# Care Management

Tufts Health Public Plans' integrated care management services are intended to support the delivery of person-centered, coordinated activities to support members' goals and better health outcomes. Here is a list of the topics in this chapter:


- Overview of Integrated Care Management Services
  - Disease Management
- Complex Care Management (CCM) Services
- Health Needs Assessment
- Peer Support
- Emergency Room (ER) Visits and Follow-Up Services
- Maternal and Child Health Program
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  - Prenatal and Postpartum Extra Benefits and Services
  - Notification of Birth
- Massachusetts-Specific Care Management Services and Programs
  - Community Health Services
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- Rhode Island-Specific Care Management Services and Programs
  - Transition of Care (ToC) Programs
  - Care Coordination
  - Complex Care Management (CCM)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Assistance


Refer to the Tufts Health One Care chapter for specific care management guidelines for Tufts Health One Care.

## Overview of Integrated Care Management Services (ICM)

Tufts Health Public Plans' Integrated Care Management (ICM) programs are based on best practices and evidence-based guidelines employed across the case management industry and are aligned with the Case Management Society of America's Standards of Practice. The program offers a multidisciplinary and team-based approach to provide members with access to appropriate care and services. This approach allows the team to assist providers, members, and, when authorized, members' families and caregivers to successfully navigate the continuum of care.

A Tufts Health Public Plans care manager is available to work with each member and their caregivers (when authorized) to design individualized care plans outlining members' personal goals and health care preferences, and to engage them in their treatment and recovery. Tufts Health Public Plans works with primary care offices and other health care and social service providers to coordinate access to care and avoid duplication of services. This integrative method is based on what may be members' most critical needs.

The ICM team has varied professional training and experiences in behavioral health, nursing, nutritional counseling, respiratory therapies, community health work and more. The team is diverse and represents a wide range of cultural and linguistic backgrounds, which enables Tufts Health Public Plans to effectively interact with members, address cultural barriers, adapt to unforeseen challenges, and coordinate access to high-quality health care services. Tufts Health Public Plans leverages translation services per members' preferences in order to effectively communicate with them and their caregivers.

Contact Provider Services at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island) to refer members who may benefit from one of Tufts Health Public Plans' ICM programs.

### Disease Management

Disease Management (DM) is incorporated into Integrated Care Management Services. DM provides members diagnosed with diabetes, asthma, chronic kidney disease, end-stage renal disease, chronic obstructive pulmonary disease and/or heart failure with tools to increase their ability to self-manage their disease and any associated co-morbidities. Using an evidence-based comprehensive clinical assessment, coupled with motivational interviewing techniques, Disease Managers who are licensed registered nurses (RNs), assist members in developing member-centric care plans with disease-specific interventions, such as education, coaching, advocacy, and care coordination of health care and social services.

The program interventions are established using the guidelines for the National Heart Lung and Blood Institute, American Diabetes Association, American Lung Association, and Global Initiative for Obstructive Lung Disease and American College of Cardiology Foundation/American Heart Association.

Tufts Health Public Plans also offers members online educational resources and community supports, texting programs and digital coaching programs.

Goals of Disease Management include:

- Increasing quality of care and reducing utilization of medical services
- Collaborating with members and providers on member-centered goals and care plans that are based on evidence-based condition-specific clinical assessments
- Assessing education gaps and increasing treatment plan adherence, such as medication regimens and provider visits
- Reduce unnecessary hospital admissions and emergency room visits
- Decrease HEDIS gaps-in-care rates by working with members to collaborate with their providers to schedule and review tests, as well as their medication regimen

Tufts Health Public Plans identifies members for DM through sources such as:

- Pharmacy and medical claims data
- Medical utilization
- HEDIS-like criteria
- Known risk factors
- Member self-referral
- Internal referrals by Utilization Management and Integrated Care Management staff
- External referrals from caregiver, health care or social service providers, inpatient facility providers, outpatient providers, community service agency staff, vendors and authorized representative(s)

Once identified, members will be outreached for participation with the ability to “opt-out” if they choose. Member outreach methods include phone outreach, text messaging with opt-out available, where appropriate. Members can be referred without prior authorization or precertification.

