Care Coordination Work Group

Meeting Minutes
September 25, 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	Hospital – Tory Starr (Sutter Health) – ***Co-Chair***
X	Clinic – J. Miguel Suarez, MD (HALO)	X	Health Plan – 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) – *Excused*
	IPA – Anna Berens (EHS) – *Excused*	X	Health Plan – David Eibling, MD (Molina)
X	Hospital – Ashley Brand (Dignity Health)	**PRESENTER**	
		X	Hospital – Laura Niznik Williams (UC Davis)

Group Members (13) / Presenter (1) in Attendance: 14
Public in Attendance: 16

Staff: Sherri Chambers

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Topic	Minutes
Welcome and Agenda Review – *Sandy Damiano, PhD*	Sandy Damiano welcomed group members, guests, and members of the public and facilitated introductions. Materials: All members received a copy of the agenda, 2017 GMC Enrollment Data, 2017 IPA Enrollment Data, Resettlement Agency Contact List, Dignity Health Emergency Department (ED) Data, Kaiser ED Data, UC Davis ED Data, ED Data Summary, Anthem Blue Cross Case Management Programs PowerPoint, Anthem Care Management Referral Form, and Health Net Case Management. *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 Agenda Topics: Announcements and Data, Emergency Department Utilization, Care Management Programs, 2017 Data Summaries, and Public Comment.
Announcements & Data – *Sandy Damiano and All*	Data: • GMC Enrollment Data (*posted on the website*) – As of September 1, Sacramento County GMC enrollment was **437,965** with a net increase of 2 members over the previous month. Anthem and Kaiser had increases, Health Net and Molina had decreases. The default rate was 30%, the lowest in the state. San Diego's default rate was 38%. • IPA Enrollment Data (*posted*) – As of September 1, total IPA enrollment was 281,527. River City Medical Group had the largest enrollment followed by EHS, Hill, and Nivano. Imperial Holdings is new with Anthem but had no enrollment as of the date of the data pull. In terms of delegated members, plans are as follows: Anthem (89%), Health Net (99%), and Molina (14%). Looking at non-Kaiser plans only, a total of 79% of members are delegated. Announcements: • Refugee Resettlement Agency Contact List (*posted*) – Newly arriving refugees are enrolled in GMC. Health Plans requested contacts to assist with issues. Contacts for the five resettlement agencies are included. Some have their own case management programs. County staff is providing a basic Medi-Cal Managed Care training to resettlement agencies on September 29. • EMS Routing Meeting – Sandy sent an email to plans, hospitals, and Advanced Life Support providers inviting them to a presentation on a software routing application that improves patient care for non-emergency calls to 911. The meeting is October 24.

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Announcements & Data – *Sandy Damiano and All*	• Hepatitis A – San Diego and Santa Cruz Counties are dealing with Hepatitis A outbreaks, especially prevalent among individuals who are homeless and/or using illicit drugs. The County Health Officer issued an advisory recommending vaccination of persons at high risk of infection and asking Health Plans to cover the vaccinations for their high-risk members. Sandy sent the information to the plans. • Health Risk Assessment of Seniors & Persons with Disabilities (SPD) – APL 17-013 outlines requirements for stakeholder input. If plans are interested in getting stakeholder input prior to the January 2018 deadline, the last opportunity will be the meeting on December 4. • New Plan Update (UnitedHealthcare) – Debbie Tanabe reported that UnitedHealthcare will go live on October 1 as planned. They are starting to receive members now. Sandy noted that staff will be updating the various resources posted on the website to include UnitedHealthcare information.
Emergency Department Utilization – *Sandy Damiano and Hospital Systems*	Sandy Damiano facilitated a discussion on Emergency Department (ED) Utilization. Dignity Health, Kaiser, and UC Davis presented utilization data for the period July 2016 through December 2016 and discussed strategies aimed at getting patients into the appropriate level of care. – *All materials are posted on the website*. **Dignity Health** – Ashley Brand reviewed data and discussed strategies for reducing avoidable ED utilization. Key Points: • They used ICD-10 codes to determine ED visits for primary care. • Mercy San Juan and Methodist had the highest percentages of ED visits for primary care by GMC Medi-Cal members, presumably because primary care access is low in those regions. • The 2015 and 2016 data remain consistent. • Patient Navigation Program (funded by Health Net) – For the period of July 2016 through June 2017, this program touched 7,000 patients, and 69% of those were scheduled for follow-up appointments. For members who declined appointments, they provided education on plan services. Among patients served in the program, they saw a 57% reduction in unique patients presenting to ED for primary care, and a 50% reduction in ED visits for primary care. • Using a framework similar to Kaiser, they identify high utilizers and create care plans that are uploaded to their system. If a high utilizer presents to the ED, they have already been assigned a case manager. The care plan is available in the system no matter which Dignity hospital the patient visits. This program has been successful. • They are looking to pilot a program for high utilizers with Health Net.

