnesota to hear the same message. This outreach also emphasized the "no wrong door" approach, where all members would hear the same message about vaccines, no matter the reason they called, and health plans would also help their family members get vaccinated, regardless of their family members' health plan.

Working with community to unify messaging

Health plans also initiated innovative projects to reach members during this pilot. One plan provided a total of \$250,000 to nine Federally Qualified Health Centers (FQHCs) to raise awareness and increase access to COVID-19 vaccination. Through a combination of direct calls, text messages, mailings, and community events, they reached over 8,000 members over three months. As a part of this project, the Native American Community Clinic (NACC) in Minneapolis was able to do multiple postcard mailings and hosted three COVID-19 vaccine community education events where the vaccine was made available. Food and other incentives were provided. NACC, which is also an MDH Community Engagement Contractor, leveraged this funding to partner with other local nonprofit organizations to do door knocking and passed out flyers the day of events. FQHCs were able to provide staffing that spoke multiple languages and were able to reach out to community members with a culturally relevant message.

Demographics of outreach to SVI quartile 1 during the partnership

Access to SVI information allowed health plans to focus their outreach to populations living within SVI quartile 1 ZIP codes, the most disadvantaged, as well as reaching out to SVI quartiles 2 through 4. SVI was selected as a vaccine equity metric by MDH in part to help prioritize Black, Indigenous and other communities of color (BIPOC) disproportionately impacted by COVID-19 and facing vaccine disparities early in the vaccination roll out. Fifty-four percent of Minnesotans who identify as American Indian live in SVI quartile 1 ZIP codes and the numbers are similarly high for Black (53%) and Hispanic (47%) Minnesotans and those with limited English proficiency (59%). At the start of the pandemic, first dose COVID-19 vaccination rates for eligible members from these communities significantly lagged behind the statewide average with only 38.5% of eligible Black Minnesotans, 41.2% of Hispanic Minnesotans, and 42.4% of Native Minnesotans having received one dose as of May 1, 2021. There were similar gaps in vaccination among Minnesotans less than 50 years old and those who did not live in the Twin Cities metro area. Of note, rates were higher in adults age 65 and older because they were eligible for vaccination earlier, and vaccination did not open up to everyone age 16 and older until March 2021.

Overall, health plans reported a greater percentage of their outreach for their eligible members living in SVI quartile 1 ZIP codes for a variety of demographics: race/ethnicity, age, and geography. Overall, based on the race/ethnicity information, health plans reached out to about 78% of all of their members living in SVI quartile 1, compared to 68% of their members living in SVI quartiles 2-4. See Appendix 3 for definitions of race/ethnicity and Appendix 4 for data tables for Figures 3-5.

Note: One of the health plans did not provide complete information about member demographics, and therefore are not included in the following demographic bar charts (See Figures 3-5).

Figure 3. Race/Ethnicity: Percentage of eligible members (ages 12+) that received outreach by SVI ZIP code quartile

