TUFTS Health Plan

2023 Quality Improvement Work Plan Summary

Project	Objectives/Actions
Tufts Health Plan (THP) Commercial Member Services and Satisfaction **Project Description:** Identify opportunities for Call Center staff and Member Support Teams to collaborate on member issues to help expedite resolution. Create a formalized process for timely resolution of member issues requestion action/input from inter-departmental teams. The overall goal is to improve the perception and satisfaction of members when they call the call center for quality and efficient resolution to their inquiries especially when inter-departmental coordination is required. **Product (s):** THP Commercial HMO/EPO/POS/PPO	**Activity 1:** Continue to identify opportunities to enhance Member Services & Member Support communication and reassignment for issues requiring research and monitoring for more immediate resolution of issues. • Track Service Form reports • Monitor TAT of GIC Service Forms • Continuously review and update SupportPoint documentation with most relevant details **Activity 2:** Create formalized TAT process; identify key contacts, define program guidelines, and develop SLA template. • Meet with identified departments/teams to present the plan, SLA, and come to a mutually agreed upon process • Monitor results of time to resolve issue
Tufts Health Public Plans Member Services and Satisfaction **Project Description:** Focus on creating a formalized process for timely resolution of member issues requiring action/input from inter-departmental teams; outline the process, work with the appropriate contacts outside of Servicing, create service level agreements (SLAs) for response times, and monitor time to respond/resolve issues. The goal of this project is to improve the member experience by providing timely resolution of issues when inter-departmental coordination is required. **Product (s):** Tufts Health Public Plans (THPP): Together (MA); RITogether, QHP Direct	**Activity 1:** Create the process; identify key contacts, define program guidelines, and develop SLA template. **Activity 2:** Meet with identified departments/teams to present the plan, SLA, and come to a mutually agreed upon process. **Activity 3:** Monitor results from request intake to resolution.
Tufts Health Plan Senior Products Member Services and Satisfaction **Project Description:** Focus on creating a formalized process for timely resolution of member issues requiring action/input from inter-departmental teams; outline the process, work with the appropriate contacts outside of Servicing, create service level agreements (SLAs) for response times, and monitor time to respond/resolve issues. The goal of this project is to improve the member experience by providing timely resolution of issues when inter-departmental coordination is required. **Product (s):** Tufts Health Plan Medicare HMO, CarePartners of Connecticut Medicare HMO	**Activity 1:** Create the process; identify key contacts, define program guidelines, and develop SLA template. **Activity 2:** Meet with identified departments/teams to present the plan, SLA, and come to a mutually agreed upon process. **Activity 3:** Monitor results from request intake to resolution.
Senior Care Options (SCO) Member Satisfaction	**Activity 1:** Develop and implement SCO Member Governing Board Structure and Meetings