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Emergency Department Utilization – *Sandy Damiano and Hospital Systems*	Questions & Answers: • Is most of the connectivity through navigators? *Ashley: Yes, through Sacramento Covered.* **Kaiser** – Cathy Lumb-Edwards reviewed utilization data. Key Points: • Data is reported for three facilities. Kaiser Roseville is in Placer County, but Sacramento County residents have access. • Primary Care Visit data is based on ED Acuity Level 4 and 5. • 34% of the patients seen in the ED had visits for primary care. Of those, 41% were GMC Medi-Cal members. • Volumes and utilization have been consistent over time. Kristie Brown, Kaiser Health Plan, and Kimberly Anderson, Permanente Medical Group, discussed strategies for reducing avoidable ED utilization. • A high utilizer committee meets monthly. It is a multi-disciplinary team that works to develop strategies to help patients and providers. • Through a partnership with Molina, they are seeing a decrease in Molina member utilization. • With the Transitions of Care Coach, Molina has an onsite presence. An onsite partnership also exists with River City Medical Group. • Through KP Health Connect, Health Plans, IPAs, and clinics can access their medical record. If the provider or plan has access, they can see what services were provided by Kaiser and what follow-up care is needed. This improves continuity of care and reduces duplication. • Focus in the coming months: Optimizing care plans. They want to ensure case manager instructions are being followed for non-Kaiser members that present at Kaiser facilities. Questions & Answers: • Can we get a blank template of a care plan? *Yes. Will send a copy to the County.* • How many Kaiser members are accessing various EDs? *A large number. The care plan adds value. For those with a care plan, a daily alert is created so that the care plan can be adjusted if needed.* • Work with River City was mentioned. Is it similar to the work with Molina? *Yes, it is data sharing.*

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Emergency Department Utilization – *Sandy Damiano and Hospital Systems*	**UC Davis Medical Center** – Laura Niznik Williams reviewed data and discussed strategies. Key Points: • Primary care visit data was pulled using a list of CPT Codes Level 1 and 2. • About 18% of the total ED visits were for primary care. • Sacramento Covered also provides patient navigation. The navigator assists with follow-up appointments. Laura focused on ED Mental Health Initiatives for her report since many who access the ED present with mental health conditions. • Dedicated ED Pod –The 63 ED beds are organized into four pods. One pod is dedicated to those with mental health issues. • Emergency Psychiatric Team consists of psychiatrists, physicians, nurses, social workers, case managers, etc. They help stabilize patients. • They are working with their primary care network on how to treat mental health issues, including use of telepsychiatry, care coordination services, etc. • MH Triage Navigator Program – This is a partnership with the County Mental Health Plan (MHP) and TLCS (contractor). The navigator is onsite five days a week and connects patients to services more quickly than hospital case managers can. Ashley noted that TLCS navigators have access to Avatar to see if patients are connected to County MHP. • Collaboration with UC San Diego for substance use issues. An Alcohol and Drug Counselor is onsite five days a week to provide intervention and help connect patients to substance use services. • Turning Point Crisis Residential – This is a partnership with Turning Point for 6 crisis residential beds. Staff can refer patients from the ED to Turning Point Crisis Residential when they require that level of care. Patients receive more wraparound services. **Sutter** – Tory Starr apologized for the lack of a data report. He noted the following: • The data has not changed as far as volume. • Coordination is better with the navigator programs. • Their interventions are similar to the other health systems.