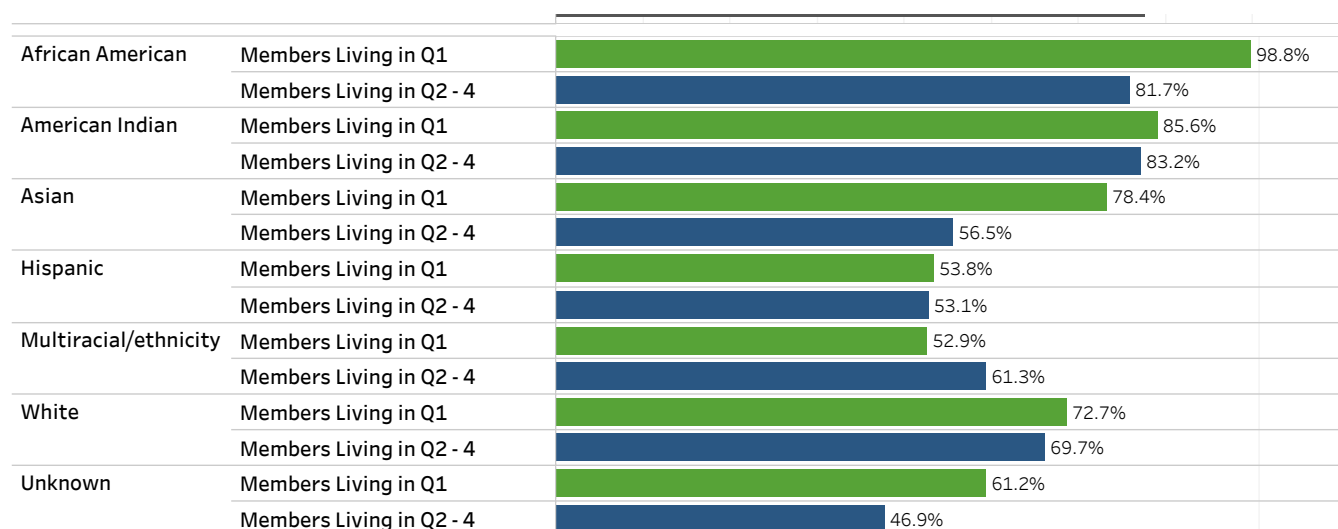


Figure 4. Age: Percentage of eligible members (ages 12+) that received outreach by SVI ZIP code quartile

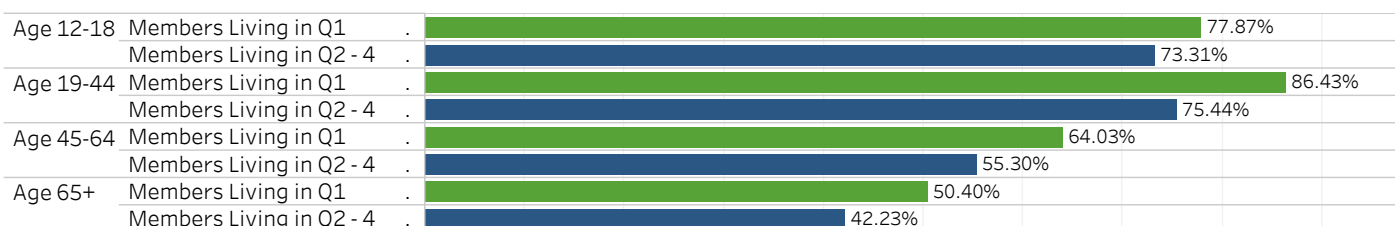


Figure 5. Geography: Percentage of eligible members (ages 12+) that received outreach by SVI ZIP code quartile

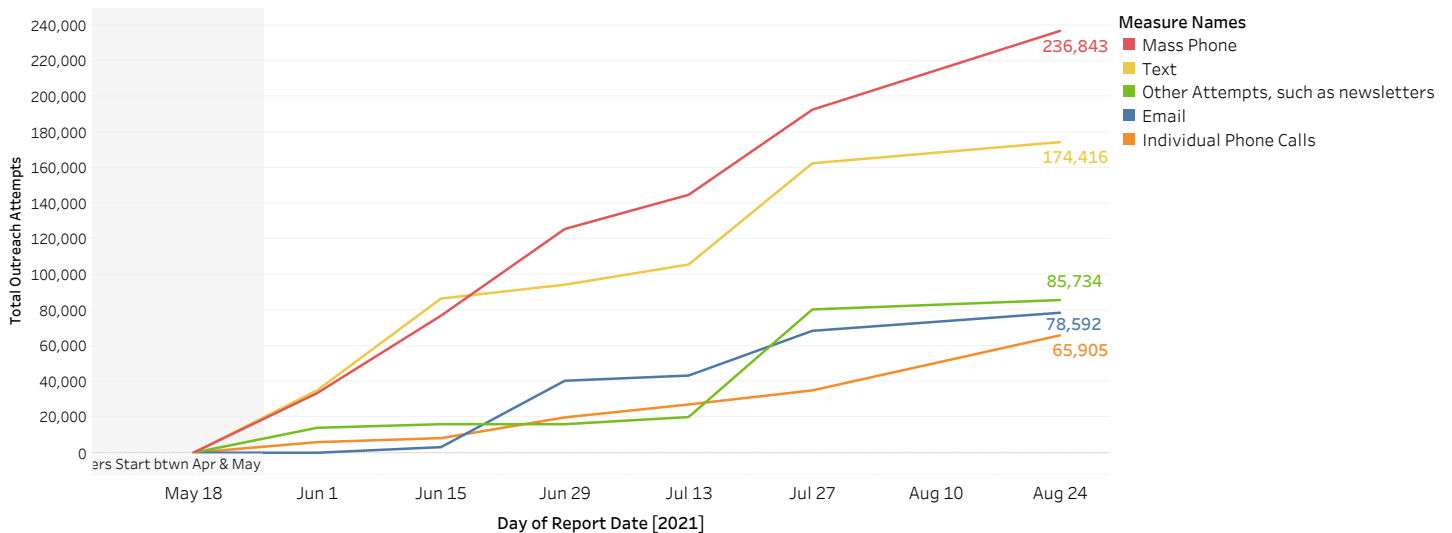
Greater MN	Members Living in Q1	69.1%
	Members Living in Q2 - 4	65.1%
Metro	Members Living in Q1	83.7%
	Members Living in Q2 - 4	70.2%
Unknown	Members Living in Q1	53.2%
	Members Living in Q2 - 4	44.8%

