CARE MODEL FOR TUFTS HEALTH PLAN SCO

The following topics are covered in this chapter:

The overarching construct for the Tufts Health Plan Senior Care Options (HMO-SNP) is to improve access to medical, behavioral health and social services for all enrolled members. The Tufts Health Plan SCO care model is based on the below core principles and practices, which Tufts Health Plan believes form the foundation for measurable cost savings and improved health outcomes.

Affordability: Tufts Health Plan SCO is designed to minimize cost sharing on the part of the member to improve access to affordable care.

Handle all aspects of the member's needs holistically: medical, behavioral, social and community: The SCO model of care integrates the member's Medicaid and Medicare benefits into one benefit package, allowing the primary care team (PCT) to coordinate medical and social/community benefits in an integrated way.

"High-touch" model with a consistent, primary point of contact: The Tufts Health Plan SCO model of care is intended to be a high-touch model that provides frequent contact (via telephone or in person) between plan staff and members to educate members on their condition, address their concerns, proactively monitor health status and identify health care needs.

A care manager with appropriate language skills are assigned to each member and serve as the primary point of contact, whenever feasible. When a care manager with appropriate language skills is not available, a medically trained interpreter is used. Other members of the care team with specialized skills may need to contact the member as well; however, they are introduced through the trusted relationship between the member and the care manager.

Member engagement and education: The PCT creates an individualized plan of care (IPC) for all SCO members. The IPC is actively managed and updated as the member's situation changes. Members, their families and caregivers are all critical to the care management process and are engaged to the greatest extent possible.

Identify high-risk members and provide care coordination and case management services: All SCO members are evaluated for care coordination needs through initial and ongoing clinical assessments and other health risk assessment tools. All SCO members will receive some level of care coordination, and members with more acute and complex needs are provided more intensive case management through their PCT.

Primary care focused: Tufts Health Plan believes that a well-executed primary care strategy is critical to the success of managing the dual eligible population. The care management model is structured to support a partnership between the PCP and the member through a supportive "safety net" team approach.

Managing transitions of care: Tufts Health Plan places great importance on continuity of care between settings to reduce inefficiencies and duplication of services and to help ensure that the member is being cared for in the setting that best meets their needs. Tufts Health Plan's model is built around actively coordinating transitions of care to or from acute settings, skilled nursing facilities (SNF), long-term care settings and the member's place of residence.

Information systems support and centralized communication tool: Tufts Health Plan uses a secure, web-based care management application that houses a summary record of each member's medical information and care plan. The PCT has access to the care management application 24 hours a day, seven days a week.

Tufts Health Plan is founded on the following core principles:

- Integrate and manage all components of a member's needs (medical, behavioral and social) to promote independent functioning in the most appropriate, least restrictive environment.
- Provide timely access to necessary services and preventive care.
- Assign each member a care manager to coordinate all aspects of care. The type of care manager and the intensity of the care management that the member receives will differ depending on the member's clinical complexity and level of need.
- As part of the comprehensive initial assessment, the RN care manager creates and manages an IPC. The IPC is unique to each member and focuses on the scope, duration and frequency of home- and community-based services (HCBS), taking into account the availability of caregiver and other informal supports.
- Perform routine follow-up assessments thereafter to facilitate early identification of changes in condition, while IPCs are adjusted accordingly.
- Provide support to the care manager, as needed, through a team of clinical experts that includes, but is not limited to, behavioral health clinicians, registered nurses (RNs) and nurse practitioners (NPs)
- Ensure the use of individualized goal setting to engage members and caregivers while focusing on stabilization, self-management and autonomy. Members, families and caregivers are considered critical to care planning and should be engaged to the greatest extent possible.
- Coordinate safe transitions of care to ensure that the member is being cared for in a setting that best meets their needs and preferences.

Primary Care Team (PCT)

The PCT consists of a group of Tufts Health Plan SCO network providers, including but not limited to the member, a PCP, a care coordinator, a geriatric support services coordinator (GSSC) and a Tufts Health Plan RN or BH care manager. The PCT works to help ensure effective coordination and delivery of covered services to all SCO members. The PCT roles and responsibilities are described below.

