

# Meeting Minutes December 8, 2020 – One Care Implementation Council Meeting

**Meeting Location:** Zoom

**Date:** December 8, 2020 10:00 AM – 12:00 PM

**Council Member attendees:** Suzann Bedrosian, Crystal Evans (Co Vice-Chair), Dennis Heaphy (Chair), Jeff Keilson, David Matteodo, Paul Styczko (Co Vice-Chair), Kestrell Verlager, Chris White, Darrell Wright.

**Unable to attend:** Dan McHale, Sara Willig

**Key Stakeholders and Presenters:** Corri Altman Moore (MassHealth), Dr. Richard Antonelli (Boston Children’s Hospital, Harvard Medical School), Jennifer Baron (CMS), Maggie Carey (UMass), Jean Carlevale (MassHealth), Daniel Cohen (MassHealth), Hilary Deignan (UMass), Sophie Hansen (CCA), Dr. Lisa Iezzoni (Mongan Institute, Harvard Medical School), Henri McGill (MassHealth), Ken Preede (CCA), Alysa St. Charles (UMass), Danielle Westermann (Tufts).

**Presentations/Discussions:** Agenda; November 10<sup>th</sup> IC meeting minutes; MassHealth Presentation titled *Implementation Council Meeting, December 8th*; Implementation Council presentation titled *Next Up in Ongoing Conversation to Strengthen Integrated Care Coordination Model*.

[Documents available online](#)

## Executive Summary and Action Items:

### Welcome/review November 10th meeting minutes

Paul Styczko, Implementation Council (IC) Vice Co-Chair, opened the meeting and asked for a motion to approve the minutes from the November 2020 meeting. The motion was seconded and carried.

### MassHealth Update

Henri McGill, One Care Program Manager, presented *MassHealth Presentation Implementation Council Meeting, December 8<sup>th</sup>*, reviewing the One Care Plan Clinical Audit of Care Coordination Processes, MassHealth efforts to address Health Disparities, and an Overview of the new MassHealth Managed Care Entity (MCE) Bulletin 44 on Community Support Program for Chronically Homeless Individuals.

### Care Coordinator Model Discussion

Dennis Heaphy, Implementation Council Chair, presented *Next Up in Ongoing Conversation to Strengthen Integrated Care Coordination Model, December 8, 2020*, to continue the discussion on Care Coordination with Richard Antonelli, MD, MS, of Harvard Medical School and Boston Children's Hospital, and Lisa Iezzoni, MD, MSc, of Harvard Medical School and the Mongan Institute.

Richard Antonelli, MD, MS, presented on the Minimum Expectations of the Care Coordinator, and Lisa Iezzoni, MD, MSc, presented on the Patient-Centered Outcomes Research Institute (PCORI) One Care Project Aim and Study Findings: Care Coordination.

### Action Items / Next Steps

Look at the National Committee for Quality Assurance (NCQA) Enhanced Care Plan Measure being adopted by MassHealth to use with ACOs and see how it can be adapted to use with One Care populations.

### Motions

Suggested language for future motions are as follows:

- Create a Quality Measure Workgroup that will review current quality measures, survey questions, create guidelines, core measures, supplemental measures, developmental, and developing survey questions. The Quality Measure Workgroup will also provide an overview of the protocols used in the oversight of plans quality.
- Plans shall provide a quarterly report on trends identified from grievance and appeals data (in collaboration with My Ombudsman), corrective action plans in place, and plan progress on these plans. In addition, plan progress in creating, implementing, and measuring health equity strategies and progress of quality measure workgroup.

## Meeting Minutes:

### Welcome/review November 10th meeting minutes

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### MassHealth Update

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### Questions / Comments:

- IC member stated that the MassHealth audit on plan care planning and care coordination will be helpful and asked whether the IC will receive reports of any findings.
  - MassHealth replied that a summary will be given to the IC and that the IC will be asked to provide feedback on the review tool used in the clinical review of plans.
  - MassHealth further stated that Jean Carlevale is listening in at this IC meeting. She is a nurse with the Office of Clinical Affairs and will be integral to the development and implementation of the review tool.
- Several IC members stated a desire to see results of the audit and expressed that they were happy that the audit is taking place.
- IC member stated they were excited that MassHealth is making efforts to address health disparities and offered to help MassHealth with ensuring things are done in an accessible way if needed.
  - MassHealth replied that they will be asking the IC to help identify metrics for inequity.

