One Care:
Implementation Council Meeting

MassHealth Demonstration to
Integrate Care for Dual Eligibles
January 11, 2024, 10:00AM – 12:00PM
Virtual Meeting via Zoom

MassHealth Agenda

- Background – CMFI Shared Learning Workstream
- CMFI Shared Learning Modules
- Shared Learning Taskforce
- CMFI Module Training Completion Data

Background

The Care Model Focus Initiative (CMFI) identified challenges in defining the Care Coordinator role, promoting person-centered relationships, encouraging ICT representation, and facilitating “navigation” on Enrollees’ behalf.

Objectives

- Establish principles guiding Care Coordinators in executing their roles; connect principles with expected outcomes to drive a goal-oriented approach to the Care Coordinator role
- Develop options to drive person-centeredness in executing the Care Coordinator role

Scope

- Align on and develop principles to which Care Coordinators can refer to successfully execute their roles
- Brainstorm potential materials, programs, and/or exercises to standardize elements of Care Coordinator training across health plans
- Explore and document best practices for Care Coordinator relating to Enrollees, navigating to advance Enrollee goals within the health plan, and engaging with Care Teams

CMFI Deliverable

- Training modules oriented on Care Model Focus Initiative (CMFI) recommendations to enhance care coordination by guiding Care Coordinators in best practices for person-centered care, Enrollee advocacy, conducting clinical trainings, executing comprehensive assessments and care planning, and collaborating with care team including the Long-term Supports Coordinators (LTS-Cs).

CMFI Shared Learning Module Roadmap

MassHealth and ForHealth Consulting co-led the Care Coordinator Shared Learning Workgroup in defining their approach to delivering training modules oriented on CMFI recommendations for enhancing care coordination.

Modules	Training Topics		Target Month
Module 1 – Best Practices in Person Centered Engagement	▪ Introduction to Shared Learning ▪ CMFI Core Team Introduction	▪ Introduction to Module 1 ▪ Engagement Practices	January 2023 *Complete (live/online)*
Module 2 – Best Practices as Enrollee Internal Advocate	▪ Introduction to Module 2 ▪ People Management ▪ Health Plans' Procedures, Policies, Staff	▪ Covered Services and Flexible Benefits ▪ LTSS Denial Process Training	March 2023 *Complete (live/online)*
Module 3 – Clinical Training	▪ Introduction to Module 3 ▪ Disabilities ▪ Substance Use, Misuse, and Dependency	▪ Mental Health Conditions ▪ Medical Conditions ▪ Key Preventative Care	June 2023 *Complete (live/online)*
Module 4 – Care Coordinator/ LTS-C Joint Training	▪ Role of LTS-C ▪ Care Team Convening and Facilitation	▪ Care Coordinator/LTS-C Collaboration and Communication	Oct/Nov 2023 *Complete (live/online)*
Module 5 – Housing Search Guidance and Resources Training	▪ Introduction to Module 5 ▪ One Care Plan Internal Housing Resources	▪ EOHHS Housing Search 'Tips & Tricks' ▪ DMH Housing Services & Supports	July 2024 *Complete (live/online)*

Shared Learning Taskforce Input

MassHealth and ForHealth Consulting supported the establishment of a multidisciplinary Taskforce to provide input on module content; Taskforce members relayed knowledge of One Care's history, priorities, and Enrollees via monthly meetings.