PCPs

When enrolling, every Tufts Health Plan SCO member must select a PCP. The role of the PCP is to provide primary care and participate in the development of each member's IPC. PCT meetings are organized to discuss the status and plan of care for each member of the PCP's panel that is enrolled in Tufts Health Plan SCO. The frequency of these meetings depends on the member's acuity and level of need.

Key tasks of the PCP include the following:

- Providing overall clinical direction and serve as the central point for integration and coordination of all covered services
- Providing primary medical services, including acute and preventive care
- Participating in PCT meetings, during which changes to complex member's IPC are reviewed and approved
- Promoting independent functioning of the member in the most appropriate, least restrictive environment with the proper supports in place
- Assisting in the designation of a health care proxy, if the member wants one

- Communicating with the member and member's caregiver/s about their medical, social and psychological needs

Care Coordinators

The care coordinator is responsible for acting as a support to the RN care managers to assist with administrative duties such as ordering durable medical equipment and setting up transportation services.

Tufts Health Plan attempts to provide members with care coordinators based on relevant language skills.

Geriatric Support Services Coordinators

The geriatric support services coordinator (GSSC) is employed by an aging services access point (ASAP) and is part of the PCT. Organized under Massachusetts law, ASAPs are local agencies that manage the home health care program and perform various services for and on behalf of elderly residents in Massachusetts. ASAPs also arrange for HCBS (e.g., Meals on Wheels, adult day health) through subcontractors.

In turn, ASAPs use GSSCs to provide services to members. The GSSC is responsible for:

- Serving as a care manager for Community Well members
- Performing, arranging and/or participating in ongoing assessments of the health and functional status of members and developing community-based care plans and related service packages necessary to improve or maintain member health and functional status
- Participating in the development and execution of a member's IPC
- Participating as part of a member's PCT
- With authorization from Tufts Health Plan SCO, arranging and coordinating the provision of appropriate community long-term care and social support services, such as assistance with housing, home-delivered meals, transportation, or other community-based services
- Monitoring the provision and outcome effectiveness of community-based services as defined by the member's IPC

Community Health Worker

Serving as an extender, under the supervision of an RN, the Community Health Worker can:

- Participate in select ongoing assessments of the health and functional status of members
- Carry out care plan interventions at the direction of the RN, particularly in the hands on practical, tactical inventions in the home and in the community with members
- Provide health education to members to promote self-management, particularly for members in need of assistance with health literacy
- Escort members to appointments

Nurse Care Managers (RN Care Manager)

As part of the PCT, RN care managers are registered nurses responsible for the following:

- Acting as the care manager for complex members and those living in the institutional setting for long-term care
- Implementing and executing the IPC for all SCO members on their caseload
- Monitoring the provision and effectiveness of community-based services as defined by the member's IPC
- Conducting the minimum data set-home care (MDS-HC) assessment for community SCO members who meet the criteria on their caseload
- Facilitating the implementation of all HCBS to keep members in the least restrictive setting
- Ensuring the safe transition of members from one setting to another (i.e., hospital to home) and facilitating the implementation of all HCBS
- After discharge to a community setting, perform a 2-day post-hospital assessment and intervention and a medication reconciliation and review by day 7
- Participating in PCT meetings

- Ensuring the completion of clinical and functional member assessments, including those required by the Massachusetts Executive Office of Health and Human Services (EOHHS), to determine the enrollee's rating category
- Monitoring the care and provide consistent feedback to the PCT on member progress
- Working closely with the care coordinator, PCP and GSSC to help ensure open lines of communication

Behavioral Health Care Managers

BH care managers may be assigned as a member of the PCT for those members with complex behavioral health issues. They are responsible for the following:

- Conducting special assessments for behavioral health on an as-needed basis
- Acting as a consultant to the PCT for difficult to manage members
- Providing access to behavioral health services

Transition Manager (TM)

