Care Management Resource Guide for Tufts Health Plan Medicare Preferred

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Chapter 5: Medical Management ............................................................................... 27
  Overview ....................................................................................................................... 27
  Guiding Principles of Rounding in Skilled Nursing Facilities ........................................ 27
  Meetings ............................................................................................................................ 28
    Medical Management Meetings ................................................................................ 28
    Quality Meetings ......................................................................................................... 29
  Inpatient Notification Management ................................................................................ 29

Chapter 6: Externally Managed Groups ........................................................................ 30
  Overview .......................................................................................................................... 30
  Integrated Care Management Program ........................................................................... 30
    Program Requirements (Specifications) ........................................................................ 30
    Integrated Care Management Capabilities .................................................................. 31
  Tufts Health Plan Medicare Preferred Responsibilities and Oversight .......................... 31
    Responsibilities .......................................................................................................... 31
    Oversight ..................................................................................................................... 32
  Integrated Delivery Network Responsibilities .................................................................. 32
  External Operations ......................................................................................................... 33
  Communication .............................................................................................................. 33
  Education and Training ................................................................................................. 33

Chapter 7: Geriatric Condition Management ................................................................ 34
  Geriatric Conditions ....................................................................................................... 34
    Falls ............................................................................................................................... 34
    Incontinence ................................................................................................................. 34
    Cognition ..................................................................................................................... 35
    Dementia Care Consultation Program ........................................................................ 35
    Depression ................................................................................................................... 36
    Medication Adherence ................................................................................................. 37
    Hearing ........................................................................................................................ 37
    Advanced Life Planning/Goals of Care ....................................................................... 37
    Palliative Care .............................................................................................................. 38
    Hospice Care .............................................................................................................. 38

Chapter 8: Behavioral Health/Substance Use Disorders ............................................. 40
  Overview .......................................................................................................................... 40
  Designated Facility Management .................................................................................... 40
    PCP-Directed Management ......................................................................................... 40
  Accessing Inpatient and Intermediate Levels of Care .................................................. 41
    Members Assigned to Designated Facilities ............................................................. 41
    Members Assigned to PCP-Directed Care .................................................................. 41
  Clinical Management for Inpatient and Intermediate Levels of Care .......................... 41
### Accessing Outpatient Behavior Health and/or Substance Use Disorder Treatment

- Transitions Program
- Substance Use Disorder Program
  - Substance Use Disorder Family Navigator

### Chapter 9: Operations

- Admission Report
- Admission Companion Report
- End Stage Renal Disease
- Health Risk Assessment
- Hospice Log
- Institutional Log
- Managing Self Audits
- High Risk Report
- Transplants
- Evidence of Coverage
- Referrals
- Out-of-Area Benefit
- Prior Authorization
- Payment Policies
- Quality Assurance and Improvement
- Observation Program
- Grievances, Organization Determinations, and Appeals
  - Treatment Team Definition
- Denial Letters
- Member Service Referrals
- Pharmacy
  - Home Health
  - Part B Notification
  - Medication Reconciliation
    - Documentation
    - Coding
  - COB/Subrogation
- Use of Out-of-Plan Providers and Carve-Outs
- Additional Resources
  - Non-covered Items/Equipment List
  - Quality Improvement Organization Fast-Track Appeal
Chapter 10: Policies ........................................................................................................... 53
  Complex Care Management Policies .............................................................................. 53
    Population Assessment .................................................................................................. 53
    Purpose .......................................................................................................................... 53
    Policy ............................................................................................................................. 53
    Procedure ...................................................................................................................... 53
  Tufts Health Plan Medicare Preferred Care Management Complex Member Identification -
    Data Sources .................................................................................................................. 54
    Purpose .......................................................................................................................... 54
    Policy ............................................................................................................................. 54
    Procedure ...................................................................................................................... 54
  Access to Care Management ............................................................................................ 54
    Purpose .......................................................................................................................... 54
    Policy ............................................................................................................................. 55
    Procedure ...................................................................................................................... 55
  Care Management Systems .............................................................................................. 55
    Purpose .......................................................................................................................... 55
    Policy ............................................................................................................................. 55
    Procedure ...................................................................................................................... 56
  Care Management Process ............................................................................................... 56
    Purpose .......................................................................................................................... 56
    Policy ............................................................................................................................. 56
  Measuring the Effectiveness of the Care Management Program .................................... 57
    Purpose .......................................................................................................................... 57
    Policy ............................................................................................................................. 57
    Procedure ...................................................................................................................... 58

Chapter 11: Outcomes and Measures ............................................................................. 59
  Reporting Requirements ................................................................................................... 59
  Monthly Process Metrics (Complex, Tier 2/Chronic, Transitions, Wellness) ................. 59
    Reporting Objectives ....................................................................................................... 59
  Monthly Member Level Patient Health Questionnaire 2 Referral Report for Centers for
  Medicare & Medicaid Services Chronic Condition Improvement Plan (CMS CCIP) .......... 60
  Quarterly Process Metrics ............................................................................................... 60
    Reporting Objectives ....................................................................................................... 60
  Other Reporting ................................................................................................................ 60
  Frequently Asked Questions Regarding Reporting ......................................................... 61

Appendix A: High Risk Member Report .......................................................................... 62
Appendix B: High Risk Member Definitions ..................................................................... 63
Appendix C: Admission Report ......................................................................................... 64
Appendix D: Admission Report Guide ............................................................................. 66
Appendix E: Inclusion Criteria for Ad Hoc to Complex and Criteria ...................... 74
Appendix F: Complex Care Manager ........................................................................ 75
Appendix G: Process Metric Specifications ............................................................. 77
Appendix H: Tier 2/Member Chronic Report ............................................................ 88
Appendix I: Chronic Care Manager Role ................................................................. 89
Appendix J: Skilled Nursing Facility Rounding Program ......................................... 91
Appendix K: Admission Companion Report ............................................................ 101
Appendix L: Admission Companion Report Guide .................................................. 102
Appendix M: Integrated Delivery Network Deliverables ........................................ 104
Appendix N: Integrated Delivery Network Responsibilities .................................... 114
Appendix O: Six Item Screener Information ............................................................ 116
Appendix P: Hospice Log ....................................................................................... 132
Appendix Q: Custodial Skilled Episode Letter ....................................................... 134
Appendix R: Institutional Log .................................................................................. 137
Appendix S: Tufts Health Plan Medicare Preferred Audit Tool ................................ 139
Appendix T: Tufts Health Plan Medicare Preferred Audit Tool Guide .................... 141
Overview of Integrated Care Management Model

As Americans live longer, many develop multiple chronic health conditions that require complex and coordinated care. More than 125 million Americans have at least one chronic health condition and 60 million have more than one chronic health condition. Many of these patients are elderly and are often less healthy, confused by their treatments and medications, and overwhelmed by paperwork. By 2025, the cost to manage the care of this population with chronic conditions is expected to reach $1.07 trillion.

Health plans continue to add programs to manage medical costs while improving outcomes. These programs include inpatient utilization management (UM), population management, and, most recently, integrated health care management. In 2011, the Tufts Health Plan Medicare Preferred Care Management department adopted the Integrated Care Management Model to address the increasingly complex care needs of our members.

The guiding principles of this model include:

- The Care Manager, Primary Care Provider (PCP), interdisciplinary care team specialists, and member interacting as a team
- Use of the most current evidence-based guidelines to manage geriatric patients with multiple chronic conditions, avoid redundant services, and prevent avoidable admissions
- A focus on developing geriatric expertise, with a strong commitment to medication adherence, fall prevention, advanced life planning, and other issues that are challenges for seniors
- A standardization of the member experience across the entire Tufts Health Plan Medicare Preferred population
- Measurement of standard outcome/process metrics across the network
- Coordination of the efforts of all health care providers, including hospitals, emergency departments, specialty clinics, rehabilitation facilities, home care agencies, hospice programs, and social service agencies
- Smooth transitions between sites of care, with an intensive focus on transitions in and out of hospitals
- Education and support of family caregivers
- Facilitation of access to community resources

The Tufts Health Plan Medicare Preferred Integrated Care Management Model is designed to improve transitions and coordination of care using:

- Early identification of high risk members through predictive modeling
- Clinical guidelines
- Care Managers as educators and coaches
- Member self-management of chronic illness
Using a team approach, the model aims to increase member self-management and decrease avoidable admission/readmission to the hospital for complex and chronic members who can be managed in their home. Ongoing support through telephonic care management can reinforce member education, and the use of self-management tools can reduce avoidable admissions that are prevalent in this population. The Tufts Health Plan Care Manager works with each identified member, the PCP, and other members of the care team to create a member-focused plan of care.

To be successful, medical groups must be expert in managing members with multiple chronic and complex conditions.

Required components of the Integrated Care Management program include:

- Transitions management - discharge planning/care coordination (for additional information, refer to Chapter 4, Transitional Intervention)
- Chronic illness management (for additional information, refer to Chapter 3, Rising Risk Chronic Illness Management Program)
- Complex care management (for additional information, refer to Chapter 2, Complex Program)
- Care Management - One Care Manager for every 850 members, coordinating with the PCP to manage the top 10 to 15% of members who drive a significant portion of the cost and utilization trend
- Inpatient UM
- Provider engagement and performance management, including:
  - Actionable data to medical groups and PCPs to facilitate management
  - Dashboards to monitor trends against benchmarks and best practice
  - Clinical collaboration and consultation to manage both individual members and targeted populations to improve outcomes
  - Joint efforts to identify opportunities and execute on initiatives to improve quality
  - Identification and engagement of both preferred and “best-in-class” providers

**The Tufts Health Plan Medicare Preferred Predictive Model**

To identify members who need care management, Tufts Health Plan Medicare Preferred uses a predictive statistical model based on 100 predictor variables selected by clinical knowledge and literature review. These variables, for which the data source is claims information, include demographics, disease history, and utilization history.

Using this model, Tufts Health Plan Medicare Preferred can:

- Stratify members based on their probability of admission within the next six months into risk categories
- Identify medically complex members prior to hospitalization, allowing earlier intervention of care management
The following table illustrates the populations and how this model targets these populations:

| Top 3.5% of population | Tier 1: Complex members, many of whom have chronic diseases with multiple co-morbidities | • Individualized care planning, including:  
• Psychosocial issues  
• Careful management of care transitions  
• Frequent face-to-face interactions  
• Home and nursing home visits |
|------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| The next 3.5 to 10% of population | Tier 2: Chronic disease and other variables that increase the risk for admission | • Early intervention  
• Closely monitor and manage conditions  
• Develop individual care plans  
• Manage admissions and transitions of care |
| Within the top 20% | • Transition risk on *Day of Admission Report*: congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), Falls, or a Readmission  
• Failed post discharge call, i.e, poor confidence or inability to self-manage  
• Any members identified as complex and chronic, and not enrolled in a program  
• Any ad hoc referral for Transition Management | • Ongoing monitoring for changes in health status  
• Preventative care  
• Care plans to reduce admission risk |
| The remaining 80% of population | Rest of the population mainly healthy, increasing risk over time | • Preventative care  
• Annual health assessment  
• Ongoing monitoring for change in health status |

**Tufts Health Plan Medicare Preferred Care Manager**

Care Managers should have a professional license in a health care field with initial geriatric certification or the equivalent commitment to staff development (e.g., Guided Care Certification). In addition, Care Managers should obtain at least five continuing education units (CEU) per year related to geriatric care management. For additional information, refer to specific program chapters for role competency requirements.

The Care Manager ratio for the Integrated Care Management Model for Tufts Health Plan Medicare Preferred physician practices is 1 Care Manager for every 850 members. Included in the 1:850 ratio is the assumption that complex members will be managed by a Complex Care Manager with a panel of no more than 80 complex members. The 1:850 ratio does not include Care Manager resources for managing Inpatient UM activities.

The number of required Care Managers and how those Care Managers are deployed to provide adequate staffing to meet the Complex, Chronic, and Transitions Care Management member needs depends on the size of the Tufts Health Plan Medicare Preferred physician group panel.
The following examples demonstrate how to determine the breakdown and needs of the group:

- **Example #1** - A physician group practice has 4,000 Tufts Health Plan Medicare Preferred members. To meet the 1:850 ratio, this practice needs 5 Care Managers ($4,000 \div 850 = 4.7$). Assuming that the top 3.5% of the members are complex, the group would be managing 140 complex members ($4,000 \times 0.035$).

To maintain the Complex Care Manager ratio of 1:80, 2 Care Managers would be dedicated to complex member management. The remaining 3 Care Managers would be available to manage the remaining 15% of high risk members ($12.5\% \times 4,000 = 500$), who would be a mix of chronic and transitions.

- **Example #2** - A physician group practice has 1,500 Tufts Health Plan Medicare Preferred members. To meet the 1:850 ratio, this practice needs 1.8 Care Managers. Assuming that the top 3.5% of the members are complex, the group would be managing 52.5 complex members ($1,500 \times 3.5\% = 52.5$).

The 0.8 of a Care Manager could manage the complex members and the 1.0 of a Care Manager would have the remaining case load of high risk members ($12.5\% \times 1,500 = 187$), who would be a mix of chronic and transitions.

**Custom Care - Value-Based Insurance Design**

**Benefit Design**

To encourage patients to consume high value clinical services, the Value-Based Insurance Design (VBID) model tests the utility of structuring patient cost-sharing and other health plan design elements. The increase in preventative and specialized services encouraged in the design of this benefit is expected to improve quality by reducing chronic illness complications and exacerbations, and reduce high cost utilization such as avoidable hospitalizations. In 2016, the Centers for Medicare and Medicaid Services (CMS) announced a VBID model test opportunity for Medicare Advantage plans for launch in 2017 in select states.

After submitting a proposal to CMS, Tufts Health Plan Medicare Preferred was selected to participate in the VBID model test. Tufts Health Plan Medicare Preferred sought to achieve several core objectives when designing its VBID model:

- Remove barriers to care for clinically complex members
- Increase participation in Tufts Health Plan Medicare Preferred care management programs
- Enhance provider engagement in pursuit of quality
- Support a CMS innovation opportunity

A member population with specific chronic conditions is eligible to opt-in to the VBID benefit. Members who opt-in are required to participate in care management as a contingency to receive the benefit. Members who meet all criteria receive the following reductions in their co-pay cost shares for the duration of the model test period:

- PCP office visit copay will be zero
- Cardiologist and/or pulmonologist office visit copay will be at the normal PCP level (from the specialist level)
- All other specialist office visits will be at the usual copay level
- All other plan rules and benefits will remain the same
Population Definition

Members are continuously identified as eligible throughout the model test period based on claims submitted to the health plan. Members are informed of their eligibility for the benefit within 30 days of being identified, and must opt-in to care management to receive the cost-share benefit.

The eligible population is defined as congestive heart failure (CHF) and/or chronic obstructive pulmonary disease (COPD) Members, identified by the following characteristics:

- Two or more office or outpatient visits in the past year
- One admission for CHF or COPD in the past year
- One emergency room or urgent care visit for CHF or COPD in the past year

**NOTE:** Exclusions include hospice and institutional. Inclusions include end stage renal disease (ESRD).

Overview of Custom Care

Custom Care intervention is a care management program required for members who opt-in to the VBID benefit. Similar to other care management programs, Custom Care uses the latest clinical guidelines, member educational materials, motivational interviewing, and self-management support strategies to educate, counsel, and empower members and their caregivers to play a more central role in managing their health. The unique aspect of Custom Care is the long-term engagement established through the benefit design, with the intention of continuous screening and monitoring the population with chronic illness over the course of the model testing period. Eligible members can opt-in at any time, and remain in the program unless they decline or become unable to contact, at which point they lose their VBID benefit due to not participating in care management.

Members who participate in Custom Care are monitored with evidence-based tools for geriatric conditions, disease-related declines, and their ability to self-manage their chronic illness. At any point, members who meet the criteria for Complex or Chronic Programs (determined using Appendix A, High Risk Member Report or Appendix E, Inclusion Criteria for Ad Hoc to Complex and Criteria) are managed with the appropriate program specifications (refer to Chapter 2, Complex Program and Chapter 3, Rising Risk Chronic Illness Management Program) as they benefit from higher touch, home visits, and defined action plans. Members with the VBID benefit then return to the Custom Care Wellness engagement level when they no longer need or benefit from the higher level program requirements.

Wellness Group

To preserve clinical resources for the most in-need membership, the Wellness population is a low-touch intervention that uses the evidence-based Vulnerable Elder Survey (VES). Non-clinical and unlicensed staff (i.e., a navigator, medical assistant, or coordinator) can conduct this survey. Tufts Health Plan sends disease-specific mailings to this population. These mailings are intended to encourage this population’s knowledge base and health literacy.

Risk Management Group

Care managers coach the Risk Management group and, as appropriate, refer members to community-based programs or specialty services, such as:

- Health Living Center of Excellence: Chronic Disease Self-Management Program
- Group disease self-management programs in their community/housing unit/residential facilities
- Hospital HF or COPD clinic-based programs
- Aging Service Access Point (ASAP) programs
Initial Care Management Program Enrollment for Custom Care

<table>
<thead>
<tr>
<th>Engagement Tier</th>
<th>Complex/Chronic Management</th>
<th>Wellness Monitoring</th>
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<tbody>
<tr>
<td>Criteria</td>
<td>• Predictive Model (refer to <em>The Tufts Health Plan Medicare Preferred Predictive Model</em>)</td>
<td>• Vulnerable Elderly score $&lt;= 3$</td>
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<td></td>
<td>• High Risk Report (refer to <em>Appendix A, High Risk Member Report</em>)</td>
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<tr>
<td></td>
<td>• Ad Hoc Criteria (refer to <em>Appendix E, Inclusion Criteria for Ad Hoc to Complex and Criteria</em>)</td>
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<tr>
<td>Program Content</td>
<td>• High touch integrated model as defined in <em>Chapter 2, Complex Program</em> and <em>Chapter 3, Rising Risk Chronic Illness Management Program</em></td>
<td>• Quarterly Outreach by non-clinician/navigator resource*</td>
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<tr>
<td></td>
<td>• Advanced Illness and Goals of Care</td>
<td>• Vulnerable Elder Survey to screen for rising risk</td>
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<tr>
<td></td>
<td>• Dementia Care coordination and planning as needed</td>
<td>• Encourage PCP and Specialist visits</td>
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<tr>
<td></td>
<td>• Home visit for most frail</td>
<td>• Educational mailings</td>
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<tr>
<td></td>
<td>• Transition to lower level of oversight when goals of intensive program met</td>
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*Clinical staff can be used if medical group staffing does not include navigator type role.

Assessments and Processes

The completion of an assessment is part of care management enrollment. The initial assessment may be a comprehensive or disease-specific assessment dependent on the system and group processes. Evidence-based screening tool (e.g., the VES) can be used for initial enrollment, but is recommended for ongoing screening.

Outcomes and Reporting

Members who enroll in Custom Care remain active within the program for the duration of the VBID benefit offering. Cases should not be closed for this population unless the member declines or becomes unable to contact. Documentation in the reporting metrics will include Program Enrolled: Wellness (see *Appendix G, Process Metric Specifications*).
Tufts Health Plan will measure the following outcome metrics for the population receiving the VBID benefit:

- Emergency Department (ED) visits/1000
- Skilled nursing facility (SNF) days/1000
- Inpatient (IP) admissions/1000
- PCP visits per member per year
- Cardiologist or Pulmonologist visits per member per year
- % of members with 0 medical visits in the year
- Total medical expenses per member per month (pmpm)
Complex Program

Population Description

The Complex Program targets the top 3 to 4% of membership that are at the highest risk for readmission. These frail members often suffer from chronic and/or multiple co-morbid conditions, as well as psychosocial issues that put them at risk.

Members are identified for the Complex Program in one of the following ways:

- Using the predictive modeling described in Chapter 1, Integrated Care Management
- Based on the High Risk Member Report (for additional information, refer to Appendix A, High Risk Member Report and Appendix B, High Risk Member Definitions)
- Based on the Admission Report (for additional information, refer to Appendix C, Admission Report and Appendix D, Admission Report Guide)
- After meeting ad hoc admission criteria (for a sample, refer to Appendix E, Inclusion Criteria for Ad Hoc to Complex and Criteria)

For additional information, see Tufts Health Plan Medicare Preferred Care Management Complex Member Identification - Data Sources.

Overview of Complex Program

The Complex Program uses the latest clinical guidelines and educational material to manage members with multiple chronic conditions, co-morbidities, and co-existing functional impairments. This program also aims to improve overall medical care delivery, outcomes, and psychosocial support from family, friends, community outreach programs, and home healthcare providers. Constantly moving members toward healthier living, the issues addressed in the program include those related to education, transportation, access to healthcare providers, clinical evaluations, needs assessments, and disease management.

The Complex Program achieves its goals through a partnership between a Care Manager, a member, and a Primary Care Provider (PCP). Members who agree to participate in the program are assessed for geriatric conditions and psychosocial issues that could impact quality of life and medical cost. These issues include, but are not limited to, the following:

- Cultural and linguistic needs/limitations
- Caregiver resources
- Social Determinants of Health
- Functional status with activities of daily living
- Clinical history
• Mental health status, including cognitive functions
• End-of-life planning and goals of care
• Health plan coverage eligibility and benefits
• Geriatric condition management
• Medication adherence and reconciliation
• Fall risk

These assessments can be either face-to-face member interactions or through telephonic care management. Care Managers use the assessment results to create a member-centered plan that includes:

• Member-identified and prioritized goals
• Schedule for follow-up with specific time frames
• Documentation of barriers with a solution-focused plan
• Documentation of member’s self-management plan with specific individual intervention barriers

After the goals are identified, member-centered interventions are determined, such as the need for skilled home care interventions, referral to community outreach programs, and referral to specialty team members.

The Care Manager coordinates member interventions using computer documentation, follow-up phone calls, and monthly updated complex reports. Member action plans are available to the member/family for continued reference. The treatment plan’s focus can change as the impact of each of the member’s chronic conditions change. Adjustments are made to the care plan based on the member’s progress, goal attainment, and newly identified needs. Members should be assessed for palliative care and/or hospice needs, and be referred as indicated.

**Care Manager Adherence to the Complex Program**

Adherence to the program’s treatment plan and identified goals is monitored through specific measures identified and discussed during interaction with the member. For additional information, see Chapter 10, Policies.

**Education and Disease Self-Management**

Education and disease self-management focuses on the disease process or condition and the steps that the member can take to help control the progress of the chronic condition and to manage symptoms. As part of the education, how the members’ co-morbid conditions, lifestyle, and cultural needs effect their chronic disease are also discussed. Using a teach-back communication method to confirm that the member understands what he/she has learned can help improve health literacy. This teach-back technique involves asking members to verbally state, in their own words (i.e., teach-back), what they learned from their health care provider. Teach-back is one of the 11 top evidence-based patient safety practices endorsed by the following groups: The National Quality Forum, American Academy of Family Physicians, American College of Surgeons, American Hospital Association, American Nursing Association, and Joint Commission. Additional information regarding teach-back principles is available on the following Web site: Agency for Healthcare Research and Quality.

**NOTE:** To view teach-back information on this Web site, enter teach back in the Search field, and then press Enter. Teach-back information is displayed in the search results.

Evidence-based educational materials that Tufts Health Plan has vetted can be shared with members. Tufts Health Plan’s list of these materials is available on request.
Complex Care Manager Roles and Competencies

Roles

The Care Manager’s role includes:

- Comprehensive care management and care coordination for a panel of frail elderly patients that includes the following services
  - Providing comprehensive geriatric assessment
  - Developing and communicating (with member, caregiver, and PCP/health care team) a comprehensive care plan based on evidence-based best practice for chronic illness
  - Collaborating with interdisciplinary care team members, when necessary
  - Ensuring that the member Action Plan is available to the member, family, and other care providers
  - Providing proactive management and follow-up (home visits and telephone calls) according to the care plan
  - Managing and coordinating all transitions of care for complex members, including:
    - Communicating the care plan to all providers in all settings of care (i.e., emergency department, hospital, rehabilitation facility, nursing home, home care, specialty care)
    - Assuring that relevant providers receive timely clinical data for care treatment decisions in all care settings (i.e., emergency department, hospital, rehabilitation facility, nursing home, home care, specialty care)
  - Providing direct caregiver support, as needed
  - Facilitating patient and caregiver access to community resources relevant to patient’s needs, including referrals to transportation programs, Meals on Wheels, senior centers, chore services, etc.
    - Incorporating self-care and shared decision-making in all aspects of patient care

For additional information regarding the Care Manager’s role in managing the complex population, see Appendix F, Complex Care Manager.

Competencies

The Care Manager’s competencies include demonstrating:

- Ability to be a creative problem solver
- Advanced clinical experience
- Advanced understanding of geriatric conditions
- Understanding of goals, medications, exercise, and diet related to chronic illness and common geriatric conditions
- Ability to work with all stakeholders to improve patient quality of life
- Understanding of Tufts Health Plan Medicare Preferred benefits and how to help members use these benefits appropriately
- Understanding of member benefits external to Tufts Health Plan Medicare Preferred
- Understanding of appropriate resource utilization of internal consultants (social worker/palliative care)
- Understanding of Motivational Interviewing and the ability to incorporate into practice
• Understanding of teach-back principles and the ability to incorporate these principles into practice
• Ability to facilitate goals of care discussions and assist with end-of-life planning

Annual Evaluation of Complex Care Management

For information regarding Tufts Health Plan Medicare Preferred process metrics specifications, refer to Appendix G, Process Metric Specifications.
Population Description
The Rising Risk Chronic Illness Management Program focuses on the next 3.5 to 10% of members identified as having a geriatric condition and/or specific chronic illness (e.g., heart failure, chronic obstructive lung disease, Type 2 diabetes) that places them at higher risk for admission in the next six months. Other conditions include (but are not limited to): falls, incontinence, impaired cognition, polypharmacy/medication adherence issues, behavioral health issues, psychosocial concerns, and other syndromes that contribute to the risk of avoidable admissions.

Members are identified for the Chronic Illness Management Program using one of three ways:

• Based on the Tier 2 List (for a sample, refer to Appendix H, Tier 2/Member Chronic Report)
• Based on the Admission Report (for a sample, refer to Appendix C, Admission Report and Appendix D, Admission Report Guide)
• After meeting ad hoc admission criteria (for a sample, refer to Appendix E, Inclusion Criteria for Ad Hoc to Complex and Criteria)

Overview of Risking Risk Chronic Illness Management Program
The Rising Risk Chronic Illness Management Program uses the latest clinical guidelines, member educational materials, motivational interviewing, and self-management support strategies to educate, counsel, and empower members and their caregivers to play a more central role in managing their health. Members who agree to participate in the program are assessed for geriatric conditions and the ability to self-manage their chronic illness and, subsequently:

• Individualized action plans are co-developed to assist members in making life-style and necessary behavioral changes to manage their conditions
• Members are coached to follow an action plan when they have symptoms (i.e., adjust medications, initiate a call to their Primary Care Provider (PCP), make physician office appointments, and follow their medication regimen)
• Members are coached to make appropriate life-style changes such as modifying diet, stopping smoking, participating in exercise, losing weight

To achieve these objectives, the Chronic Illness Program conducts telephonic assessments and care management, uses community resources, skilled home care interventions, and other identified needed interventions. Some members may also benefit from a referral to palliative care for assistance with goals of care discussions and symptom management. Evidence-based educational materials that Tufts Health Plan has vetted can be shared with members. Tufts Health Plan has a list of these materials that is available on request.
During telephonic care management, motivational interviewing techniques and health coaching is used to:

- Help members follow their treatment plans set in place by their PCP and specialties
- Help members relate these plans to their personal goals
- Help members overcome barriers to effective treatment.

**Adherence to the Chronic Illness Program**

Adherence to the program’s treatment plan and identified goals is monitored through specific measures identified and discussed during each phone call to the member, repeat hospitalization or emergency room visits, and reports from the home care nurse.

