



Tufts Health Unify: Women's Health

One Care Implementation Council

November 13, 2018

Background and Context – Women’s Services

Individualized Care Plans: Care model design offers opportunity to tailor care plans to each member’s needs, including those unique to women’s health

Care Management Aim: To always leverage the integrated care model to manage the member’s complex care needs and meet their expectations

- Member Centered
- Integrated Care Team Model (Medical, Behavioral, Social)
- Assessment, Care Planning, and ongoing member evaluation
- Care Coordination

Today’s Focus: Case study approach to illustrate the member journey

- Pregnancy / Post Partum
- Acute care and crisis management
- HEDIS Women’s health quality measures

Case Study 1: High Risk Pregnancy

A pregnant member had a history of chronic behavioral health, substance use and medical conditions (asthma and sickle cell). The member's health was further complicated by a history of incarceration, domestic violence, unstable housing, and high ED utilization.

During her pregnancy, the member continued to struggle with drug addiction. She lost her apartment and had difficulty keeping her medical appointments.

The member communicated a commitment to sobriety and a goal to have a healthy baby. She was assigned a Community Support Partner (CSP) who facilitated the member's access to a Crisis Stabilization Program, a Women's Shelter program (including medical clinic), and a female obstetrician.

Due to the member's struggle with her addiction, missed appointments, and insecure housing, the member's pregnancy was classified as high risk. Tufts Health Plan authorized the member to remain inpatient through delivery given the member's health and concern for the baby..

Case Study 1: High Risk Pregnancy

Outcome & Key Takeaways

All care management decisions were made with goal of keeping member sober and reducing harm to her baby.

The member remains in staffed housing with her child and is working toward permanent housing. She continues to have a strong relationship with her Care Manager and CSP who have helped her to re-engage with her PCP, accept transportation to appointments and reconnect with her estranged family.

Today, she remains sober and is parenting with support from community based service providers. She is managing her child's medical needs at Children's Hospital.

The baby is now a healthy 3 months old and meeting all her milestones. The Care manager and CSP remain important members of the mother's and baby's care team.

Case Study 2: Community Supports

A *Tufts Health Unify* Community Health Worker reached out to a member when she was at risk of being disenrolled by the end of the month. The member was pregnant and had a history of panic attacks.

The CHW helped the member gather and fax her proof of income and other relevant documentation to MassHealth. By this point, the member had missed appointments with her OBGYN and her BH provider. The CHW called MassHealth daily to make an urgent request to have the member's eligibility restored. The member's enrollment was backdated and she had no lapse in coverage.

Once the member's eligibility was resolved and appointments rescheduled, the CHW used the relationship she established with the member to learn about the type of services she might need to help her manage children. The member admitted to struggling with food insecurity for her and her family.

Case Study 2: Community Supports

Outcome & Key Takeaways

The *Tufts Health Unify* Community Health Worker assisted the member through the redetermination process so that the member could focus on having a healthy pregnancy.

The CHW used her knowledge of various community resources to help the member address food insecurity. The member has access to SNAP and WIC benefits. The CHW accompanied the member to the *Daily Table* to learn about the collaboration with SNAP (get \$1 back on every dollar spent on produce and prepared meals).

Through the Bob's Charitable Foundation, the member received a bassinet for the baby. The member's Care Manager assisted with obtaining a breast pump and car seat. The CHW, setup an appointment at ABCD to obtain assistance for living room furniture, school supplies and clothes for kids, and help to pay utility bills.

Finally, the CHW referred the member to Room to Grow, a parenting group for new mothers.

Case Study 3: Chronic Mental Illness

A 35 year old homeless member was struggling with schizophrenia and psychosis. After a recent admission at an acute behavioral health facility, she was found to be 22 weeks pregnant and without prenatal care.

The member's Care Manager completed an assessment where we learned that she has limited family and social supports and has a long history of mental health concerns. The member was a native Russian speaker and spoke little English.

Recognizing the importance of medication compliance, the Care Manager assigned a Community Support Partner to help coordinate services, such as an "injection clinic" so her medication could be given quarterly instead of by mouth.

