Implementation Council Meeting 01.12.21

Documents Submitted

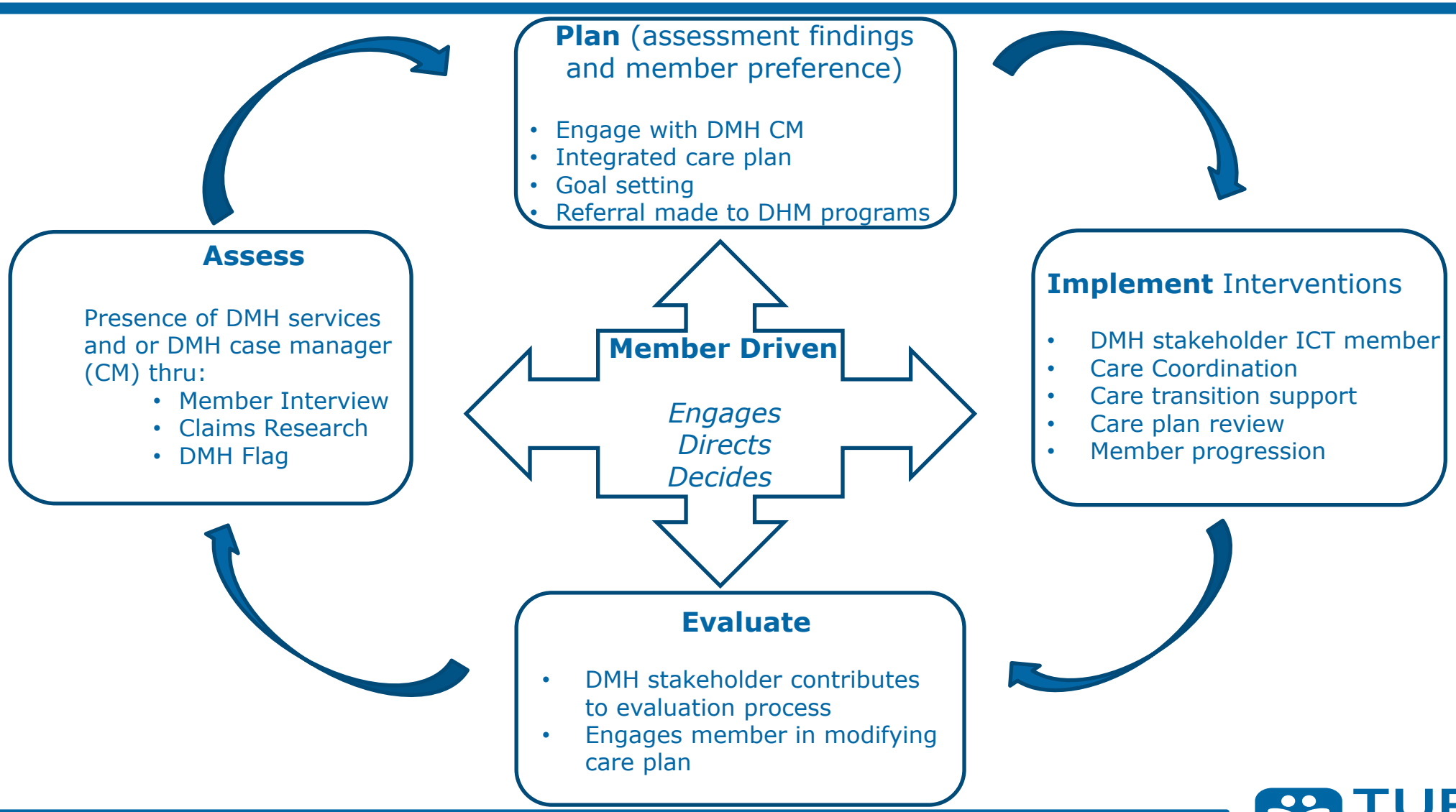
Slide 1: Member Journey Map

Slides 2- 8: Excerpts from policies, procedures, guidelines

Slides 9- 11: Training

Slide 12: Member Story

Member Journey: Identify DMH Services, Make Referrals, Integrate Care



TUFTS Health Plan

Written Policy: Coordination and Integration of Care

TUFTS Health Plan

Tufts Health UNIFY
Coordination and Integration of Care
Policy and Procedure

Policy Name:	Coordination and Integration of Care
Department:	UNIFY Care Management
Policy #:	UNIFY-Care Management-10
Effective Date:	July 1, 2020
Applicable Products	Medicare-Medicaid (MMP Dual)
Policy Owner Position Title:	Director of Care Management, Public Plans
Revision Date:	July 1, 2020

I- Purpose:

To ensure Tuft Health Unify members are provided with health care services that are accessible based on the needs of the members and provided timely in accordance with the Three-Way Contract, and other Tufts Health Plan Policies, Procedures and guidelines.

