Tufts Health Plan Senior Care Options (SCO) Model of Care Training

For PCPs and Providers
2020 Annual Training

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Purpose of the Training

To update providers on developments in Tufts Health Plan SCO's Model of Care, inclusive of its Care Management Program.

While meeting the CMS requirement which mandates annual provider training

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Agenda

- What is the Model of Care?
- What changed in 2020?
- Review of the Model of Care:
  - Description of SNP population
  - Care coordination
  - Provider network
  - Quality measurement and performance improvement
- General reminders and information

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Tufts Health Plan SCO Overview

Tufts Health Plan SCO is a benefit plan offered through a three-way contract between Tufts Health Plan, the Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare and Medicaid Services (CMS).

Tufts Health Plan SCO provides MassHealth Standard (Medicaid) and Medicare coverage plus additional benefits. It is a Dual Special Needs Plan (D-SNP).

There is no member cost-share for covered services received from providers participating in the Tufts Health Plan SCO network.

All members are required to choose a PCP participating in the network.

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Who is eligible?

Individuals are eligible to enroll if they:

- 65+ — Are at least 65 years of age or older
- Have MassHealth Standard (Medicaid) coverage
- Live within the service area
- DO NOT have End Stage Renal Disease (ESRD) at time of enrollment

Also **DO NOT** reside in an intermediate care facility for mental health conditions or in a chronic or rehabilitation hospital as an inpatient

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What is the Model of Care

"In accordance with **Centers for Medicare and Medicaid Services** (CMS), a **Special Needs Plan** (SNP) **Model of Care** (MOC) must provide the structure for care management processes and systems that will enable **Medicare Advantage Organization** (MAO) to provide coordinated care for special needs individuals."

- CMS has developed standards and scoring criteria for clinical and non-clinical elements and corresponding factors for the MOC
- National Committee for Quality Assurance (NCQA) approval process is based on evaluation and approval of the SNP MOC using CMS scoring guidelines
- CMS has also implemented a multi-year approval process that allows plans to be granted a longer approval period based on higher MOC scores

More information at https://snpmoc.ncqa.org/

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CMS requirements for SNPs

As a SNP, Tufts Health Plan SCO is required by CMS regulations to have a comprehensive care model, which must include the following elements:

1. Description of SNP Population to be Served
    - Specific population in the service area, as well as vulnerable populations within general population
2. Care Coordination
    - SNP staff structure
    - Health Risk Assessment Tool (HRA)
    - Individualized Care Plan (ICP)
    - Interdisciplinary Care Team (ICT)
    - Care Transition Protocols
3. Comprehensive Provider Network
    - Provider expertise to support population
    - Clinical practice guidelines for providers and Care Transition Protocols
    - Model of Care training for provider network
4. Quality Measurement and Performance Improvement
    - Measurable goals and performance outcomes to monitor and evaluate the care model on a regular basis

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What's changed in 2020?

- Added Community Care Partners (CCPs) for members residing in an institution
  - An RNCM assigned to oversee the care rendered by the long-term care (LTC) facility, and to serve as an advocate for the member
- Included Geriatric Support Services Coordinators (GSSCs) and Community Health Workers (CHWs) as non-clinicians who can perform interim quarterly assessments under supervision of RNCM

Role	Level of member managed
RNCM	Level 3 and 4
CHW	RN Extender, supportive staff not care managing
GSSC	Level 1 and 2
Care Coordinators	Supportive staff not care managing

- Onboarding Nurse title changed to Assessment Nurse
- Goals and measures updated for 2021
  - Updated targets, added/removed measures

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Description of the Special Needs Plan (SNP) population

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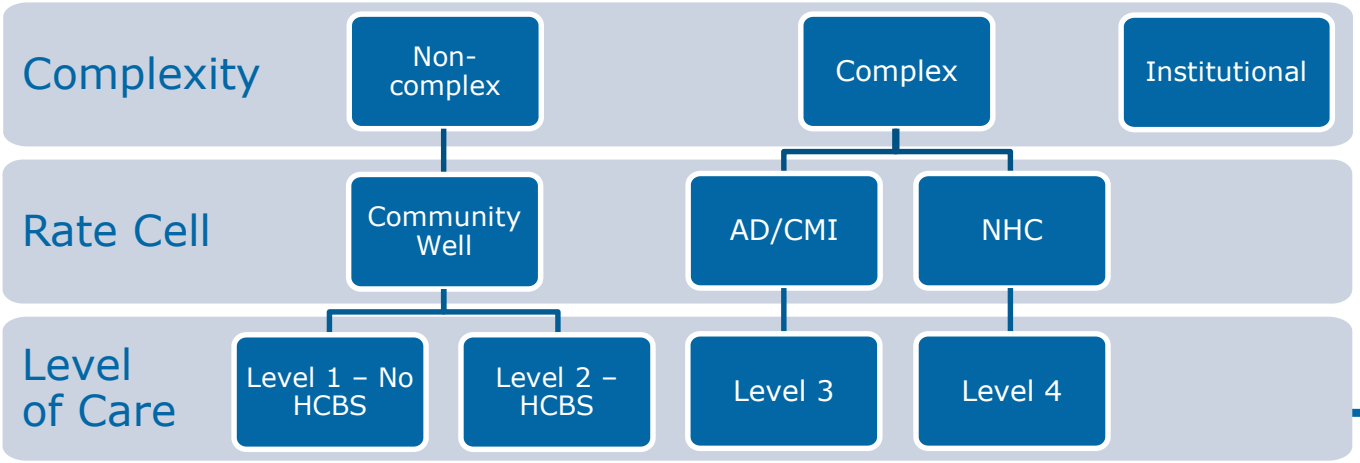
Rate Cells and Levels of Care

All members are enrolled as Community Well until they are evaluated by an Assessment Nurse or RN Care Manager, who will submit an MDS-HC to MassHealth to determine their **Rate Cell**.

Members are separated into **Levels of Care** based on their Rate Cell to determine the most appropriate Care Manager, services and touch point frequency.



Reimbursements are based on Rate Cells, so it is important to assess members accurately and re-assess if function changes.

