TUFTS Health Plan

2022 Quality Improvement Work Plan Summary

Project	Objectives/Actions
Member Service and Satisfaction – Commercial Product (s): Commercial HMO/EPO/POS/PPO, Commercial Freedom, Qualified Health Plan (QHP) Premier/Marketplace **Project Description**: Improve the perception and satisfaction of members when they call the call center for quality and efficient resolution to their inquiries.	• Monitor and adjust Tiered Staffing Model to best suit the needs of the Call Center and support a model that retains staff and increases the experience and tenure of staff on the phones while reducing turnover. • Identify opportunities to enhance Member Services & Member Experience communication and reassignment for issues requiring research and monitoring for more immediate resolution of issues. • Ensure staffing allows for Member Experience focus and time dedicated to the Repeat Caller Program.
Member Service and Satisfaction Product (s): Tufts Health Plan Medicare HMO, CarePartners Connecticut **Project Description:** Create a robust set of resources for Customer Service Representatives to answer HMO Dental Benefits inquiries more effectively.	• Review all Customer Service content related to dental benefits. • Evaluate existing educational tools and resources to aid Customer Service Representatives in answering Member inquiries.
Patient Safety Product (s): All products **Project Description**: When a member needs inpatient behavioral health care, documentation of informed consent, complete medication orders, the assessment of risk and plans to mitigate it, and aftercare that involves coordination with a primary care provider are associated with improved patient safety during and after hospitalization. Through an audit of inpatient behavioral health admissions, we will assess for the presence of these elements in the medical record. Where gaps are identified, we will work with providers to identify improvements in documentation and/or process.	• Conduct annual BH Medical Record Audit with an expanded number of providers, for an expanded number of members across product lines • Score audit tools and draft provider results letters. Letters need to identify gaps and request a CAP. • Score CAPs turned in by providers. • Mail letters to all providers who had “in progress” items on their CAPs to request updates. Request detailed responses within 2 weeks of date of letter. • Score results and reassess project for addition of any 2023 activities.
Cultural and Linguistic Services Product (s): Commercial: HMO, POS, PPO, QHP Premier, Tufts Health Plan Medicare Preferred (THPMP), Tufts Health Public Plans (THPP): Together (MA); 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. Given the challenges from the COVID-19 pandemic and racial equity in 2021, we aligned key priorities for 2022 to best serve members/community.	• Perform annual assessment of members’ cultural needs and preferences • Health Equity/Population Health: Expand efforts to collect REL, analyze disparities, and implement health equity programs • Anti-racism: provide training for managers, leaders, and other staff on anti-racism training related to courageous conversations • Cultural Competence/Multilingual Servicing: Continue deployment of specialized training. Improve direct language access for members
Tufts Health Plan Behavioral Health Antidepressant: Medication Management and Initiation and Engagement of Drug and Alcohol Treatment	a) • Medical care managers to continue depression screening for Commercial members as part of the Priority Care Program.