The Transition Manager (TM) is a nurse liaison who will manage a member's transitions of care by collaborating & communicating with the member's care team. The TM will follow members through their acute care or extended care admission, proactively driving a multidisciplinary communication strategy regarding barriers and solutions to a safe and successful discharge home or into long term care. There responsibilities include but are not limited to:

- Conducting an initial comprehensive clinical review specific to the members history, including level of engagement, risk factors, comorbidities, ED utilization, hospitalization, and extended care history
- Facilitating medical management/ICT meetings to support discussions regarding readmission, advanced care planning and avoidable admission efforts
- Conducting ongoing clinical reviews to assess ongoing discharge planning recommendations

Customer Relations Representative

While not a member of the PCT, CRRs play an important role in educating members about the plan, as well as their rights. CRRs work with members to assign an in-network PCP and quickly address nonclinical questions or concerns that members may have.

Note: Tufts Health Plan attempts to hire CRRs who speak the members' primary languages and assign these CRRs to members based on relevant language skills.

CRRs are responsible for executing ongoing administrative tasks for members (e.g., processing grievances, replacing lost membership cards) as well as facilitating a mailing of the welcome letter and completion of the orientation call.

Care Management Process

Tufts Health Plan is committed to supporting members in such a way that allows them to remain safely in the community for as long as possible. Because a member's health status and care can change, they are frequently reassessed and re-stratified into levels of care management that respond to changing needs.

Assessments are used to stratify members into the appropriate level of care management. The levels of care, the associated level of risk, how these members typically present, and the type of care manager for each subset of membership are defined in the following table:

Level of Care	Level of Risk	Definition	Primary Care Manager
Community Well (with no HCBS)	Noncomplex	No activities of daily living (ADL) or instrumental activities of daily living (IADL) deficits High functioning Limited or no chronic diseases	GSSC

Level of Care	Level of Risk	Definition	Primary Care Manager
Community Well (some HCBS)	Noncomplex	Members living in the community with conditions or situations requiring coordination of one or more support services due to ADL or IADL deficits, but who are deemed to be an a stable state	GSSC
Alzheimer's Dementia/Chronic Mental Illness (AD/CMI)	Complex or Noncomplex	Members living in the community with a diagnosis of Alzheimer's, dementia, or a chronic mental illness, often with conditions or situations that require coordination of one or more support services due to ADL or IADL deficits	RN Care Manager supported by Behavioral Health Care Manager and Dementia Care Consultant as indicated
Nursing Home Certifiable	Complex	Members with conditions or situations that require expert coordination of multiple support services due to two or more ADL deficits, and who are deemed to be in an unstable state	RN care manager supported by interdisciplinary team as needed; supportive roles as needed include medical director, behavioral health clinician, advanced illness consultant, dementia care consultant
Institutional	Long-term custodial care	Long-term resident of a nursing facility	Community Care Partner (CCP)

Assessment and Risk Categories

At a minimum, all SCO members receive an initial assessment, as well as ongoing assessments, at state-mandated intervals consistent with their health and social support needs.

Initial Assessments

An initial assessment is a comprehensive assessment of a member that includes the following:

- An evaluation of a member's clinical, functional, nutritional and physical status
- Determination of a member's advance directive and service preferences
- The medical history of the member
- Key contact information, including relevant family members
- A screening for potential behavioral health issues, including tobacco, alcohol and drug use
- An assessment of the member's need for long-term care services, including the availability of informal support
- Specific elements of the minimum data set (MDS-HC), if required

Ongoing Assessments

An ongoing assessment is a periodic reevaluation of a member that is conducted on a routine basis after the initial assessment. The purpose of this assessment is to monitor and assess a member's ongoing clinical, functional and nutritional status and to determine if the current plan of care adequately supports the member in their current living arrangement.

For members residing in an institutional settings, the expectation is that the nursing facility will collaborate and share pertinent clinical information with the CCP, who will use it along with any claims and inpatient utilization activity as the base of their quarterly review and annual assessment process.

