Tufts Health Public Plans
Unify Program

Implementation Council Presentation

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TUFTS Health Plan

Agenda

1. Overview of Care Management Emergency Management Structure
2. Triage and Addressing Member Needs
3. Access to Ongoing Care
4. COVID-19 Testing
5. Responding to COVID-19 Positive Members
6. Supplies and Member Education
7. Day Program Attendance and Follow-up
8. COVID-19 Data

Emergency Management: Planning Framework

THP has implemented a robust emergency management framework to ensure the safety of staff and members as we deliver care and coordinate services

- Care management activities have been curtailed based on recommendations of the CDC, DPH, guidance received by external regulators and policy set by THPs internal emergency management team
- Ongoing operations management and contingency planning will also be informed by new information and guidance as it is received
- The highest priority is to ensure staff safety while meeting needs of members who are at greatest risk for decompensation due to exposure to the virus and or potential disruption in critically needed community-based services
- In-home visits for high risk members will be evaluated on a case by case basis. Since care managers do not function as direct care providers, any member who requires a face to face risk assessment will be managed using the VNA/LTSS network and supported by telephonic care management

Emergency Management: Risk Assessment

THP has implemented a robust emergency management framework to ensure the safety of staff and members as we deliver care and coordinate services

- Ongoing risk assessment occurs through daily huddles with the care team, led by a clinical manager
- The purpose of these huddles is to triage members who require additional interventions to ensure their safety and prevent risk for clinical (physical and behavioral) destabilization
- During this process, members are triaged based on their risk profile and care plans modified to reflect emerging member needs & appropriate interventions as agreed upon by the member.
- The member's Interdisciplinary Care Teams (ICT) are activated with a goal to establish stabilization care plan, including critical follow-up, PCP visits, and provision of additional services
- Care plan review and revisions are made based on member triage, clinical assessment and reflect risk mitigation strategies
- Daily phone call debriefs inform follow-up activities

Emergency Management: Case Prioritization

Clinical Complexity	• Complex members who are dependent on in-home services, transportation and PCA • Members with gaps in documented contingency plans • Members newly discharged from inpatient facility for immediate outreach and assessment, including the need for referrals to VNA, ASAP, other community services • Members who need in-home assessment by VNA for immediate risk assessment • Members who have VNA skilled services that are critical to the member's stabilization plan and follow up with VNA to assess potential risk of service disruption • Any members identified based on the clinical judgement of the care manager
Psycho-Social Needs	• Members with potential food insecurity and need referral to LTSS for meal services • Members who may require personal emergency (Lifeline) device to manage though crisis period • Members receiving dialysis and are dependent on transportation • Homeless members with/without stable connections to local shelters
Other Dependency	Members with care plans including extended stay in vulnerable community-based programs, including but not limited to: • Dialysis Units • Adult day health program • Group adult foster care • Group Homes • BH Partial day programs • Dayhab programs

Emergency Management: Care Coordination

THP is making sure our network partners are able to ensure member safety and continue to provide high-quality care

Outreach all ASAPs, ILCs and community partners to inquire about their emergency management planning activities, including but not limited to the following:

- Triage system to identify high risk members in need of outreach and/or home visits
- LTS-C capacity and back-up staffing plans
- Criteria that informs members targeted for in-home assessments
- System to prioritize LTSS referrals
- Outreach to transportation vendors (CTS) to inquire about their approach to manage containment and ensuring continuity of care
    - Infection control practices are in place with staff (and in vehicles)
    - Personal protection equipment available for members
    - Any changes in vendor operations to comply with CDC guidelines
- For members with complex VNA/Home Health care plans, the CM will outreach the VNA to case conference and identify additional intervention and assessment needs

