Addressing Social Determinants of Health in Response to COVID-19

July 2020

TUFTS Health Plan

Agenda

1. Approach to Assessment for COVID-19
2. Identifying Needs During COVID-19
3. Telehealth Utilization
4. Member Outreach and Education
5. Cityblock Health COVID Response

Approach to Assessment for COVID-19

Members were prioritized based on their risk status, including clinical condition, psych-social factors, SDoH factors and based on the judgement of their care manager

- The prioritization process included the following factors:
  - Risk stratification algorithms identified members for priority outreach
  - Members who were dependent on community-based services to ensure their independence and safety at home (PCA, transportation, meals, medication management, dialysis, VNA, methadone treatment, etc.)
  - Homeless members
  - Language barriers
  - Other risk factors identified based on the member's care plan

As part of ongoing outreach, the member's care plan was reviewed and revised to reflect their needs and preference

- Example: *Two Unify members are married and both are blind. They have 3 children. They were identified as high risk in March. The CM added home delivered meals for this couple and contacts them regularly to monitor and assess their status.*

Identifying Needs During COVID-19

A comprehensive COVID assessment was developed based on CDC guidelines and included the following elements:

- **Assessing for COVID symptoms**
  - Educating on symptoms and referring to PCP
  - Educating and facilitating Telehealth visits
- **Educating on prevention of COVID transmission**
  - Washing hands, masks, cleaning surfaces, social distancing and access to PPE
- **Assessment of current services**
  - Frequency of any LTSS services, any disruption or anticipated disruption, contingency planning
  - Availability of transportation for essential medical and social needs
- **Availability of and access to food, medications, supplies, oxygen or any DME**
- **Behavioral health needs**

The COVID assessment informed care plan revisions, targeted interventions based on members preferences and the cadence outreach frequency to members to ensure their safety during this period

Food Insecurity

Food needs are evaluated as part of the COVID assessment. Additional home delivered meals and grocery delivery are provided to members as needed. All requests regarding food access were authorized. There were no members that required nutritionally tailored meals.

- Fourteen members had food-related needs identified directly related to COVID
  - Four members were authorized for grocery delivery services
  - Six members were authorized for home delivered meals
  - Three families chose to provide meals themselves vs introduce potential exposure to the virus
  - One member had partial home delivered meals and partial assist by family
- Example: *Member is dependent on food delivery through Peapod. Peapod's delivery policy changed due to the pandemic and they would only 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 deliver the food directly to the member's apartment and even carried them into his apartment so that he would not have to carry/ lift them.*

Housing

As part of COVID outreach and assessment, housing and shelter needs are assessed.

- Three homeless members accepted housing and support from their family members.
- 2 Shelters expanded services by adding meals and the ability for members stay in the shelter through the day with a medical note.
- CMs were able to help 2 members to obtain necessary letters to keep them at the shelter and relatively safe during this emergency period.
- Example: *One member that is homeless and difficult to maintain contact with called her CM for assistance. The shelter that this member utilized added additional meal service and the ability to have members stay in the shelter through the day with a medical note. Her case manager was able to call the provider, with the member on the phone, and obtain the letter needed to help keep this member safe during this emergency period.*

Transportation

As part of COVID outreach and assessments, transportation needs are assessed. As a result of that assessment:

- Four members received opted to receive transportation from their family member vs utilize the transportation benefit to minimize exposure
- There was no interruption in transportation for critical medical appointments, dialysis, and medication assisted therapy visits
- During the pandemic period there was a decrease in transportation requests

Social Isolation

Assessing social isolation is an important component of the member's COVID assessment process and all members outreached were evaluated, including need for additional support. The COVID assessment includes a depression screen that also identifies members at risk.

Members in need of additional support were managed in the following manner:

- Increase in member outreach for member's in need and based on member preferences
- Referrals are made to Peer Support Specialists. Peers Specialist make telephonic contact with members frequently (once per week or greater) to provide support, share resources and help decrease social isolation.
- Coordinating referrals to additional community services, including access to peers, telehealth counseling/therapy, telehealth AA