**Chronic Care Manager Roles and Competencies**

**Roles**

The Care Manager’s role includes:

- Conducting comprehensive clinical and social geriatric focused assessment that identifies:
  - Health and social service needs that were not met
  - Barriers to treatment, such as financial needs, lack of transportation, untreated symptoms of depression, and inadequate social support that could impede quality of life
  - Member’s and/or caregiver’s confidence level in managing his/her chronic condition
- Developing a comprehensive care plan in collaboration with member and/or caregiver to ensure optimum disease/condition management that promotes self-management practices and improves continuity of care:
  - Partnering with member and PCP to develop member-centric Plan of Care
  - Ensuring that the member Action Plan is available to member, family, and other care providers
  - Collaborating with interdisciplinary care team members, when necessary
  - Facilitating referrals to other team members and community-based providers/resources to meet the specific needs of the member/caregiver, including referrals to clinical social work, clinical pharmacist, behavioral health, specific PCP follow-up for medical assessment/management, palliative care, disease-specific programs (pulmonary rehabilitation, biometric monitoring), transportation programs, meals on wheels, senior centers, chore services, etc.
- Providing support, coaching, and self-management skills for member to assist the member/caregiver in understanding and following his/her physician's plan of care and the importance of making lifestyle changes needed to improve their health:
  - Using disease-specific, evidence-based teaching models to support member education
  - Incorporating motivational interviewing in health coaching technique to strengthen the member's motivation for and commitment to change
Competencies

The Care Manager's competencies include:

- Communicating effectively with team members to identify members at risk for readmission who are appropriate for the Chronic Illness Program
- Demonstrating the ability to work with PCPs and members to create a member-specific care plan to promote member self-management of chronic disease and/or conditions
- Demonstrating the ability to work with all stakeholders to improve patient quality of life and end-of-life planning
- Having knowledge of disease-specific community resources and their capability for providing care
- Demonstrating an advanced ability to evaluate a member's capacity to meet his/her self-care needs and demonstrating that the member's goals and preferences are incorporated into the care plan
- Demonstrating an understanding of evidenced-based treatment strategies for chronic diseases and/or conditions
- Demonstrating an understanding of health coaching principles, including:
  - Strategies to evaluate member’s and/or caregiver’s confidence level in managing chronic conditions
  - An understanding of motivational interviewing techniques and ability to incorporate into practice
  - An understanding of Teach-Back principles and ability to incorporate into practice
- Demonstrating an understanding of geriatric condition management
- Demonstrating an understanding of appropriate use of resources such as internal consultants (social worker/palliative care) and external disease-specific vendors

For additional information regarding Care Manager roles, refer to Appendix I, Chronic Care Manager Role.
4 Transitional Intervention

Population Description

This chapter describes the members in the top 20% of the population at risk who may need their transition managed. These members have had a hospitalization or admission to a skilled nursing facility (SNF), putting them at greater risk for readmission due to the disruptions caused by the hospitalization. Within an inpatient event, there can be ensuing changes in medications, deconditioning, decline in health status, and other related challenges for geriatric members. These changes can make transitioning to home a challenge.

The members who are managed and reported in transitions reporting include:

- Members identified as Transition Risk on the *Day of Admission Report*
- Members who fail the post-discharge phone call due to lack of knowledge or lack of confidence in their self-management abilities
- Members identified for Complex or Chronic programs but who are not enrolled in either program

The transitions of the members who are enrolled in Complex or Chronic programs will be managed by their Complex or Chronic Care Managers. In addition, these members will not be reported as transitions, as this would result in double counting.

Members are identified for the Transitional Intervention in one of three ways:

- Based on the *High Risk Member Report* (for a sample, refer to Appendix A, *High Risk Member Report*)
- Based on the *Admission Report* (for a sample, refer to Appendix C, *Admission Report*)
- Ad hoc referral based on a hospital, SNF, or community-based Care Manager’s concerns regarding a member’s ability to successfully transition home due to a limited understanding of the following:
  - The reason for his/her hospitalization
  - Ability to manage medication administration
  - Signs or symptoms that warrant calling his/her Primary Care Provider (PCP)
  - A treatment regimen

The screening for a “transitions” intervention includes, at a minimum, a standardized phone call assessing the member’s confidence in his/her ability to manage his/her post-discharge needs.

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1 Examples of specific triggers for a transitions assessment include hospital admissions for congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), a fall, or a previous readmission.
Transitional Intervention Overview

After a member is identified for Transitional Intervention, a Care Manager conducts a transition of care assessment and identifies member-specific needs in such areas as:

- Medication adherence
- Fall risk
- Lack of understanding of red and yellow flags of worsening condition
- Self-management deficits
- Psychosocial deficits

The Care Manager collaborates with the member to identify a Plan of Care to address identified needs. The Care Manager continues to oversee the overall Plan of Care to support a successful transition. This is achieved through a series of phone calls lasting up to 45 days, during which the Care Manager re-assesses member needs and determines if the risks are being mitigated by coaching, hands-on help from family or community support, and whether the member’s ability and confidence to self-manage his/her care has improved.

In an effort to prevent readmission, the Care Manager reinforces the signs and symptoms that warrant a call or visit to the PCP or the Care Manager. In addition, the Care Manager identifies other parties/community resources (e.g., Visiting Nurse Association (VNA)-vetted programs, a hospital program, Aging Services Access Points (ASAP), clinical pharmacist, clinical social worker). that address members specific needs.

The members’ readiness for self-management is measured using objective questions, including “confidence” in the ability to manage care and the ability to “teach back” understanding of medication regimes, symptom identification, and action plans. Members are ready to be discharged when the above measures indicate an ability to self-manage. Members not independent within the 45-day time frame should be referred for enrollment in the Complex or Chronic Illness Program.

Care Manager Roles and Competencies

Roles

The Care Manager’s role includes:

- Managing and coordinating member transitions of care
- Communicating the care plan to providers in all settings of care (i.e., emergency department, hospital, rehabilitation facility, nursing home, home care, specialty care)
- Proactive managing members and follow-up according to the Plan of Care
- Providing direct caregiver support, as needed
- Facilitating patient and caregiver access to community resources relevant to members’ needs, including referrals to transportation programs, Meals on Wheels, senior centers, chore services, etc.
- Developing member self-care skills and use of shared decision making in all aspects of patient care planning
Competencies

The Care Manager’s competencies include demonstrating:

• The ability to communicate effectively with team members to facilitate successful transitions of care and prevent readmission
• Knowledge of Complex and Chronic Program criteria to enable member referral appropriately
• An understanding of referral responsibilities regarding community resources
• An understanding of levels of care and SNF benefits
• An understanding of a member’s denial process and appeal rights
• The ability to actively participate in relationship building with external providers
• An understanding of and ability to identify member psychosocial needs vs. medical needs, and the ability to identify associated Tufts Health Plan Medicare Preferred benefits
• An understanding of geriatric condition management
• An understanding of appropriate resource utilization of consultants as available (e.g., social worker/palliative care, pharmacy)
Overview

Tufts Health Plan Medicare Preferred Integrated Care Management Model relies on a foundation of strong medical management principles that require infrastructure for, and management of, the delivery of health care services to our members across the continuum. Medical management is led by a Medical Director and relies on preferred provider networks with systematic means of communication. The Care Manager also plays an important role in the medical management team.

Key tenets for medical management infrastructure include:

- **Medical Director:**
  - Full-time preferred, but varies on size of group
  - Responsible for applying Medicare coverage criteria in case of a dispute with a provider
- **Plan for home hospital inpatient management, including identification of daily rounder (Primary Care Provider (PCP) and/or Hospitalist)**
- **24-hour medical coverage**
- **Access to inpatient medical record system**
- **Plan for preferred provider relationships, especially skilled nursing facilities (SNF) and home health providers, also including Acute Rehabs, and Long-Term Acute Care (LTAC)**
- **Plan for SNF management, including dedicated physicians or nurse practitioner (NP) rounders at preferred SNFs (see Guiding Principles of Rounding in Skilled Nursing Facilities below)**
- **Plan to impact Emergency Department utilization**
- **Integrated Care Management program for high risk members**
- **Plan for regular Medical Management meetings**

**Guiding Principles of Rounding in Skilled Nursing Facilities**

The overall aim of this program is to assist the member/caregiver in navigating the transitions of care while providing a structure to ensure high quality outcomes. The guiding principles of this program include:

- **Identified Medical Doctor (MD)/NP rounders who will actively participate in the short-term management of Tufts Health Plan’s Health Maintenance Organization (HMO) members while in a preferred SNF. MD/NP rounders will:**
  - Conduct a face-to-face admission assessment within 24 to 48 hours of admission
  - Actively participate in the multidisciplinary discharge planning process
- Provide 24/7 call coverage with communication processes in place to ensure coordination of plan of care
- Provide a minimum of weekly rounds, as well as any additional necessary rounds

The medical group will identify a subset of SNFs (preferred SNF referral circle) in their geographic area that meet the defined quality and performance standards. The medical group will:
- Direct at least 80% of their admissions to this subset of preferred facilities.
- Develop systems/processes for regular communication and, at a minimum, meet annually with preferred SNFs to share data/clinical outcomes

The group Care Manager will:
- Actively participate in oversight and management of members in the SNF
- Inform home hospitals and others of their preferred facilities to facilitate appropriate referral
- Actively participate in the care planning and multidisciplinary discharge planning process
- Identify and follow up on any readmissions to the acute setting or other quality events

Tufts Medicare preferred offers a SNF Rounding Service based on these principles. For additional information, refer to Appendix J, Skilled Nursing Facility Rounding Program.

Meetings

Medical Management Meetings

Medical management meetings are a vital means of communication for the medical group and Care Managers to regularly discuss members care, whether inpatient or outpatient. To facilitate effective management of the high risk population, interdisciplinary meetings with the PCP are recommended. These meetings serve many purposes, including:

- Developing concurrent plans of care that use a team approach to manage specific high risk members
- Identifying obstacles to effective care and developing mitigation strategies
- Creating a learning environment by evaluating outcomes, conducting case reviews, facilitating discussion, and providing constructive, respectful feedback
- Improving effectiveness of the Care Management role by providing clinical input for individual member-centric plan of care
- Improving process and outcome of care
- Monitoring group performance
- Identifying opportunities for improvement
- Developing strategies to manage population
- Developing strategies to work with preferred SNFs and home care agencies
- Providing information regarding regulatory changes, provider updates, and topics from the Tufts Health Plan Medicare Preferred Medical Directors meetings

The following actions can maximize the effectiveness of Medical Management meetings:

- Co-developing the agenda with a broad focus on medical management
- Creating an environment that facilitates discussion and learning
- Establishing clear expectations, roles, and responsibilities of all participants
• Developing an annual plan for medical management with goals and priorities, and incorporating metrics and reporting
• Integrating quality metrics, monitoring, and reporting

**NOTE:** Minutes, attendees, and utilization decisions/recommendations must be recorded at these meetings.

Attendees at these meetings should include the following:

• Group Medical Director
• PCPs
• Hospitalist (if appropriate)
• SNF rounder (physician/NP)
• Care Managers from all programs
• Ad hoc attendees
  - Preferred SNF or Home Care representative
  - Specialists
  - Hospital Care Management
  - Tufts Health Plan Medicare Preferred representatives

At a minimum, full group meetings must occur on a monthly basis, while best practice is ongoing communication between the Group Medical Director/Group Leader/PCP and Care Manager to provide updates and discuss individual issues. In addition, the Group Medical Director/Group Leader is responsible for communicating with PCPs as necessary.

**Quality Meetings**

Quality meetings with peer-protected minutes and attendees documented are required on a monthly basis. Agenda topics for these meetings can include:

• Annual discussion of *Tufts Health Plan Medicare Preferred Quality Initiative Work Plan*
• Sentinel events reported to the Tufts Health Plan Medicare Preferred Quality department

**Inpatient Notification Management**

Acute inpatient level of care determinations rely on the use of a nationally recognized standard (e.g., Tufts Health Plan uses Interqual®) for acute hospital admissions. LTAC, acute inpatient rehabilitation (AIR), and SNF admissions and home health care services are guided by Centers for Medicare & Medicaid (CMS) definitions for each level of care. For additional information, refer to the following:

• *Appendix C, Admission Report*
• *Appendix D, Admission Report Guide*
• *Appendix K, Admission Companion Report*
• *Appendix L, Admission Companion Report Guide*
• *Home Health*
Overview

“Externally managed” (formerly known as delegated) means that Tufts Health Plan designated another entity (an Integrated Delivery Network (IDN) or Medical Group) to perform certain functions on its behalf; however, responsibility and accountability for the functions being performed remain with Tufts Health Plan. Tufts Health Plan Medicare Preferred’s externally managed network is comprised of IDNs. These IDNs are networks consisting of medical groups in risk arrangements with Tufts Health Plan Medicare Preferred. The IDNs and medical groups are delegated for implementation and management of the Integrated Care Management Program.

Integrated Care Management Program

In 2011, the Tufts Health Plan Medicare Preferred Care Management department adopted the Integrated Care Management Model to:

- Address the increasingly complex care needs of members
- Ensure a consistent member experience throughout the Tufts Health Plan Medicare Preferred network

For additional information regarding the Integrated Care Management Model, refer to Chapter 1, Integrated Care Management, as well as other chapters in this guide.

To achieve external management status, IDNs or Groups must demonstrate adoption of the Integrated Care Management Model components and must cooperate with all Tufts Health Plan Medicare Preferred requirements as outlined in this guide. Tufts Health Plan Medicare Preferred’s Provider Engagement Clinical Consultants are available to groups who want to achieve external management status. IDNs/Groups that want external management status must satisfy the requirements outlined in Appendix M, Integrated Delivery Network Deliverables.

Program Requirements (Specifications)

The Integrated Care Management Model for externally managed programs requires leadership of a Medical Director and Care Management Leadership staff. Externally managed IDNs/Groups must meet and maintain policies and procedures consistent with the Tufts Health Plan Medicare Preferred Care Management program. This includes, but is not limited to, the specific requirements of:

- Tufts Health Plan Medicare Preferred Care Management Resource Guide
- Centers for Medicare & Medicaid (CMS) Manual
- CMS Chronic Care Improvement Plan (CCIP)
- CMS Star requirements
**Integrated Care Management Capabilities**

The Integrated Care Manager is embedded within the medical group setting and has the ability to:

- Use assessment tools to create detailed care plans for targeted members
- Create an individual care plan to be shared with Primary Care Provider (PCP) and care team
- Create an individual action plan to be reviewed with the enrolled member
- Engage and coach member in self-management of chronic disease
- Use community resources to augment care plan
- Apply discharge criteria
- Demonstrate supporting systems to document care plans, track action steps, due dates, and member utilization activity
- Demonstrate a capability to integrate care plans into members electronic medical record (EMR)
- Perform utilization care management
- Ensure adherence to Tufts Health Plan Medicare Preferred payment policies
- Ensure adherence to Interqual or equivalent criteria for Inpatient utilization
- Ensure adherence to CMS criteria for skilled nursing facilities (SNF) and home health agency (HHA) utilization management (UM)
- Identify opportunities to mitigate iatrogenic conditions or delays in care that may adversely impact quality
- Facilitate discharge planning/transition of care program for those admissions not enrolled in Integrated Care Management programs
- Identify members who may be appropriate for referral to Integrated Care Management programs
- Utilization review may be telephonic for acute setting; however, Care Management for SNF members must be provided on site.
- Require on-site management for SNF

**Tufts Health Plan Medicare Preferred Responsibilities and Oversight**

**Responsibilities**

Tufts Health Plan Medicare Preferred will fulfill the following responsibilities:

- Identifying high risk/high cost members, including:
  - Producing daily admission/high risk report
  - Providing ongoing predictive modeling reporting
  - Providing data from Health Risk Assessment

- Supporting the development of the Care Management role, including:
  - Providing competencies/sample job descriptions for Care Managers
  - Providing best-practice “seminars” for Care Management Leadership for both clinical and regulatory requirements
  - Providing geriatric seminars for Care Managers for continuing education unit (CEU) opportunities
• Reporting outcome metrics to facilitate performance monitoring, including:
  - Admissions and Readmissions trend reports
  - Cost per member trend reports
  - SNF bounce-back rate
  - Inpatient length of stay
  - Home care utilization
  - Ambulatory sensitive conditions
  - Fall rate
  - Hospice rate
  - Member satisfaction by medical group
• Overseeing delegation, including ensuring that the provider organization is meeting program specifications as outlined herein
• Performing fast-track appeals overturn rate/staff
• Maintaining Organizational Determination process, Notice of Denial of Medical Coverage (NDMC), and member appeal data

**Oversight**

Tufts Health Plan's oversight process includes meeting with the Tufts Health Plan Medical Director and/or Clinical Nurse Consultant and Contract Specialist on both a quarterly and as needed basis to review the performance of program reporting and utilization. In addition, as part of the oversight process, the Provider Engagement Clinical Nurse Consultant performs regularly scheduled site visits to each IDN to review program and performance metrics, and to perform record reviews or discuss summary results of record reviews done in advance of meeting.

Annual evaluation of external management functions is conducted using documentation including, but not limited to:

• Meeting minutes
• Chart reviews
• Policy and procedure reviews
• Audits
• Integrated Care Management program metrics

The externally managed groups are expected to supply documentation sufficient to meet Tufts Health Plan and accreditation and regulatory requirements.

**Integrated Delivery Network Responsibilities**

• Identified medical and care management leadership
• Administrative processes with accountability for completion of the end-to-end processes
• Work flows for all Care Manager functions
• Quality Improvement (QI) process and structure, including participating in Tufts Health Plan Medicare Preferred's QI work plan for CMS
• Medical group performance evaluation and improvement plan
• Compliance and regulatory guidelines and criteria and associated processes and work flow
• Benefit management - provide information updates and educational resources to group/Care Managers
• Orientation, education, and training
• Communication regarding product and regulatory changes
• Collaboration and support

For additional information, refer to Appendix N, Integrated Delivery Network Responsibilities.

External Operations
All externally managed medical groups are required to follow Tufts Health Plan Medicare Preferred’s policies in accordance with the CMS rules and regulations. For additional information, refer to Chapter 9, Operations.

Communication
Tufts Health Plan’s provider engagement consultants will offer informational IDN webinars/conference calls throughout the year. Representation from each IDN is expected to participate to ensure that important information and updates are received. The IDN leadership is responsible for disseminating updated information to their respective Care Managers.

Education and Training
Leadership at each IDN is responsible for training and developing their Care Management staff. This includes orientation and training new staff regarding Tufts Health Plan Medicare Preferred’s policies and procedures.
Geriatric Conditions

The prevalence of geriatric conditions, such as dementia and falling, are similar to those of chronic diseases in older adults and are associated with physical and psychosocial disability. Although prevalent, geriatric conditions are not part of healthy aging and potentially can be prevented or treated. Individuals impacted by various geriatric conditions can experience decline in activities of daily living and decline in overall well-being.

In geriatric care management, it is essential to assess the individual as a whole using a multifaceted approach, with the goal of promoting independent function and wellness. To prevent or minimize further decline in functional and cognitive functioning, screening and assessment for common geriatric conditions should be conducted to identify those who can benefit from care management intervention. Although there are numerous conditions that are common in the geriatric population, Tufts Health Plan Medicare Preferred identified the following conditions for assessment and intervention by Care Managers.

Falls

According to the Centers for Disease Control and Prevention (CDC), falls are the leading cause of death in individuals who are 65 years and older. In addition, falls are the most common cause of non-fatal injuries and hospital admissions related to trauma (for additional information regarding falls, see Important Facts about Falls on the CDC Web site). Fall prevention is a joint responsibility between the primary care provider (PCP) and Care Manager. Tufts Health Plan Medicare Preferred recommends certain elements be included in a member’s physical exam to screen for fall risk and to treat potential causes.

Incontinence

Urinary incontinence in the elderly is not considered a condition of normal aging; however, it is common and the prevalence of incontinence increases with age. Multi-factorial causes include age-related factors, co-morbid conditions, medications, and functional and cognitive impairments. Because urinary incontinence is often under-diagnosed and under-treated, it is essential to assess for this condition because of the significant associated morbidity and quality of life impact.

PCPs should conduct active case finding and screening for incontinence in elderly men and women to determine the cause of incontinence and the appropriate treatment approach. For additional information and assessment tools, use the following links on Tufts Health Plan’s Web site:

- Urinary Incontinence Assessment in Older Adults: Part I - Transient Urinary Incontinence
- Urinary Incontinence Assessment in Older Adults: Part II - Established Urinary Incontinence
Cognition

The risk for age-related cognitive decline increases with age. Decline in cognition/memory often leads to poor treatment compliance, safety, decision-making, and psychosocial well-being. A decline in cognition directly impacts quality, cost, and utilization. Screening and identification of cognitive decline in the early stages can identify those individuals who may require a change in their medical treatment plan and/or those who may be at risk of developing delirium or functional impairments.

Care management staff is required to use the Six-Item Screener to screen for potential cognitive decline for members enrolled in the chronic or complex programs. The Six-Item Screener is quick (less than five minutes), easy to administer, and validated for telephonic use. It has a sensitivity of 88.7% and specificity of 88%.

A positive screen is determined by two or more misses on the Six-Item Screener. After a positive screen is identified, a Care Manager is expected to notify the PCP for recommended follow up. This notification should be completed via fax, phone call, or electronic health record, and documented accordingly. (For additional information regarding the Six-Item Screener assessment, refer to Appendix O, Six Item Screener Information.)

Follow up with the PCP to determine the etiology or whether the cognitive decline is reversible is imperative for the appropriate treatment planning. Effective interventions (i.e., Alzheimer’s Association, community supports, long-term care planning, advance directives) can be implemented by the Care Manager to assist the individual and his/her caregiver in dealing with the consequences of cognitive decline. (For additional information regarding process metrics and outcome reporting, refer to Appendix G, Process Metric Specifications.)

For additional information on age-related cognitive decline, use the following link on Tufts Health Plan’s Web site: Mental Status Assessment of Older Adults: The Mini-Cog.

Dementia Care Consultation Program

The Dementia Care Consultation program is coordinated between Tufts Health Plan and the Alzheimer’s Association Massachusetts/New Hampshire chapter.

Dementia care consultation is an in-depth, personalized service for individuals and families facing the many decisions and challenges associated with Alzheimer’s disease or related dementias. The goal of the Dementia Care Consultation program is for each family to develop an understanding of a dementia diagnosis; make plans to maximize the independence of the person with memory loss; secure needed resources; and develop strategies for the best possible symptom management and communication. Dementia Care Consultants have expertise directly related to dementia, as well as training from the Alzheimer’s Association. In addition, these consultants have direct access to the Alzheimer’s Association’s training and programs.

Any member who has or cares for someone with concerns regarding memory or cognitive changes can be referred to this program; formal diagnosis is not needed. To access the Dementia Care Consultation Referral Form, use the following link on Tufts Health Plan’s Web site: Dementia Care Consultation Referral Form.

Email completed forms to the following Tufts Health Plan mailbox: dementiaconsults@tufts-health.com.

To complete the initial consultation, the Dementia Care Consultant contacts the identified caregiver by phone or in person at the Alzheimer’s Association office within two weeks. During this consultation, the following areas can be assessed:
- Exploration of diagnosis (if there is one) and caregiver/member understanding of the diagnosis
- Presenting symptoms and behaviors
- Level of functioning: activities of daily living (ADL) and instrumental activities of daily living (IADL)
- Level of structure and engagement
- Safety concerns, e.g., driving, wandering, financial, home safety
- Supports, services, and respite
- Approach to care
- Caregiver capacity to provide needed care
- Future planning needs

In addition, the Dementia Care Consultant can offer assistance related to:

- Education about the disease process
- Connection to Alzheimer’s Association programs and services
- Discussions and recommendations related to:
  - Management of challenging behaviors
  - Communication
  - Approach to care
  - Accessing and introducing new services
  - Safety concerns
  - Future care planning
  - Recommendations provided to caregiver, care manager, and PCP

The Dementia Care Consultant either emails or faxes written feedback highlighting the assessment and areas discussed to the referring Care Manager. The Care Manager is responsible for sharing this information with member's PCP. In addition, the Dementia Care Consultant sends a personalized care plan to the caregiver. This care plan outlines the recommendations and any resources that were discussed during the assessment. Follow-up is provided until the identified needs are met.

**NOTE:** Caregivers can be re-referred at any time. The Dementia Care Consultant is also available to consult on cases as needed.

In addition to direct referrals, Tufts Health Plan partnered with the Alzheimer's Association Massachusetts/New Hampshire chapter to provide dementia caregiver education programs on-site for interested medical groups. For medical groups interested in hosting a program, Tufts Health Plan will assist in planning, facilitating, and promoting the program.

**Depression**

Although depression is common later in life, it is not a normal part of aging and can be treated. Depression has been found to have an adverse effect on the course and outcome of individuals with chronic conditions, such as arthritis, chronic obstructive pulmonary disease (COPD), asthma, cardiovascular disease, cancer, diabetes, and obesity. If left untreated, depression can impact an individual physically and psychosocially, and can often lead to increased health care costs and decreased quality of life.

Screening older adults for depression is recommended and, when present, a collaborative care approach to improve condition management is recommended. This approach should involve the PCP, mental health specialists, and other providers. You can use measures from the Patient Health Questionnaire (PHQ) to determine if the individual is exhibiting depressive symptoms, i.e., “little interest or pleasure in doing
things”, “feeling down, depressed, or hopeless”. For additional information and assessment tools, use the following links:

- American Psychiatric Association Practice Guidelines
- The Geriatric Depression Scale (GDS) on Tufts Health Plan’s Web site

**Medication Adherence**

There are numerous reasons why an individual might not follow through on medication regimen, including inability to pay for medication, lack of knowledge regarding the need for the medication, and poor health literacy or cognition problems. An individual’s inability to adhere to his/her treatment plan often leads to increased health care costs and decreased quality of life. Member-centered care plans should include assessment for medication adherence barriers or risk factors.

For additional information on assessment of medication adherence and tips on effecting change in the individual, use the following link: Case Management Society of America (CMSA).

**Hearing**

According to the National Institute on Deafness and Other Communication Disorders (NIDCD), hearing sensitivity declines progressively with age. Disabling hearing loss affects:

- 2% of 45 to 54-year-old adults
- 8.5% of 55 to 64-year-old adults
- 25% of 65 to 74-year-old adults
- 50% of adults who are 75 or older

It is estimated that less than one in three (30%) of adults aged 70 and older who could benefit from hearing aids have never used them. A significant impact of declining hearing sensitivity is the lack of the ability to understand speech, which can have a significant effect on quality of life. Depression, anger, loss of self-esteem, and social isolation are often associated with hearing loss.

A hearing loss assessment can assist in identifying those in need of treatment. To access a hearing loss screening tool, use the following link on Tufts Health Plan’s Web site: Hearing Screening in Older Adults: A Brief Hearing Loss Screener.

**Advanced Life Planning/Goals of Care**

The aim for Advanced Illness management (Serious Illness Management) is to improve the quality of care as life comes to an end by providing care that matches what the member wants. To achieve this goal, efforts directed towards members, providers, and clinicians are needed. Members need to be able to express what matters most to them as they decline, and providers/clinicians need to be able to conduct and document these conversations so that members’ wishes are honored when necessary.

In addition, members need an opportunity to express what matters most to them in the context of their cultural beliefs. Opportunities for these conversations should be created when members are well, and should be reviewed as disease processes progress. The first step in this process is asking members what is important to them should a sudden event, medical or trauma. Family and provider participation in the conversation is very important. The second step in the process is members identifying a Health Care proxy with whom they have spoken, and who can honor their wishes should the member become unable to speak for themselves.
Some members may remain relatively healthy the rest of their lives; however, for those high risk frail elders who are identified for care management, subsequent conversations to are necessary to uncover their understanding of their diseases, as well as the explanation from the provider about hopes and worries given the progress of their condition. Increasing functional decline is a significant indicator for the need to conduct a Serious Illness conversation. Depending on the individual circumstances, a Massachusetts Orders for Life Sustaining Treatment (MOLST) order set may be appropriate to ensure that members’ wishes are clearly documented to ensure that these wishes will be honored when necessary.

The Advance Directives documentation has two parts:

- The Health Care proxy should be completed and available to all providers, and what matters most should also be available.
- Goals of Care is another way to express what matters most to a member/family, and helps guide future conversations about prognosis and plans of care. These kinds of ongoing conversations with all the stakeholders will promote treatment plans that match members’ wishes and promote living well.

The Tufts Health Medicare Program Advanced Illness initiative, Voice Your Choice, is a way to:

- Encourage members to express their wishes
- Create an open dialog with clinicians when members are well so that all members of the team, including family members, are able to participate in planning for the management of illness as it advances to its conclusion, resulting in high member satisfaction and high quality of care at end of life.

For additional information, use the following link on Tufts Health Plan’s Web site: Advanced Directives Resources.

**Palliative Care**

Palliative care is comprehensive medical care to treat the symptoms and stress of serious illness. Palliative care consultation and services can benefit members with chronic disease or life-threatening illness who do not have a prognosis of less than six months but who need improved symptom management to improve quality of life and decrease the risk for readmission.

A palliative care consultation is also a good option when discussions regarding goals of care have been difficult to initiate with a member. In this situation, a palliative care specialist works collaboratively with the PCP and the member to initiate these difficult discussions and to integrate goals of care into the member’s treatment plan.

