2021 Quality Improvement Work Plan Summary

Project	Objectives/Actions
Member Service and Satisfaction – Commercial Product (s): Tufts Health Plan (THP) Commercial HMO/EPO/POS/PPO, Commercial Freedom, Qualified Health Plan (QHP) Premier **Project Description**: Improve the perception and satisfaction of members when they call the call center for quality and efficient resolution to their inquiries.	• Monitor Tiered Staffing Model introduced in the Call Center during Q4 2020 which is designed to retain staff and increase experience of staff on the phones while reducing turnover. • Revisit and revise escalation paths for call center issues requiring research and monitoring for more immediate resolution.
Member Service and Satisfaction – Tufts Health Plan Medicare Preferred Product (s): Tufts Health Plan Medicare Preferred Massachusetts, Senior Care Options (SCO), Tufts Health Plan Medicare HMO CarePartners Connecticut **Project Description:** Getting Members the help and service they need, CAHPS question 34	• Create and institute a process to ensure returned ID cards get to the Member • Set up a process in the call center where representatives validate addresses when a Member calls • Mining Macess call notes tagged with the 'Benefits' (which is typically the highest percentage of daily calls) and the second top category (varies from day to day)
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 or to the provider, developed with the provider by THP, or communicated to the provider after QOCC review of quality of care event as a part of the THP investigation of Adverse Events.	• Collect 2020 network data on falls and SREs • Ensure staff training on project activities • Refine measurement points • Assess the continuation of the project in an ongoing manner throughout the year
Cultural and Linguistic Services Product (s): Commercial: HMO, POS, PPO; QHP Premier; Commercial Freedom; 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 2020, we aligned key priorities for 2021 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 Product (s): Commercial (HMO/POS, PPO); Qualified Health Plan (QHP) Premier; THPMP	a) • 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

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.	become involved in the case management programs. CMs help to address any medication compliance issues. • Optum to screen members in the disease management program for depression using the PH-2 screener. Case management staff will follow up with those members who have answer yes to both questions to provide support or help with referral to behavioral health services. • Depression screenings to continue for THPMP members that are in a complex case management program, though THPMP Case Managers. 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.
Senior Care Options (SCO) Performance Improvement Projects Product (s): SCO **Project Description:** a) Reducing Acute Inpatient Readmissions b) Flu Immunization c) Reducing barriers to Telehealth	a) • Readmissions Forum: Held monthly to track and trend readmission utilization data over time. Provides a forum to discuss opportunities to reduce readmission rates with multi-disciplinary stakeholders. • SNF Readmission Workflow: integration into current SCO huddles and CCP Monthly meetings. The RCA tool will be completed and reviewed by APN. Data and trends presented monthly at CCP forum. • Implementation new Transitions of Care (TOC) Management Program: In 2021 Senior Products care management will implement a targeted TOC program focused on reducing readmissions, and helping members manage in the community in the 30-45 days post inpatient discharge within a defined segmentation. This program will include TOC Nurses and TOC Coordinators/Paraprofessionals. The TOC Nurses will ensure that members with an unplanned admission have a 2 day Post Hospital Intervention Assessment and Intervention (PHA), and a

	medication reconciliation and review by day 7. Additionally, the member will have a telephonic touch on weeks 3 and 4 of discharge as indicated. The TOC Nurse will ensure a plan is put in place to reduce or eliminate the risk of a readmission by focusing on the transitions of care. b)/c) • Project workgroups will meet monthly to design the project including: identify interventions/activities for implementation, monitor progress, identify and address barriers and brainstorm solutions. • Barrier Analysis including fishbone diagram will be completed. Actionable barriers will be identified and will help inform the project's activities • CY19 and CY20 flu immunization data will be pulled. • CY 20 telehealth utilization data for both products will be pulled. • Numeric goals/performance targets will be confirmed once baseline data is pulled. • Population Analysis will be completed using Baseline (CY20) data.
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.
Care Management and Continuity and Coordination of Medical Care Product (s): Commercial HMO/POS, PPO; THP Freedom; QHP Premier, **Project Description**: The coronavirus pandemic has forced the Commercial Case Management team to look at disaster planning processes and the impact on transitions of care and provider collaboration. This project will focus on standardizing policies, revamping the transition coordinator role, enhanced collaboration with the UM team, and alternative approaches for preventive and follow-up care with providers	• Track number of cases brought to UM/CM rounds for collaboration on discharge planning for members hospitalized with transition barriers. Continuous evaluation of rounds process • Give summary steps taken by Tufts Health Plan to augment prior authorization policies for UM performed during the pandemic. • Review and update pandemic policy at least annually • Provide model using one pilot provider group on transition of care management collaborations based on new policies and workflows (telehealth use, Pre-auth processes, UM processes, and decrease in elective procedures).