Case Study 3: Chronic Mental Illness

Outcome & Key Takeaways

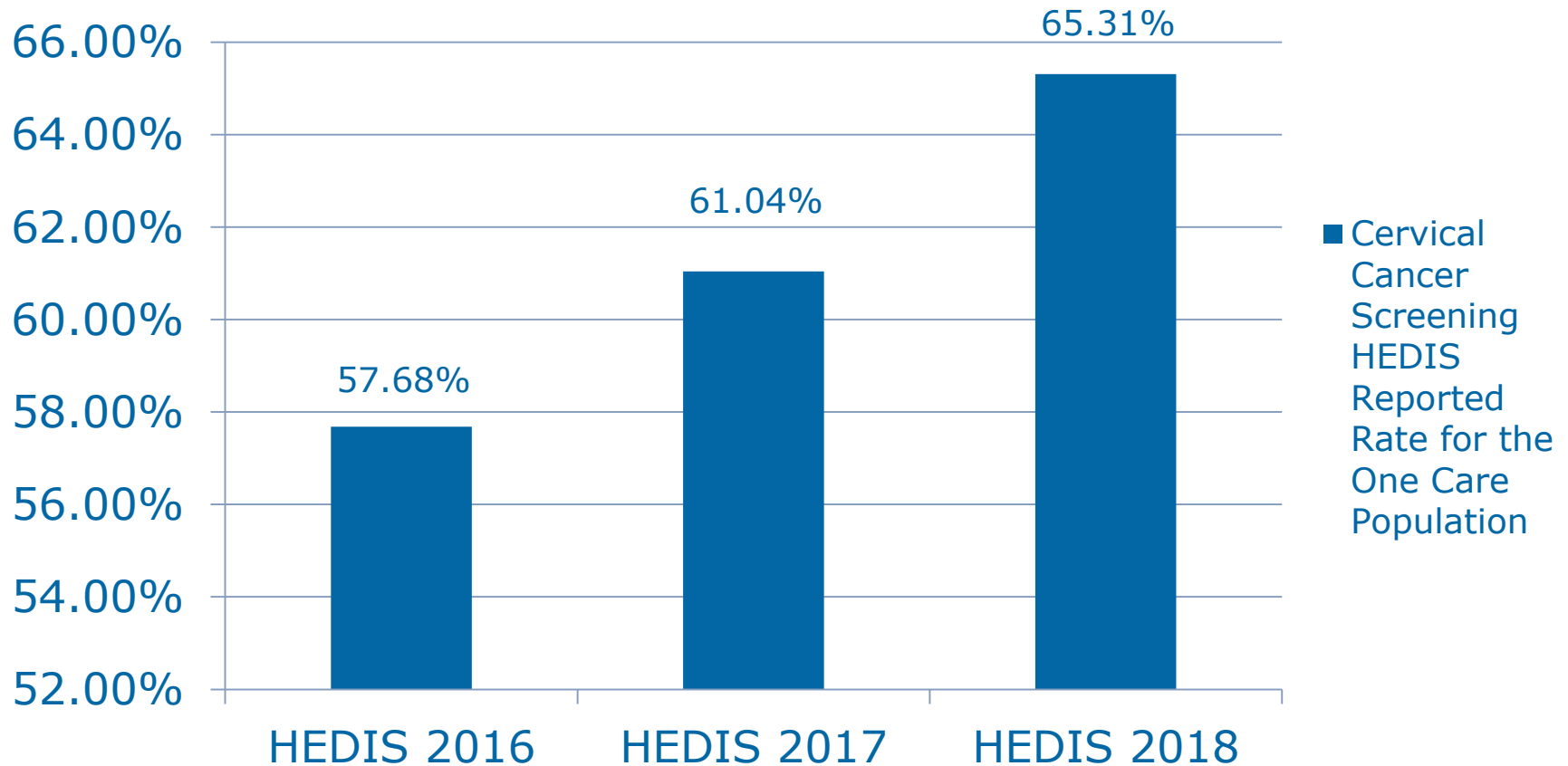
The member gained access to a shelter and was connected to a female obstetrician, a midwife, and a consistent Russian interpreter . Her prenatal course is on-track. Her mental illness has stabilized and she is alert and oriented. She is now living in an apartment and functioning at her highest level with support from her CSP and LTSS.