Change in Condition

In addition to regularly scheduled ongoing assessments, trigger events due to a member's change in condition

can result in a reassessment. There are several categories of trigger events:

- An acute episode (e.g., an emergency department visit or hospitalization)
- A change in medical condition (e.g., development of pneumonia)
- A change in social condition (e.g., loss of a caregiver)

Features of the Tufts Health Plan SCO Care Model

Tufts Health Plan's holistic approach to care management incorporates the steps described below.

Intake

After enrollment, intake into the Tufts Health Plan care management system occurs as quickly as possible to help ensure the following:

- Continuity of care with existing providers, services, medications, etc.
- Rapid identification of risk factors and new services needed to stabilize the member

Members receive an orientation call and welcome kit within the first 30 calendar days of a member's enrollment. Welcome kits include the following:

- A welcome guide
- Transportation benefit flyer
- OTC brochure
- MassHealth OTC drug list
- Preferred extras brochure
- EOC
- Provider directory/Formulary availability notice
- Miscellaneous forms (Ombudsman program info, privacy notice, AOR form)

Initial Assessments

The RN care manager typically conducts an initial in-home assessment within 30 calendar days of a member's enrollment and within five business days if a member is institutionalized or if institutional placement is pending. Initial assessments are comprised of the following four mandatory key elements:

- An evaluation of clinical status, functional status, nutritional status and physical well-being
- The medical history, including relevant family members and illnesses
- Screenings for behavioral health status and tobacco, alcohol and drug use
- An assessment of the need for long-term care services, including the availability of informal support

When an in-home assessment cannot be completed in the community, it is preferable for it to be conducted via video chat is the member has capacity to do so. Otherwise it is conducted Over the phone.

The initial assessment also serves as the health risk assessment (HRA) that drives identification of the appropriate level of care for each member. The HRA is a health screening assessment tool used to identify the initial health, functional and psychosocial needs of the member. Based on the results of this assessment, the most appropriate care manager is assigned. The initial assessment includes a functional assessment tool that evaluates the member's current functional needs and the member's need for additional or more appropriate community-based support services (e.g., Meals on Wheels, homemaker services), based on a review of ADLs and IADLs.

In addition, the IPC is completed as part of the initial assessment. The IPC is always reviewed with and agreed upon by the PCP, member, caregiver and other members of the PCT before being considered final. The IPC is developed after the initial assessment and updated thereafter with any major change in condition. A plan of care is developed and includes identified problems, goals and interventions. The plan of care is reviewed and updated with each assessment.

For those members living in the community who are identified as being nursing home certifiable, RN care managers conduct the MDS-HC assessment. This assessment is a clinical screening tool mandated by federal law that assesses key domains of function, health and service use. For institutional members, the facility

completes the MDS 3.0 as required by federal law.

Monitoring and Ongoing Assessments

An ongoing assessment is a periodic reevaluation of a member. This assessment is conducted on a routine basis after the initial assessment. The purpose of this assessment is to monitor and assess a member's ongoing clinical, functional and nutritional status and to determine if the current plan of care is adequately supporting the member in their current living arrangement.

The care manager reassesses members at established intervals depending on their acuity and level of need. The established intervals are as follows:

- Community Well members (with no HCBS) are assessed telephonically every six months
- Community Well members (with HCBS) are assessed every six months
- AD/CMI members are assessed via home visits alternating with telephonic assessments every quarter (for complex cases) or every six months
- Nursing home certifiable members are assessed via home visits every quarter using the MDS submitted by the SNF as the basis for further inquiry and evaluation
- Institutional members are assessed using claims history, utilization activity and collaborations with direct care at the SNF
- Any member can be reassessed at any time with a significant change in condition

Medical reassessment of all enrollees by the PCP includes a complete history, annual physical and routine and episodic visits as needed. It is the expectation that the PCP uses their clinical judgment to determine how frequently they need to reassess the enrollee.

When an in-home assessment cannot be completed in the community, it is preferable for it to be conducted via video chat is the member has capacity to do so. Otherwise it is conducted over the phone.