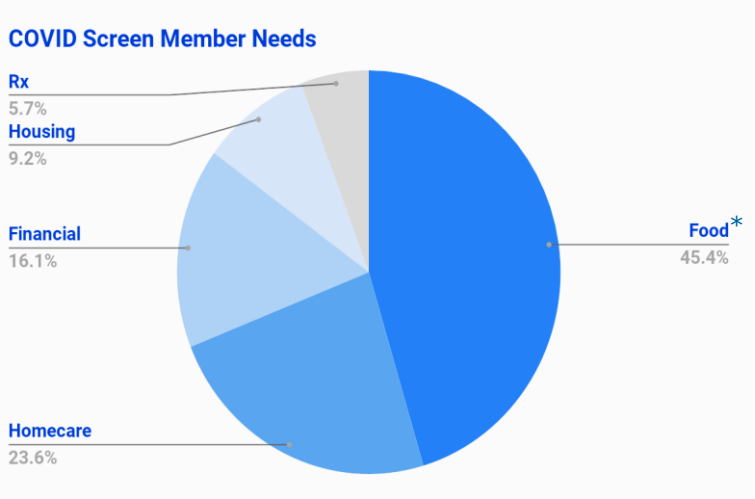
Triage and Addressing Member Needs

What criteria are you using to triage high risk populations' needs and what process are you using to ensure their health needs are being met?

- As part of an organization-wide emergency management system, THP has developed a comprehensive member triage and response process:
  - Analytics-driven insights allow us to stratify members based on clinical risk and as informed by CDC and Public Health guidelines
  - A COVID-19 assessment tool was developed based on CDC guidelines
  - Members are outreached to complete a COVID assessment and intervene as needed
  - All Unify CMs and managers have received COVID-19-specific training to support identification and resolution of member needs
  - Members are connected with appropriate resources based on assessment findings, including **rapid referral** to VNA for in-person clinical assessment
  - A resource directory has been developed for ready access to services
  - Daily COVID huddles with care team to ensure timely escalation/follow-up
  - High needs members are reviewed daily to ensure safety
- Analogous process exists for CBH to ensure care consistency

Triage and Addressing Member Needs

- COVID-19 Assessment includes key elements to assess member needs and risks that inform care coordination activities:
  - COVID-19 symptoms and testing
  - Support Systems to address social isolation
  - Back-up contingency plans
  - Educate / transition to Telehealth intervention
  - Adequate supply to medication, medical supplies, food
  - Frequent contact by care manager to ensure continuity of communication
  - Depression screening: PHQ2 assessment tool with referral to BH clinician for in depth PHQ9 assessment and follow-up
- Member feedback:
  - Food delivery, Access to AA, Medications
- Family and Support System feedback:
  - Willingness to engage with members and support them



Worcester Member Responses (Cityblock Health)

*CBH has implemented an emergency meals program which provides frozen, shelf stable and fresh food packages to members based on need

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Triage and Addressing Member Needs

A member that is dependent on food delivery through Peapod. Peapod's delivery policy changed due to the pandemic and they would only to deliver food to his lobby entrance. The member lives alone on the second floor and cannot lift or carry heavy objects due to medical issues so he would be unable to go downstairs to collect his food. He was very concerned that someone might steal his groceries if they were left unattended. The CHW worked with Peapod to adjust their policy and safely deliver the food to the member's apartment so that he would not have to carry/ lift them.

A member who has struggled with sobriety for many years. Since July 2019, she has been able to maintain sobriety. She started attending AA meetings by phone during the COVID-19 pandemic and reports that it has been extremely helpful. She has also been connected to a Unify Peer Specialist who connects with her on a weekly basis for additional supports.

A member with several medical conditions including a recent CVA (stroke). Because she is at high risk and very anxious about COVID-19, she was fearful and did not want to leave her home. Because of her recent stroke, she is on anticoagulant medication ("blood thinner") therapy that requires frequent blood testing and medication adjustments. Her Case Manager coordinated with the member's providers, the Tufts' UM team and Medical Director to support the member and authorize out of network, in-home blood draws.

Access to Ongoing Care

How are you providing members with critical preventative care or other ongoing critical medical needs that are unrelated to COVID-19?

Care managers follow THP emergency management protocols and CDC guidelines:

- Clinical Care Continuity
  - Members' COVID-related assessment and follow-up are integrated into the members' care plan
  - Care managers evaluate any disruption in ongoing medical and behavioral follow-up within the context of COVID emergency management
  - Medical and behavioral appointments are held through provider-based telehealth
  - Planned medical follow-up is managed based on emergency management protocols set by providers and facilities
  - Medication delivery systems have been implemented through local pharmacies
- Social Support Engagement
  - Leverage peer support for members with limited support and in recovery programs
  - Where appropriate, family members are engaged to support
  - Socially isolated members are contacted more frequently, including daily check ins
  - LTS-Cs are engaged in member contact activities

COVID-19 Testing

How do you identify who needs COVID-19 testing done? What is your process if someone needs a COVID-19 test done?