## Complex Care Management (CCM) Services

Tufts Health Public Plans’ NCQA-accredited Complex Care Management program serves members with hard-to-manage, unstable, or long-term medical and/or behavioral health conditions. Members in this program receive support from a licensed health care professional and clinical support staff who can assist with navigating the health care delivery system to facilitate appropriate care and access to services. This program strives to help members attain optimal and functional well-being, initiate early interventions to avoid complications, and minimize the onset of secondary disabling conditions.

The Behavioral Health and Medical Care Management clinicians provide a range of services to help members achieve better health outcomes, including:

- Performing comprehensive behavioral, physical and social need assessments
- Developing and implementing a member-centric, comprehensive care plan
- Coordinating care with caregivers, providers, and community resources
- Providing targeted health education for members and their authorized representatives
- Enabling a link between clinical services and available community resources
- Educating and empowering members to take an active role in managing their health
- Working to decrease Emergency Room (ER) visits and acute inpatient lengths of stay
- Encouraging the use of health care resources as appropriate and in line with clinical guidelines

Tufts Health Public Plans identifies members with complex medical and/or behavioral health conditions that are at risk for future hospitalization, significant health care needs or high health care costs through sources such as:

- Predictive modeling tools
- Utilization data, including facility admissions and pharmacy claims
- External referrals from member, caregiver, or health care or social service providers
- Internal referrals from Behavioral Health Utilization Management, Medical Utilization Management and Integrated Care Management staff

Additionally, Complex Care Management may be beneficial for:

- Members with multiple health conditions or intensive medical and/or behavioral health needs
- All members being considered for or being worked up for a transplant (either solid organ or BMT/SCT)
- Pregnancy
- Poor immunization record
- Current inpatient stay in a level 3 or 4 nursery (NICU) or special care nursery
- Co-existing diseases and/or co-morbidities affecting the recovery process members with any of the following conditions:
  - Catastrophic event (e.g., overdose, suicide attempt, victim of physical assault and multiple traumatic injuries)
  - Admission related to alcohol and/or drug use
  - Supportive Service Needs (i.e., inpatient or recently discharged members who require supportive services beyond the discharge planning period)
  - Conditions requiring episodic but extensive use of resources
  - Complex diagnosis, such as (but not limited to):
  - Traumatic brain injury
  - Progressive debilitating musculoskeletal or neurological disorders
  - Shaken infant syndrome
  - Severe and persistent mental illness
  - Adult or childhood obesity
  - Cancer
  - HIV/AIDS
  - Serious emotional disturbances
  - Congenital abnormalities of the nervous system
  - Encephalopathy

  - Central nervous system tumors or other mass lesions
  - Spinal cord injury
  - Degenerative neurological, metabolic or genetic diseases
  - Cerebral vascular accident
  - Terminal diagnosis
- Functional impairments impacting personal skills and/or clinical needs

## Health Needs Assessment

Tufts Health Public Plans utilizes the Cotiviti Interactive Voice Response (IVR) program to assess the needs of our newly enrolled Together pediatric (under 18-years-old) and adult populations in Massachusetts and Rhode Island. This program is available as an IVR call as well as a paper assessment. Members are called via the IVR system, and if not reached a callback number is provided. Paper surveys are mailed to members who do not complete the Health Needs Assessment by phone.

The assessments are based on validated evidence-based tools and address mind, body, lifestyle, biometrics, and social determinants of health. They are designed to solicit responses to risk factors that indicate potential need for Care Management interventions due to specific needs for immediate access to services due to potential or confirmed significant health and social issues. Providers are encouraged to assist members with obtaining and completing the assessment tools. Health Needs Assessments can be accessed by calling Provider Services at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island) or through the Integrated Care Management Department at Tufts Health Public Plans.

## Peer Support

Our Peer Support program provides support to members who are taking the first steps in recovery from a behavioral health condition or substance use. A Peer Recovery Specialist works with members who have recently entered or completed acute treatment or have needed medical care for a behavioral health and/or substance use-related illness to create a personalized recovery plan and provide information on treatment programs and community supports.

Peer Support can be accessed by calling Provider Services at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island).

## Emergency Room (ER) Visits and Follow-Up Services

For members evaluated in Emergency Rooms (ERs) and not admitted to an inpatient level of care, care management staff, upon notification of the ER visit, conduct outreach and make reasonable efforts to assist members with scheduling a follow-up appointment with a provider after ER discharge. Care management staff also make reasonable efforts to ensure communication of the ER discharge plan to the member's primary care provider (PCP) and any identified care coordination entities involved in the member's care.

