TUFTS Health Plan

a Point32Health company

General Behavioral Health Performance Specifications

These performance specifications apply to the following Tufts Health Plan products:

☐ Tufts Health Plan Commercial[1]
☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

These performance specifications apply to the following Tufts Health Public Plans products:

☐ Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plan)
☐ Tufts Health RITogether (a Rhode Island Medicaid Plan)
☒ Tufts Health One Care (a dual-eligible product)

These general behavioral health performance specifications apply to all Tufts Health Public Plans network providers at all levels of care. Providers are expected to comply with all applicable regulations set forth in the Code of Massachusetts Regulations and all requirements of the service-specific performance specifications for each level of care for which they are contracted. All Performance Specifications are located on the Behavioral Health Performance Specifications page on Point32Health's provider website.

The requirements outlined within the service-specific performance specifications take precedence over these general performance specifications.

MISSION STATEMENT

Mission Statement: To improve the health and wellness of the diverse communities we serve.

Vision Statement: Every life improved through access to high-quality, affordable healthcare.

Tufts Health Plan Values: Demonstrating these values with our key stakeholders – colleagues, clients, providers and community partners – empowers us to achieve our mission of improving the health and wellness of the diverse communities we serve.

- Excellence- We deliver the highest quality products, services, and experiences.
- Integrity- We earn trust, act honestly and ethically, and are accountable.
- Collaboration- We leverage individual strengths and encourage all points of view.
- Innovation- We promote continuous improvement and adopt new ideas.
- Diversity and Inclusion- We embrace differences and act equitably.

Tufts Health Public Plans (THPP) providers are expected to deliver behavioral health services in a manner which supports:

- Clinical experience and innovation in the provision of care;
- Ethical care and professional integrity;
- Member accessibility;
- Integration of behavioral health and physical health throughout all service delivery processes;
- Coordination of care including integration with primary care clinicians (PCPs);
- Data-driven practice, including evidence-based practices, outcomes measurement, and utilization management;
- Technical competence and innovation.

All providers must provide care that is timely, accessible, and linguistically and culturally competent. All providers shall be responsive to the linguistic, cultural, and other unique needs of any minority, homeless person, enrollees with special health care needs, including individuals with disabilities or other special populations. Providers must provide care and treatment that promotes recovery and wellness.

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1. Commercial products include HMO, POS, PPO, and CareLink[SM] when Tufts Health Plan is the primary administrator.
2. Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

STAFFING REQUIREMENTS

1. The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted.
2. The provider complies with the staffing requirements of the applicable licensing body.
3. The provider ensures that program staff members are qualified through education, experience and/or training to provide support and treatment to the population served by the programs.
4. Any staff member diagnosing, treating and billing for services who is not an independently licensed behavioral health clinician must be directly and continuously supervised by supervisors who are, and supervision notes are to be maintained by the supervisor. THPP reserves the right to review records to confirm adequate levels of supervision.
5. At minimum, staff should receive 1 hour of supervision per 20 contact hours, and supervision should be provided commensurate with licensure level and consistent with credentialing criteria.
6. For all clinical reviews with THPP, providers must utilize appropriately credentialed clinicians for service reviews.

CONSENT FOR TREATMENT

1. The provider identifies the Member's custodial status and obtains all consent forms and releases of information in compliance with that status.
2. The provider obtains a consent for treatment form signed by the Member or parent/guardian/caregiver.
3. The provider obtains appropriate consent for information sharing in order to coordinate care.
4. The provider is in compliance with current laws and standards regarding consent and release of information and conducts staff training as changes occur.
5. If the Member or parent/guardian/caregiver of a minor declines or restricts the consent for coordination, the provider documents this as such in the Member's health record. Attempts are continually made and documented to engage the Member in giving consent, as appropriate to their treatment plan.