II- Scope:

Tufts Health UNIFY Care Management

Care Coordination include coordinating services Between settings of care, including appropriate discharge planning for short term and long-term hospital and with the services the member receives from community and social support providers

H. Coordinating services with Federal, State, and Community Agencies:

Tufts Health Unify makes efforts to collaborate, coordinates, and participate in initiatives, processes and activities of EOHHS agencies with which specific members have an affiliation. Such agencies include, but are not limited to:

a. The Department of Developmental Services (DDS);
b. The Department of Mental Health (DMH);
c. The Department of Public Health and DPH's Bureau of Substance Addiction Services (DPH/BSAS);
d. The Massachusetts Commission for the Blind (MCB);
e. The Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH);
f. The Massachusetts Rehabilitation Commission (MRC); and
g. The Executive Office of Elder Affairs (EOEA). (EOEA).

TUFTS Health Plan

Written Policy: Coordination and Integration of Care – continued

TUFTS Health Plan

Tufts Health UNIFY
Coordination and Integration of Care
Policy and Procedure

Policy Name:	Coordination and Integration of Care
Department:	UNIFY Care Management
Policy #:	UNIFY-Care Management-10
Effective Date:	July 1, 2020
Applicable Products	Medicare-Medicaid (MMP Dual)
Policy Owner Position Title:	Director of Care Management, Public Plans
Revision Date:	July 1, 2020

I- Purpose:

To ensure Tuft Health Unify members are provided with health care services that are accessible based on the needs of the members and provided timely in accordance with the Three-Way Contract, and other Tufts Health Plan Policies, Procedures and guidelines.

E. Care Coordination:

a. Tufts Health Unify offer its members a care coordination program through:
   i. A Care Coordinator or Clinical Care Manager (CCM) for medical and Behavioral Health Services;
   ii. Through a Long-term Supports (LTS) Coordinator, contracted from a community-based organization, for members required LTSS;
b. Tufts Health Unify provides members with information on how to contact their coordinator(s) designated by the ICT
c. Long-Term Services and Supports (LTSS)
   i. In delivering the Covered Services that relate to LTSS Tufts Health Unify provides coordination of care and expert care management through the ICT that ensure:
      1. The LTS Coordinator executes the responsibilities as specified in the Three-Way Contract.
      2. The Care Coordinator and LTS Coordinator, as part of the ICT, participate in determinations of appropriateness for institutional and community long term care services
      3. The measurement of the Functional Status of the members is performed through the Comprehensive Assessment.

d. Behavioral Health:

i. Behavioral health needs are systematically identified and addressed by the member's PCP and/or ICT at the Comprehensive Assessments using appropriate behavioral health screening tools. When appropriate, Tufts Health Plan ensures that referrals for specialty Behavioral Health Services are made promptly, monitored, and with member consent and per the member preferences documented in the Comprehensive Assessment and documented in the Centralized Enrollee Record.

ii. Behavioral Health Responsibilities: Tufts health Unify manages timely access to and the provision of all Behavioral Health Services by establishing and contracting with a Behavioral Health Provider Network. When services for Emergency Conditions are needed, the member could seek care from any qualified Behavioral Health Provider, including Emergency Services Program (ESP) providers. The care-management protocol for members encourages appropriate access to behavioral health care in all settings. For members who require Behavioral Health Services, the Behavioral Health Provider:
   1. With the member and/or the member's authorized representative, if any, develop the behavioral health portion of the ICP for each member in accordance with accepted clinical guidelines
   2. With the input of the PCP and/or ICT, as appropriate, determine clinically appropriate interventions on an on-going basis, with the goal of promoting the independent functioning of the member and the stabilization, continuing improvement, or recovery from behavioral health conditions

F. Integration and Coordination of Services: Tufts Health Unify promotes and supports advances in PCPs' and other providers' capabilities to perform as patient-centered medical homes and/or health homes that provide integrated primary care and behavioral health care. This may take the form of Behavioral Health Services being integrated into a primary care setting or vice versa. Tufts Health Plan supports capacity development in at least the Foundational Elements of Primary Care and Behavioral Health Integration as described in the Three-Way Contract. About the overall integration and coordination of medical, behavioral health and LTSS, beyond supporting ICTs, Tufts Health Unify also uses qualified peers and non-medical staff (e.g., Community Health Workers) to support and connect members with community-based resources.