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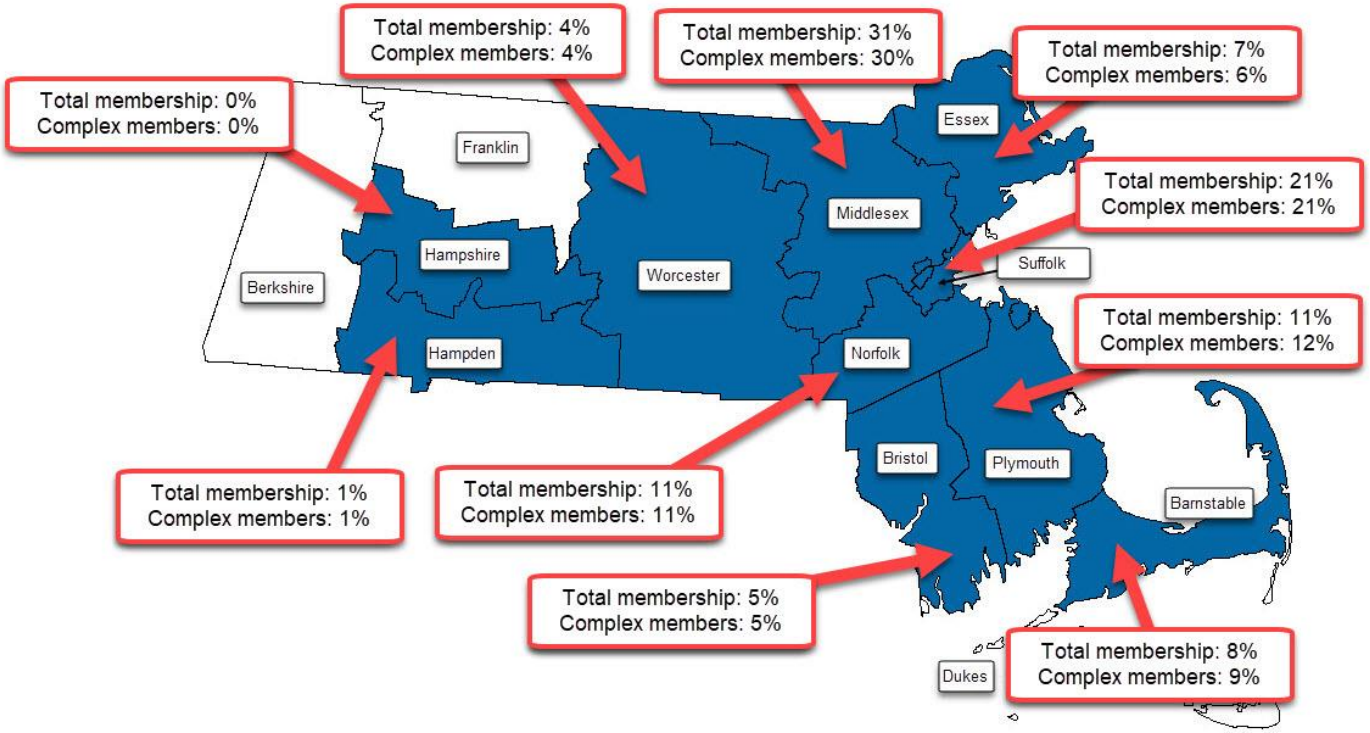
Description of the SNP population



County	% Total	% Complex
Barnstable	8%	9%
Bristol	5%	5%
Essex	7%	6%
Hampden	1%	1%
Hampshire	0%	0%
Middlesex	31%	30%
Norfolk	11%	11%
Plymouth	11%	12%
Suffolk	21%	21%
Worcester	4%	4%

County distribution as of October 2020

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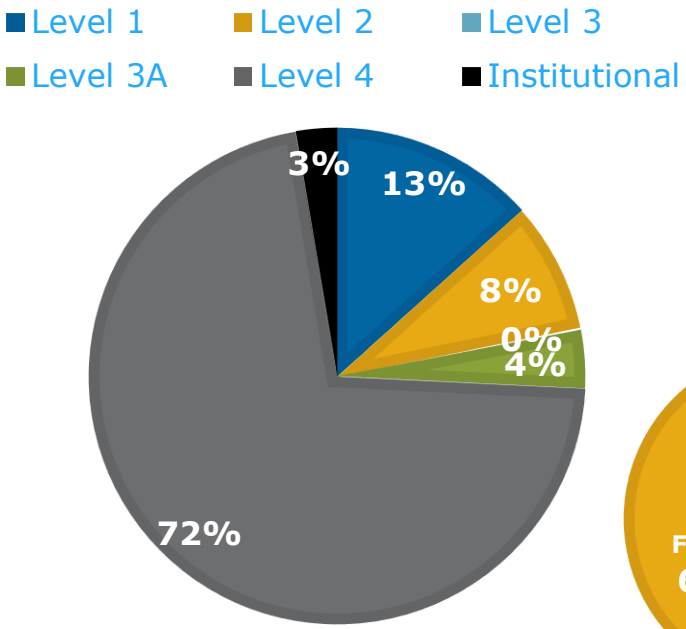
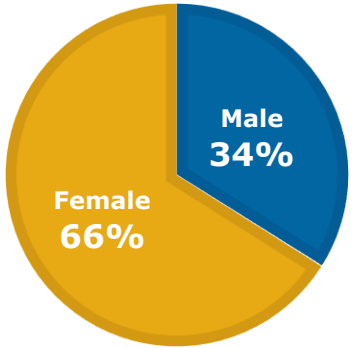
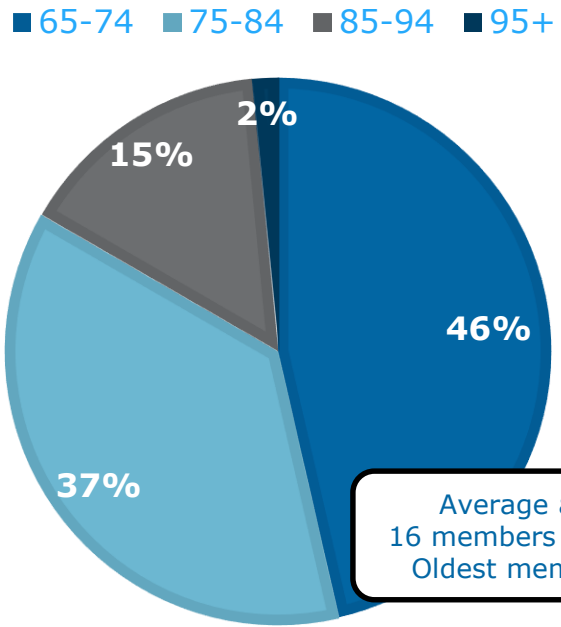
Description of the SNP population