Key Takeaways

- The Care Manager went directly to the member when we learned of her BH inpatient admission
- A rapid assessment and individualized care plan completed before facilitate member discharge
- Care plan developed with a focus to remove “social determinants of health” barriers
- Involvement of CSP and LTSS-C critical to care plan success

HEDIS: Cervical Cancer Screening (CCS)

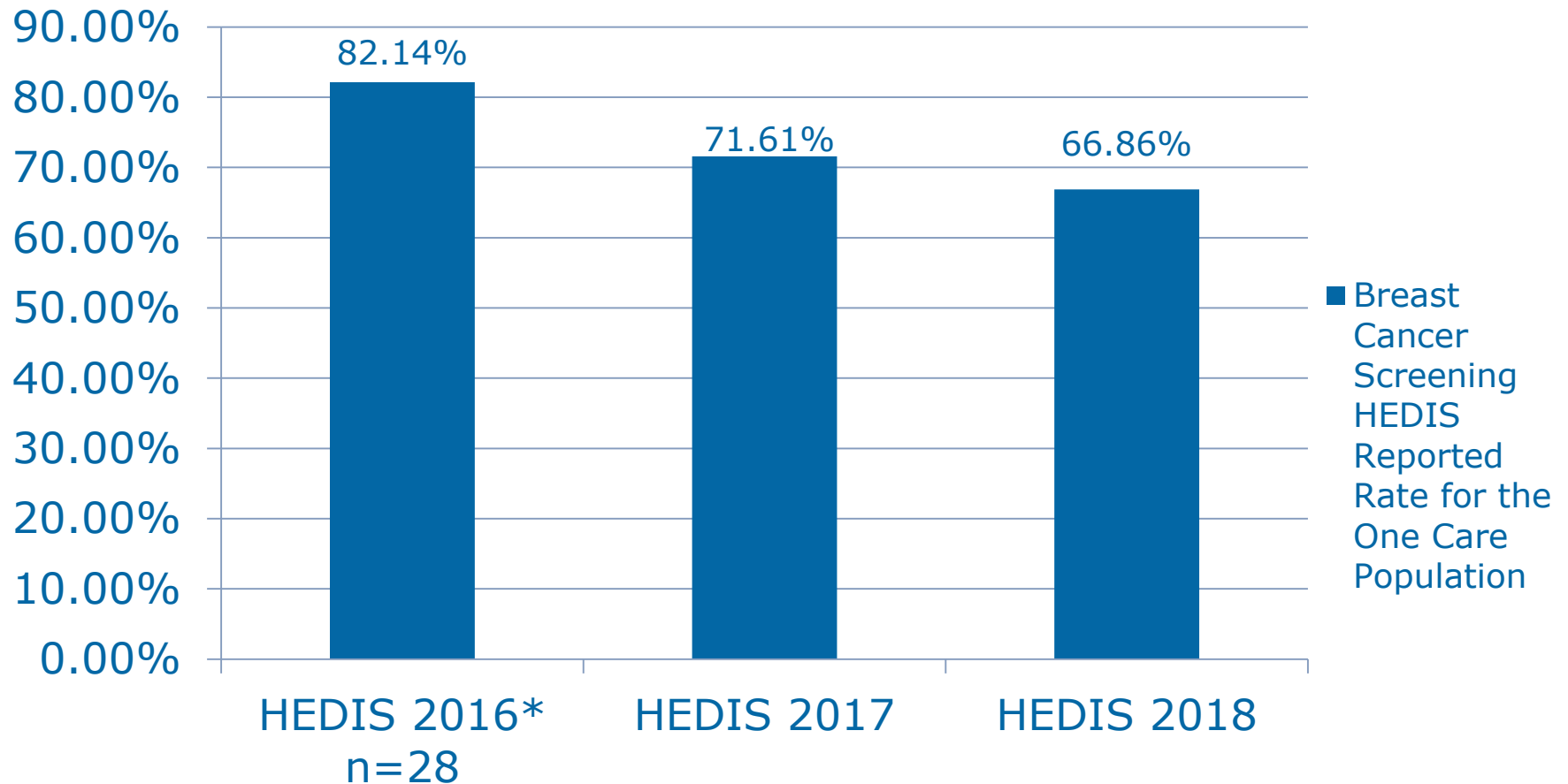
Cervical Cancer Screening



*CCS is a Medicaid only measure reported only to EOHHS
*2018 MA Medicaid 75th Percentile Benchmark for CCS: 72.4%
*2018 National 75th Percentile Benchmark: 65.96%

HEDIS: Breast Cancer Screening (BCS)