TUFTS Health Plan

Written Policy: Care Mgt Assessment Process & Individualized Care Plan

TUFTS Health Plan

Tufts Health UNIFY
Care Management Assessment Process and Individualized Care Plan Development and Management Policy and Procedure

Policy Name:	Care Management Assessment Process and Individualized Care Plan Development and Management
Department:	UNIFY Care Management
Policy #:	UNIFY-Care Management-01
Effective Date:	January 1, 2019
Applicable Products	Medicare-Medicaid (MMP Dual)
Policy Owner Position Title:	Director of Care Management, Public Plan
Revision Date:	March 09, 2020

I- Purpose:

To ensure the Tufts Health UNIFY program has defined the components of and processes for Tufts Health UNIFY Member initial and ongoing assessments, including the development of an individualized care plan.

A. Assessments:

a. Comprehensive Assessment

i. Tufts Health Plan Public Plan UNIFY completes a Comprehensive Assessments for each new Enrollee on an ongoing basis, including:

1. Within 90 days of each Enrollee's Effective Enrollment Date into the Contractor's plan, and at least annually thereafter; or

2. Whenever an Enrollee experiences a major change that is:

a. Not temporary or episodic;
b. Impacts on more than one area of health status; and
c. Requires interdisciplinary review or revision of the ICP.

ii. The Comprehensive Assessment includes completion of an assessment tool, developed by THP Public Plan UNIFY and informed by at least one in-person meeting covering expanded domain each Enrollee to creation of his or her ICP. Thi the same time as the MDS-HC assessment.

a. As appropriate to the Enrollee's nee developed assessment tool includes and special considerations, which m during the Contract period:

v. Functional Status, including ADL and IADL limitations, and what the Enrollee identifies as his/her strengths, weaknesses, interests, and choices about daily routine;

vi. Current mental health and substance use, and history of mental health and substance use treatment, including consideration of:

1. Type, duration and frequency of services, including medications;
2. Specialized supports that may be needed, particularly for individuals who utilize the emergency room for a psychiatric or behavioral issue;
3. LTSS;
4. Earlier onset of dementia for individuals with intellectual disabilities;

B. Individualized Care Plan (Plan of Care (POC) and Individualized Plan of Care:

a. During the initial assessment, the assigned Clinical Care Manager develops an individualized care plan with the member within 90 days of their initial effective day with the Plan.
b. The ICP incorporates the results of the Comprehensive Assessment and specifies any changes in providers, services, or medications.
c. The ICP will be developed by the ICT under the direction of the Enrollee (and/or the Enrollee's representative, if applicable), and in consultation with any specialists caring for the Enrollee, in accordance with 42 C.F.R. 438.208(c) (3) and 42 C.F.R. 422.112(a) (6) (iii) and updated periodically to reflect changing needs identified in Comprehensive Assessments. The Enrollee will be at the center of the care planning process.

C. Services provided to Enrollees with DMH affiliation:

Tufts Health Unify ensures that Covered Services are provided to all enrollees with DMH Affiliation as follows:

a. The ICP specifies that all BH Services required during any acute BH Inpatient Services stay, identifies discharge plans and, when appropriate, indicates the need for DMH Community-Based Services or continuing inpatient psychiatric care as part of the ICP

TUFTS Health Plan

Collaboration with a Member's External Federal, State and Community Based Care Manager

TUFTS Health Plan

Tufts Health Unify

Care Management Procedure: Collaboration with a Member's External Federal, State and Community Based Care Manager

Department: Public Plans	**Effective Date**:	09/24/2020
Procedure Owner Position Title: Ashley Crane-Bassett, Clinical Manager	**Review Date**:	09/24/2021
Applicable Products: Unify	**Retire Date**:	TBD

I. Purpose

The purpose of the process is to provide Unify staff with guidance with the identification of and collaboration with a Unify Members' Care Manager (CM) from an external agency. These Care Managers may be affiliated with either Federal, State and/or Community Based Organizations that assist the member with receiving care and services that promote independent living within their community.

