2019 Quality Improvement Work Plan Summary

Project	Objectives/Actions
Member Service and Satisfaction – Commercial Product (s): Commercial (HMO, POS, EPO, POS) **Project Description**: To improve member satisfaction through member education of how their plan works when utilizing benefits and understanding how cost-share applies to services. Specific attention will be focused around member education opportunities.	• Analyze member data specific to Information or Help Needed as documented in MACESS documentation system notes, by Product and Provider Group. • Collect specific member feedback through survey verbatims, repeat caller, member interviews, Your Voice audience & listening to calls to help create educational opportunities. • Develop 2-3 educational initiatives based on collective member feedback in March 2019.
Member Service and Satisfaction – Tufts Health Plan Medicare Preferred Product (s): Tufts Health Plan Medicare Preferred (THPMP), Senior Care Options (SCO) **Project Description:** To positively influence Tufts STAR Measure 24 (Customer Service), by initiating activities focused on 3 CAHPS Survey questions. Particular focus will be placed on quality service and accuracy of information provided to member.	• Further promote Supervisor and Team Lead development and engagement initiatives, to include de-escalation techniques and basic customer service/"soft skills". • Schedule and plan continuing education sessions and refresher training for all call center staff in 2019. • Work with staff to improve navigation and information available to representatives.
Patient Safety Product (s): All products **Project Description**: Evaluation of the effect on patient safety by performing follow up to changes in practice communicated by the provider to THP as part of the THP investigation of Adverse Events, as well as recommendations communicated to a provider after QOCC review of Quality of Care events.	• Examine impact of follow up with providers: provider adoption of recommendations communicated to provider by THP after QOCC review of Quality of Care event • Volume assessment: volume of adverse events that provider-follow up is done on • Use in conjunction with other provider assessment tools such as the Provider of Concern Report: will cross reference the cases that are being tracked with the Provider of Concern report • Assess opportunity to provide feedback to providers related to the impact of follow up/recommendations communicated to providers for specific adverse event types
Cultural and Linguistic Services Product (s): Commercial: HMO, POS, PPO; QHP Premier; THPMP ; Tufts Health Public Plans (THPP): Together, RITogether, QHP Direct, **Project Description:** Collect and utilize Race, Ethnicity and Language (REL) data in order to find and address any health care inequities, to create new quality improvement initiatives where necessary, and to promote high quality care for all our members.	•Perform annual assessment of member's cultural needs and Preferences • Conduct every other year satisfaction survey of diverse members • Health Equity/ Population Health: Expand efforts to collect REL, analyze disparities, and implement health equity Programs • Perform annual assessment of member grievances related to race, culture, or language
Readmission Management – Tufts Health Plan Medicare Preferred Product (s): Tufts Health Plan Medicare Preferred (THPMP)	• Complete promulgation of new Root Cause Analysis Tool (RCA)and Readmission Review • Ensure the RCA Tool and Readmission Review Policy and