Successes in messaging, outreach, and support to SVI ZIP code quartile 1

Throughout the COVID-19 pandemic, MDH has developed and distributed trusted and reliable public health messaging with and to Minnesota’s diverse communities. MDH staff along with community contractors and partners co-created messaging specifically around vaccine efficacy and safety, provided specific information around vaccination for 12- to 17-year-olds, co-administration of vaccines, access to vaccine incentive programs, and shared a Frequently Asked Questions (FAQ) document for plans to use. Health plans in turn shared call center scripts that MDH provided input on and DHS provided rapid approval to align messaging and the necessary contractual compliance for Medicaid enrollee outreach.

As noted above, health plans engaged in many forms of outreach throughout the partnership. From the start of the partnership through August 2021, health plans made **over 640,000 outreach attempts** to their members living in SVI quartile 1 ZIP codes. This included over 65,000 individual calls to members using a template script for consistency. Mass (automated) phone calls were the most common way to reach out to members, followed by text messaging. Other formats included newsletters, email, and post cards. See Figure 6 for a graph of total outreach attempts by type.

Figure 6. Total outreach attempt by type to eligible members (ages 12+) living in SVI ZIP code quartile 1



“One member was not able to be reached with multiple attempts back in June for the original vaccine outreach. They were also unable to be reached for their HRA [health risk assessment] in August 2020 and late July/early August 2021. A few days after the final attempts to contact him for his HRA [health risk assessment], the CC [care coordinator] called again to discuss the vaccine and financial incentive being offered by the state. The member answered the phone on this attempt and shared he was in fact interested in the vaccine. CC [care coordinator] was able to help him schedule a vaccine appointment over the phone for just a few days later as well get him signed up for the financial incentive. CC [care coordinator] also re-offered the HRA [health risk assessment] and the member agreed to schedule a date to complete that as well. Despite five recent phone calls in the last eight weeks, CC [care coordinator] was successfully able to reach him on this attempt!” -Health Plan

Health plans decreased vaccine access barriers

Although the COVID-19 vaccine is free in the U.S. awareness of this fact as well as lack of an interpreter and lack of transportation are known barriers for some to receive health care. Speaking English “Less than Well” and having “No Vehicle” are components of the SVI and therefore prioritizing people who live in high SVI areas for these specific supports can help improve access to vaccination and other services. During various outreach efforts, health plans supported their members to receive the vaccine by assisting them with scheduling an interpreter and/or setting them up with transportation to a vaccination appointment covered by their Non-Emergency Medical Transportation (NEMT) benefit. Through member communications, about three out of five interpreter requests from all types of communication were made by members living in SVI quartile 1 ZIP codes and about half of all transportation requests were made by SVI quartile 1 ZIP codes*. See Figures 7 and 8 for interpreter and transportation requests by SVI ZIP code quartile.

Figure 7. Interpreter Request by SVI ZIP code quartile

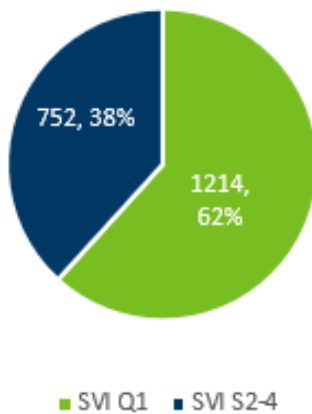
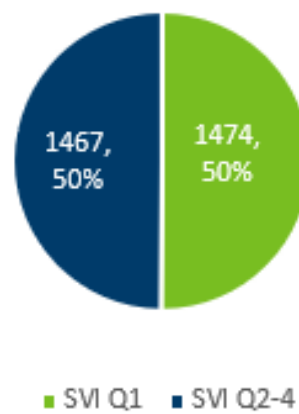


Figure 8. Transportation Request by SVI ZIP code quartile



Several health plans launched focused aspects of their vaccine campaigns and tried a variety of communications styles to reach out to members. Some health plans engaged communities through community workers, used one-on-one engagement strategies to engage with people in their primary language, and connected their members with trusted community sources. Health plans also increased vaccine access to communities through mobile vaccination sites, drive-through clinics, and sharing of vaccination information. Health plan employees also noted that some outreach attempts resulted in vaccine hesitant members scheduling a vaccine and that they heard excitement from their members about receiving an incentive for getting a vaccine.