GENERAL RECORD KEEPING

1. All providers must comply with, at minimum, all statutory and regulatory requirements applicable to Member medical records. In addition, all Member medical records, whether paper or electronic shall, at a minimum:
    - Be maintained in a manner that is current, detailed, and organized and that permits effective patient care, utilization review and quality review;
    - Include sufficient information to identify the Enrollee, date of encounter and pertinent information which documents the Enrollee's diagnosis
    - Describe the appropriateness of the treatment/services, the course and results of the treatment/services and treatment outcomes;
    - Be consistent with current and nationally accepted professional standards for providing the treatment/services, as well as systems for accurately documenting the following:
        - Enrollee information including, among other things, primary language spoken;
        - Clinical information;
        - Clinical assessments
        - Treatment plans;
        - Treatment/services provided;
        - Contacts with the enrollee's family, guardians, or significant others;
        - Treatment goals and outcomes;
        - All contacts with state agencies, as applicable; and
        - Pharmacy records
    - Be consistent with commonly accepted standards for medical record documentation, as follows:
        - Each page in the record contains the patient's name or ID number
        - Personal biographical data include the address, home telephone, mobile telephone, work telephone number, name of employer, marital status, primary language spoken, and any disabilities, such as visually impaired, hearing impaired or uses a wheelchair.
        - All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier, or initials.
        - All entries are dated.
        - The record is legible to someone other than the writer.
        - Significant illnesses and medical conditions are indicated on the problem list.
        - Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
        - Past medical history is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents, past medical history relates to prenatal care, birth, operations, and childhood illnesses.
        - For children, adolescents and adults, there is appropriate notation concerning the use of cigarettes, alcohol, and substances.

  - The history and physical examination identify appropriate subjective and objective information pertinent to the patient's presenting complaints.
  - Laboratory and other studies are ordered, as appropriate.
  - Working diagnoses are consistent with findings.
  - Treatment plans are consistent with diagnoses;
  - Encounter forms or notes have a notation, regarding follow-up care, calls, or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
  - Unresolved problems from previous office visits are addressed in subsequent visits.
  - For children, adolescents and adults, there is appropriate notation for under- or over-utilization of specialty services or pharmaceuticals.
  - If a consultation is requested, there is a note from the specialist in the record.
  - Consultation, laboratory, and imaging reports filed in the chart are initialed by the practitioner who ordered them to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
  - There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
  - There is evidence that preventive screening and services are offered in accordance with the EPSDT Periodicity Schedule, or for individuals over age 21, the provider's own practice guidelines, including the administration of behavioral health screenings.
- For records pertaining to inpatient services in hospitals, include the following information:
  1. Identification of the member;
     i. The name of the enrollee's physician;
     ii. Date of admission, and dates of application for and authorization of MassHealth benefits if application is made after admission;
     iii. The plan of care;
     iv. Initial and subsequent continued stay review dates;
     v. Reason and plan for continued stay if the attending physician believes continued stay is necessary; and
     vi. Other supporting material that the provider's utilization management or other staff believes appropriate to be included in the record.
  2. Provide a copy of medical records pertaining to Member, at THPP's request, for the purpose of monitoring the quality of care provided by the provider in accordance with federal regulations the purpose of conducting performance evaluation activities of THPP, including but not limited to, EOHHS's annual External Quality Review and outcomes measurement studies performed by EOHHS.