IV. Identification of External Care Managers

1. ICT Education
   - a. Assessment Process
     - i. The ARN will identify any external Care Managers during the ICT education process and document their contact information within the "Contacts" section of CCMS
       1. If the member agrees, the Care Manager will be added as an ICT member within the "Contacts" section of CCMS **(See Section VI.c – Documentation)**
          - a. If the member does not have a direct phone number for the external Case Manager, the applicable department/agency's main phone line will be documented **(See Section VIII – Resources)**
       2. Update the member's ICP if they are a DMH client **(See Section VI.b - Documentation)**
   - b. Outside of the Assessment Process
     - i. The lead Care Manager will identify any external Care Managers during the ICT education process and/or other care management processes
       1. If the member agrees, the Care Manager will be added as an ICT member
          - a. Document their contact information
          - b. If the member does not have a direct phone number for the external Case Manager, the applicable department/agency's main phone line will be documented **(See Section V.a – Documentation)**
          - c. Update the member's ICP if they are a DMH client **(See Section V.b Documentation)**

TUFTS Health Plan

Collaboration with a Member's External Federal, State and Community Based Care Manager – con't

2. Transitions of Care
   a. Inpatient
      i. The TOC (BHCM) and RN Care Manager will review the DOAR report for any active DMH, DDS, DCF & DYS flags for those members who are newly admitted to an inpatient facility
      ii. The TOC staff will review the member "Contacts" in CCMS for any applicable ICT CM contact data **(See Section VI.c – Documentation)**
         1. If present, they will notify the external Care Manager of the event
         2. If not present, and the member is flagged with a State agency affiliation, the TOC staff will reach out to the applicable agency's main number and ask for the members assigned CM (**see Section VIII – Resources)**
      iii. Whenever TOC staff schedules an ICT meeting with the member and the facility, the TOC staff member will invite the external care manager, with the member's permission and follow the standard ICT procedures for documentation, including the ICP
         1. The ICT meeting process will not be cancelled if the Care Manager from external agency chooses not to engage in the ICT process

V. Collaboration Goals

1. Unify staff shall attempt to collaborate with Care Managers from external agencies to facilitate the sharing of information, develop and reinforce the Member's ICP during transitions of care
   a. For member who are DMH clients, the Unify TOC staff shall ensure, that the ICP specifies:
      i. All Behavioral Health services required during any acute BH inpatient services stay
      ii. When appropriate, the ICP shall indicate the need for DMH Community-Based Services or continuing inpatient psychiatric care
      iii. Discharge plans for the Behavioral Health inpatient stay

Individualized Care Plan Elements

ICP Elements	ID Number	Description	Comment Bubble
Problem	501034	Need for Coordinated Care	
Goal	500908	Integration of DMH services	Example: ICT meeting scheduled once every two months as agreed to by the member
Intervention	501269	Identify DMH rep and ensure rep is actively engaged in care planning process	Example: Member prefers morning ICT meetings on M-W-F

TUFTS Health Plan

Written Policy: Care Management Procedure: BH Community Resources

TUFTS Health Plan

Tufts Health Unify

Care Management Procedure: BH Community Resources

Department: Public Plans	**Effective Date:**	1/1/2019
Procedure Owner/Title: Ashley Crane-Bassett, Clinical Manager	**Review Date:**	2/1/2019
Applicable Products: Unify	**Retire Date:**	TBD

I. Purpose

The purpose of this document is to provide a structured process that will ensure the consistent work flow for referring members to State-Operated Community Mental Health Centers (SOCMHCs) when a member needs specific services from a community agency.