Project Description: Institute SCO consumer facing required boards/meetings and identify opportunities to increase education /re-education based on input. **Product (s):** Senior Care Options	**Activity 2:** Conduct two (2) SCO Consumer Advisory Meetings in 2023
Patient Safety **Project Description:** Inpatient Behavioral Health Medical Record Elements for Patient Safety. When a member needs inpatient behavioral health care, documentation of informed consent, complete medication orders, risk assessment and mitigation, and aftercare involving coordination with a primary care provider (PCP) are associated with improved patient safety during and after hospitalization. We will audit a meaningful sample of inpatient behavioral health hospitalization medical records to evaluate the documentation of these elements. Opportunities for improvement will be identified and providers may need to submit a corrective action plan (CAP). **Product (s):** All Products: THP Commercial HMO/EPO/POS/PPO, Tufts Health Public Plans (THPP): Together (MA); RITogether, QHP Direct, THPP Unify, Tufts Health Plan Medicare HMO, CarePartners of Connecticut Medicare HMO, SCO	**Activity 1:** August 2023: Request audit universe from IT concurrently with universe request (Together, Careplus) for BH Medical Record Audit. The universe for this project will include the Careplus and Together members, Unify, Commercial, and Medicare members who had an inpatient psychiatric hospital admission between 1/1/2023 and 6/30/2023. **Activity 2:** Sept/Oct 2023: Request and receive medical records and audit. Score audit tools and draft provider results letters (each RN on team is assigned a certain number of charts to review and will write provider outcome letters; Manager to review scores and letter drafts before sent). Mail letters by early November. Letters need to identify gaps and request a CAP. **Activity 3:** December 2023: Score CAPs turned in by providers. For any providers who indicate that an improvement is "in progress," we will send a second letter indicating that we will follow up in December (2023) or January (2024) to request an update and details. **Activity 4:** December 2023/January 2024: 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. **Activity 5:** January 2024: Score results and reassess project for addition of any 2024 activities.
Culturally & Linguistically Appropriate Services **Project Description:** Collect and utilize Race, Ethnicity and Language (REL) data in order to find and address health care inequities, to create new quality improvement initiatives where necessary, and to promote high quality care for all our members. To achieve this mission, health equity will become central to what we do as an organization working together with leaders across the business to: create an integrated portfolio of initiatives, aligned with key equity focus areas and the greatest opportunity for impact to our members, our communities, and our business. **Product (s):** All Products: THP Commercial HMO/EPO/POS/PPO, Tufts Health Public Plans (THPP): Together (MA); RITogether, QHP Direct, THPP Unify, Tufts Health Plan	**Activity 1:** Perform annual assessment of members' cultural needs and linguistic preferences a) Conduct satisfaction survey(s) of diverse members through member advisory panels convened in MA for SCO and Unify, SMS surveys for RITogether members, and annual SCO survey to capture member feedback b) Conduct assessment of linguistic and cultural capabilities of the Point32Health provider network c) Perform annual assessment of member grievances related to race, culture, or language d) Identify and assess opportunities to support teams requiring cultural competency training or additional capabilities **Activity 2:** Health Equity/Population Health: Expand efforts to collect REL, analyze disparities, and implement health equity programs:

Medicare HMO, CarePartners of Connecticut Medicare HMO, SCO	a) Develop and implement a strategy for the collection and storage of race, ethnicity and language (REL) and SDOH data b) Analyze REL for membership through self-reported and RAND estimated data (includes Unify and SCO) c) Create an integrated portfolio of initiatives, aligned with key equity focus areas and the greatest opportunity for impact to our members, our communities, and our business d) Establish repeatable measurement processes for our health equity portfolio to understand our impact and demonstrate value over time e) Build out REL/SDOH dashboards with population health, risk adjustment, and provider utilization platforms to identify and address health disparities f) Prioritize and implement interventions to analyze of health disparities by race/ethnicity to improve awareness, access, and support of equitable & culturally sensitive standards of care g) Increase external investment in efforts that address underserved and underrepresented populations through the Heath Equity Compact, Diversity IN and the Point32Health Foundation h) Expand external leadership through participation in the Disparities Solutions Center: Disparities Leadership Program, the Commonwealth Fund, and the MAHP Racial Disparities Work Group to advance health equity **Activity 3:** Anti-racism: provide training for managers, leaders, and other staff on anti-racism training related to courageous conversations a) Establish process and policies to increase development of diverse staff across levels, particularly leadership b) Deploy training on advancing an inclusive culture, and addressing microaggressions c) Track and measure cultural competency training completion of provider group practitioners d) Anchor community engagement and philanthropy on addressing systemic racism, equity, and social justice **Activity 4:** Cultural Competence/Multilingual Servicing: Continue deployment of specialized training. Improve direct language access for members a) Implement recommendations from the 2022 Member Language Access Plan assessment project and deploy cultural engagement tools b) Continue deploying mandatory transgender training modules for new Public Plans Care Management staff c) Boost efforts to collect REL and cultural information in our provider network through tracking of provider data on practitioner's culture, ethnicity, race