	• Analyze data and develop lower tier stratification logic for Basic TTH program • Report on program development to demonstrate shift in Transition Coordinator (TC) role during pandemic when their role shifts from outreaching members post elective surgeries to outreaching members with lower risk scores from the inpatient setting • Track and trend the Covid-19 member outreach activities • Develop and enhance TC job description, workflows, and tools •Provide TC education
Coordination between Medical and Behavioral Healthcare Product (s): Commercial (HMO/POS, EPO, PPO); Qualified Health Plan (QHP) Premier, Tufts Health Public Plans (THPP): Together (MA); RITogether; QHP Direct **Project Description:** a. **Inpatient Behavioral Health Facility Communication with Member's Primary 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 and of the discharge. THP expects all inpatient behavioral health facilities to routinely document communication with the PCP for every member who has an assigned PCP. 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. Members involved in the integrated case management program are tracked. c. **Data Collection for Coordination of Medical and Behavioral Healthcare**	a) • To continue to work with inpatient behavioral health facilities to increase collaboration with a member's PCP through the inpatient behavioral health facilities' submission of the discharge summary to a member's PCP. • Through newsletter article and other activities, to educate behavioral health providers about the importance of Behavioral health providers communicating with a member's PCP. b) • 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. • Members with substance use disorder will be included in this collaboration, as well as other medical and behavioral health illnesses. c) • Data to be collected on depression through the Antidepressant Medication management (AMM) HEDIS measure. • The AMM measure also addresses appropriate use of pharmacological medications. • Data to be collected on alcohol and substance use disorder through the Initiation and Engagement of Treatment (IET) HEDIS measure. • Data to be collected on 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.
Tufts Health Public Plans (THPP) Member Services & Satisfaction Product (s): Tufts Health Public Plans (THPP): Together (MA); RITogether; Unify; QHP Direct **Project Description:** 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	• Identify areas of opportunity for the development of new resources, refresher courses, and increased communications based on the trend data from OQA, the repeat caller program, and member escalations. 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.

overall quality of service provided to members contacting the call center for assistance.	• Inform staff of current and future changes and coverage updates through quarterly meetings with the call center manager. Provide servicing updates 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.
Tufts Health Public Plans Follow Up After Mental Health Hospitalization Product (s): Tufts Health Public Plans (THPP): Together (MA); RITogether; 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
Tufts Health Public Plans Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) 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)	• Mail Provider education about the importance of annual diabetes screening and patient education, along with member gaps in care lists to all Providers who prescribed antipsychotic medication as treatment for schizophrenia or bipolar disorder. • Submit Article to Provider Update Newsletter about importance of Diabetes Screening among members with Schizophrenia or Bipolar Disorder • Contact high volume Community Health Centers and provide the list of members with gaps in care. Encourage the Health Centers to coordinate Diabetes screening with Primary Care Physician follow up • Identify the best practices of top performing provider groups and share the information with lower performing provider groups • BH HEDIS/Quality improvement team will attend monthly BH Community Partner (CP) Agency meetings and work with the CP Management/QI team to improve SSD performance.
Public Plans—Unify Product (s): THPP Unify **Project Description:** a) Provide Unify members with a high-quality transportation service delivery system.	a) • Complaints and grievances will be monitored on a monthly and quarterly basis as part of the internal monitoring and FDR monitoring facilitated by Tufts Health Unify. • A workgroup with representatives from Tufts Health Unify and Coordinated Transportation Solutions (CTS) will held on a bi-weekly and monthly basis to review complaints/grievances that

