



# Care Management Training Plan Template

*NOTE: This document is a guide/resource for your organization to use, per your individualized needs, in the development of your own training plan.*



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## Phase 1: Agency Core/Onboarding Trainings

Must be completed prior to staff providing service. These are core training requirements, though your agency may have additional trainings that you offer new staff.

Agency orientation
Training to meet the needs of clients as specified in the treatment plan
Training in client rights
Training in confidentiality
Training in infectious diseases and bloodborne pathogens
Medication administration training
Training in alternatives to restrictive interventions
First aid and seizure management (for services provided in licensed facilities)
CPR & Heimlich maneuver (for services provided in licensed facilities)

## Phase 2: Core Care Management Trainings

Must be completed before staff provide services; trainings must be completed by care managers, care management supervisors, and care management extenders. These trainings can be taken through any Tailored Plan.

Training Topic	Curriculum Summary
Behavioral Health I/DD Tailored Plan eligibility and services	<ul style="list-style-type: none"><li>• Highlighting the differences between the Standard Plan (SP) and Tailored Plan (TP), including identifying data sources and how best to utilize data in day-to-day work.</li><li>• Understanding the importance of risk stratification and performance measurement in order to effectively measure outcomes.</li><li>• Highlighting the essential elements of care coordination, engagement success and patient centered care planning.</li><li>• Principles of integrated and coordinated physical and BH care and I/DD and TBI services.</li><li>• Recognizing behavioral health crises and how best to respond.</li><li>• Highlighting the eligibility and services available including those that are covered under the 1915(b) waiver and the 1915(c) Innovations and TBI waiver, including how care coordination techniques are unique to the population.</li></ul>
Whole-person health and unmet resource needs	<ul style="list-style-type: none"><li>• A deeper dive into physical health, behavioral health and social determinants of health needs and the relationship among them (the aim is to have staff assess the member's whole health presentation and provide the relevant interventions emphasizing whole health integration).</li><li>• Identifying, utilizing, and helping the member navigate available social supports and resources at the member's local level.</li><li>• Understanding and addressing ACEs, trauma, and trauma-informed care</li><li>• Highlights why risk stratification is important when assessing for whole health needs, including the essential elements of care plan building and identifying community resources.</li><li>• What is meant by long term services and supports (LTSS), what specific services are covered.</li><li>• Cultural competency, including sensitivity considerations for tribal populations and forms of bias that may affect BH I/DD Tailored Plan members.</li></ul>

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Training Topic	Curriculum Summary
Community integration	<ul style="list-style-type: none"> <li>• Understanding the principles of community inclusion.</li> <li>• Understanding the functional abilities necessary for independent living (ADL/ IADL), including how and where to find needed resources and the importance of care coordination with the multidisciplinary team.</li> <li>• Performance measures used to determine successful community integration efforts.</li> <li>• Skills to conduct diversion from adult care homes and other congregate settings, institutional settings, and correctional facilities.</li> <li>• Knowledge of supportive housing.</li> <li>• Available programs and resources to assist members in securing employment, supported employment, apprenticeships, volunteer opportunities, vocational rehabilitation and training, or other types of productive activities that support community integration.</li> <li>• Care management skills necessary to promote successful community integration and support improvement of functional and self-management skills.</li> </ul>
Components of health home care management	<ul style="list-style-type: none"> <li>• Orientation to the six core health home services:               <ol style="list-style-type: none"> <li>1. Comprehensive care management</li> <li>2. Care coordination</li> <li>3. Health promotion</li> <li>4. Comprehensive transitional care/follow-up</li> <li>5. Individual and family supports</li> <li>6. Referral to community and social support services</li> </ol> </li> <li>• A deep dive into the essential elements of care management, including how to work together as part of a multi-disciplinary group, and the chronic conditions of the population served in health homes.</li> <li>• How to use risk stratification when making health home decisions.</li> </ul>
Health promotion	<ul style="list-style-type: none"> <li>• How to engage and empower individuals and communities to choose healthy behaviors and make changes that reduce the risk of developing chronic diseases and other morbidities.</li> <li>• Specific examples of health promotion in action, with an emphasis on common physical comorbidities of TP population, such as tobacco cessation strategies, self-management and self-help recovery resources, and medication management.</li> <li>• Common physical comorbidities of BH I/DD Tailored Plan populations.</li> <li>• Key issues and interventions for metabolic disorders (e.g., diabetes and heart disease).</li> <li>• Roles and responsibilities for medication management.</li> <li>• Health promotion strategies that tie in to NCCARE360 and other IT infrastructure.</li> </ul>
Other care management skills	<ul style="list-style-type: none"> <li>• Care management delivery principles that are crucial to the member experience are presented here, including:               <ul style="list-style-type: none"> <li>• Trauma-informed care</li> <li>• Motivational interviewing</li> <li>• Transitional care services</li> <li>• Person-centered practices</li> <li>• Family-driven and youth-guided practices</li> <li>• Care planning in disaster scenarios</li> </ul> </li> <li>• Crucial areas of knowledge are also highlighted here, such as dual eligible definitions and services, services targeting justice involved members, LTSS needs, and Medicare/ PACE enrollment.</li> </ul>