Members by Level





Members by Age Range



Average age: 77
16 members aged 100+
Oldest member: 109

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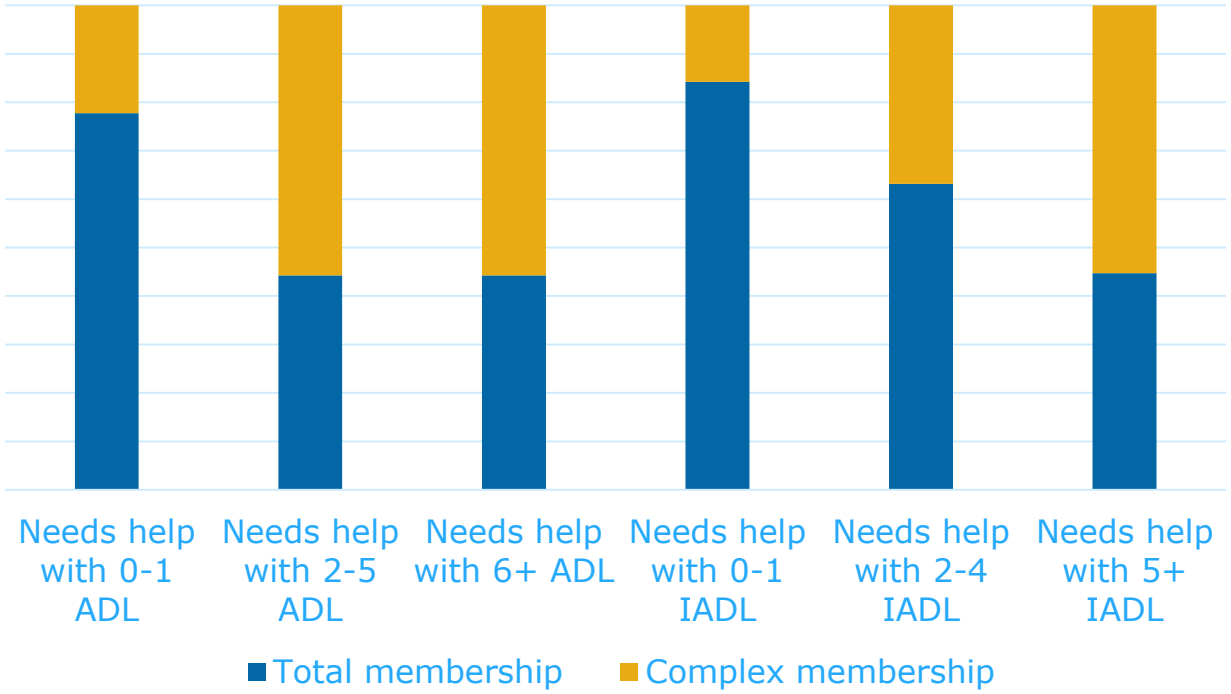
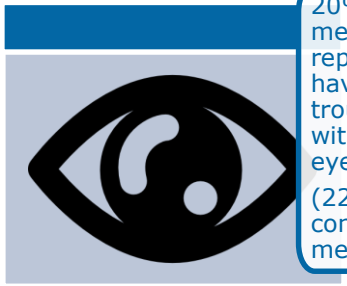
Description of the SNP population



19% of members report having trouble hearing (22% of complex members)



20% of members report having trouble with their eyesight (22% of complex members)

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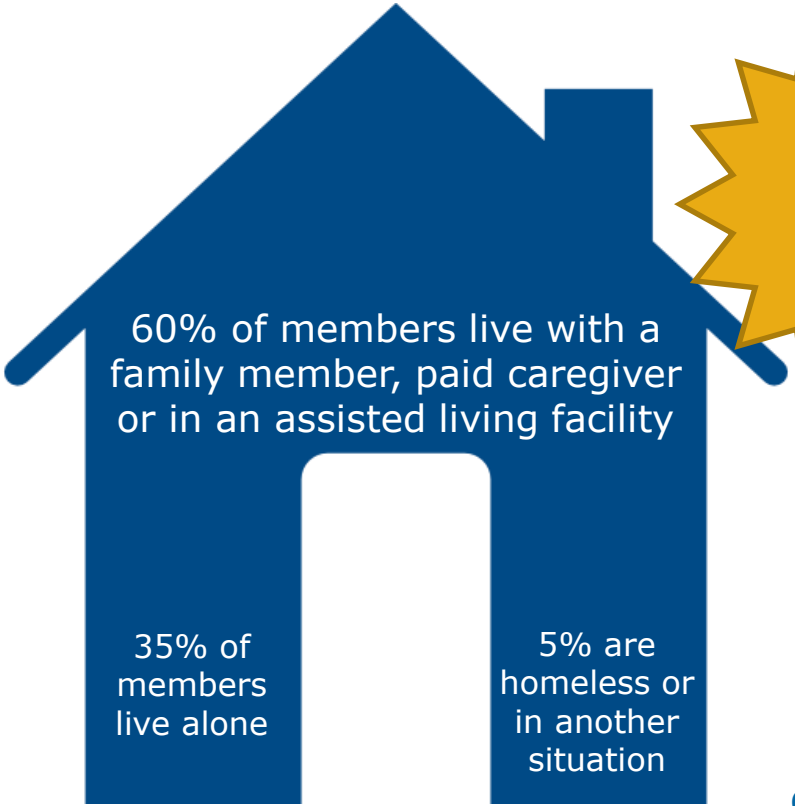
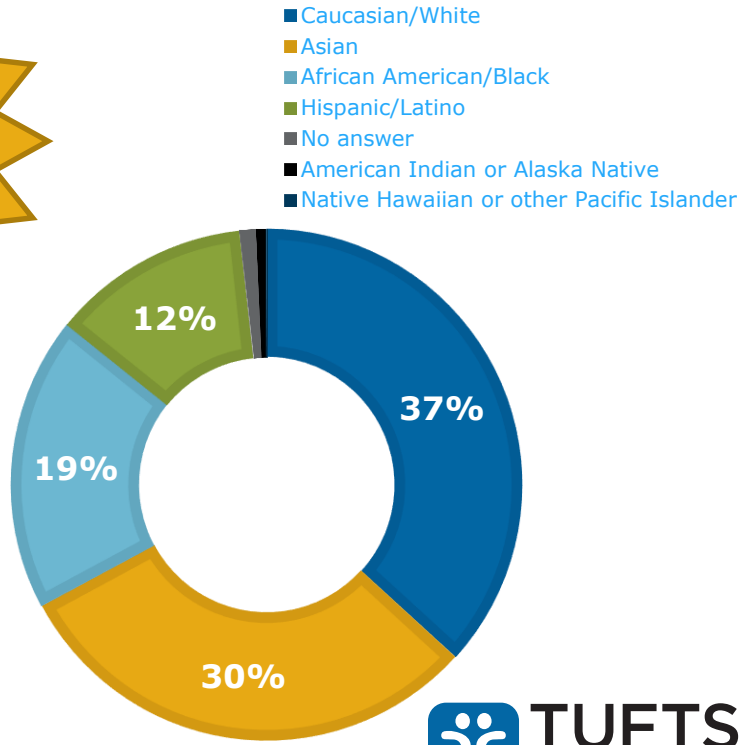
The most vulnerable: Complex members



96% of members say they have someone who can help them



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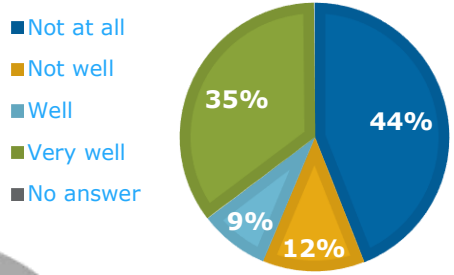
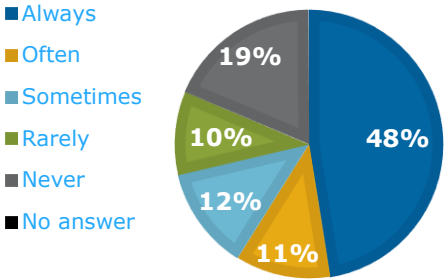
The most vulnerable: Complex members

Top 5 primary languages	
English	38%
Chinese (Mandarin)	14%
Spanish	12%
Cape Verdean Creole	6%
Haitian Creole	6%

How well do you speak English?