Products (a): Commercial (HMO/POS, PPO), Qualified Health Plan (QHP) Premier, QHP Direct, THPMP, Tufts Health Public Plans (THPP): Together (MA); RITogether, THPP Unify Products (b): Commercial (HMO/POS, PPO), Qualified Health Plan (QHP) Premier, QHP Direct; THPMP, Tufts Health Public Plans (THPP): Together (MA); RITogether **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 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. • THPP completes a health needs assessment on new members that includes screening for depression and other BH issues. Members referred to BH/ Intensive Case Mgt. CM as needed. • Depression screenings to continue for THPMP members that are in a complex case management program, though THPMP Case Managers. • Information to be posted on the Tufts Health Plan website to educate providers about the National Depression Screening Day in October. • Educational depression brochures on Tufts health Plan website available to members. Depression brochure addresses antidepressant medication compliance. • Share brochure with BH Community Partners, Providers at Health Centers and ACO partners during quarterly data exchange and reporting meetings**.** • Education to PCPs regarding HEDIS AMM measure and "Treatment of Depression in the Primary Care Setting" to continue through articles posted on the web, in newsletters and in e-mails. • Mental Health, Pharmacy and QHI department will continue to work together to explore other possible depression interventions. b) • THP Utilization managers will continue with our designated and contracted inpatient facilities regarding the importance of developing a comprehensive discharge plan for those members who have been hospitalized with substance abuse diagnoses. • Working with substance use disorders providers to identify "Centers of Innovation". These providers will provide improved access to SUD treatment as well as demonstrate innovative strategies to support members to continue in their recovery such as a focus on medication assisted therapies, outreach and telemedicine. The selection of providers to be geographically based to cover the state. • Working with Shatterproof, a national non-profit organization, to identify quality metrics for SUD providers. This will help us to profile providers who provide best practices when working with SUD patients and to direct our members to those providers. • THP Addiction Recovery Care Management (ARCM) 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. • THP Peer Recovery Specialist to work with commercial and public plans members who are currently admitted to substance use facilities. The Peer Recovery Specialist can support members with accessing providers and other community services to assist them in their recovery. The Peer Recovery Specialist provides information on treatment programs, and, also community supports available that will be helpful in supporting the member and their family. • Allied Health and Contracting departments will work to continue to increase our database of substance use disorder providers at all levels of care. Survey posted on tuftshealthplan.com provider section to obtain information from BH providers who specialize in treating substance use disorder. BH department to create internal database of these providers and their availability to be used when referring members for treatment. • Updated provider search is available to members on the THP website which provides more accurate information about availability of behavioral health providers and their specialties. This will allow members better access to providers who specialize in treating patients with a substance use disorder and who have availability to see new patients. • Ongoing development and updating of tuftshealthplan.com public web page providing member-friendly information on screening, treatment and resources regarding substance use disorder. • Information to be posted on the Tufts Health Plan website to educate providers about the National Alcohol Screening Day in April. • Partnership with Spectrum Pear Therapeutics 12-month commercial pilot with Spectrum and three other providers (CHA, West End Clinic, Faulkner). CBT Modules to assist with substance abuse treatment
Senior Care Options (SCO) Readmission Management Product (s): SCO **Project Description:** a) Reducing Acute Inpatient Readmissions	a) • Interventions related to readmissions are now added to the member's Care Plan. b) • Implementation new Transitions of Care (ToC) Management Program • Align SCO transition of care workflows with enterprise • New Team; Manager, 2 acute TM positions, 3 extended care. A primary focus is to close any communication gaps with dc to community. • Complete transition of UM to the enterprise. • Situation Background Assessment Recommendation (SBAR) tool and Readmission Review: Implemented in 2021 and applied to

	assist the quality improvement process related to all SCO readmissions. The SBAR Tool is used to analyze and address the root cause related to each individual hospital admission event and to trend readmission patterns. • Weekly transitions of care trend meeting implemented. • SCO Huddles: Occur 4 times per week to review all readmissions using root-cause-analysis processes, identify potentially high-risk transitions, facilitate decision making/actions to mitigate risk and assign accountability for identified actions and document follow up for acute medical and psychiatric inpatient admissions and transitions of care. • SCO IDT: held as needed to discuss high risk members at risk of readmission. NCM to indicate categorically what source of problem is that would cause readmission risk. This will lead to a targeted approach to prevent readmissions. • CCP Alignment to SCO LOB • The CCPs with align with SCO LOB, the staff will move into the TOC team. The LTC management will be scaled back so the staff can focus attention on the most complex members that are cycling in acute care and are in need of palliative and treat in place plans • SNF Readmission Workflow: integration into current SCO huddles and CCP
CarePartners of Connecticut COPD Admissions (Medicare HM) Product (s): CarePartners of Connecticut Medicare HMO **Project Description:** Reduce the COPD Acute Inpatient Admission Rate through the identification and management of Co-Morbid Depression	• Members who have a positive PHQ-2 screen will receive a PHQ-9 screen followed by PCP referral for any positive result and behavioral health clinician support as appropriate. • The Nurse Care Manager (RN CM) for CPCT members will include treatment for depression on member's care plan where appropriate to improve care coordination. • Disease-specific educational materials or content will be shared with members to encourage self-management of their COPD and Depression when appropriate. The RN CM will review any information provided in subsequent contacts to facilitate understanding. • For members with COPD and depression plus a positive PHQ screen, outreach to PCPs will occur to prompt appropriate treatment referrals and/or medication therapy as needed. • Offer Geriatric Psych APN or Geriatric psychiatrist consultant for one to one PCP education as needed.
Senior Care Options and Medicare HMO BH Telehealth; Unify Performance Improvement Project: BH Telehealth PIP; Public Plans MCO BH Telehealth PIP Product (s): THPMP, SCO, Tufts Health Public Plans (THPP): Together (MA); RITogether, THPP Unify **Project Description**: Improve access to BH Telehealth services via reduction of known barriers.	a) THP Interventions • Increase Access to BH Telehealth services • The teams will continue to attend monthly work group meetings to review data reports, discuss project milestones/ progress, as well as address barriers pertaining to access to BH telehealth services. • (RITogether and MCO only): Collaborate with the THP Community Relations and Marketing teams to partner with radio media outlets to promote THP Behavioral telehealth services for the targeted sub-population (members 13-17 years old)