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# Additional training modules for specific populations

Must be completed within 30 days of staff providing services.

Training Topic	Curriculum Summary
Additional Trainings for care managers and supervisors serving members with intellectual or developmental disability (IDD) or a traumatic brain injury (TBI)	<ul style="list-style-type: none"> <li>• Discusses what having a traumatic brain injury and intellectual or developmental disability means, how it impacts one's functional abilities, physical health, and behavioral health, and how it impacts caregivers.</li> <li>• Understanding HCBS, related planning, and 1915(c) services and requirements.</li> <li>• How to access services under HCBS and assistive technologies.</li> <li>• Understanding the changing needs of individuals with and I/DD or a TBI as they age, including when individuals age out of school-related services.</li> <li>• Educating members with an I/DD or a TBI about consenting to physical contact and sex.</li> </ul>
Additional trainings for care managers and supervisors serving children	<ul style="list-style-type: none"> <li>• Child- and family-centered team meetings, how they should be conducted, and the purpose they serve.</li> <li>• Understanding of the System of Care approach, including knowledge of child welfare, school, and juvenile justice systems.</li> <li>• Methods for effectively coordinating with school-related programming and transition planning activities.</li> <li>• Deeper dives into NC child welfare laws, principles and techniques for working with the juvenile justice system and working knowledge of the Individuals with Disabilities Education Act (IDEA).</li> </ul>
Additional trainings for care managers and supervisors serving pregnant and postpartum women with substance use disorder (SUD) or SUD history	<ul style="list-style-type: none"> <li>• Best practices for addressing needs of this cohort, effects of substance abuse on pregnant women, prenatal and postnatal services, and medication assisted treatment.</li> <li>• Discussion of high-risk actions such as breastfeeding, infant opiate withdrawal and neonatal abstinence syndrome (NAS).</li> <li>• Methods for coordinating with the local health department (LHD) or Wellcare of North Carolina, Inc. for management of high-risk pregnancies.</li> <li>• Understanding of family issues associated with pregnancy and SUD and family support interventions.</li> </ul>
Additional trainings for care managers and supervisors serving members with LTSS needs	<ul style="list-style-type: none"> <li>• Methods for coordinating with supported employment providers, the Division of Vocational Rehabilitation, and other general employment resources such as the Employment Security Commission.</li> <li>• Discharge planning from skilled nursing facilities.</li> <li>• Knowledge of service lines which assist with and support ADL and IADLs.</li> <li>• Working knowledge of services specific to cognitive issues due to chronic health conditions or disability.</li> <li>• Ability to assess community living risks including risk of falls, weight loss, home maintenance and safety, driving safety.</li> <li>• Dually eligible populations in CAP-C, CAP-DA and PACE.</li> <li>• Knowledge of Centers for Independent Living and how to access support from these resources.</li> <li>• Working knowledge of area agencies on aging, adult foster care resources.</li> <li>• Knowledge of state operated intermediate care facilities, skilled nursing facilities and neuromedical units.</li> <li>• Knowledge of community veteran's organizations and service systems, including introduction to Tricare coverage.</li> </ul>

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## Phase 3: Care management platform (CMP) training

Must be completed prior to staff providing services; staff must have completed all prior agency and care management trainings prior to this training. Please allot at least one week for staff to complete this training.

- Care management platform (one of the following):
  - Jiva
  - Clinically integrated network (CIN)
  - Other purchased care management platform
  - NCCARE360
- Additional health information technology (HIT) training, as required

## Phase 4: Refresher trainings

To be completed on an ongoing basis after go-live.

- Core skills
- Population-specific topics
- Targeted training on identified areas for technical support
- Compliance
- Ongoing participation in the CMA Learning Collaborative
- Additional training “based on needs determined by care management supervisors
- Billing and documentation