VII. Training

- **a.** The Unify team members shall receive education and training relative to the member referral process
- **b.** Scheduling:
  - **i.** Training at the start of this new procedure launch for all role participants
  - **ii.** Training for new employees (role-specific training)
  - **iii.** Ad hoc training pertaining to role competencies and coaching opportunities
- **c.** Clinical managers will be responsible for coaching on expectations and monitoring performance:
  - **i.** If a gap is identified for the team, the Clinical Managers will collectively perform a needs analysis and conduct retraining
  - **ii.** If a gap is identified for the individual, the responsible Clinical Manager will provide coaching, education and continued monitoring of the process

IV. Behavioral Health Community Agency Need Criteria

- **a.** A member that is with Tufts Health Plan Unify
- **b.** Member has a severe mental health diagnosis within the last 12 months
- **c.** A member who has the above and agrees to the referral be put in on their behalf
- **d.** Additional criteria is outlined in attached document 104 CMR 29.00

V. Care Manager Responsibility

- **a.** If member meets all the criteria as listed above the care manager will then submit a referral to DMH on the behalf of the member.
- **b.** Services could include: Adult Community Clinical Services (ACCS), Respite Services, Program of Assertive Community Treatment (PACT), Clubhouses, Recovery Learning Communities (RLCs), DMH Case Management, and Homelessness Services.

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- **c.** Applications can be submitted online or via fax. Application is attached in Supporting Documents.
- **d.** A care manager or a TOC BH can initiate the application process depending on the need and the members current location. For example if the member is in a hospital setting or at home.

VI. Documentation

1.

Note Type	Type	Note Type	Reason	Comments
BH Referral	Member	Unify Clinical Team	Referral	Update Care Plan for Referral Interventions

TUFTS Health Plan

Staff Training to support Appropriate Referral and Member Education

Peer Specialist Support and Community Resources

Jeanne Boudreau, Peer Specialist – Unify
Dawna Osborne, Peer Specialist - Unify

Presentation

Learning Objectives

By the end of this presentation you will be able to:

- Explain the shift in paradigms of mental illness
- Identify and explain recovery and peer-based initiatives
- Explain the purpose of Recovery Learning Communities (RLC)
- Explain the purpose of WRAP curriculum
- Identify when and how to engage Peer Specialist in the Care Management process

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TUFTS Health Plan

Recovery Learning Communities

- RLC provides welcoming, safe, understanding, judgement-free spaces where individuals of diverse backgrounds can gather for healing and growth. We are a community of peers in recovery from mental health challenges, addiction and or traumatic life experiences.
- The RLC supports individuals on their journeys to obtaining and maintaining wellness in a variety of ways, including: 1:1 peer support, peer support groups, self-directed recovery-oriented trainings, advocacy and through an array of community events and activities.

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TUFTS Health Plan

RLC Information Based on Region

Central Area

Central Mass RLC/Kiva Center

209 Shrewsbury Street Worcester, MA 01604

Phone: 508-751-9600

Fax: 508-751-9601

info@centralmassrlc.org

On the web: http://www.centralmassrlc.org/

West

Western Mass. RLC

Western Massachusetts Training Consortium

187 High Street, Suite 303 Holyoke, MA 01040

Phone: 413 539-5941

Toll free 866-641-2853

Fax: 413 536-5466

info@westernmassrlc.org

On the Web: www.westernmassrlc.org

Northeast

Northeast RLC

Northeast Independent Living Program

20 Ballard Road Lawrence, MA 01843

Phone: 978-687-4288 (V/TTY)

Fax: 978-689-4488

On the Web: www.nilp.org

Boston

Metro Boston RLC

Solomon Carter Fuller Center

85 E. Newton Street, Ground Floor Boston, MA 02118

Phone: 617-305-9976

info@bostonresourcecenter.org

On the Web: www.metrobostonrlc.org

Southeast

SERLC Director: Sandra Whitney Sarles

c/o 45 Plant Road

Suite 119

Hyannis, MA 02601

Cell:(774) 212-4519

sandra.whitney-sarles@bmc.org

info@southeastrlc.org

The Southeast RLC has 5 RCCs: Fall River, Taunton, Brockton, Hyannis and Quincy.