How often do you need help reading health-related materials?



Would you like the assistance of an interpreter or the language line?
Yes – 45%
No – 55%

The Primary Care Team (PCT)

Also known as Interdisciplinary Care Team (ICT)

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Some Expectations of Tufts Health Plan SCO PCPs

Review and Contact

- the Individual Care Plan (ICP) sent by Tufts Health Plan after the initial assessment and at minimum annually thereafter; Contact the Care Manager for suggested changes
- assessments sent by Tufts Health Plan Nurse Practitioner staff; Contact the APN when needed to coordinate care
- Medication Reviews performed by Tufts Health Plan Pharmacy Staff: Contact the Pharmacy Staff when needed to coordinate care

Respond

- to Nurse Care Manager requests to coordinate care and/or attend Interdisciplinary Care Team meetings when able

Provide/Complete

- Provide EMR access or submit annual history and physical annually
- Provide latest available member contact information and attempt to bridge the gap in communication with members refusing Tufts Health Plan assessments and/or unable to be reached (if requested)
- Recall members to fill gaps in care on quality measures
- Complete required model of care training and continuing education annually

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Primary Care Access Standards

Primary care providers have the responsibility of monitoring the care of their Tufts Health Plan SCO members by providing them with medical management that is both high quality and cost-efficient.

One important aspect of this requirement is being available to members **24 hours a day, 7 days a week** via direct contact or through a PCP-arranged network provider alternative.

Appointments for…	Should be Seen/Scheduled
Emergency care	Same day
Urgent care	Within 24 hours
Non-urgent symptomatic care	Within 1 week
Preventive/ routine care	Within 30 days

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Annual Tufts Health Plan SCO Provider Continuing Education

Tufts Health Plan SCO Primary Care providers are expected to have annual continuing education in the following areas:

- Depression
- Alcohol and substance use
- Dementia, including Alzheimer's disease
- Identification and treatment of incontinence
- Preventing falls
- Identification and mandatory reporting of abuse, neglect and exploitation of elderly individuals
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Diabetes

Links to the free CEUs can be accessed on line at:
https://tuftshealthplan.com/documents/providers/training/sco-cont-ed

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Current Model of Care Quality Goals

1. Improve access to care for medical, social and behavioral health services
2. Improve coordination of care and appropriate delivery of services through alignment of the HRAT, ICP and ICT
3. Promote and enhance transitions of care
4. Improve access to and utilization of preventive services
5. Promote appropriate utilization of services

Current MOC **Provider** Performance Measures

- Care of Older Adults - Annual Pain Assessment and Functional Status Assessments
- % of members discharged from acute inpatient hospital setting and return to any hospital with any admission diagnosis within 30 days of discharge
- COPD admission and COPD readmission rates
- CHF admission and readmission rates
- % of members who are seen by their PCP/specialist for a post-discharge visit within 7 calendar days of discharge from an acute facility
- % of members who receive a medication reconciliation within 30 days of discharge from an acute facility to the home setting

Current MOC **Provider** Performance Measures

- Breast cancer screening rates 65-74
- Colorectal cancer screening rates
- Immunization rates for influenza and pneumococcal vaccines
- Osteoporosis management in women who have had a fracture
- Disease modifying anti-rheumatic medications for members with rheumatoid arthritis
- Initiation of statin therapy for diabetes and for CVD
- STARS Part D medication adherence rates:
  - 80% compliance with fills for oral diabetic, statins and hypertensive medications

Care coordination

Staff supporting the program, including care management roles and responsibilities:

- Clinical Manager
- Assessment Nurse
- Nurse Care Manager
- Nurse Practitioner
- 24/7 On-Call Nurse Practitioner
- Behavioral Health Clinician
- Geriatric Support Services Coordinator
- Community Health Worker
- Care Coordinator
- Clinical Administrative Staff
- Clinical Pharmacist or Pharmacy Technician
- Dementia Consultant

Assessment Nurse

A registered nurse who conducts initial assessments:

- Identifies the clinical, behavioral and social needs of the member
- Develops initial Service Plan and Care Plan for new members based on assessment results
- Initial assessments must be done face to face*

* During normal operating times

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Clinical Manager

Responsible for:

- Oversight and monitoring of care management functions and delivery of metrics to ensure adherence to clinical quality, compliance metrics and care model delivery
- Direct oversight and responsibility of RNCMs and/or Clinical Consultant team
- Oversight of the clinical performance of the Aging Service Access Points (ASAPs)
- Acts as a clinical consultant to the field-based Care Managers and Supervisors on individual cases
- Identifies additional opportunities for growth and development of the Clinical Team

RN Care Manager (RNCM)

Healthcare Professional (RN) responsible for managing care for members with complex care needs:

- Completes initial assessments for community members as needed
- Secondary Care Manager for Level 3 members, conducting annual assessments and assessments for change in condition
- Ongoing assessments for Level 4 members, including:
  - Development and implementation of Individualized Care Plan (ICP or Care Plan)
  - Key player in ICT/PCT meetings
  - Initiates HCBS in collaboration with GSSC
  - Care coordination and planning in collaboration with PCP
  - Post-hospitalization Assessments (PHAs) and follow-through
  - Disease Management Program assignment and implementation
- MDS-HC completion annually for Level 3 and 4 members
- Resource and support for BHCM, GSSC, CHW and CC staff

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Nurse Practitioner

Licensed Nurse Practitioner (NP) serving as a consultant for high-risk members and those with complex conditions:

- Consult to ICT/PCT for all members, regardless of Level, regarding medical conditions
- Acts a resource for the clinical teams as it relates to chronic and complex patient management with advanced level insight and support with regards to high chronic disease burden, decline in functional status, progressive disease trajectories and goals of care discussions and planning
- Support and enhance the overall plan of care for our members that are member centric and intervention based through all transitions of care
- Conduct annual comprehensive exams that help build the foundation for short and long term care needs and establish those relationships needed to promote health promotion and wellness

Advanced Practice Nurse (APN) Clinical Care Delivery Program

Members will continue to be managed by an RNCM, with an additional support system comprised of an interdisciplinary team of clinicians and specialists that focus on advanced illness management with additional attention to progressive disease trajectories and complicating social determinants.