## Maternal and Child Health Program

The maternal and child health services are designed to support all pregnant members and complement provider care. Tufts Health Public Plans works closely with providers to coordinate prenatal and postpartum care for new mothers and newborns.

Tufts Health Public Plans' trained staff will perform further screening for the purpose of care management stratification and outreach based on the level of support the member is identified as needing. This program includes:

- High-risk pregnancy care management and low-risk care coordination
- Information regarding Tufts Health Public Plans wellness incentives (the EXTRAS program)
- Information on the Doula Program, which allows members to work with a doula during and after pregnancy
- Information on Ovia, a free app offering support for overall reproductive health, including pre-conception, looking to conceive, to conception and perimenopause/menopause

## Prenatal Registration

If providers notify Tufts Health Public Plans of a member's pregnancy using the Prenatal Registration Form, the member may become eligible for a variety of prenatal services and counseling. Tufts Health Public Plans will notify the member about childbirth and/or breastfeeding classes, and the importance of having a postpartum visit.

## Doula Program (Tufts Health Together and Tufts Health RITogether)

The Doula Program is a state-funded benefit offered by the Commonwealth of Massachusetts and the State of Rhode Island. Through this benefit, eligible members of certain Tufts Health Together ACPPs and Tufts Health RITogether may engage with a specially trained doula for antepartum, birth, and postpartum support. Members will receive outreach from a doula beginning at 28 weeks gestation, or they may contact Member Services to enroll.

Participating doulas provide the following services:

- Emotional, physical and educational support for mother and family about the pregnancy, labor and delivery, and postpartum expectations
- Breastfeeding education and support
- Instruction and support for newborn care

The outcome goals of the Doula Program include:

- Decreasing the risk of adverse birth outcomes and their consequences
- Decreasing NICU and Special Care Nursery admissions
- Decreasing preterm births
- Increasing postpartum visits between 21 and 56 days after delivery
- Improving member satisfaction
- Decreasing overall maternity costs

### Tufts Health Together

Doula services are provided by the State of Massachusetts and typically provide two antepartum visits, attendance for support at labor and delivery, and two postpartum visits.

Members may be identified for referral to the Doula Program by a High-Risk Pregnancy Nurse Care Manager or Care Coordinator. Referrals can also come from: screening by Tufts Health Public Plans Low-Risk OB Coordinators; internal referrals from Member Services, Medical Utilization Management and Integrated Care Management staff; provider referrals; and member self-referral.

### Tufts Health RITogether

Doula services are provided by the state of Rhode Island and include three prenatal visits, one labor and delivery visit and three postpartum visits. Referrals are not required.

### Prenatal and Postpartum Extra Benefits and Services

As part of the care provided to pregnant members, providers should encourage them to take advantage of the services that Tufts Health Public Plans offers, such as:

- Assistance with choosing an OB/GYN, certified nurse midwife or other pregnancy care provider, as well as a pediatrician or PCP for their baby
- Coordination of services for medically and socially high-risk pregnancies through the Complex Care Management Program, High-Risk Maternity care management services, the Early Intervention Partnership Program or other available community resources
- Prenatal and postpartum home visits from a visiting nurse at no additional cost to the member, if the member qualifies
- Breast pumps, and special and prescription formulas

### Notification of Birth

To help ensure continuity of care for mothers and newborns, and to facilitate the enrollment of newborns into MassHealth (for Massachusetts members, including Tufts Health One Care) or Tufts Health RITogether (for Rhode Island members), the admitting or delivering hospital must notify Tufts Health Public Plans of each delivery by phone at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island) or by fax at **888-415-9055** (Massachusetts) or **857-304-6404** (Rhode Island).

Massachusetts facilities must also submit a Notification of Birth form (NOB-1) to MassHealth within 10 days after the birth for members of the following plans:

- Tufts Health Together with Cambridge Health Alliance
- Tufts Health Together with UMass Memorial Health
- Tufts Health One Care

Record Tufts Health Public Plans for the mother's plan in "Section I: Mother's Information" on the NOB-1 form.

Rhode Island facilities must fax a RITogether Notification of Birth form to **857-304-6404** within 30 days after the birth.