**NOTE:** Members can continue to receive treatment for their disease while receiving the support and expertise of a Palliative Care team. This option might appeal to members who are not ready to forgo treatment, but who need additional end-of-life care and support. Members who move into the final stage of a terminal illness with a life expectancy of less than six months can transition to hospice care for medical services, emotional support, and spiritual resources.

For additional information and resources regarding palliative care, use the following link on Tufts Health Plan’s Web site: Advanced Directives Resources.

**Hospice Care**

Hospice care is considered the model for quality compassionate care for people with life-limiting illness. Hospice is a Medicare benefit available to those members with a terminal illness and a life expectancy of less than six months. In addition to helping to manage the emotional challenges involved in caring for a dying family member, hospice services also support family members.
Hospice is provided by an interdisciplinary care team focused on providing comfort and improving the quality of life for its members. Members who elect hospice have chosen to forgo additional curative means of treatment.

According to the National Hospice and Palliative Care Organization, an estimated 1.5 to 1.6 million patients received hospice care in 2013 and approximately 84% of those patients were 65 years of age or older. The growth of this age group will drive the growth in hospice utilization to support quality end-of-life care.

For additional information about the Tufts Medicare Preferred Hospice benefit, refer to the Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Hospice Payment Policy.
Overview
Tufts Health Plan Medicare Preferred manages the Inpatient Behavioral Health needs of members in two ways:
• Through designated facilities (DF)
• Through Primary Care Provider (PCP)-directed care, also known as Fee for Service (FFS)

Designated Facility Management
Tufts Health Plan uses a network of DFs for behavioral health services. Tufts Health Plan Medicare Preferred HMO members are assigned to a DF based on their PCP medical group. The DF network is a subset of Tufts Health Plan-contracting facilities, and DFs are chosen for their ability to provide quality services, manage clinical services across levels of care, and serve the geographic needs of their assigned Tufts Health Plan membership. Each DF is contractually responsible to provide the following clinical functions:
• Triage assessment
• Level-of-care assessments
• Acute inpatient behavioral health treatment
• Intermediate levels-of-care
• Discharge planning
DFs may have additional responsibilities for clinical management and oversight of its assigned membership, including providing or arranging:
• All behavioral health inpatient and/or intermediate levels of care
• Concurrent clinical management for that episode of care
DFs can also provide services to other Tufts Health Plan Medicare Preferred members who are not part of their assigned membership.

PCP-Directed Management
When a member’s PCP medical group chooses to direct a member’s behavioral health needs themselves, the PCP is responsible for determining where the member is treated for all levels of behavioral health treatment, and Tufts Health Plan is responsible for level-of-care, coverage, and utilization management (UM) decisions.

NOTE: PCP-directed care is also known as FFS.
Accessing Inpatient and Intermediate Levels of Care

Members Assigned to Designated Facilities

A member can access inpatient and intermediate behavioral health treatment by going to the emergency room for evaluation, and/or the PCP office or a nursing home can call the DF directly to discuss the case. The member’s DF provides oversight for the treatment of inpatient and intermediate level-of-care. The DF also registers the inpatient/intermediate admission with Tufts Health Plan.

The DF is responsible for providing or arranging all inpatient and/or intermediate levels of care for its assigned membership along with ongoing clinical management for the continued episode of care. While DFs are contracted to make level-of-care and admission decisions for their assigned membership, they are not able to deny services.

In some situations, a member, based on clinical evaluation, may be authorized to a facility separate from the DF. This circumstance is rare and usually happens when the DF does not have an available bed or when the DF determines that the member requires more specialized treatment, such as eating disorder treatment or a setting that effectively manages a member’s comorbid medical and Behavioral Health needs.

Members Assigned to PCP-Directed Care

• When the medical group chooses not to participate in the DF program, the PCP is responsible for directing where the member will receive behavioral health care. PCPs can direct their Tufts Health Plan Medicare Preferred HMO members to their home hospital, a DF, or any contracted hospital.

• A Tufts Health Plan Medicare Preferred member can go to any Tufts Health Plan emergency room for an evaluation. The member can then be directed by his/her PCP to any Tufts Health Plan-contracted inpatient or partial hospital program, as needed.

Clinical Management for Inpatient and Intermediate Levels of Care

To assist in coordinating care and discharge planning, the Tufts Health Plan Behavioral Health Utilization Manager is in contact with the inpatient facility periodically during the admission. Clinical management is focused on the member’s discharge planning needs and readmission prevention. Facilities are expected to proactively communicate with PCPs regarding the member’s admission, including medication reconciliation and health information exchange to inform treatment planning during the admission and post-discharge plans. (For a sample Admission Report, refer to Appendix C, Admission Report.)

Accessing Outpatient Behavior Health and/or Substance Use Disorder Treatment

• The PCP approves and authorizes all outpatient specialty care, including outpatient behavioral health care. These services for Tufts Health Plan Medicare Preferred are not centrally managed at Tufts Health Plan.

• A representative from the PCP can call Tufts Health Plan’s Behavioral Health department for assistance searching for contracted services, if needed.
• The PCP must authorize all outpatient psychological and neuro-psychological testing.

**Transitions Program**

The Transitions Program provides discharge information to medical groups so that they can conduct telephonic care management to members who have been hospitalized for behavioral health treatment and are returning home. Eligibility is open to members who are at risk for readmission, as evidenced by:

- A recent psychiatric readmission
- A history of noncompliance either with outpatient services or taking medication as prescribed
- Ineffective self-management
- Co-occurring conditions that can make self-management more challenging

Enrolled members are followed through their 30-45 day post-hospitalization period, and telephonic support is provided to attend aftercare appointments and complete their provider’s recommendations for care. Care management goals include:

- An assessment and review of the discharge plan and the member's/caregiver's ability to follow the plan
- Support of the member/caregiver to follow through on outpatient specialty services and adhere to the medication directions prescribed by his/her provider
- Education regarding the member’s condition
- Conversations with the member and caregiver regarding the coordination of care
- Identification of barriers to successfully follow the treatment plan

Sources of referrals to the program include:

- Tufts Health Plan-contracting and non-contracting facilities with psychiatric inpatient services
- Tufts Health Plan Medicare Preferred Care Managers working with members with both psychiatric and medical issues
- Providers who are currently working with members diagnosed with a psychiatric disorder and who have assessed their patient to be at risk for an inpatient hospitalization

**Substance Use Disorder Program**

The Substance Use Disorder Program provides telephonic care management to members who have been recently hospitalized for substance use disorder treatment and are returning home, or who have been identified by an outpatient provider as needing support around substance use, sobriety, and recovery. Eligibility is open to members with a substance use disorder, as evidenced by, but not limited to:

- A recent detoxification on a medical unit, hospitalized due to a medical condition during which substance use was identified, or hospitalized for medical problems that were caused or worsened by substance abuse
- Ineffective self-management
- Co-occurring conditions that can make self-management more challenging

Enrolled members are followed through their post-hospitalization period and telephonic support is provided to attend aftercare appointments and complete their provider's recommendations for care on their road to recovery. Care management goals include:
• An assessment and review of the discharge plan and the member's/caregiver's ability to follow the plan
• Support of the member/caregiver to follow through on outpatient services and adhere to the medication directions prescribed by his/her provider
• Education regarding the member's condition
• Conversations with the member and caregiver regarding the coordination of care
• Identification of barriers to successfully follow the treatment plan

Sources of referrals to the program include:
• Tufts Health Plan-contracting and non-contracting facilities with psychiatric inpatient services
• Tufts Health Plan Medicare Preferred Care Managers working with members with a substance use disorder
• Providers who are currently working with members diagnosed with a substance use disorder and who have assessed their patient to be at risk for an inpatient hospitalization or other potential concerns regarding their substance use

**Substance Use Disorder Family Navigator**

The Substance Use Disorder Family Navigator is a licensed clinician available to members, family members, and providers for assistance with substance abuse resources, support, information, and assistance navigating the complex treatment options for sobriety and recovery. The Substance Use Disorder Family Navigator is available for single consultations or short-term support as a transition into more intensive Care Management.

For referrals and questions, contact the Behavioral Health Department at 800-208-9565.
This chapter provides a brief overview of some operational tasks and links to operational policies and procedures that you will need to create or use as daily work flows.

**Admission Report**

The *Admission Report* is a working tool that will help Care Managers identify high risk, high priority inpatient members who will benefit from more immediate care management, and transition of care oversight (for a sample of this report, see *Appendix C, Admission Report*). The report:

- Provides a snapshot of all Tufts Health Plan Medicare Preferred members with inpatient status (acute, skilled nursing facility (SNF), and rehabilitation) who do not have a discharge date in the Tufts Health Plan Medicare Preferred preregistration system
- Flags members with Complex, Chronic/Tier 2, and Transition Risk status, and also provides high risk indicators by member to allow the Care Manager to quickly prioritize his/her daily case load for intervention
- Provides information on how to report coordination of benefits (COB)/subrogation cases and cases being considered for bridging

For additional information, see *Appendix D, Admission Report Guide*.

**Admission Companion Report**

This report is a *Companion Report* to the daily *Admission Report*, and lists both future elective and current mental health admissions. Like the *Admission Report*, this report identifies Complex, Chronic, and Transition Risk members allowing care teams to coordinate care for these high risk individuals.

For a sample of this report, see *Appendix K, Admission Companion Report*. For additional information, see *Appendix L, Admission Companion Report Guide*.

**End Stage Renal Disease**

Tufts Health Plan Medicare Preferred receives the *End Stage Renal Disease* notification from the Centers for Medicare & Medicaid Services (CMS) identifying members who have been reported by the dialysis center as meeting the criteria for end stage renal disease. Tufts Health Plan Medicare Preferred provides medical groups a monthly *End Stage Renal Disease Log* with the information provided by CMS. If the group is aware of end stage renal disease members under their care who are not on the CMS list, the expectation is that the group will work with the dialysis center to ensure proper notification to CMS. Neither Tufts Health Plan nor the medical group has the opportunity to correct errors on the end stage renal disease report.
Health Risk Assessment

• Gives Tufts Health Plan a snapshot of actual/potential health needs of newly enrolled Medicare Preferred members
• Performed by newly enrolled members who answer a health risk assessment survey on the telephone, online, or on paper
• Results are sent to Primary Care Providers (PCP) and, if Care Manager flags are triggered, a Care Manager referral can be generated and a Care Manager will be notified

Hospice Log

Tufts Health Plan Medicare Preferred creates a monthly Hospice Log based on information reported to CMS by the hospice agency. The purpose of the log is to notify Tufts Health Plan of all member hospice elections, revocations, and deaths. Because this information is not available in a timely manner, Tufts Health Plan Medicare Preferred requests that Care Managers also notify non-hospice member deaths. Hospice election information is necessary for proper claims adjudication and for tracking network and group hospice utilization and length of stay.

Care Managers are expected to review the Hospice Log for accuracy and then update and return it to Tufts Health Plan on a monthly basis.

For a sample of a Hospice Log, see Appendix P, Hospice Log.

Institutional Log

The Tufts Health Plan Institutional Log uses information from CMS to identify members who are residents in long-term care facilities. CMS uses the information included in the Minimum Data Set (MDS) that is reported by Medicare-certified skilled nursing facilities to determine long-term institutional status. Tufts Health Plan Medicare Preferred members residing in a long-term institution for 90 days prior to the payment month are classified as long-term institutional status. Tufts Health Plan Medicare Preferred members remain in long-term institutional status until they have been discharged to the community for a period longer than 14 days. A long-term institutional status is determined for Tufts Health Plan Medicare Preferred members and added as a factor in risk-adjusted payments.

Care Managers are expected to:

• Review and update the Institutional Log by adding new long-term institutional members (with the date that they became custodial) to the list and returning the updated list to Tufts Health Plan Medicare Preferred.
• Regularly review custodial member’s records for episodes of treatment in place, which qualify as skilled level of care. These episodes must be recorded with the Health Plan, and the SNF is obligated to seek reimbursement for them.

**NOTE:** For a sample of the letter template, refer to Appendix Q, Custodial Skilled Episode Letter.

• Manage Part B requests for their custodial members.

For a sample of an Institutional Log, see Appendix R, Institutional Log.
Managing Self Audits

Tufts Health Plan Medicare Preferred has an expectation that Care Managers perform self-audits of clinical documentation at the management and peer level will be performed with the goal of improving member care and service. The audits will be completed quarterly and results reported quarterly to Tufts Health Plan Medicare Preferred. An example of a self-audit tool is in Appendix S, Tufts Health Plan Medicare Preferred Audit Tool. This tool assesses the completion and quality of the documentation for the Complex and Chronic Member assessments and ongoing care management. For additional information, refer to Appendix T, Tufts Health Plan Medicare Preferred Audit Tool Guide.

High Risk Report

The High Risk Report (see Appendix A, High Risk Member Report) is a working tool that will identify the top 10% of the group's high risk members for Care Managers. The report flags members with a Complex (Tier 1) or Chronic (Tier 2) status based on an aggregate of indicators (for a list of the high risk definitions, see Appendix B, High Risk Member Definitions). A Care Manager will be able to quickly identify these members to begin immediate interventions, with the goal of reducing the risk of readmission while working to provide members the highest quality of life possible. The report also provides the probability of an admission within the next six months based on the indicators. The High Risk Report is updated monthly with new members appearing in bold blue. Inpatient utilization is based on ten months of claims and a two-month preregistration look back.

Transplants

The medical group issues referrals for transplants and is responsible for ensuring that the transplants are performed at a Tufts Health Plan Medicare Preferred-contracted and Medicare-approved transplant facility. After the member is admitted, the group manages the inpatient care of transplants for the member. For a listing of Medicare-approved transplant facilities in the Tufts Health Plan Medicare Preferred network, use the following link on the Provider Portal of Tufts Health Plan’s Web site: Tufts Health Plan Medicare Preferred HMO Medicare-Approved Facilities.

Evidence of Coverage

For information regarding evidence of coverage, use the following link on the Tufts Health Plan Medicare Preferred Web site: Tufts Health Plan Medicare Preferred Documents.

Referrals

The Referral Authorization Request Form must be used to refer Tufts Health Plan Medicare Preferred members to a specialist. Tufts Health Plan Medicare Preferred members are encouraged to see specialists within their PCP’s network. If a member requests to see a specialist outside of the PCP’s network and the PCP’s treatment decision is that the member can access the same care within the PCP’s network, then the member should be informed that he/she has the option to contact Tufts Health Plan Medicare Preferred to request an organization determination. For additional information regarding the organization determination process, refer to Grievances, Organization Determinations, and Appeals.

For additional information, use the following link on the Provider Portal of Tufts Health Plan’s Web site: Tufts Health Plan Senior Products Provider Manual, Prior Authorizations.
Out-of-Area Benefit

The Tufts Health Plan Medicare Preferred Out-of-Area Benefit provides coverage of urgent and emergent events occurring 30 miles or more from the selected PCP’s home hospital. Events and post-acute care services related to the out-of-area episode of care are managed by a Tufts Health Plan Medicare Preferred Care Manager (includes both internally and externally managed groups). When a medical group or PCP grant prior authorization for care/services outside of the service area (30 miles or more from the home hospital), the care is not covered under the Out-of-Area Benefit, and is the medical group’s responsibility to manage any related subsequent events and services.

For additional information, use the following link on the Provider Portal of Tufts Health Plan’s Web site: Tufts Health Plan Senior Products Provider Manual, Prior Authorizations.

Prior Authorization

For a current list of procedures, services, medication, and items requiring prior authorization, use the following links on the Provider Portal of Tufts Health Plan’s Web site:

- Tufts Health Plan Medicare Senior Products Provider Manual, Prior Authorizations
- Tufts Health Plan Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Payment Policies

To view Tufts Health Plan Medicare Preferred payment policies, access the Provider Resource Center on Tufts Health Plan’s Web site.

Quality Assurance and Improvement

Tufts Health Plan Medicare Preferred continuously evaluates the quality of care in all health care settings that it serves and advocates for improvement when necessary. For standards and guidelines, use the following link on the Provider Portal of Tufts Health Plan’s Web site: Tufts Health Plan Medicare Preferred Senior Products Provider Manual, Quality Administrative Guidelines.

For additional information, use the following links on the Provider Portal of Tufts Health Plan’s Web site:

- Tufts Health Plan Quality Improvement Member Grievance Report Form
- Tufts Health Plan Quality Improvement Occurrence Report Form

Observation Program

Care Managers are encouraged to use the observation status when the member’s problem related to an inpatient facility is reasonably expected to resolve within 48 hours. For detailed information on this program, use the following link on the Provider Portal of Tufts Health Plan’s Web site: Tufts Health Plan Medicare Preferred Senior Products Provider Manual, Observation Program.

Grievances, Organization Determinations, and Appeals

Tufts Health Plan Medicare Preferred members have the right to file both appeals and grievances, or to request organization determinations related to their care. A grievance is when a member is dissatisfied
with the quality of care received. An organization determination is a decision made by the Plan that is based on a request by the beneficiary/authorized representative (including a physician) to pay for goods or provide services. The request for an organization determination can be the result of: 1) a) disagreement with the Treatment Team or 2) a request for coverage by the Plan. If a negative organization determination is reached, a member has the right to appeal that decision.

**Treatment Team Definition**

A Treatment Decision is a decision between the provider (Treatment Team) and a beneficiary/authorized representative without the Plan’s direct involvement. The Treatment Team may be comprised of, but not limited to, the member’s PCP, Medical Group Director, group nurse practitioner (NP), office nurse, Care Manager.

**NOTE:** All Care Managers, both for internally and externally managed groups, are considered part of the Treatment Team and are not acting on behalf of the Plan. This includes the Out-of-Area Care Manager.

As a member of the Treatment Team, a Tufts Health Plan Medicare Preferred Care Manager participates in making treatment decisions/recommendations for members. If a member agrees with a treatment decision, the Care Manager should document the discussion/rationale in the medical record.

If the member disagrees with the treatment decision, the Care Manager should document the discussion/rationale for the decision in the medical record, and offer the member the opportunity to contact Tufts Health Plan Medicare Preferred to request an organizational determination (for example, an acute inpatient member requests a discharge to acute rehabilitation, and the treatment team recommends sub-acute level of care).

**NOTE:** It is not necessary for the Care Manager or medical group representative to notify Tufts Health Plan Medicare Preferred.

If a member is exhausting his/her SNF, acute inpatient rehabilitation, or long-term acute care hospital benefit, the Care Manager is required to notify the member/member’s authorized representative and the facility of the impending benefit exhaustion 15 calendar days prior to the date the coverage will end. The Care Manager is also required to complete and fax the *Tufts Health Plan Medicare Preferred Extended Care Exhaustion of Benefit Notification Form* to the Precertification department. This form enables the Care Manager to communicate specific information relative to the member’s benefit exhaustion to the Precertification department.

After receiving the form, the Precertification department uses the information to generate the *Notice of Denial of Medical Coverage and Payment* (NDMCP) and then faxes it to the facility to be delivered to the member. In addition to serving as the formal Plan notification to the member of benefit exhaustion, the NDMCP provides the member with his/her appeal rights and the process to request an appeal if the member disagrees with the benefit exhaustion.

For additional information on the extended care exhaustion and benefit notification process, use the following links on the Provider Portal of Tufts Health Plan’s Web site:

- [Tufts Medicare Preferred HMO Extended Care Exhaustion of Benefit Notification Form](#)
- [Instructions for Tufts Medicare Preferred HMO Extended Care Exhaustion of Benefit Notification Form](#)

For additional information on appeals and grievances, use the following link on the Provider Portal of Tufts Health Plan’s Web site: [Tufts Health Plan Medicare Preferred Senior Products Provider Manual, Member Appeals and Grievances](#).
Denial Letters
For a complete list of Tufts Health Plan Medicare Preferred denial letters, definitions, delivery method, time frames, and written notice requirements, use the following link on the Provider Portal of Tufts Health Plan’s Web site: Tufts Health Plan Medicare Preferred PPO Notice and Letter Templates.

Member Service Referrals
Member Service department staff members are trained regarding the Integrated Care Management model and Care Manager functions. They have been trained regarding what qualifies as areas of concern that may indicate the need for Care Manager involvement.

While answering calls in the Call Center, based on caller statements, a Member Service department staff member may identify a member who is in potential need of Care Manager outreach. The staff member will offer to forward the information to the Care Management department. When the caller agrees, the information is sent via email. Then, a Care Management department staff member reviews the member information and contacts the member within five business days.

NOTE: When the member belongs to an externally managed medical group, the information is forwarded via email to the appropriate medical group contact.

Pharmacy
For information on Tufts Health Plan Medicare Preferred pharmacy benefits, use the following link on the Provider Portal of Tufts Health Plan’s Web site: Tufts Health Plan Pharmacy Information.

Home Health
Home health services do not require prior authorization; however, the Care Manager will have clinical conversations with the home health agency (HHA) to ensure that the member’s goals are being achieved. For information about home health services for Senior Products, refer to the Home Health Payment Policy in the Tufts Health Plan Provider Resource Center.

Part B Notification
Part B notification refers to services that SNFs’ rehabilitation services provide for Tufts Health Plan Medicare Preferred custodial members. The appropriate Care Managers will assess the requester’s clinical rationale, and ensure that member goals are being met.

Medication Reconciliation
As of January 1, 2017, Tufts Health Plan requires an improved comprehensive medication reconciliation documentation standard for all Tufts Medicare Preferred Health Maintenance Organization (HMO) and Tufts Health Plan Senior Care Options (SCO) members. This is to support the standardization of best practice across the network and increase the focus on avoidable admissions and readmissions, while addressing new expectations set forth by CMS.

The required documentation and/or coding must be completed within 30 days of patient discharge from an acute or non-acute inpatient facility to the community.
We must be able to review the member’s discharge medications and the member’s current outpatient medications in the documentation. Notification of completed medication reconciliation, as well as any identified concerns, must be shared with the member’s PCP.

**Documentation**

One or a combination of the following evidence meets the criteria for best practice documentation:

- Notifications that the medications prescribed or ordered upon discharge were reconciled with the current medications
- A medication list in a discharge summary that is present in the outpatient chart and evidence of reconciliation with the current medications conducted by a registered nurse, clinical pharmacist, or prescribing practitioner (e.g. nurse practitioner, physician assistant, or physician)
- Notation that no medications were prescribed or ordered upon discharge

**NOTE:** The date of member’s discharge must be noted in the electronic medical record (EMR). In addition, a signature (electronic or written) of the clinician who completed the medication reconciliation must be included.

Medication reconciliations can be performed only by a registered nurse, clinical pharmacist, or prescribing practitioner (e.g. nurse practitioner, physician assistant, or physician).

**Coding**

- NCQA HEDIS rules for this measure: Medication reconciliations (using approved codes) must be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse.
- Medical Providers: The submissions of transitional care management codes (TCM) 99495 or 99496 are appropriate and reimbursable. The submission of reporting code 1111F is also appropriate but not reimbursed.
- Care Management: If care managers are completing medication reconciliation post-discharge and coding is inappropriate or not applicable, documentation in accordance with specifications described above are required.
- Home Care Agencies: The submission of CPT code 1111F in combination with code G0299 on the same claim will comply with NCQA HEDIS measure requirements. Code G0299 confirms that a registered nurse completed the medication reconciliation.
- Audit: Verification is subject to audit by Tufts Health Plan.

**COB/Subrogation**

For information, see *Appendix D, Admission Report Guide*.

**Use of Out-of-Plan Providers and Carve-Outs**

Infrequently, a Clinical Nurse Liaison (CNL) or Care Manager will need to facilitate an admission to a non-contracted facility (i.e., SNF, Long-Term Acute Care, Acute Inpatient Rehabilitation) or a non-contracted home health care agency. In this instance, the CNL/Care Manager will determine the medical necessity and appropriate level of care, then instruct the provider to notify the Tufts Health Plan Medicare Preferred In-Patient Notification department. Following discharge, the provider can bill Tufts Health Plan Medicare Preferred at the same billing rate as traditional Medicare or Medicaid. For home health care, the CNL/Care
Manager should request that the provider use the *Universal Health Forms* with the number of visits requested and supporting documentation.

If there is the need for a medication carve-out at SNFs or for durable medical equipment (DME) from non-contracted providers, the CNL/Care Manager should contact the Allied Health Contract (AHC) Manager assigned to SNFs when requesting a medication carve-out. The CNL/Care Manager should inform the AHC SNF contract manager of key elements (e.g., Care Manager name and number, member name, member ID, drug name, dosage, frequency, duration, member's weight).

If there is the need for DME, the CNL/Care Manager should contact the AHC Manager assigned to DME, and request the DME and key demographics referenced above.

Call Provider Services (1-800-279-9022) to contact both AHC Managers.

**Additional Resources**

**Non-covered Items/Equipment List**

For information on non-covered items/equipment, use the following link on the Provider Portal of Tufts Health Plan’s Web site: *Tufts Health Plan Medicare Preferred Coverage Resources*.

**Quality Improvement Organization Fast-Track Appeal**

Quality Improvement Organization (QIO) is designated by CMS to serve as the designated QIO for the Tufts Health Plan Medicare Preferred service. QIO receives appeal requests from members who disagree with the *Notice of Discharge* that they have received. In the hospital or other acute level-of-care settings, the *Important Message No. 2 (IM No. 2)* serves as the *Notice of Discharge* or *Important Message* (IM). SNFs, Comprehensive Outpatient Rehabilitation Facilities (CORF), and HHAs use the *Notice of Medicare Non Coverage* (NOMNC).

1. When QIO receives a call within the required time frame after the delivery of the *IM No. 2* or NOMNC, QIO activates the fast-track appeal process.

2. After the process has been initiated, QIO notifies the Appeals and Grievances department at Tufts Health Plan. The Appeals and Grievances department representative then contacts the appropriate facility or provider to request that a copy of the *Notice of Discharge* be faxed to him/her.

3. An Appeals and Grievances Analyst determines if the NOMNC or IM was issued correctly and contacts the appropriate Care Manager to obtain the *Discharge Summary document*.

4. The Care Manager must return the completed *Discharge Summary* document to the Appeals and Grievances department within two hours of being notified by the Analyst or by the end of business that day, whichever comes first. This information is used to write the letter which goes from the Health Plan to the facility/provider. A copy is also mailed to the member’s home on record and to the PCP’s office. The acute setting letter is the *Detailed Notice of Discharge* (DNOD). The SNF/HHA letter is the *Detailed Explanation of Non Coverage* (DENC).

5. The member’s medical record from the hospital or SNF is sent directly to the QIO. The SNF and HHA record are sent to Tufts Health Plan Medicare Preferred for review before Appeals and Grievances forwards it to KEPRO (effective 6/8/2019).

6. If the *Notice of Discharge* is upheld, QIO notifies the provider, the member, and Tufts Health Plan. If the notice is overturned, QIO notifies the provider, the member, and Tufts Health Plan.
On occasion, the group’s Care Manager performs a clinical reinstatement before the QIO decision has been rendered. When done, this halts the fast-track appeal process. For additional information, use the following links on Tufts Health Plan’s Web site:

- [Hospital Discharge Summary Form](#)
- [Hospital Discharge Summary Form Instructions](#)
- [SNF/HHA/CORF Discharge Summary Form](#)
- [Tufts Health Plan Medicare Preferred HMO SNF/HHA/CORF Discharge Summary Form Instructions](#)
- [HMO Reinstatement of Services](#)
Complex Care Management Policies

Population Assessment

Purpose
The purpose of this policy is to ensure a process to provide ongoing assessment of the needs of the general population on, at minimum, an annual basis to adjust the procedures to facilitate linking members with care management services that meet their needs.

Policy
Tufts Health Plan Medicare Preferred will review the population at least annually to assess the characteristics and needs of its member population and relevant subpopulations. This assessment will be used to review and update care management processes and resources to address member needs.

Procedure
The Tufts Health Plan Medicare Preferred Management Team, in conjunction with analysts from the Actuarial department, routinely reviews information about the Tufts Health Plan Medicare Preferred population. These reviews determine eligibility for care management services in the Clinical Data work group and ad hoc meeting with the Tufts Health Plan Medicare Preferred Medical Director and management teams. Characteristics of specific population include, but are not limited to:

- Ethnicity
- Custodial members
- Hospice members
- Members with:
  - Multiple chronic conditions
  - Psychiatric diagnoses
  - Geriatric conditions
Tufts Health Plan Medicare Preferred Care Management Complex
Member Identification - Data Sources

Purpose
The purpose of this policy is to identify data sources used to identify potential members for Tufts Health Plan Medicare Preferred care management.