Project Description: Reducing Acute inpatient Readmissions by Adapting the Project Red Protocols for a Managed Care Setting	Procedure is in use at all HMO internally managed groups • Once implementation is complete at the internally managed groups, begin process of ensuring the Independent Practice Associations (IPAs)/Integrated Delivery Networks (IDNs) who are Delegated Care Management have a similar tool and process in place. • Transition Management Program • Timely Receipt of Discharge Information
Tufts Health Plan Behavioral Health: Antidepressant Medication Management and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Product (s): Commercial (HMO/POS, PPO); THPMP **Project Description:** The project focuses on a) working with members and providers on supporting members with a diagnosis of major depression who are newly prescribed an antidepressant medication and b) working with providers to support members with a new episode of alcohol or other drug dependence to initiate treatment within 14 days of initial diagnosis and continue treatment.	• Medical care managers to continue depression screening for Commercial members as part of the Priority Care Program. Medical care managers to refer to BH care managers as appropriate for consultation and referral when there are behavioral health issues that need to be addressed. • Behavioral Health care managers (CMs) to review medication issues and adherence in assessment with all new members who become involved in the case management programs. CMs help to address any medication compliance issues. • Educational depression brochures offered to members who contact the Tufts Health Plan Mental Health telephone queue. Depression brochure addresses antidepressant medication compliance. • Substance Use Transitions care management program provides support to members who are in early recovery from the use of opiates, alcohol or other substances. Care managers to work with members to understand and follow through with their aftercare plans, and begin to take charge of their recovery. • Substance Use Navigator to work with members who have been diagnosed with substance use issues to support them with accessing providers and other community services to assist them in their recovery.
Senior Care Options (SCO) Performance Improvement Projects Product (s): SCO **Project Description:** a) Reducing Behavioral Health Readmissions: b) Reducing COPD Admission Rate c) Reducing Acute Inpatient Readmissions	a) • Inpatient Discharge Planning – The designated BH Care Manager (CM) will collaborate with the inpatient facility to foster the discharge planning process. Collaboration between the SCO BH Care Manager and the inpatient Care Management staff will bridge the gap between hospital admission and discharge to community • Transitions Management- The BH Care Manager will contact the member within 2 business days of discharge to perform a standardized transitions assessment and intervene where needed. • SCO RN Care Manager will perform medication reconciliation within 7 days of discharge. Intervention to ensure congruence with discharge b) • Make sure members who have screened positive for PHQ-2 receive behavioral health clinician support and a PHQ-9 screening

	followed by PCP referral for positive results. • Also the SCO Care Manager will put treatment for depression on member's care plan where appropriate to improve care coordination. • Send disease-specific educational materials from a new vendor, KRAMES, to help members self-manage their COPD and Depression. RN CM to review materials with the member upon subsequent contact to ensure the resource content is fully understood. c) • Complete promulgation of new Root Cause Analysis Tool (RCA) and Readmission Review • Report has been requested on the current state difference between the discharge date and provider notification discharge for SCO members to determine how large the gap is. This analysis and a subsequent action plan will be completed in 2019.
CarePartners of Connecticut COPD Admissions (THPMP) Product (s): Tufts Health Plan Medicare Preferred (THPMP) (Connecticut) **Project Description:** Establish baseline for the COPD Acute Inpatient Admission rates as well as the rate of identification and management of Co-Morbid Depression	• Members who have screened positive for PHQ-2 receive behavioral health clinician support and a PHQ-9 screening followed by PCP referral for positive results. • Care Manager will put treatment for depression on member's care plan where appropriate to improve care coordination. • Send disease-specific educational materials from a new vendor, KRAMES, to help members self-manage their COPD and Depression. RN CM to review materials with the member upon subsequent contact to ensure the resource content is fully understood. • Outreach to PCPs who have members with COPD and depression to ensure they make appropriate treatments referrals and or facilitate prescriptions for anti-depressants were needed.
Case Management and Continuity and Coordination of Medical Care (Commercial) Product (s): Commercial HMO/POS, PPO **Project Description**: The goal of this project will be to analyze the palliative care and aging subsets of this new program, supporting overall well-being related to functional status, longevity, and comfort.	<u>Palliative Care</u> • Documentation of Internal Collaboration with VNA agencies, hospice entity, Physicians, Medical Management and other team members –to be completed in discharge assessment within CM documentation system • CM Staff Palliative Care Certification • Staff Training related to end of life care, advanced directives <u>Aging Program</u> • Identification tracks—predictive modeling, members, claims, internal departments, external providers • Education related to program to internal departments (Sales, Provider Engagement, Medical Management, Precertification) • Dementia Care Consultant Referrals
Coordination between Medical and Behavioral Healthcare Product (s): Commercial (HMO/POS, PPO); THPMP **Project Description:** a. Designated Facility Communication with Member's Primary	• PCP communication chart audits to be held in April and October 2019 to validate the inpatient behavioral health facility's notification of admission and submission of the discharge to the PCP. An incentive bonus has been added to the Designated

