THPP Unify

Implementation Council Meeting

11/12/19

TUFTS Health Plan

Table of Contents

Language Key

- Care Coordinator: Contractually-defined term
- "Care Coordinator": THPP *Unify* internal role on the care management team

Care Coordinators: Contract Requirements

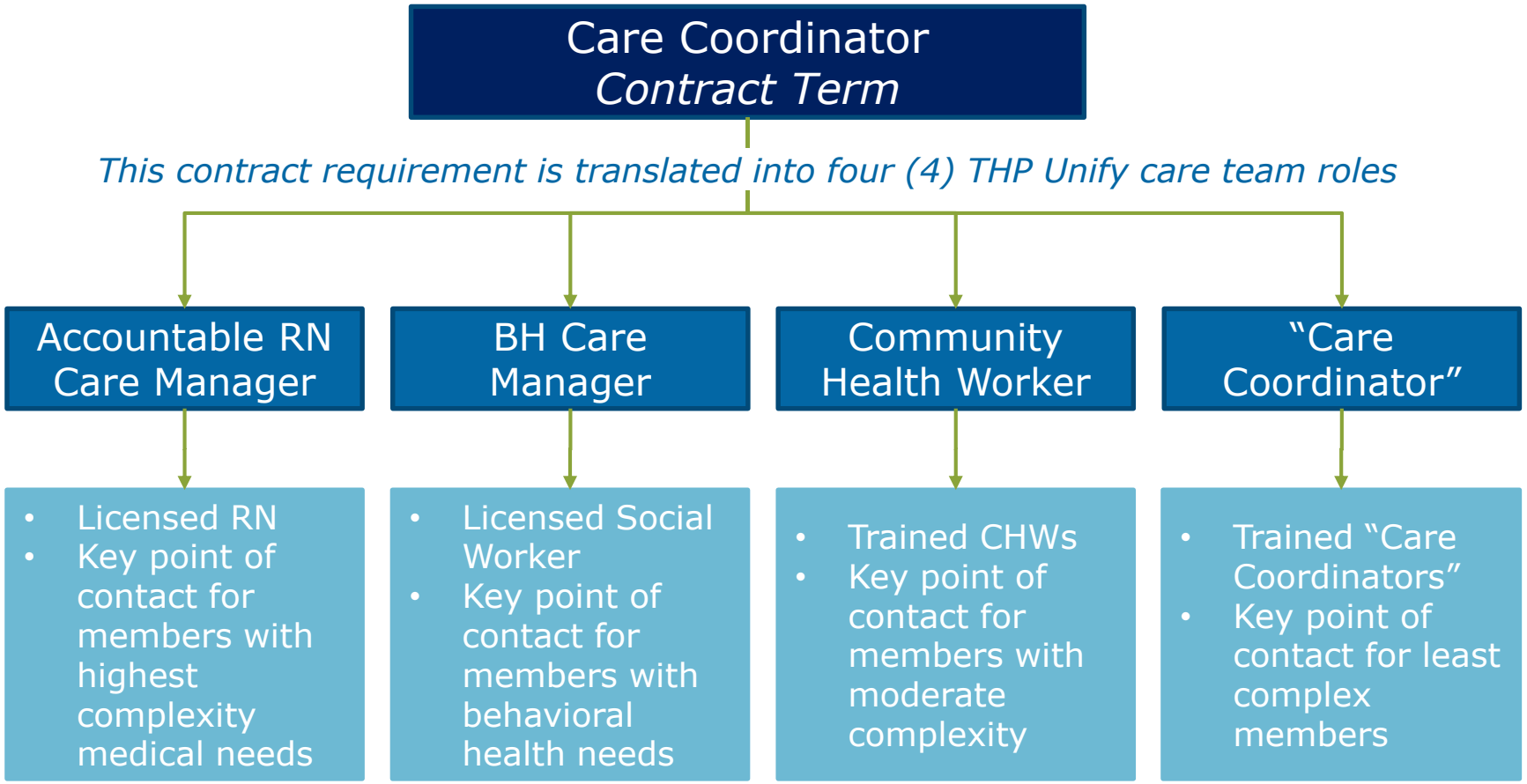
Care Coordinator is a contractually-defined term, with specific responsibilities and requirements.