	• SCO only: Asian American CM focus group b) Provider Interventions • Provider Education: Provider Webinars, Provider Update Article • The BH Medical Director will outreach to high performing BH Telehealth providers in order to gather feedback related to best practices to share with lower performing providers. c) Member Interventions • Member Education and Outreach: articles promoting access to BH telehealth services will be published in the Well Magazine Article to promote member accessof BH Telehealth. • Questions regarding BH telehealth have been added to CAHPS and BH Member Experience survey. • Loaner phones are offered to members to utilize for BH telehealth appointments with providers. The loaner phones are not smart phones and only eligible to a subset of members. • Together MCO only: Member Focus Group is currently in process, as members are being recruited. The purpose of this focus group is to solicit feedback related to barriers that may prevent a member from utilizing BH telehealth services. • Unify only: City Block Health offers doxy.me (a BH video platform) for members.
Care Partners of Connecticut Product (s): Tufts Health Plan Medicare HMO, CarePartners CT **Project Description:** Utilize Care Management interventions to support diabetic members in achieving a controlled HbA1c.	a) CCIP/PIP Workgroup: • CCIP/PIP Workgroup will continue to meet at minimum monthly to complete the project work plan and to monitor project outputs. The workgroup will revise improvement interventions until the project goal is met. b) Member Assessment and Education interventions: • Disease-specific educational materials or content will be shared with members to encourage self-management of their Diabetes when appropriate. The RN CM will review any information provided in subsequent contacts to facilitate understanding. • Caregivers will be offered support and teaching to complement the member's as appropriate. • PGIs will be added to the care plan as appropriate and updated with each contact. • PHQ 2 screen will be performed. c) Provider Outreach and Referrals Interventions: • Members who have a positive PHQ-2 screen will be shared with the PCP for further assessment and potential Behavioral Health referral. • Members with medication therapy education needs or barriers to adherence will be shared with the PCP and a Pharmacy referral recommended or placed. • Members requiring intensive dietary education will be shared with the PCP and a Dietician referral recommended. • Members with an HbA1c >9 for 12 months will be shared with the PCP and an Endocrinologist referral recommended.

	• Members requiring additional general education and support will be shared with the PCP and a Diabetic Educator referral recommended. d) CPCT Care Management Delegation to Oversight for ICP IPA: • ICP has been educated on CCIP
Case Management and Continuity and Coordination of Care Commercial: HMO, POS, EPO, PPO, QHP Premier/Marketplace **Project Description:** 1) ED Utilization: This project aims to improve the rate of utilization for avoidable member visits to the emergency department (ED) through improvement of continuity and care coordination, member education and provider collaboration. 2) Plan all Cause Medical 30-day readmission: This project aims to address gaps in care between care settings to improve the member's quality of care, quality of life and health outcomes. 3) Asthma Care Management Program: This project aims to improve the asthma referral and screening process for applicable Commercial products, to promote member education to increase health literacy, encourage timely coordination of provider services and implementation of care management interventions to help the members self-manage their asthma condition. 4) Annual Influenza Vaccinations: This project addresses improvement of the utilization rate of members receiving annual influenza vaccinations.	1) ED Utilization (Interventions): a) Commercial Program Management and Evaluation • Project team will meet regularly to brainstorm actionable interventions, as well as provide updates on progress. • Commercial team assesses the overall effectiveness of the transitions of care (ToC) Program. • The Commercial Team utilizes PHM data, metrics, and conduct file reviews to analyze the outcomes and impact of the TOC program strategy, at least quarterly and a year-end annual report. b) Member Interventions: • CM team to utilize data and reports related to ED visits to provide targeted interventions to targeted population based on their clinical risk score to provide needed support. • The CM team, based on the target population's diagnosis and clinical risk score, will attempt to complete an initial outreach to the member within a maximum 72 hours from the identified ED discharge date. • The CM team will attempt to complete an assessment with the engaged member, using the member's identified assessed needs to help develop their care plan, if warranted. CM will ensure medication review, assistance with scheduling follow-up appointments with PCP and/or other providers, publish member article via THP website. c) Provider Interventions: • Publish educational article via the THP "Provider Update" newsletter to offer collaboration. • Commercial Team and Medical Directors will collaborate with inpatient facilities to offer education and share improvement strategies to ensure safe, effective discharge planning and follow-up after ED visit occurs with the member. • Encourage providers to educate assigned members (using data to drive practice) on the appropriateness of using the PCP office, or UCCs vs the ED 2) 30- day Readmissions Interventions: a) THP/ Commercial Program Management and Evaluation • Project team will meet regularly to brainstorm actionable interventions, as well as provide updates on progress. • Commercial team assesses the overall effectiveness of the transitions of care (ToC) Program. • The Commercial Team utilizes PHM data, metrics, and conduct file reviews to analyze the outcomes and impact of the TOC program strategy, at least quarterly and a year-end annual report. b) Member Interventions:

	• CM team to utilize data and reports related to identifying opportunities to provide targeted interventions to identified members based on their clinical risk score to provide needed support • The CM team, based on the target population's diagnosis and clinical risk score, will attempt to complete an initial outreach to the member within a maximum 72 hours from the identified discharge date. • The CM team will attempt to complete an assessment with the engaged member, using the member's identified assessed needs to help develop their care plan, if warranted. CM will ensure the following details are addressed during the outreach: Medication review, assistance with scheduling follow-up appointments with PCP and/or other providers, publish member article via THP website. c) Provider Interventions: • Publish educational article via the THP "Provider Update" newsletter to offer collaboration. Articles will focus on educating the provider on how to foster appropriate use of Urgent Care Centers (UCCs) and the physician's office for non-emergent issues instead of visiting the ED. • Commercial Team and Medical Directors will collaborate with inpatient facilities to offer education and share improvement strategies to ensure safe, effective discharge planning and follow-up after hospitalization occurs with the member. • Encourage providers to educate assigned members (using CM data to drive practice) on preventing rehospitalizations, the appropriateness of using the ED, PCP office, UCCs, etc. 3) Asthma Care Management a) Project lead will work with the Commercial teams to develop outreach mechanisms and internal monitoring controls to ensure identified members receive support for their prescribed asthma treatment plan. • CM team will receive a report containing targeted asthma cases to be outreached and followed-up on based on their assessed needs. CM will document interactions/ outreach attempts with members in their CCMS record. b) Project lead will work with the THP Commercial teams to create a process to auto-create referrals of members needing additional support with managing their asthma treatment plan. • Project lead will work with the PHM Data Analytics team to leverage asthma screening results to help stratify the population (based on clinical risk) for CM services and to maximize member's independence in managing their asthma condition in all environments (home, work, school, etc.). • Project lead will work with this workgroup to create an educational article to foster the importance of asthma medication compliance to improve the population's health literacy in this area.

Public Plans Member Services and Satisfaction Product (s): Tufts Health Public Plans (THPP): Together (MA); RITogether, QHP Direct **Project Description:** Focus on representative education, availability of resources, and training 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.	• Identify areas of opportunity for the development of new resources, refresher courses, and increased communications based on the trend data from OQA, member escalations, and call coaching. Where appropriate and identified, modify, and update existing resources. • Provide performance feedback through monthly coaching of Member Services representatives (MSRs) provided by the MSR's supervisor and Team Leads. In addition, monitor the time spent on monthly coaching to ensure all representatives are receiving valuable and actionable feedback. • Inform staff of current and future changes and coverage updates through a monthly newsletter with updates provided by the call center management team. (With the move to a remote workforce, the newsletter will replace the quarterly all-staff meetings.) In addition, servicing updates will continue to be provided through biweekly team huddles including pertinent agenda items geared toward real-time coverage updates. Ensure shared information is accessible to MSRs in SupportPoint. • Monitor the quality and accessibility of information available to Member Services representatives in order to ensure the information provided to members is accurate and timely. a) Hold bi-weekly meetings with the documentation team to ensure SupportPoint documents are easily searchable, clear, concise, and provide complete information. b) Internally monitor Support Point usage monthly and provide individualized team data to Supervisors for coaching opportunities. • Systematically monitoring all resource documents used by call center staff to ensure they are providing up-to-date information; these include benefit grids, SupportPoint, and training materials.
Tufts Health Public Plans Follow Up After Mental Health Hospitalization Product (s): Tufts Health Public Plans (THPP): Together (MA); RITogether, THPP QHP Direct **Project Description:** It is important for members who have been hospitalized with a psychiatric illness to begin their outpatient aftercare as soon as possible following their discharge, follow up care by a behavioral health provider is critical. The HEDIS FUH measure assesses that adults and children, 6 years of age and older, who had an inpatient psychiatric admission have an outpatient follow up visit with a mental health practitioner within 7 or 30 days of discharge. The focus of this project is to increase the rate of compliance with this measure.	• Behavioral Health HEDIS/Quality improvement workgroup will meet monthly to review performance on measures and activities. • Inpatient Utilization Management team continue to focus on discharge planning, working with facility discharge planners to ensure every member has a timely behavioral health outpatient appointment scheduled prior to discharge from facility. • Step down to a partial hospital program is encouraged where appropriate. If a member is referred to partial hospital, a follow up appointment with a behavioral health outpatient provider should also be scheduled. • Request hospital staff to perform discharge planning meetings with patients to emphasize the importance of FUH. • Profile hospitals and identify both top and low opportunities for improvement. Part of the activity will include sharing FUH performance with hospitals to drive performance management, stressing importance of this measure, for quality care and reduction in possible readmissions