On the Web: www.southeastrlc.org

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TUFTS Health Plan

Kiva (Worcester County RLC Schedule)

Monday Lunes 7-21-28	Tuesday Martes 1-8-15-22-29	Wednesday Miercoles 2-9-16-23-30	Thursday Jueves 3-10-17-24-31	Friday Viernes 4-11-18-25	Saturday Sábados 5-12-19-26-4
Morning Jump Start Peer Support 9:30 ~ 10:30	Sharing & Caring Conversation 10:00 ~ 11:00	Walking Group with Andrei 9:15 ~ 9:45	Living with Loss 10:00 ~ 11:00	Kiva opens at 12:00 noon on Fridays	Over the phone Peer Support 7:00 ~ 7:30pm Conference Call (508) 556 ~ 4226
American Sign Language 10:45 ~ 11:45	Community Gathering Starts at 11:15	Wellness Wednesday 9:30 ~ 10:30	Alternatives to Suicide 11:15 ~ 12:15	Sharing & Caring Conversation 12:30 ~ 1:30	PPAL Parent / Professional Advocacy League Every 2nd and 4th Wednesday, monthly at 5:30pm For more info contact Kathy: parentsupportgroup@ppal.net 508-767-9725
Coping with Anger 11:00 ~ 12:00	Almuerzo Latino (Latin Lunch) Bilingual 12:30 ~ 1:30	Peers of Color Support 10:45 ~ 11:45	Voice Hearers & Alternative Realities 12:30 ~ 1:30	Recovery Through Art 1:45 ~ 3:15	
Apoyo entre Compañeros Spanish Peer Support 11:15 ~ 12:15	Trauma Informed Addiction Support Dual Diagnosis 1:30 ~ 2:30	Compulsive Behavior Support 12:00 ~ 1:00	Spirituality & Wellness 1:35 ~ 2:35	Recovery Thru Rhythms (Drum Circle and more) 3:30 ~ 4:30	
Breaking Cycles 12:00 ~ 1:00	QiGong Mind, Body and Spirit Practice	Life After Violence 1:00 ~ 2:00	System Survivors 2:35 ~ 3:30	Karaoke/Spoken Word 4:30 ~ 6:00	

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TUFTS Health Plan

TUFTS Health Plan

Staff Training to Support Appropriate Referral and Member Education

Club Houses

- The Massachusetts Clubhouse Coalition is dedicated to expanding employment, housing, educational, social, and leadership opportunities available to Massachusetts citizens who have a mental illness.
- The MCC was organized to uphold and promote the values, principles and financial integrity of the international Clubhouse model toward the empowerment of people with mental health needs.
- Toward this purpose the MCC will take action, advocate, provide support, and offer opportunities to network and educate ourselves and the community while working as an organization to remove barriers to successful community integration. The Massachusetts Clubhouse Coalition is committed to helping Clubhouses and individual Clubhouse members reach their full potential.

TUFTS Health Plan

ILC

-There are over 600 Independent Living (IL) Centers throughout the US that practice the cross disability philosophy: the belief that all people with disabilities share a common thread that brings them together. Centers are private not-for-profit organizations that are run by and for persons with disabilities. –

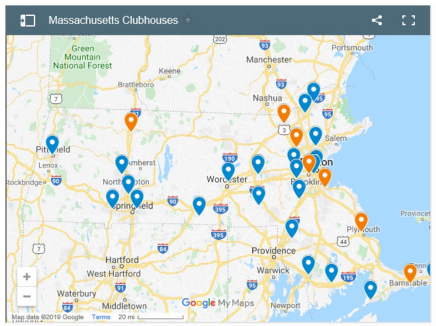
-The staff must be at least 51% persons with disabilities and the nonprofit board must be at least 51% persons with disabilities.

-Massachusetts has 11 Independent Living Centers (ILCs) located throughout the state.

- Independent Living Centers are not places to live rather they are agencies which provide information, support and advocacy to support people with disabilities to live in the communities of their choice.

TUFTS Health Plan

Club Houses



https://www.massclubs.org/massachusetts-clubhouses/

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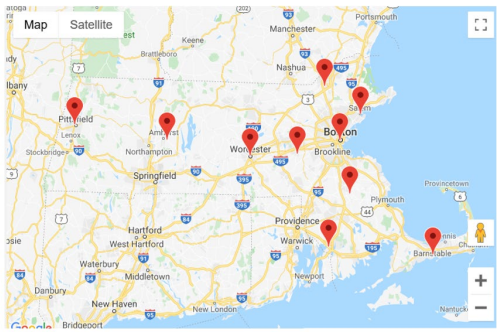
TUFTS Health Plan