Policy
• On a monthly basis, members will be identified as candidates for complex care management through the use of a predictive modeling methodology.
• To reflect preregistration data and high risk indicators that apply to members, members will be identified on the Admission Report (to see a sample of this report, refer to Appendix C, Admission Report) and the High Risk Report (to see a sample of this report, refer to Appendix A, High Risk Member Report).
• Members will be identified by providers or other care managers during utilization management and discharge planning process.

Procedure
1. The Actuarial department analyzes data related to member identification. Tufts Health Plan medical and pharmacy claims history are gathered on a monthly basis to produce population segmentation with risk scoring.
2. Membership data with Centers for Medicare & Medicaid Services (CMS) risk scores are processed and flagged for care management evaluation.
3. The clinical parameters for complex care are identified and reviewed monthly by the Tufts Health Plan Medicare Preferred Care Management leadership team and Medical Director.
4. Identified members comprise a list of potentials members for care management. A greater number of members will be identified than will be able to be assigned.
5. When the member is an inpatient, the Care Manager will screen the member for an evaluation.
6. When the member is an outpatient, the Care Manager will prioritize the evaluation of members based on their risk.
7. Day of Admission data is available daily through the Tufts Health Plan Precertification department.

Access to Care Management

Purpose
The purpose of this policy is to ensure that members meeting the criteria for complex care management services are referred to the program by multiple sources in a timely way.
Policy

The Tufts Health Plan Medicare Preferred network uses multiple sources for referral to complex care management services, including, but not limited to:

- Claims data
- Information gathered through the utilization management (UM) or discharge planning process
- Information gathered through the member’s involvement with other programs or services provided (i.e., enrollment in the congestive heart failure program)
- Member or caregiver self-referral
- Provider referral

Procedure

1. Claims data is reviewed on a monthly basis to determine if a member meets the criteria for the complex care algorithm.

2. Daily reports that identify all members with an open preregistration and their associated risk factors are sent to Care Managers. These reports are used to identify and prioritize the completion of the initial assessment by the Care Manager.

3. Members and/or caregivers can make a self referral to the program, either by contacting the Plan, their providers, and/or Care Manager. Providers can also make ad hoc referrals for complex care management programs. Information about the programs is available to members, caregivers, and providers in a variety of mediums including, but not limited to, the Internet, mailings, and medical management meetings.

4. The Plan maintains a file that indicates the source of member referrals. The Tufts Health Plan Medicare Preferred management team and Medical Director routinely analyze this file.

Care Management Systems

Purpose

The purpose of this policy is to assure that the assessment and management of members is based on evidence-based decision support tools that minimize management variability. Documentation is maintained in an electronic system that provides automatic documentation of member, provider, and caregiver interactions and reminders for the care plan.

Policy

The Tufts Health Plan Network uses a Care Management System that does the following:

- Uses evidence-based clinical guidelines/algorithms and logic scripts to assess and manage Complex Care Management patients
- Includes automatic documentation of staff member’s ID, and is date- and time-stamped with each interaction with members, providers, or practitioner involved in the care
- Includes automated prompts for follow-up with reminders for next steps as required by the care plan
Procedure
The Care Manager will use evidence-based and standardized tools to complete the following:
• Minimize treatment variability
• Improve health outcomes
• Reduce health care costs
• Increase patient involvement and adherence

Care Management Process

Purpose
The purpose of this policy is to establish a standardized process to assess the needs of each member referred to the program and to develop an effective and individualized member care plan.

Policy
The initial assessment covers a broad scope of health-related topics. Members and Care Managers explore these topics to identify the member’s achievable health goals and opportunities to improve self-management of health conditions, as well as influence health-related behavior for optimal health and identify member-centric goals. The Care Manager will complete all activities involved in the member initial assessment period within 30 days of the receipt of a new care request or assignment of a direct referral.
The following are the components of an initial assessment:
• Health status and any condition-specific issues
• Clinical history, including medications
• Daily living activities
• Mental health and cognitive status
• Life planning activities
• Cultural, linguistic, visual, and hearing needs, preferences, or limitations
• Caregiver resources and involvement
• Benefits within the organization and from community resources
• Self-management ability

The process creates an individualized care management plan with the following:
• Provides prioritized goals that consider the member's and caregiver's goals, preferences, and desired level of involvement in the care management plan
• Provides a time frame for re-evaluation
• Identifies resources to be used, including appropriate level of care
• Includes planning for continuity of care, including transitions of care and transfers
• Provides collaborative approaches to be used, including family participation
• Provides educational materials that encourage member self-management
• Evaluates member social needs and personal preferences that drive activities to support the care management plan
The process identifies the following:

- Available resources for member referral as part of benefits or other health organizations and a follow-up process to determine whether members act on referrals
- Barriers to member receiving or participating in the care management plan
- A follow-up plan and schedule
- Development and communication of a member self-management plan

The process assesses member progress against the care management plan, including the following:

- Overcoming barriers to care
- Meeting treatment goals
- Maintaining self-management
- Maintaining the desired level of involvement in care management activities

## Measuring the Effectiveness of the Care Management Program

### Purpose

The purpose of this policy is to:

- Identify at least three measures that validate the effectiveness of the care management program across its entire population or subset of the population
- Ensure that these measures have significant and demonstrable bearing that enables the appropriate intervention that would result in significant improvement of the population

Additionally, based on the results of the measurement and analysis of care management effectiveness, the organization will do the following:

- Implement at least one intervention to improve performance
- Remeasure to determine change in performance

### Policy

The Tufts Health Plan Medicare Preferred network measures care management activities that have significant influence in the improvement of the health of its membership. The measures may include, but are not limited to:

- Fall risk
- Medication adherence
- Advance Directives
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Readmission reduction
- Member satisfaction
- PAM

Based on the results of the identified measures, the organization identifies opportunities for improvement and implements measures to improve performance, thereby improving the health of its population.
Procedure

The organization measures the effectiveness of its care management program using three measures. For each measure, the organization does the following:

1. Identifies a relevant process or outcome
2. Uses valid methods that provide quantitative results
3. Sets a performance goal
4. Clearly identifies measure specifications
5. Analyzes results
6. Identifies opportunities for improvement, if applicable
7. Develops a plan for intervention and re-measurement
Outcomes and Measures

Reporting Requirements
Integrated Care Management Reporting metrics for the Integrated Care Management Program include Process Metrics. Data tracking and reporting requirements are received for the Tufts Health Plan Medicare Preferred Membership enrolled in Care Management Programs. These standards provide the ability to identify and track opportunities for improvements in the delivery of the Integrated Care Management Program.

For additional information, refer to Appendix G, Process Metric Specifications.

<table>
<thead>
<tr>
<th>Process Metrics</th>
<th>Complex Care Management</th>
<th>Tier 2/Chronic Management</th>
<th>Transitions Management</th>
<th>Wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Process Metrics (including Goals of Care)</td>
<td>Quarterly Process Metrics (including Goals of Care)</td>
<td>Monthly Member Level Variable Report</td>
<td>Monthly Member Level Variable Report</td>
<td></td>
</tr>
<tr>
<td>Monthly Member Level PHQ2 Referral Report</td>
<td>Monthly Member Level Variable Report</td>
<td>Monthly Member Level Variable Report</td>
<td>Monthly Member Level Variable report</td>
<td></td>
</tr>
</tbody>
</table>

Monthly Process Metrics (Complex, Tier 2/Chronic, Transitions, Wellness)
This reporting file provides Tufts Health Plan Medicare Preferred with a monthly data feed for all members who have a new or changed disposition code for the Complex, Chronic, Transition, or Wellness program within the reporting month.

Reporting Objectives
The objectives of these reports include:
- Tracking referral source into Complex, Chronic
- Reconciling status of members sent to the Integrated Delivery Network (IDN)/Medical Groups on the Tufts Health Plan Medicare Preferred Complex and Chronic Tier 2 Lists and Custom Care Wellness
• Allowing Tufts Health Plan Medicare Preferred to know which members are enrolled in Integrated Management Programs
• Allowing Tufts Health Plan Medicare Preferred to track duration of members enrollment in programs
• Measuring Goals of Care completion and responses
• Measuring cognitive screening completion and action taken on positive screens

**Monthly Member Level Patient Health Questionnaire 2 Referral Report for Centers for Medicare & Medicaid Services Chronic Condition Improvement Plan (CMS CCIP)**

The objective for the Patient Health Questionnaire 2 (PHQ2) reporting is to ensure that members who are enrolled in the High Risk Care Management Programs receive timely screenings both at the time of initial enrollment and subsequent intervals. Tufts Health Plan Medicare Preferred reviewed the effect that behavioral health comorbidities have on the management of chronic obstructive pulmonary disease (COPD), and found that members with COPD and behavioral health comorbidities have higher morbidity, utilization, and cost than members with COPD alone. Further, undetected and untreated behavioral health conditions among members with COPD can be barriers to effective treatment, exacerbate existing conditions, and negatively impact outcomes.

The goal is to track and improve the rate of PHQ2 screening for members with COPD, and track results of positive screens so members can receive appropriate diagnosis and treatment for depression and become better equipped to self-manage their chronic condition. The schedule for PHQ2 screening will be at the time of initial assessment, and any subsequent PHQ2 screening followed by referral to PCP and or BH for positive PHQ2 results.

**Quarterly Process Metrics**

This reporting is conducted on members in the Complex Care Management Program. Reporting should include all members who have agreed to participate and have a disposition code of ENROLLED ACTIVE.

**Reporting Objectives**

The objectives of this report include ensuring that:

• Members who are newly enrolled in the Complex Care Management Program receive timely assessments, care plans, and actions plans
• The initial assessment is completed within 30 days of being assigned to a Care Manager
• Members with a completed Depression Screen
• Members with Goals of Care answered
• Members are screened for declining cognitive function and action is taken

**Other Reporting**

Tufts Health Plan Medicare Preferred reserves the right to require reporting mandated by CMS. Tufts Health Plan Medicare Preferred strives to give as much notice as possible for CMS-required changes.
Frequently Asked Questions Regarding Reporting

Q Should members who are referred to the Complex Care Management Program and who are subsequently determined to be ineligible for this program still be counted in the denominator for the process metrics?

A No. Only include those members who meet the definition during the time period measured.

   The definition is all Tufts Medicare Preferred members who had a new case opened that remained open for 60 days during the reporting period. If a member is deemed ineligible or is discharged from the program before 60 days, do not include him/her in the denominator.

Q Should I only report on members identified via the High Risk Report?

A No. Regardless of referral source, include all eligible members in your Complex Care Management Program reporting.

Q Is it possible that the same members will be on the Tufts Health Plan list every month or is the list refreshed so that only new members appear?

A The top 3.5% of complex members appear on the list every month. There is an indicator for members who are appearing on the report for the first time. The date that the member was first identified on the report is also listed.

Q Is it possible for members to drop off of the High Risk Report from month to month?

A The report identifies the top 3.5% acute members. Since the cutoff of 3.5% is somewhat inexact, it is possible for a member who is hovering at that point to not appear on the list in subsequent months. We expect that you will evaluate each new member on the list to determine if he/she is appropriate for your Complex Care Management Program. If he/she is appropriate, we expect that he/she would remain in your Complex Care Management Program as long as he/she meets your criteria, regardless of whether or not he/she appears on the list in subsequent months.

Q What happens to members who are eventually closed when they are no longer complex?

A We ask that you report discharge dates on the Member Level Data Report.
A sample of a *High Risk Member Report* is on the next page.

<table>
<thead>
<tr>
<th>Last Place Care Reg ID:</th>
<th>7/2/2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Fall Reg ID:</td>
<td>4/23/2010</td>
</tr>
<tr>
<td>Report Updated:</td>
<td>1/23/2010</td>
</tr>
</tbody>
</table>

**Inpatient Utilization:**
- **Inpatient Utilization:** 12/2009-1/30/2010
- **55+**
- **High Cost**
- **CMS High Risk**
- **Rehospitalized**
- **Recent Freq Flyer**
- **ESRD**
- **Falls Reg**
- **Pulmonary Care Reg**

**Additional Claims:**
- **Enf DM**
- **Enf HF**
- **Enf COPD**
- **Enf SO**
- **HRA**
- **Adv, Del.**
- **HC Proxy**

---

### High Risk Member Report

#### Med Group

<table>
<thead>
<tr>
<th>PCP</th>
<th>Last Name</th>
<th>First Name</th>
<th>MID</th>
<th>DOB</th>
<th>Inst Hlth ESRD</th>
<th>Med Days</th>
<th>CMS High Risk</th>
<th>Rx 7+</th>
<th>Cost 95+</th>
<th>85+</th>
<th>Falls Reg</th>
<th>Ambulance</th>
<th>Recent Freq Flyer</th>
<th>Read adm</th>
<th>Pol Cmty Reg</th>
<th>HF COPO</th>
<th>Adm Prep</th>
<th>Complex Member</th>
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</tr>
</tbody>
</table>

※Study: Identified as Complex

Inpatient utilization is based on 6 months claims and 2 months pre-reg

**Monday, January 16, 2011**
The following is sample of a **High Risk Member Definitions**.

### High Risk Member Definitions

**Instit.:** Current Institutional member as reported by CMS and/or Case Management logs.

**ESRD:** Current ESRD member as reported by CMS.

**M/S Admits:** Number of Med/Surg admits in the last 12 months with 0-day lag. The value is based on 10 months of claims and 2 months of pre-reg data.

**CMS High Risk:** The member has an average risk score of at least 2.5 for the last 12 months with 0-day lag.

**Rx 7+:** The member has filled at least 7 unique prescriptions within the last 3 months with 0-day lag.

**Top 20% Cost:** The member is in the top 20% by medical cost (PMPM) based on the last 12 months of claims with 60-day lag.

**85+:** The member is at least 85 years old as of the report date listed in the header.

**Falls Reg.:** The member was identified as having a fall in the last 12 months with 60-day lag or has been classified as med-high risk for a future fall as of the last available Falls Registry identification date (Jan, Apr, Jul, Oct). Identification is based on claims and self-reported data.

**Ambulance:** The member has had at least one ambulance transport in the last 6 months with 60-day lag.

**Recent Freq Flyer:** The member has had at least 3 Med/Surg admissions within a 6 month time period. The most recent admission must be during the last 6 months with 0-day lag. The value is based on 10 months of claims and 2 months of pre-reg data.

**Readmtd.:** The member had at least 1 readmission in the last 12 months with 0-day lag. The value is based on 10 months of claims and 2 months of pre-reg data. A readmission is defined as: An admission to any acute care facility for any diagnosis within 30 days of discharge from an acute inpatient facility.

**Pall. Care Reg.:** The member was identified as having a life limiting condition as of the last available Palliative Care Registry identification date (Feb, May, Aug, Nov). Members are identified based on claims indicating an advanced disease state for Oncology, ESRD, ESLD, COPD, CHF, and Dementia.

**HF:** The member was identified as having HF with the strong likelihood of being classified by NYHA criteria as stage 3-4 (moderate to severe).

**COPD:** The member was identified as having high acuity COPD.

**Admit Prob:** The probability that the member will have at least one acute inpatient admission in the next 6 months. The value is represented by a percentage range.

**Complex/ Tier 1:** The member was identified as being in the top 3.5% for risk of an acute inpatient admission within the next 6 months.

**Chronic/Tier 2:** The member was identified as being in the top 3.5-10% for risk of an acute inpatient admission within the next 6 months.

---

1. The discharge date and readmit date are excluded from the 30 days.

2. Excludes transfers

---

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A sample of an Admission Report is on the next page.
| Member Name | Date Of Birth | Member Age | Member ID | Admit Hospital Name | Admitting Diagnosis | Admission Date | Admission Status | Admission Class | Attending MD | PreReg Number | PCP Name | Medical Group | Priority | Med Surg Readmissions | In Palliative Care Registry | In Falls Registry | Identified with HF | Identified with COPD | Rx 7+ |
|-------------|---------------|------------|-----------|---------------------|---------------------|----------------|----------------|----------------|---------------|-------------|----------|--------------|----------|----------------|-------------|-----------------|----------------|----------------|----------------|-----------|
| NEW ENGLAND BAPTIST HOSP IN PT | | | | Osteoarthrosis | 2/24/2014 | pending Surgical | | | | | | | | | | |
| UMASS MEMORIAL MED CENTER- INPT | | | | Spondyloarthropathy | 2/21/2014 | STILL IN Surgical | | | | | | | | | | |
| HEALTH ALLIANCE HOSPITAL- INPT | | | | Ch obstr asth w exacer | 2/20/2014 | STILL IN Medical | | | | | | | | | | |
| STIRLING VILLAGE LLC | | | | Cereb art occl w infarct | 2/20/2014 | STILL IN SNF - Level 1B | | | | | | | | | | |
| KINDRED NURSING & REHAB -RIVER | | | | Hip & thigh injury NEC | 2/20/2014 | STILL IN SNF - Level 1B | | | | | | | | | | |
| STIRLING VILLAGE LLC | | | | Fracture neck of femur | 2/20/2014 | STILL IN SNF - Level 1B | | | | | | | | | | |
The following is a sample of the Admission Report Guide.

Admission Report Guide

Overview

The Admission Report (see attached) is a working tool that will help Care Managers identify high risk, high priority inpatient members who will benefit from more immediate care management and transition of care management. The report provides a snapshot of all Tufts Health Plan Medicare Preferred (TMP) members with inpatient status (acute, SNF, rehab) that do not have a discharge date in the TMP pre-registration system. The report prioritizes members with Complex, Tier 2/Chronic and Transition Risk-status and also provides high risk clinical indicators by member to allow the Care Manager to quickly prioritize their daily caseload for intervention.

The report is also intended to improve operational efficiency, as it contains a blank Admission Status field which will allow the external Care Manager to document the member admission status (i.e. discharge date), and then email the report back to the TMP Pre-registration department. Because the report is provided in Excel format, users may also manipulate the format to accommodate other needs, such as creation of a daily census or use for weekly management meetings.

The Admission Report is scheduled for email delivery daily (except Sunday.) The auto-generated email will be from Dale Mickey. Do not send questions to this mail address.

Selection Criteria

The report includes admissions in the TMP pre-registration system meeting the following criteria:

- Admission date on or prior to today (date report run)
- No discharge date in TMP’s pre-registration system
- Excludes deleted pre-registrations
- Excludes Mental Health admissions*
- Excludes future elective admissions*
- Excludes Observation stays

*These will be provided on the Companion Report.

Note: High risk indicators are present for admissions occurring on or after October 1, 2010.
Report Details

<table>
<thead>
<tr>
<th>Report Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name</td>
<td></td>
</tr>
<tr>
<td>Member Age</td>
<td>Age as of admission date</td>
</tr>
<tr>
<td>Member ID</td>
<td>TMP Member ID</td>
</tr>
<tr>
<td>Admit Hospital Name</td>
<td></td>
</tr>
<tr>
<td>Admitting Diagnosis</td>
<td>Diagnosis provided at time of pre-registration</td>
</tr>
<tr>
<td>Admission Date (sorted in</td>
<td>Admission date requested at time of pre-registration</td>
</tr>
<tr>
<td>descending order)</td>
<td></td>
</tr>
<tr>
<td>Admission status</td>
<td><strong>To be filled in by Care manager:</strong> Leave blank if still in or fill in discharge date or SDC – Surgical Day Center OBS – Observation Never admitted (examples: ER only, cancelled admission)</td>
</tr>
<tr>
<td>Admission Class</td>
<td>Indicates Medical, Surgical, Rehab Levels and SNF Levels</td>
</tr>
<tr>
<td>Attending MD</td>
<td>Attending Physician provided at the time of pre-registration</td>
</tr>
<tr>
<td>Prereg Number</td>
<td>Assigned at the time of pre-registration</td>
</tr>
<tr>
<td>PCP Name</td>
<td>Member’s PCP as of admission date</td>
</tr>
<tr>
<td>Medical Group</td>
<td>Member’s Medical Group as of admission date</td>
</tr>
<tr>
<td>Priority</td>
<td>Indicates if the member met Complex, Chronic/Tier 2 or Transition Risk criteria currently defined as:</td>
</tr>
<tr>
<td></td>
<td>• <strong>Complex:</strong> The member was identified as being in the top 3.5% for risk of an acute inpatient admission within the next 6 months.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Tier 2/Chronic:</strong> The member was identified as being in the top 3.5-10% for risk of an acute inpatient admission within the next 6 months.</td>
</tr>
<tr>
<td></td>
<td>• <strong>Transition Risk:</strong> The member had at least 1 of the following readmission risk factors (from the High Risk algorithm)</td>
</tr>
</tbody>
</table>

Originated 12/2010, Revised 2/1/13, 01/15/15.
<table>
<thead>
<tr>
<th>Report Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least one readmission in the last 12 months with 0 day lag or the member was identified as having a fall in the last 12 months with 60 day lag or has been classified as med-high risk for a future fall as of the last available Falls Registry identification date. Or the member has been identified with CHF Or COPD Or In Palliative Care Registry Or Rx 7+</td>
<td>The first four clinical indicators meet the minimum requirement for follow up for Transition programming.</td>
</tr>
<tr>
<td>Clinical Indicator definitions: Med /Surg Readmissions</td>
<td>The member had at least 1 readmission in the last 12 months with 0 day lag. The value is based on 10 months of claims and 2 months of pre-reg data. A readmission is defined as: an admission to any acute care facility for any diagnosis within 30 days of discharge from an acute inpatient facility.</td>
</tr>
<tr>
<td>In Palliative Care Registry</td>
<td>The member was identified as having a life limiting condition as of the last available Palliative Care Registry Identification date (Feb, May, Aug, Nov). Members are identified based on claims indicating an advanced disease state for Oncology, ESRD, ESLD, COPD, CHF, and Dementia.</td>
</tr>
<tr>
<td>In Falls Registry</td>
<td>The member was identified as having a fall in the last 12 months with 60 day lag or has been classified as med-high risk for a future fall as of the last available Falls Registry identification date (Jan, Apr, Jul, Oct). Identification is based on claims and self-reported data.</td>
</tr>
<tr>
<td>Identified with Heart Failure</td>
<td>The member was identified as having Heart Failure with the strong likelihood of being classified by New York Heart Assn (NYHA) criteria as stage 3-4 (moderate to severe).</td>
</tr>
<tr>
<td>Identified with COPD</td>
<td>The member has been identified as having high acuity COPD.</td>
</tr>
<tr>
<td>Identified as having Rx 7+</td>
<td>The member has filled at least 7 unique prescriptions within the last 3 months with 0-day lag.</td>
</tr>
<tr>
<td>Report Column</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| | At least one readmission in the last 12 months with 0 day lag or the member was identified as having a fall in the last 12 months with 60 day lag or has been classified as med-high risk for a future fall as of the last available Falls Registry identification date.  
Or the member has been identified with CHF  
Or COPD  
Or In Palliative Care Registry  
Or Rx 7+  
The first four clinical indicators meet the minimum requirement for follow up for Transition programming. |
| **Clinical Indicator definitions:**  
**Med /Surg Readmissions** | The member had at least 1 readmission in the last 12 months with 0 day lag. The value is based on 10 months of claims and 2 months of pre-reg data. A readmission is defined as: an admission to any acute care facility for any diagnosis within 30 days of discharge from an acute inpatient facility. |
| **In Palliative Care Registry** | The member was identified as having a life limiting condition as of the last available Palliative Care Registry Identification date (Feb, May, Aug, Nov). Members are identified based on claims indicating an advanced disease state for Oncology, ESRD, ESLD, COPD, CHF, and Dementia. |
| **In Falls Registry** | The member was identified as having a fall in the last 12 months with 60 day lag or has been classified as med- high risk for a future fall as of the last available Falls Registry identification date (Jan, Apr, Jul, Oct). Identification is based on claims and self-reported data. |
| **Identified with Heart Failure** | The member was identified as having Heart Failure with the strong likelihood of being classified by New York Heart Assn (NYHA) criteria as stage 3-4 (moderate to severe). |
| **Identified with COPD** | The member has been identified as having high acuity COPD. |
| **Identified as having Rx 7+** | The member has filled at least 7 unique prescriptions within the last 3 months with 0-day lag. |
**Opening and closing the report**

The report will be sent in HTML format and needs to be saved in Excel. Two examples are below. Remember to follow HIPAA guidelines for maintenance of PHI.

**Example 1**
1. Click on the report to open it.
2. Right click anywhere in the report and choose **Export to Excel**.
3. Then choose **File, Save As** to your preferred location.
4. Save the file with your IDN name or # and today’s date.

**Example 2**
1. Right click on the attachment.
2. Choose **Open With**.
3. Choose **Excel** (double click or click OK).
4. Click **File, Save As – IDN name or # and today’s date**.
5. Change **Save As** type to **.xls**.
6. Save the file with your IDN name or # and today’s date.
Using the report

I. For Daily Management of Inpatient Members

1. Care Managers should check the report first thing each morning to identify new, high-priority admissions. The report will be delivered daily, (except Sunday), prior to 7AM.
2. The report is sorted by **Admission Date** to allow the Care Manager to quickly identify new admissions.
3. The **Priority** and **Admitting Diagnosis** columns will provide information to allow the Care Manager to quickly assess clinical severity and priority of the member.
4. The five clinical indicators on the far right of the report will provide additional clinical information related to each member.
5. The Care Manager will synthesize the content of this report to prioritize their workload and determine whether to reach out to hospital Care Managers for individual members.

II. For Sending Discharge Date/Disposition to TMP

Care Managers will use the report to document discharge dates or other status by adding the information directly in the Admission Status field. **Email discharge dates back to THP at a minimum of three times per week.** Sending discharge dates on a timely basis will make the report more manageable, accurate, and will expedite claims payment.

Updating the report

Enter the **discharge date** if applicable, or **case status** into the **Admission Status** field. Case status can be used to correct inaccurate information for accurate payment. Case Status will be one of the following:

- SDC
- OBS
- Never admitted [ER only, cancelled admission, etc.]

**Clarifying/Correcting Data on the Report; Delay Days, Custodial status, See new notes for Coordination of Benefits/Subrogation and Bridging policy (see next page)**

It is the responsibility of the facility to pre-register the case, however, take the steps below to clarify or correct information on the report that is inaccurate (example: to correct dates for levels of care, to notify TMP a SNF member is becoming custodial or to identify delay days with identification of responsible party or that case is a coordination of benefit case).

1. Insert a new "row" under the inaccurate information.
2. Copy and paste at least two identifiers (Member Name, S00 number, dob, etc) into the new row.
3. Type the accurate information in the appropriate column or write a clarifying note.

**End of Month**

By the first day of the new month give Discharge date or note that member is “Still in”. Pre Registration will then understand the Admission status for your “still in” member and the End of Month procedure will be completed.
Returning the report to TMP Pre-Reg Department

1. Save the document with the IDN name or # and today’s date.
2. Attach the updated document to your secure email. Using the secure domain name between Tufts Medicare Preferred and your IDN will ensure the email is secure.
3. In the subject line type your IDN name or #.
4. Email the edited document to the following email address to assure correct payments. 
   preregistration_case_close_out@tufts-health.com

Bridging Policy
(revised November 2012)
**MCR = Medical Claims Review
Email address: THPMPMCRProgram@tufts-health.com (for external CM)
Email for Internal CM:

Summary: What Groups Must Do

<table>
<thead>
<tr>
<th>Readmission Interval</th>
<th>Notification of Group</th>
<th>Clinical Information Provided</th>
<th>Notification Of Group</th>
<th>Effectuation</th>
<th>Appeals</th>
<th>Notification Of Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14 Days</td>
<td>TMP</td>
<td>Hospital Record Group provides any information to support decision to bridge</td>
<td>TMP sends group cc of the letter to hospital with bridging decision either way</td>
<td>If bridged, claim denied retroactively deducted from future hospital payments. Deducted from HSF expense</td>
<td>Hospital has right to appeal decision to bridge</td>
<td>If overturned, hospital notified, group cc'd on notification</td>
</tr>
<tr>
<td>15-30 Days</td>
<td>Group sends email to MCR to initiate review process Include rationale for bridging admissions</td>
<td>TMP requests Hospital Record Group provides any information to support decision to bridge</td>
<td>TMP sends group cc of the letter to hospital with bridging decision either way</td>
<td>If bridged, claim denied retroactively deducted from future hospital payments. Deducted from HSF expense</td>
<td>Hospital has right to appeal decision to bridge</td>
<td>If overturned, hospital notified, group cc'd on notification</td>
</tr>
</tbody>
</table>
III. For Creating Weekly Management Meeting Census Reports

Because the report is in Excel format, Care Managers can use this format to create weekly management reports or census reports.