ACCESS STANDARDS

1. The provider offers hours of operation comparable to those offered to individuals with commercial insurance or to Medicaid fee-for-service if only MassHealth Members are served.
2. Along with complying with our overall provider requirements listed in the provider handbook, providers must offer the following appointment availability:
   - **Emergency Services:** Immediately, on a 24-hour basis, seven days a week, with unrestricted access to Enrollees who present at any qualified provider, whether a network provider or a non-network provider
   - **ESP services:** Immediately, on a 24-hour basis, seven days a week, with unrestricted access to Enrollees who present for such services
   - **Urgent Care:** Within 48 hours for services that are not emergency services or routine services
   - **All other behavioral health services:** Within 14 calendar days
     i. **Non-24-hour Diversionary Services:** Within two calendar days of discharge
     ii. **Medication Management:** Within 14 calendar days of discharge.
     iii. **Other outpatient services:** within seven calendar days of discharge
     iv. **Intensive care coordination services:** Within the time frame directed by EOHHS.
   - For services described in the inpatient or 24-hour diversionary services discharge plan:
   - Routine behavioral health services intake within 10 working days of a request
3. Other outpatient services within seven calendar days of discharge The provider reports bed/service availability as required by EOHHS on the Massachusetts Behavioral Health Access website, MABHAccess.com, for all levels of care included in the website.
4. The provider manages services to reduce and eliminate the necessity of maintaining waiting lists. Providers who are not able to offer access that complies with the THPP's access standards must refer Members to another THPP provider to ensure that Members receive services in a timely manner.

5. Providers contact THPP for assistance with making referrals as needed. If there are barriers to accessing covered services, the provider notifies Tufts Health Plan Public Plans as soon as possible to obtain assistance. All such activities are documented.
6. The provider follows all administrative responsibilities as listed in the provider manual, including but not limited to:
    - Ensuring Tufts Health Plan Public Plans has your correct and current provider information
    - Meeting regulatory requirements
    - Getting credentialed and re-credentialed
    - Having an NPI and Tax ID number
    - Verifying eligibility
    - Referring to services they need
    - Checking for 3rd party liability
    - Referring for integrated care management activities
    - Referring patient for health coaching
    - Following claims and prior authorizations procedure
7. With consent, the Member and his/her parent/guardian/caregiver/family members/other natural supports are active and integral participants throughout the service delivery process, including assessment, treatment planning, treatment services, discharge planning and related meetings. All such activity is documented in the Member's health record.
8. The provider makes best efforts to offer meetings, such as treatment planning meetings, and services, such as family therapy sessions, at times and locations convenient to the Member and the family's schedule, including evening and weekend meeting times.
9. All behavioral health providers (including Behavioral Health Community Partners) state agency staff, primary care physicians, and other supports are engaged in treatment and discharge planning meetings.

SUBSTANCE USE DISORDER TREATMENT PROVIDERS

To the extent permitted by law, all substance use disorder treatment providers are required to submit to DPH/BSAS the data required by DPH.

All substance use disorder treatment providers are required to track, by referral source and submit to THPP such tracked information:

- All referrals for services
- The outcome of each referral (i.e., admission, etc.); and
- If the substance use disorder treatment provider refuses to accept a referral, the reason for the refusal.

BEHAVIORAL HEALTH CLINICAL ASSESSMENT AND CANS

1. All providers prepare an individualized written behavioral health clinical assessment and treatment plan for all Members starting behavioral health treatment.
2. All assessments and treatment plans must be completed within the time frames set forth below:
    - Acute inpatient treatment: within 24 hours of admission;
    - 24-hour diversionary services: by the end of the second visit; and
    - Behavioral health outpatient services: by the end of the second visit
3. Behavioral health clinical assessments are conducted by behavioral health providers who have training and experience that match the Enrollee's clinical needs based on their presenting behavioral health problem(s) and diagnosis.
4. All behavioral health clinical assessments conducted by behavioral health providers are in writing, dated and signed, and include, at a minimum, the following:

- History of presenting problem
- Chief complaints and symptoms
- Strengths of the enrollees and caregivers that will be used in treatment planning
- Past metal health and/or substance use disorder history;
- Past medical history
- Family, social history, and linguistic and cultural background
- Current substance use disorders
- Mental status exam
- Present medications and any allergies
- Diagnosis
- Level of functioning
- Treatment plan
- Crisis assessment planning
- Name of and contact information for the PCP