	• Identify the best practices of top performing provider groups and share the information with lower performing groups. • Utilize our care management transition to home program to work with all members being discharged from an inpatient BH facility to support them to adhere to scheduled appointments. Members to receive a timely follow up phone call to trouble shoot barriers to FUH which often includes lack of appointment. or transportation. • Continue to develop and operationalize telehealth options for PP members and providers and ensure that providers and members are aware that telehealth may be an option for members who have challenges to making an in-person appointment. • External provider search database to have provider availability information updated on a regular basis to provide more accurate information to members and facilities to find available outpatient providers. • Ongoing recruitment effort by allied health to contract additional outpatient PP BH providers for both MA and RI • Continue to explore innovative partnerships with providers to encourage timely outpatient aftercare treatment, including telehealth, for members who have been hospitalized. • Care Navigation Project to begin in 2022 for MA Public Plans members in which staff will be available to provide direct assistance to members with scheduling appointments with BH providers.
Public Plans Coordination of Care Product (s): Tufts Health Public Plans (THPP): Together (MA), THPP Unify **Project Description:** Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD). Metabolic Monitoring for Children and Adolescents on Antipsychotics: Assesses the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year.	• BH HEDIS/Quality improvement workgroup will meet monthly to review its performance. • BH HEDIS workgroup will produce educational materials for ACOs to share with their PCP and Prescribers • The workgroup will produce and distribute monthly gaps in care reports for ACOs, MCOs, CityBlock, BH Community Partners and Tufts ICM • The "Gaps in Care" report will include members diagnosed with schizophrenia or bipolar disorder, who were dispensed antipsychotic medication and have not had a diabetes screening test during the measurement year
Unify Interdisciplinary Care Team (ICT) Meetings Product (s): Tufts Health Public Plans (THPP): Together (MA), THPP Unify, THPP QHP Direct **Project Description:** The goal of this project is to increase ICT meeting engagement for members. The member-specific ICT includes the member and their family, friends or advocates, the member's assigned Care Manager and the member's PCP. THP aims to include all providers involved in a member's care, including BH and LTSS providers, state agencies, the member's, Care Coordinators, Community Health Workers, Peer	a) THP Interventions • The project work group meets at least monthly to review data reports related to ICT meetings, share opportunities for improvement, as well as discuss ideas for implementing and measuring actionable interventions. • High risk cases are discussed at weekly UM/CM rounds to identify if a member warrants an ICT meeting to address newly or existing assessed needs. • CM Team meets during huddles to discuss high risk cases to address monitoring of ICT measures. - During these huddles, the