Centralized Enrollee Record (CER)

The CER is a single, centralized electronic record with the primary purpose of documenting SCO member status. The CER is used to facilitate communication among the PCT and other providers that could require access (e.g., behavioral health providers, ER physicians). The CER or a summary abstract is available to any provider who requires access 24 hours a day, 7days per week.

Discharge Planning

Per Managed Care Entity (MCE) Bulletin 64, providers must assess each admitted member's current housing situation at the time of admission and as part of the general discharge planning processes to assess whether the member is experiencing or at a risk for homelessness[1]. Discharge planning staff must screen admissions data, including but not limited to age, diagnosis, and housing status within 24 hours of admission.

For any member determined by the provider to be experiencing or at a risk for homelessness, discharge planning must begin no later than 3 business days after the member's admission, unless required to begin sooner. To assist in the discharge planning process, providers must complete the following:

- Invite and encourage the member's support team[2] to participate in the member's discharge planning
- Determine whether a member not receiving services from the Department of Mental Health (DMH), Department of Developmental Services (DDS), or Massachusetts Rehabilitation Commission (MRC) who is also experiencing or at a risk for homelessness may be eligible to receive services from some or all of the agencies
- Determine whether any member experiencing or at a risk for homelessness has any substance use disorder and offer support as outlined in MCE Bulletin 64
- Ensure discharge planning staff are aware of and utilize available community resources to assist with discharge planning for members experiencing or at a risk for homelessness as outlined in MCE Bulletin 64

[1] As defined by MCE Bulletin 64.
[2] Support team includes, but is not limited to the member, member's family, guardians, PCP, BH providers, key specialists, Community Partners, cases managers, emergency shelter outreach or case management staff, care coordinators, and other support identified by the member.

- Make reasonable effort to prevent discharges to emergency shelters of members who have skilled care needs, members who need assistance with activities of daily living, or members whose BH conditions would impact the health and safety of individuals residing in the shelter

For any member experiencing homelessness who is expected to be inpatient for fewer than 14 days, the provider must contact the emergency shelter in which the member most recently resided, if known, to discuss the member's housing options post discharge. If the member has not resided in an emergency shelter, or if the emergency shelter in which the member most recently resided is unknown, the provider must contact the local emergency shelter to discuss the member's housing options post discharge. If a member is being discharged to an emergency shelter:

- Provide at least 24 hours advance notice to the shelter prior to discharge
- Provide the member with access to paid transportation to the emergency shelter
- Ensure that the shelter has an available bed for the member.

For some members, discharge to an emergency shelter or the streets may be unavoidable. For these members, the provider must:

- Discharge the member only during daytime hours
- Provide the member a meal prior to discharge
- Ensure that the member is wearing weather appropriate clothing and footwear
- Provide the member a copy of their health insurance information
- Provide the member with a written copy of all prescriptions and at least one week's worth of filled prescription medications, to the extent clinically appropriate and consistent with all applicable federal and state laws and regulations

Care Transitions

Tufts Health Plan is committed to ensuring continuity of care between settings. The foundation of coordinated transitions is to:

- Communicate information about the member's baseline status from the PCT to the treating provider
- Communicate information about the member's status from the treating provider to the PCT to facilitate planning for return to the most appropriate care setting

The PCT coordinates transitions between care settings through the use of established communication processes between the PCP, care manager, member and caregiver/family member. As part of the transitions between settings, the PCT is responsible for:

- Reinstating prior services, as applicable and arranging new services, as needed
- Coaching the member on the discharge summary either prior to the member leaving the hospital or at home within 2 business days of discharge
- Arranging an appointment with the member's PCP within seven days of discharge
- Conducting an intense follow-up with the member to help ensure adherence to appointments, medication and treatment regimens, as well as educating the member on early identification of changes in condition
- Reassessing and re-stratifying the member, as appropriate
- Updating the IPC accordingly

Advance Directives

Tufts Health Plan conducts advanced care planning discussions with members early and often and encourages PCPs to do the same. Tufts Health Plan's goal is to have discussion regarding advance directive with all SCO members within 90 days of enrollment and to have an advance directive in place within the first year of enrollment.