b) Removing Barriers to Telehealth c) Flu Immunization d) Interdisciplinary Care Team Meetings: Increase Interdisciplinary Care Team (ICT) Meetings for Complex/High Members	will identify root causes and determine the appropriate follow up action to prevent re-occurring incidents. • A Consumer Advisory Council (CAC) will be held on a quarterly basis that will facilitate discussion with members about their personal transportation experiences, issues they have encountered and suggestions for improvement. b) &C) • Project workgroups will meet monthly to design the project including: identify interventions/activities for implementation, monitor progress, identify and address barriers and brainstorm solutions. • Barrier Analysis including fishbone diagram will be completed. Actionable barriers will be identified and will help inform the project's activities. • Baseline (CY20) telehealth utilization data will be pulled. • Baseline CY19 and CY20 flu immunization data will be pulled • Numeric goals/performance targets will be confirmed once baseline data is pulled. • Population Analysis will be completed using Baseline (CY20) data. d) • COVID19 social distancing restrictions for all medical and behavioral health treatment facilities and provider practices have prevented previously identified PIP interventions from being initiated. Those interventions targeted in-person engagement with providers and skilled nursing facilities to increase the number of ICT meetings. They will be replaced with the following: • Collaborate with the providers of Unify members to promote their involvement in the ICT process.
Public Plans—Rhode Island Developmental Screening Product (s): THPP RITogether **Project Description:** Improve the rate of developmental screening for Rhode Island members in their first 3 years of life. Early and Periodic Screenings are essential to Preventative Care, Dental Care, Diagnosis and Treatment of Mental health, and Developmental and Specialty Services.	• Member Outreach/Education: RI CM team to conduct outreach via a monthly mailing. • Data/Analytics/Reporting: Leverage KIDSNET registry data to improve reporting accuracy as THP's analytics are limited to claim-based reporting. • Provider Outreach/Education: Utilize Provider Updates and THP Web Site for reminders of importance of early screening and education and around correct claims/bulling workflows to ensure completed screening are captured appropriately.
Public Plans Performance Improvement Projects, MassHealth MCO Product (s): a) THPP Together (MA MCO); THPP Qualified Health Plan Direct, THPP RITogether b) THPP Together c) THPP Together **Project Description:** a) Improving Behavioral Health Screenings and Follow Up for Adolescents	a) • Member Education: 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 • Provider Education: 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 b) & c)

b) Improve flu immunization rates among the MA Together population c) Removing Barriers to Telehealth	• Project workgroups will meet monthly to design the project including: identify interventions/activities for implementation, monitor progress, identify and address barriers and brainstorm solutions. • Barrier Analysis including fishbone diagram will be completed. Actionable barriers will be identified and will help inform the project's activities. • Baseline CY19 and CY20 flu immunization data will be pulled. • Baseline (CY20) telehealth utilization data will be pulled. • Numeric goals/performance targets will be confirmed once baseline data is pulled. • Population Analysis will be completed using Baseline (CY20) data.
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
Public Plans Continuity and Care Coordination Across Settings Product (s): Tufts Health Public Plans: Qualified Health Plan (QHP) Direct, THPP Together (MA), RITogether **Project Description:** a) Decrease the rate of adult emergency department (ED) utilization through improvement of continuity and care coordination, member education and provider collaboration. b) Improve care transitions between care settings	a) • ICM 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 ICM 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. b) • ICM 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 ICM 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.
Tufts Health Public Plans Asthma Disease Management Product (s): Public Plans: Qualified Health Plan (QHP): THPP Direct, THPP Together, THPP RITogether **Project Description:** Improve the referral and screening process for the Tufts Health Plan Integrated Care Management Program, to ensure timely coordination of provider services and implementation of care management interventions to help the population manage asthma treatments.	• 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. • CM will assist population in facilitating discussions and appointments with providers to ensure wrap around and community resource (care coordination) are offered to the member • Project lead will work with the MA and RI ICM 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.).
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:** Improving the rate of preventative (well-child) visits for members aged (13-17 years old) to foster early screening, counseling and intervention. Preventive care/well visits for adolescents should include screening and counseling on the following: BH, tobacco and SUD, violence and injury prevention, sexual behavior, as well as nutritional health.	Member interventions • Promote well-child visits to foster early screening, counseling and intervention (based on EPTSD appointment schedule). • Health literacy promotion messages for adolescents and parents. • Publish member article on THT and THD website pages • Reinforce regular PCP visits. Provider interventions • Team will meet monthly to monitor WCV (well child visits) rates and access 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