IV. Coordination of Benefits/Subrogation

- Tufts Health Plan has a new Subrogation and Third-Party Liability (TLP) Recovery program with the Rawlings Company LLC (Rawlings).
- Some examples of cases that might be reported:
  - Motor Vehicle Accidents
  - Slip or Fall or Premises Liability
  - Workers’ Compensation.
- There are 3 options to choose from for submission
  - Complete as much of the form, as you can then:
    - Call the Rawlings Company at (888)846-4512
    - Fax the correspondence to the attention of MANUAL FILE COORDINATOR at (502) 753-7064
    - Complete the “Manual Referral Form” and email it to The Rawlings Company
The following illustrates the inclusion criteria for ad hoc referrals to complex and chronic care.

## Guidelines for Ad Hoc Referrals for Chronic and Complex Programs

**Goal:** create objective criteria for identify appropriate members for Care Manager Intervention

*Note: Some criteria qualify and some criteria require several*

<table>
<thead>
<tr>
<th>CHRONIC</th>
<th>COMPLEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. One or more chronic conditions (CHF, COPD, Diabetes, ESRD, Parkinsons, etc) WITH self-management deficits:</td>
<td>1. Catastrophic/Traumatic Injury (stroke, brain injury) OR</td>
</tr>
<tr>
<td>a. IADL and/or 1 ADL deficit</td>
<td>2. 2 or more chronic conditions with IADL and multiple ADL deficits OR</td>
</tr>
<tr>
<td>b. Medication adherence</td>
<td>3. Cognitive Impairment and lives alone OR</td>
</tr>
<tr>
<td>c. Exercise</td>
<td>4. New Oncology Dx</td>
</tr>
<tr>
<td>d. Diet</td>
<td></td>
</tr>
</tbody>
</table>

**OR**

One or More chronic conditions and 2 or more of the following risks:

<table>
<thead>
<tr>
<th>CHRONIC</th>
<th>COMPLEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 1 or more admits in the last 6 months</td>
<td>a. 2 or more admits in the last 6 months</td>
</tr>
<tr>
<td>b. Medication adherence issues</td>
<td>b. Medication adherence issues</td>
</tr>
<tr>
<td>c. Altered mental status with teachable caregiver</td>
<td>c. Altered mental status</td>
</tr>
<tr>
<td>d. Lives alone</td>
<td>d. Lives alone</td>
</tr>
<tr>
<td>e. 1 – 2 falls in the past 6 months</td>
<td>e. 3 or more falls in the past 6 months</td>
</tr>
<tr>
<td>f. 7+ medications</td>
<td>f. 10+ medications</td>
</tr>
<tr>
<td>g. Age 85+</td>
<td>g. Age 85+</td>
</tr>
<tr>
<td>h. Psychosocial issues</td>
<td>h. Psychosocial issues</td>
</tr>
<tr>
<td>i. Community Resource Needs</td>
<td>i. Community Resource needs</td>
</tr>
</tbody>
</table>

If the member has an aggregate of needs that fall outside these clinical guidelines, the Care Manager’s Clinical judgment should prevail.
The following table describes the Complex Care Manager’s role.

<table>
<thead>
<tr>
<th>Description of Complex Care Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key concepts for the Complex Care Manager role include:</td>
</tr>
<tr>
<td>• Manage the complex member through all levels of care (acute, home, facility, etc.).</td>
</tr>
<tr>
<td>• Use the Complex Care Manager’s clinical judgment regarding where best to complete the initial Complex Assessment</td>
</tr>
<tr>
<td>NOTES: Only a subset of members require a home visit</td>
</tr>
<tr>
<td>• Develop close working relationships with community resources, preferred facilities, preferred providers, and other supportive services</td>
</tr>
<tr>
<td>• Ensure that motivational interview techniques are used and assessment of the member and/or caregiver's confidence in managing the member's care is addressed</td>
</tr>
<tr>
<td>• Ensure appropriate care plans are in place and regular follow-up are provided to track member's progress in adherence to his/her physician's treatment plan</td>
</tr>
<tr>
<td>In addition, the Complex Care Manager is responsible for:</td>
</tr>
<tr>
<td>• Working as a team with the member, Primary Care Provider (PCP), and other providers to manage members identified for chronic care management</td>
</tr>
<tr>
<td>• Ensuring that member needs are met in a timely manner</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Essential Function</th>
<th>Description</th>
<th>Tools/Workflow</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Assessments</strong></td>
<td>Use clinical judgment to determine the most appropriate setting to complete the assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Formal assessments that address both medical and psychosocial issues and required community supports</td>
<td>Complex Assessment</td>
</tr>
<tr>
<td><strong>Create Evidence-Based Plan of Care (POC) and Member Action Plan</strong></td>
<td>Develop POC based on assessment results and member goals</td>
<td>Complex Program Workflows</td>
</tr>
<tr>
<td></td>
<td>Solicit PCP and/or nurse practitioner (NP) input, as needed, to complete initial assessment within 14 to 21 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete all open initial assessments within 30 days of assignment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop and distribute Action Plan to the member with instruction and the Chronic Care Manager’s contact information</td>
<td>Action Plan templates</td>
</tr>
<tr>
<td></td>
<td>Mail a copy of the Action Plan to the PCP and/or NP</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing Proactive Management and Members/Caregiver Coaching</strong></td>
<td>Open complex cases should be followed according to member need, but at a minimum contact member on a monthly basis to monitor engagement and adherence, identify new areas of concern or problems, and assess need to revise the POC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NOTES: The intensity and frequency of interactions will be member-specific and will be based on their current Action Plan and any change in status.</td>
<td>Use of clinical judgment to prioritize cases and interventions</td>
</tr>
<tr>
<td></td>
<td>Communication with the member’s practitioner about the member’s health conditions and treatments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide ongoing coaching to meet member goals</td>
<td>Member Action Plan</td>
</tr>
<tr>
<td></td>
<td>Diagnosis-specific education material mailed</td>
<td>Diagnosis-specific education material mailed</td>
</tr>
<tr>
<td></td>
<td>Motivational interview/coaching tips and tools</td>
<td>Motivational interview/coaching tips and tools</td>
</tr>
</tbody>
</table>
### Description of Complex Care Manager

#### Community Resource Development/Coordination of Care

- Coordinate services/information among providers/caregivers
- Participate at PCP appointment when indicated

Refer to and consult with skilled home health care or community services/resources to facilitate management of member needs and goals

**NOTE:** This can include specific vendors for tele-health monitoring, oxygen therapy, disease management programs at community hospital, disease-specific organizations, or at Councils on Aging

- List of community agencies/resources
- Best Practice Metrics

#### Ongoing Health Coaching

- Assessment of member and caregiver’s ability to self-manage
- Ongoing health coaching with emphasis on assessing member and/or caregiver’s ability to follow physician treatment plans
- Complete weekly updates with focus on progress to goals and eliminating barriers to care

#### Facilitate Transitions of Care

Develop close working relationships with a limited number of preferred providers, skilled nursing facility (SNF) rounders, and facility Care Managers

Each group/integrated delivery network (IDN) identifies preferred network and sets expectations regarding transitions of care and collaboration of “handoffs”

- Transition of Care Workflow and Assessment tools
- Preferred Provider SNF/HHC educational presentation on new model and transitions of care

Upon admission to a facility:

- Communicate member goals, pertinent history and potential barriers to facility Care Manager
- Proactively reach out to the family/caregiver to identify member/family concerns/expectations
- Communicate with the Visiting Nurses Association (VNA) either before the member is discharged or during the first visit
- Review the initial SNF/HHC (home health care) assessment, focusing on whether goals are being met; follow up with facility Care Manager/VNA provide, as needed
- Go on site, as needed, to facilitate the discharge plan and/or to monitor the member’s progress/barriers to discharge

Upon discharge:

- Assume responsibility for post-discharge follow-up
- Focus on medication reconciliation
- Chose to use Wellness Coordinator or other staff to make post discharge for follow up phone calls (this is optional)
- Choose to perform a joint home visit with VNA or NP to ensure that the member has made a safe transition (this is optional)

- Transition of care assessment tool
- Discharge Checklist
- Medication bags
- Contacts/relationships with community-based agencies
- Guidelines for pharmacy/mental health/SW/palliative care
The following illustrates Process Metric Specifications.

### 2019 Process and Outcome Metric Reporting Requirements

<table>
<thead>
<tr>
<th>Process Metrics</th>
<th>Complex Care Management</th>
<th>Tier 2/Chronic Management</th>
<th>Transitions Management</th>
<th>Wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Member Level Variable Report Monthly Member Level PHQ2 Referral report</td>
<td>Monthly Member Level Variable Report Monthly Member Level PHQ2 Referral report</td>
<td>Monthly Member Level Variable Report Monthly Member Level PHQ2 Referral report</td>
<td>Monthly Member Level Variable Report</td>
<td></td>
</tr>
</tbody>
</table>

### Introduction

The reporting metrics for the Integrated Care Management Program include both process and outcome metrics. Data tracking and reporting are required for the entire Tufts Health Plan Medicare Preferred membership enrolled in care management programs. Standard reporting requirements will provide the ability to identify and track opportunities for improvements in the delivery of the Integrated Care Management Program. Outcome measures will demonstrate effectiveness of programs and opportunities for improvement.

### I. Process Metrics: Complex Member and Goals of Care Quarterly Report

#### A. Reporting Objective

The objective of the complex member quarterly report is to ensure that members who are newly enrolled in the Complex Care Management Program receive timely assessments, care plans and actions plans. Note: It is expected that members who are identified on the Tufts Health Plan Medicare Preferred Monthly High Risk (Complex and Tier 2/Chronic) reports will 1) be assigned to a Care Manager within 30 days, 2) have a completed initial assessment, care plan and action plan within 30 days of being assigned to a Care Manager, 3) be asked about goals of care during the first 60 days of enrollment into the Complex program and 4) receive a depression screening.

#### B. Quarterly Process Metrics

Quarterly process metrics are reported on Complex members who have a disposition code of ENROLLED - ACTIVE. The report should include:

1. Numerator for each metric and total denominator (Please note, total denominator for percent of Complex and Chronic/Tier 2 Members with documented goals of care differs from the denominator for the remainder of the goals of care metrics; (Please see Specifications section for specifics)
2. Percentage of Complex Members with a completed Initial Assessment within 30 days of case assignment to care manager
3a. Percentage of Complex and Chronic/Tier 2 Members with documented answers to Goals of Care question
I. Process

3b. Of the Complex / Chronic Tier 2 Members who are enrolled
   – Percent of Complex Members with a documented Longevity goal
   – Percent of Complex Members with a documented Function goal
   – Percent of Complex Members with a documented Comfort goal
   – Percent of Complex Members who did not wish to answer

4. Percentage of Complex Members with a documented Care Management Plan

5. Percentage of Complex Members who have received a Member Action Plan

6. Percentage of Complex Members who have received a Depression Screen

I. Process Metrics: Complex Member Quarterly Report, cont. (includes Goals of Care reporting)

C. Specifications

1a. Denominator for calculating percentages for all metrics (except metrics for specific member answers to Goals of Care question – see below), includes the following:
   a) Members who are Enrolled active in Complex and Chronic Tier 2 care management program regardless of referral source
   b) Members who hit their 60th day of enrollment during the reporting period (i.e. If member is enrolled active in Q1 buts hits 60th day during Q2, then the member should only be included in the Q2 report)
   c) Members with a current disposition code of Enrolled - Active as of last day of the reporting period
   d) Members who have been in program for at least 60 days (since date member became enrolled active)

1b. Denominator for calculating percentages for specific member answers to Goals of Care question is the total number of Complex members with goals of care specified

NOTE: Given the definition of the denominator (1a and 1b), those members that were open at least 60 days and discharged before the last day of the quarter are exempt from quarterly reporting

2. Multiple medical groups can either be rolled up to the IDN level or reported individually

3. File Format: See Appendix 1

4. File naming convention
   The preferred format is a tab delimited text file with the following naming convention:
   TMP_Complex_Mbr_Quarterly_Q##_yyyy_XXX.txt
   Please substitute the 'XXX' with the medical group number or IDN name.
   The second preference for file format is an Excel file with the same naming convention (.xls).

D. Definitions

1. Initial Assessment
2. Depression screen: PHQ-2
3. Goals of Care: 1) Members who respond to Goals of Care question and 2) Members who report goal of Longevity, Function or Comfort or Members who did not wish to answer
4. Care Management Plan: Medical and behavioral plan for managing and monitoring the member’s condition
5. Member Action Plan: Member-centric document created and sent to member
I. Process Metrics Quarterly Cognitive Screening report (new 2016) separate file

A. Reporting Objective
The reporting objective is to perform dementia screening on all new Complex and Tier 2 members and measure the incidence of positive screens that lead to PCP, MSW or Dementia Care Consultant referrals.
A second objective is measure caregiver strain for those members who have positive screen and to measure completion of Goals of Care discussion for all members with positive screening.

B. Quarterly Cognitive Screen process Metrics
Quarterly process metrics are reported on Complex and Tier 2 (chronic) members who have a disposition code of ENROLLED - ACTIVE. The report should include:
1. Numerator for each metric and total denominator (Please note, total denominator for percent of Complex or Chronic/Tier 2 Members with documented completed cognitive screens differs from the denominator for the remainder of the cognitive screen metrics; (Please see Specifications section for specifics)
2. Number and percentage of Complex members with completed Cognitive Screen
3. Number and percentage of Complex members with positive screen
4. Number and percentage of members with positive screen with referral to PCP or medical provider
5. Number and percentage of members with positive screen with referral to MSW
6. Number and percentage of members with positive screen with referral to Dementia Care Consultant
7. Number and percentage of members with positive screen with completed Goals of Care
8. Number and percentage of members with positive screen with completed Caregiver Strain
9. Repeat same measures for Tier 2/Chronic members

C. Specifications
1a. Denominator for calculating percentages for all metrics (except metrics for specific actions made as a result of a positive cognitive screen - see below), includes the following:
   a) Members who are Enrolled active in Complex and Chronic Tier 2 Care management program regardless of referral source
   b) Members who hit their 60th day of enrollment during the reporting period (i.e. If member is enrolled active in Q1 but hits 60th day during Q2, then the Member should only be included in the Q2 report)
   c) Members with a current disposition status of Unassigned or disposition code of Enrolled - Active as of last day of the reporting period
   d) Members who have been in program for at least 60 days (since date member became enrolled active)

1b. Denominator for calculating percentages for Positive Cognitive screen with referrals or Goals of care or caregiver strain completed is the number of Complex and Chronic members with a Positive Cognitive Screen.

NOTE: Given the definition of the denominator (1a and 1b), those members that were open at least 60
II. Process

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**A. Reporting**
- days and discharged before the last day of the quarter are exempt from quarterly reporting
- Multiple medical groups can either be rolled up to the IDN level or reported individually
- File Name: See Appendix 1
- File Naming convention
  - The preferred format is a tab delimited text file with the following naming convention:
    - Quarterly_COGNITIVE_Q#_yyyy_IDN.txt
      - Please substitute the 'XXX' with the medical group name of IDN name,
      - The second preference for file format is an xls with the same naming convention (.xls).

**4 Definitions**
1. Cognitive Screen: 6 Item Screener: Cognitive Screen (Used with Permission): Christopher M. Callahan, MD, Frederick W. Unverzagat, PhD, Siu L. Hui, PhD, Anthony J. Perkins, Ms, And Hugh C. Hendrie, Mba, Chba: Medical Care: Volume 40, Number 5, Pp 771–781©2002 Lippincott Williams & Wilkins, Inc. please insert this statement into your Documentation system
2. Positive Screen: 2 or more questions are missed
3. Referral to PCP (medical provider) documentation in system expect this for all positive screens
4. Referral to MSW and or Dementia Care Consultant documentation in system this as is indicated by assessment
5. Goals of care as documented in system
6. Caregiver Strain as documented in system

**II. Process Metrics: Monthly Metrics for Complex, Tier 2/Chronic, Transition Management and Wellness**

**A. Reporting Objectives**
- The monthly member level process metrics report will provide Tufts Health Plan Medicare Preferred a monthly data feed for all members who have a new disposition code for either the Complex, Tier 2/Chronic, Transitions or Wellness programs within the reporting month. The report also allows Tufts Health Plan Medicare Preferred to:
  - Track referral source for members enrolled in Complex, Tier 2/Chronic programs
  - Reconcile members’ status, as identified on the Tufts Health Plan Medicare Preferred High Risk Complex and Tier 2/Chronic lists , which are sent monthly to the IDN/ Medical Groups
  - Identify which members are enrolled in Integrated Care Management Programs
  - Track duration of members’ enrollment in programs

**B. Specifications**
1. File format: See Appendix 2
2. File naming convention: The preferred format is a tab delimited text file with the following naming convention:
   - TMP_Member_Level_Detail_XXX_MonYR.txt
     - Please substitute the 'XXX' with the med group number or the IDN name. The second preference for file format is an Excel file with the same naming convention (.xls).
3. Report is required to be sent to Tufts Health Plan Medicare Preferred every month (See Section IV. Report Submission Schedule for 2013 IDN Reporting Schedule
4. Report file format must match exactly
5. Use of Disposition Codes: Pre-enrollment disposition status should only be used to relay why a member was not enrolled in a program:
   - CLINICALLY NOT APPROPRIATE
   - INELIGIBLE
   - MEMBER DECLINED
   - MIN REQUIREMENT NOT MET
   - UNABLE TO CONTACT

6. For an enrolled member, with a disposition status of ENROLLED – ACTIVE, a disposition status of ENROLLED – DISCHARGED should be used if the member is discharged from the program, regardless of the reason.

7. Transitions reporting (New 2013): ENROLLED – ACTIVE disposition and enrolled date, then, at time of discharge, ENROLLED-DISCHARGED followed by discharge date.

8. Wellness reporting (New 2017) Enrolled active same as above, Only discharge if moving to Complex or Tier 2 level of CM or member opt out after being enrolled.

### III. Patient Questionnaire - 2 PHQ2

#### A. Reporting Objective
The objective for the PHQ2 reporting is to ensure that members who are enrolled in the High Risk Care Management Programs receive timely screenings both at the time of initial enrollment and subsequent intervals. TMP reviewed the effect that BH comorbidities have on the management of COPD and found that members with COPD and BH comorbidities have higher morbidity, utilization and cost than members with COPD alone. Further, undetected and untreated BH conditions among members with COPD can be barriers to effective treatment, exacerbate existing conditions and negatively impact outcomes. The goal is to track and improve the rate of PHQ2 screening for members with COPD and track results of positive screens so members can receive appropriate diagnosis and treatment for depression and become better equipped to self-manage their chronic condition(s). The schedule for PHQ2 screening will be at time of initial assessment and any subsequent PHQ2 screening followed by referral to PCP and or BH for positive PHQ2 results.

#### B. Specifications:

**File Format: See Appendix 4 below**

- **File naming convention:** The preferred format is a tab delimited text file with the following naming convention: TMP_POS_PHQ2_Referral_XXX_MonYR.txt or .xls
- **Reporting Population:** Complex and Tier2/Chronic members with enrolled active status and have a completed assessment; or have had a repeat PHQ2 during the reporting month. TMP will identify who has COPD and being managed.

- Please substitute the 'XXX' with the med group number or the IDN name. The second preference for file format is an Excel file with the same naming convention (.xls).

- Report is required to be sent to Tufts Health Plan Medicare Preferred (Darlene Burgess) (See Section IV below) following to this schedule.

- Report file format must match exactly.

### IV. Report Submission Schedule

#### 2019 IDN Reporting Schedule

<table>
<thead>
<tr>
<th>Monthly Member Level File, Caregiver Strain and PHQ2 survey</th>
<th>Quarterly Process Metrics File</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Month</td>
<td>Due Date</td>
</tr>
<tr>
<td>December 2018</td>
<td>January 9, 2019</td>
</tr>
<tr>
<td>January 2019</td>
<td>February 12, 2019</td>
</tr>
<tr>
<td>February 2019</td>
<td>March 13, 2019</td>
</tr>
<tr>
<td>March 2019</td>
<td>April 10, 2019</td>
</tr>
<tr>
<td>April 2019</td>
<td>May 8, 2019</td>
</tr>
<tr>
<td>May 2019</td>
<td>June 12, 2019</td>
</tr>
<tr>
<td>June 2019</td>
<td>July 10, 2019</td>
</tr>
<tr>
<td>July 2019</td>
<td>August 14, 2019</td>
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<tr>
<td>August 2019</td>
<td>September 11, 2019</td>
</tr>
<tr>
<td>September 2019</td>
<td>October 9, 2019</td>
</tr>
<tr>
<td>October 2019</td>
<td>November 13, 2019</td>
</tr>
<tr>
<td>November 2019</td>
<td>December 11, 2019</td>
</tr>
<tr>
<td>December 2019</td>
<td>January 8, 2020</td>
</tr>
</tbody>
</table>
### Appendix 1

**Tufts Health Plan Medicare Preferred – Quarterly Report File Layout**

Note: The file is sent on a quarterly basis with the name “Quarterly_QP_vyyyy_IDN.xls”

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Value Description</th>
<th>Type</th>
<th>Length</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDN</td>
<td>Name</td>
<td>Char</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>MED_GROUP</td>
<td>IDN total in separate line, next line Med group IPA number</td>
<td>Char/Num</td>
<td>3</td>
<td>123</td>
</tr>
<tr>
<td>QUARTER</td>
<td></td>
<td>Char</td>
<td>2</td>
<td>Q1</td>
</tr>
<tr>
<td>YEAR</td>
<td></td>
<td>Char</td>
<td>4</td>
<td>2013</td>
</tr>
<tr>
<td>Total_Complex</td>
<td>Number of Complex members who agree to participate or are enrolled in Complex program and hit 60th day during reporting period (Denominator)</td>
<td>Num</td>
<td>10</td>
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</tr>
<tr>
<td>NUM_INITIAL_ASSESS</td>
<td>Number of Complex members with a completed Initial Assessment within 30 days of case assignment to Care Manager</td>
<td>Num</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>PCT_INITIAL_ASSESS</td>
<td>Percentage of Complex members with a completed Initial Assessment within 30 days of case assignment to Care Manager</td>
<td>Num</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NUM_COGC</td>
<td>Number of Complex members with Goals of Care specified</td>
<td>Num</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>PCT_COGC</td>
<td>Percentage of Complex members with Goals of Care specified</td>
<td>Num</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NUM_COLONGEVITY</td>
<td>Number of Complex members with documented Longevity goal</td>
<td>Num</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>PCT_COLONGEVITY</td>
<td>Percentage of Complex members with documented Longevity goal</td>
<td>Num</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NUM_COFUNCTION</td>
<td>Number of Complex members with documented Function goal</td>
<td>Num</td>
<td>10</td>
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<tr>
<td>PCT_COFUNCTION</td>
<td>Percentage of Complex members with documented Function goal</td>
<td>Num</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NUM_COCOMFORT</td>
<td>Number of Complex members with documented Comfort goal</td>
<td>Num</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>PCT_COCOMFORT</td>
<td>Percentage of Complex members with documented Comfort goal</td>
<td>Num</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NUM_COPDNWTA</td>
<td>Number of Complex members with documented Patient does not wish to answer</td>
<td>Num</td>
<td>10</td>
<td></td>
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<tr>
<td>PCT_COPDNWTA</td>
<td>Percentage of Complex members with documented Patient does not wish to answer</td>
<td>Num</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Total_Chronic</td>
<td>Number of Chronic members who agree to participate or are enrolled in Chronic program and hit 60th day during reporting period (Denominator)</td>
<td>Num</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>NUM_CHGC</td>
<td>Number of Chronic members with Goals of Care specified</td>
<td>Num</td>
<td>10</td>
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<tr>
<td>PCT_CHGC</td>
<td>Percentage of Chronic members with Goals of Care specified</td>
<td>Num</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Metric</td>
<td>Description</td>
<td>Num</td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
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<td>-----------------------------------------------------------------------------</td>
<td>-----</td>
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<tr>
<td>NUM_CHLONGEVITY</td>
<td>Number of Chronic members with documented Longevity goal</td>
<td>10</td>
<td></td>
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<tr>
<td>PCT_CHLONGEVITY</td>
<td>Percentage of Chronic members with documented Longevity goal</td>
<td></td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>NUM_CHFUNCTION</td>
<td>Number of Chronic members with documented Function goal</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT_CHFUNCTION</td>
<td>Percentage of Chronic members with documented Function goal</td>
<td>10</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>NUM_CHCOMFORT</td>
<td>Number of Chronic members with documented Comfort goal</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT_CHCOMFORT</td>
<td>Percentage of Chronic members with documented Comfort goal</td>
<td>10</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>NUM_CHPDNWTA</td>
<td>Number of Chronic members with documented Patient does not wish to answer</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT_CHPDNWTA</td>
<td>Percentage of Chronic members with documented Patient does not wish to answer</td>
<td>10</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>NUM_CARE_PLAN</td>
<td>Number of Complex members with a documented Care Management Plan</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT_CARE_PLAN</td>
<td>Percentage of Complex members with a documented Care Management Plan</td>
<td>10</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>NUM_MEMBER_ACTION</td>
<td>Number of Complex members who have received a Member Action Plan</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT_MEMBER_ACTION</td>
<td>Percentage of Complex members who have received a Member Action Plan</td>
<td>10</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>NUM_DEPRS_SCREEN</td>
<td>Number of Complex members who have received a Depression Screening</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT_DEPRS_SCREEN</td>
<td>Percentage of Complex members who have received a Depression Screening</td>
<td>10</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
## Variable Name | Value Description | Type | Length | Values
--- | --- | --- | --- | ---
IDN | Name | Char | 10 | 
MED_GROUP | IDN total in separate line, med group IPA number in next line | Char/Num | 3 | 123 |
QUARTER |  | Char/Num | 2 | Q1 |
YEAD |  | Num | 4 | 2016 |
Total_Complex | Number of Complex members who agree to participate or are enrolled in Complex program and hit 60th day during reporting period/Denominator | Num | 10 | 
NUM_COM_COG_SCR | Number of Complex members who have a completed Cognitive screen | Num | 10 | 
PCT_COM_COG_SCR | Percentage of Complex members who have a completed Cognitive screen | Num | 4 | 100% |
NUM_COM_POS_SCR | Number of Complex members who have a positive Cognitive Screen (2 or more questions missed) | Num | 10 | 
PCT_COM_POS_SCR | Percentage of Complex members who have a positive Cognitive screen (2 or more questions missed) | Num | 4 | 100% |
NUM_COM_REF_MED_PROV | Number of Complex positive screens referred to medical provider (PCP, neurologist, geriatrician) | Num | 10 | 
PCT_COM_REF_MED_PROV | Percentage of Complex positive screens referred to Medical provider (PCP, neurologist, geriatrician) | Num | 4 | 100% |
NUM_COM_REF_SW | Number of Complex positive screens referred to Social Work | Num | 10 | 
PCT_COM_REF_SW | Percentage of Complex positive screen referred to Social Work | Num | 4 | 100% |
NUM_COM_REF_DCC | Number Complex positive screens referred to Dementia Care Consultant | Num | 10 | 
PCT_COM_REF_DCC | Percentage of Complex positive screens referred to Dementia Care Consultant | Num | 4 | 100% |
NUM_COM_GO | Number of Complex positive screens with completed Goals of Care | Num | 10 | 
PCT_COM_GO | Percentage of Complex positive screens with completed Goals of Care | Num | 4 | 100% |
NUM_COM_CGS | Number of Complex positive screens with completed Caregiver Strain | Num | 10 | 
PCT_COM_CGS | Percentage of Complex positive screens with Completed Caregiver Strain | Num | 4 | 100% |
Total_Chronic/Tier2 | Number of Chronic/Tier2 members who agree or are enrolled in Chronic/Tier2 program and hit 60th day during the reporting period/Denominator | Num | 10 | 
NUM_CH_COG_SCR | Number of Chronic/Tier2 members who have a completed Cognitive screen | Num | 10 | 
PCT_CH_COG_SCR | Percentage of Chronic/Tier2 members who have a completed Cognitive screen | Num | 4 | 100% |
NUM_CH_POS_SCR | Number of Chronic/Tier2 members who have a positive Cognitive screen (2 or more questions missed) | Num | 10 |
<table>
<thead>
<tr>
<th>Metric Code</th>
<th>Description</th>
<th>Num</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCT_CH_POS_SCR</td>
<td>Percentage of Chronic/Tier2 members who have a positive Cognitive screen (2 or more questions missed)</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NUM_CH_REF_MED_PROV</td>
<td>Number of Chronic/Tier2 positive screens referred to medical provider (PCP, neurologist, geriatrician)</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>PCT_CH_REF_MED_PROV</td>
<td>Percentage of Chronic/Tier2 positive screens referred to medical provider (PCP, neurologist, geriatrician)</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NUM_CH_REF_SW</td>
<td>Number of Chronic/Tier2 positive screens referred to SW</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>PCT_CH_REF_SW</td>
<td>Percentage of Chronic/Tier2 positive screens referred to SW</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NUM_CH_REF_DCC</td>
<td>Number of Chronic/Tier2 positive screens referred to Dementia Care Consultant</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>PCT_CH_REF_DCC</td>
<td>Percentage of Chronic/Tier2 positive screens referred to Dementia Care Consultant</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NUM_CH_GOC</td>
<td>Number of Chronic/Tier2 positive screens with completed Goals of Care</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>PCT_CH_GOC</td>
<td>Percentage of Chronic/Tier2 positive screens with completed Goals of Care</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>NUM_CH_CGS</td>
<td>Number of Chronic/Tier2 positive screens with Caregiver Strain</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>PCT_CG_GCS</td>
<td>Percentage of Chronic/Tier2 positive screens with Caregiver Strain</td>
<td>4</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Tufts Health Plan Medicare Preferred - Member Level Variables

Note: The file is sent on a monthly basis and includes all members who have a new disposition code for the Complex, Tier 2 /Chronic, Transitions or Wellness Programs within the reporting month.

