Implementation Council

THP Unify Update

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Care Coordination

Presented by:

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Context

- Overview: Model Of Care
- Interdisciplinary Care Model
- Case Study Responses
- Conclusion and Discussion

Program Goals:

Improve access to and coordination of medical, behavioral and social services that can reduce unnecessary and preventable admissions, emergency room visits, facility based care, while promoting self directed care and independence for its members

- Member is central to the care planning process
- An interdisciplinary care team (ICT) model is key to effectively coordinate care and services for members across the care continuum
  - Member chooses the ICT membership, engages in and drives their care planning and evaluation process
  - Primary care engagement
  - **LTS C active participant**

Critical Success Factors:

- Member Engagement
- Provider Engagement
- **Care Management**

TUFTS Health Plan

Philosophy of care management model

"Nothing about me without me."

- Our care model is member-centric and focused on the needs, values and preferences of individual members
- Our efforts focus on areas where we make a meaningful difference for our members
- Care planning is inclusive and based on the principle of shared decisions between members and their interdisciplinary team
- Care management strategies follow the member's "personal" commitment to overall health management and self-direction
- Care coordination is best supported through an integrated care delivery model

Gorski, David. "Dr. Donald Berwick and "patient-centered" medicine: Letting the woo into the new health care law?". Jul 20 2010. https://sciencebasedmedicine.org/dr-donald-berwick-and-patient-centered-medicine-letting-the-woo-into-the-new-health-care-law/

Care Management Approach:

As the primary source of contact for the member, the care manager is responsible for **working with the member and based on preferences,** to:

- Develop the individualized plan of care, based on ongoing assessment
- Work with the member to manage their plan of care
- Ensure continuity of care whenever possible
- 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)
- Serve as a strong member advocate

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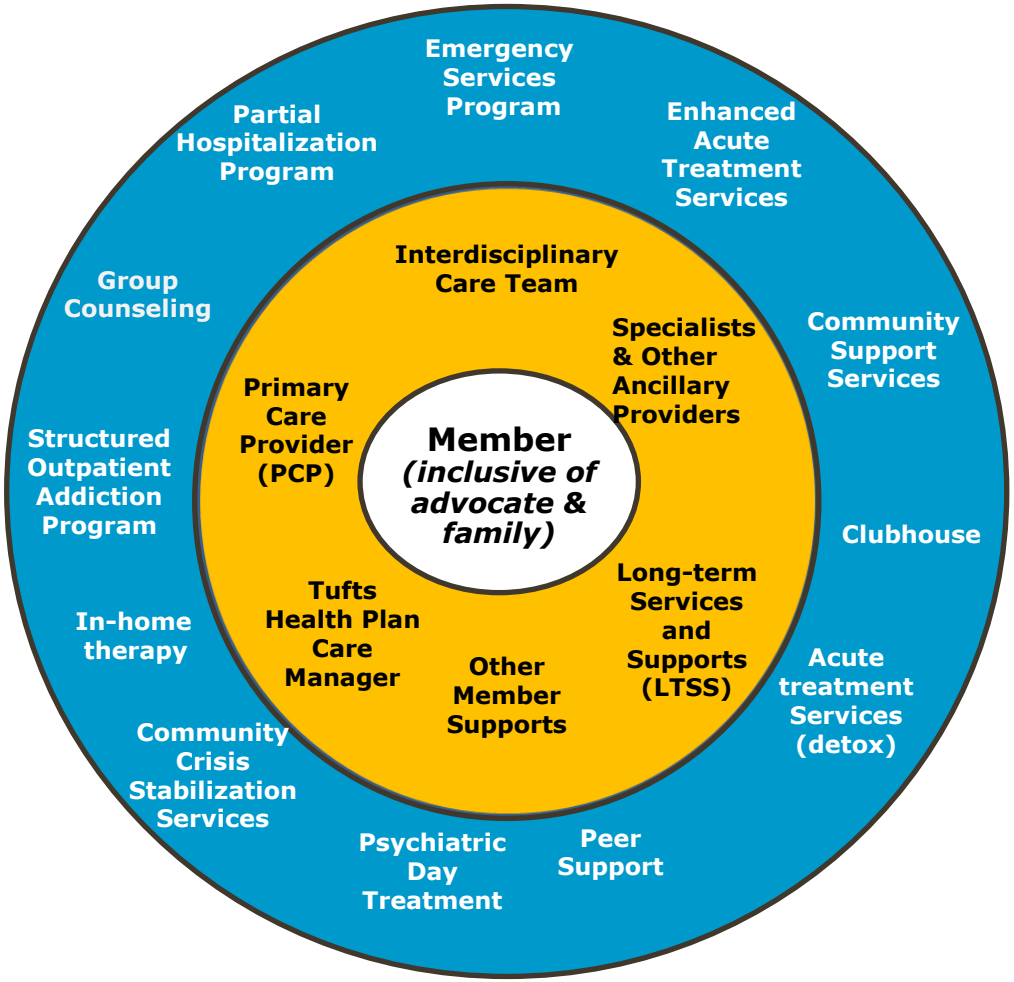
Behavioral health model of care / Example



Tufts Health Plan's model of care is designed around an interdisciplinary care team that is member-focused.

Coordination of health services, including mental health, substance use, and primary care, is necessary to achieve positive outcomes for people with complex health care needs.

The member's care manager is the primary point of contact and works with the member and their LTS C to ensure coordination of services and member progression toward goals

TUFTS Health Plan

Case Studies

Analysis and Care Management Approaches

Andrea: Traumatic Brain Injury

Profile	Care Management Approach

• Complex member with cognitive deficit
• Social isolation
• PCA compensates for service gaps
• Lack of knowledge re: benefit
• Barrier to self direction
• Care manager not responsive
• Lack of advocacy / Fear
• Member rights/protection
	• Comprehensive Assessment
	  ○ Psycho-social
	  ○ Functional / Safety
	  ○ Risk Profile
	• Access LTSS
	  ○ LTS C / Advocacy
	  ○ CSP / Peer support
	  ○ Non medical transport
	• ICT
	  ○ Access and setting of care
	  ○ Care coordination
	  ○ Member choice
	  ○ Address barriers
	  ○ PCA boundaries

Bernie: Auto Accident

Profile	Care Management Approach

• Loss of independence / Chronic pain / Limited mobility / falls
• Social isolation
• Lack of member engagement based on past experience with his care team
• Attempts to self direct care (transportation, purchases walker)
• Care manager not engaged / lack of empathy and advocacy
• Depression / Relapse risk
	• Comprehensive Assessment
	  ○ Psycho-social assessment
	  ○ Functional / Safety
	  ○ Risk Profile
	• Access LTSS
	  ○ LTS C
	  ○ CSP / Peer support
	  ○ Non medical transportation
	  ○ Personal Care
	  ○ DME
	• ICT
	  ○ Home safety/Physical Therapy
	  ○ Pain management
	  ○ Social Stimulation
	  ○ Depression Treatment

Conclusions / Discussion

- Assessment Process drives care planning and care coordination
- Member engagement optimizes the assessment and care planning process
- Leverage LTS C whenever possible
- Leverage ICT to advance the member's care plan and progression
- The relationship the member has with their care manager is critical
- Knowledge of benefits and advocacy drives self direction
- Influencing members without taking charge