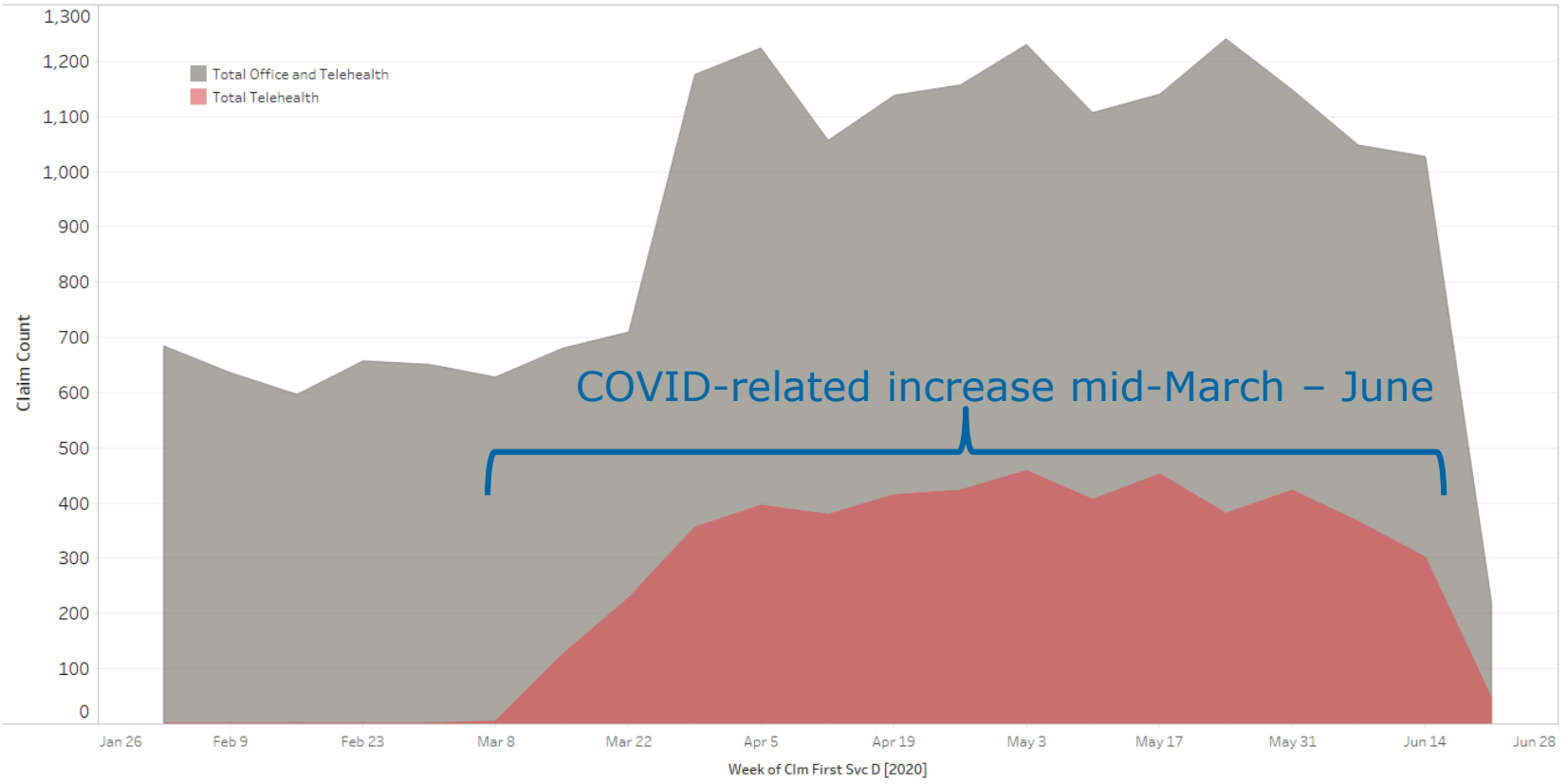
As part of depression screening, members who screen positive were referred to a behavioral care manager for further evaluation and intervention, including facilitating access to tele health services for supportive counseling and therapy.

- 23 members score positively and transfer to a BH CM for further evaluation
  - 11 members were referred to their provider for telehealth services
  - 2 members with high anxiety were referred to their provider for medication management medication regime
  - 10 members received first time BH referrals.