Contract requirements:

- Every member must have an ICT
- The ICT must include a care coordinator, or clinical care manager
- The health plan is required to establish its own qualifications for a care coordinator, and is responsible for training
- A care coordinator acts as a single point of contact for members
- A care coordinator must be a trained professional
- Care coordinators are to participate in the comprehensive assessment, ensure ICT meetings are held, monitor ongoing services, and ensure appropriate member input
- For members with complex needs, the care coordinator may be a Clinical Care Manager

Care Coordinators: THP *Unify*

THP Unify translates this contract requirement into an integrated care teams where each member has a primary ***Relationship Lead***

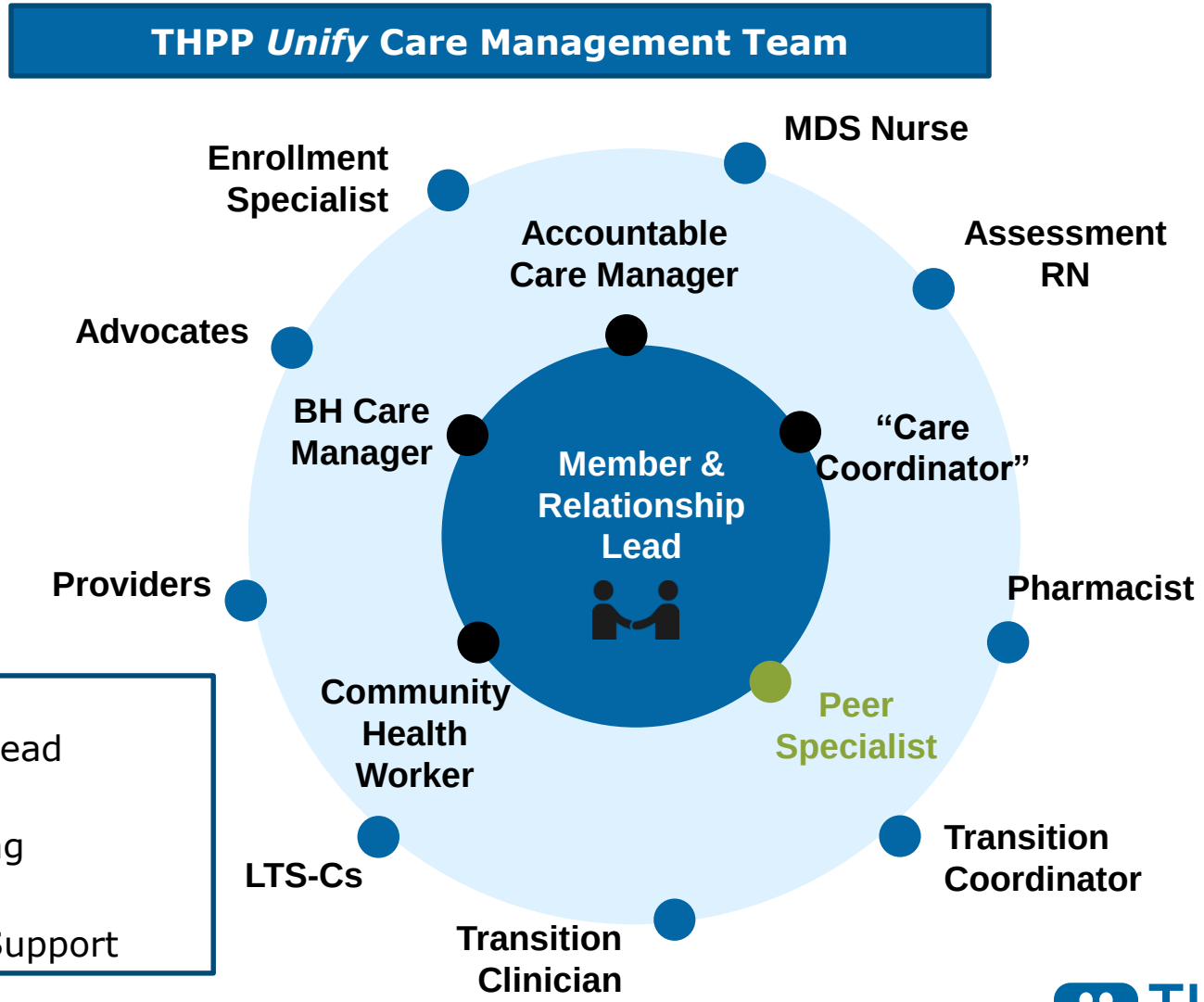


Care Team Composition: THP *Unify* Model

The Unify model of care creates interdisciplinary care teams that allows care team members to work at the top of their license

	Team Roles	Relationship Lead
Core Care Team *Panel: Approximately 400 members*	Accountable Nurse Care Manager (Team Lead)	Highest acuity members
	BH Care Manager	High-acuity BH members
	Community Health Worker	Moderate acuity
	"Care Coordinator"	Lowest acuity
	Peer Specialist	*Team-based support*
	Support Teams	**Function**
Supporting Roles	Enrollment Team	Support initial member outreach and engagement
	Assessment Team	Specialists in completing in-home comprehensive assessments
	Care Transitions Team	Support all transitions between care facilities
	Clinical Pharmacy Team	Support complex medication management

THPP *Unify* Care Team



TUFTS Health Plan