	d) Expand efforts to incorporate new provider attributes on ethnicity and culture in our provider directory
Case Management and Continuity and Coordination of Medical Care **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. Preventable ED visits and hospital readmissions are a challenge for both the member and the health care system. Using internal metrics from data analytics for total number of ED visits and ED utilization of 4 or more visits (high utilizers) as benchmarks, Point32Health works with members and provider partners to address these issues to monitor and evaluate transitions of care process and efforts. **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. Improving the Medical 30-day readmission rate can help drive quality improvement efforts and monitor progress in reducing readmissions for this population. Readmission to the hospital within 30 days of discharge is frequently avoidable and can lead to adverse member outcomes and higher costs. The Plan All-Cause Readmissions (PCR) measure assesses the percentage of acute inpatient hospital discharges resulting in an unplanned hospital readmission within 30 days progress in reducing readmission. The Commercial Transitions of Care process will provide support via actionable interventions to ensure members avoid adverse outcomes following an inpatient discharge to the community. **3) Asthma Care Management Program:** The prevalence and cost of asthma treatments have increased over the past decade, demonstrating the need for better access to care and medication management. 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. The CDC and Massachusetts	**Project 1: ED Utilization** **Activity 1:** Commercial Program Management and Evaluation a) Project team will meet regularly and frequently to brainstorm actionable interventions, as well as provide updates on progress. b) Commercial team assesses the overall effectiveness of the transitions of care (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. c) 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. **Project 1: ED Utilization** **Activity 2:** Member Interventions: a) 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 targeted population includes all members who visited and discharged from an ED (Medical and BH ED visits) facility. Data reports are available per LOB. b) 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. c) 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: a. Medication review. b. Assistance with scheduling follow-up appointments with PCP and/or other providers. d) Publish member articles via the THP website. **Project 1: ED Utilization** **Activity 3:** Provider Interventions: a) 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. b) Commercial Team and Medical Directors will collaborate with inpatient facilities to offer education and share improvement

Department of Public Health recommend annual influenza vaccination for all members 6 months and older. Influenza (flu) is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness. Serious outcomes of flu infection can result in hospitalization or death. Some members, such as older people, young children, and people with certain health conditions, are at high risk of serious flu complications. The best way to prevent seasonal flu is to encourage members to get vaccinated by the end of the month of October each year. Collaboration with providers (PCP offices, Community Health / flu clinics [i.e.: CVS Minute and community public health clinics]) to strategize on actionable interventions to increase the rate of administered influenza vaccinations. Utilizing data, encourage PCPs to administer the vaccination during routine office visits, as well as foster best documentation practices for including documentation of the service in the assigned member's record. **Product (s):** THP Commercial HMO/EPO/POS/PPO	strategies to ensure safe, effective discharge planning and follow-up after ED visit occurs with the member. c) Encourage providers to educate assigned members (using data to drive practice) on the appropriateness of using the PCP office, or UCCs vs the ED **Project 2: Plan all Cause Medical 30-day Readmission** **Activity 1:** Commercial Program Management and Evaluation a) Project team will meet regularly and frequently to brainstorm actionable interventions, as well as provide updates on progress. b) Commercial 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. c) 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. **Project 2: Plan all Cause Medical 30-day Readmission** **Activity 2:** Member Interventions: a) 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 targeted population includes all members who visited and discharged from a (Medical and BH ED visits) facility. Data reports are available per LOB. b) 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. c) 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: a. Medication review. b. Assistance with scheduling follow-up appointments with PCP and/or other providers. d) Publish member article via the THP website. **Project 2: Plan all Cause Medical 30-day Readmission** **Activity 3:** Provider Interventions: a) 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. b) 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. c) 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. **Project 3: Asthma Care Management Program** **Activity 1:** 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. b) 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. c) 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 3: Asthma Care Management Program** **Activity 2:** a) Project lead will work with the Commercial teams to create a process to auto-create referrals of members needing additional support with managing their asthma treatment plan. b) 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.). c) 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. **Project 4: Annual Influenza Vaccinations** **Activity 1:** a) Outreach to members encouraging them to obtain the influenza vaccine. b) Member education related to influenza (flu) vaccine information to be published in member update article posted on the THP website.

