

One Care Implementation Council Meeting
Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA
Boston, MA

February 13, 2018 10:00 am – 12:00 pm noon

Council Meeting attendees: Suzann Bedrosian, Lydia Brown (participated by phone), Crystal Evans, Dennis Heaphy (Chair), Jeffrey Keilson (participated by phone), David Matteodo, Henri McGill, Dale Mitchell, Paul Styczko, Howard Trachtman (Vice Chair), Sara Willig, and Florette Willis (Vice Chair).

Key Stakeholders and Support Staff attendees: Corri Altman Moore (MassHealth), Jennifer Baron (CMS), Maggie Carey (UMass Support), Daniel Cohen (MassHealth), Malinda Ellwood (MassHealth), Andrew Falacci (UMass Support), Raymond Gomez (Tufts Health Plan), Andrew Johnson (Tufts Health Plan), Joshua Krintzman (Commonwealth Care Alliance), Lisa McGlinchy (UMass Shared Learning - by phone), Scott McManus (One Care Ombudsman Office), Burt Pusch (One Care Ombudsman Office), John Ruiz (Commonwealth Care Alliance), Amanda Shea (One Care Ombudsman Office), Bea Thibedeau (Tufts Unify), Liz Shaw (CCA), Amanda Mackey (CCA).

Unable to Attend: Dan McHale

Handouts: Agenda; Meeting minutes from 1-9-18 (DRAFT), 2017-2018 IC Workplan (DRAFT), MassHealth presentation, CCA and Tufts presentations, presentations from Dennis Heaphy. Documents will be available online at

<https://www.mass.gov/service-details/one-care-implementation-council>

1) Welcome/Review of Agenda/Introductions

- Implementation Council Co-Chair Howard Trachtman opened the meeting.

2) Approval of Meeting Minutes and IC Work Plan

- January 9th Implementation Council meeting minutes were approved with 12 ayes, 0 nays, and 1 abstention.
- The 2017-2018 Implementation Council Work Plan was approved unanimously.

3) MassHealth Update

- MassHealth, provided an overview of the requirements of the LTS Coordinator in the current contract:
 - There is an emphasis on member choice; a member is able to request one at any time. The member should have a choice of CBOs (when possible) as well as a choice between at least two different coordinators, even if it is from one CBO.
 - The LTS Coordinator participates as any other member care team at the discretion of the member.
- Further explanation on the LTS Coordinator exists in the three-way contract (section 2.5.c.4), or online at mass.gov/MassHealth/duals.
 - MassHealth described its current work drafting an amendment to the three-way contract, which will include some of the more recent suggestions of the Implementation Council and the One Care Ombudsman to clarify the requirements for the LTS Coordinator.

Questions and Comments Raised during Presentation:

- IC Member asked MassHealth if there is standard process for educating enrollees about the LTS Coordinator, and if there is a single document to do so.
 - MassHealth referenced the one-page document MassHealth provided for the meeting. This “one-pager” is accessible at: www.mass.gov/masshealth/onecare.

4) CCA Presentation: presented by CCA Representative Laura Black, Vice President of Care Partnership and Service Delivery, Liz Shaw, RN, and Amanda Mackey, LTS Coordinator

- CCA offers the LTS Coordinator at the initial assessment, and periodically through the member's time with the plan.
- CCA tries not to force anything on members, but quickly reacts to members' needs when they arise; in the course of a conversation, in the course of a fixed visit, such as an assessment, or at other times.
- CCA strives to "meet our members where they are" - to be in a place where they can quickly react when the need arises.
- The role of the LTS Coordinator is to work with members to find and identify resources to support their wellness, dependence and recovery. They educate the care team on what the LTSS needs are for the members. They come from independent community organizations, such as ASAPs, from recovery learning communities (RLCs), or from independent living centers (ILCs).
- CCA presented two case studies to illustrate the role of the LTS Coordinator.
 - The first story focused on a member who did not want any long-term services. After meeting with CCA, the member accepted some LTSS, and then over the course of several months gradually agreed to increase services.
 - CCA finds members agree to more services over time when they are able to trust the worker in their home. Building a solid relationship from the onset is crucial to a positive member experience.
 - The second story focused on a member who was reluctant to allow services into her own home. The CCA LTS Coordinator described an incident where she was able to work out a home-related issue for the member. The experience highlights how LTS Coordinators help solve unforeseen issues for members well after the initial assessment.

