Health Plans – Strengthening Emergency Roles and Partnerships

Policy Paper

Edition 1.0, 2.20.20

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Contents

This document is for health plan administrators, legislators, state health department policymakers, planners, and advocates. The content highlights the need for health plan member-centered emergency practices in large emergencies.[1]

PROBLEM

Disasters are increasing in frequency, intensity, scale, and duration due to climate-related changes, natural and human-causes, outdated infrastructure, and other large-scale emergencies. In emergencies, the indisputable evidence documents, but undercounts the high death rates among people with disabilities and older adults after large disasters. In the United States, people with disabilities and older adults are 2 to 4 times more likely to die or sustain a critical injury during a disaster than people without disabilities.[2]

[1] This article is not about the equally important "Continuity of Operations Plans" (COOPs) which should also be in place. COOPs focus emergency items such as ensuring service continuation, staffing, communication, supplies, decision-making, access to data, alternate and temporary work location mutual aid, communication of emergency messages, and updating emergency plans.

[2] United States Senate Special Committee on Aging Hearing on: "Disaster Preparedness and Response: The Special Needs of Older Americans" Wednesday, September 20, 2017, by Paul Timmons, President, Portlight Inclusive Disaster Strategies, Inc.

This death rate is much higher due to the increased mortality rates in the months after these events caused by the cycle of worsening conditions and increased psychological, social, health and physical stressors. These higher mortality rates are often a consequence of the interruption of power, especially for those dependent on life-sustaining equipment, and limited access to critical supplies, mobility devices, durable medical equipment, medications, oxygen, health care (dialysis, chemotherapy, other infusion therapies), home health care and attendant services.

Expectation Mismatch and Magical Thinking - There is an expectation mismatch that includes widespread magical thinking that mistakenly assumes that government emergency responders will take care of the emergency needs of community members. The reality is that the needs of disaster-impacted people far outweigh the collective resources and capabilities of the government, especially in large-scale events. Government emergency service providers need knowledgeable and prepared partners to help with the specific and often complex health maintenance needs of people with disabilities supported by health plans.

Whether anticipated or not, history confirms that health plans are inundated by the immediate, life-saving, and life-sustaining needs of people they serve during large emergencies. This is especially true for high-risk and disproportionally impacted members of health plans who will need assistance more than ever, immediately and throughout the under-estimated and what is often a long-lasting recovery process. Rapid response can also prevent hospitalization or institutionalization.

PURPOSE

The purpose of these health plan member-centered emergency practice recommendations is to embed resilient uniform protocols and processes. Health plans are often overlooked as essential partners before, during, and after emergencies. Health plans refer to health insurance plans across all lines of business, employer-sponsored coverage, individual and group insurance market, and public programs (Medicare and Medicaid). Plans offer medical services to their members and include models for delivering services such as HMO, indemnity, Medigap, preferred provider organization, and point-of-service plans.

Health plans, public and private, serve the vast majority of people with disabilities. Medi-Caid and Medicare managed care plans, in particular, are in the unique position to serve a proactive role in addressing and protecting the narrower margins of health resilience, safety, and independence of the people they support before, during, and after an emergency.

Health plans are often overlooked as an essential partner before, during, and after large emergencies. These partners include local community services to assist the government, businesses, vendors and providers, and community service

organizations (See 5. Community Partnerships). Large emergencies and disasters typically affect a large area, many people and often overwhelms local resources which can lead to involving state and federal agencies.

Recommendations

These health plan member-centered emergency practice interventions serve to create minimum and uniform services. These services contribute to a broad, effective, and sustained ability to prepare for and respond to large emergencies. These six recommendations intend to embed proactive and sustainable planning and response emergency practices into policies, processes, procedures, protocols, training, audits, exercises, and partnerships. Implementing options for these recommendations include contract updates, regulations, legislation, planning documents, staff training, and guidance.

1. CARE PLANNING AND CARE COORDINATION

Require health plans and providers to work with their high-risk members to develop and maintain an emergency plan as part of the member's care plan. High-risk individuals include those with severe gaps in their emergency plans. Examples of high-risk individuals include those who:

- lack support from family, friends, and others,
- are geographically isolated,
- are least able to receive, understand or act on emergency alerts,
- are power-dependent on life-saving, sustaining, and supporting equipment (respirators, ventilators, mobility devices),
- require oxygen, dialysis, chemotherapy,
- are least able or unable to get to pharmacies and distribution sites for power, food, water.

A regularly updated database of high-risk members should be established with new members being added each time an individual with a qualifying diagnosis or need is identified through a claim or an encounter. For example, Florida's contract with Medicaid health plans requires that a well-documented emergency plan is in place for specific members. Sunshine Health®in Florida reviews these plans with members every 90 days.