Breast Cancer Screening



*Rate for HEDIS 2016 was not reportable due to small denominator

*2018 MA Medicaid 75th Percentile Benchmark for BCS: 70.49%

*2018 National 75th Percentile Benchmark: 64.08%

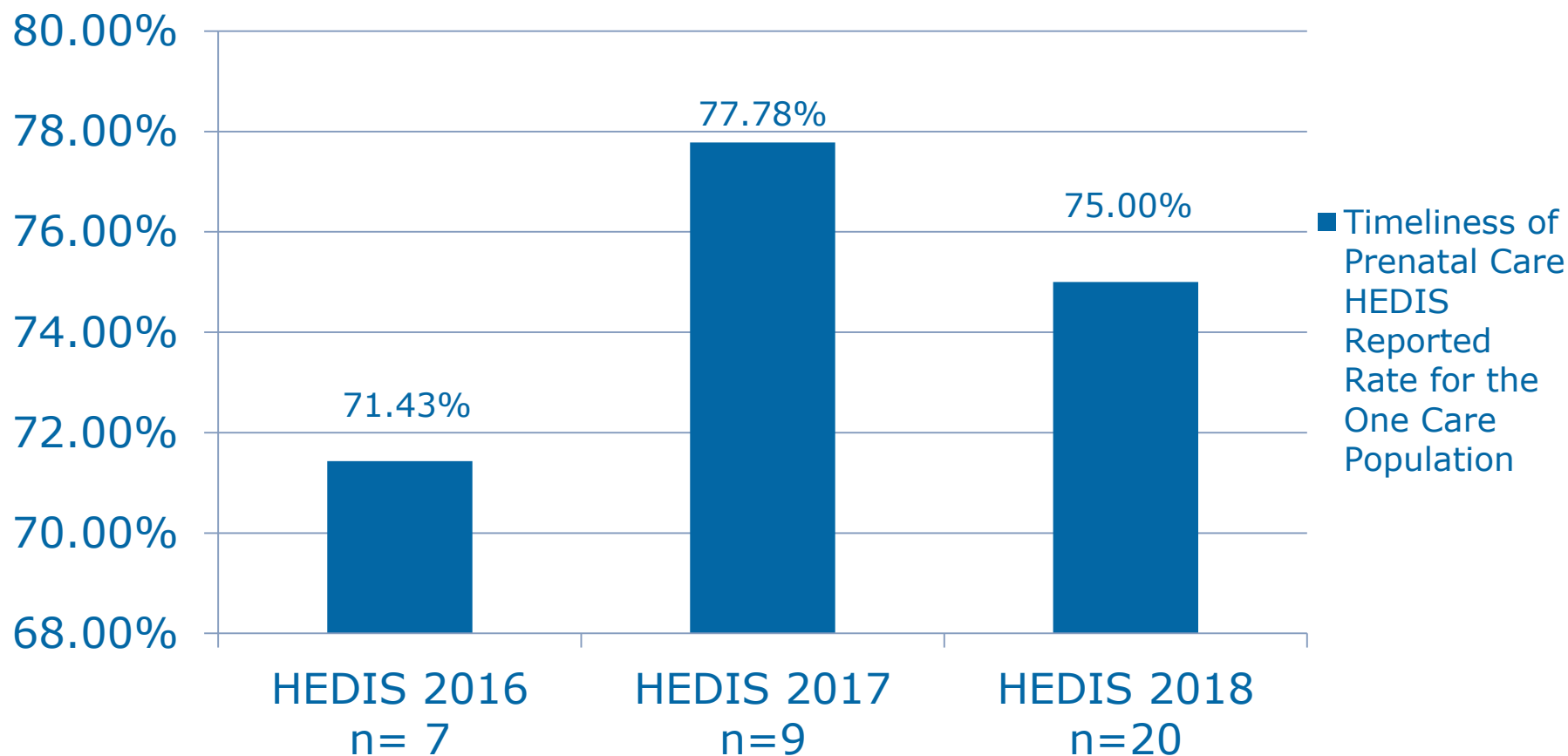
Future / Next Steps

- THP is committed to further leveraging existing THP women's health programs to support our Unify members
 - Doula Program
 - High risk OB
- Our Women's Health Workgroup participant will be a woman from our care management team, who we believe will bring valuable experience from the community
- THP will continue to evaluate and develop additional, specialized clinical programs based on the needs of our population

Appendix 1: HEDIS

Timeliness of Prenatal Care (PPC-T)

