Care Coordination Work Group

Meeting Minutes
March 27, 2017, 3:00 PM – 5:00 PM

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

	COMMITTEE MEMBERS		
	Advocate – Jenni Gomez (LSNC) – *Excused*	X	Health Plan – Steve Soto (Molina) – ***Chair***
X	Clinic – J. Miguel Suarez, MD (HALO)	X	Health Plan – Alicia Pimentel for Lydia Mata (Anthem)
X	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	X	Health Plan – Debbie Tanabe (UnitedHealthcare)
X	IPA – Janice Milligan (River City Medical Group)		Health Plan – Sylvia Gates Carlisle, MD (Aetna)
	IPA – Anna Berens (EHS)	X	Hospital – Tory Starr (Sutter Health) – ***Co-Chair***
		X	Hospital – Rosemary Younts (Dignity Health)

Group Members in Attendance: 12
Public in Attendance: 9

Staff: Sherri Chambers

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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. It was noted that Lydia Mata was unable to attend the meeting, but Alicia Pimentel was in attendance for Anthem Blue Cross. *Welcome to Debbie Tanabe, Director of Healthcare Services, UnitedHealthcare, who is replacing Kevin Kandalaft on the Work Group*. Materials: All members received a copy of the agenda, 2017 GMC Enrollment Data, 2017 Committee Planning Handout, County Mental Health Plan Data, Data Based Strategies Handout, Health Plans 2016 Data Comparison, Health Plans 2015 Data Comparison, Molina's Data Summary Report, Anthem Blue Cross' Data Summary Report, Health Net's Data Summary Report, and Kaiser's Data Summary Report. *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*	Care Coordination Release of Information (ROI) – The DRAFT ROI was distributed to all Medi-Cal Managed Care Committee members, and feedback was requested by March 27. As of today, only two responses have been received. Please send feedback to Sherri Chambers at ChambersS@saccounty.net . GMC Enrollment Data – As of March 1, Sacramento County GMC enrollment was 442,403 with an increase of 3,405 over the previous month. The default rate was 22%, the lowest in the state. San Diego's default rate was 39%, and the statewide average was 38%. 2017 Work Group Planning – Document was updated based on committee feedback and other changes. Key Points: • Aetna and UnitedHealthcare are preparing for July go live. Sandy has emailed the State DHCS for more information and is waiting to hear back. • Drug Medi-Cal Organized Delivery System – Sacramento is in Phase 3. Uma Zykofsky is presenting the ODS Implementation Plan and will solicit feedback at the April Medi-Cal Managed Care Committee meeting. • Health Homes – The program is no longer on hold. New implementation dates are pending. • Health Information Exchange (HIE) was on the agenda for the last Medi-Cal Managed Care Committee meeting, but needed to be postponed. Following a brief discussion, Steve Soto and Jonathan Porteus agreed to present at the May meeting. • The Board of Supervisors approved homeless services and housing strategies. Sandy has asked DHA for a panel presentation of the strategies for the Medi-Cal Managed Care Committee meeting in June.

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	<u>County Mental Health Plan Data</u> – County Mental Health Plan (MHP) pulled point in time data as of December 2016 and sent a list of members to each health plan. The handout shows the total number of GMC members receiving County MHP services relative to the total number of GMC enrollees on December 1, 2016. The handout also shows the number of unduplicated adults receiving County MHP services as of December 2016, broken down by plan. <u>Health Plan Networks</u> – Staff asked Health Plans for information on their network structure. This will be a valuable resource. *Thank you to Molina for assisting with the creation of an example!* <u>New Publication</u> – The Center for Health Care Strategies (CHCS) has published a new brief: "Using a Cost and Utilization Lens to Evaluate Programs Serving Complex Populations: Benefits and Limitations." The brief discusses the difficulties in evaluating the success of a program. Staff will send a link to the brief in the next email blast.
Data Summary Reports – *Sandy Damiano, Tory Starr, and Health Plans*	Sandy Damiano recapped the data pull process. Health Plans pulled data for the top 50 adult utilizers based on non-primary care encounters for January through June 2016 (six months). Kaiser participated in the 2016 data pull and also provided 2015 data. Molina updated their 2015 data. Staff prepared handouts showing the four plans side-by-side, as well as handouts showing each plan's data. – *All are posted on the website*. Tory Starr reminded work group members that the goal in sharing data is to work better together in order to best serve the Medi-Cal population. He asked the plan representatives to focus on strategies and learning lessons when reviewing the data reports. Tory reviewed the Data Based Strategies handout. – *Posted on the website*. <u>Areas of Focus for Designing Strategies</u>: • How do we identify the members needing complex care services? • How do we engage these members? • How do we best execute the coordination of an individual's care? • How can we work together better? This will be a challenge with 6 plans. We need to build partnerships. • Partners need to know their responsibilities and follow through. Accountability is key. **<u>Molina</u>** – Steve Soto reviewed and discussed the Data Summary Report highlights. <u>Key Points</u>: • The data reflects a very high churn rate: Only 8 of the 2015 top 50 utilizers are still with Molina in 2017. It is difficult to determine what success our interventions are having if the members are no longer with the plan.

