Care Coordination Work Group

Meeting Minutes
July 24, 2017, 3:00 PM – 5:00 PM

DHHS Administration
7001-A East Parkway
Sacramento, CA 95823
Conference Room 1

	COMMITTEE MEMBERS		
X	Advocate – Hillary Hansen (LSNC)	X	Health Plan – Sonja Gonzales for Steve Soto (Molina)
X	Clinic – J. Miguel Suarez, MD (HALO)	X	Health Plan – Lydia Mata (Anthem)
	Clinic – Jonathan Porteus, PhD (WellSpace)	X	Health Plan – Jane Tunay (Health Net)
X	DHHS Primary Health – Sandy Damiano, PhD	X	Health Plan – Cathy Lumb-Edwards (Kaiser)
X	DHHS Behavioral Health – Uma Zykofsky		Health Plan – Debbie Tanabe (UnitedHealthcare) – *Excused*
X	IPA – Janice Milligan (River City Medical Group)		Health Plan – Sylvia Gates Carlisle, MD (Aetna)
X	IPA – Anna Berens (EHS)	X	Hospital – Tory Starr (Sutter Health) – ***Co-Chair***
		X	Hospital – Ashley Brand (Dignity Health)

Group Members in Attendance: 12
Public in Attendance: 8

Staff: Sherri Chambers

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Topic	Minutes
Welcome and Agenda Review - *Tory Starr, Co-Chair*	Tory Starr welcomed group members and members of the public and facilitated introductions. It was noted that Steve Soto was unable to attend the meeting, but Sonja Gonzales was in attendance for Molina Healthcare. *Ashley Brand, Dignity Health, is replacing Rosemary Younts on the Work Group. Rosemary will continue to represent Dignity Health on the Medi-Cal Managed Care Committee. Hillary Hansen, Legal Services of Northern California, is replacing Jenni Gomez on the Work Group and Medi-Cal Managed Care Committee due to Jenni's promotion. Welcome Ashley and Hillary.* Materials: All members received a copy of the agenda, 2017 GMC Enrollment Data, Health Plans 2016 Data Comparison, Anthem Blue Cross Case Management Programs, Molina Healthcare Data Summary Strategies, and Comparison of Health Homes / High Utilizer Data Indicators. *All meeting materials are posted on the website.* Link: http://www.dhhs.saccounty.net/PRI/Pages/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/GI-MCMC-Care-Coordination-Work-Group.aspx
Announcements & Data – *Sandy Damiano*	GMC Enrollment Data – As of July 1, Sacramento County GMC enrollment was 435,114 with a net decrease of 3,012 from the previous month. This is the 4th consecutive month with a decrease. Since December 1, 2016, enrollment has declined by more than 7,000 members. The default rate was 35%, among the lowest in the state. San Diego's default rate was 43%. Health Risk Assessment of Seniors & Persons with Disabilities (SPD) – Requirements are outlined in APL 17-013, posted on the DHCS website. Link: http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx • Plans must comply by January 1, 2018. • Plans are required to develop two processes to identify risk of each newly enrolled SPD. • Plans must submit the processes to DHCS for approval, including how stakeholder and consumer input will be incorporated. Action: The Plans agreed to discuss work group input and report back at the next meeting. Proposed State Plan Amendment – DHCS will submit a State Plan Amendment 17-030 to authorize time-limited supplemental payments for certain physician services, including new patient and established patient office / outpatient visits, psychiatric diagnostic evaluation, and psychiatric pharmacological management services. The payments will be funded through the Proposition 56 Tobacco Tax. *Note: DHCS will also seek federal approval to authorize corollary payments for certain physician services in Medi-Cal Managed Care*. Link: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pro_SPA.aspx

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	Urgent Care Clinic List – This list of urgent care clinics by plans and IPAs has been updated and posted. *Thank you Plans and IPAs for providing information to keep our website resources current!* Link: http://www.dhhs.saccounty.net/PRI/Pages/healthcare-resources.aspx
Data Summary Reports – *Sandy Damiano, Tory Starr, and Health Plans*	Sandy Damiano provided background information regarding the data pull process. Health Plans previously presented data for the top 50 adult utilizers based on non-primary care encounters for the first six months of 2016. Today they will present data for the full year. We now have two years of data and should have a good baseline. Plan reports will include data highlights, definitions and clarifications, and interventions planned or ongoing as a result of the data. Staff prepared a side-by-side summary of all plans' data and handouts from Anthem and Molina about their programs. – *All materials are posted on the website*. **Health Net** – Jane Tunay reviewed and discussed the highlights for Health Net. Key Points: • For this data pull, all diagnoses were considered. Previous data pulls considered the primary diagnosis only. • 100% of the top utilizers had ten or more ED visits. • 66% had at least one inpatient stay; 52% had two or more. • Members in Complex Care Management increased to 26%, higher than in previous data pulls. • Because all diagnoses were included, there are higher percentages of comorbid and chronic conditions. • The Health Education Department hosts diabetes and hypertension education classes and promotes resources for heart health, immunizations, prenatal and postpartum care, diabetes, and hypertension. • They have a Case Management program to reduce ED utilization and ensure members are receiving services through the appropriate channels. This has been implemented in the four Dignity Health hospitals. • Management has met with River City Medical Group to discuss high ED utilizers. • After each data pull information is provided to respective IPAs. Questions & Answers: • What are the criteria to get into Complex Case Management? *Members can self-refer or can be referred by the Provider. Members can decline case management services.* • Is Complex Case Management the same as the program with Dignity? *No, they are different programs. The program with Dignity is focused on ED utilization and getting patients connected to primary care.* • Why are so many accessing the ED rather than seeing the Primary Care Provider? *Still trying to figure it out.*