5.) Tufts Presentation: Presented by Bea Thibedeau, Director of Clinical Management and Long-Term Care Services from Tufts Unify

- *NOTE Tufts' clarified data on slide 3: the C3 population utilizes the service the most at 37% (not 67%).*
- All members who use LTSS are assigned an LTS Coordinator. The coordinator drives the care plan, works with the member to evaluate the plan, and collaborates with the Care Manager to make sure there is a shared strategy and the member is meeting their goals based on their needs and wants
- Tufts discussed ways to strengthen the role of the LTS Coordinator, and the best practices to make it happen.
- Personal care attendants (PCAs) drive LTSS year after year, and are the largest portion of Tufts' LTSS services. There are challenges to better care coordination, especially because only 27% of their member population uses the program. Many do not feel they need these services.
- Tufts signified a lack of activity around peer support and advocacy. It is an aspect Tufts needs, and wants, to improve.
- The member's LTSS assessment, including the option for an LTS Coordinator, occurs at the beginning of the enrollment, but it is continuous thereafter. The comprehensive assessment is a psycho-social history type of assessment. From there, the LTS Coordinator does a more targeted social and functional assessment for the member. After the first assessment, there are situational assessments arising when members' needs or changes warrant them. Often times, the member still refuses the situational assessment. However, increasing coordinator services will help to increase LTSS use.
- Education for the member is a large step of the process, and includes educating providers as well.
- The care manager is primarily responsible for the member's care and needs. Assessment of need is ongoing throughout the care model.
- After the assessment and coordinator offering, Tufts refers members to Community Based Organizations (CBOs), offering options at both Aging Service Access Points (ASAPs) and Independent Living Communities (ILCs). It is here the relationship

starts and the LTS Coordinator becomes part of the member's care plan, in coordination with the care manager.

Questions and Comments Raised During the Presentation:

- IC Member asked for further clarification on the ICT (independent care team).
 - Tufts explained the ICT is a group of specialists including, the member's physician, care manager and others. The team members each play a role in the member's care. The ICT meets together to review care plans and compile progress reports on a situational basis. In addition, Tufts tries to get the providers to engage with the member's ICT.
 - Tufts identified three areas of quality: (1) member satisfaction; (2) regulatory and contract requirements; and (3) how well the team is integrating and getting the member to feel their care is being coordinated.
- IC Member asked for clarity on the LTS Coordinator caseload.
 - Both CCA and Tufts estimate the average caseload for coordinators at between 90 and 120 members.
- IC Member asked what the LTS Coordinators do for the homeless population. Personally, the member had 27 people assigned to her at a shelter, and wonders how a coordinator could better manage the care?
 - CCA clarified that it was the LTS Coordinator's role to communicate with One Care members in her caseload, especially when they are homeless. She has been the "clearinghouse" in instances where she began managing all care (including housing issues and payments). She tried to pull in the LTS Coordinator after establishing housing.
- IC Member explained how there are people trained in dealing with members in the homeless population.
 - Tufts described the homeless population as the most challenging. The members who want to have housing are the ones Tufts feels it can help the most. Tufts has been trying innovative practices with the homeless population in Suffolk County. Tufts started to pay attention to the "in and out" cycle of homeless folks, particularly around emergency rooms and detox

facilities with a Boston hospital. Tufts wants to make the connection between the care manager and the case manager in the emergency room to see if there is any way to connect with members who come into the emergency room.