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Data Summary Reports – *Sandy Damiano, Tory Starr, and Health Plans*	• Members in Complex Care Management increased from 56% in 2015 to 82% in 2016. • Molina is continuing the programs launched in 2016: Emergency Department Support Unit (EDSU); Transitions of Care Program in which nurses are stationed at hospitals to manage members; the Complexist Program launched through Molina Medical Clinics; and Community Connectors who assist with reaching the hard-to-reach members. • Based on weekly reports from EDSU, Molina is beginning to have some success reaching members with high ED utilization and getting them reassigned to primary care providers or other appropriate resources. • Healthcare services staff are tracking high utilizers to ensure they are referred to the Complexist program. • Currently focusing on post-discharge clinics (for certain specialists) so that patients have a better transition from an inpatient stay back to the primary care provider. • Created a new Case Management Dashboard that merges high utilizers with high risk members to reduce unnecessary ED utilization and hospital readmissions. • Getting case managers involved with community partners who assist in coordinating services. • Working on building partnerships between the plan and providers, including a new Provider Advisory Committee starting in April. • Core Teams involving CFO, CMO, and COO and other high level staff are evaluating performance on various measures. **Anthem Blue Cross** – Alicia Pimentel reviewed and discussed the Data Summary Report highlights. Key Points: • 54% of members from the 2016 list are no longer enrolled with Anthem in 2017. • The Complex Discharge Planning Team consists of 3 full-time nurses who work on getting members to a lower level of care following an acute hospital stay. • The High Intensity Interval Team (HIIT) was piloted last year and is being expanded. A Behavioral Health Social Worker reaches out to members with high ED utilization. • The Safe Choice Program targets members with high ED utilization and inappropriate opiate utilization. • The Post-Discharge Team follows members for 30 days after an acute hospital stay to coordinate all post-acute care. They conduct weekly outreach to make sure members get to their primary care and specialty appointments. • Care Managers meet quarterly with River City Medical Group to discuss case management strategies. River City handles routine discharge planning for its members and works with Anthem for more complex members.

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Data Summary Reports – *Sandy Damiano, Tory Starr, and Health Plans*	**Health Net** – Jane Tunay reviewed and discussed the Data Summary Report highlights. Key Points: • ED utilization is very high at 98% in each year. This will be a focus for this year. • Only 6% to 8% of members are in Complex Care Management. • They wanted to complete the 2016 data pull and compare it with 2015 to develop interventions. • A Vice President and a Program Manager for Case Management have been hired. The data will be shared with them. • The Health Education Department has developed initiatives targeting diabetes, hypertension, and heart health. **Kaiser** – Cathy Lumb-Edwards reviewed and discussed the Data Summary Report highlights. Key Points: • Medi-Medis are a carve out for GMC so there is no data. The medical group manages that population. • Homelessness is identified by either the DHA P.O. Box, no address listed, or stated homeless. Percentage of members experiencing homelessness is low due to the Permit to Enroll criteria. • Mental Health Specialty is carved in for Kaiser, so there is no data listed for that parameter. • The Comprehensive Care Coordination Program was rolled out in 4th quarter 2015. The program included a full-time data leader. *Data is now dictating our steps on a day to day basis.* • The Care Coordination team consists of nurses, social workers and a pharmacist. • Care Coordinators all have smart phones. They are finding the best way to reach patients with complex needs is texting. Group discussion: Tory Starr asked the plans how they identify candidates for complex care programs. • Molina – Focus on members with multiple touch points or multiple conditions. Also through EDSU. • Kaiser – Level 3 and Level 4 patients are automatically enrolled (Kaiser does not need consent). • Anthem – Will follow up with the requested information. • Health Net – Ongoing pilot with River City Medical Group. Steve Soto expressed concern with the churn rate and suggested that it may be worthwhile to approach the State about it. Some members wanted to know what diagnoses are rolled up in the SUD category. Some had

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<table>
<tr><td></td><td colspan="2">questions about Anthem's Safe Choice Program: How are members targeted for the program? Is there any data on program success? Several members had questions about the role of the IPAs in assigning members to complex care management. Due to variations in data among Health Plans for the diagnostic categories, it was agreed that more information was needed about how each data parameter was pulled.

Tory Starr thanked the plans for their work and for beginning to try interventions. He noted that there seems to be an issue involving inappropriate ED utilization. He asked if the plans have any data showing whether increased access to primary care providers correlates with decreased ED utilization. Steve Soto indicated Molina has begun reviewing that issue, and he will report back regarding when the data will be available.

<u>Follow Up</u>:
• Determine what diagnoses are rolled up in the SUD category. – Health Plans
• Explain how data was pulled for chronic, comorbid, and behavioral health conditions. – Health Plans
• Specify the number of members from the 2015 data pull who are still enrolled in 2017. – Health Plans
• Determine when plans will be able to provide the data for the full 12 months of 2016. – Health Plans
• Respond to plan-specific questions. – Health Plans
• Email and track Health Plan assignments. – Planner</td></tr>
<tr><td>Public Comment</td><td colspan="2">The following provided public comment:
• Jennifer Stork, Planned Parenthood: Planned Parenthood does primary care in Monterey and Santa Cruz counties. The Health Plan uses incentives to increase primary care utilization. One incentive involves publishing every ED visit on the provider portal. The provider then receives an incentive for completing a follow up visit within a certain timeframe.</td></tr>
<tr><td>Closing Remarks and Adjourn</td><td colspan="2">Steve Soto thanked everyone for attending and participating in today's meeting. With no additional business to discuss, the meeting adjourned.</td></tr>
<tr><td rowspan="2">Next Meetings</td><td>Medi-Cal Managed Care Advisory Committee Meeting
Monday, April 24, 2017 / 3:00 – 5:00 PM</td><td rowspan="2">Location:
DHHS Admin Building
Conference Room 1
7001A East Parkway</td></tr>
<tr><td>Care Coordination Work Group Meeting
Monday, May 22, 2017 / 3:00 – 5:00 PM</td></tr>
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