Care Model for Tufts Health Plan Senior Care Options (SCO)

The following topics are covered in this chapter:

- Interdisciplinary Care Team
  - PCPs
  - Care Coordinators
  - Geriatric Support Services Coordinators
  - Community Health Worker
  - Nurse Care Managers (RN Care Manager)
  - Community Care Partner (CCP)
  - Behavioral Health Care Manager
  - Dementia Care Consultant
  - Transition Manager
  - Member Services Representative
- Care Management Process
- Assessment and Risk Categories
  - Initial Assessments
  - Ongoing Assessments
  - Change in Condition
- Features of the Tufts Health Plan SCO Care Model
  - Intake
  - Initial Assessments
  - Monitoring and Ongoing Assessments
  - Centralized Enrollee Record (CER)
  - Discharge Planning
  - Care Transitions
  - Advance Directives

The overarching construct for Tufts Health Plan Senior Care Options (SCO), a Dual Special Needs Plan (D-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 Tufts Health Plan SCO model of care integrates the member's Medicaid and Medicare benefits into one benefit package, allowing the Interdisciplinary Care Team (ICT) 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 is assigned to each member and serves 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 ICT creates a care plan for all Tufts Health Plan SCO members. The care plan 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 Tufts Health Plan SCO members are evaluated for care coordination needs through initial and ongoing clinical assessments and other health risk assessment tools. All Tufts Health Plan 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 ICT.

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 ICT 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 registered nurse (RN) care manager creates and manages a care plan. The care plan 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 care plans 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, 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.

Interdisciplinary Care Team (ICT)

The ICT 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. The ICT works to help ensure effective coordination and delivery of covered services to all Tufts Health Plan SCO members.

Interdisciplinary Care Team Responsibilities

Interdisciplinary Care Team (ICT) providers actively cooperate with Tufts Health Plan SCO and other providers participating in a member's ICT. Cooperation includes, without limitation:

- timely communication and information sharing regarding the member's health status, needs, services, and transitions of care;
- participation in care management and care coordination activities, including ICT meetings and care planning activities;
- development, implementation, review, and updating of member care plans within the scope of the provider's services; and
- timely sharing of current care plans, assessments, progress notes, and other care management or care coordination documentation relevant to the member's care. Providers are responsible to furnish such documentation upon request and otherwise provide information reasonably necessary to support coordinated care delivery, continuity of care, quality improvement activities, and the achievement of clinical and quality outcome objectives.

Specific ICT 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 care plan. ICT meetings are organized to discuss the status and care plan 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 ICT meetings, during which changes to complex member's care plans 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 ICT. Organized under Massachusetts law, ASAPs are local agencies that manage the home health care programs 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:

- 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 as part of a member's ICT
- 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 care plan

Community Health Workers

Community Health Workers (CHWs) are frontline public health workers who apply their unique understanding of the experience, language and/or culture of the populations they serve. The CHW will arrange, coordinate, evaluate, and advocate for safety net services that provide for basic needs such as education, housing, healthcare, health harming legal issues, transportation and counseling assistance. CHWs are responsible for the following tasks:

- Providing direct social care navigation and care management through face-to-face visits and telephonic support to members that have been identified with unmet health related social needs (HRSN).
- Bridging the gap between communities and health and human services by increasing members' health knowledge and ability to be self-reliant.
- Assisting members in navigating state and federal benefits and applying when a member meets qualifications.
- Assisting members in accessing Community Based Organization resources with referrals and warm hand offs.
- Using recovery strategies such as motivational interviewing, empathic listening, harm reduction, positive behavioral support techniques, limit setting and strength-based approaches to support members in attaining stated goals.
- Providing direct services, such as:
    - 1:1 informal health education
    - Chronic diseases education
    - Social support
    - Care coordination and provider navigation
    - Health services enrollment and health insurance navigation skills
    - Ensuring the coordination, completion, and follow-up to preventive health screenings

Nurse Care Managers (RN Care Manager)

As part of the ICT, 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 care plan for all Tufts Health Plan SCO members on their caseload
- Monitoring the provision and effectiveness of community-based services as defined by the member's care plan
- Conducting the Uniform Core Assessment (UCA) for Tufts Health Plan SCO members
- 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 ICT 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 ICT on member progress
- Working closely with the care coordinator, PCP and GSSC to help ensure open lines of communication

Community Care Partner (CCP)

A CCP is responsible for the care management of a caseload of beneficiaries residing in long-term care settings.