	c) IVR, e-mail, and/ or text (members/ parent or guardian) reminders. d) Referrals to Intensive Care Management care coordination program, when warranted or requested. **Project 4: Annual Influenza Vaccinations** **Activity 2:** a) Collaboration with providers (PCP offices, Community Health / flu clinics [i.e.: CVS Minute and community public health clinics]) to strategize on actionable interventions to increase the rate of administered influenza vaccinations. b) Utilizing data, encourage PCPs to administer the vaccination during routine office visits, as well as foster best documentation practices for including documentation of the service in the assigned member's record. c) Provider update article related to influenza vaccine information to be published in the THP "Provider Update" newsletter. d) Sharing of member data and characteristics with providers based on CY2022 claims data.
Continuity and Coordination of Medical Care: Public Plans ED Utilization **Project Description:** Improving transitions between care settings is critical to improving the member's quality of care, quality of life and health outcomes. The main goal of the Tufts Health Public Plans Transitions of Care (ToC) program is to ensure members avoid adverse outcomes following a discharge from a facility to the community. This project aims to promote effective processes related to care transitions to prevent medication errors, identify issues for early intervention, prevent unnecessary hospitalizations and readmissions, support member preferences/ choices, and to avoid duplication of processes and efforts to utilize resources more effectively. **Product (s):** Tufts Health Public Plans (THPP): Together (MA), RITogether, QHP Direct	**Activity 1:** THP Interventions (for all applicable products) a) Project team will meet regularly and frequently to brainstorm actionable interventions, as well as provide updates on progress. b) 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 will also access and utilize advanced data to denote trends and possible impact on program changes. c) 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. d) Team reviews data related to 4 or more ED visits within a 365-day period. e) The CM Team provides appropriate educational materials, available in multiple languages. f) The CM team provides appropriate referrals for additional care and services as applicable. **Activity 2:** Member Interventions (for all applicable products): a. CM team utilizes 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. b. 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. c. 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: d. Medication review. e. Follow up on member SDoH needs (per ToC assessment) f. Assistance with scheduling and reminding members of follow-up appointments with PCP and/or other providers. g. Publish member education article via THP website providing information on: - Appropriate use of the ED for emergent issues. - Promoting use of PCP office visits for non-emergent concerns. - Appropriate use of urgent care centers. - Fostering importance of post discharge follow-up after care. **Activity 3:** Provider Interventions (for all applicable products): a) 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. b) The Team will collaborate with inpatient facilities to ensure safe, effective discharge planning and follow-up after ED visit occurs with the member. c) Encourage providers to educate assigned members (using data to drive practice) on the appropriateness of using the PCP office, or UCCs vs the ED.
Continuity and Coordination of Medical Care: Public Plans 30-day Readmission **Project Description:** Improving transitions between care settings is critical to improving the member's quality of care, quality of life and health outcomes. The main goal of the Tufts Health Public Plans Transitions of Care (ToC) program is to ensure members avoid adverse outcomes following a discharge from a facility to the community. This project aims to promote effective processes related to care transitions to prevent medication errors, identify issues for early intervention, prevent unnecessary hospitalizations and readmissions, support member preferences/ choices, and to avoid duplication of processes and efforts to utilize resources more effectively. **Product (s):** Tufts Health Public Plans (THPP): Together (MA), RITogether, QHP Direct	**Activity 1:** THP Interventions (for all applicable products): a) Project Team will meet regularly and frequently to brainstorm actionable interventions, as well as provide updates on progress. b) The Team is responsible for reviewing data reports and key performance metrics on a monthly, quarterly, and annual basis. c) 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. d) The CM Team provides appropriate educational materials, available in multiple languages. e) The CM team provides appropriate referrals for additional care and services as applicable. **Activity 2:** Member Interventions (for all applicable products):

	a) Care Manager (CM) team to utilize data reports to provide actionable and targeted interventions to identified members in need of additional support relating to medical and BH transition of care outreach and follow up for coordination of care. Data reports are available per LOB. b) 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. c) 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). d) 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. Articles published via THPP website. **Activity 3:** Provider Interventions (for all applicable products): a) Collaborate with inpatient facilities to ensure safe, effective discharge planning and follow-up occurs with the member. b) 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.
THPP Well Child Visits Adolescent Members **Project Description:** Adolescence is a time of physical, cognitive, social and emotional change. It is also a time when mental health conditions, Substance Use Disorder (SUD) and health risk behaviors may first emerge. Well child visits during this stage when regular preventive care visits can provide opportunities for early identification, early intervention and appropriate management do not occur regularly. Adolescents make up 21% of the population in the U.S. This generally healthy population tends not to seek well care visits. Three out of four adolescents report engaging in behaviors that risk overall health (abuse of alcohol and other substances, unprotected sex, poor eating and exercise habits and physically	**Activity 1:** MEMBER INTERVENTIONS: a) Member education to members • Publish Well child annual visit member article on THP website pages. • Foster importance of well child/preventive health visits including screenings. • Reinforce regular PCP visits. b) Collaborate with internal THP team to promote well-child visits to foster early screening, counseling, and intervention (based on EPSDT appointment schedule). c) Health literacy promotion messages for adolescents and parents. d) Collaborate with Marketing and Community Relations teams to distribute materials in English and Spanish at the following locations:

endangering behaviors). These behaviors impact chronic diseases in adulthood. The goal is to improve the rate of preventative (well-child) visits with a PCP and/or OB/GYN for members aged 12-21 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 **Product (s):** Tufts Health Public Plans (THPP): Together (MA), RITogether, QHP Direct	• Food pantries. • WIC offices. • School nurse offices. • Community spaces. • Other locations to be identified. **Activity 2:** PROVIDER INTERVENTIONS: a) Team meets on a regular basis 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. b) 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. c) Publish Provider article, encouraging well /preventive visits. • If positive screens show up during the visit, the provider is encouraged to initiate a referral for follow up specialty services. d) 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. **Activity 3:** THP INTERVENTIONS a) The Well Child workgroup will meet at least quarterly throughout the 2023 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. b) The workgroup will review demographic data related to race, ethnicity, language and gender in order to identify target populations. The workgroup will then focus on actionable and appropriate interventions supporting the populations most at risk.
THPP Continuity and Coordination between Medical and BH: Improving BH Screenings and follow-up among Adolescent members **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 that address the continuity and coordination between medical care and behavioral healthcare: Provider education and follow up with member's PCP recommending Behavioral Health Screening for Adolescent Members (12-21 years old) be completed during well-child visit.	Activity 1: Member Education: a) A reminder letter will be sent to the parents of members 12-20 years old explaining the importance of Behavioral Health screening during well child visits (Early and Periodic Screening, Diagnostic and Treatment services (EPDST)). (Direct& RI Together) b) Information about the Importance of BH Screening will be added to the New Member welcome package c) 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) d) The member website BH Overview page will be updated with a Find a Provider quick link button and Finding a Provider for

Product (s): Tufts Health Public Plans (THPP): Together (MA), RITogether, QHP Direct	Counseling & Therapy with explanation about provider licensure types to assist members in finding a provider that is right for them. **Activity 2:** Provider Education: for high volume, low preforming Provider Group (Together, Direct, RI Together) a) Inform PCPs of commonly used BH screening instruments that are offered in multiple languages for adolescents, and young adults, remind PCPs of relevant procedure codes to use when submitting claims for performing screenings, and include a website link to access potential screening tools. b) Publish article in 2023 Provider Newsletter about the importance of BH screening during PCP annual well child visits. c) 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. **Activity 3:** Provider Outreach/Collaboration: (Together, Direct, RI Together) Outreach activity will be aimed at high volume, low performing PCPs about their BH screening performance. Performance will be determined by reviewing completed BH screening claims data for members 12-21 years old during last 12 months. a) 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 b) 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. **Activity 4:** Project workgroups will meet regularly throughout the 2023 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.
Continuity and Coordination Between Medical and BH: Behavioral Health Antidepressant Medication Management (AMM) **Project Description:** The Antidepressant Medication Management (AMM) Project is focused on working with members and providers in supporting members with a diagnosis of major depression who were newly prescribed an antidepressant medication, to remain compliant with their	**Activity 1:** Medical care managers to continue depression screening for 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. **Activity 2:** Behavioral Health care managers (CMs) to review medication issues and adherence in assessment with all new members who become involved in the case management

medication for an acute phase of treatment (12 weeks) and also for a continuation phase of treatment (6 months). **Product (s):** THP Commercial HMO/EPO/POS/PPO, Tufts Health Public Plans (THPP): Together (MA); RITogether, QHP Direct, THPP Unify, Tufts Health Plan Medicare HMO	programs. CMs help to address any medication compliance issues. **Activity 3:** Depression screenings to continue for THPMP members that are in a complex case management program, though THPMP Case Managers. **Activity 4:** Educational depression brochures on Tufts health Plan website available to members. Depression brochure addresses antidepressant medication compliance. **Activity 5:** Share brochure with BH Community Partners, Providers at Health Centers and ACO partners during quarterly data exchange and reporting meetings. **Activity 6:** Education to PCPs regarding HEDIS AMM measure to be provided through articles posted on the web, in newsletters and in provider e-mails.
Continuity and Coordination Between Medical and BH: Initiation and Engagement of Drug and Alcohol Treatment (IET) **Project Description:** The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) Project is focused on working with providers to support members with a new episode of alcohol or other drug dependence to initiate treatment within 14 days of the initial diagnosis (initiation phase); and to continue in treatment with two or more additional visits within 30 days (engagement phase). **Product (s):** THP Commercial HMO/EPO/POS/PPO, Tufts Health Public Plans (THPP): Together (MA); RITogether, QHP Direct, THPP Unify, Tufts Health Plan Medicare HMO	**Activity 1:** 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. **Activity 2:** a) THP Addiction Recovery Care Management (ARCM) program will provide support to commercial and public plans members who are in early recovery from the use of opiates, alcohol, or other substances. b) The ARCM team will meet face to face with high volume providers to discuss their processes on initiating and engaging members in substance abuse treatment; discuss barriers and brainstorm ideas on closing gaps. **Activity 3:** 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 community supports available that will be helpful in supporting the member and their family. **Activity 4:** Allied Health and Contracting departments will work to continue to increase our database of substance use disorder providers at all levels of care.