As an organization, THP rapidly responded to authorizing telehealth services

Behavioral Health Telehealth / Unify Members

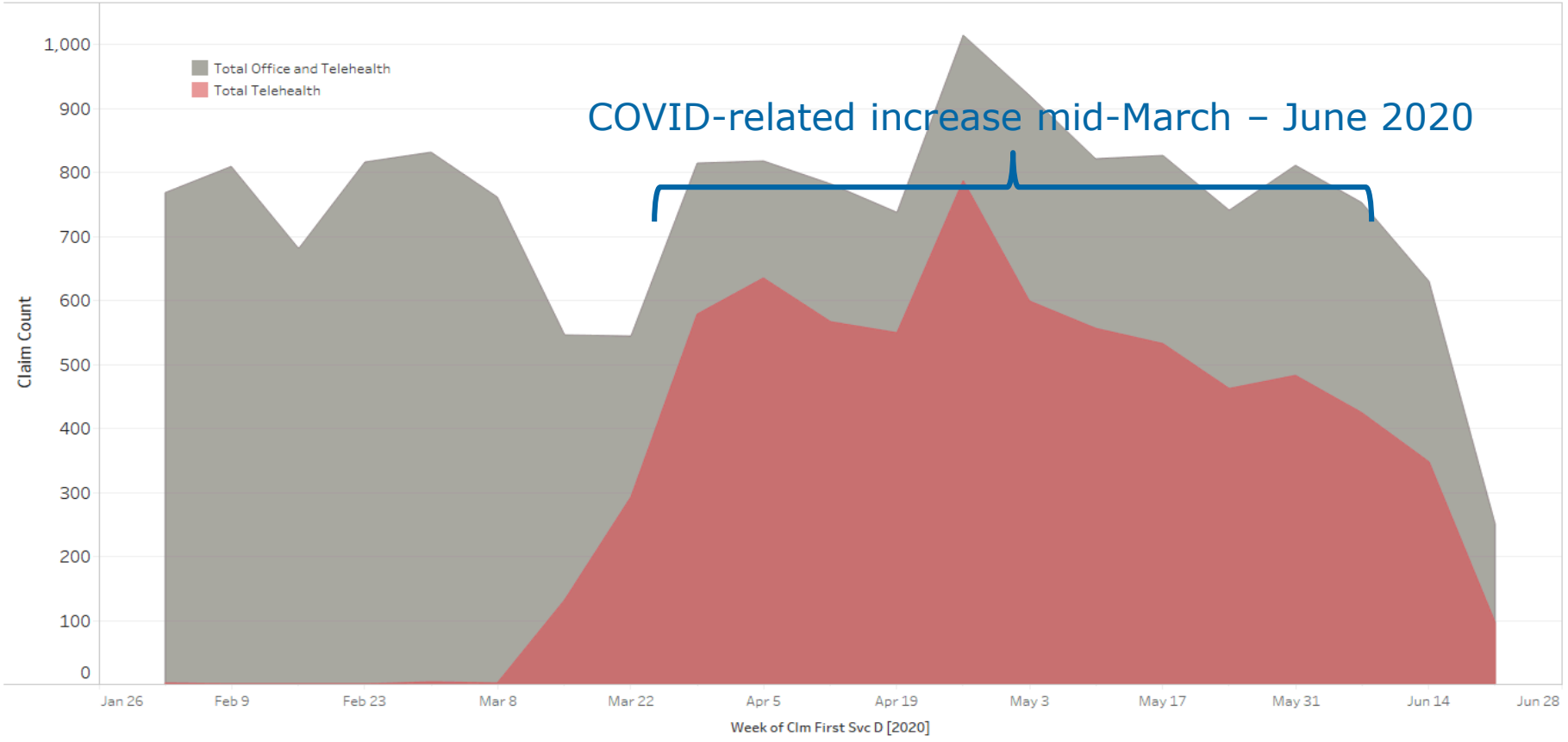
Behavioral Health utilization increased significantly since the start of the pandemic, driven by telehealth utilization



TUFTS Health Plan

Medical Telehealth / Unify Members

Medical Health telehealth visits increased significantly since the start of the pandemic, offsetting any reduction to in-person utilization



TUFTS Health Plan

Reducing COVID Transmission

As part of our initial COVID member outreach, disease transmission risk, prevention and PPE was assessed.

- Members are educated on preventative measures (handwashing, masks, disinfecting services, social distancing)
- Member education material related to COVID was provided to members, including mailing this information to members who were not successfully outreached
- The marketing and communications team at THP developed a COVID plan that included updated website, provider education, and text messaging
- A COVID resource library was developed, including how to access PPE through local community organizations and through Mass health

- Example: *Two members that tested positive were in contact with the Mass Health Hotline for PPE. 10 members referred to two community resources for PPE resources. The CM contacted the provider of one member that was going to daily chemotherapy. Provider was able to provide member with masks. Several members reported to CM that they were making their own cloth masks.*

Outreach to Specific Groups

Members that are not proficient with English or others with potential limits to access or understanding based on cultural or ethnic status were prioritized for outreach.

- The COVID assessment includes a language need assessment and the Interpreter line or Mass Relay Line is utilized as indicated.
- Example: *A member with English as her second language 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.*

Alternatives to HCBS

As guidance was received from regulators, all members affected were assessed for impact and alternative interventions. Care plans were revised based on the members needs.