Individual emergency plans should include:

- low cost and no-cost actions
- identifying, communicating with, and maintaining personal support teams which are made up of people willing to help each other in an emergency (family, friends, personal assistants, attendants, caregivers);
- maintaining and updating emergency contact list

- signing up for all available alert and notification services
- realistic options for accessing:
  - evacuation plan (that goes beyond relying on 1st responders)
  - alternative power sources during power outages, planning for alternative methods of powering life-saving, sustaining, and supporting equipment
  - water, food, medication, and supplies needed for evacuation or sheltering-in-place

2. LIFE-SAFETY CHECKS

Require protocols for coordinating with community and government partners conducting emergency life safety calls, and when needed, in-person visits, for those high-risk members (See **1. CARE PLANNING AND CARE COORDINATION).**

These checks can also serve to divert unnecessary admissions to hospitals and nursing homes and replace critical devices, equipment, supplies, and medications.

Sunshine Health® care coordinators helped members in the 2017-218 pre-hurricane to board up windows and post-hurricane they delivered food, water, oxygen, medications, equipment, and supplies via face-to-face visits. They shipped meals, tracked where the power grid was down and made in-person visits to those areas a priority. Because emergency information is often changing, Sunshine Health® created an internal centralized point, called “Response Central”, for staff to get current and reliable updates on frequently changing information.

Sunshine Health® prioritized members with pre-identified serious gaps in their emergency plans and those with complex health needs into a tiered system, which enabled first contacting members projected to be the most disproportionately impacted.

This first contact group included members with complex health care needs, who may not be able to get or understand emergency alerts, need dialysis, chemotherapy, and temperature regulated medication (insulin and biologics, for example), who are dependent on power to operate essential life-sustaining equipment and motorized mobility devices, who lack emergency support from family, friends or others, who need food, water, oxygen, medications, power, equipment, and supplies and who are unable, or least able, to get to commodity distribution points.

Anthem Blue Cross Blue Shield, Amerigroup, Superior Health Plan® in Texas and Sunshine Health® dispatched service coordinators to conduct in-person life safety checks when members could not be reached. Anthem

distributed cell phone solar chargers and bottled water, when needed, to members during these visits. These health plans also instituted member tracking when evacuations resulted in transport to another county or state. [3]

3. EMERGENCY PERFORMANCE CLAUSES FOR CONTRACTED PROVIDERS AND SUPPLIERS

The legislature, state agencies, and health plans must share responsibility for integrating specific emergency performance clauses into the provider, supplier, and contract agreements.

Contract clauses will reinforce the performance requirements that are part of the vendor/providers' compliance requirements with the Centers for Medicare & Medicaid Services' Rule on Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.[4]
Require vendors who supply life-saving, supporting and sustaining therapies, equipment, and supplies, upon delivery and repair, to include instructing users verbally and in writing on how to activate emergency procedures for their equipment.

For example, require providers to instruct users on emergency procedures for their equipment:

- emergency backup power options (alternative ways to safely power the equipment) with clear verbal and written instructions in usable formats and preferred languages upon delivery of equipment and supplies to the end-user.
- how long batteries and backup systems will last
- how to extend use with limited or no power
- dialysis and other critical infusion therapy providers must give written and verbal instructions, so individuals know what to do and where to go if these providers' sites become unavailable due to the emergency.

Providers should also develop monitoring procedures to assess the up-to-date accuracy and effectiveness of these instructions (clarity, practicality, plain understandable and culturally appropriate text).

Develop Strong Qualifications for Emergency Plan Reviewers and Guidelines for Emergency Plans.

To prevent minimalistic or cursory plan reviews, State departments responsible for long term care facility licensing should develop essential and robust qualifications for emergency plan reviewers and establish minimum guidelines for

[3] Roth, M., Kailes, J. & Marshall, M., "Getting it Wrong: An Indictment with a Blueprint on Getting it Right," (May 2018), available at http://www.disasterstrategies.org/index.php/news/partnership-releases-2017-2018-after-action-report.

[4] Centers for Medicare & Medicaid Services, "Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule," (Nov. 16, 2016), available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.

emergency plans that include clear performance measures and benchmarks for preparedness and corrective action plans.

State departments responsible for long term care facility licensing should conduct meaningful audits that examine the specific details of every facility's emergency plans related to, but not limited to:

- Compliance with the CMS Emergency Preparedness Rule
- Evaluating the ability to accept and appropriately serve additional admissions during emergencies
- Developing and regularly updating memoranda of understanding with multiple "like" facilities of variable distances away (within 10 miles, 20 miles, neighboring city, and states) who have space for (often using unconventional spaces like common areas and dining rooms) and agree to accept their residents in an emergency.
- Assessing realistically the numbers of staff who will remain and or return to work after a disaster
- Assessing the adequacy of plans for supplementing staffing to meet the needs of residents and emergency admissions if needed, and
- Transportation provider agreements for evacuations. [5]

4. MEMBER EMERGENCY COMMUNICATIONS

Require communication protocols to convey information before, during, and after an emergency for members, family members, attendants, and caregivers. The use of communication methods should include call centers, outbound (automated or manual) calls, text, and postings on social media and websites.