The APN will support the clinical teams at any time additional input is sought and when the member meets higher risk criteria.

- **High risk acute inpatient admission**
  - Required ICU stay while in the hospital
  - Hospital stay > 7 days
  - Poor prognosis
- **High risk hospital discharge / High risk SNF discharge**
  - Required ICU stay while in the hospital
  - Hospital stay > 7 days
  - Recommended skilled stay but discharged home
- **Significant decline and functional limitations as a result of medical**
  - New CAD/MI with poor EF/endurance, new CVA with deficits, progressive dementia with indications of FTT requiring more and more care, etc.
- **High Re-Admission rate as identified on re-admission reports**
  - High Re-Admission rate (> 2 in the past 2 months)
  - In patient stay / not observation stays
- **Multiple ED visits**
  - Medication reconciliation revealed concerning medication regimen
- **Alignment of progressive disease trajectories lacking with associated poor prognosis**
- **Frail elder w/ multiple co-morbidities and in need of complex medical management**
  - New diagnosis of CAD w/ renal issues, diabetic on insulin with new renal failure and dialysis, etc.
- **Significant decline and functional limitations as a result of new and or end stage medical conditions**
  - New CAD/MI with poor EF/endurance, new CVA with deficits, progressive dementia with indications of FTT requiring more and more care, etc.

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24-hour on-call nurse

Per EOHHS, SCO is required to provide members with 24/7 access to a clinical professional, which we do through our toll-free Customer Relations line.

- Customer Relations will answer M-F between 8am-8pm, and will contact the member's CM if necessary
  - Members may also reach out to their CM or Care Coordinator directly during regular business hours (8am-5pm)
- After 8pm, members reach a recording where they can leave a message for Customer Relations, or press 1 for urgent medical issues
- Senior Products NPs have a weekly rotation for after-hours calls
  - Calls are documented in CaseTrakker, and follow-up Tasks assigned as needed

Behavioral Health Care Managers (BHCM)

Behavioral Health Clinicians providing support and care management for members with behavioral health needs:

- Assist with early identification and intervention of behavioral health and substance abuse needs
- Serve as Care Manager for Level 3 members rated with Alzheimer's Dementia/Chronic Mental Illness (AD/CMI)
- Collaborate with RN Care Manager on coordination of care with Department of Mental Health as needed
- Assist with referrals to behavioral health providers
- Collaborate with ICT/PCT on coordination of care for members with serious and persistent mental illness and substance use disorders
- With RN Care Manager, co-manage Level 4 members with behavioral health conditions

Geriatric Support Services Coordinators (GSSC)

Community resource contracted through Aging Services Access Point (ASAP)

Can serve as Care Manager for Community Well members and perform assessments for all members

- Biannual telephonic assessments for Level 1 members
- Biannual face-to-face assessments for Level 2 members
- Can perform one quarterly face-to-face assessment for Level 3 or Level 4 members

Coordinates Home and Community-Based Services (HCBS)

Collaborates with RNCM and BHCM on care coordination, ICP and Plan of Care implementation

Participates as needed for ICT/PCT meetings

Assists with Medicaid (MassHealth) eligibility issues

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Community Health Worker

Additional community support for the member, assisting CMs in following up on member Care Plans:

- Serves as RNCM extender/support, particularly when GSSC assistance is not available, focusing on in-home work with members to implement Care Plan interventions as assigned by CMs
- Assists RNCM with completion of Care Plan Interventions for Complex members residing in the community requiring assistance with ADLs
- Works collaboratively with RNCM, ICT/PCT and providers to increase member knowledge, motivation and treatment through targeted interventions that address the member's holistic needs from a psychosocial, medical and socioeconomic perspective
- Primary resource to support members experiencing loneliness/social isolation

Care Coordinators (CC)

Member-facing office staff supporting field-based Care Managers:

- Responds to member phone calls and questions regarding HCBS and Durable Medical Equipment (DME)
- Calling provider offices for clinical information, including History & Physicals (H&Ps) and referral documentation
- Faxing clinical information to HCBS providers, including requests for services, member Care Plans and referrals
- Scheduling assessment visits on behalf of Care Managers and Nurse Practitioners
    - Schedulers supporting Care Managers are in the process of being embedded within SCO Area Teams

Clinical Administrative Staff

Office staff supporting behind-the-scenes Care Management processes for all SCO staff:

- Coordinates intake process for new members
- Sends members in Disease Management Programs educational materials approved by EOHHS
- Creates Outpatient Events (OPEs) to authorize HCBS on behalf of Care Managers
- Supports Care Coordinators with administrative tasks
- May have additional projects/assignments as needed

Clinical Pharmacist & Pharmacy Technicians

Clinical Pharmacist supervises a group of Pharmacy Techs, embedded in the ICT/PCT, to improve quality of care through:

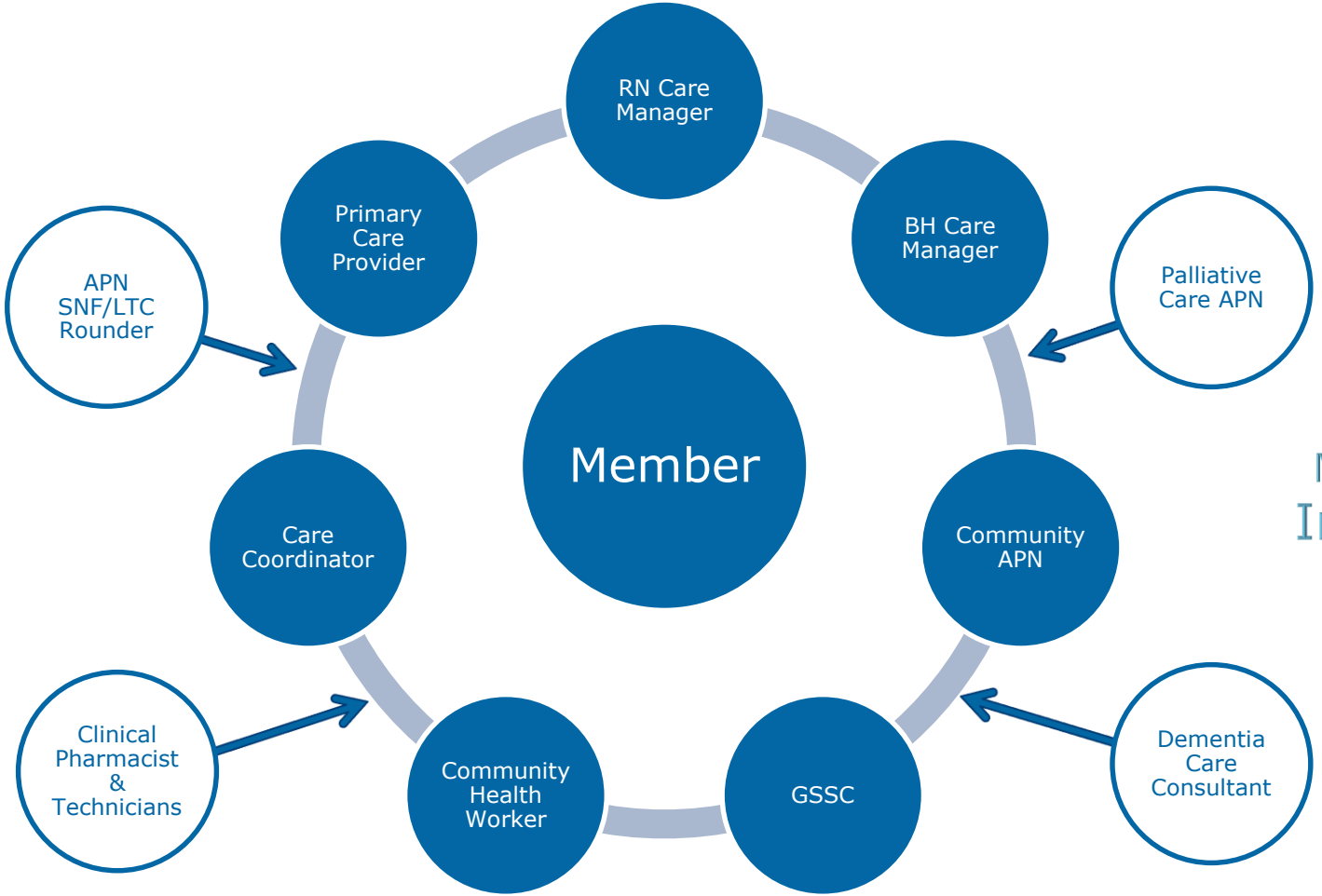
- Care coordination
- Medication management programs
- Consultative services
- Quality initiatives
- Comprehensive medication management reviews to improve outcomes, reduce drug related problems and reduce admissions/readmissions
- Examples:
  - Advises member and ICT/PCT on the selection, dosages, interactions and side effects of medications
  - May teach member how to administer medications
  - May perform medication reconciliation and review

Dementia Care Consultants

The Dementia Care Consultant is a THP employee who sits at the Alzheimer's Association to support all THP members/caregivers by:

- Providing information to members and/or caregivers to develop a better understanding of their diagnosis and develop strategies for symptom management
- Screening members for changes in cognitive function and providing tools, education, support and care planning
- Coordinating care with Care Manager, family, PCP and other members of the ICT/PCT in short-term, focused interventions

Primary Care Team (PCT)



May also be called Interdisciplinary Care Team (ICT)

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Specialized network expertise

THP contracts and credentials in the Service area with over:

- 1,200 primary care physicians
- 5,000 specialists
- 40 acute care hospitals
- 350 sub-acute facilities
- 15,000 individual, group, and facility providers encompassing many ancillary services: including but not limited to clinical psychologists, Licensed Independent Clinical Social Workers (LICSWs), and other behavioral health providers; physical and occupational therapists and speech pathologists; durable medical equipment providers; chiropractic service providers; and free-standing laboratory facilities, imaging facilities, dialysis centers, and ambulatory surgical centers
- 800 dentists
- 1,500 routine vision care providers
- ASAP for Home and Community Based Services (HCBS)

Assessments and Care Planning

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Core Care Model

The care model focuses on an integrated approach to care management, including medical, behavioral, social and long-term needs.

- A SCO member's Primary Care Team (PCT) includes a Primary Care Provider (PCP), and may also include a Registered Nurse Care Manager (RNCM), a Behavioral Health Care Manager (BHCM), a community health worker (CHW), a care coordinator , and a Geriatric Support Services Coordinator (GSSC) from an Aging Services Access Point (ASAP)
- Based on the member's needs, the PCT may also include ,a Clinical Pharmacist or Pharmacy Technician, a Nurse Practitioner and/or other health specialists

Every member has an Individualized Plan of Care (ICP) that is developed during assessment.

- The plan is updated as the member's condition and needs change
- Initial ICP and at minimum annual update mailed to Member/Caregiver and PCP
- A Centralized Enrollee Record (CER), accessible to all members of the care team, contains all activity related to the member's care

Touch point frequency

	Level 1 Community Well	Level 2 Community Well w/HCBS	Level 3 AD/CMI	Level 4 NHC	Institutional
Calls/Letters	Welcome Call made during first 30 days by Customer Relations				Welcome Letter sent within first 30 days by CR
Initial Assessments	Initial face-to-face assessment completed within 30 days by RNCM/Assessment Nurse				
Ongoing Assessments	• Telephonic • Due every 180 days • Completed by GSSC	• Face-to-face • Due every 180 days • Completed by GSSC or CHW	• Face-to-face • Due every 90 days • Completed by BHCM or RNCM • 1 assessment annually by GSSC or CHW • Annual visit w/RNCM required	• Face-to-face • Due every 90 days • Completed by RNCM/NP • 1 assessment annually by GSSC or CHW *(select members)* • Annual visit w/RNCM required	• In-facility • Due every 90 days • Completed by CCP
MDS Requirement	No MDS-HC		MCH-HC Submitted Annually		SNF responsible for MDS 3.0

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Health Risk Assessment (HRA)

The Comprehensive Assessment, also known as the Health Risk Assessment Tool (HRAT):

- Evaluates the medical, functional, cognitive, psychosocial and mental health needs of each members
- Gathers information about the member's living arrangements; family and social supports; function; current health status; cognition; behavioral health; substance use/abuse; preventive health measures; medication/health history; lab data; advance directive status and goals of care
- Identifies factors that may be contributing to illness and/or the need for support services

Other assessments

In addition to the initial and ongoing Comprehensive Assessment, CM Staff will perform supplementary assessments as indicated by the member's identified level of risk as well as their complexity, diagnoses and/or health care utilization.

- Minimum Data Set – Home Care (MDS-HC): Completed annually by an RN/NP and submitted to EOHHS to capture the member's Rate Cell
- History and Physical (H&P): Obtained annually from the PCP
- Functional Assessment: Completed annually and with service plan changes for any member receiving HCBS
- Disease Management Program Assessments: Face-to-face after program enrollment and annually after
- Behavioral Health Assessments: Face-to-face or telephonic; completed by BHCM as needed

Interim assessments

In addition to regularly scheduled ongoing assessments, members are reassessed more frequently if certain trigger events occur, such as:

- Acute episode such as an ER visit or hospitalization
- Change in medical/functional condition such as the development of pneumonia
- Change in social condition such as the loss of a caregiver

Disease Management Programs

The Disease Management Programs focus on five diseases:

- Diabetes
- Depression
- Dementia
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure

The program includes the provision of educational materials, disease-specific assessments, and member coaching and referrals to specialty programs, as needed.