Care Coordinators: Advocacy

A primary role of Care Coordinators is to advocate on behalf of their members, ensuring that members' priorities are addressed as a part of their care plan

- Care Coordinators (Relationship Lead) are the primary contact, ensuring the following:
  - Coordination and continuity of care
  - Access to necessary services as determined by the member-driven care plan
  - Supporting member advocacy
- Care Coordinators are advocates for their members and facilitate members' access to appropriate services. Care Coordinators are also expected to educate their members on services available
- THPP *Unify* has robust oversight and management infrastructure to support Care Coordinators in finding the appropriate balance between addressing member needs, supporting members' dignity of risk, and managing overall utilization
- THPP *Unify* utilizes an extensive vetting process to identify and recruit Care Coordinators who can best serve as member advocates

Care Coordinators: Service Authorization

Member-Focused Service Authorization

Care management and service authorization staff **collaborate** to evaluate requests involving **specific member needs**

Integrated **care plan informs service authorization decisions**, keeping larger outcomes in mind

Extensive experience making service authorization decisions for Members who require **review outside of established guidelines**

UM clinicians to use **Member goals and desired outcomes** in service authorization decisions, in collaboration with THPP Medical Director

Care managers serve as **Member advocates** and ensure UM Clinicians have all information necessary to make informed decisions