Minimum information should relay:

- how to reach the health plan and providers,
- how to contact the 24-hour nurse hotline where to go to receive health services,
- changes in how the health plan approves services such as seeing an out-of-network provider or removal of quantity restrictions for medications,
- how to obtain or quickly replace consumable supplies and durable medical equipment, and medications,
- what community resources to use for the latest emergency information and or specific assistance.
- how to access critical care services like dialysis and chemotherapy, how to reschedule procedures, and how to access food, water, and transportation.

[5] Roth, M., Kailes, J. & Marshall, M., "Getting it Wrong: An Indictment with a Blueprint on Getting it Right," (May 2018), available at http://www.disasterstrategies.org/index.php/news/partnership-releases-2017-2018-after-action-report.

During the 2017-2018 emergencies:

- Anthem provided members and non-members with a free 24-hour nurse hotline and online access to a doctor for assistance with specific medical, mental health, and behavioral health issues at www.livehealthonline.com. Kiosks at various locations also offered this service via Telehealth (video connection with doctors) and included blood pressure measurement. The Anthem wheelchair accessible mobile health clinic in Houston, donated by American Well, had one of these kiosks.[6]
- Superior Health Plan® in Texas made 14,000 outbound calls to their members receiving long term services and supports four to five days before Hurricane Irene made landfall to help members activate their emergency plans. For example, these calls prompted people to complete such tasks as filling prescriptions early and have their grab and go bags and evacuation plans ready.[7]

5. **COMMUNITY PARTNERSHIPS**

Require health plans, beyond health care coalitions, to establish partnerships with local emergency services, inclusive of government, businesses, vendors and providers, and community service organizations. The latter include independent living centers, centers serving individuals with intellectual and developmental disabilities, public and private personal care services, area agencies on aging, aging disability and resource centers, disability-specific organizations, community health clinics, and Federally Qualified Health Centers.

These partnerships can share responsibilities for enhancing a coordinated response before, during, and after emergencies. For example, life safety checks can be coordinated by leveraging partnerships with organizations that maintain current lists of those who will be the most disproportionally impacted and in need of life-saving, life-sustaining, and life-supporting assistance.

Anthem, during 2017-2019, quickly contracted with Portlight Strategies who facilitate projects involving disaster relief for people with disabilities, and the Partnership for Inclusive Disaster Strategies to increase the effectiveness of member outreach services. This partnership built upon 1.) trust resulting from an existing relationship of several years. This agreement collaboration paired Anthem's health care expertise with Portlight's disaster response

[6] Ibid.

[7] Ibid.

competencies, deep understanding of the complexities and nuances of the lived disability experience, and 2) a current and robust connectedness to other local and self-organized responders (such as the Cajun Navy) helped Anthem respond more quickly and support people in their communities." [8] "Rapidly augmenting Anthem's response with Portlight and the Partnership's expertise just made good sense, enlisting experienced responders and local community engagement experts with the know-how, creativity, nimbleness, and flexibility to help our members get immediate critical needs met," explained Merrill A. Friedman, Senior Director, Disability Policy Engagement, Federal Affairs, Anthem, Inc. [9]

Sunshine Health® is working to strengthen partnerships with Centers for Independent Living. They are piloting this approach with the Miami Center for Independent Living serving the same Medicaid population to optimize shared capacity to co-manage information during disasters and provide updated information via automated outbound calls. Sunshine Health® is also partnering with Florida's Association of Centers for Independent Living to determine each Center's capacity to provide emergency preparedness and disaster response services. [10]

6. GUIDANCE

Some of these recommendations above will require extra resources for the health plans to be truly effective in their implementation. Additional resources should be integrated in the revenue models to fund the development of health plan guidance to document good practice, comparable to the brief health plan examples provided above. These emerging promising practices can help other plans with ideas for future customization and implementing similar practices. Guidance content should include customizable tools, actionable steps, job aids and checklists.

SUMMARY

There is much we know, can anticipate, and need to plan for. The lessons observed are clear; they just must be applied. Pre-packaged planning tools and embedded procedures contribute to minimizing surprises and maximizing efficiencies and productivity before, during, and after emergencies. A rapid emergency response avoids wasting time trying to plan and organize tasks during a high-pressure response where every minute counts. Robust emergency planning processes, procedures, protocols, policies, partnerships, and training directly correlates to optimizing life-saving, life-sustaining, and life-supporting outcomes for people with disabilities.

[8] Ibid.

[9] Ibid.

[10] Ibid.

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02.20.20

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