Tennessee Health Link Engagement Evaluation User Guide

General Record Tool

Member records will include all applicable documentation within one calendar year prior to the date of review unless specified otherwise. Additional data can be requested at the discretion of the MCO.

Enrollment Criteria

1. The reasons for initiation of THL service is clearly documented and identified by a licensed clinician within 30 days of enrollment.

    We recommend that each provider have a specific process be used to reflect this requirement. The reasons should be clearly documented, an example is: THL services is recommended to address medication compliance and housing needs.

2. There is evidence of the member's consent to participate in the THL (or evidence of not opting out).

    Consents must be signed at initial enrollment and at any re-enrollment, such as after being discharged from the program.

3. There is clear evidence of functional need, based upon the DLA or other equivalent functional need assessment, within 30 days of enrollment.

    The functional need assessment can be done within 30 days prior or 30 after enrollment, but should be completed prior to the care plan. The functional need assessment should be completed for **ALL** eligibility categories of THL (Category 1, 2, or 3).

4. For children with DCS involvement, the record supports THL eligibility by verification the child meets DCS Level 1 or 2 status (THL eligibility is suspended for levels 3, 4, and 4+)*.

    This applies only to members in the stated levels of service.

Person-Centered Care Plan

5. There is evidence of a completed person-centered care plan within 30 days of THL enrollment.

    This is aligned with the Activity Requirements Appendix in the 2018 Provider Operating Manual.

6. The person-centered care plan is updated every six months or earlier as needed to address the care coordination needs of the member.

    This is to ensure that the continuation criteria outlined in the level of care guidelines are met.

7. All person-centered care plans are signed by Coordinator, Licensed Clinician and Member/Guardian.

   All signatures must be within 30 days of the updated person-centered care plan.

8. All person-centered care plans are specific, measurable, attainable, relevant, and time-based.

   The care plan should include frequency, duration, and target dates of completion.

9. The functional need assessment was updated at a minimum of every six months.

   The functional need assessment can be completed more frequently based on the needs of the member.

10. All person-centered care plans are comprehensive and reflective of data from the most recent functional need assessment, gaps in care, and any other applicable service provider.

    A comprehensive person-centered care plan incorporates data from the FNA, gaps in care (CCT or MCO provided), and any other applicable service provider. See Provider Operating Manual: "Comprehensive care management: Initiate, complete, update, and monitor the progress of a comprehensive person-centered care plan as needed."

11. The updated person-centered care plans clearly addresses barriers to progress with relevant updated interventions.

    This applies only to the care plan updates NOT THE INITIAL CARE PLAN. The updated plan should address any barriers to progress and support the continuation of goals beyond 6 months.

Coordination of Services

12. The record documentation demonstrates efforts to provide member and family support such as: providing high-touch in- person support, provider caregiver psychoeducation or training, identify resources to assist individuals and family supporters, and check-ins with member.

    Appropriate releases should be completed prior to any collaboration. See Provider Operating Manual: "Member and family support: Provide high-touch in-person support, provider caregiver counseling or training, identify resources to assist individuals and family supporters, and check-ins with member."

13. The record documentation demonstrates collaborative efforts from the member's primary and specialty care providers to incorporate into the comprehensive person-centered care plan, as appropriate per assessment.

    Appropriate releases should be completed prior to any collaboration. Specialty care providers would include current/previous behavioral health providers, but not the member's current Health Link. See Provider Operating Manual: "Care coordination: Participate in member’s physical health treatment plan, support scheduling and reduce barriers to adherence for medical and behavioral health appointments, facilitate and participate in regular

interdisciplinary care team meetings, follow up with PCP, proactive outreach with PCP, and follow up with other behavioral health providers or clinical staff."

14. There have been active attempts to facilitate access to community supports, communicate member needs to community partners (e.g. schools, food banks, etc.), and provide information and assistance in accessing services.

    Appropriate releases should be completed prior to any collaboration. See Provider Operating Manual: "Referral to social supports: Identify and facilitate access to community supports, communicate member needs to community partners, and provide information and assistance in accessing services." This would include schools for school age children.

15. If member has received inpatient or ER services, the THL has provided transitional care to include assistance in discharge planning, support in crisis situations, and/or establishing and/or confirming follow-up care post discharge.

    Appropriate releases should be completed prior to any collaboration. See Provider Operating Manual: "Transitional care: Provide additional high touch support in crisis situations, participate in development of discharge plan for each hospitalization, develop a systemic protocol to assure timely access to follow-up care post discharge, establish relationships, and communicate and provide education."

16. There is documented evidence in the record that the THL is supporting health promotion with the member.

    Appropriate releases should be completed prior to any collaboration. See Provider Operating Manual: "Health promotion: Educate the member and his/her family. Example: educating the member and his/her family on independent living skills" The goal for health promotion is to enable the member to self-manage his/her health.

Continued Service Review Tool

Member record reviews will only view documentation within the six months prior to the date of review unless otherwise requested by the MCO.

Continuation of Services

1. Per MCO review of the provider documentation and/or MCO data, member demonstrates progress toward targeted goals within the past 6 months or barriers to their progress have been addressed.

   Guidance for the measuring of progress would come from the person-centered care plan and/or the functional need assessment. The THL progress notes would be the main source of documentation related to this question.

2. Member has current BH treatment needs, or other specialty care needs, that require THL Care Coordination Services?

There is an expectation that the member will either be active in outpatient behavioral health treatment or become active as a result of THL services.

3. There is documented evidence in the record that demonstrates the THL provider conducted appropriate and/or varied efforts to engage the member during the most recent 3-6 months (F2F visits, CM reassignment, utilizing MI/MET strategies, appropriate incentives, enlisting a Peer Specialist).

   There is a recommendation that the provider conducts at least one face-to-face activity with the member every 3 months.

4. Demonstrated care coordination attempts to close THL quality medical and behavioral gaps/measures.

   The THL quality medical and behavioral gaps/measures referenced are outlined in the most recent provider operating manual.

5. There is documented evidence in the record that the THL is supporting recovery and resilience through strategies to assist the member with utilizing supports in their natural environment.

   Recovery is evaluated using SAMHSA definition, "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." https://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf
   The American Psychological Association defines resilience as the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress..." American Psychological Association. The road to resilience. Washington, DC: American Psychological Association; 2014. Retrieved from http://www.apa.org/helpcenter/road-resilience.aspx.