Taskforce

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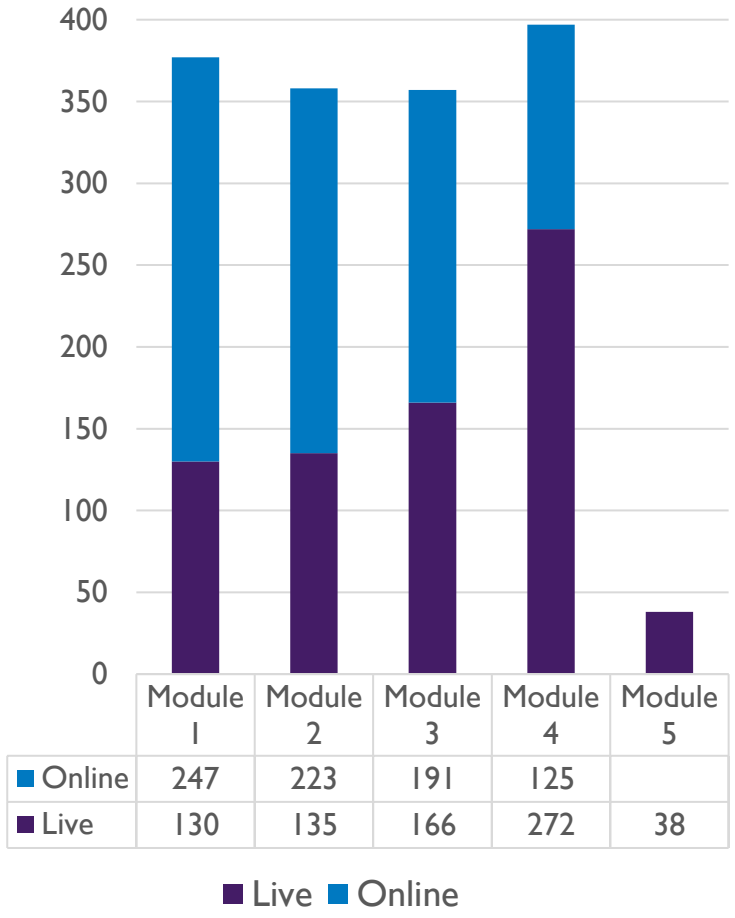
Legend:	Permanent participant	Optional participant	Kick-off meeting only participant

MODULES 1-5 TRAINING COMPLETION DATA

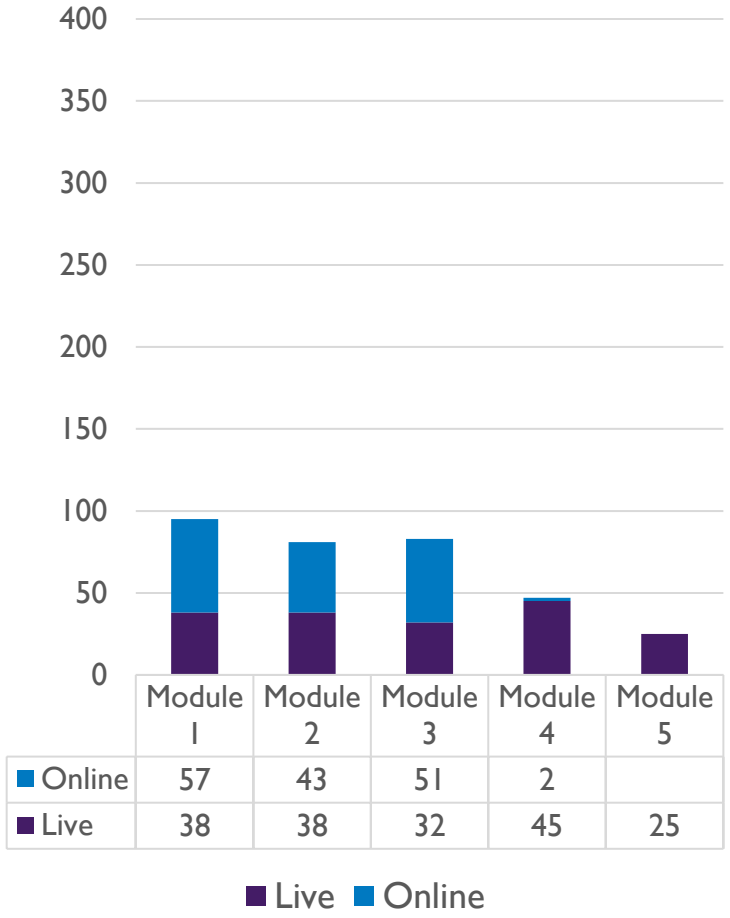
Completion data for Modules 1 through 5, as of 07/31/2024