Appropriateness of site of service delivery is considered in all UM decisions

Care Coordinators: Additional Responsibilities

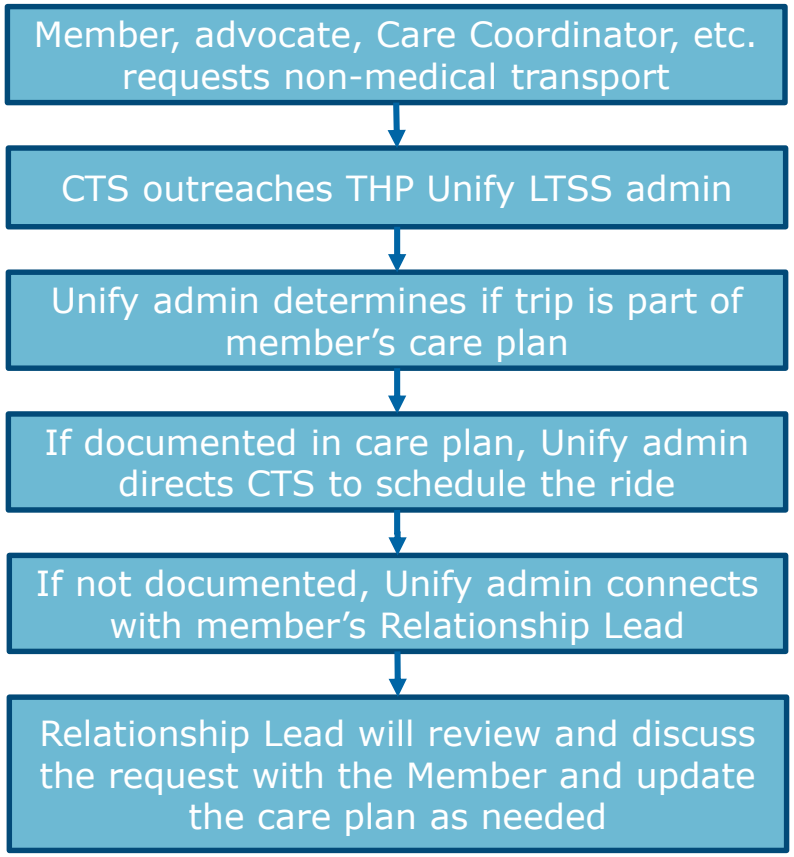
As the primary source of contact for the member, the Relationship Lead (Care Coordinator) is responsible for working with the member to:

- Develop the individualized plan of care, based on ongoing assessment and members' priorities
- Address members' medical, behavioral and social needs
- Work with the member to manage their plan of care
- Coordinate services on the member's behalf
- Promotes the role of the LTS-C as an advocate and ensure that LTSS services are provided when needed
- Manage the member's care transitions
- Help to remove barriers to care
- Arranging home and community based services, including transportation to medical appointments
- Educating the member and caregiver(s)

Non-Medical Transportation

THP Unify provides non-medical transportation through our transportation vendor, CTS, in a member-centric manner.

- Determination of need is driven by the member's care plan via the **transportation assessment**
- The members' care plan will include problems, goals and interventions focused on non-medical transportation needs, as needed
- The care plan is developed in partnership with the member and their advocates
- The Care Coordinator works as an advocate of the Member, supporting them in identifying non-medical transportation needs and ensuring those needs are appropriately reflected in the care plan



Non-Medical Transportation: Member Vignettes

Member Vignette #1: Family Relationships

- As part of their care plan, the member is interested in re-establishing their relationship with their estranged family member. The member believes this is an important step in their recovery journey.
- The member and care coordinator agree to start with 2 visits per month. The care coordinator updates the member's care plan to include **non-medical transportation to visit family**.
- The member's progress is evaluated as part of an ongoing member outreach and the care plan is revised based on the needs and input of the member.

Member Vignette #2: Access to Church Services

- As part of their care plan, the member is interested in working on their spiritual health and report they are interested in going to church 2 Sundays per month. The member believes this will help manage their anxiety and depression.
- The member and care coordinator agree to start with 1 visit per month. The care coordinator updates the member's care plan to include **non-medical transportation to church.**
- The member's progress is evaluated as part of an ongoing member outreach and the care plan is revised based on the needs and input of the member.

Non-Medical Transportation: Member Vignettes

Member Vignette #3: Redetermination

- As part of their care plan, the member is interested in taking more responsibility for managing their redetermination process. The member and their LTS-C agree to develop a plan to support the member's success.
- The LTS-C communicates with the member's care coordinator who updates the care plan, including documenting the need for **non-medical transportation to the enrollment office** to ensure the member is timely in their paperwork submission.
- The LTS-C agrees to work with the member and support them during this process and ensure the member's goal was achieved.

Member Vignette #4: Grocery Shopping

- As part of their initial assessment, the member reports multiple hospitalizations due to chronic alcohol use and a related history of malnutrition resulting from food insecurity during periods of homelessness.
- The member has committed to a recovery plan and reports sobriety for the last 3 months. Their PCP is concerned about their nutrition intake. The member wants to focus on improving their nutritional status, but declines home delivered meals.
- Their preference is to manage their own grocery shopping and meal prep. The member's care plan reflects this goal, including documenting the need for weekly **non-medical transportation to the grocery store.**