## Massachusetts-Specific Care Management Services and Programs

The following Care Management services and programs are for members with a Massachusetts plan:

### Community Health Services

Tufts Health Public Plans community health services are provided by community health workers who support members and their families by coordinating access to services that address social determinants of health. The community health workers provide members both telephonic and on-site support to assist in the following ways, including but not limited to:

- Provide information and guidance on how to access primary care and specialty services
- Get information about and apply for food assistance programs, including SNAP
- Learn about and request benefits such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), if eligible
- Help Navigate the Department of Transitional Assistance (DTA) and/or the Social Security Administration
- Provide information about programs that help cover utility costs
- Connect to additional community-based services beyond those offered through our program
- Identify disability-related resources
- Access transportation options for medically necessary appointments, if eligible
- Receive health education and information tailored to specific needs
- Explore available community resources and public benefits

- Support coordination and communication with healthcare providers
- Learn about alternatives and community resources for ongoing care when benefits are limited or exhausted

## Transition of Care (ToC) Programs (for Tufts Health Together and Tufts Health Direct)

Members' post-discharge outcomes are often complicated by concurrent medical and behavioral health co-morbidities as well as social determinants of health. The Tufts Health Public Plans Transition of Care (ToC) Program utilizes a case management approach to help ensure care continuity for Tufts Health Together and Tufts Health Direct members transitioning between health care settings and home as their condition and care needs change. Tufts Health Public Plans leverages existing provider and community-based case managers to preserve existing treatment relationships and avoid duplication of services. When members have case managers from provider sites and other community health teams, the case managers from these entities are typically considered the "lead" case managers. Tufts Health Public Plans care management staff work to inform providers of admission events and reconnect members to their treatment in the community with these providers.

Behavioral health ToC services aim to optimize the wellness of members being discharged from an inpatient psychiatric facility, dual diagnosis, acute residential treatment program, community-based acute treatment program or emergency department. Physical health ToC services are provided to members identified at risk of readmission that are being discharged from acute, rehabilitative or skilled nursing facilities. Integrated Care Management Department staff will outreach members within two business days of discharge notification and conduct interventions such as:

- Completion of a ToC Assessment to assess type and priority of needs to be addressed for the primary goal of preventing avoidable readmissions
- Outreach calls and support in the form of referrals, appointment reminders, and education on health plan benefits and services, including Tufts Health Public Plan Community Health Workers providing assistance to address social determinants of health
- Review of discharge instructions and conducting medication review to assess whether the member has filled all of their prescriptions and understands the importance of medication adherence
- Efforts to ensure that the member has scheduled a follow-up appointment with the PCP or treating specialist within seven days of discharge, assisting with appointment scheduling and transportation as necessary
- Coordination of care across the medical and behavioral health continuum of care, including communication of event notification to providers and other community health teams as appropriate
- Education on, and referring member/designated caregiver to, resources available to aid in the navigation of the health care system, community services and publicly funded programs

Additionally, the ToC program for MassHealth members provides the following support (this is not an all-inclusive list):

- Addressing patient-centered, interdisciplinary interventions by providing members with knowledge and support to promote self-management of their condition
- Assisting the member/caregiver with understanding discharge instructions, as well as the ability to verbalize specific instructions using the teach-back method. Members/caregivers who may need additional support will receive the education from the care manager to facilitate understanding
- Care managers acting as a liaison between providers and entities across multiple settings including medical, BH and community supports
- Care managers referring members who are homeless or at risk for homelessness in Massachusetts to community support programs with member consent

# Rhode Island-Specific Care Management Services and Programs

The following Care Management services and programs are available to Tufts Health RITogether members:

## Transition of Care (ToC) Programs

Behavioral Health and Medical Care Managers initiate care transition plans after members of Tufts Health RITogether leave an acute, subacute, or skilled nursing facility; transitional care unit; or rehabilitation setting. A transition of care plan may also be initiated when a member transitions to Tufts Health RITogether from another health plan. Through programs for behavioral health and medical transitions of care, Tufts Health Public Plans strives to:

- Identify and facilitate appropriate care and services for members who would benefit from interventions
- Ensure members have follow-up care with their Provider
- Ensure members know and understand their condition(s)
- Educate members about self-managing their condition(s)
- Reduce readmissions and ED utilization
- Provide individualized and integrated short-term care coordination to each member
- Identify incidences of, and develop interventions to improve, underused or overused services
- Improve members' overall health

Tufts Health Public Plans' care managers also work with ancillary providers (e.g., visiting nurse associations, durable medical equipment vendors) to assist a members' receipt of timely services. Transitional care can last from 6 to 12 weeks.