Specialists, and anyone else the member delegates. The ICT collectively shares responsibility for delivering coordinated care and providing services that best meet the member's needs. This includes assisting the member in developing and participating in member centric care plan.	team reviews reports and targets members for actionable interventions. • The team will work on initiating ICT meetings during a member's inpatient hospital either via telehealth or in person. • Unify: CM Team reviews ICT KPIs via the tableau dashboard and project monitor. b) Provider Interventions: • Team collaborate with providers to promote their involvement in the ICT process if member is agreeable. • An article will be published in the Provider Update Newsletter to encourage providers to foster the importance of ICT meetings with their assigned patients. c) Member Interventions: • CM Team will provide education to members regarding importance of attending ICT meetings. - Members are encouraged to communicate their preference regarding who they wish to participate in their ICT meetings. • Team will invite the assigned PCP to ICT meetings, including telehealth appointments that can be utilized for ICT purposes as well (provided the member agrees to have PCP attend). • CM team will ensure all participating members of the ICT receive a copy of the meeting minutes. A copy is also uploaded to the member case or documented in notes.
Continuity and Coordination between Medical and Behavioral Healthcare Product (s): Tufts Health Public Plans (THPP): Together (MA), THPP Unify, THPP QHP Direct **Project Description:** It is important for a patient's overall health that behavioral health (BH) providers collaborate together with providers of a patient's medical care. Tufts Health Plan Behavioral Health Department has developed activities for two opportunities for improvement that address the continuity and coordination between medical care and behavioral healthcare: a) Improving BH Screenings and follow-up among Adolescent members • Provider education and follow up with member's PCP recommending Behavioral Health Screening for Adolescent Members (13-17 years old) be completed during well-child visit.	a) Member Education: • A reminder letter will be sent to the parents of members 13-17 explaining the importance of Behavioral Health screening during well child visits (Early and Periodic Screening, Diagnostic and Treatment services (EPDST)). The letter will include a link to the Tufts Health Plan website for BH educational articles • A BH educational article for members will be submitted and posted on the THP website about the importance of BH screening for early detection and intervention (Together, Direct, RI Together) b) Provider Education: for high volume, low preforming Provider Group (Together, Direct, RI Together): • Inform PCPs of commonly used BH screening instruments that are offered in multiple languages for adolescents, remind PCP of relevant procedure codes to use when submitting claims for performing screenings, and include a website link to access potential screening tools. • Publish article in 2022 Provider Newsletter about the importance of BH screening during PCP annual well child visits. • Publish a Frequently Asked Questions (FAQ) guide of BH resources, coaching techniques and best practices gathered from high preforming Providers and our ACO Partners to promote BH screening in the PCP setting. c) Provider Outreach/Collaboration: (Together, Direct, RI Together):

	• Outreach activity will be aimed at high volume, low preforming PCPs about their BH screening performance. Performance will be determined by reviewing completed BH screening claims data for members 13-17 during last 12 months. • The BH Quality work group will meet with our ACO partners to work collaboratively on sharing integrated care best practices to increase BH screening and collaborative care in the PCP setting • PCP Outreach: Letters along with Frequently Asked Questions document (FAQ) will be sent to Lower Performing PCPs with members lists attached indicating members that need BH screenings. d) BH Quality improvement workgroup will meet monthly to review performance. (Together, Direct, RI Together): • Project workgroups will meet regularly throughout the 2022 measurement cycle to monitor the project's interventions and activities for improvement. The workgroup will continue to monitor the project's progress, identify barriers, and brainstorm solutions.
Senior Care Options Member Satisfaction Product (s): SCO **Project Description:** Management of overall SCO member satisfaction by utilizing various channels of member feedback.	• Activity 1: Develop SCO Member Governing Board structure and meetings • Activity 2: Conduct 2 SCO advisory meetings in different geographies/languages • Activity 3: Identify opportunities to expand healthy food grocery benefit
Senior Care Options Member Satisfaction (SCO) Product (s): SCO **Project Description:** Management of overall SCO member satisfaction by utilizing various channels of member feedback.	• Administer SCO member survey (Q2, 2021) • Review monthly/quarterly appeals and grievance reports/meetings (include report out to EOHHS every 6 weeks) • Conduct quarterly SCO member advisory council meetings to solicit feedback (pending COVID). • Identify and implement improvements to at least 2 member challenges
THPP Continuity and Coordination of Care ED Utilization Product (s): Tufts Health Public Plans: Qualified Health Plan (QHP) Direct, THPP Together (MA), RITogether **Project Description:** The goal is to reduce the rate of avoidable adult emergency department utilization (EDU) through improvement of continuity and care coordination, member/ caregiver education, provider communication and collaboration.	a) THP Interventions (for all applicable products) • Project team will meet regularly and frequently to brainstorm actionable interventions, as well as provide updates on progress. • Team assesses the overall effectiveness of the ToC Program, as the team is responsible for reviewing data reports and key performance metrics on a monthly, quarterly, and annual basis. The expectation is that staff also access and utilize advanced data to denote trends and possible impact on program changes. • The Team utilizes PHM data, metrics and conduct file reviews in order to analyze the outcomes and impact of the ToC program strategy, at least quarterly and a year-end annual report. • Team reviews data related to 4 or more ED visits within a 365-day period. b) Member Interventions (for all applicable products): • CM team to utilize data and reports related to ED visits to provide actionable interventions to the targeted population