Somali speaking CHW [community health worker] reached out to Somali member for a requested call back from an IVR [interactive voice response]. The member was vaccinated but wanted help to get her kids scheduled. The mother told all of her kids to gather around the phone and get vaccinated for COVID. The CHW had a group discussion with the family, supporting getting them all scheduled. -Health Plan

*Some health plans only included interpreter and transportation requests that came through the targeted COVID-19 vaccine outreach, while other health plans included all requests, no matter their point of entry into their system.

Fostering trust and relationships between state agencies, health plans, and community organizations

The information-sharing through regular meetings was also helpful to identify barriers other plans/the state were facing in connecting members to vaccination appointments. – Health Plan

Finally, the focus on SVI was an important tool to help us focus outreach on members/areas of the state that may need the most support in working through barriers. – Health Plan

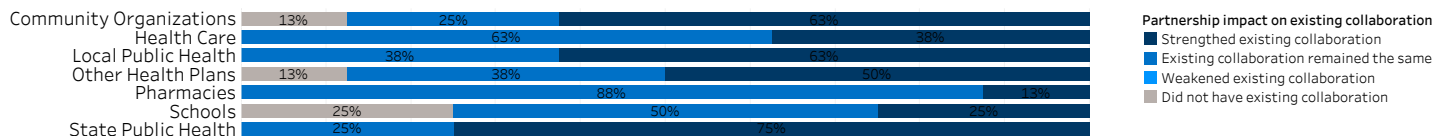
Overall, the partnership has fostered stronger relationships between state agencies (MDH and DHS) and between health plans statewide. Through open dialogue at partnership meetings, participants noted increased trust between health plans and with state agencies. Health plans discussed barriers and successes and helped each other problem solve. Together, they built a shared understanding, developed common goals and strategies, and prioritized and focused work. The partnership used SVI to prioritize vaccinating Minnesotans who live in

SVI quartile 1 ZIP code areas (highest disadvantage). This collaboration also allowed for the development of a shared outreach messaging framework and uniform messages in multiple formats (such as text and phone) that participating health plans could use to communicate with their unvaccinated members. This partnership decreased duplication of work between the plans.

Collaboration

More than half of the health plans indicated that this partnership allowed them to strengthen their relationships with community organizations, local public health, other health plans, and state public health. Additionally, half of the health plans indicated that they developed a new relationship with at least one community organization and three of the eight plans indicated that they developed a new relationship with at least one local public health agency and at least one other health plans. See Figure 9 for the impact of the partnership on collaboration.

Figure 9. Impact of the partnership on collaboration



Barriers encountered

Invalid contact information and member hesitancy

The partnership did experience some challenges. All health plans reported many invalid phone numbers or emails and/or they could not leave members a voicemail. About one in five members living in SVI quartile 1 ZIP codes had an invalid or wrong phone number. During outreach attempts, members also expressed concerns about vaccine safety, legitimacy of outreach, and the necessity of the vaccine. Some members did not feel comfortable talking about their vaccination status or would not provide a reason why they were not vaccinated.

Distrust of the outreach efforts is an ongoing challenge resulting in member hesitation to answer calls or no interest in discussing COVID-19 when members are reached. -Health Plan

Barriers continue to be the same with invalid phone numbers or no email addresses. Some members sent very degrading and offensive text messages in response to our text messages. -Health Plan

Health plan staff capacity and balance

Health plan staff also indicated that their capacity was stretched thin doing these outreach attempts and that over time there was a decreasing return on investment. It was hard to find members with barriers who wanted to get vaccinated. Health plan employees also expressed fatigue, both compassion and COVID-19 fatigue. It was hard reaching out to members and facing distrust and resistance.

Health plans staff also expressed difficulty in balancing how much flexibility to give employees with how they reached out to members (i.e., having them follow templates and instructions) versus giving staff autonomy over their work. It was also a balance for employees to act quickly and reach out to more members versus taking time to develop relationships with fewer members. Health plan employees had to think about maintaining the members' trust as they want to keep serving that member beyond COVID-19.