CCA



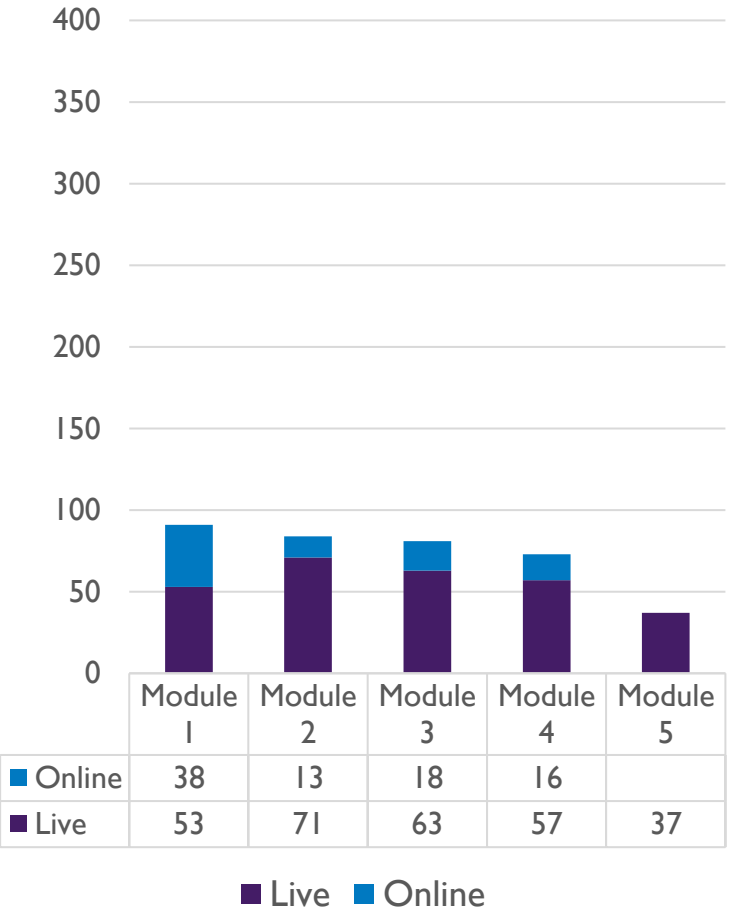
	Module 1	Module 2	Module 3	Module 4	Module 5
Online	247	223	191	125	
Live	130	135	166	272	38

Tufts



	Module 1	Module 2	Module 3	Module 4	Module 5
Online	57	43	51	2	
Live	38	38	32	45	25

UHC



	Module 1	Module 2	Module 3	Module 4	Module 5
Online	38	13	18	16	
Live	53	71	63	57	37

Appendix: Care Coordinator Training – Topics

Initial and ongoing training is critical to supporting the role the Care Coordinator plays in delivering person-centered care.

- ❑ Techniques in establishing trust in the relationship and communication approaches, including active listening
- ❑ Establishing understanding with the Enrollee on how best to communicate with one another -- expectations about type and frequency of contact; best way to contact if problems or questions arise; Enrollee needs from Care Coordinator and Care Coordinator needs from Enrollee for optimal results
- ❑ Care team convening and facilitation
- ❑ Role of the LTSS-C and how to fully utilize that role in the care team
- ❑ How to develop person-centered care plans based on Enrollee, assessment, and care team input
- ❑ Health plan functional organization, with focus on exposing the organization to the Care Coordinator role and explaining to both the Care Coordinator and other functional units how to interact successfully (medical, LTSS, BH, dental, pharmacy, transportation, community-based, vendors)
- ❑ Health plan utilization management and prior authorization processes – making sure the Enrollee interests are well-presented in submitting service requests and understanding administrative and clinical requirements
- ❑ Health plan processes for internal escalation of Care Coordinator concerns about Enrollee care

Appendix: Care Coordinator Training – Topics *(continued)*

Initial and ongoing training is critical to supporting the role the Care Coordinator plays in delivering person-centered care.

- ❑ Covered services and flexible benefits: ensure Care Coordinators are versed in these and know specific processes for accessing, including how to prepare requests; ensure Care Coordinators can effectively communicate these to Enrollees; and ensure Care Coordinators understand how MassHealth and Medicare services interface for maximum coverage
- ❑ How to use and refer to community-based services and supports: understanding the role and value of community health workers, peer supports, and other non-medical, community-based resources – especially to address recovery, social determinants of health and health equity issues
- ❑ How to interface with government and non-profit human service providers (e.g., DMH, DDS, BSAS, ILCs, ASAPs, RLCs, community action entities, etc.)
- ❑ ADA requirements and interfacing with the accessibility enforcement structure within the health plan