- Immediate care needs and current services, including but not limited to any care coordination or management activities and any services being provided by state agencies, such as DMH, DDS, MRC, MCB, DCF, DYS, or EOE
- Health conditions
- Medications
- Ability to communicate their concerns, symptoms, or care goals
- Clinical formulation, rationale for treatment, recommendations, and strengths
- Include the CANS Tool for Enrollees under age 21, and for Enrollees aged 21 and over, other behavioral health screening tools identified and approved by EOHHS

5. Behavioral health clinical assessments conducted by behavioral health providers for individuals under age 21, where the CANS Tool is required, are completed by behavioral health providers who are certified CANS providers.
6. All clinicians, including psychiatrists, psychiatric residents, psychiatric nurse mental-health clinical specialists, psychologists, licensed independent clinical social workers (LICSWs), licensed alcohol and drug counselors 1 (LADC1), licensed mental health counselors (LMHCs), licensed marriage and family therapists (LMFTs), licensed clinical social workers (LCSWs), and unlicensed Master's level clinicians working under the supervision of a licensed clinician, who provide behavioral health services to Enrollees under the age of 21 in certain levels of care, including diagnostic evaluation for outpatient therapy (individual counseling, group counseling and couples/family counseling), in-home therapy, inpatient psychiatric services and community-based acute treatment services:
   - Participate in CANS training sponsored by EOHHS
   - Become certified in the use of the CANS Tool and recertified every two years
   - Use the CANS Tool whenever they deliver a behavioral health clinical assessment for an Enrollee under the age of 21, including the initial behavioral health clinical assessment, and at a minimum, every 180 days thereafter during ongoing treatment
   - Use the CANS Tool as part of the discharge planning process from inpatient psychiatric hospitalizations and community-based acute treatment services
   - Subject to consent by the Member, parent, guardian, custodian or other authorized individual, as applicable, input into the CANS IT system the information gathered using the CANS Tool and the determination of whether or not the assessed Enrollee is suffering from a serious emotional disturbance (SED). If consent is not given, the provider still must enter SED information into the CANS IT system.
   - Ensure the ability to access and use the CANS IT system and data contained therein, and shall, as further directed by EOHHS, participate in any testing or development processes as necessary for EOHHS to build the CANS IT system
7. A CANS must be completed as part of the discharge plan from inpatient, CBAT, ICBAT, in-home therapy or intensive care coordination levels of care.

TREATMENT PLANNING

1. All providers must ensure that the Member, his/her guardians, and family members, as appropriate, are included in the development and modification of the Enrollee's treatment plan and in the treatment itself, and that they attend all treatment plan meetings, provided that for adult Enrollees, the Enrollee has rendered his/her consent for these individuals to participate in the treatment and treatment plan-related activities.
2. The provider completes a comprehensive and individualized initial treatment plan built upon the assessment and developed with the Member and/or parent/guardian/caregiver, and with consent, family members, the PCP, other involved providers and supports identified by the Member.
   - The treatment plan is signed, dated, and documented in the member's health record.
   - The treatment plan includes but is not limited to objective and measurable goals; time frames; expected outcomes; the Member's strengths; links to primary care, especially for Members with active co-occurring medical conditions; a plan to involve a state agency case manager, when appropriate; and treatment recommendations consistent with the service plan of the relevant state agency, if involved.
   - The treatment plan is consistent with the Member's diagnosis, describes all services needed during the course of treatment, and reflects continuity and coordination of care.
   - The time frames for the completion of the initial treatment plan are delineated in each of the service-specific performance specifications.
3. The provider assigns a multi-disciplinary treatment team to each Member within the time frames delineated in each of the service-specific performance specifications. A multidisciplinary treatment team meets to review the assessment, and initial treatment plan and discharge plan within time frames delineated in each of the service-specific performance specifications.
4. The treatment plan is implemented, reviewed, and revised throughout the course of treatment based on the provider's continual reassessment of the Member and with the Member's participation. The Member's progress in achieving the treatment goals is documented in progress notes and treatment plan updates in the Member's health record.
5. If the Member terminates treatment without notice, every effort is made to contact the Member to re-engage in treatment or to provide assistance to transfer the Member to another appropriate source of care prior to discharging

the Member. Such activity is documented in the Member's health record. When the Member is identified as having state agency and/or other collateral involvement, including BH CPS, or is participating in care management, those collateral contacts are informed of the Member's treatment status.