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Data Summary Reports – *Sandy Damiano, Tory Starr, and Health Plans*	*Janice Milligan noted that the Medi-Cal Expansion population is new to the managed care model.* • With only 26% in Complex Case Management, do you have strategies to engage more members? *The Case Management department is directly contacting the top 50 utilizers to try to engage them.* **Anthem Blue Cross** – Lydia Mata reviewed and discussed Anthem's highlights. *See Anthem handout for a description of their programs.* Key Points: • 100% of the top utilizers had at least one inpatient stay. • 22% in Complex Care Management reflects only Plan programs and does not include IPA programs. • Comorbidities are very high. 94% of top utilizers have three or more chronic conditions. • The Safe Choice and Choice Plus Opioid Pharmacy Program started in April 2016. Preliminary data shows a reduction in ED utilization. • Complex Discharge Planning is a telephonic program targeting high inpatient utilizers. • Readmission Reduction Initiative (face-to-face) started October 2016. One LCSW onsite at hospitals meets with high utilizers while they are hospitalized. The targeted engagement rate is 85%, compared to about 30%-40% with telephonic programs. • High Intensity Interval Team (HIIT) is a telephonic case management program led by Behavioral Health. The program started June 2016 and has been very successful. They have seen improved medication adherence. • Complex Case Management – Telephonic long term case management services. • Care Coordination Program – Short term case management services administered by Anthem and IPAs. • The Behavioral Health team is proposing a face-to-face outreach program targeting members with diabetes and SUD. Start date TBD. Questions & Answers: • How do we know which program a member qualifies for? *Anthem has a central case management referral system. They review the claims and make the decision. The face-to-face program is top priority, followed by telephonic.* • How do telephonic services equate to Complex Care Management? *These are great programs, but we have limited resources. Members with complex needs can step down from face-to-face to telephonic care management once staff builds rapport. The non-clinical team looks for additional ways to reach members (alternate phone numbers, through PCP and hospital partners, etc.).*

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Data Summary Reports – *Sandy Damiano, Tory Starr, and Health Plans*	• Behavioral Health diagnosis seems low at 22% when Major Depressive Disorder is 60% and Psychotic Disorder is 34%. *Will need to check and report back.* **Kaiser** – Cathy Lumb-Edwards reviewed and discussed Kaiser's highlights. Key Points: • More than 50% of the top utilizers are Seniors and Persons with Disabilities (SPD). • There is high ED utilization among all Plans. • Mental Health Specialty is carved in for Kaiser, so there is no data listed for that parameter. • Once a top utilizer, they usually stay a top utilizer, even though they may change plans. Questions & Answers: • What does Kaiser do to get high utilizers into complex case management? *Began a segmentation model in 2015 based on utilization, then overlaid SPD criteria. Now looking at a new overhaul with clinical diagnoses plus social determinants.* • How do you decide how long to keep them in complex case management? *May have been keeping them too long. In order to create capacity, we are looking at different models.* • How do you achieve 90% in Complex Case Management when people can decline? *Since 2015, the approach is different from a disease management model. We do not give up on the difficult to engage. We are utilizing texting more often. Staff attends additional training.* **Molina** – Sonja Gonzales reviewed and discussed Molina's highlights. *See Molina handout for a description of programs.* Key Points: • 66% of the top utilizers had three or more ED visits. • 94% had at least one inpatient stay. • Behavioral Health diagnosis is very high at 76%. • Emergency Department Support Unit (EDSU) works with the Transitions of Care (TOC) and Case Management teams. • The Case Management team follows a care model alignment. They meet every other week and review utilization data, looking at high risk and at-risk members. • Referrals may come from PCPs or members can self-refer to case management.