- The CCP directly interfaces with beneficiaries and their caregivers, Rounders, SNF/LTC facility staff, Tufts Health Plan UM clinicians and other members on the ICT in identifying risk factors, and ensuring that Beneficiaries' needs are being met at the facility
- Facilitates the care transitions process that can include transition to and from inpatient settings, SNF facilities, or hospice care, or discharge from long-term care back to the community
- Performs frequent reviews and document the member's status during a skilled inpatient stay
- Coordinates regular ICT meetings, including involving the RN CM early and often if the member is expected to return to the community
- Identifies discharge needs to facilitate the member's transition back to the safest environment
- Performs quarterly reviews and annual comprehensive reviews of all long-term care members
- Works closely with the facility and member to develop and evaluate the member's care plan
- Ensures long-term care members receives Part B services with any changes in status to promote the best quality outcomes

Behavioral Health Care Manager

BH care managers may be assigned as a member of the ICT for those members with complex behavioral health and/or substance use issues. They are responsible for the following:

- Conducting interventions for behavioral health and/or substance use needs on an as-needed basis
- Acting as a consultant to the ICT for difficult to manage members
- Providing access to behavioral health and/or substance use services

Dementia Care Consultant

A Dementia Care Consultant can be assigned as part of a member's ICT to support the member and/or their caregivers who are experiencing complex needs related to the member's diagnosis of Alzheimer's and other forms of dementia or other concerns of cognitive decline. The Dementia Care Consultant will:

- Provide disease-specific education, symptom management strategies, emotional support and regularly scheduled follow up
- Refer to community resources, Alzheimer's Association support groups, education programs, and advocacy opportunities
- Engage with the PCP as indicated and care management team to recommend updates to the ICP

Transition Manager (TM)

The Transition Manager (TM) is a nurse liaison who will manage a member's transitions of care by collaborating and 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. Their 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

Member Services Representative

While not a member of the ICT, Member Services plays an important role in educating members about the plan, as well as their rights. Member Services works with members to assign an in-network PCP and quickly address non-clinical questions or concerns that members may have.

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

Member Services is responsible for executing ongoing administrative tasks for members (e.g., processing grievances, replacing lost membership cards).

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 Other (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	RN Care Manager
Community Other (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 in a stable state	RN Care Manager
Community Behavioral Health (CBH)	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 care manager, community health worker, nurse practitioner, 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 Tufts Health Plan 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 Uniform Core Assessment (UCA)

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 care plan adequately supports the member in their current living arrangement.

For members residing in an institutional setting, 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
    - MassHealth OTC drug list
    - Preferred extras brochure
    - Provider directory/Formulary availability notice
    - Miscellaneous forms (Ombudsman program info, privacy notice, AOR form)
- OTC brochure
- EOC

Initial Assessments

The RN care manager typically conducts an initial in-home assessment within 30 calendar days of a member's enrollment. 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 if 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 care plan is completed as part of the initial assessment. The care plan is always reviewed with and agreed upon by the PCP, member, caregiver and other members of the ICT before being considered final. The care plan is developed after the initial assessment and updated thereafter with any major change in condition. A care plan is developed and includes identified problems, goals and interventions. The care plan is reviewed and updated with each assessment.

For those members living in the community who are identified as being Community Behavioral Health or nursing home certifiable, RN care managers conduct the Uniform Core Assessment (UCA). 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 care plan 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 Other members (with no HCBS) are assessed telephonically every six months
- Community Other members (with HCBS) are assessed every six months

- CBH members are assessed via home visits alternating with telephonic assessments every quarter (for complex cases) or every six months for non-complex members
- Nursing home certifiable members are assessed every quarter
- 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 due to 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 if 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 ICT 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, 7 days 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 MassAbility 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
- 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

[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, case managers, emergency shelter outreach or case management staff, care coordinators, and other support identified by the member.

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 ICT (Interdisciplinary Care Team) to the treating provider
- Communicate information about the member's status from the treating provider to the ICT to facilitate planning for return to the most appropriate care setting

The goal is to facilitate planning for return to the most appropriate care setting. The ICT 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 ICT 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 care plan 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 Tufts Health Plan SCO members within 30 days of enrollment and at every ongoing assessment in order to have an advance directive in place within the first year of enrollment.

PUBLICATION HISTORY

03/12/24	reviewed; edits to ICT, Features of the Tufts Health Plan SCO Care Model; Advance Directives; and administrative edits
07/01/26	removed reference to Community Partners (CP) related to a member's support team due to end of CP program.
09/01/26	update for consistent use of term, "care plan"; updated use of MDS-HC to Uniform Core Assessment (UCA).
10/01/26	added contractual responsibilities for providers as participants on the Interdisciplinary Care Team (ICT).
11/01/26	updated reference to MassAbility