6. All providers will make referrals for appropriate behavioral health services to be provided upon discharge from any level of behavioral health care.

CARE COORDINATION

1. The provider seeks informed consent from the Member in order to coordinate admissions, assessment, treatment/care planning and discharge planning with the following collaterals, as appropriate to the level of care. The type and amount of information shared is appropriate to the purpose and the role of those to/from whom the information is being communicated/requested, including the following:
   - Parents, guardians, caregivers, family, significant other, and natural supports
   - PCP
   - ESP and MCI
   - 24-hour levels of care, including psychiatric hospitals, community-based acute treatment (CBAT) and intensive community-based acute treatment (ICBAT) programs, community crisis stabilization (CCS), etc.
   - Behavioral Health Community Partners
   - State agency personnel (when providing services to Members involved with a state agency), including DMH, DCF, DYS, DPH, DDS and/or DTA
   - Local education authority (LEA) (applies to all children, whether a regular education or special education student)
   - Police departments and local court systems;
   - Outpatient treaters and prescribers;
   - Other community-based providers, including CBHI services such as in-home therapy (IHT) and intensive care coordination (ICC), community support programs (CSPs), and substance use disorder programs
   - Other collaterals appropriate to the Member and/or the level of care
   - Care coordination efforts are documented in the Member's health record.

DISCHARGE PLANNING

1. The provider ensures that all staff that are responsible for discharge planning are knowledgeable about the continuum of behavioral health and medical services as well as other services and supports in the community, and discharge planning skills and strategies.
2. Staff involved in discharge planning are trained on the use of the MABHAccess.com website and are expected to utilize this resource to locate available step-down and other aftercare services for Members.
3. The provider identifies barriers to discharge planning and aftercare and develops strategies to assist the Member with arranging and utilizing aftercare services, making best efforts to ensure that the discharge plan (or other such document(s) that contain the required elements) is consistent with his/her benefit coverage.
4. Ensure that for all state agency clients, the treatment plan specifies all behavioral health services required during the acute stay, identifies discharge plans, and when appropriate, indicates the need for DMH community-based care services.
5. When it is anticipated that the Member's discharge plan shall include DMH community-based care services, ensure that the DMH community-based care services case managers participate in each treatment team meeting.
6. Provider assists the Member in scheduling a follow-up appointment for the Member with his/her PCP.
7. With the Member's consent, the provider, in collaboration with the Member, his/her family, and/or his/her supports, develops a written, individualized, person-centered, strengths-based discharge plan prior to the Member's discharge from any inpatient service, or if appropriate, any other behavioral health service, that is documented in the Member's health record.
8. Prior to the Member's discharge, the provider provides the Member with a copy of the discharge plan (or other such document(s) that contain the required elements). The plan includes, but is not limited to:
   - Identification of the members needs, including but not limited to:
     - i. Housing
     - ii. Finances
     - iii. Medical Care
     - iv. Transportation
     - v. Family, employment, and educational concerns
     - vi. Natural community and social supports
     - vii. For Members discharged from inpatient mental health services and for other Members as clinically indicated, an updated crisis prevention plan for adults that follows the principles of recovery and resilience, or an updated safety plan for youth and their families, and/or a relapse prevention plan, as applicable. Such a plan is directed by the Member and is designed to expedite a consumer- or family-focused clinical disposition in the event of a psychiatric crisis, based on the experience gained from past treatment. It identifies triggers that may lead to or

escalate a psychiatric crisis and includes a preferred disposition as well as the Member's preferences. The plan may be implemented by an ESP/MCI provider, a medical or behavioral health provider, the PCP or another individual as directed by the Member.