	Activity 5: Availability surveys to be completed to obtain information from BH providers who specialize in treating substance use disorder. **Activity 6:** Updated provider search available to members on the THP website which provides more accurate information about availability of behavioral health providers and their specialties. **Activity 7:** Ongoing development and updating of tuftshealthplan.com public web page providing member-friendly information on screening, treatment, and resources regarding substance use disorder. **Activity 8:** Information to be posted on the Tufts Health Plan website to educate providers about the National Alcohol Screening Day in April. **Activity 9:** For MCO follow up with PCPs via mailings and e-mails to educate practices on IET measure, making referrals and advise them of members on gap lists.
Continuity and Coordination Between Medical and BH: Public Plans Coordination of Care: HEDIS Follow Up After Hospitalization (FUH) **Project Description:** 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. **Product (s):** THP Commercial HMO/EPO/POS/PPO, Tufts Health Public Plans (THPP): Together (MA); RITogether, QHP Direct, THPP Unify, Tufts Health Plan Medicare HMO	**Activity 1:** Behavioral Health HEDIS/Quality improvement workgroup will meet monthly to review performance on measures and activities. **Activity 2:** 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. **Activity 3:** 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. **Activity 4:** Request hospital staff to perform discharge planning meetings with patients to emphasize the importance of FUH. **Activity 5:** Identify the best practices of top performing provider groups and share the information with lower performing groups. 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 **Activity 6:** 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. **Activity 7:** Utilize telehealth options for members. Valera Health has been identified as a virtual provider for MA members only. **Activity 8:** Ongoing recruitment effort by allied health to contract additional outpatient PP BH providers for both MA and RI **Activity 9:** Care Navigation Project live for PP members in MA and staff will be available to provide direct assistance to members with scheduling appointments with BH providers. **THPP MA Together Only Activity 1**: Meet with ACO behavioral health workgroups on a regular basis to discuss strategies for improvement for this measure **THPP MA Together Only Activity 2:** Discussions with hospitals that have outpatient clinics about "bridge visits," within timeframe needed to be HEDIS compliant for member to return to facility outpatient clinic for outpatient follow-up **THPP MA Together Only Activity 3:** Discussion with ACOs about Care Partners (CP) referral process. Ongoing discussion with BH CPs about satisfactory discharge planning for members. Sharing of information with hospitals about which members have BH CPs **THPP MA Together Only Activity 4:** Reminder calls to members on a day before their scheduled follow-up appointment.
Continuity and Coordination Between Medical and BH: Public Plans Coordination of Care: HEDIS SSD & APM **Project Description:** HEDIS SSD - Improving Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) HEDIS APM - 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. **Product (s):** Tufts Health Public Plans (THPP): Together (MA); RITogether, THPP Unify	**Activity 1:** BH HEDIS/Quality improvement workgroup will meet monthly to review its performance. **Activity 2**: BH HEDIS workgroup will produce educational materials • For ACOs to share with their PCP and Prescribers • Workflows for Tufts ICM/ BHCM, CHW, Social Care Mgr., CityBlock and BH CP to educate staff **Activity 3:** The workgroup will produce and distribute monthly gaps in care reports for ACOs, MCOs, CityBlock, BH Community Partners, Tufts HP ICM, CHW and Social Care managers. The "Gaps in Care" report will include members who are using antipsychotic medication and have not had diabetes glucose/A1c or LDL/cholesterol screening during the measurement year **Activity 4:** Mail Providers (PCP & Prescribers) 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. **Activity 5:** 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. **Activity 6:** Submit Articles to Provider Update Newsletter about importance of Diabetes Screening among members with Schizophrenia or Bipolar Disorder and the importance of Metabolic Monitoring for members under 18 yo taking antipsychotic medication. **Activity 7:** Identify the best practices of top performing provider groups and share the information with lower performing provider groups. **Activity 8:** SSD only BH HEDIS/Quality improvement PM will attend quarterly BH Community Partner (CP) Agency meetings and work with the CP Management/QI team to improve SSD performance. **Activity 9:** SSD only workgroup will educate Community Partner Agency's on the importance BH/Medical care coordination to close SSD gaps.
Senior Care Options (SCO) Readmission Management **Project Description:** Reducing Acute Inpatient Readmissions. **Product (s):** SCO	**Activity 1:** Member Interventions a) Pilot: Medically Tailored Meals for CHF members (Mom's Meals) **Activity 2:** SCO CM Interventions a) Post Discharge Serial Outreach for high-risk members b) Implement post discharge COVID and CHF pathways for RNCMs c) Create inventory for in-home/treat in place vendors **Activity 3:** Provider Interventions a) SDoH Department collaboration to increase provider engagement for high-risk, high-volume members b) Improve Medication Reconciliation performance (EOHHS PIP)
THPP Unify Continuity & Coordination of Care: 30-Day PCR (Plan All Cause Readmission) **Project Description:** Improve member continuity and care coordination by reducing medical and behavioral health re-admission rates through the utilization of the Transition Of Care (TOC) program that focuses on collaboration with facilities for discharge planning and timely follow up and coordination upon discharge.	**Activity 1:** Point32Health / Cityblock Intervention a) The project team will meet monthly to review all activities/actions, identify potential barriers and utilize available reporting metrics to assess progress toward the project goals. **Activity 2:** Member Interventions - Pre-Hospitalization a) The project team will arrange for the the publication of a member education article every 6 months encouraging the

