Care Coordination Work Group

Meeting Minutes
April 25, 2016, 3:00 PM – 5:00 PM

DHHS Administration
7001A East Parkway
Sacramento, CA 95823

Conference Room 1

	COMMITTEE MEMBERS		
X	Advocate – Todd Higgins (Disability Rights)	X	Health Plan – Steve Soto (Molina) – ***Chair***
	Advocate – Jenni Gomez (LSNC)		Health Plan – Joel Gray (Anthem Blue Cross)
X	Clinic – J. Miguel Suarez, MD (HALO)		Health Plan – Jane Tunay (Health Net)
X	Clinic – Jonathan Porteus, PhD (WellSpace)	X	Health Plan – Kevin Kandalaft (United Healthcare)
X	DHHS, Primary Health – Sandy Damiano, PhD	X	Health Plan – Sylvia Carlisle, MD (Aetna)
X	DHHS, Behavioral Health – Uma Zykofsky	X	Hospital – Tory Starr (Sutter Health) – ***Co-Chair***
X	IPA – Janice Milligan (River City Medical Group)	X	Hospital – Rosemary Younts (Dignity Health)
X	IPA – Anna Berens (EHS)		
	GUESTS		
X	Cathy Lumb-Edwards (Kaiser Health Plan)	X	Leslie Fonseca (Molina Healthcare)

Group Members in Attendance: 12
Guests: 2

Public in Attendance: 9
Scribe: Karen Giordano

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Topic	Minutes
Welcome and Agenda Review - *Steve Soto, Chair*	Steve Soto welcomed group members and members of the public and facilitated introductions. Materials: All members received copies of the Agenda, Care Coordination Work Group Draft, Meeting Calendar, Case Management and Care Coordination PowerPoint Presentation (PPP), National Committee for Quality Assurance (NCQA) 2016 Health Plan Accreditation Standards, and Aetna's Medicaid Integrated Care Management Handout. (Materials are posted on the website.) Website link: http://www.dhhs.saccounty.net/PRI/Pages/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/GI-MCMC-Care-Coordination-Work-Group.aspx ▪ Agenda: Today's agenda includes Charter and Goals, Inventory of Case Management & Care Coordination Services, MCQA Case Management Standards Review, Target State, Service Gaps, Experiments, Next Steps and Public Comment. ▪ Dr. Sylvia Carlisle will represent Aetna on the work group. Guests today include Leslie Fonseca (Molina) and Cathy Lumb-Edwards (Kaiser GMC Health Plan).
Case Management and Care Coordination – *Steve Soto*	Steve Soto reviewed the Case Management and Care Coordination PPP – *available on website.* Key Points: ▪ DHCS established contract requirements for health plans that include comprehensive medical case management, procedures for monitoring and coordinating care (delivered in and out of network) and the provision of services either through basic or complex case management. ▪ Plans have to establish methods through data sources (utilization review, assessments, referrals, etc.) to identify members who can benefit from complex care management. ▪ Complex care management services for Seniors and Persons with Disabilities (SPDs) are based on a Person-Centered Planning approach and provision of discharge planning to ensure services and care. ▪ Health Plans are subject to oversight by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC).
Charter and Goals– *Tory Starr*	Tory Starr asked members what they would like to accomplish from the Work Group. *The list was not reviewed or prioritized. No decisions were made. It included the following concepts:* ▪ Establishing community-wide standards, central community hub to bring coordination efforts together, common language and terms, keep focus on "improving clients' lives," determine a pilot population, review best practices, decrease fragmentation, reduce silos, difficulty for the expanded population to understand and

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	navigate the system, access to service gaps, primary care shortage, narrow the initial goal to something concrete such as medical transportation (since each plan and provider does things differently), start small by working on access (which is still problematic), transportation, navigation, common language/terms, reduce duplication of efforts, figure out where/how to start, look at what may be working (services for older adults in San Diego, taking away barriers one at a time (ex. transportation), leverage resources, ED navigation, education and outreach to members and navigators, information sharing (IT), work on the basics (appointments), and review how others are doing care coordination (Ohio). ▪ Could start with a population (newly eligible expanded Medi-Cal, seniors, homeless), start small with basics (develop common language/terms, transportation, access to appointments), work on infrastructure and IT, review most expensive population to determine population and/or gaps, or ED utilization for primary care. ▪ Look at barriers such as community confusion with navigators and members on how to select a plan/PCP, and access. Need to building competence within the system for members and navigators, shared funding, start with basic building blocks within a population, change practices to fit population needs.
Inventory of Case Management and Care Coordination – *Plans*	Steve Soto facilitated discussion of current state of case management and care coordination. <u>Molina</u> (Leslie Fonseca): 1. Emergency Department Support Unit (EDSU): 24/7 a. The Nursing Team reviews and oversees inpatient, medical or behavioral health admissions using applicable clinical guidelines and criteria to assure appropriateness of admission, level of care and length of stay taking into account the individual's medical/social needs and medical necessity of the admission. Assists with transition and discharge planning at the time of admission to ensure that appropriate services are provided that will promote safe discharge, optimum patient treatment outcomes, as well as follow up care with the member's PCPs and Specialists. Utilizes all workflows and processes with regards to the Molina Emergency Department Support Unit (EDSU) Program goals in ensuring that all Molina members receive ***the right care, at the right time, at the right place.*** 2. Inpatient Review Team: Registered Nurses and Medical Directors who perform Utilization Review and assist with discharge planning utilizing daily rounds to achieve positive outcomes. Each hospital has an assigned nurse and Medical Director as well as a Complex Discharge Planner 3. TOC Staff: hospital based and telephonic team to meet with members during the hospitalization and for 30 days post discharge. Social Workers, Nurses and BH Specialists 4. Outpatient Case Management Team/Community Connectors: A team of highly skilled staff to coordinate care for members as well as Community Connectors who locate members who we can't establish contact with by phone.

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	UnitedHealthcare (Kevin Kandalaft): Plan uses a dual model, Person-Centered Care and Practice-Centric Concept and includes social determinants. Once in the proprietary platform, the algorithm triggers if someone needs to participate in this program. Transitions of care are embedded within the model. Providers can come in and out of platform to get data. One person in the health plan is the responsible point person for client's care. River City Medical Group (Janice Milligan): Provides complex case management for Anthem and Health Net. They have started a small pilot (100 members) with high ED utilization, accessing care with County Mental Health Plan for alcohol/drug services and/or mental health services. Provides transportation for members, 15% are homeless. Aetna: Aetna provided a handout, "Aetna Medicaid Integrated Care Management" – *available on website. There was not sufficient time for Aetna to discuss care coordination.* Several commented on the absence of Anthem Blue Cross and Health Net. All concurred that all plans must participate.	
Public Comment	No public comment.	
Closing Remarks and Adjourn	Steve Soto thanked everyone for attending and participating in today's meeting. With no additional business to discuss, the meeting adjourned.	
Next Meetings	***Medi-Cal Managed Care Advisory Committee Meeting*** Monday, May 23, 2016 / 3:00 – 5:00 PM	**Location:** DHHS Admin Building Conference Room 1 7001A East Parkway
	Care Coordination Work Group Meeting Monday, June 27, 2016 / 3:00 – 5:00 PM	