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Type</th>
<th>Length</th>
<th>Format</th>
<th>Values</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TMP_MID</td>
<td>Char</td>
<td>9</td>
<td></td>
<td></td>
<td>TMP Member ID</td>
</tr>
<tr>
<td>DATE_CASE_ASSIGNED</td>
<td>Date</td>
<td>8</td>
<td>DDMONYY*</td>
<td></td>
<td>Date the data is loaded and available to CM</td>
</tr>
<tr>
<td>REF_DATE</td>
<td>Date</td>
<td>8</td>
<td>DDMONYY</td>
<td></td>
<td>Date the file is received from THP or ad hoc referral received</td>
</tr>
<tr>
<td>REF_SOURCE</td>
<td>Char</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROGRAM_REFERRED</td>
<td>Char</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROGRAM_FOCUS_REFERRED</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>PROGRAM_ENROLLED</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>PROGRAM_FOCUS_ENROLLED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DATE_MBR_AGREED</td>
<td>Date</td>
<td>8</td>
<td>DDMONYY</td>
<td></td>
<td>Date the member agrees to participate (begin/schedule assessment)</td>
</tr>
<tr>
<td>DATE_ASSESSMENT_COMPLETE</td>
<td>Date</td>
<td>8</td>
<td>DDMONYY</td>
<td></td>
<td>Date initial assessment completed and initial care plan generated</td>
</tr>
<tr>
<td>DISPOSITION_CODE</td>
<td>Char</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DISPOSITION_DATE</td>
<td>Date</td>
<td>8</td>
<td>DDMONYY</td>
<td></td>
<td>Only changes when disposition is updated</td>
</tr>
</tbody>
</table>

**Note:** The file is sent on a monthly basis and includes all members who have a new disposition code for the Complex, Tier 2 /Chronic, Transitions or Wellness Programs within the reporting month.

**DISPOSITION_CODE**

- **ENROLLED - ACTIVE**: Assessment complete and initial care plan generated
- **ENROLLED - DISCHARGED**: Member declined
- **UNABLE TO CONTACT**: Member declined
- **CLINICALLY NOT APPROPRIATE**: i.e. custodial, hospice, unable to communicate
- **MIN REQUIREMENT NOT MET**: i.e. deceased, trimmed with the plan
- **INELIGIBLE**: i.e. deceased, trimmed with the plan

**Variables Description**

- **TMP_MID**: TMP Member ID
- **DATE_CASE_ASSIGNED**: Date the data is loaded and available to CM
- **REF_DATE**: Date the file is received from THP or ad hoc referral received
- **REF_SOURCE**: Referred discharge planning/transition of care
- **PROGRAM_REFERRED**: Referred via discharge planning or transition of care
- **PROGRAM_FOCUS_REFERRED**: Referral
- **PROGRAM_ENROLLED**: Those members that have opted into Custom Care and do not meet Complex or Tier 2 criteria
- **PROGRAM_FOCUS_ENROLLED**: Not classified
- **DATE_MBR_AGREED**: Date the member agrees to participate (begin/schedule assessment)
- **DATE_ASSESSMENT_COMPLETE**: Date initial assessment completed and initial care plan generated
- **DISPOSITION_CODE**: Assessment complete and initial care plan generated
- **DISPOSITION_DATE**: Only changes when disposition is updated

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**Originated 10/2013 11 of 12**

2019 Process Metrics

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2019 Process and Outcome Metric Reporting Requirements
The report on the following page is a sample of a Tier 2 Member Report.

### High Risk Member Report

<table>
<thead>
<tr>
<th>Med Group</th>
<th>PCP</th>
<th>Last Name</th>
<th>First Name</th>
<th>MID</th>
<th>DOB</th>
<th>M/S</th>
<th>Admits</th>
<th>CMS High Risk</th>
<th>Rx 7+</th>
<th>MS Admits</th>
<th>Top 20% Cost</th>
<th>55+</th>
<th>Falls Reg</th>
<th>Ambulance</th>
<th>Recent Freq</th>
<th>Pall Care Reg</th>
<th>Readmittd</th>
<th>Pall Care Reg</th>
<th>HF COPD</th>
<th>Admit Prob</th>
<th>Complex Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

*Newly Identified as Complex or Tier 2 (never previously identified in selected category)
*Newly Identified as Complex or Tier 2 (not identified in selected category within the last 3 mos)
The table on the following pages describes the Chronic Care Manager’s role.

<table>
<thead>
<tr>
<th>Essential Function</th>
<th>Description</th>
<th>Tools/Workflow</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Assessments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Assessments</td>
<td>Formal assessments that address both medical and psychosocial issues and required community supports</td>
<td>Chronic Illness Assessment (CIA) and Disease Specific Assessments (e.g., Chronic Obstructive Pulmonary Disease (COPD), heart failure)</td>
</tr>
<tr>
<td></td>
<td>Assess member’s readiness/commitment to change through completion of the appropriate assessment</td>
<td>Training regarding behavior change assessment</td>
</tr>
<tr>
<td><strong>Create Evidence-Based Plan of Care (POC) and Member Action Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop POC based on assessment results and member goals</td>
<td>Chronic Program Workflows</td>
</tr>
<tr>
<td></td>
<td>Solicit PCP and/or nurse practitioner (NP) input, as needed, to complete initial assessment within 14 to 21 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete all open initial assessments within 30 days of assignment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Using motivational interview and coaching techniques, work with the member and/or caregiver to develop an action plan that focuses on self-management of his/her disease (including symptom management), and enhances his/her active participation in medical care and decision-making</td>
<td>Action Plan templates</td>
</tr>
</tbody>
</table>
### Description of Chronic Care Manager

#### Coaching Members and Caregivers

<table>
<thead>
<tr>
<th>Provide the following:</th>
<th>• Welcome letter/action plan provided to member and PCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Information on wellness and self-management of chronic conditions</td>
<td>• Diagnosis-specific education material mailed</td>
</tr>
<tr>
<td>• Education and information about preventive health issues and recommended medical testing</td>
<td>• Motivational interviewing/coaching tips and tools</td>
</tr>
<tr>
<td>• The importance of complying with recommended treatments</td>
<td></td>
</tr>
<tr>
<td>• Communication with the member’s practitioner about his/her health conditions and treatments</td>
<td></td>
</tr>
</tbody>
</table>

#### Community Resource Development/Coordination of Care

<table>
<thead>
<tr>
<th>Consult with the PCP, specialists, subject matter experts, and/or pharmacist for medication literacy and/or adherence, as needed</th>
<th>• List of community agencies/resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to and consult with skilled home health care or community services/resources to facilitate management of member needs and goals</td>
<td>• Best Practice Metrics</td>
</tr>
<tr>
<td>NOTE: This can include specific vendors for tele-health monitoring, oxygen therapy, disease management programs at community hospital, disease-specific organizations, or at Councils on Aging</td>
<td></td>
</tr>
</tbody>
</table>

#### Ongoing Health Coaching

| • Assessment of member and caregiver’s ability to self-manage | • Ongoing health coaching with emphasis on assessing member and/or caregiver’s ability to follow physician treatment plans |
| • Ongoing health coaching with emphasis on assessing member and/or caregiver’s ability to follow physician treatment plans | • Complete weekly updates with focus on progress to goals and eliminating barriers to care |
The Skilled Nursing Facility (SNF) Rounding Program presentation follows.
THP SNF Rounding Model

- Focuses on managing medical and rehabilitation services in the SNF at the sub acute level
- The THP/vendor NP co-manages member with the receiving/attending MD at identified SNF’s
- THP/vendor NP first call 24/7
- The member’s plan of care is based on their individual functional improvement goals.
- Designed to enhance quality and functional status to promote positive outcomes
## Role of the THP Nurse Practitioner

- THP NP/Attending SNF MD co-management model
- THP NP provides “first call” coverage 24/7
  - Returns calls within 15 minutes of receipt
- Completes Admission History and Physical w/i 48 hrs of admission. Conduct medication reconciliation.
- Identifies and aligns member, caregiver goals
- Coordinates care with member, family, attending physician, group case manager, other members of interdisciplinary team
- Participates in weekly team conferences and family meetings
- Monitors members’ progress toward goals
- Facilitates members’ transition to the next level of care
  - PCP follow up visit is in place at time of discharge
  - Provide prescriptions for new medications with 30 day supply
  - Discharge summary note is faxed to PCP
NP Interfaces

◆ NP admits pt, evaluates medical needs and begins to develop plan of care. Communicates with member /family to validate and document baseline function, anticipated d/c destination and support system.

◆ NP communicates w/group CM and SNF MD rounder re: pt status.

◆ NP responsible for initiating and implementing POC while in the SNF. Communicates and collaborates w/facility CM re: POC.
Nurse Practitioner Interfaces

- Participates in wkly team meetings, gains team consensus for POC and d/c plan, communicates w/family and updates SNF rounder as necessary.
- Collaborates with facility team regarding progress/barriers toward goal and documents findings and plan.
- Based on team input, NP initiates discharge plan or change in level of care. Collaborates w/MD SNF rounder and group CM re: final discharge disposition. Documents episode of care and d/c plan, writes d/c orders.
- NP provides d/c summary to PCP.
Interfaces w/ Facility Staff

- Facility CM/SW communicate and collaborate w/NP on admission as to pt status, initial goals for treatment and tentative d/c destination and supports.
- Facility CM/SW initiate family contact to verify prior level of function, tentative d/c plan and support system. *Arranges for family meeting w/I 72 hrs.*
- Facility CM/SW facilitate wkly team meeting and family meetings.
- Facility staff communicates directly with NP regarding any concerns about medical management/ POC/d/c plan.
- Achieve team consensus for POC and d/c plan and ensure documentation supports POC, progress/barriers and team decisions.
- Facility CM communicates w/group CM re: authorizations and level changes.
- Facility CM collaborates w/ NP and other members of the team (SW, rehab, nsg) to initiate and implement d/c plan.
Role of the Medical Group’s Case Manager at the Enrolled SNF

Group CM is responsible to call Post Acute Program Coordinator with any potential SNF admissions

When a member is admitted to a SNF the CM will:

- Meet the member/family, clarify/validate baseline functional status, member/family goals and anticipated discharge plan.
- Participate in weekly care planning meeting, family meeting.
- Collaborate/communicate w/ NP re: goals, barriers to progress and facilitates any change in LOC.
- Review cases with NP, as necessary, to facilitate plan of care. Communicates functional goals, progress and any barriers to plan of care to PCP/Med Group at medical management meetings.
- Collaborates/communicates w/NP re: discharge plan, identifies preferred providers for post acute services/DME (as necessary).
Role of Group Case Manager (cont.)

- Complete authorization process to facilitate claims payment.
- Communicate regularly w/member/family regarding progress/barriers to goal and anticipated d/c plan/estimated length of stay.
- Collaborate with NP and facility CM to initiate discharge plan and delivery of advanced notice.
- Review medical record to ensure documentation supports plan of care (POC).
- Notify Program Coordinator of any custodial members with skilled needs as soon as possible.
**Physician Group Responsibilities**

- Identify MD facility rounder (or accept recommendation of THP care team) who will co-manage members in collaboration with THP NP
- Develop and support systems for coverage and communication to ensure continuity of care
- Leverage group medical management meetings to discuss/review SNF cases
- Ensure NP/CM access to Physicians in a timely basis
- Medical Director takes active role in ensuring appropriate and timely post discharge follow-up care
- Participate in regular meetings and forums to monitor quality and outcomes of SNF rounding program
SNF- Provider Responsibilities

- 24/7 admissions, direct ED admits, access to LTC beds
- Therapy 6x/wk, focusing on functional goals for d/c
- Access to clinical documentation
- Provide internal Case Manager to facilitate POC and continuity
- Communication and collaboration b/w internal and external CM, team, SNF rounder
- Facilitate initial team meeting w/i 72 hrs of admission and wkly thereafter with participation of external CM and SNF rounder
- Facilitate family meeting w/i 3-5 days of admission
- Clear identification of all SH members (ST and custodial)
- Patient education needs id’ed and teaching started at admission
- On going clinical assessment and mgmt of geriatric conditions
- Collaboration and support for Advance Notice process
- Participate in quarterly CQI and outcomes evaluation
A sample of an *Admission Companion Report* is on the following page.

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Date Of Birth</th>
<th>Member ID</th>
<th>Type</th>
<th>Facility Name</th>
<th>Admission Date</th>
<th>Diagnosis Description</th>
<th>Procedure Description</th>
<th>Attending Provider</th>
<th>PCP Name</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Future Elective</td>
<td>BRIGHAM AND WOMENS HOSP-INPT</td>
<td>12/21/2012</td>
<td>Merkel cell CA face</td>
<td>Exc deep cervical node</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Future Elective</td>
<td>NEW ENGLAND BAPTIST HOSP IN PT</td>
<td>12/26/2012</td>
<td>Osteoarthrosis NOS-low LE</td>
<td>Total knee replacement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>BETH ISRAEL DEACONESS MED-INPT</td>
<td>2/5/2010</td>
<td>Depressive disorder NEC</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Tewksbury Hospital</td>
<td>5/24/2012</td>
<td>Schizophrenia NOS-unspec</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Tewksbury Hospital</td>
<td>9/5/2012</td>
<td>Schizophrenic disorders</td>
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</tr>
<tr>
<td>Tewksbury Hospital</td>
<td>10/11/2012</td>
<td>Schizophrenia subch/exac</td>
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<td></td>
</tr>
<tr>
<td>Emerson Hospital - IN PT</td>
<td>12/5/2012</td>
<td>Psychosis NOS</td>
<td></td>
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</tr>
<tr>
<td>Norwood Hospital - PSYCH</td>
<td>12/8/2012</td>
<td>MDD one epis-NOS</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>St Elizabeths MED CTR - PSYCH</td>
<td>12/10/2012</td>
<td>Alcohol dep NEC &amp; NOS</td>
<td>Complex</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallmark Health Sys INPT PSYCH</td>
<td>12/13/2012</td>
<td>Dementia in CCE w behav</td>
<td></td>
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</tbody>
</table>
The following is a sample *Admission Companion Report Guide*.

### Daily Companion Report Guide
**Mental Health, Future Elective**

#### Overview
This report is a "Companion Report" to the daily Admission report. Like the Admission report this report will identify Complex, Tier 2/Chronic and Transition risk member’s activity. The information from this report can be used in your Complex, Chronic, or Transition Care Management care planning and communications with members and care team.

The data in this report was excluded from the Admission report because it does not need to be closed out or returned to Pre – Registration.

You will receive this report daily in a separate email from the Admission report. Opening it works the same way the Admission report does.

The report includes events in the TMP pre-registration system meeting the following criteria:
- Mental Health: will appear at time of admission and continue on report until the TMP Mental Health dept closes case with DC date.
- Future Elective: the report will display once, contain elective admissions that are pre-reg’d the day prior to report run regardless of how far into the future they fall. On date of admission this will appear on the Admission Report.

#### Opening and closing the report
The report will be sent in HTML format and depending on how you wish to use it you can save it to Excel. Remember you do not need to return it to TMP. Remember to follow HIPAA guidelines for maintenance of PHI.

**Example 1**
1. Left click on the report icon to open it.
2. Right click anywhere in the opened report and choose *Export to Excel*.
3. Then go to tool bar and choose *File, Save As*, to your preferred location.
4. Save the file with your description, IDN name, and today’s date.

**Example 2**
1. Right click on the attachment icon.
2. Choose *Open With*.
3. Choose *Excel* (double click or click *OK*).
4. Then go to tool bar *File > Save As* – with your description, IDN name or # and today’s date.
5. Change Save As type to *.xls*.

#### Report Details

<table>
<thead>
<tr>
<th>Report Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Group</td>
<td>Medical Group Provider Unit number at time of pre-registration</td>
</tr>
<tr>
<td>Member name</td>
<td></td>
</tr>
<tr>
<td>Report Column</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>Member ID</td>
<td>TMP Member ID</td>
</tr>
<tr>
<td>Admission Type</td>
<td>Mental Health or Future Elective</td>
</tr>
<tr>
<td>Facility Name</td>
<td>Location for admission outpatient procedure</td>
</tr>
<tr>
<td>Admission Date</td>
<td>Date of admission or date of scheduled Future Elective or Surgical Day Care procedure</td>
</tr>
<tr>
<td>Diagnosis Description</td>
<td>Diagnosis provided at time of pre-registration</td>
</tr>
<tr>
<td>Procedure Description</td>
<td></td>
</tr>
<tr>
<td>Attending</td>
<td>Attending Physician provided at time of pre-registration</td>
</tr>
<tr>
<td>PCP</td>
<td>Member’s PCP as of admission or pre-registration date</td>
</tr>
<tr>
<td>Priority</td>
<td>Indicates if the member met Complex, Tier 2/Chronic, or Transition Risk</td>
</tr>
<tr>
<td></td>
<td>Currently defined as:</td>
</tr>
<tr>
<td></td>
<td><strong>Complex:</strong> The member was identified as being in the top 3.5% for risk of an acute inpatient admission within the next 6 months.</td>
</tr>
<tr>
<td></td>
<td><strong>Tier 2/Chronic:</strong> The member was identified as being in the top 3.5 – 10% for risk of an acute inpatient admission within the next 6 months.</td>
</tr>
<tr>
<td></td>
<td><strong>Transition Risk:</strong> The member had at least 1 of the following readmission risk factors (from the High Risk algorithm)</td>
</tr>
<tr>
<td></td>
<td>At least one readmission in the last 12 months with 0-day lag</td>
</tr>
<tr>
<td></td>
<td><strong>OR</strong> The member was identified as having a fall in the last 12 months with 60-day lag, or has been classified as med-high risk for a future fall as of the last available Falls Registry identification date</td>
</tr>
<tr>
<td></td>
<td><strong>OR</strong> The member has been identified with CHF</td>
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<td></td>
<td><strong>OR</strong> COPD</td>
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<td></td>
<td><strong>OR</strong> In Palliative Care Registry</td>
</tr>
<tr>
<td></td>
<td><strong>OR</strong> has Rx 7 +</td>
</tr>
</tbody>
</table>
The table on the following page describes Integrated Delivery Network (IDN) deliverables required for IDN/Groups seeking status to be externally managed.
<table>
<thead>
<tr>
<th>Deliverable Category</th>
<th>End Point Deliverable</th>
<th>Time Frame</th>
<th>Status</th>
<th>Completion Date / Sign Off</th>
<th>Note: Primary Source is Integrated Care Management document</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. OPERATIONS:</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1a. Secure Gateway</td>
<td>Secure gateway established between IDN and Tufts Health Plan</td>
<td>Provide to TMP the CM contact information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1b. User Agreement for TMP Support Materials</td>
<td>Signed user agreement</td>
<td>TMP support materials disseminated to IDN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1c. IDN Responsibilities</td>
<td>Demonstrate understanding of IDN oversight responsibilities (see attached <em>Oversight Responsibilities of the Integrated Delivery Network (IDN)</em> document)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1d. Attestations</td>
<td>IDN must sign attestation that they will follow all requirements of:</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>1) TMP Care Management Resource Guide and</td>
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<td></td>
<td>2) CMS</td>
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<tr>
<td>1e. Staffing</td>
<td>Staffing plan and budget received from IDN</td>
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<tr>
<td></td>
<td>Staffing ratios for Care Management</td>
<td>Staffing statement from IDN acknowledging staffing ratios for 1:850, not including UM</td>
<td></td>
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<tr>
<td></td>
<td>CM embedded into PCP office setting</td>
<td>Plan for embedding CM into PCP office setting</td>
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<td></td>
<td>5% of time in PCP office</td>
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<td></td>
<td>Guided Care or comparable training for Complex Care Manager</td>
<td>Demonstrate completion of program</td>
<td></td>
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<tr>
<td></td>
<td>Chronic Care or comparable training for Chronic Care Manager</td>
<td>Demonstrate completion of training</td>
<td></td>
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<tr>
<td></td>
<td>Annual CEU requirement (5) in Geriatric Content</td>
<td>Demonstrate annual completion records</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1f. Job Descriptions and Competencies</td>
<td>Job Descriptions for:</td>
<td></td>
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<tr>
<td></td>
<td>Complex CM</td>
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<tr>
<td></td>
<td>Chronic CM</td>
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<td></td>
<td>Utilization (CNL) CM</td>
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<td>Competencies for:</td>
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<td></td>
<td>Complex CM</td>
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<td></td>
<td>Chronic CM</td>
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<tr>
<td></td>
<td>Utilization (CNL) CM</td>
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<tr>
<td>1g. Case Management Training Materials and Plan</td>
<td>CM role in Medical Management: Collaboration with Medical Directors and PCPs for Integrated Care Management</td>
<td>Demonstrate understanding:</td>
<td></td>
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<tr>
<td></td>
<td>Inpatient Management:</td>
<td>Inpatient criteria or comparable</td>
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<tr>
<td></td>
<td></td>
<td>TMP payment policies</td>
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<td></td>
<td></td>
<td>Discharge Planning</td>
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<td></td>
<td></td>
<td>Hospital Fast Track Appeal process</td>
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</tbody>
</table>
## Integrated Care Management Model Deliverables

<table>
<thead>
<tr>
<th>Deliverable Category</th>
<th>End Point Deliverable</th>
<th>Time Frame</th>
<th>Status</th>
<th>Completion Date / Sign Off</th>
<th>Note: Primary Source is Integrated Care Management document</th>
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</thead>
<tbody>
<tr>
<td><strong>SNF Management:</strong></td>
<td></td>
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<tr>
<td></td>
<td>CMS level of care criteria</td>
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<td></td>
<td>TMP payment policies</td>
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<td></td>
<td>Discharge Planning</td>
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<td></td>
<td>SNF Fast Track Appeal process</td>
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<td>Part b benefit</td>
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<tr>
<td><strong>Home Health Management</strong></td>
<td>CMS level of care criteria</td>
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<tr>
<td></td>
<td>TMP payment policies</td>
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<tr>
<td></td>
<td>HHA Fast Track Appeal Process</td>
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<tr>
<td><strong>Transition Management</strong></td>
<td>CMS level of care criteria</td>
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<tr>
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<td>TMP payment policies</td>
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<td></td>
<td>HHA Fast Track Appeal Process</td>
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<tr>
<td><strong>Chronic Tier 2 Care Management</strong></td>
<td>CMS level of care criteria</td>
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<td></td>
<td>TMP payment policies</td>
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<tr>
<td></td>
<td>Organizational Determination Process</td>
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<td></td>
<td>Out of Area management</td>
<td></td>
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</tr>
<tr>
<td><strong>Training plan</strong></td>
<td>developed for each group Case Manager</td>
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<tr>
<td><strong>CMs</strong></td>
<td>Training completed for each group Case Manager</td>
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<tr>
<td></td>
<td>CMs/ Medical Directors</td>
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</tbody>
</table>

### 1h. Operations Workflows

Workflows for utilization management and level of care authorization (i.e. process to review day of admission (DOA) report and inpatient/outpatient authorization and note documentation)

Sample Inpatient Authorization Screen (provide screenshot)

- **Required components include:**
  - Member Name
  - Member DOB
  - Member Age
  - Member THPMP ID#
  - Admitting Hospital Name
  - Admitting Diagnosis
  - Admission Date
  - Actual Discharge Date
  - Admit Type Description
  - Admit Status Description
  - Admission Class
  - PCP Name
<table>
<thead>
<tr>
<th>Deliverable Category</th>
<th>End Point Deliverable</th>
<th>Time Frame</th>
<th>Status</th>
<th>Completion Date / Sign Off</th>
<th>Note: Primary Source is Integrated Care Management document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Outpatient Authorization Screen</td>
<td>Required components includes: Member Name, Member DOB, Member Age, Member THPMP ID#, Provider/Vendor Name, Diagnosis, Start Date, End Date, Number of visits, Service Type, PCP Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample Authorization Note</td>
<td>Name, DOB, Sex, Tufts Medicare Preferred Member ID, Event date, Current Living Situation, Prior Level of Function, Caregiver detail, Advance Directives type, Prior Services, Co Morbidities, Admit type, Discharge Plan, Who this plan has been discussed with, Comment box for narrative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work flows for utilization performance review using Group Level Days reports and Utilization charts</td>
<td></td>
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</tr>
<tr>
<td>1i. Medical Management and Quality Improvement Plan</td>
<td>Established medical management / QI meeting meeting schedules and agreement to adopt TMP QI work plan</td>
<td></td>
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<tr>
<td>1j. Medical Group Profile</td>
<td>Identify preferred providers: SNF, Home care, Other, Complete Medical Group Profile (one for each group)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
## 2. INTEGRATED CARE MANAGEMENT IMPLEMENTATION

### 2a. Medical Management Training and Plan

<table>
<thead>
<tr>
<th>Deliverable Category</th>
<th>End Point Deliverable</th>
<th>Time Frame</th>
<th>Status</th>
<th>Completion Date / Sign Off</th>
<th>Note: Primary Source is Integrated Care Management document</th>
</tr>
</thead>
<tbody>
<tr>
<td>TMP leadership organization</td>
<td>Create a cascade of information from Medical Directors meeting</td>
<td></td>
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<tr>
<td></td>
<td>Develop a mechanism to ensure reports are distributed to Medical Leaders</td>
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<tr>
<td></td>
<td>Demonstrate ability to profile physicians and provide feedback on individual performance</td>
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</tr>
<tr>
<td></td>
<td>Create PCP incentives for actions needed to achieve goals (example: managing transitions, going to Medical directors meetings etc.)</td>
<td></td>
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</tr>
<tr>
<td>Managed Medicare basics (TMP)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Office Management</td>
<td>Physician documentation to support coding</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Demonstrate understanding of Referral Management to preferred circles</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Demonstrate understanding of Organizational Determination and office staff role</td>
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<td>Role of office in providing information for an OD OD timeframes</td>
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<td></td>
<td>Demonstrate understanding of Chronic illness and Geriatric conditions (end of life, dementia, falls, incontinence etc.)</td>
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<td>Demonstrate understanding of Ogranizational Determination and office staff role</td>
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<td>Transitions of Care and Post D/C follow up visit</td>
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<td>Demonstrate understanding of CMS criteria for LTAC and Acute Inpatient Rehab level of care</td>
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<td>Demonstrate preferred provider relationships, including SNF and home care</td>
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<td>Demonstrate understanding of CMS criteria for SNF care, Custodial level of care and Part B services and DME</td>
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### Integrated Care Management Model Deliverables

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<td><strong>Plan to impact ER</strong></td>
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<td>- Develop a relationship with hospitalists at home hospital</td>
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<td>- Plan to measure and improve member access to PCP office</td>
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<td></td>
<td>- Hospitalist coverage of ER</td>
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<td><strong>Behavioral Health</strong></td>
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<td></td>
<td>- Know whether group is PCP directed or has a Designated Facility (DF)</td>
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<td>- If PCP directed, develop Behavioral Health network</td>
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<td></td>
<td>- Understand role of DF and Tufts Behavioral Health Department in managing Inpatient mental health admissions</td>
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<td>- Demonstrate understanding of Integrated Care Management Model and PCP role in Ad Hoc referrals to programs</td>
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<td></td>
<td>- Demonstrate understanding of Care Manager roles for Complex, Chronic and Transition mgnt</td>
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<td></td>
<td>- Demonstrate understanding purpose and Plan for Medical Management meetings and Quality committee meetings</td>
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<td><strong>Training Plan developed for all of above content for each medical group:</strong></td>
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<td>- IDN Medical Director</td>
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<td>- Group / Pod Medical Director</td>
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<td>- PCPs</td>
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<td>- Office Staff</td>
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<td>- PCPs</td>
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<td>- Office Staff</td>
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<td></td>
<td><strong>Demonstrate Competencies as a result of trainings</strong></td>
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#### 2b. Care Management Software System