Product (s): THPP Unify	use of urgent care centers or to contact their PCP / physician's office for non-emergent issues. b) Cityblock will distribute 'Call Us First' literature to members to engage available resources and services for non-emergent issues. c) Cityblock will ensure that members who contact them with a clinical concern are immediately connected with their virtual care team, which includes a community rapid response team (paramedicine visits at home under direction of a virtual emergency MD), on-demand virtual providers and urgent clinical triage. d) Cityblock will deliver care to members in their home to address immediate needs which will reduce the amount of wait time for care / services. e) Cityblock will follow up with members within 3 calendar days after in-home or virtual care team services are provided to ensure that all needs have been addressed. **Activity 3:** Member Interventions - Post Hospitalization a) Cityblock will outreach members within 48 hours of notification of a discharge from an inpatient facility and/or notification of a discharge from an ED to complete a transition of care (TOC) assessment. b) Cityblock will assist members with scheduling follow up appointments with their PCP or other providers, if needed. c) Cityblock will offer members in-home paramedicine services, if appropriate and will reinforce the 'call us first' strategy. d) Cityblock will offer members in-home behavioral health services, if appropriate or will assist with referrals to diversionary services. e) Cityblock will identify additional opportunities for follow up and coordination of services and will update the individualized care plan (ICP) as necessary. f) Cityblock will collaborate with the Point32Health Behavioral Health and Medical teams whenever possible to assist with discharge planning. **Activity 4:** Provider Interventions a) Cityblock will collaborate with inpatient facilities to provide education and share improvement strategies to for safe and effective discharge planning with appropriate follow up. b) The project team will arrange for the publication of an article every 6 months in the provider newsletter that encourages providers to educate members on the importance of contacting their PCP or physician's office to communicate concerns and receive guidance on whether using the ED is appropriate. **Activity 5:** Care Navigator Program