- A list of the services and supports that are recommended post-discharge, including identified providers, PCPs, and other community resources available to deliver each recommended service
- A list of prescribed medication, dosages, and potential side effects
- Treatment recommendations consistent with the service plan of the relevant state agency for Members who are state agency involved
- For all ICC-involved youth, the discharge plan is consistent with the youth's Individual Care Plan (ICP).

9. For all youth under the age of 21, the provider makes best efforts to ensure a smooth transition for the return to home or discharge location, and to the next service, if any, by:
    - Linking to necessary services and making appropriate referrals, including Children's Behavioral Health Initiative (CBHI) services and community support program (CSP), if indicated
    - Documenting in the Member's health record all efforts related to these activities, including the Member's and family's/guardian's/caregiver's active participation in discharge planning
    - Reviewing and updating any of the crisis planning tools (safety plan, advance communication to treatment providers, supplements to advance communication and safety plan), in collaboration with the youth, family, ICC provider if enrolled in ICC, and if indicated, with the youth's ESP/MCI provider, and sending a copy to those providers where consent is given
    - Educating the youth and family regarding use of the ESP/MCI service if needed in the future including access to their mobile and other community-based services
10. Additional discharge planning requirements for Members who are homeless:
    - The provider makes all reasonable efforts to discharge any homeless Members to living situations other than emergency shelters.
    - The provider provides comprehensive discharge planning for all homeless Members, exhausts all potential avenues to secure placement or housing resources and utilizes all community resources to assist with discharge planning.
    - The provider documents in the Member's health record all efforts related to these activities.
11. For Members who are minors: if reasonable attempts have been unsuccessful to involve their parents/guardians/caregivers in treatment and discharge planning, and/or the parents/guardians/caregivers are unable to participate in planning meetings, the provider presents treatment findings and recommendations to parents/guardians/caregivers at the time of discharge. These findings and recommendations are documented in the Member's health record.

SERVICE, COMMUNITY, AND COLLATERAL LINKAGES

1. The provider must request written consent from the Member to release information to coordinate care regarding mental health or substance use disorders services, or both, and primary care. The provider must document all instances in which consent was not given, and if possible, the reason why consent was denied. The provider must communicate and coordinate with the PCP regarding the Member's care.
2. Ensure that in the process of coordinating care, each Member's privacy is protected in accordance with the privacy requirements
3. Coordinate with staff in other state agencies, or community service organizations, if the agency/organization is already involved in serving the Member, or provide information and referral if the agency/organization may be helpful in meeting such needs Ensure that for all state agency clients, a release of information is requested to be used to inform the identified agency of the Enrollee's current status
4. Provide a Member's clinical information to other providers, as necessary, to ensure proper coordination and behavioral health treatment of Enrollees who express suicidal or homicidal ideation or intent, consistent with state law
5. Work with BH CPs to assist such Enrollees with in accessing appropriate services, including but not limited to, providing navigation and referral
6. Ensure that providers utilize a screening, brief intervention, and referral to treatment (SBIRT) model for Enrollees with potential substance use disorder treatment needs as directed by THPP and EOHHS
7. Programs actively engage in collaboration with Executive Office of Health and Human Services (EOHHS)-funded programs, including but not limited to:
    - Department of Mental Health (DMH)-funded programs, such as community-based flexible supports
    - Department of Children and Families (DCF)-funded programs that support the safety, permanency, and well-being of youth in the care and custody of the Commonwealth
    - Bureau of substance abuse services (BSAS)-funded programs for Members, such as recovery homes to promote continuity of services for substance use disorders from acute care to supportive and rehabilitative care and recovery supports
    - Department of Developmental Services (DDS) programs that involve rehabilitative and habilitative services for persons with developmental disabilities

- Department of Youth Services (DYS) programs that help Members stay in the community and avoid recidivism to DYS
- Other programs and initiatives within EOHHS, MassHealth, and Department of Public Health (DPH) related to PCP coordination and pharmacy management, including federal and state grant programs
- Prevention and wellness programs at the state, regional and local level