- Six members were affected by Adult Day Health (ADH) closures:
  - Five of the six members outreached reported they **preferred** to rely on their family (available to quarantine impact) to assist them. As such, they declined additional PCA services
  - One of the six members did accept additional PCA services

- Members were also outreached by the ADH provider to provide social contact, offer support, allow the members to voice any questions or concerns, including updates on potential re-opening of programs
  - One member was called daily by their ADH provider and discussed plans to re-open including their safety protocol

Other Relevant Information

- Due to the quarantine, members reported that family was available to assist. They accepted help from family and declined opportunity for additional services to minimize their exposure. To date, these services have not resulted in use of the home health benefit to aid family members to become paid caregivers.
- Review and revision of care planning based on members' needs is ongoing.

COVID-19 Data

THP members as of 7/7/2020

Outreach	• Attempted for 100% of members • Successful assessment for 69.4% of members • Weekly attempts ongoing for members in need of outreach
COVID-19 Testing	• 23 Members positive • 1 Member deceased
Disruptions	• No identified members have had PCA service disruptions • No members referred to HHA in lieu of PCA services • 6 members were affected by ADH closures • 1 member has increased PCA services due to ADH closure

TUFTS Health Plan

Cityblock Health COVID Response

Cityblock launched in MA on March 2nd, and almost immediately realigned priorities and resources to respond to the new set of critical risks from COVID-19

- Cityblock recognizes the huge risk that our population represents for infection with comorbidities, in-home care disruption, unmet clinical and social needs and worked quickly to assess and support those needs
- **Key interventions included**:
  - Increased intensity of urgent in-home care. Launched a rapid, in-home paramedicine operation with <90-minute response (this was not planned for MA prior to COVID)
  - Continued to focus on Provider care, including in-home where needed to prevent members from unnecessary exposure to hospitals and practices
  - Developed a COVID assessment for immediate deployment

Cityblock Health COVID Assessment

- Cityblock Developed a COVID-risk assessment, and prioritized it over existing assessments. This screen emphasizes immediate safety, assuming rapidly changing conditions.
- Cityblock completed **1,778 Covid-19 assessments** between March 24 and July 6

Clinical Flag	Count	Intervention examples
Food insecurity	97	CHP provided referrals to food pantries, assist member with SNAP applications, assisted members with sign up for grocery delivery service, provided emergency care packages of food to members, delivered groceries to member
Loss of homecare	46	CHP/NCM advocated for members reinstatement of services, assisted members to find replacement PCA/HHA services, assisted with renewal paperwork
Financial emergency	33	CHP assisted members to identify available resources and complete applications for utility assistance, unemployment, fuel assistance; followed up on applciations until service was approved
Housing Instability	26	CHP assisted members with housing search, applying for rental payment assistance, applying for public housing, obtaining and submitting paperwork, securing a safe place at sober hosuing, shelters and apartments
Medication need	15	NCM escalated RX needs to providers and obtained medications, CHP enrolled members in to RX delivery services, CHP/PA picked up and delivered emergency supplies of medication, PA perscribed new medication for innefective script.

Cityblock Health Member Stories

Cityblock prioritized COVID-19 Assessments in order to ensure that they identified and addressed as many urgent or life-threatening issues that were experienced by our members as a result of Covid-19 and stay-at-home orders.

1) A COVID Screen uncovered a member who had been turned away from his permanent living situation and was now living in a remote trailer without adequate sanitation. This member reported no food in the house going in to a long, holiday weekend. Their CHP delivered an emergency food package to the member and worked with a local pantry to have groceries delivered. The CHP explored housing options with the member and as a result was able to identify friends he could stay with until he secured permanent housing.

2) During a COVID assessment, the Cityblock CHP learned that a member was considering cancelling their needed PCA services due to COVID concerns. The CHP secured PPE (gloves and face masks) which made the member comfortable in continuing PCA services.

3) Assessed member was living in volatile situation with roommate/landlord who had assaulted them, causing bodily injury. The ongoing conflict was causing anxiety & depression and alcohol use as a coping mechanism. The CHP escalated to a BH Specialist, and they worked together to support the member emotionally while working to secure housing alternatives. The member is now stable and living in a sober living house found by Cityblock.

4) During a COVID Assessment, the Cityblock Community Health Partner (CHP) learned that the assessed member was critically in need of food, had no food in the house and had not eaten that day. The member also has complex medical needs and a diagnosis of depression contributing to their food insecurity. The only food pantry in his rural hometown had already allowed an extra visit for the month despite a strict policy against the practice. A Cityblock team member was deployed to the home of the member, delivering enough healthy food to last a week, during which sustainable options could be identified.

5) During a COVID screen, a member reported that they were involved in a domestic violence situation, had run out of their psychiatric medication, and had less than two days worth of food. Their CHP immediately delivered an emergency care package of food, the care team's PA renewed an expired prescription and the team's Nurse Care Manager filed a care and protection order with the Department of Children and Families. In subsequent conversations, the member revealed that she had secured food for the long term, was feeling safe, and feeling better with regard to their mental health.