	a) Cityblock will utilize staff embedded at UMass Memorial Medical Center in Worcester, MA to meet members at the ED and serve as a liaison with the ED provider team. b) Cityblock will educate the ED provider team of the services and supports that can be offered within the community in an effort to divert potential admissions when safe and appropriate. c) Cityblock will target expansion of the care navigator program to Boston Medical Center in Boston, MA and Lowell General Hospital in Lowell, MA in 2023.
Unify Interdisciplinary Care Team (ICT) Meetings **Project Description:** The goal of this project is to increase the number of ICT meetings for Tufts Health Unify members. The ICT includes the member, the member's assigned Care Manager, the member's PCP and any other individual or provider at the discretion of the member. The ICT collectively shares responsibility for developing an individualized care plan (ICP) and for delivering and coordinating care and providing services that best meet the member's needs. **Product (s):** THPP Unify	**Activity 1:** Point32Health / Cityblock Interventions a) The project team will meet with Cityblock monthly to review and discuss data related to ICT meetings, ideas for the implementation and measurement of actionable interventions and the identification of opportunities for improvement. b) Cityblock will review members during case conferences to identify high risk members who require ICT meetings. c) Cityblock will review members who are coming due for ICT meetings on a weekly basis and will ensure that Care Managers follow up with scheduling. d) Cityblock will attempt to coordinate ICT meetings while members are inpatient. e) Cityblock will attempt to coordinate ICT meetings for members upon engagement. **Activity 2:** Provider Interventions a) Cityblock will collaborate with providers to promote their involvement in the ICT meeting process upon engagement and during the scheduling process. b) A new systematic invitation system will be developed and implemented in Q1 2023 for Cityblock to send invitations to providers for ICT meetings. **Activity 3:** Member Interventions a) Cityblock will use an established template / script during initial engagement and ongoing assessments to provide education to members regarding the importance of holding ICT meetings regularly. b) Cityblock will encourage members to communicate their preferences of who they wish to participate in their ICT meetings. • ICT member preferences will be clearly documented, reviewed and approved during regular assessments and acuity check ins. • Upon approval by the member, their ICT members will be added to the ICT section in the Centralized Enrollee Record (CER).

	c) Cityblock will ensure that all pre and post ICT meeting activities are clearly documented within the Centralized Enrollee Record (CER). • Pre-meeting activities will include the invitation of ICT members (including the PCP) and their response for participation in addition to the development and distribution of the meeting agenda. • Post-meeting activities will include the distribution of the meeting notes to all invitees (regardless of their attendance) and the completion of any follow ups or action items.
Continuity and Coordination of Medical Care: Asthma Disease Management **Project Description:** The annual cost of asthma largely depends on the level of control of the condition. The cost per uncontrolled asthma member is more than twice as high as that of a member with controlled asthma. The main goals of asthma management are to optimize control of asthma symptoms and reduce the risk of asthma exacerbations, while minimizing medication adverse effects. A person with well-controlled asthma should be able to participate in work, school, play, and sports without limitation due to their asthma condition. The essential components of asthma management are member education, control of asthma triggers, monitoring for changes in symptoms or lung function, and pharmacologic therapy. This project aims to improve the referral and screening process for the Tufts Health Public Plans Integrated Care Management Program, to ensure timely coordination of provider services and implementation of care management interventions to help the population manage asthma treatments. **Product (s):** Tufts Health Public Plans (THPP): Together (MA); RITogether, QHP Direct	**Activity 1:** a) The workgroup will meet regularly and frequently to brainstorm actionable interventions, provide updates on progress and assess effectiveness of initiatives. b) Project lead will collaborate with the workgroup to create an educational article to foster the importance of asthma medication compliance to improve the population's health literacy in this area. **Activity 2:** a) The workgroup will collaborate with the ICM and HE teams to develop outreach mechanisms and internal monitoring controls to ensure identified members receive support for their prescribed asthma treatment plan. b) ICM 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 EMR. **Activity 3:** The workgroup will develop a process to utilize gap in care lists for outreach to asthma cohorts and provider offices to ensure care coordination. a) CHWs will outreach to members on gap in care list based per the developed outreach workflow. • CHW will provide outreach and follow-up based on assessed needs for support and education for their prescribed asthma treatment plan, as well as care coordination for members as needed. • CM team will assist population in facilitating discussions and appointments with providers to ensure wrap around and community resource (care coordination) are offered to the member. b) The workgroup will focus interventions on targeted sub-populations based on population analysis. Disparities among socioeconomic, racial and ethnic groups will be addressed in the population analysis. c) 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.). **Activity 4:** The team will develop a plan to engage school-based health to collaborate related to improving asthma care for school aged members.