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Data Summary Reports – *Sandy Damiano, Tory Starr, and Health Plans*	• The Quality Department is working with PCPs and providing "Gap In Care" reports. • The new data pull will be sent to IPAs this week. Group discussion – Tory Starr asked the plans, IPAs, and FQHCs to explain how PCPs are educated about the various case management programs. • Molina – The Provider Services team goes out to the PCPs and shares data-driven information. • Anthem – The Provider Relations team goes out and educates. Case management and non-clinical staff build relationships with physicians and clinics to make sure they know about available services. • Health Net – The Provider Relations team visits and provides education. Education is also provided through provider updates. They host provider-related events, sometimes in conjunction with IPAs. • Kaiser – Attend physician business meetings, conduct presentations, however the physicians want to receive the information. • EHS – Representatives in the field provide education. Providers are given a resource binder. • River City – Resource manual, dinner meetings, Navigator meetings at Capitol Health Network. • HALO – It is difficult due to multiple plans with different ways to accomplish a common goal. Work continues to educate providers. Adding pop-up messages. Ashley Brand commented that it would be helpful for hospitals to have a list of programs, how to refer, and any feedback loop. Sandy Damiano said staff will be asking Plans to update the Care Coordination Guides. These are a good tool for navigators and providers. Tory requested plans discuss initial outcomes of their pilots and thanked the Plans for their reports and for sharing best practices. **Health Homes** – Sandy Damiano reminded members that implementation of the Health Homes Program begins in Sacramento in July 2019 (Members with Physical Conditions/SUD) and January 2010 (Members with Serious Mental Illness). Staff created a new document showing Health Homes criteria compared with the High Utilizer Data Indicators. *See Handout posted on the website.* • High utilizer data pull did not include Traumatic Brain Injury or Obesity. Do we want to include for 2017? • One Health Home category is hypertension and one other of four conditions. We pulled each condition separately. Do we wish to pull comorbidities? Keep same and pull data two different ways? • Health Homes has "chronic" homelessness for one of the acuity/complexity levels. There are different definitions. No one is aware of a DHCS definition for chronic homelessness. There is a HUD definition. • Do group members want to modify indicators for 2017, or continue with the same indicators and do a

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Data Summary Reports – *Sandy Damiano, Tory Starr, and Health Plans*	separate data pull for Health Homes? • How will homelessness be defined? • Previous data pulls included 50 members. Should the number be increased? We started with 50 since we were trying something new. • Discussion – Several group members indicated they would like to increase the number of members in the data pull. Some Plans wanted to talk to their data experts before deciding on changes. Sandy noted the questions need to be clear: 1) Add indicators? 2) Do a secondary data pull? 3) Increase the sample size? 4) Frequency of data pull – Quarterly? Semi-annually? Tory Starr asked how the providers and health systems can work more closely together, since the hospitals control major access points and can facilitate getting members into case management programs. Ashley Brand suggested getting hospital social work staff together with Plan and IPA social workers. Ashley added that hospitals need to know which members are enrolled in a plan service, so they can engage them rather than duplicating work. Janice Milligan stated that the top 50 members are accessing all the hospitals. Janice added that IPAs get notified right away for inpatient admissions but not ED utilization. Hillary Hansen commented that some members switch plans due to lack of access to a specialist. These members could benefit from additional education/communication. Many echoed the need for patient education and building trust. Uma Zykofsky questioned the comparability of the plans' case management programs. Uma pointed out how confusing it is in Sacramento because there are three non-Kaiser plans all using the same providers. Next Steps – Tory Starr requested Plans provide the following information at the next meeting: • How many members are enrolled into case management programs? • What are the outcomes? • Staff will work on plan assignments and potential meeting items. Long Range Goals – • Determine effectiveness of the programs. • Share what is working. • Connect members to the programs. • Make it a system that can be ongoing.

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Public Comment	The following provided public comment: • **J.R. Caldwell, Sr., Beneficiary and Medi-Cal Managed Care Advisory Group Member:** Plans are great about sending letters, but they need to follow up with phone calls. Keep in contact with members and they will not want to go to another plan. In your letters, ask for ten minutes of the patient's time for a phone call. Members of the public are looking for personal contact. Some need to hear it, not just read it. A phone call makes a world of difference.	
Closing Remarks and Adjourn	Next Meetings – Sandy Damiano announced: Medi-Cal Managed Care Committee Meeting on August 28 will focus on the Split Mental Health Benefit (two-part topic, to be continued in October). Hillary Hansen will present the advocate perspective on how the split benefit is working. We will have data from the Plans and County Mental Health Plan, a handout with Mental Health criteria and services, and a worksheet with split benefit questions. We will also review a Care Coordination Release of Information mock up created by county for use within and across systems. Little feedback was received on the draft release. Care Coordination Work Group Meeting on September 25 will focus on ED utilization data from the four hospital systems and items from today's meeting. Tory Starr 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, August 28, 2017 / 3:00 – 5:00 PM ***Care Coordination Work Group Meeting*** Monday, September 25, 2017 / 3:00 – 5:00 PM	**Location:** DHHS Admin Building Conference Room 1 7001A East Parkway