



Care Management is a clinical approach that engages members with chronic or complex health conditions like diabetes, cancer, heart disease, a high-risk pregnancy, or a behavioral health issue to help them better understand their condition, navigate the health care system, and take ownership of their care. The goal? To achieve the best possible health and quality of life for patients while keeping costs under control.

At Tufts Health Plan, care management is an integral part of every plan we offer. Every day, Provider Care teams and Pharmacy Benefits Management teams coordinate closely to identify members who could use a little extra help. They then proactively reach out to those members to help keep them on track. "Our goal," says Dr. Claire Levesque, Chief Medical Officer, Commercial Division, "is to ensure that all of our members are working their way through the health care system and accessing the very best quality care."



Care Management at Tufts Health Plan, by the numbers:

100% of our medical care managers are registered nurses

of patients enrolled in Tufts Health Plan care management are very or extremely satisfied with their experience

of the members we reach with our clinical programs are engaged by our care management team



According to the CDC, 90% of the country's \$3,8 trillion in annual healthcare expenditures are attributed to the treatment of chronic and mental health conditions. Care management can helpimprove health outcomes and decrease the cost of care for everyone. Goals of care management include:

¹ Health and Economic Costs of Chronic Diseases, Centers for Disease Control (CDC), 2017





Reducing ER visits and hospital admissions

By helping to make sure members are keeping up with their recommended care and making healthy lifestyle choices, care managers can help members prevent complications. Our care managers also teach members and their caregivers how to recognize early warning signs of worsening disease, to help avert health crises before they happen.



Reducing readmissions after hospitalization

Follow-up care is critical after a hospital stay or procedure. This may include medical appointments, physical therapy, home care and medications. Our care managers reach out to members after their discharge from the hospital to make sure they're engaged in their follow-up care. Studies found that care management programs targeting the hospital-to-home transition have successfully reduced hospital readmissions and lowered costs.²



Ensuring that both medical and behavioral health needs are met

People with behavioral health conditions have a greater risk of developing chronic diseases, while those with chronic diseases have higher rates of behavioral health disorders.³ At Tufts Health Plan, our medical care managers and behavioral health care managers work side by side—literally, in some cases. This means they can easily collaborate to help ensure that our members' full range of needs are being met.



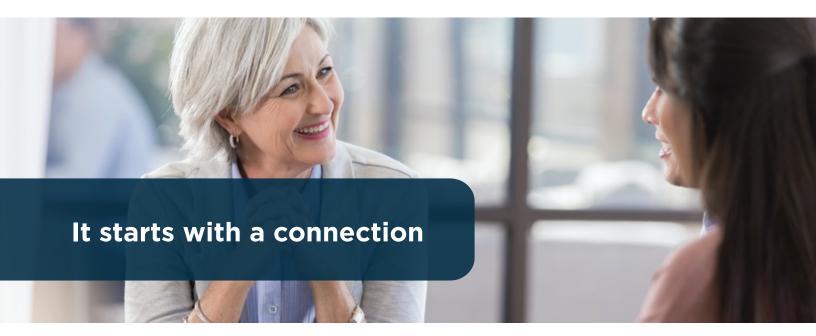
² Care Management of Patients with Complex Health Care Needs, Robert Wood Johnson Foundation Policy Brief No. 19, December 1, 2009

³ Association of Mental Health Disorders With Health Care Utilization and Costs Among Adults With Chronic Disease, JAMA Network, August 23, 2019



Improving the quality of care patients receive

When they're working with a care manager, members are more likely to keep their preventive and primary care appointments and stay in close contact with their providers. As a result, providers can more carefully monitor their patients' health and intervene as needed helping them achieve better health outcomes.



At Tufts Health Plan, our care managers create one-one-one connections with members who could benefit from care management, rooted in trust, collaboration, and compassion. The member and care manager work closely together, based on the member's schedule, needs, and comfort, guided by the care manager's knowledge of the system and the best ways to coach members towards their health goals. All of our care managers receive training in motivational interviewing, disease-specific care, and the unique cultural aspects of health care, so they can provide guidance that's custom-tailored to each member.



Our approach to care management is unique in that it truly puts patients at the center. As Care Manager Marcella Poulin explains: "Our care management isn't really based on what we want. It's based on what the member wants. Part of our job is empowering them to self-manage and be their own advocate when they walk into the medical office." Care Management Team Manager Sharon Soucy adds, "We're not giving medical advice, but we have that medical perspective so we can help members understand what things mean or what they've been told, be it medication or diet or anything else."

Our Care Managers support members by:

- Helping them understand a new diagnosis, and what their treatment will entail
- Encouraging and empowering them to become active participants in their own care
- Working with them to set goals and take concrete actions, like making an appointment with their primary care physician, setting up a mail-in pharmacy account, or downloading and using a fitness app
- Coaching them to communicate effectively with providers, with tips like bringing a notebook to appointments and writing down questions in advance
- Ensuring they have what they need for home care, follow-up visits, and medication management after a hospital or rehabilitation stay
- Helping them find community resources for challenges that may affect their health, like lack of transportation to medical appointments, or food or housing insecurity
- Screening them for potential behavioral health issues and helping them access professional help or additional resources if needed
- Communicating with clinical and pharmacy teams to help coordinate members' care and address any issues around appointments, follow-up care, prescriptions, etc.





Communities of color face disproportionate challenges and barriers when it comes to receiving quality health care. As a result, Black and Latinx individuals tend to suffer poorer health outcomes than Whites from many chronic conditions, including cardiovascular disease, cancer, asthma, and diabetes.⁴

Health care equity is also a real issue when it comes to the LGBTQ population. People who are LGBTQ are at higher risk than their heterosexual and cisgender counterparts for a number of medical conditions, diseases, and infections, including cancer, obesity, and behavioral health issues.⁵ There are also barriers to health care access for LGBTQ individuals, most of which can be traced back to discrimination and oppression.⁶



⁴ Disparities in Health, Mass.gov, 2012

⁵ LGBTQ+ Health Disparities, Cigna, May 2021

⁶ Lesbian, Gay, Bisexual, and Transgender Health, HealthyPeople.gov, 2020

Our care management programs include:

- Cancer/Oncology
- Chronic Conditions (diabetes, heart disease, etc.)
- Memory Loss, Alzheimer's Disease, and Dementia
- Pediatric Care
- Pregnancy Support
- Stroke and Neurological Conditions
- Transition to Home

At Tufts Health Plan, care management is an integral part of our work toward achieving health equity. By proactively reaching out to individuals with chronic conditions, we can help ensure that nobody falls through the cracks, no matter what their race, gender, sexuality, or economic situation. All of our care managers receive cultural competency training, to help them understand cultural nuances and the specialized needs of particular populations so we can better serve all of our members, and many of our care managers speak languages other than English.

Our robust care management program is an essential part of our organization's commitment to improving the quality and affordability of health care for all of the members we serve—no matter what health challenges they may face. To learn more, contact your rep or visit us at tuftshealthplan.com/employercontact.