ILC



https://www.mass.gov/independent-living-centers

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TUFTS Health Plan

TUFTS Health Plan

Staff Training to Support Appropriate Referral and Member Education

DMH Services

Type of Services	What do they do?	Who would benefit?	Contact Information
Adult Community Clinical Services (ACCS) formerly known as CBFS	(ACCS) provides clinical interventions and peer and family supports to people living in the community to assist them in developing skills, establishing natural support and resources to live successful, independent lives within their community. The following indicators and data demonstrate ways in which individuals are progressing through ACCS services toward the ultimate goal of independent community living.	Anyone that would meet the criteria for services under the 104 CMR 29.00 https://www.mass.gov/doc/reg-104cmr29pdf/download	617-626-8035 Email: accsombudsperson@massmail.state.ma.us https://www.mass.gov/doc/accs-referral-form/download
Program of Assertive Community Treatment (PACT)	A multidisciplinary team approach providing acute and long-term support, community based psychiatric treatment, assertive outreach, and rehabilitation services to persons served.	Anyone that would meet the criteria for services under the 104 CMR 29.00 https://www.mass.gov/doc/reg-104cmr29pdf/download	Main Call Department of Mental Health Metro Bosto Area Office, Main at (617) 626-9200
DMH Case Management	State-operated service that provides assessment of needs, service planning development and monitoring, service referral and care coordination, and family/caregiver support.	Anyone that would meet the criteria for services under the 104 CMR 29.00 https://www.mass.gov/doc/reg-104cmr29pdf/download	Main Call Department of Mental Health Metro Bosto Area Office, Main at (617) 626-9200

Type of Services	What do they do?	Who would benefit?	Contact Information
Recovery Learning Communities (RLC)	Recovery Learning Communities (RLCs) are consumer-run networks of self-help/peer support, information and referral, advocacy and training activities. Training in recovery concepts and tools, advocacy forums and social and recreational events are all part of what goes on in a Recovery Learning Community.	The doors are open to all individuals with a serious mental illness. RLCs work collaboratively with mental health providers, other human service agencies and the community at large to forward the mission of community integration and respect for people with mental health conditions. RLC activities are designed to appeal to the range of people in the community, including people of all racial and ethnic backgrounds and people of all co-occurring disabilities. RLCs are for everyone.	https://www.mass.gov/service-details/recovery-learning-communities
Clubhouse	Clubhouse Services provide skill development and employment services that help individuals to develop skills in social networking, independent living, budgeting, accessing transportation, self-care, maintaining educational goals, and securing and retaining employment.	Massachusetts citizens who have mental illness.	https://www.massclubs.org/massachusetts-clubhouses
Emergency Services (ESP)	Mobile behavioral health crisis assessment, intervention, stabilization services, 24/7, 365 days per year. Services are either provided at an ESP physical site or in the community.	Anyone.	https://www.mass.gov/doc/appendix-c-esp-statewide-directory-2/download?_ga=2.65767342.1205025815.1609352413-799971234.1599054322

Member Journey

Joseph is a single 58 yr. old male who lives alone
Medical Diagnosis: A-fib, Morbid Obesity, Heart Failure, Type II DM
BH Diagnosis: Bipolar Disorder, Generalized Anxiety Disorder, Major Depressive Disorder

Joseph has been a Unify member since 2018. At the time of the initial assessment, he presented to be thriving and functioning well in the community. Medical and Behavioral Health providers were in place. Regular visits with PCP, Cardiologist, OP Therapist and Psychiatrist. All of whom member voiced that he trusted and was very satisfied with.

Initial change in status – hospitalization brought about by current cardiac issues

Most significant change – March at the start of the pandemic – increase in anxiety, panic, paranoia and social isolation

Care Team involved with member: BHCM, ACM, PS, CC, RN TOC, DMH Caseworker, PCP, Psychiatrist, OP Therapist

Interventions put in place that are a direct result of close collaboration between Unify BHCM and DMH Caseworker:

Regular ICTs attended by DMH Caseworker and OP Therapist at BMC,(at one point where DMH caseworker was in member's home during the ICT, who initiated a video call with Unify BHCM), uninterrupted medical and BH appointments, transportation arrangements to all in person visit appointments, telehealth appointments, BH Community resources: Companion, Clubhouse

Care Team (Internal and External) are working towards the same goals of:
increasing member's independence with managing his appointments; decreasing anxiety and need for reassurance by providing member with consistent messaging; improving member compliance to medical and BH treatment by improving coping skills and understanding boundaries