	based on their clinical risk score to provide needed support. The targeted population includes all members who visited and discharged from an ED (Medical and BH ED visits) facility. • The CM team, based on the target population's diagnosis and clinical risk score, will attempt to complete an initial outreach to the member within a maximum 72 hours from the identified ED discharge date. • The CM team will attempt to complete a ToC assessment with the engaged member, using the member's identified assessed needs to help develop their care plan, if warranted. CM will ensure the following details are addressed during the outreach: Medication review, Follow up on member SDoH needs (per ToC assessment), Assistance with scheduling and reminding members of follow-up appointments with PCP and/or other providers, Publish member education article via THP website. c) Provider Interventions (for all applicable products): • Publish educational article via the THP "Provider Update" newsletter to offer collaboration. Articles will focus on educating the provider on how to foster appropriate use of Urgent Care Centers (UCCs) and the physician's office for non-emergent issues instead of visiting the ED.
THPP Continuity and Coordination of Care: 30-day PCR (Plan All Cause Readmission) Product (s): THPP Public Plans: Together, RITogether, Qualified Health Plan (QHP): THPP Direct **Project Description:** The goal of this project is to improve member continuity and care coordination across multiple settings to reduce avoidable medical and behavioral health re-hospitalization rates, utilizing the transitions of care (TOC) program.	a) THP Interventions (for all applicable products): • Project Team will meet regularly and frequently to brainstorm actionable interventions, as well as provide updates on progress. • The Team is responsible for reviewing data reports and key performance metrics on a monthly, quarterly, and annual basis. • The Team utilizes PHM data, metrics, and conduct ToC file reviews in order to analyze the outcomes and impact of the program strategy, at least quarterly and a year-end annual report. b) Member Interventions (for all applicable products): • Publish member education articles to encourage use of Urgent Care Centers (UCCs) and the physician's office for non-emergent issues instead of visiting the ED. • Care Manager (CM) team to utilize data reports to provide actionable and targeted interventions to members in need of additional support relating to medical and BH transition of care outreach and follow up for coordination of care. • The CM team, based on the member's diagnosis and clinical risk score, will attempt to complete an initial outreach with member within a maximum of 72 hours from the identified inpatient admission and/or emergency department discharge to identify need for follow-up and other post-discharge coordination of services. • Collaborate with UM department when possible to assist with discharge planning support. • The CM team, will complete an assessment with the engaged member, using the member's identified assessed needs to help develop their care plan, and to ensure the following details are

	addressed: Medication review. assistance with scheduling follow-up appointments with PCP and/or other providers. follow up on member SDoH needs (per assessment). c) Provider Interventions (for all applicable products): • CM Team will collaborate with inpatient facilities to offer education and share improvement strategies to ensure safe, effective discharge planning and follow-up occurs with the member. • Publish provider article in the Provider Update Newsletter to encourage providers to stress the importance of educating the member on following up with the PCP/ physician's office to communicate and to assess the appropriateness of when the member should be seen by the PCP or the ED.
Tufts Health Public Plans Well Child Visits for Adolescent Members (13-17 years old) Product(s): Public Plans: Qualified Health Plan (QHP): THPP Direct, THPP Together **Project Description:** Continuity of care is defined as the integration and coordination of medical information and care across a member's specific providers and related settings / facilities (BH and medical). The goal of this project is to improve the rate of preventative (well-child) visits with a PCP, for adolescent members aged 13-17 years. Preventive care/well visits for adolescents will include actionable interventions related to education, screening, and counseling on the following: BH, tobacco, SUD, violence and injury prevention, sexual behavior, as well as nutritional health.	Member interventions • Provide education to members: • Collaborate with internal THP team to promote well-child visits to foster early screening, counseling, and intervention (based on EPSDT appointment schedule). • Health literacy promotion messages for adolescents and parents. • Publish member article on THT website pages. • Foster importance of well child/preventive health visits including screenings, counseling, and interventions, especially during the pandemic. • Reinforce regular PCP visits. • Collaborate with Marketing and Community relations teams to distribute materials in English and Spanish at the following locations: food pantries, WIC offices, school nurse offices, community spaces, other locations to be identified. PROVIDER INTERVENTIONS: • The team will facilitate conversations and relationships between the member and provider. If positive screens show up during the visit, the provider is encouraged to initiate a referral for follow up specialty services. • Team will meet monthly to monitor WCV (Well Child Visit) rates and assess barriers to goals, as well as assign corrective actions when applicable goals are not being met. This information will be shared with providers. • Review and act upon data related to gap in care (missed well child appointments and associated screenings). THP will be sharing gaps in care data with providers that demonstrate a high incidence of missed well child office visits. • Publish Provider article, encouraging well /preventive visits with areas of focus such as: • Early screening, counseling, intervention • Monitor growth and development, support psychological and emotional well-being, and encourage healthy lifestyles; and • Build confidence in adolescents to utilize the health care system effectively and appropriately

