# Slide 1: THPP Unify Implementation Council Meeting

11/12/19

# **Slide 2: Table of Contents**

* Role & Scope of Care Coordinators
* Care Coordinators and Member Advocacy
* Non-Medical Transportation

**Language Key**

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

# Slide 3: 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

# Slide 4: Care Coordinators: THP Unify

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

The following information is show in an hierarchical organization chart

* **Care Coordinator Contract Term**

This contract requirement is translated into four (4) THP Unify care team roles

* Accountable RN Care Manager
  + Licensed RN
  + Key point of contact for members with highest complexity medical needs
* BH Care Manager
  + Licensed Social Worker
  + Key point of contact for members with behavioral health needs
* Community Health Worker
  + Trained CHWs
  + Key point of contact for members with moderate complexity
* “Care Coordinator”
  + Trained “Care Coordinators”
  + Key point of contact for least complex members

# Slide 5: 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

## Core Care Team (Panel: Approximately 400 members)

**Team Roles**

* Accountable Nurse Care Manager (Team Lead)
* BH Care Manager
* Community Health Worker
* “Care Coordinator”
* Peer Specialist

**Relationship Lead**

* Highest acuity members
* High-acuity BH members
* Moderate acuity
* Lowest acuity
* Team-based support

## Supporting Roles

**Support Teams**

* Enrollment Team
* Assessment Team
* Care Transitions Team
* Clinical Pharmacy Team

**Function**

* Support initial member outreach and engagement
* Specialists in completing in-home comprehensive assessments
* Support all transitions between care facilities
* Support complex medication management

are Transitions TeamClinical Pharmacy Team Support complex medication management

# Slide 6: THPP Unify Care Team Note:the following information is shown in concentric circles with the Member & Relationship Lead in the center. The next outer circle includes the Relationship Lead Options including the Peer Specialist which is a team-based support, and the outer edge of the circle includes the Key Support Resources.

**THPP Unify Care Management Team**

## Relationship Lead Options

* Accountable Care Manager
* “Care Coordinator”
* Peer Specialist (Team-based Support)
* Community Health Worker
* BH Care Manager

## Key Supporting Resources

* MDS Nurse
* Assessment RN
* Pharmacist
* Transition Coordinator
* Transition Clinician
* LTS-Cs
* Providers
* Advocates
* Enrollment Specialist

# Slide 7: 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

# Slide 8: Care Coordinators: Service Authorization

Member-Focused Service Authorization

* Care management and service authorization staff **collaborate** to evaluate requests involving **specific member needs**
* Extensive experience making service authorization decisions for Members who require **review outside of established guidelines**
* Care managers serve as **Member advocates** and ensure UM Clinicians have all information necessary to make informed decisions
* Integrated **care plan informs service authorization decisions**, keeping larger outcomes in mind
* UM clinicians to use **Member goals and desired outcomes** in service authorization decisions, in collaboration with THPP Medical Director
* **Appropriateness of site of service delivery** is considered in all UM decisions

# Slide 9: 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)

# Slide 10: 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

**Note**: The following is displayed in rectangles one below the other, with arrows between each item illustrating the process flow.

Member, advocate, Care Coordinator, etc. requests non-medical transport

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CTS outreaches THP Unify LTSS admin

Unify admin determines if trip is part of member’s care plan

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If documented in care plan, Unify admin directs CTS to schedule the ride

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If not documented, Unify admin connects with member’s Relationship Lead

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Relationship Lead will review and discuss the request with the Member and update the care plan as needed

# Slide 11: **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.

# Slide 12: 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.**