Call Provider Services at **844-301-4093** to refer a member for behavioral health or the medical Transition of Care Program.

## Care Coordination

Tufts Health Public Plans' behavioral health, medical, and community health workers provide Care Coordination services, which are designed to help members who may or may not have a chronic disease but have acute physical, behavioral health, or social care needs that impact health status, or are at risk of further exacerbation of their illness. When the members' needs warrant immediate attention, Care Coordination will ensure access to primary care and behavioral health services.

The goal of Care Coordination is to reduce the impact of any adverse outcome. Services may include assistance with making or keeping needed medical or behavioral health appointments, and referrals related to the members' immediate needs. Members are identified for Care Coordination because their needs can be addressed in a time-limited fashion and do not meet the criteria for Complex Care Management programs.

Integrated Care Management staff provides both phone outreach and in-person support to assist members with such needs such as:

- Provide information and guidance on how to access primary care and specialty services
- Get information about and apply for food assistance programs, including SNAP
- Learn about and request benefits such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), if eligible
- Help Navigate the Department of Transitional Assistance (DTA) and/or the Social Security Administration
- Provide information about programs that help cover utility costs

- Connect to additional community-based services beyond those offered through our program
- Identify disability-related resources
- Access transportation options for medically necessary appointments, if eligible
- Receive health education and information tailored to specific needs
- Explore available community resources and public benefits
- Support coordination and communication with healthcare providers
- Learn about alternatives and community resources for ongoing care when benefits are limited or exhausted
- Access other community services in addition to services provided by Tufts Health Public Plans, including but not limited to:
  - Community Health Teams
  - Home Stabilization Program agencies
  - Rhode Island Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) services
  - Rhode Island Department of Children, Youth, and Families (DCYF) services
  - Rhode Island Department of Health (DOH) services
  - Rhode Island Department of Human Services (DHS) services
  - Addiction Treatment and Support
  - Special Education
  - Waiver Services

Call Provider Services at **844-301-4093** to refer a member for Care Coordination services.

### Complex Care Management (CCM)

Tufts Health Public Plan's CCM program is to help members regain optimal health and improved functional capability in their preferred natural setting, while utilizing cost-effective strategies. This program requires a comprehensive assessment of the member's condition; determination of available benefits and resources; development and implementation of a care management plan with goals prioritized by the member, as well as monitoring and follow-up to measure progress and success of the set goals.

CCM encompasses both adult and pediatric populations and includes services related to medical, behavioral health, high-risk obstetrical and community health services. The program provides a comprehensive, integrated approach to optimize wellness outcomes for adult and pediatric members. CCM screening triggers include but are not limited to:

- Spinal Injuries
- Transplants
- High Risk Pregnancy
- Serious Trauma
- HIV/AIDS
- Special Health Care Needs
- Complex and chronic behavioral health conditions
- Severe and persistent mental illness and Substance Use Disorder

Call Provider Services at **844-301-4093** to refer a member for Complex Care Management.

# Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Assistance

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is the foundation for ensuring comprehensive and necessary medical care to all Medicaid recipients under the age of 21. Compliance with this program is essential for prompt identification of problems that, if left undiagnosed or untreated, could create greater disabilities or diminish one's likelihood of achieving future life goals. Tufts Health Public Plans works to ensure that our members, especially those who are children, receive all services required to diagnose and treat potential and ongoing problems in a timely and culturally sensitive manner. Based on the EPSDT Periodicity Schedule, the care management team provides outreach calls and mailings to remind members about upcoming and past due wellness visits, offering assistance to address the barriers to attending appointments. Staff will also outreach to providers with members who have missed wellness visits.

PUBLICATION HISTORY

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|---|---|
| 01/01/24 | Updated plan name to Tufts Health One Care |
| 03/12/24 | Updated "Emergency Room (ER) Visits Follow-Up Services," "Care Coordination" and administrative edits |
| 07/01/24 | Added "Peer Support" section |
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| 08/01/26 | Updated Table of Contents |
| 10/01/26 | Updated language in RITogether Doula program to remove requirement for recommendation of service |