### Care Coordinator Model Discussion

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### Questions / Comments:

- IC member asked whether there is anything the IC can do to help standardize care plans beyond supporting the Enhanced Care Plan Measures, (ECPM).
  - Dr. Antonelli stated that CMS is pushing multiple Medicaid programs, including MassHealth, to implement standardized care plans. Dr. Antonelli further stated the IC should evaluate existing measures to evaluate care planning as well as national guidelines from groups like the National Committee for Quality Assurance (NCQA).

- Dr. Antonelli stated that standardizing care coordination should be drawn from a care integration framework. Dr. Antonelli clarified that care coordination is different from care integration, which is collaboration between members of the care team as reported by the member.
- IC Chair asked about tools for care planning versus care coordination.
  - Dr. Antonelli stated that he supports care planning tools that ensure person-centered care integration. Dr. Antonelli further stated that securing funding for these tools for policy purposes is difficult, because these tools do not have what would be considered trackable performance measures.
  - Dr. Antonelli stated there are ways to measure activity that are important to payers but less relevant to care integration.
- IC Chair asked if there are best practices in care planning that help ensure person-centered care.
  - Dr. Antonelli stated there are best practices for care planning in publications and journal articles, but these documents are too broad or too technical, so there are problems translating these best practices into something useful on the ground.
  - Dr. Antonelli stated there is a useful best practice guide called Shared Plan of Care, or SPOC. Dr. Antonelli also suggested NCQA's resources.
- IC member asked if there were effective care planning examples from around the country from which One Care could borrow. IC member stated they recognized that system-wide implementation is a challenge.
  - Dr. Antonelli stated that there are no care planning measures that have been endorsed by the National Quality Forum that the IC can instantly implement.
  - Dr. Antonelli stated that people with complex health needs are included in broader populations like Medicaid, LTSS cohorts, and pediatric care and the IC could identify and utilize applicable measures for those populations that would apply to the One Care population.
  - Dr. Antonelli recommended the IC create a task force to identify successful care coordination and care planning programs that could be used in One Care. Dr. Antonelli stated that the task force should also determine how those care coordination and care planning policies can be measured and sustained.
  - Dr. Antonelli stated that no single person can fully coordinate care for a person with complex needs. Dr. Antonelli stated that care integration of all care (including specialty care, behavioral health and LTSS) is the goal, and gave the example of how nursing, medical, subspecialty, and social workers might work together as one team for one person.
  - Dr. Antonelli further stated that team collaboration requires interprofessional communication and education.
  - Dr. Antonelli added that many states are interested in this right now as was seen with the Health Resources and Services Administration (HRSA) who started a National Care Coordination Academy with seventeen states participating (when only four were expected to enroll).
- IC member stated that they experienced what they consider to be the two extremes of care coordination and that effective care coordination requires trust.