*** Reminder:** Chronic Care Improvement Program on COPD and Depression

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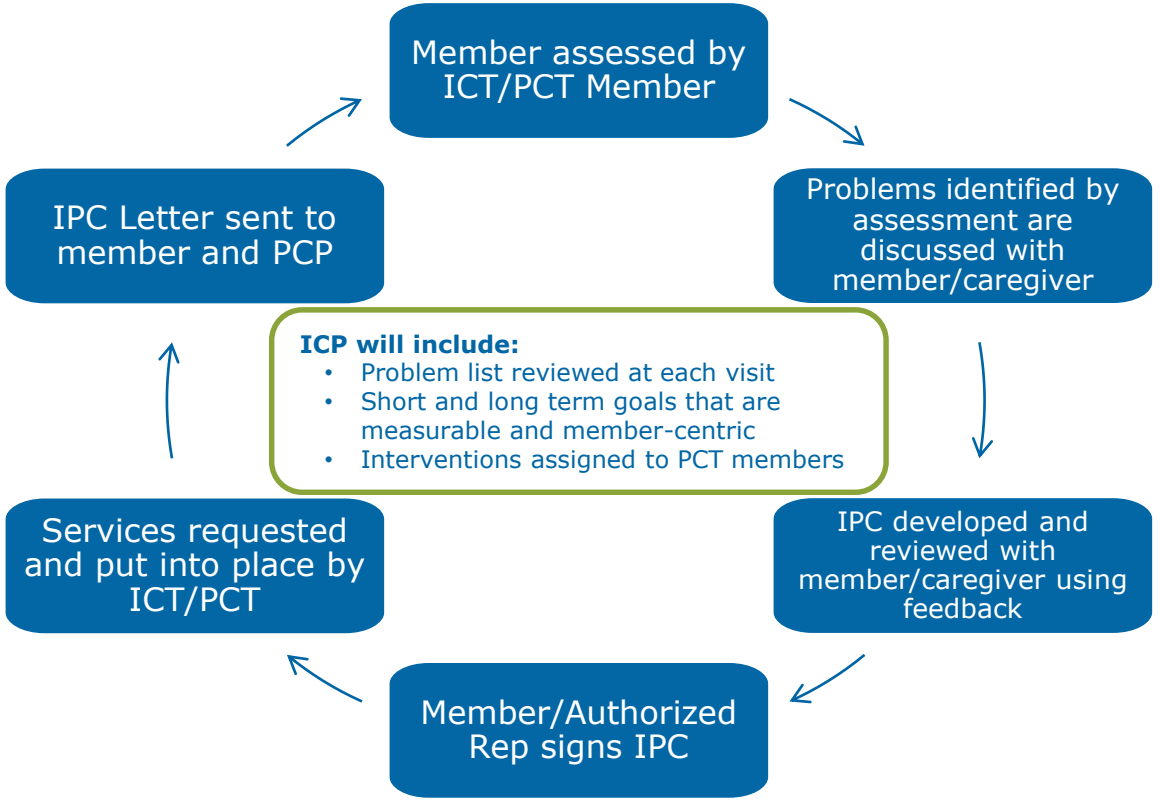
PCP Contact Guidelines

At minimum…

- Initial and annual ICP mailed to PCP
- Notification of transitions of care
- Notification of changes in functional status
- Care Manager initiation of telephonic contact by the PCP in developing the plan of care and to coordinate care (no less than annually)

Individualized Plan of Care (IPC) Process



Initial assessment and IPC completed by RNCM or Onboarding Nurse to ensure member is assigned the correct Level and CM

Initial IPC completed on carbon copy form and signed during visit by member/authorized representative; Annual IPCs are mailed for signature (with SASE)

Members are re-assessed every 3-6 months (based on Level), or with any change in member's condition

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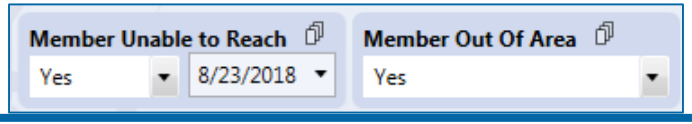
Care Planning Reminders – UTR/OOA

Members are determined to be Unable to Reach (UTR) after 3 phone calls at different days and time:

- ✓ All phone call attempts are documented in the Eval Task or an Activity Log
- ✓ UTR letter sent to member
- ✓ Populate Member Unable to Reach field on Member File and update with date of last phone call attempt
- ✓ If member is also Out of Area (OOA): Populate Member Out Of Area field and email SCO_Enrollment@tufts-health.com to begin 6-month countdown process

For new members:
Complete and document within first 30 days of enrollment

For existing members:
If applicable, complete and document before the annual assessment due date



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Care Planning Reminders – ICPs

- ✓ **Institutional**, **Unable to Reach** and **Members Refusing Assessment** must also have an annual ICP issued
  - ICPs for Institutional members will only have THP SCO Care Management listed in their Service Plan
  - See example Problems/Goals/Interventions for members who are unable to reach, out of area or refusing assessments
- ✓ **ICP** must be mailed to the member annually, and either verbal or written approval documented
  - Verbal approval documented on Plan of Care screen with each visit
  - Written approval documented when member/caregiver returns ICP in self-addressed, stamped envelope to Admin Team, who upload to CaseTrakker

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Transitions of Care (TOC)

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Use of clinical practice guidelines and care transition protocols

THP endorses existing evidenced-based guidelines and distributes them to plan providers via the provider website, Provider Newsletter and provider training, including:

1. Preventive health guidelines, involving screening for disease
2. Clinical practice guidelines, outlining a recommended treatment path or use of ancillary services

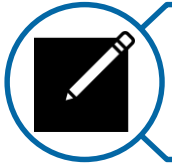
THP's clinical practice and preventive health guidelines are designed to support preventive health, behavioral health, acute disease treatment protocols and/or chronic disease management programs.

THP standard guidelines and practice protocols are customized for the geriatric population.

The Care Management Team receives alerts and reminders for individual beneficiaries if there are gaps in care per the guidelines.

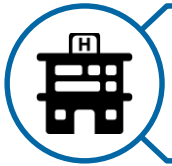
Providers are expected to maintain continuity of care during transitions.