	• Foster early screening, counseling, and intervention; • Reinforce health promotion messages for both adolescents and their parents. • Team will review data reports to identify utilization rates by health centers to solicit feedback on best practices that can also be shared with lower performing health centers. THP Interventions • Project team will meet regularly and frequently to brainstorm actionable interventions, as well as provide updates on progress.
Flu Vaccination PIP's **a) Senior Care Options Flu Vaccination** **b) Unify Performance Improvement Project: Flu Immunization PIP** **c) Public Plans MCO Flu Vaccinations PIP** Product(s): Public Plans: Qualified Health Plan (QHP): THPP Direct, THPP Together, SCO **Project Description:** The goal of this project is to increase the influenza vaccination utilization rate by addressing health disparities that impact the target population.	As of 8/1/21- City Block has been delegated to manage CM services for the Unify LOB. The internal Unify Program Management Team is currently collaborating with City Block to implement actionable interventions. City Block reports that they have the capabilities to administer the flu shot to members that are home bound. Focus Populations: • SCO: Haitian Creole • Together MCO: Black American, African and Spanish • Unify: African, Black American and Native American Activity 1: THP Interventions a. The project work group continues to meet at least monthly. The work group regularly reviews data reports to identify opportunities for improvement, as well as address gaps and barriers to member's access to obtaining the vaccine. b. The team will share ideas regarding how to mitigate barriers related to member hesitancy for accessing and receiving the vaccine. c. The team will work with the THP Multicultural Flu Task Force to address barriers for access to flu clinics and other vaccination sites by providing information to members residing in the Southern part of MA. d. SCO, RITogether, MCO: The CM teams will be provided with Motivational Interviewing training to refresh their skills related to member engagement strategies. The training will utilize population characteristics data to identify the targeted population, so that their specific barriers can be identified and addressed. a. The team will review and utilize HEDIS (Healthcare Effectiveness Data and Information Set) CAHPS survey and claims data to monitor and impact the rate of MCO influenza vaccine utilization. b. Members enrolled in Care Management (CM) are administered a Comprehensive Assessment, which includes a question regarding their influenza vaccination status. Members assigned to CM will continue to receive education regarding this vaccine. Activity 2: Provider Interventions

	a. Provider education will be offered via the THP Provider Update Newsletter article, which is published monthly. This article encourages providers to promote the importance of the Influenza vaccine to members. The article also includes information on administration of the COVID booster and flu vaccine at the same time. b. THP Provider Webinars are being offered to promote the importance of the influenza vaccine. c. Medical Directors (MDs) will reach out to high volume health centers/provider sites who demonstrate high influenza vaccination rates to solicit feedback on best practices. The MDs to discuss best practices for encouraging members to get the vaccine with lower performing providers. Activity 3: Member Interventions a. An article will be published monthly via the online Member Wellness Magazine to educate members on the importance of receiving an influenza vaccine. o Success stories related to CMs assisting members with obtaining an influenza vaccine. b. MCO only: A Member Focus Group (MFG) is currently under development and recruitment of members is in process. The purpose of the MFG is to solicit feedback on this and other projects, as well as member experience with CM services. c. Unify and SCO: Consumer Advisory Councils is currently in place and utilized to gather member feedback to identify barriers to members accessing and obtaining the vaccine. d. Unify: Members mailed post cards with flu vaccine reminder. e. Care Managers will outreach assigned members to promote the importance of obtaining the vaccine. The purpose of this intervention is to address related health implications and identify barriers related to access to the vaccine.