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<td><strong>Identify CM software system</strong></td>
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<td><strong>Provide for review high level business requirements</strong></td>
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<td></td>
<td><strong>Document final IT specifications</strong></td>
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<td></td>
<td><strong>Timeline for IT build, including anticipated completion date</strong></td>
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<td><strong>Demonstrate integration of software system, including:</strong></td>
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<td>- Complex assessment, care plans, action plans and interventions that meet program specifications</td>
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<td></td>
<td>- Chronic assessment, care plans, action plans and interventions that allow for care planning and monitoring of chronic diseases. Required to include, but is not limited to:</td>
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<td>- CHF</td>
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<td>- COPD</td>
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<td>- Falls</td>
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<td>- CAD/CHF (2012 CMS Requirement)</td>
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### Integrated Care Management Model Deliverables

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<tbody>
<tr>
<td><strong>Transition</strong></td>
<td>Transition assessment, care plans, action plans generated with goal of member/caregiver independence in 30-45 days. Required to address, but not limited to:</td>
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<td></td>
<td>Medication adherence</td>
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<td>Fall risk</td>
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<tr>
<td></td>
<td>Understanding of 'red' and 'yellow' flags</td>
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<td></td>
<td>Self management deficits</td>
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<td>Psychological deficits</td>
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<td></td>
<td>All assessments demonstrate integration of clinical practice guidelines</td>
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<td></td>
<td>Demonstrate integration of software system in use</td>
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#### 2c. Care Management Program Specifications

**Initiatives to Manage Transition of Care**

- Demonstrate process for post-discharge telephone calls
- Identification of members
- Screening call script for 1 call
- Triage process to transitions program (for those members who verbalize low confidence or who have other care needs - see transitions program below)
- Demonstrate process for post-discharge follow up for PCP visits within seven (7) days of discharge
- Who schedules appointment and how is member made aware of appointment
- Plan to address appointment access issues

**Transitions Program Components**

- Transition assessment, care plans, action plans and interventions with goal of member/caregiver independence in 30-45 days. Required to address, but not limited to:
  - Readmission risk
  - Medication adherence
  - Fall risk
  - Understanding of 'red' and 'yellow' flags
  - Self management deficits
  - Psychological deficits

**Documentation Required:**

- Initial assessment
- Care plans
- Action plans
- Interventions

**Criteria for:**

- Admission to program
- Transitions referral
- Disposition

**Workflows for:**

- TMP list management
- Ad hoc referrals
- Case assignment to CM
- Ongoing care management

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<td>Complex Care Management</td>
<td>Signed policy attestation OR provide own written policy for managing complex</td>
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<td>Complex Clinical Practice Guidelines</td>
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<td>Complex Program Components:</td>
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<td>Initial assessment within 30 days. Assessment should include the following components:</td>
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<td></td>
<td>Initial assessment of member health status, including condition specific issues</td>
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<td>Documentation of clinical history, including medications</td>
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<td>Initial assessment of the activities of daily living (ADLs) and independent activities of daily living (IADLs)</td>
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<td>Initial assessment of the mental health status, including cognitive functions</td>
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<td>Evaluation of cultural and linguistic needs, preferences and limitations</td>
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<td>Evaluation of the visual and hearing needs, preferences and limitations</td>
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<td>Evaluation of available benefits from the organization and community resources</td>
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<td>Assessment of life-planning activities</td>
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<td>Assessing patient progress towards goals</td>
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<td>Care plan with prioritized goals</td>
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<td>Creating Member action plan</td>
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<td><strong>Chronic Care Management</strong></td>
<td>Signed Policy Attestation OR Provide Own Written Policy for Managing Chronic - CHF, COPD</td>
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<td></td>
<td>Ad hoc referrals</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Case assignment to CM</td>
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</tr>
<tr>
<td></td>
<td>Ongoing care management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3. Reporting

#### 3a. Monthly Reporting

Demonstrate **understanding** of metrics reporting requirements for:

- Monthly member level file
  - Complex
  - Chronic
  - Transition
- Care giver Strain file
- SF12v2 file

Demonstrate appropriate reporting file formats for:

- Monthly member level file
- Care giver Strain file
- SF12v2 file

#### 3b. Quarterly Reporting

Demonstrate **understanding** of metrics reporting requirements for quarterly reporting.
# Integrated Care Management Model Deliverables

<table>
<thead>
<tr>
<th>Deliverable Category</th>
<th>End Point Deliverable</th>
<th>Time Frame</th>
<th>Status</th>
<th>Completion Date / Sign Off</th>
<th>Note: Primary Source is Integrated Care Management document</th>
</tr>
</thead>
<tbody>
<tr>
<td>3c. Reporting Schedule*</td>
<td>TMP provide IDN with monthly process metrics and quarterly outcome metrics reporting schedule (see att)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* see attached 2012 Process and Outcome Metric Reporting Requirements

## 4. Member Transition Plan

### 4a. Vendor Transition
- d/c Date (contract notice)
- d/c Date

### 4b. CM Program Transition
- Demonstrate plan for transition of members from Think Health Complex Chronic Transitions
- Complex
- Chronic
- Transitions
- December 11, 2012 (if transitioning members from internally managed)

### 4c. Transition of Members Receiving Services
- Plan to transition members receiving services in:
  - Acute hospital inpatient
  - LTAC / rehab hospital inpatient
  - SNF
  - Home care
  - DME
  - Other
The table on the following page describes Integrated Delivery Network (IDN) responsibilities.

<table>
<thead>
<tr>
<th>Task</th>
<th>IDN Responsibility</th>
<th>IDN Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administrative processes with accountability for completion of the end-to-end process</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IDN intercedes as necessary to facilitate completion of these administrative processes.</td>
<td></td>
</tr>
<tr>
<td><strong>Claims payment processes such as review of 10-day claims report, with timely resolution of claims discrepancies</strong></td>
<td></td>
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<tr>
<td><strong>Timely submission of authorization logs to facilitate claims payment</strong></td>
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<tr>
<td><strong>Identifies cases for potential &quot;bridging&quot; review, or other medical claims review triggers</strong></td>
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<tr>
<td><strong>Process and structure</strong></td>
<td></td>
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<tr>
<td><strong>Facilitate/support development and implementation of Quality Improvement Plan with documented monthly Quality improvement meetings</strong></td>
<td></td>
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<tr>
<td><strong>Submission of Quality events</strong></td>
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<tr>
<td><strong>Medical group identifies and develops collaborative relationship with selected referral circle and monitors utilization trends and leakage</strong></td>
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</tr>
<tr>
<td><strong>Compliance with regulatory guidelines and criteria and associated processes and workflows</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CMS policies and procedures; provide training, support and oversight for all regulatory processes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monitor performance to identify trends/patterns and opportunity for improvement in process or outcome and develop specific action plans as needed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specific compliance tasks:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Member requests, organizational determinations, and appeals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Fast track appeals and clinical reinstatements associated with NPDRC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Member non-compliance issues;</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benefit Management: provide informational updates and educational resource to groups and care managers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specific updates include:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Annual changes in TMP Evidence of Coverage (EOC), Summary of Benefits, prior authorization, and referrals;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E CMS coverage guidelines;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Access to CMS website</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orientation, education and training</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>New group training and ongoing record reviews</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IDN responsible for clinical training and competencies (via record reviews) of all providers in its network.</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing education and training to meet compliance or regulatory requirements/standards</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assess competency of all Care Managers on hire and annually.</td>
<td></td>
</tr>
<tr>
<td><strong>Provide Floater Holiday coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IDN is aware of Tufts Floater Holidays and early close days. Provides voice mail coverage messages for these times.</td>
<td></td>
</tr>
<tr>
<td><strong>Annual CEUs in Geriatric Content</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IDN maintains records of CM staff annual CEUs in Geriatric content (5 CEU annually)</td>
<td></td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facilitate communication between TMP MP and individual groups/care managers regarding changes or updates in process, administrative, coverage, compliance, or business policies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IDN CM leadership will participate in TMP MP IDN Webinars and convey information to IDN medical groups and Care Managers.</td>
<td></td>
</tr>
<tr>
<td><strong>Collaboration and Support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Collaborate with TMP MP Clinical Consultants and medical group/care managers to:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Monitor performance toward targets;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IDN will participate and collaborate with Provider Engagement Clinical consultants monthly and quarterly for IDN steering meetings.</td>
<td></td>
</tr>
</tbody>
</table>
IDN Responsibilities

- Develop, revise plans to improve outcomes/ performance;
- Develop strategies for members who present Management or adherence challenges
This appendix contains the following information regarding the Six Item Screener:

- Six Item Screener Primary Literature
- Six Item Screener Assessment
- Six Item Screen Work Flow
- Example of Provider Notification via Fax
Six-Item Screener to Identify Cognitive Impairment Among Potential Subjects for Clinical Research

Christopher M. Callahan, MD,† Frederick W. Unverzagt, PhD,‡ Su L. Hui, PhD,† Anthony J. Perkins, MS,† and Hugh C. Hendrie, MB, CHB*†‡

Objective. To design a brief cognitive screener with acceptable sensitivity and specificity for identifying subjects with cognitive impairment.

Design. Cohort one is assembled from a community-based survey coupled with a second-stage diagnostic evaluation using formal diagnostic criteria for dementia. Cohort two is assembled from referrals to a specialty clinic for dementing disorders that completed the same diagnostic evaluation.

Setting. Urban neighborhoods in Indianapolis, Indiana and the Indiana Alzheimer Disease Center.

Patients. Cohort one consists of 344 community-dwelling black persons identified from a random sample of 2212 black persons aged 65 and older residing in Indianapolis; cohort two consists of 651 subject referrals to the Alzheimer Disease Center.

Measurements. Formal diagnostic clinical assessments for dementia including scores on the Mini-mental state examination (MMSE), a six-item screener derived from the MMSE, the Blessed Dementia Rating Scale (BDRS), and the Word List Recall. Based on clinical evaluations, subjects were categorized as no cognitive impairment, cognitive impairment-not demented, or demented.

Results. The mean age of the community-based sample was 74.4 years, 59.4% of the sample were women, and the mean years of education was 10.1. The prevalence of dementia in this sample was 4.3% and the prevalence of cognitive impairment was 24.6%. Using a cut-off of three or more errors, the sensitivity and specificity of the six-item screener for a diagnosis of dementia was 88.7 and 88.0, respectively. In the same sample, the corresponding sensitivity and specificity for the MMSE using a cut-off score of 23 was 95.2 and 86.7. The performance of the two scales was comparable across the two populations studied and using either cognitive impairment or dementia as the gold standard. An increasing number of errors on the six-item screener is highly correlated with poorer scores on longer measures of cognitive impairment.

Conclusions. The six-item screener is a brief and reliable instrument for identifying subjects with cognitive impairment and its diagnostic properties are comparable to the full MMSE. It can be administered by telephone or face-to-face interview and is easily scored by a simple summation of errors. (Med Care 2002; 40:771–781)
inclusion or exclusion criteria. Excluding subjects with cognitive impairment may be desirable when the study relies on self-reports of functioning, mood, health-related quality of life, or health services utilization as outcome measures. Other investigators may adjudge that adherence to specific self-care behaviors, study protocols, or other complex tasks require intact cognitive function. Scientists studying dementing disorders often seek to efficiently screen a large numbers of subjects in a first-stage assessment to identify those patients most likely to meet criteria for dementia in a second-stage assessment. Despite the frequent goal to efficiently identify older adults with cognitive impairment or identify those with a high probability of dementing disorders, there is no consensus on how to best balance the need for accuracy with limited resources and time.

Clearly, these issues are not limited to research. Clinicians faced with the resource constraints of daily clinical practice also seek screening tests, which can balance accuracy with efficiency. There are already numerous measures of cognitive impairment developed for use in clinical settings. These instruments typically range from 10 to 30 items. Most of these questionnaires have demonstrated sensitivity and specificity as an aid to the diagnosis of dementia. Unfortunately, these instruments can take from 7 to 15 minutes to complete and some require props, paper, and pencil, or other face-to-face interactions. In addition, these longer scales do not always perform with greater accuracy in comparison to shorter scales. One solution to the time burdens of these longer questionnaires has been two-stage screening. For example, Lachs et al have suggested using three-item recall as an initial screen for cognitive impairment followed by the Mini-Mental State Examination (MMSE) for those patients unable to recall all three items. This first-stage screen is reported to have excellent sensitivity (97%), but poor specificity (43%) which makes it useful as an initial screen to identify those subjects unlikely to have the condition.

However, in some clinical trials, investigators may be more interested in optimizing specificity. For example, in the design of an ongoing multisite study of late life depression, investigators were faced with the challenge of balancing the need to exclude older adults who would be unable to provide self-reports or adhere to the protocol with the competing goal to include older adults who might have poor cognitive performance because of a treatable depression. Indeed, it is often difficult to determine what magnitude of cognitive impairment renders a potential subject ineligible for meaningful participation. Many patients with mild cognitive impairment may be capable of providing self-reports and following study protocols. An overzealous exclusion of subjects with mild cognitive impairment might unnecessarily reduce the generalizability of a study. Thus, different studies would be expected to make different choices in balancing the competing needs for sensitivity and specificity.

We sought to develop a brief screen for cognitive impairment that would balance diagnostic accuracy with the logistic demands of screening a large group of subjects in an efficient manner. This report provides a detailed description of the sensitivity, specificity, and predictive value of a six-item screener for cognitive impairment among older adults. There are several advantages of this six-item screener over existing scales in addition to its brevity. First, each of the six items comes from the MMSE, which allows for comparison among the many studies utilizing this longer questionnaire. Second, the six-item screener can be administered over the telephone and it is scored simply by summing the number of errors. Third, the diagnostic performance of the scale can be varied by choosing a cut-off score to match the study goals. The six-item screener is offered as an efficient tool to identify patients with cognitive impairment either as a one-stage screen with acceptable specificity to exclude those with moderate to severe impairment, or as the first stage of a two-stage screen to identify probable cases of dementia.

Materials and Methods

Study Samples

The impetus for this study was the need for a brief cognitive screener to efficiently exclude patients with moderate to severe cognitive impairment in a multisite study of late life depression. The data for this study come from two projects funded by the National Institute on Aging that are investigating the prevalence, incidence, risk factors, and treatment of dementia. The first source of subjects is a study on the prevalence of dementia among a community-based sample of black persons. The second source is from the subjects...
assembled from referrals to the Indiana Alzheimer Disease Center. Both groups of subjects complete the same clinical evaluation process by the same group of clinicians associated with the Indiana Alzheimer Disease Center. However, in the first sample, subjects are identified by a community-based screening program and in the second sample, subjects are referred to the Center. The two samples are described below followed by a description of the common clinical evaluation.

For the community-based sample, the geographic target area consisted of 29 contiguous census tracts with a total population of 82,387 and total households of 32,954 in the 1990 US Census. Black persons comprised 86% of this population, which also represents more than two-thirds of Indianapolis’ elderly black population. A random sample of 60% of residential addresses was constructed by the Indianapolis Water Company using all residential addresses in the target area, and identified homes were then visited by interviewers from May 1, 1992-April 30, 1993. Patients residing in nursing homes are not included in this sample. Eligible subjects had to be (1) a resident at a sampled address, (2) black, and (3) age 65 years or older. A total of 7590 households were approached, 4915 of which did not have an eligible resident. Of the 2582 eligible persons, 2212 (85.7%) agreed to participate. These subjects were screened with the Community Screening Instrument for Dementia (CSI-D).

Details of the development, content, scoring, and psychometric properties of the CSI-D have been previously published. Briefly, the CSI-D is composed of two parts: a 33-item scale assessing the subject’s cognitive performance and a 24-item scale assessing a relative’s perception of a decline in the subject’s functional or social abilities. Items for the CSI-D were selected from several widely used screening instruments including the Cambridge Mental Disorders in the Elderly Examination, the Mini-Mental State Examination, the Dementia Rating Scale, the Comprehensive Assessment and Referral Evaluation, and the East Boston Memory Test. The items selected test cognitive function across multiple domains but specifically exclude literacy dependent items. A discriminant function was derived in developmental work on the CSI-D to establish an empirically derived cut-off score that best differentiated between demented and nondemented with a structured clinical assessment as the gold standard. Subjects were classified into “poor,” “intermediate,” or “good” performance groups based on their discriminant function score. In a community prevalence study, the sensitivity of the CSI-D was 87% and the specificity was 83%.

A stratified sample of the community-based subjects was selected for full clinical assessments based on their performance on the CSI-D. All subjects who scored poorly on the CSI-D were invited for clinical assessments and we also selected a 50% sample of those with intermediate performance, and a 5% sample of those with good performance. Patients aged 75 and older were over-sampled in the 5% sample so that 75% of the patients with good performance on the CSI-D would be 75 years of age or older. Rates of cognitive impairment, dementia, and Alzheimer’s disease among this community-based sample have been previously published. The impact of age, gender, education, and occupation on cognitive performance in this sample has also been previously published. There were 351 patients selected for full clinical assessments but seven were too severely impaired to complete the standardized questionnaires. Data for the remaining 344 (98%) subjects are included here.

The second set of subjects comes from patient referrals to the Alzheimer Disease Center at the Indiana University School of Medicine. The differences in sampling strategies for these two samples are considerable and are reflected in the demographic and clinical characteristics provided in Table 1. Patients are referred to this Center both for diagnosis and for treatment and it is the only Center of its kind in Indiana. Notably, patients from this sample are not initially screened but referred by family, caregivers, or providers for evaluation. Thus, the CSI-D is not performed as the first stage assessment of the clinical sample. The clinical sample is not limited to black persons who were the focus of the community-based study described above. There were 662 subjects referred for the clinical assessment, but eleven were too severely impaired to complete the standardized questionnaires. Data for the remaining 651 (98%) subjects are included here.

Clinical Assessments

All clinical assessments of subjects from the community-based cohort were made blinded to the screening status. A geriatric psychiatrist or neurologist conducted a complete physical and
neurologic examination. Cognitive assessments included the MMSE, the cognitive performance portion of the CAMDEX, and the Consortium for Establishment of Registry for Alzheimer Disease (CERAD) battery. In addition to the MMSE, the CERAD battery includes the Animal Fluency Test (a measure of semantic fluency in which subjects generate as many names of animals as possible in 60 seconds), the Boston Naming Test (a 15-item test of confrontation naming of line drawings of objects), Constructional Praxis (a test of graphomotor skill in which subjects copy geometric figures), and the Word List Recall (a 10-item word list is presented three times with free recall and recognition assessed after a brief, filled interval). Where possible, a relative of the subject was also interviewed. A research nurse met with a spouse or other relative and completed the semi-structured Informant Interview. The interview provides information on the presence, duration, and severity of symptoms of memory, language, judgment and reasoning, and personality change. Informants are also asked to characterize the subject’s performance of instrumental and basic activities of daily living (ADLs). The CERAD-modified version of the Blessed Dementia Scale was calculated from the Informant Interview for those subjects where an informant could be interviewed. The Blessed consists of 11 items assessing memory, comprehension, shopping/money management, performance of household chores, dressing, feeding, and toileting.

On the basis of the above evaluation, participants were classified as normal, cognitive impairment-not demented, or demented. Patients were diagnosed as cognitive impairment-not demented if: (1) the informant reported a clinically significant decline in cognition; (2) the physician detected a clinically significant impairment in cognition; or (3) the participant's scores on cognitive testing fell below the 7th percentile; and if there was no clinically important impairment in the performance of activities of daily living. The 7th percentile is approximately equivalent to 1.5 standard deviations (SD) below the mean, the level of impairment specified by Mayo Clinic in their criteria for mild cognitive impairment. For a diagnosis of dementia both DSM-III-R and ICD-10 criteria had to be satisfied. On the basis on this clinical assessment, patients were dichotomized into demented and nondemented groups. Patients with dementia were then further categorized into those with and without possible or probable Alzheimer disease as defined by NINCDS/ADRDA criteria. For the purposes of the current study, we focus on the diagnosis of normal, cognitive impairment-not demented, or dementia. In all tables, the cognitive impairment group includes both patients with the “cognitive impairment-not demented” diagnosis and the dementia diagnosis.

### Design of Six-Item Screener

In designing the six-item screener, we sought to balance the instrument’s diagnostic properties with brevity, ease of administration, and validity. Because investigators working on different projects might seek to optimize sensitivity as opposed to specificity or vice versa, we also sought...
to design a screener that would allow a variety of “cut-off points.” The hallmark of dementia is a deficit in short-term memory. The MMSE is heavily loaded with memory items though some are more sensitive than others. For example, temporal disorientation occurs before disorientation to place. Within temporal orientation, problems with day of the week, month, and year are rarely seen in those not experiencing dementia (high specificity). Three-object recall is the best assessment of new learning ability in the MMSE and has consistently been identified as having excellent discrimination for identification of subjects with cognitive impairment (high sensitivity). Three-object registration has more to do with language, hearing, and attention. Although registration is a necessary step in successful recall, it does not in itself discriminate well between those with and without dementia. The rest of the MMSE items tap language, attention, or praxis and while any of these may be impaired in any given patient with dementia, no one domain or item is reliably implicated, some of these items are more sensitive to education, and some require props or motor skills not assessable by telephone. Thus, we chose the three-item recall (apple, table, penny) and three-item temporal orientation (day of the week, month, year) to design the six-item screener. Notably, the three-item recall question in the CSI-D is “boat, house, and fish” consistent with prior work on this instrument.12

We present the sensitivity, specificity, predictive value, and area under the receiver operating characteristic (ROC) curve for the six-item screener using cognitive impairment as the gold standard and then with dementia as the gold standard. Analyses of the community-based sample analyses are weighted, with individual weights being inversely proportional to the sampling proportion in that stratum. To compare the performance of the six-item screener with the full MMSE, we present the diagnostic properties of the MMSE in this same population and report the mean scores and ranges on the MMSE, Word List Recall, and Blessed Dementia scale at each level of subject performance on the six-item screener. As noted above, approximately 2% of both sample populations could not be tested on the MMSE because of the severity of their impairment. Among the subjects adjudged to be testable, coding of responses to the MMSE required that the respondent provide the correct answer or the item was coded as incorrect. However, 21% of the community-based sample and 8% of the clinical sample either refused or could not perform the Word List Recall. Also, 53% of the community-based sample and 31% of the clinical sample did not have an informant and therefore do not have scores on the Blessed Dementia Rating Scale.

**Results**

Table 1 provides the clinical characteristics of the two samples. As would be expected from the differences in sampling strategy, the community-based sample consists of black persons who are older, less educated, and less likely to have cognitive impairment or dementia as compared with the Alzheimer Disease Center sample.

Tables 2 to 5 present the diagnostic properties of the six-item screener as compared with the MMSE

### Table 2. Sensitivity, Specificity, and Predictive Value of Six-Item Screener Among the Community-Based Sample

<table>
<thead>
<tr>
<th>Six-item Screener</th>
<th>Cognitive Impairment as Gold Standard</th>
<th>Dementia Diagnosis as Gold Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sens</td>
<td>Spec</td>
</tr>
<tr>
<td>≥0</td>
<td>344</td>
<td>100.0</td>
</tr>
<tr>
<td>≥1</td>
<td>273</td>
<td>97.7</td>
</tr>
<tr>
<td>≥2</td>
<td>190</td>
<td>74.2</td>
</tr>
<tr>
<td>≥3</td>
<td>120</td>
<td>50.4</td>
</tr>
<tr>
<td>≥4</td>
<td>75</td>
<td>27.8</td>
</tr>
<tr>
<td>≥5</td>
<td>45</td>
<td>14.8</td>
</tr>
<tr>
<td>6</td>
<td>18</td>
<td>4.7</td>
</tr>
</tbody>
</table>

MMSE = Mini-mental state examination; Sens = sensitivity; Spec = specificity; PPV = positive predictive value; NPV = negative predictive value; ADC = Alzheimer’s Disease Center.
using cognitive impairment or dementia as the gold standard in both the community-based and clinic-based patient populations. It must be stressed that these two instruments are being compared in the same population(s) of patients against a separate gold standard clinical diagnosis. In addition to sensitivity and specificity, we present the positive and negative predictive values. Predictive value is a property both of the sensitivity and specificity of the test and the prevalence of the disease in the population under study. A test with higher sensitivity optimizes negative predictive value whereas a test with higher specificity optimizes positive predictive value.

As demonstrated in Tables 2 to 5, the six-item screener performs well in comparison with the longer MMSE. In both populations and using either gold standard, one can identify a cut-off score on the six-item screener that would compare favorably with the MMSE in terms of diagnostic accuracy. Indeed, as a first stage screening tool among a community-based population to identify subjects with cognitive impairment the six-item screener performs at least as well as the MMSE. The six-item screener performs less well in comparison to the full MMSE when one compares the instruments in a population with a high prevalence of disease and using dementia as the gold standard. However, even in this population, one can choose a cut-off score that optimizes sensitivity and specificity. Table 6 compares the area under the ROC curves for the six-item screener as compared with the MMSE.

Table 7 compares the mean scores of three other commonly used instruments to screen for cognitive impairment with scores on the six-item screener. Mean MMSE, Word List recall, and Blessed Dementia Scale scores progressively worsen as the number of errors on the six-item screener increase. This finding is consistent across all three comparison scales and at each level of

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**Table 3.** Sensitivity, Specificity, and Predictive Value of the MMSE Among the Community-Based Sample

<table>
<thead>
<tr>
<th>MMSE Score</th>
<th>N</th>
<th>Sens</th>
<th>Spec</th>
<th>PPV</th>
<th>NPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤27</td>
<td>269</td>
<td>91.5</td>
<td>56.2</td>
<td>42.9</td>
<td>94.9</td>
</tr>
<tr>
<td>≤26</td>
<td>241</td>
<td>76.5</td>
<td>10.9</td>
<td>10.4</td>
<td>89.6</td>
</tr>
<tr>
<td>≤25</td>
<td>206</td>
<td>71.5</td>
<td>87.3</td>
<td>66.9</td>
<td>89.5</td>
</tr>
<tr>
<td>≤24</td>
<td>172</td>
<td>53.3</td>
<td>92.1</td>
<td>70.9</td>
<td>84.6</td>
</tr>
<tr>
<td>≤23</td>
<td>213</td>
<td>44.4</td>
<td>93.2</td>
<td>70.1</td>
<td>82.4</td>
</tr>
<tr>
<td>≤22</td>
<td>108</td>
<td>39.9</td>
<td>94.8</td>
<td>72.8</td>
<td>81.2</td>
</tr>
</tbody>
</table>

**Table 4.** Sensitivity, Specificity, and Predictive Value of Six-Item Screener Among the ADC Clinical Sample

<table>
<thead>
<tr>
<th>Six-item Screener Errors</th>
<th>N</th>
<th>Sens</th>
<th>Spec</th>
<th>PPV</th>
<th>NPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>651</td>
<td>100.0</td>
<td>0.0</td>
<td>61.3</td>
<td>100.0</td>
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<tr>
<td>1</td>
<td>477</td>
<td>93.7</td>
<td>59.1</td>
<td>78.4</td>
<td>85.6</td>
</tr>
<tr>
<td>2</td>
<td>372</td>
<td>84.0</td>
<td>85.3</td>
<td>90.1</td>
<td>77.1</td>
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<tr>
<td>3</td>
<td>306</td>
<td>74.2</td>
<td>96.0</td>
<td>96.7</td>
<td>70.1</td>
</tr>
<tr>
<td>4</td>
<td>245</td>
<td>60.9</td>
<td>99.2</td>
<td>99.2</td>
<td>61.6</td>
</tr>
<tr>
<td>5</td>
<td>173</td>
<td>43.1</td>
<td>99.6</td>
<td>99.1</td>
<td>52.5</td>
</tr>
<tr>
<td>6</td>
<td>107</td>
<td>26.6</td>
<td>99.4</td>
<td>99.1</td>
<td>46.1</td>
</tr>
</tbody>
</table>

MMSE = Mini-mental state examination; Sens = sensitivity; Spec = specificity; PPV = positive predictive value; NPV = negative predictive value; ADC = Alzheimer’s Disease Center.

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776
performance on the six-item screener. Using this table, an investigator can extrapolate mean scores on the six-item screener to corresponding scores on the longer scales if one seeks to compare levels of cognitive impairment to studies using the longer scales. As shown in Table 8, the number of errors on the six-item screener is highly correlated with performance on the other three scales.