- The COVID-19 screening tool enables our trained CMs to identify members with exhibiting symptoms of COVID-19, in addition to non-COIVD medical and BH needs
  - Members identified as potential COVID cases (or other non-COVID-19 related clinical need) are connected with their physician for further testing/treatment
  - Members at risk of depression or other BH conditions are connected with a BH CM for further assessment and follow up
- Organizational communications strategy reinforces CM outreach:
  - Members have access to our nurse line or their CM with any questions around COVID-19 and testing
  - SMS (incl. Robo-Call/Letters) campaign informs our members about critical COVID-19 resources, extended coverage, and wellness tips
  - THP website includes information & resources for members around all COVID-related topics

A member reported to care management that she had tested positive for Corona. She was very concerned and worried. The TOC nurse was able to call the hospital and clarify that she was positive for influenza, but she was not positive for COVID-19. She was very relieved and appreciated the clarification, education and support.

Responding To COVID-19 Positive Members

What do you do if a One Care member tests positive for COVID-19?

Hospitalized Members

- The Unify Transition of Care (TOC) team coordinates with inpatient facilities to ensure members have the services and information they need to safely transition back to the community and back to the care of their primary care manager

Members in the Community

- The primary care manager, with RN support, reinforce and support the member's prescribed treatment plan, including:
  - Monitoring members more frequently and assessing for increased needs
  - Reinforcing CDC guidelines for self-quarantine and self-care
  - Coordinating access of PPE through community and State resources
  - THP will be stocking PPE for distribution to members if other options are not successful

A member who typically does not answer our calls or engage in care management. During his recent hospitalization and despite his continued struggle with sobriety since discharge, the member has been consistently engaging with the TOC team. To maintain this connection, they have extended their usual monitoring period and in collaboration with the assigned case manager, they have been coaching and reinforcing his coping skills, community resources and medication adherence.

Supplies and Member Education

What are you doing to educate members and provide PPE, supplies, etc. to prevent COVID-19 transmission?

- THP has an organized a comprehensive approach to ensure all members receive the latest information and education related to COVID 19:
  - Outreach and care coordination by the care manager
  - Member education material specific to COVID-19
  - 24/7 Nurse line and access to Unify on-call system
  - Resource directory available to identify, coordinate, and secure resources, including PPE, sanitizer, etc.
  - SMS (incl. Robo-Call/Letters) campaign informs our members about critical COVID-19 resources, extended coverage, wellness tips, and directs them to the THP website for more information and resources
- Worcester members benefit from Cityblock Health's education/prevention programs:
  - CHPs provide education to members on accessing MassHealth PPE Program for healthcare workers.
  - BH clinicians offer a weekly video conference for members which includes COVID-19 education and coping skills.
  - Care Team can provide remote monitoring, instructions, & request cloth masks for members that are mailed by CBH directly to member's homes. Furthermore, they can also purchase cleaning supplies, hand sanitizer and gloves for members using the Member Goodwill Policy.
  - Clinical staff ensure members receiving homecare have adequate PPE and provide education

Day Program Attendance and Follow-Up

What are you doing for members who used to attend day programs to ensure they are getting their needs met? Do you have a schedule for these members that you could share?

- As guidance on Adult Day Health was received, the Unify CM team identified members who would be impacted, along with alternatives available for these members, including assessment for additional PCA, Home health Aide and LTSS services
- Family members have engaged with the member to provide additional supervision and oversight
- The members needs are continuously assessed as part of ongoing outreach and follow-up

COVID-19 Data

THP members as of 5/7/2020

Outreach	Attempted for 100% of members Successful* for 62% of members Weekly attempts for members still in need of outreach
COVID-19 Testing	14 Members positive 3 Members pending results 1 Member diseased
Disruptions	No identified members have had PCA service disruptions No members referred to HHA in lieu of PCA services 10 members were affected by ADH closures 2 have increased PCA services (1 pending) due to ADH closure