Care Provider (PCP): Communication with a member's PCP is recommended to occur during the course of an inpatient behavioral health admission to inform the provider of the admission, to review the course of inpatient treatment, and to assist with coordination of care and discharge planning. All designated facilities (DFs) must routinely document communication with the PCP for every member who has an assigned PCP. The behavioral health department will conduct medical record review two times a year to review appropriate documentation of PCP communication by the Designated Facility (DF). b.Behavioral Health and Medical Case Managers Coordination of Care Project: Tufts Health Plan medical case managers and behavioral health case managers are working together in consultation with each other and co-management to share cases where there are co-morbid medical and behavioral health issues. c. Data Collection for Coordination of Medical and Behavioral Healthcare	Facility contracts for 2019 for 90% compliance with this measure. • Improvement plan to be developed for any Designated Facility that falls below 80% compliance with these measures. • Behavioral Health case managers to consult with medical case managers on cases where there are co-existing medical and behavioral disorders. This occurs for both members who are inpatient as well as on an outpatient basis. ' • Behavioral Health case managers will also work directly with members who are involved with medical case managers, as appropriate. • Behavioral Health case manager will consult with and refer to medical case managers in BH cases where there is medical co-morbidity. • Data to be collected on depression through the Antidepressant Medication management (AMM) HEDIS measure. • Data to be collected on alcohol and substance use disorder through the Initiation and Engagement of Treatment (IET) HEDIS measure.
Tufts Health Public Plans (THPP) Member Services & Satisfaction Product (s):Tufts Health Public Plans (THPP): Direct, THPP Together, THPP RITogether, THPP Unify **Project Description:** a) Focus on representative education, availability of resources, and training in order to provide exceptional quality service to those members calling the call center for assistance. The goal of this project is to increase the overall quality of service provided to members contacting the call center for assistance. b) By focusing on the quality and accessibility of information available to Member Services representatives in SupportPoint, the information provided to members will be accurate and timely. The goal of this project is to increase SupportPoint usage rates.	a) • Use the monthly QA trend data to identify areas of opportunity for the development of new resources, refresher courses, and increased communications. Areas of opportunity will be defined as those trends which directly correspond to low scoring call quality metrics. • Schedule monthly one-on-one coaching between supervisors and Member Service representatives to provide performance feedback. • Provide servicing updates to representatives through weekly team huddles including pertinent agenda items geared toward real-time coverage updates. b) • The Call Center Manager and Member Experience Manager will attend regularly scheduled work groups with the documentation team to ensure documents are easily searchable, clear, concise, and provide complete information. Meetings will be held at least monthly, and more frequently if appropriate. • Form topic-specific work groups to address new and/or changing benefits, as appropriate.
Coordination of Care between Medical and Behavioral Health (THPP) Product (s): THPP Together **Project Description:** a) Improving 7-Day Follow-Up After Mental Health Hospitalization (FUH) and b) Improving Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	a) • Reminder calls to members on a day before their scheduled follow-up appointment. • In-patient UM team will remind the hospitals to make an aftercare appointment to members discharged from their facilities. • Targeted outreach calls to lower performing large provider groups and brainstorm with the leadership of each facility on how to improve their FUH rate. • Identify the best practices of top performing provider groups