Societal barriers

Staff capacity was the biggest challenge. On the outreach side, we had to be mindful of the asks of our internal and delegated care coordinators, as they had been conducting outreach throughout the spring and, frankly, it is hard to hear "no" over and over again. -Health Plan

Racism is a public health crisis and continues to be a challenge that members of color face in experiencing their best health. We need to continue to advocate for and act with intention to change their pervasive problem through our policies, with our providing in the community. -Health Plan

Health plans also reported several societal barriers that inhibited their efforts. Health plans cited that systematic racism remains a public health problem that challenges vaccine outreach efforts through increased barriers in access to care, historical violation of trust by health care and government organizations with Black, Indigenous and other communities of color and racial disparities in the social drivers of health. COVID-19 has also been politicized and people have steadfast views on COVID-19 that are hard to change.

Moving forward and next steps

The partnership continues to move forward and figure out where to go next. All health plans are interested in continuing this collaboration given all of the benefits. Members want to continue to collaborate on communication and messaging for a unified, statewide message and continue to navigate how to partner with and use community messengers.

In terms of topics for the partnership to focus on, there is a large interest in addressing social determinants of health, food and housing access, health equity (including metrics), mental health, and substance abuse. There is also some interest in discussing respiratory disease, colorectal screenings, preventative care appointments, and climate change.

A focus on social determinants of health (SDoH) with consistent messaging in terms of needing help from providers in assessing members for SDoH could help shift the focus moving forward to address other areas of health inequity within Minnesota. A consistent application to manage SDoH referrals would be helpful. Regardless of the topic, having consistent messaging and idea sharing is a helpful factor in the partnership. -Health Plan

Appendix 1. Evaluation Methods and Analysis

Methods

Health plan information was collected in REDCap twice a month in June and July, and once a month in August and September. Information that health plans reported came from their internal data as well as MIIC data. For the reports due in **June and July**, health plans answered questions about the following topics for members living in SVI Q1 and members living in SVI Q2-4 for the specified reporting dates:

- Number of members who received at least one vaccine dose and a full vaccination series.
- Number of members who needed interpreter and/or transportation services.
- Number of outreach attempts by type (email, text, individual phone calls, mass phone calls, other).
- If plans reached out to members outside of SVI Q1 and/or if they reached out to members outside of MHCP (Minnesota Health Care Plans).
- Barriers and successes.

For the report due in **August**, in addition to the questions answered in June and July, the health plans also reported on:

- Partnership's impact on collaboration with other partners (including health care providers, local and state public health, pharmacies, schools, community organizations, and other health plans).

For the report due in **September**, in addition to the questions answered in June and July, the health plans also reported on:

- Experience being in the partnership, such as how the partnership helped health plans overcome obstacles and connect with their members facing barriers to COVID-19 vaccination. Health plans also reported on the challenges they still face in reaching their members and ideas on future direction of the partnership.
- Number of *unvaccinated* and total vaccine eligible members (ages 12+) in SVI Q1 and Q2-4, at the start of their partnership and on August 24, 2021.
 - The number of members with at least one vaccine dose was calculated by subtracting the number of unvaccinated members from the total number of vaccine-eligible members.
- Number of vaccine-eligible members (ages 12+) living in SVI Q1 and Q2-4, they intended to reach and with invalid/wrong phone numbers at the start of their partnership and on August 24, 2021.
- Demographics (race/ethnicity, age, and geography) of all vaccine-eligible members (ages 12+) and demographics of vaccine-eligible members (ages 12+) who health plans reached out to living in SVI Q1 and Q2-4 at the start of their partnership and on August 24, 2021.

Statewide rates of people with at least one vaccine dose also came from MIIC.

Analysis

All qualitative information was analyzed for themes, which was analyzed by hand for information gathered in June and July, and NVivo was used for information in August and September. Descriptive measures were used to analyze quantitative measures in Tableau.

Appendix 2. Description of Partners

Minnesota Association of County Health Plans (MACHP)

www.MACHP.org

The Minnesota Association of County Health Plans (MACHP) is a Minnesota nonprofit association of County-Based Purchasing (CBP) plans that have come together to strengthen and promote this innovative Minnesota-grown solution. CBP is a successful model for delivering Minnesota Health Care Programs (MHCP) that has produced strong results for more than 40 years. A bipartisan coalition of legislators passed landmark legislation enacting CBP into Minnesota law in 1997, and giving counties special authority to choose this model to care for MHCP enrollees. CBP plans are a county or group of counties that elect to utilize CBP to deliver health care services primarily to people who qualify for MHCP. CBP plans are fundamentally different from other managed care models, primarily in that they are owned and operated by the local counties they serve. CBP plans add unique value to MHCP by providing enrollees with dependable access to care, enhancing health care quality, supporting health care innovation in rural areas, and coordinating with county social and health care services for more efficient and effective outcomes.