Timeliness of Prenatal Care



*PPC is a Medicaid only measure, reported to EOHHS

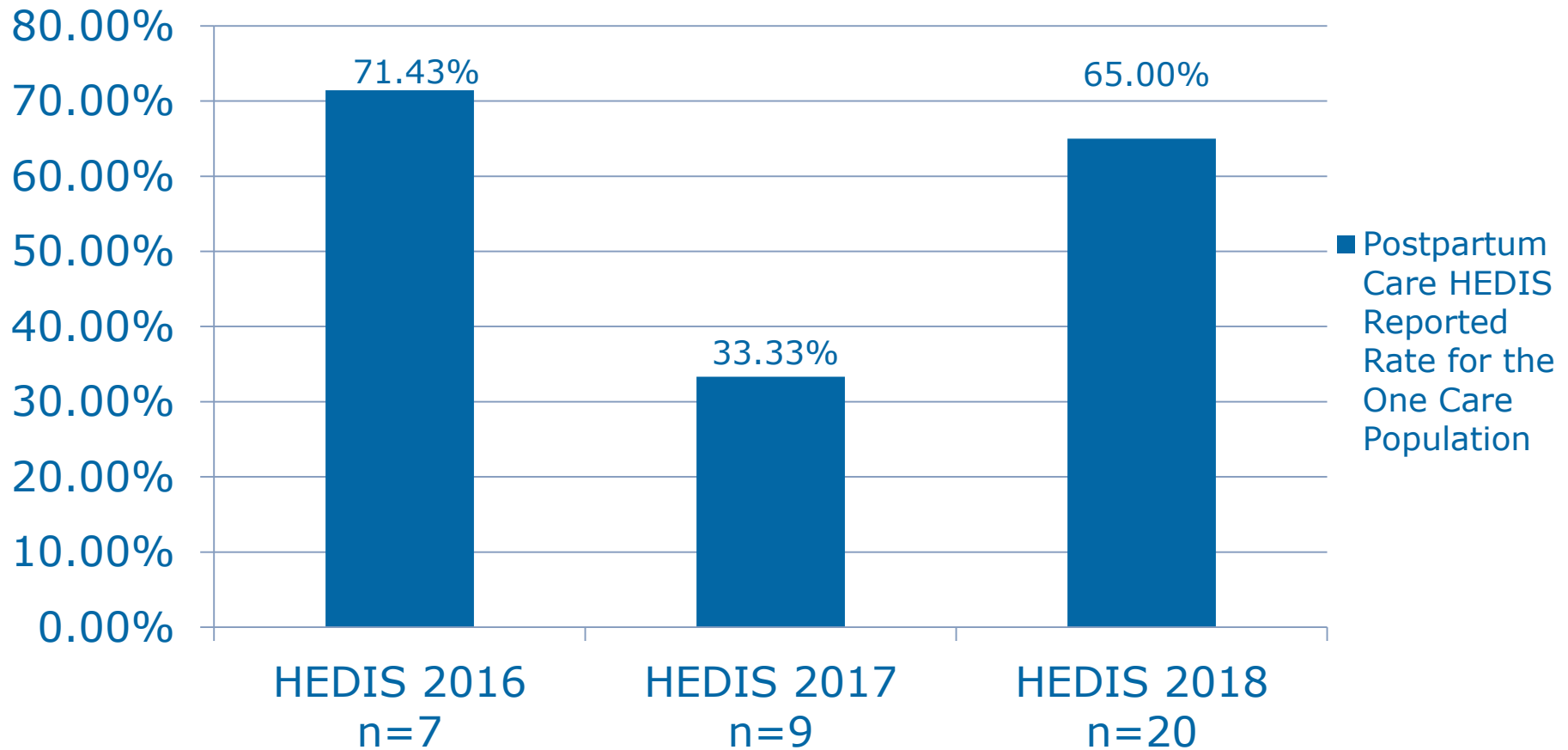
*2018 MA Medicaid 75th Percentile Benchmark for Prenatal Care: 92.99%

*2018 National 75th Percentile Benchmark: 87.06%

Appendix 1: HEDIS

Postpartum Care (PPC-P)

Postpartum Care



*PPC is a Medicaid only Measure, reported only to EOHHS
*2018 MA Medicaid 75th Percentile Benchmark for Postpartum Care 71.43%
*2018 National 75th Percentile Benchmark: 69.34%

Appendix 2: Care Management Elements Supporting Pregnant Members

Member Identification

- Pregnancy file
- Health Needs Assessment
 - Risk management
 - Social determinants
 - Peer Support
 - LTSS

Facilitate access to prenatal services with support from:

- OBGYN and primary care
- Behavioral Health
- LTSS Coordinators / Community Health Workers

Labor & Delivery

- Post partum care coordination
- Ongoing assessment and care planning