8. In order to coordinate services for Members with Medicaid, the provider develops a working relationship with the ESP/MCI provider that covers the catchment area in which the program is located. The provider:
    - Responds to referrals from the ESP/MCI to their programs in a timely fashion
    - Trains staff on the appropriate use of the ESP/MCI services, including services available in the community as alternatives to hospital emergency department visits
    - Ensures that staff educate Members about the availability of ESP/MCI services 24 hours per day, 7 days per week, 365 days per year, including how to access services from the local ESP/MCI in the community
    - Educates staff, Members, and their families about engaging Members in the development of crisis prevention plans and/or safety plans as part of the crisis planning tools for youth, and/or relapse prevention plans, as applicable, and with Member consent, sending a copy of these plans to the ESP/MCI director at the Member's local ESP/MCI.
9. The provider makes reasonable efforts to assist Members with identifying transportation options, when needed, including public transportation, prescription for transportation (PT-1) forms, etc.

PRIMARY CARE PROVIDER COORDINATION

1. Throughout the course of treatment, as applicable and with appropriate consent, to ensure integration of care, the provider assesses and makes inquiries about the Member's medical/health status, utilization of medical visits and compliance with medical treatment through self-report, communication with the Member's PCP, BH CP if applicable, and/or other health care professionals identified by the Member.
2. The provider communicates with the Member's PCP via telephone or in writing with Member/guardian consent, and such communication is documented in the Member's health record. For inpatient and 24-hour diversionary services, this communication takes place within one business day. For all other services, this communication takes place within five (5) business days.
3. Provider can access a Member's PCP via Tufts Health Provider Connect. Instructions on using Connect can be found in the Provider Manual.
4. The provider contacts the PCP for the following purposes:
    - To notify him/her regarding admission or enrollment in services and the reason(s) for such admission/enrollment;
    - To obtain information regarding health status, including but not limited to, medical and medication information;
    - To coordinate assessment, treatment, and discharge planning;
    - To share diagnostic and treatment/care plan information;
    - To coordinate medication, if applicable; and
    - To notify him/her of discharge and involve him/her in discharge and/or aftercare planning as indicated.
5. With appropriate consent, the provider maintains ongoing communication and collaboration with the PCP for these purposes, as well as to provide information to the PCP about the course of the Member's behavioral health treatment, including psychopharmacology and notable metabolic studies and/or other medical information. The provider utilizes information from the PCP to inform the Member's assessment, treatment/care plan and discharge plan on an ongoing basis.
6. To facilitate communication between the behavioral health provider and the PCP, providers of all levels of care are encouraged to utilize the Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form. This form can be located in the Provider Resource Center.

QUALITY MEASUREMENT AND IMPORVEMENT PROGRAM (QMIP)

1. Providers cooperate with THPP's QI activities to:
    - Improve the quality of care, services, and the Member experience, including the collection and evaluation of data and participation in THPP's QI programs
    - Allow the organization to collect and use performance measurement data
    - Assist the organization in improving clinical and service measures
2. Providers are expected to participate in and implement results from quality measurements and improvement initiatives conducted by Tufts Health Plan Public Plans. Such initiatives may include but are not limited to:
    - On-site program review;
    - Health record reviews;
    - Outcomes measurement initiatives;
    - Utilization management initiatives;
    - Member satisfaction surveys conducted on-site, telephonically and/or via written survey by consumer satisfaction teams;

- Provider satisfaction surveys; and
- Provider profile reports

3. Provider must measure and collect clinical outcomes data, to incorporate that data in treatment planning and within the medical record, and to make clinical outcomes data available to Tufts Health Plan Public Plans and EOHHS, upon request.
4. Provider must make available behavioral health clinical assessment and outcomes data for quality management and network management purposes.

DOCUMENT HISTORY

- January 2024: Tufts Health One Care (a dual-eligible product) name change.
- December 2023: Updated CANs timeline
- December 2020: Template Updates