	and share the information with lower performing groups b) • Produce the gaps in care reports for both ACOs and MCOs on the regular basis. • Outreach to ACOs and get their participation to accept the monthly gaps in care lists and distribute to their PCPs for follow up. • Mail out the gaps in care lists to MCO PCPs who billed for schizophrenia or bipolar disorder for their patients. • Outreach calls to MCO members who have been identified in the gaps in care reports. • Identify the best practices of top performing provider groups and share the information with lower performing provider groups.
Public Plans—Unify Product (s): THPP Unify **Project Description:** a) Emergency Department Utilization: reduce the emergency department utilization b) Behavioral Health Therapy among Depressed population: improve the therapy visit rate for Depressed members seen at targeted High Volume Health Centers c) Transportation Model for Unify Membership: Implement a new transportation provider for Unify members d) Interdisciplinary Care Team Meetings: Increase Interdisciplinary Care Team (ICT) Meetings for Complex/High Members	a) • Implement a post discharge phone call using an evidence based tool designed to assess gaps in PCP or treatment follow-up and compliance with medication regimen for all members who were reached after their discharge. • Implement a post ED follow-up phone call using a tool designed to assess gaps in PCP or treatment follow-up and compliance with medication regimen for all members who were treated and discharged from the ED. • Improve the member's understanding on how to best manage their health care needs and need for timely PCP follow-up b) • Publish Provider Update article on the importance of PCPs referring members to BH follow up care when member is in need of BH services. • Provider Outreach: Provider outreaches will be done to educate providers about the referral process and to educate on care management available at Unify. • Member Outreach: Care Managers will be outreaching to members to follow up regarding new appointments with BH providers and/or PCP. c) • Contract with new transportation vendor. • Implement new transportation provider work flow. • Managers meet weekly to review complaints about transportation. • Establish baseline by pulling CY2018 data for member transportation complaints, missed appointments, and grievances. d) • Target Providers: Collaborate with the members providers more to involve them in care planning. • Determine baseline by pulling 2018 ICT meeting data.
Public Plans—Rhode Island Product (s): THPP RITogether	14a. • Engage with inpatient providers about the importance of making a follow-up appointment before the member leaves the

Project Description: a) Follow-up After Hospitalization for Mental Illness b) Developmental Screening in the First 3 years of life	facility. • Ensure that providers are aware that telehealth may be an option for members with challenges to making an in-person appointment. • Utilize our care management team to work with members to adhere to scheduled appointments. 14b. • Monitor developmental screening as part of our Early and Periodic Screening, Diagnostic and Treatment (EPSDT) monitoring. • Claims-based reports will assist in determining current screening rates and opportunities to increase the rates for lower-performing providers through outreach. • Developing and Implement a measurement plan for the Developmental Screening measure, as determined by the specifications. • Identify opportunities to increase the rates for lower-performing providers through outreach.
Public Plans Performance Improvement Projects, MassHealth MCO Product (s): THPP Together (MCO) **Project Description:** a) Improving Behavioral Health Screenings and Follow Up for Adolescents b) Improving Health Needs Assessment (HNA) screening and provide support to members with food, nutrition and weight management concerns	a) • Member Education: will publish information on the member website educating members on BH screenings and the importance of BH screenings and follow up. • Provider Education: will educate providers on BH screenings for members and the BH provider availability database. • Provider Outreach: will target PCPs with low screening rates and conduct outreach. Will also conduct outreach to PCPs who have high rates of screening in an attempt to identify best practices. b) • ELIZA Interactive Voice Response – leverage ELIZA's IVR technology to administer health needs assessment screening to members with children age 0-17 Years to increase response rate. • Member Outreach and Support – Care managers outreach to members identified by screening response that need nutrition/food/weight support and share the following resources: -Good Measures – remind members they have access to this free application designed to combine the expertise of a Registered Dietitian (RD) with the digital platform to help them make positive changes in eating and exercise behavior. -Community Resources - relevant resources such as food pantry, healthy cooking classes and vouchers for farmer's markets in appropriate geographical areas to the member. • Provider Outreach – Care managers outreach to PCPs to encourage conversation and documentation of counseling for nutrition and physical activity in the electronic medical record.
Senior Care Options Member Satisfaction (SCO)	• Annual Member Survey Implementation/Final Report

Product (s): SCO **Project Description:** Management of overall SCO member satisfaction by utilizing various channels of member feedback.	• Quarterly Appeals & Grievance results review meetings • Review and submit monthly Appeals & Grievance report to EOHHS • Scheduled member based SCO Consumer Advisory Council meetings (at least 3 – covering different geography and languages). Results documented and distributed to SCO team. • Identify, research and implement improvements to top 3 member challenges (operational processes and/or product coverage).