Who's who in Transitions of Care (TOC)



Clinical Administrative Staff – Office-based Care Coordinators and Admins supporting field-based staff

Care Manager (CM) – GSSC, BHCM or RNCM supporting members residing in the community



Clinical Nurse Liaison (CNL) – THP Senior Products RN embedded within an inpatient facility

Community Care Partner (CCP) – THP Senior Products RN embedded within a long-term care facility

TUFTS Health Plan

Planned TOC – Before

Clinical Administrative Staff:

- Tasks the assigned Care Manager via CaseTrakker to advise of the upcoming admission
- Calls the inpatient facility on the scheduled admission date to confirm the member has been admitted
- If the admission was rescheduled or cancelled, updates CaseTrakker to reflect the change, including a new admission date (if applicable)

Care Manager:

- Reaches out to the member and/or caregiver as their main point of contact and support during this transition

Planned/Unplanned TOC – During Intake/Stay

Clinical Administrative Staff:

- Requests clinical information from the facility
- Ensures that the facility has the member's PCP contact information, and requests they make contact
- For unplanned admissions: Sends information about the member's ICP to the facility

Care Manager:

- Contacts the member's caregiver within 1 business day of admission to discuss the care transition process, confirm changes to the member's status, and offer support as a single point of contact during the transition
- Notifies HCBS providers to suspend services during admission

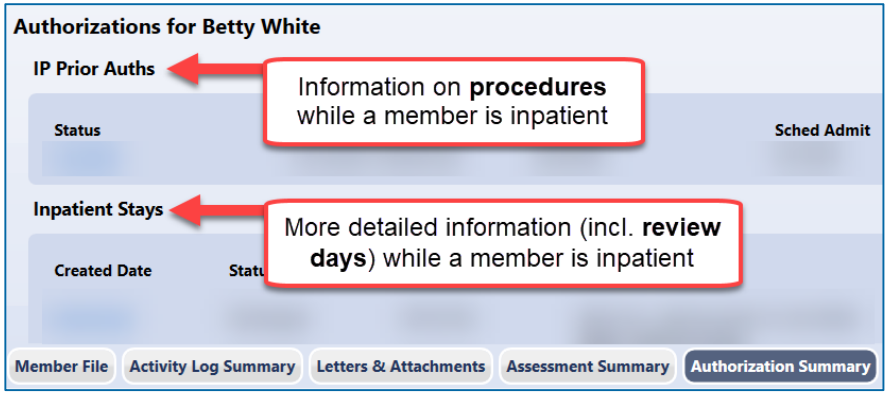
For mental health/substance abuse admissions:
The BHCM or a member of the BH Utilization Management (UM) team will work directly with the facility

TUFTS Health Plan

Planned/Unplanned TOC – During Intake/Stay

Clinical Nurse Liaison:

- Monitors progress during the inpatient stay, both with the member and the facility
- Collaborates with the CM for discharge coordination if the member is expected to return to the community, or with the CCP if the member is expected to discharge to a long-term care facility, beginning to plan at the time of admission
- Confirms the facility has been in contact with the member's PCP and facilitates information sharing
- Updates **Inpatient Stay** in CaseTrakker regularly during admission



TUFTS Health Plan

TOC – Discharging to Community

Clinical Nurse Liaison:

- Updates CTD with discharge date, which triggers PHA-2 to be assigned to Primary Owner (CM)
- Obtains Discharge Summary, if available, and sends to PCP
  - If not available, Tasks **Clinical Administrative Staff**

Care Manager:

- Communicates discharge plan with member and/or caregiver
- Reviews and updates the ICP
- Arranges for HCBS to resume, and orders new services as needed
- Convenes ICT/PCT meeting, if needed, and documents notes and follow-up in CaseTrakker
- Shares ICP with the Home Care Agency, if applicable, and ensures they receive Discharge Summary from the facility

TOC – Discharging to Community

Care Manager:

- Completes PHA-2 with member and/or caregiver to:
  - Assess member's health status and update ICP
  - Ensures that PCP/Specialist follow-up appointment is scheduled, and assist with scheduling if it is not
  - If member is at high risk for readmission: Communicates with PCP; Create action plan/crisis plan with member/caregiver; Update ICP accordingly; Consider referral to clinical programs/NP
- Completes or assigns the PHA-7 to be completed with member/caregiver to:
  - Reassess member's health status and update ICP
  - Ensure that PCP/Specialist follow-up appointment is scheduled or completed, and assist with scheduling if it is not
  - Ensure all member's needs are being adequately met
  - Complete medication review and reconciliation

TOC – Discharging to Custodial Nursing

Clinical Nurse Liaison:

- Updates CaseTrakker with discharge information from inpatient facility
- Communicates with PCP/CCP and updates ICP

Continuing Care Partner:

- Coordinates with the CNL/custodial nursing facility about member's health status, risk for admission and care plan on an ongoing basis
- Continues to outreach to member and/or custodial nursing facility for ongoing assessments and ICP updates

Care Manager:

- Reaches out to the member and/or caregiver as their main point of contact and support during this transition

Helpful Information

TUFTS Health Plan

To contact a Tufts Health Plan SCO member's Care Manager call:

888.766.9818

TUFTS Health Plan

Centralized Enrollee Record

The centralized enrollee record (CER) is a single, centralized electronic record with the primary purpose of documenting Tufts Health Plan SCO member status.

The CER is used to facilitate communication among members of the Care Team.

The CER or a summary abstract is available to any provider who requires access 24 hours a day, 7 days per week.

To obtain access, contact Provider Services: SCO-Provider_Escalation@tufts-health.com

Tufts Health Plan online resources

Tufts Health Plan SCO member website:

- tuftsmedicarepreferred.org/plans/senior-care-options-plan

Available on the member website:

- ✓ Explanation of Coverage
- ✓ Summary of Benefits
- ✓ SCO Provider Directory

Tufts Health Plan SCO provider website:

- tuftshealthplan.com/provider

Available on the provider website:

- ✓ Provider Manual
- ✓ Payment Policies
- ✓ Medical Necessity Guidelines

TUFTS Health Plan

Tufts Health Plan SCO Contact Information

Provider Services: 800.279.9022

- Providers can call with inquiries about claims, benefits, policies and care management.

Member Services: 855.670.5934

- Members can call for information about their health care coverage.
- Translation services are available: 855.670.5936

Appeals and Grievances: 855.670.5934

Provider Education: Provider_Education@tufts-health.com

- Educates providers about products, policies and procedures, and self-service technology solutions.

Tufts Health Plan Provider Website: tuftshealthplan.com/provider

- For technical inquiries, email: **Network_Tech@tufts-health.com**
- For assistance with website navigation, registration, and account maintenance, call Provider Web Support at **888.880.8699, ext. 35956**

TUFTS Health Plan

Thank You!

We appreciate your attention
and participation.

Please click **here** to attest
to the completion of this training
and to take the
Tufts Health Plan SCO
Provider Satisfaction Survey.

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