Minnesota Council of Health Plans

<https://mnhealthplans.org/>

The Minnesota Council of Health Plans is an association of nonprofit health insurers whose mission is to get Minnesotans the affordable, equitable and quality-based care they need today and in the future. We have worked for more than 30 years to improve care for everyone.

Blue Cross and Blue Shield of Minnesota

Blue Cross and Blue Shield of Minnesota

For nearly 90 years, Blue Cross and Blue Shield of Minnesota has supported the health, wellbeing and peace of mind of our members by striving to ensure equitable access to high quality care at an affordable price. With a total of 2.5 million members enrolled in a range of commercial plans and government-sponsored coverage, Blue Cross has a presence in every Minnesota county, all 50 states and on four continents.

Health Partners

<https://www.healthpartners.com/>

Founded in 1957, HealthPartners serves more than 1.8 million medical and dental health plan members nationwide. It is the largest consumer-governed, non-profit health care organization in the nation and provides care, coverage, research and education to improve health and well-being in partnership with members, patients and the community.

Hennepin Health

<https://hennepinhealth.org/>

Hennepin Health is Minnesota's only county-owned, state-certified health maintenance organization that provides health care coverage to nearly 36,000 Hennepin County residents. Hennepin Health is nationally recognized for its innovative approach, taking a holistic approach to health care by integrating traditional medical services, behavioral health services and other county and community services.

Medica

<https://www.medica.com/>

Medica is a nonprofit health plan headquartered in Minnesota that operates in Minnesota, Arizona, Iowa, Kansas, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota and Wisconsin. Medica's State Public Programs division currently serves Minnesotans enrolled in the state's MSHO, MSC+, and SNBC programs.

PrimeWest Health

www.primewest.org

PrimeWest Health is a nonprofit County-Based Purchasing (CBP) organization owned by 24 rural Minnesota counties, which make up our governing body. We are organizationally integrated with county Public Health and Social Services agencies and these agencies play key roles in addressing PrimeWest Health members' social determinants of health, behavioral health, and community health needs; improving member population health; and providing case management services. This integration enables PrimeWest Health to readily integrate and coordinate public health, social services, and behavioral health services with medical and allied health care services provided by more than 15,000 contracted health care and human services providers that make up the PrimeWest provider network.

South Country Health Alliance

www.mnscha.org

South Country Health Alliance is a county-based purchasing health plan serving nine Minnesota counties—Brown, Dodge, Freeborn, Goodhue, Kanabec, Sibley, Steele, Wabasha, and Waseca—in a joint effort to support accessible, quality health care through partnerships with community services and local health care providers for Minnesota Health Care Program enrollees. South Country began enrolling members in November 2001 and now has more than 30,000 members. The health plan offers seven programs to meet the health care needs our members.

Itasca Medical Care

www.imcare.org

IMCare is a Health Care Program Administered by Itasca County Health & Human Service (ICHHS) that provides health care coverage for people who are eligible for Minnesota Health Care Programs and live within the IMCare service area. The IMCare mission is to ensure access to high-quality, patient-centered, cost-effective health care for Itasca County residents through coordination and collaboration with local community partners and providers.

UCare

<https://www.ucare.org/>

UCare is an independent, nonprofit health plan providing health care and administrative services to more than 570,000 members throughout Minnesota and parts of western Wisconsin. UCare partners with health care providers, counties, and community organizations to create and deliver Medicare, Medicaid, and Individual & Family health plans. All of its plans are National Committee for Quality Assurance (NCQA) certified.

Appendix 3. Definitions of Race/Ethnicity

American Indian: Ethnicity indicated as non-Hispanic. Race indicated as American Indian or Alaska Native

Asian: Ethnicity indicated as non-Hispanic. Race indicated as Asian or Pacific Islander.

Black/African American: Ethnicity indicated as non-Hispanic. Race indicated as Black or African American.

Hispanic: Ethnicity indicated as Hispanic.

Multiracial /Ethnicity: Ethnicity indicated as non-Hispanic. Two or more race categories indicated.

White: Ethnicity indicated as non-Hispanic. Race indicated as White.

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