- IC Member mentioned chemical dependency as a huge issue when dealing with homeless members. Providers cannot simply judge users, but need to look at the best ways to get care to individuals.
- IC Member, affiliated with Pine Street, added that some homeless individuals not wanting to engage once they have secured housing. There is more engagement when people are homeless and utilizing shelters. Once they get their own place, they “shut the door.” It is difficult for Pine Street (and other organizations) to get information on what exactly someone needs, and coordinate services, once the individual leaves the shelter.
- IC Member asked when Pine Street should bring in CCA or Tufts to engage the individual.
 - Homeless individuals have existing relationships with providers because shelters have access to medical providers.
- IC Member explained coordinators have extensive training on how to deal with many of these types of people, including homeless individuals. The missing component is peer support. Certified peer specialists are trained to meet people “where they are at” and help to guide them towards recovery. All people need other human beings to live, grow, and recover. Reaching them can be a very difficult aspect, however.
 - CCA LTS Coordinator mentioned experience working with homeless individuals and managing their care. She emphasized how priceless it is for a member to know they are being heard.
- IC Member asked what the plans are doing for people with behavioral health and substance use issues.
 - Tufts explained its goal to amplify the services it currently offers with the ASAPs and ILCs, as well as access to peer support.

- IC Member asked about strengthening (RLCs) on the North shore and Metro Boston.
 - Tufts suggested it as an area for further work.
- IC Member suggested paying successful individuals out of treatment to join the peer support program.
 - Tufts supported the idea, and explained the need for more (ILCs) etc. There are huge opportunities within the shelter model, such as the one at Pine Street.
- IC Member suggested spending more resources on advertising to increase peer support individuals coming out of recovery.
- IC Member asked how many members in CCA use LTSS.
 - MassHealth confirmed it is roughly 52% with many in the C3 population. CCA covers the majority of members in C3, while Tufts covers a larger group of members with BH needs.
- IC Member asked how prior authorization (PAs) affects the LTS Coordinator process. Can it be restrictive for people based on pre-determined issues? In addition, are people often rejected?
 - Tufts said they rarely deny service. There are rules about notifications, but for the most part, people get what they need. Tufts explained the importance of thinking about individuals' long-term needs, such as eventually providing cooking classes to replace meal delivery.
 - CCA explained how prior authorization does not restrict the creativity the plans use to get people the services they need, for example, mixing several LTSS with homemaking services.
- Audience member said the conversation is great for the journey of the LTS Coordinator over all. It has come a long way, and this is a very positive discussion, especially because it touches on the many local determinates of health. How does the ACO rollout integrate the lessons learned from One Care?

- MassHealth explained the difference between One Care and the ACO/MCO model, where the ACOs and MCOs have many different populations than the One Care population.
- The challenge is making sure MassHealth meets the needs of the different populations enrolling into the program. Today's discussion has been a fantastic.
- ACOs will use certain lessons on LTSS from One Care. They involve different populations, but similar problems.
- IC Member mentioned members with behavioral health needs getting multiple (sometimes 12) assessments. Is there a way to combine assessments? The individual may refuse the services, even though they need them. Is there a way to make the process easier to avoid deterring members (especially the homeless population) from the services they need?
- IC Member explained it could work similarly to her translator teams who all help her with her needs at one time. In her case, she communicates with everyone at once, including her LTS Coordinator, to make the process more efficient.
- IC Member, in her last semester of a Suffolk University Master's program, mentioned her desire to conduct some research on peer support for her capstone project.

Updates from IC Council Chair Dennis Heaphy

March 27th Tele Town Hall highlights

- The event is purely a telephonic.
- IC Chair asked the Council for its help in advertising the event, as well as its advice on questions the hosts should ask about One Care.
- The call is only one hour, including a brief welcome and an introduction with AARP, who will help with the call.
- There will be polling questions.
- MassHealth suggested asking if people have ever used an LTS Coordinator or peer supports.

- IC Chair explained Massachusetts is the only state to be doing these town halls.
- Send flyer to Tom Lane for him to disseminate to provider associations

Annual Report

- Email Dennis suggestions for what information to include at dheaphy@dpcma.org.

5) Upcoming Meetings:

- Tuesday, March 13, 2018; 10:00AM – 12:00PM
One Ashburton Place, 21st Floor
Boston, MA
- Tuesday, April 10, 2018 10:00 AM – 12:00 PM
Health Policy Commission, 8th Floor Conference Room
50 Milk Street
Boston, MA