**Discussion**

We propose the six-item screener as an efficient and accurate method to screen subjects for cognitive impairment. The scale was specifically developed for studies that must screen large numbers of subjects and for studies that rely on subjects’ cognitive ability to participate in a complex intervention and/or provide self-reports. A specific inclusion criterion in such a study is often the requirement that a patient have the cognitive capacity to understand questions about their current symptoms, emotion, or function, and be able to follow the study protocol. Although this scale was originally conceived for use in research studies, the diagnostic characteristics are comparable to the MMSE or the Blessed Dementia Rating Scale and thus the six-item screener could also be used in clinical practice as a first stage assessment for cognitive impairment.

There are several important logistic features of the six-item screener that make it particularly well-suited for use in research studies compared with other brief screens recently developed.21–24 First, the scale is short and unobtrusive so that it can be readily incorporated into an initial patient assessment of eligibility. The scale takes only 1 to 2 minutes to complete as compared with 7 to 15 minutes for longer scales.8,9,24,25 Second, the scale does not include any visuospatial or motor skill tasks, it does not require any props or visual cues, and scoring requires only the simple addition of the number of errors.21–24,26,27 Thus, the six-item screener can be easily administered by telephone or in face-to-face interviews. Third, the investigator can alter the cut-off score to match the goals of the study and the targeted population.

We have demonstrated the diagnostic characteristics of the six-item screener in a community-based sample where the screening scale used (CSI-D) was independent from the six-item

### Table 5. Sensitivity, Specificity, and Predictive Value of MMSE Among the ADC Clinical Sample

<table>
<thead>
<tr>
<th>MMSE Score</th>
<th>Sens</th>
<th>Spec</th>
<th>PPV</th>
<th>NPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤27</td>
<td>93.0</td>
<td>70.6</td>
<td>83.4</td>
<td>86.4</td>
</tr>
<tr>
<td>≤26</td>
<td>88.2</td>
<td>83.7</td>
<td>89.6</td>
<td>81.8</td>
</tr>
<tr>
<td>≤25</td>
<td>82.7</td>
<td>89.3</td>
<td>92.4</td>
<td>76.5</td>
</tr>
<tr>
<td>≤24</td>
<td>77.2</td>
<td>94.4</td>
<td>95.7</td>
<td>72.3</td>
</tr>
<tr>
<td>≤23</td>
<td>73.4</td>
<td>96.8</td>
<td>97.3</td>
<td>69.7</td>
</tr>
<tr>
<td>≤22</td>
<td>68.9</td>
<td>98.4</td>
<td>98.6</td>
<td>66.7</td>
</tr>
<tr>
<td>≤21</td>
<td>64.9</td>
<td>99.2</td>
<td>99.2</td>
<td>64.1</td>
</tr>
</tbody>
</table>

**MMSE** = Mini-mental state examination; **Sens** = sensitivity; **Spec** = specificity; **PPV** = positive predictive value; **NPV** = negative predictive value; **ADC** = Alzheimer’s Disease Center.

### Table 6. Area Under ROC Curves for MMSE Compared with Six-Item Screener

<table>
<thead>
<tr>
<th></th>
<th>Gold Standard</th>
<th>Six-item screener</th>
<th>MMSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based sample</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>0.86</td>
<td>0.84</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>0.95</td>
<td>0.96</td>
<td></td>
</tr>
<tr>
<td>Clinical sample</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>0.91</td>
<td>0.93</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>0.92</td>
<td>0.95</td>
<td></td>
</tr>
</tbody>
</table>
The six-item screener described here. Notably, the six-item screener’s performance is based on a gold standard diagnosis of cognitive impairment or dementia rather than its ability to predict a total score on the full MMSE. This is important because the MMSE typically performs in the range of 80% to 85% sensitivity and specificity;28 in other words, the MMSE does not provide a gold standard for cognitive impairment or dementia. The six-item screener’s performance was excellent in both of the populations studied in this report. The scale performed nearly as well as the MMSE in these patient populations and showed a high level of validity when compared with other commonly used screens for cognitive impairment.

Although the six-item screener performed well in these two populations in terms of diagnostic accuracy for identifying older adults with cognitive impairment or dementia, it is important to note the differences in the two patient populations as described in Table 1. The community-based sample is representative of urban, black older adults, but these results may not generalize to other racial groups. Subjects in the clinical sample completed the same evaluation as the community-based sample and this sample comprises both white persons and black persons. Taken together, the two samples thereby represent a fairly broad spectrum of older adults but simply combining the results of these two samples does not create a cohort necessarily generalizable to all older adults. Although our use of a community-based sample of black persons improves upon prior studies relying only on clinical samples, exploring the generalizability of our findings is an important area for future research.

Because both clinicians and researchers seek a brief and accurate method to identify patients or subjects with cognitive impairment, multiple previous investigators have reported on the sensitivity

### Table 7. Means, Medians, and Ranges of other Screening Instruments by Number of Errors on Six-item Screener Among Community-Based Sample and Alzheimer Disease Center Sample

<table>
<thead>
<tr>
<th>No. of Errors</th>
<th>Sample</th>
<th>MMSE</th>
<th>Word List Recall</th>
<th>Blessed Dementia Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Median Range</td>
<td>Mean Median Range</td>
<td>Mean Median Range</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Comm 28.4 29.0 17–30</td>
<td>16.0 16.0 7–24</td>
<td>3.6 3.5 3.0 –7.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical 28.9 29.0 23–30</td>
<td>20.0 20.0 9–30</td>
<td>3.7 3.0 2.8–12.0</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Comm 27.0 27.0 17–29</td>
<td>14.6 15.0 5–23</td>
<td>4.4 4.0 3.0–11.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical 26.9 27.0 20–29</td>
<td>15.9 15.0 5–28</td>
<td>4.9 4.0 3.0–11.5</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Comm 25.8 26.0 16–28</td>
<td>12.1 12.0 4–20</td>
<td>3.8 3.5 3.0–14.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical 24.8 25.0 15–28</td>
<td>13.1 13.0 6–24</td>
<td>5.4 6.5 3.0–17.6</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Comm 22.4 25.0 10–27</td>
<td>10.6 12.0 0–16</td>
<td>3.8 3.5 3.0–10.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical 20.6 21.0 9–27</td>
<td>9.3 9.0 0–22</td>
<td>7.3 7.0 3–14.5</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Comm 19.4 19.0 12–24</td>
<td>8.6 10.0 0–14</td>
<td>5.1 5.5 3.0–13.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical 18.9 20.0 5–26</td>
<td>8.8 9.0 0–17</td>
<td>8.1 8.0 3.5–16.5</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Comm 14.4 16.0 3–23</td>
<td>7.1 6.0 0–13</td>
<td>6.8 6.0 4.4–10.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical 14.7 15.5 4–24</td>
<td>5.7 5.5 0–15</td>
<td>9.7 9.5 3.5–18.7</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Comm 8.9 7.5 0–21</td>
<td>3.3 1.0 0–9</td>
<td>10.2 9.4 3.9–17.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical 10.0 10.0 0–23</td>
<td>4.1 3.0 0–15</td>
<td>10.8 10.0 4.5–22.0</td>
<td></td>
</tr>
</tbody>
</table>

Comm = community-base sample; Clinical = Alzheimer’s Disease Center clinical sample.

### Table 8. Regression Coefficients Comparing Screening Scores Versus Number of Errors on Six-Item Screener

<table>
<thead>
<tr>
<th></th>
<th>Community-based Sample</th>
<th>Alzheimer’s Disease Center Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Regression Coefficient</td>
</tr>
<tr>
<td>MMSE</td>
<td>344</td>
<td>−2.4</td>
</tr>
<tr>
<td>Word List Recall</td>
<td>273</td>
<td>−1.9</td>
</tr>
<tr>
<td>Blessed</td>
<td>158</td>
<td>0.5</td>
</tr>
</tbody>
</table>
and specificity of shorter scales. Initially, these attempts included instruments of 10-to-15 items (eg, Short Portable Mental Status Questionnaire) rather than the 30-item scales such as the Mini-Mental State Examination or Blessed Dementia Scale. By the early 1980s, scientists were exploring scales as short as six items. These early efforts were limited by the use of small clinical samples of nursing home residents or medical inpatients, and the developers were typically predicting scores on longer screening tests rather than predicting the actual clinical determination of cognitive impairment or dementia.

In the 1990s, several authors reporting from Alzheimer Disease Research Centers were able to report on the sensitivity and specificity of a reduced item Mini-mental state examination. The studies by Galasko and Fillenbaum were limited to patients with Alzheimer’s disease who had been referred to the clinical center whereas the study by Wells coupled data from an Alzheimer Disease Research Center with data from the Epidemiologic Catchment Area study. Although all three of these studies demonstrated that a reduced-item Mini-mental State examination had acceptable sensitivity and specificity for identifying patients with Alzheimer’s disease, the study by Wells requires the calculation of a discriminant function score and includes a total of nine items. Although limited to Alzheimer disease subjects, the studies by Fillenbaum and Galasko have previously demonstrated that three-item recall and orientation items provide excellent discrimination for normal subjects as compared with those with cognitive impairment or Alzheimer Disease.

More recently Buschke et al reported the performance of a 4-minute, four-item, delayed free- and cued-recall test of memory impairment. The study sample included 286 volunteers recruited from physician offices and senior centers and 197 subjects from the local community identified through Medicare lists. All subjects completed a neurologic evaluation to establish a diagnosis of dementia. These authors reported a sensitivity of 86% and a specificity of 91% in diagnosing dementia using a cut-off score of 5 (range of possible scores 0–8). This level of diagnostic accuracy has not been demonstrated in an unselected community-based population. However, the primary drawback of this test for screening large research populations is the requirement that patients read a visual cue card containing the four items to be recalled, and that testing of recall be delayed from 3 to 4 minutes after reading the card. This makes completion by telephone or in-person more cumbersome.

One of the primary advantages of the six-item screener compared with the other brief cognitive screens mentioned above is its suitability for administration over the telephone. There are at least three other instruments reported in the literature that are designed specifically to assess cognitive function via telephone administration. These include the Telephone Interview for Cognitive Status (TICS), the Minnesota Cognitive Acuity Screen (MCAS), and the Structured Telephone Interview for Dementia Assessment (STIDA). All three instruments have reported acceptable sensitivity and specificity although the MCAS and STIDA studies did not target a representative community-base sample of older adults. The primary disadvantage of these three instruments is their length. Although all three instruments eliminate items that would require props or face-to-face administration, the length of these instruments approximate that of the MMSE and thereby require 10 to 20 minutes to complete. A short-STIDA has also been described but this instrument still requires 10 min to complete and the reported specificity falls to 0.77. Each of these longer telephone assessments could readily be considered as a second-stage cognitive screen to be used in tandem for those older adults scoring positive on the six-item screener.

**Conclusion**

In conclusion, we have demonstrated that a brief six-item screener that can be readily administered face-to-face or by telephone has diagnostic-test characteristics comparable with the MMSE and other longer scales designed to identify cognitive impairment or dementia. Sensitivity and specificity change precipitously but predictably as one varies the number of errors used as a cut-off point. This scale, which is a subset of the full MMSE, provides investigators with an efficient and accurate mechanism to identify patients with probable cognitive impairment.

**References**

CALLAHAN ET AL


APPENDIX A. TABLE 1. Six-Item Screener

1. I would like to ask you some questions that ask you to use your memory. I am going to name three objects. Please wait until I say all three words, then repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. Please repeat these words for me: APPLE—TABLE—PENNY.

(Interviewer may repeat names 3 times if necessary but repetition not scored.)

<table>
<thead>
<tr>
<th>Did patient correctly repeat all three words?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correct</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Incorrect</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

1. What year is this?
2. What month is this?
3. What is the day of the week?

What were the three objects I asked you to remember?

4. Apple
5. Table
6. Penny

781
Six-Item Screener Assessment

Six-Item Screener

Script:
I would like to ask you some questions that ask you to use your memory. I am going to name three objects. Please wait until I say all three words, and then repeat them.

Remember what they are because I am going to ask you to name them again in a few minutes.

Please repeat these words for me: APPLE—TABLE—PENNY.

(Interviewer may repeat names 3 times if necessary but repetition not scored.)

Did patient correctly repeat all three words? Yes ☐ No ☐

1. What is the year? Correct ☐ ☐
2. What is the month? Correct ☐ ☐
3. What is the day of the week? Correct ☐ ☐

Before asking member to repeat the words Apple, Table, Penny, ensure that at least three minutes have passed from the time you provided these names to the member. Example: Ask additional questions such as validation of address and phone number.

What were the three objects I asked you to remember?

4. Apple Recall ☐ ☐
5. Table Recall ☐ ☐
6. Penny Recall ☐ ☐

Six Item Screener: Number of objects missed (only choose one).

☐ 1.  ☐ 2.  ☐ 3.  ☐ 4.  ☐ 5.  ☐ 6.  ☐

Do responses indicate cognitive impairment?

Scoring: A score of greater than 2 missed indicates a need for further screening and diagnostic evaluation.
Six-Item Screener Work Flow

Six Item Screener Workflow

Step 1: Identify if member currently has a confirmed diagnosis of Alzheimer’s or dementia. If yes, Six Item Screener may be skipped.

Step 2: Care Manager Introduction:

I would like to ask you some questions that use your memory. I am going to name 3 objects. Please wait until I say all 3 words, then you repeat them. Remember what the 3 objects are because I am going to ask you to name them again later.

Step 3: Care Manager to name objects and have member repeat the objects. Document if the member could not repeat any of these objects.

Apple, Table, Penny

Step 4: Care Manager will introduce and ask the next set of questions to the member:
Now I am going to ask you a few basic questions.

1. What is the year? Correct YES NO
2. What is the month? Correct YES NO
3. What is the day of the week? Correct YES NO

Care Manager will use an additional set of questions, such as verifying name, address, and phone number. Clinical and other questions are appropriate also.

Step 5: Care Manager will allow 3 minutes to pass. TIP: Care Manager to observe time started or begin timer.

Step 6: Care Manager will ask second question to member
What were the 3 objects I asked you to remember?

4. Apple RECALL YES NO
5. Table RECALL YES NO
6. Penny RECALL YES NO

Step 7: Identify how many objects were missed from Step 3 and Step 5. Only choose 1 number (1-6).

Step 8: Scoring

Do responses indicate cognitive Impairment? A score of 2 misses or greater indicate need for further screening and diagnostic workup.

Step 9: Notify primary care physician for recommended follow up if score indicates further assessment needed (See Step 7)
Appropriate PCP messaging: (fax, phone call, EMR)
**Step 10:** Consider referrals to Social work secondary to care giver strain
   Appropriate messaging

**Step 11:** Consider referral to Dementia Care Consultant- Appropriate messaging

**Step 12:** Care Manager Documentation

Document results within care management documentation system.
Example of Provider Notification via Fax

Confidential Fax – Cognitive Screening Results

To:               Date:              Fax #:

Patient Name:     DOB:                  Member ID:

During a routine cognitive screening, the above named patient could not recall 2 or more of the six questions below. This indicates that your patient would benefit from further cognitive evaluation. This fax has been sent to alert you of these findings and to urge you to open a discussion with your patient and/or refer for further evaluation and treatment if indicated. Below are the results of the cognitive screening for your records.

SIX-ITEM SCREENER TO IDENTIFY COGNITIVE IMPAIRMENT:

The member was given the names of three objects (apple, table, penny) and was asked to repeat the words and to remember them for later recall questioning (minimum of 3 minute spaced interval).

1. What is the year? Correct: Yes ☐ No ☐
2. What is the month? Correct: Yes ☐ No ☐
3. What is the day of the week? Correct: Yes ☐ No ☐

What were the 3 objects I asked you to remember?

4. APPLE Recall: Yes ☐ No ☐
5. TABLE Recall: Yes ☐ No ☐
6. PENNY Recall: Yes ☐ No ☐

SIX-ITEM SCREENER NUMBER OF MISSED QUESTIONS: 1  2  3  4  5  6

☐  I have encouraged your patient to discuss the results of the cognitive screening with you and/or ____________
☐  And/or the additional topic of ______________;
☐  Member is currently enrolled in a care management program

If you have any questions regarding this information, please contact me at the phone number below.

<User’s Signature>
<User’s Name>
<User’s Title>
(888)880-8699 <user extension>

Confidentiality Notice: The document(s) accompanying this fax contain confidential information. The information is intended only for the use of the intended recipient named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this telecopied information, except for purposes of returning this fax to Tufts Health Plan, or directly delivering this fax to the intended recipient named above, is strictly prohibited. If you have received this fax in error, please notify us immediately by telephone.
The following page contains a sample of a *Hospice Log*.
<table>
<thead>
<tr>
<th>IPA</th>
<th>MID</th>
<th>Last Name</th>
<th>First Name</th>
<th>DOB</th>
<th>HOSPICE_AGENCY</th>
<th>Terminal Diagnosis</th>
<th>Hospice Start Date</th>
<th>Revocation Date</th>
<th>Date of Death</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>S00000000</td>
<td>SMITH</td>
<td>JOHN</td>
<td>XX/XX/XX</td>
<td>Life Choice Hospice - Chestnut Hill</td>
<td></td>
<td>6/27/2014</td>
<td></td>
<td></td>
<td>still there</td>
</tr>
<tr>
<td>00</td>
<td>S00000000</td>
<td>APPLESEED</td>
<td>JOHNNY</td>
<td>XX/XX/XX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>still there</td>
</tr>
<tr>
<td>00</td>
<td>S00000000</td>
<td>CAPONE</td>
<td>AL</td>
<td>XX/XX/XX</td>
<td>HealthAlliance Home Health and Hospice</td>
<td>mal pleural effusion</td>
<td>2/4/2014</td>
<td></td>
<td></td>
<td>still there</td>
</tr>
</tbody>
</table>
A sample of the Custodial Skilled Episode Letter and instructions is included in this appendix.

Tufts Medicare Preferred HMO
Custodial Skilled Episode Letter Template

[Member Name]
[Address]

[Date]

Dear [Name of Member Representative]:

We are writing to let you know the Skilled Nursing Facility services you received on [Date First and Last] from [Facility Name /Provider] will be covered by your plan.

This means you are only responsible for the cost sharing amount identified under your Skilled Nursing Facility benefit. Any charges above your cost sharing amount will be paid by your plan.

How do you know what your cost sharing amount is?
Your cost sharing amount for Skilled Nursing Facility services depends on the plan you are in. The chart on the back of this letter lists the Skilled Nursing Facility cost sharing amount for each of our individual HMO plans. (If you receive your benefits from a current or former employer, see your Evidence of Coverage (EOC) booklet, contact your benefits administrator, or call Customer Relations for benefit information.) You should receive a bill in the mail shortly with the correct cost sharing amount.

What if you already paid for services?
If you already paid for Skilled Nursing Facility services above your cost sharing amount and need a reimbursement, give us a call at the number below. We can help you get a reimbursement for the amount you don’t need to pay.

For more information
If you have any questions, call Customer Relations at 1-800-701-9000 (TTY 1-800-208-9952). Representatives are available Monday through Friday, 8:00 a.m. - 8:00 p.m. (From October 1 – February 14, representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m.). After hours and on holidays, please leave a message and a representative will return your call on the next business day.

Sincerely,

(Tufts Health Plan Medicare Preferred
Or Medical group and Skilled Nursing Facility)

Skilled Nursing Facility chart on back
2014 Skilled Nursing Facility cost sharing amounts
for individual Tufts Medicare Preferred HMO plans*

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Skilled Nursing Facility member cost sharing amount</th>
</tr>
</thead>
</table>
| Tufts Medicare Preferred HMO Prime Rx Plus  
Tufts Medicare Preferred HMO Prime Rx  
Tufts Medicare Preferred HMO Prime No Rx | For each admission you pay:  
$20 per day for days 1-20  
$0 per day for days 21 – 100 |
| Tufts Medicare Preferred HMO Value Rx  
Tufts Medicare Preferred HMO Value No Rx | For each admission you pay:  
$30 per day for days 1-20  
$60 per day for days 21-44  
$0 per day for days 45 – 100 |
| Tufts Medicare Preferred HMO Basic Rx  
Tufts Medicare Preferred HMO Basic No Rx | For each admission you pay:  
$50 per day for days 1-20  
$100 per day for days 21-44  
$0 per day for days 45 – 100 |
| Tufts Medicare Preferred HMO Saver Rx | For each admission you pay:  
$25 per day for days 1-20  
$75 per day for days 21-44  
$0 per day for days 45 – 100 |

For more detailed information on this benefit, see your Evidence of Coverage (EOC) booklet.

**Where can you find an EOC booklet?**
An EOC booklet is sent to you each year in September. You can also find an EOC booklet for your plan on the Plan Documents page of our website at tuftsmedicarepreferred.org.

**What if you receive your benefits from a current or former employer?**
If you receive your benefits from a current or former employer, your cost sharing amount may be different. Please see your Evidence of Coverage (EOC) booklet, contact your benefits administrator, or call Customer Relations for benefit information.

Tufts Health Plan Medicare Preferred is an HMO plan with a Medicare contract. Enrollment in Tufts Health Plan Medicare Preferred depends on contract renewal.

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, and copayments may change on January 1 of each year.

H2256_2014_292 Approved
Tufts Medicare Preferred HMO Custodial Skilled Episode
Letter Instructions

The purpose of this letter is to inform a member of the use of Skilled Nursing Facility (SNF) benefits while the member is living in a long term care facility. Tufts Medicare Preferred HMO members, who reside in a SNF as long-term care residents, have Care Managers (CM) who perform retrospective chart reviews. At times, skilled orders/treatments are identified. The CM will use this letter to inform both the member and the facility of a Medically Necessary Skilled Nursing Facility episode which is a Tufts Medicare Preferred HMO benefit. Care Manager can notify the Precertification Department of skilled episode admission and discharge dates.

Note: Care Managers who are employed by Tufts Health Plan will use the Tufts Health Plan Medicare Preferred letter head. Care Managers employed by a Medical Group will send the letter on the group letter head. This letter will be updated annually to reflect any changes in member cost sharing.

TUFTS MEDICARE PREFERRED HMO CARE MANAGER RESPONSIBILITIES

Upon determination that use of a member’s Skilled Nursing benefit is appropriate:

1. Complete letter’s first sentence:
   We are writing to let you know the Skilled Nursing Facility services you received on [Date First and Last] from [Facility Name/Provider] will be covered by your plan.

2. Print letter on appropriate letterhead (TMP or Medical Group letterhead)

3. Send to member/ADR and Cc Skilled Nursing Facility

4. Save in member record
The following page contains a sample of an Institutional Log.
<table>
<thead>
<tr>
<th>Group</th>
<th>Member ID</th>
<th>Last Name</th>
<th>First Name</th>
<th>DOB</th>
<th>Facility_name</th>
<th>Facility_Town</th>
<th>Original Admit Date</th>
<th>Date Custodial Discharge</th>
<th>Discharge Date</th>
<th>Discharge Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>500000000</td>
<td>MOUSE</td>
<td>MICKEY</td>
<td>5/15/1928</td>
<td>Disney's Home for Retired Characters</td>
<td>Orlando</td>
<td>10/19/2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>00</td>
<td>500000000</td>
<td>WHITE</td>
<td>SNOW</td>
<td>2/4/1938</td>
<td></td>
<td>Hollywood</td>
<td>10/20/2014</td>
<td>11/7/2014</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
The table on the following page provides an example of Tufts Health Plan Medicare Preferred’s Audit tool.
### Integrated Care Management QI Record Review

**IDN/Medical Group:**

**Reviewer:**

**Date of Review:**

<table>
<thead>
<tr>
<th>MEMBER INFORMATION</th>
<th>PROGRAM INFORMATION</th>
<th>INITIAL ASSESSMENT</th>
<th>INITIAL PROBLEM LIST</th>
<th>INITIAL CARE PLAN</th>
<th>ONGOING CARE PLANNING</th>
<th>INITIAL ACTION</th>
<th>ONGOING ACTION PLAN</th>
<th>EVIDENCE OF INTEGRATION</th>
<th>CRITERIA FOR DISCHARGE</th>
<th>TOTAL SCORE/COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case #</td>
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<tr>
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</tr>
</tbody>
</table>

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P:\MPGroup\MP1\GTT Communications\_rev0\04 Material Master List|v7 and IDN\Record Review Tool
The following is a guide to Tufts Health Plan Medicare Preferred’s Audit tool.

<table>
<thead>
<tr>
<th>MEMBER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member name</td>
</tr>
<tr>
<td>Member ID</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROGRAM INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program: Complex, Chronic, or Transitions</td>
</tr>
<tr>
<td>Program Focus: CHF or COPD (CCM or Tier 2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INITIAL ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Case Assigned to CM</td>
</tr>
<tr>
<td>Date IA is complete</td>
</tr>
<tr>
<td>IA Completed w/in 30d of Assignment (CCM or Tier 2) or 2 - 7 days Transitions Management</td>
</tr>
<tr>
<td>PAM survey complete (CCM or Tier 2)</td>
</tr>
<tr>
<td>IF case is closed: date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INITIAL PROBLEM LIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Problem List for CCM or Tier 2</td>
</tr>
</tbody>
</table>

Page 1
## INITIAL CARE PLAN (CCM or Tier 2 ONLY)

<table>
<thead>
<tr>
<th>Component</th>
<th>0 = No Evidence of integration</th>
<th>1 = Partially meets integration</th>
<th>2 = Goals and problems aligned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prioritized Goals Consistent w/Problem list</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification of barriers to meeting goals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of schedules for f/u communication w/team &amp; member</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## ONGOING CARE PLANNING (CCM or Tier 2 ONLY)

<table>
<thead>
<tr>
<th>Evidence of Care Plan updates</th>
<th>Signs of collaboration, new plan and goals, new interventions, tasks scheduled: 0 = No evidence 1 = Some partial updating noted 2 = Current plan of care with updates</th>
</tr>
</thead>
</table>

## INITIAL ACTION (CCM or Tier 2 ONLY)

<table>
<thead>
<tr>
<th>Member Centric Goals</th>
<th>Supporting documentation that goals are member focused 0 = No 1 = Partially addressed member focused goals 2 = Yes</th>
</tr>
</thead>
</table>

## ONGOING ACTION PLAN (CCM or Tier 2 ONLY)

<table>
<thead>
<tr>
<th>Action Plan Modification</th>
<th>Current and updated depending on each IDN/Group requirements 0 = No 1 = Partially updated 2 = Yes</th>
</tr>
</thead>
</table>

## EVIDENCE OF INTEGRATION

<table>
<thead>
<tr>
<th>Documented CP shared w/PCP (CCM or Tier 2)</th>
<th>This could be in different locations depending on system, looking for evidence CM discussed member problem/goals/plan example discussed at medical management meeting: 0 = No 2 = Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented AP shared w/PCP &amp; other team members (CCM or Tier 2)</td>
<td>This could be a copy mailed to PCP, handed out at MM meeting etc. 0 = No 2 = Yes</td>
</tr>
<tr>
<td>Criteria for Discharge</td>
<td>Details</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Communication - All Management (CCM, Tier 2, or Transitions)</td>
<td>Evidence of calls to other care team members, PCP, providers, family, member, evidence of mailings where appropriate: 0=N 1=some evidence but needs improving 2: detailed documentation of calls and contacts with team/PCP/Member/vendors</td>
</tr>
<tr>
<td>0/1/2</td>
<td></td>
</tr>
<tr>
<td>Member demonstrates competency in Self Management Caregiver demonstrated competency in Member Management (CCM or Tier 2)</td>
<td>Evidence of teach back, confidence questions answered and reviewed, medication management clear. Documentation if discharged because of transition to Hospice, Custodial, no longer TMP member, or other 0=No documented evidence 1=Some evidence-partially meets 2=Evidence of member competency clear and documented CGS completed, care giver teach back evident in notes or plan of care 0=N 2=Y</td>
</tr>
<tr>
<td>0/1/2</td>
<td></td>
</tr>
<tr>
<td>PAM Survey completed prior to discharge with a Level 3 or 4 (CCM or Tier 2)</td>
<td>0=N, 2=Y</td>
</tr>
<tr>
<td>0/2</td>
<td></td>
</tr>
<tr>
<td>Less than 2 ED visits &amp; no unplanned admissions for 6mths. (CCM or Tier 2)</td>
<td>0=N, 2=Y</td>
</tr>
<tr>
<td>0/2</td>
<td></td>
</tr>
<tr>
<td>Transitions management: 30-45 days</td>
<td>0=N, 2=Y</td>
</tr>
<tr>
<td>0/2</td>
<td></td>
</tr>
</tbody>
</table>