- IC member stated that they had a care coordinator who was wonderful and involved in making sure the member's needs were met and goals achieved. IC member stated that this coordinator was promoted, and it took four months before the member was assigned a new coordinator.
- IC member stated that they had a very different experience with the second care coordinator who suggested member make it a goal to lose weight when the member mentioned wanting to address chronic pain.
- IC member asked how trust and safety can be measured in care coordination.
  - Dr. Iezzoni stated that the survey on the One Care program included questions asking how members felt, including if they felt they were being treated like a child. Dr. Iezzoni further stated that including member's feelings are part of comprehensive care coordination.
  - Dr. Antonelli stated that the Pediatric Integrated Care Survey (PICS) model does not focus on trust but asks about reliability. He said in the adult integrated outcome care model and PICS, strengths, formulation plan, and goals are all measured. Dr. Antonelli stated that if members are reporting positive outcomes and experiences with care coordination, trust can be interpreted as a proxy measure.
- IC member asked how to improve care coordination for members with complex needs, where a care coordinator may not understand everything necessary for that member to receive the care they need.
  - IC member explained that they are a vent user and have had seven care coordinators in four years. They feel that because of the care coordinator's lack of knowledge, they are frequently "dumped" by coordinators who do not have adequate knowledge to help them.
  - IC member stated they have not been able to get proper vent supplies since March due to the pandemic. IC member stated that most of their providers do not know what medical supplies are needed because vents are specialized medical equipment. IC member further stated that requests for supplies are denied by the payer because they have not been able to provide a proper medical reason for the supplies and the payer does not understand how vents work.
  - IC member stated that a previous care coordinator was replaced by a care coordinator who was previously an ICU nurse who understands their needs, resulting in better outcomes.
  - Dr. Antonelli stated that care integration is a team effort and that this experience is not uncommon among people with complex needs. Dr. Antonelli stated that the care coordinator does not have to be a content expert, but the care coordinator should be able to facilitate within the care team to make sure the member is getting what they need.
- IC Chair stated that some people describe the care coordinator as a quarterback, not a gatekeeper. IC Chair asked how the IC should work with MassHealth to ensure this.
  - Dr. Antonelli suggested the member be the quarterback because person-centered care requires that the member "call the plays." Dr. Antonelli stated that the care coordinator responds to the member's needs and identifies resources to help the member achieve

- their goals. Dr. Antonelli added that the care coordinator responsibilities do not end with “I don’t know” but should rather be “I don’t know, but I will find out.”
- Dr. Antonelli stated that a facilitator is a better analogy because a facilitator would know when a situation should be elevated and to whom should be responsible.
  - IC member stated that it is already difficult enough to get in touch with a care coordinator and anticipates it would be even more difficult to get access to all team members.
    - Dr. lezzoni stated that she is not familiar with the current state of One Care, but the 2016 survey found many differences in the way care coordination worked statewide. Dr. lezzoni stated that there were significant differences between behavioral health and physical health care coordination.
    - Dr. Antonelli stated that issues with care coordination and issues with communication should be distinguished from one another.
  - IC member asked how to make sure the plans and MassHealth are not overburdened by program oversight requirements.
    - Dr. Antonelli stated that the goal of care integration is a person-centered care model that includes multidisciplinary coordination with a robust communication link between all members of the team.
  - CMS stated there is a difference between measuring contractual compliance versus quality of care as is described by the member. CMS added that they appreciate the approaches of measuring the quality of care coordination being discussed since the IC often has more flexibility and room for innovation than CMS and MassHealth.
  - MassHealth noted the timeliness of this discussion as MassHealth just announced the upcoming audit on One Care plan care coordination and care planning. MassHealth added that the IC, MassHealth and plans need to come to consensus about what the role of the care coordinator is (i.e., facilitator, quarterback).
  - CCA stated they are looking forward to further discussion and to a consensus on the care coordinator role.
  - Tufts stated they are looking forward to further discussion. Tufts added that it can be difficult putting theory into practice in ways that make the member feel what the plan intends.
  - IC Chair stated that One Care is addressing the needs of a population with complex needs and there is no one-size-fits-all solution. IC Chair stated that this discussion was beneficial to thinking about quality measures in ways that are adequate, fair, and equitable.
  - Dr. Antonelli added the following to the Zoom chat for the Council to consider:
    - *My recommendation is that the Council focus on person-centered care coordination, not care coordinator as a person. What are the desired outcomes and how do they get achieved? I am sure that care coordination is best served by a TEAM.*
    - *Differentiate COMMUNICATION from Care Coordination. Ultimate outcome is person-reported care integration.*
  - IC member stated they would like to learn more about care coordination metrics. IC member stated a “cheat sheet” for the workgroup would be helpful to have productive conversations.

The meeting was adjourned.