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Emergency Department Utilization – *Sandy Damiano and Hospital Systems*	Discussion – Sandy thanked the hospital systems for their work. She reviewed the ED Data Summary (*posted*). When looking at the utilization data from all *non-Kaiser* hospitals, some striking observations can be made: • 46% of the ED visits for primary care were by GMC Medi-Cal members. • 57% of the ED visits for primary care were by beneficiaries with any Medi-Cal. All hospital systems are trying a variety of interventions to decrease avoidable ED utilization. Health Plans have also developed strategies involving complex care coordination (began in 2016). Hopefully these combined efforts will be reflected in the data. Next Steps – We will ask the hospital systems to complete a similar data pull next year.
Care Management Programs – *Tory Starr and Health Plans*	Tory Starr facilitated a discussion on Care Management Programs. Health Plans were asked to describe the programs they have in place and the effectiveness of those programs. – *All materials are posted on the website.* **Anthem Blue Cross** – Lydia Mata provided a PowerPoint Presentation on Anthem Case Management (*posted*). Key Points: • A complete description of each program is available in the July meeting materials (*posted*). • The Safe Choice program has served 25 members since August 2016. They have seen an 82% reduction in ED utilization and an 83% reduction in inpatient utilization among enrollees. They have State permission to lock members into one pharmacy and one prescriber. The program started in Tulare and Sacramento Counties and is now being expanded. • The Choice Plus Program targets members with high utilization but only one pharmacy and one prescriber. 55 members have been enrolled. Services include pain management and specialty referrals. They have seen moderate reductions in ED and inpatient utilization. • Complex Discharge Planning is a new telephonic program with 21 members since May 2017. They have seen a 15% reduction in readmissions. Enrollees are referred from hospitals and Utilization Management. • Readmission Reduction Initiative is a face-to-face program in three hospitals with 66 members since November 2016. An onsite LCSW meets the member bedside and follows the member through the post-discharge primary care appointment. • High Intensity Interval Team (HIIT) is a telephonic Behavioral Health program. 121 enrollees since October 2016. Members are referred based on chronic illness indicators. • Complex Case Management is a telephonic program with 35 members since 2017. The program serves high utilizers with two or more comorbidities. Early results show an increase in utilization. Referrals are

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Care Management Programs – *Tory Starr and Health Plans*	through multiple channels; triage nurses decide which program is the best fit. • Care Coordination Program is a telephonic program with 67 members. They have seen a slight increase in utilization. Questions & Answers: • Who is doing the work in the various programs? *Lydia: I will add that information to the PowerPoint. All programs use licensed clinical staff (RN/LCSW).* • How do members know which program they are in? *Lydia: They get a letter informing them of enrollment in case management and what services they will receive. The letter does not state the name of the program.* **Health Net** – Jane Tunay reviewed and discussed Health Net's Case Management handout (*posted*). Key Points: • Basic Case Management is delegated to contracted IPAs. • Complex Case Management is delegated for River City Medical Group members, and is retained by Health Net for EHS and Hill Physicians members. • Integrated Care Management is comprised of complex case management and care coordination. Eligible members have multiple comorbidities, multiple hospitalizations, or catastrophic illness. 2,000 members have been managed in 2017. They have seen reduced ED and inpatient utilization and readmissions. • Disease Management – *Be In Charge!* Program serves members with asthma, diabetes, or heart failure. Materials are mailed to enrollees to improve education and self-management. Providers may refer members and members may self-refer. 1,500 members were enrolled as of September 21. Questions & Answers: • How does it work with River City responsible for complex case management? *Janice Milligan: River City uses Health Net standards for complex case management. We have 5 dedicated staff: 2 RNs, 2 navigators, and 1 Social Worker.* • Do you have outcome data such as reduction in ED or inpatient utilization? *Jane: I will need to follow up.* • Can you provide the referral form? *Jane: Yes.* **Molina** – Dr. David Eibling, Regional Medical Director, provided a brief care management update: • Care management programs are in a state of transition due to changes at Molina.

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Care Management Programs – *Tory Starr and Health Plans*	• Transitions of Care nurses are in the hospitals and coordinate the management of members with Molina clinics and doctor's offices. • Case managers and Community Connectors also work to manage patients. • Will try to report back with some data. • He appreciated the partnership with hospitals including data sharing.
2017 Data Summaries – *Sandy Damiano*	Sandy Damiano facilitated a discussion on the data parameters for the 2017 high utilizer data pull. Plans were asked to provide feedback on modifying the data pull parameters with consideration to the Health Homes Program criteria. Plan Feedback: • Frequency – All agreed to pull data twice per year. • Sample size – Responses varied. Sandy recommended 3-5% to be consistent with Health Homes. Plans agreed to pull the top 3%. • New indicators – All agreed to add Obesity and Traumatic Brain Injury. • Chronic homelessness – Plans indicated challenges in using the HUD definition. It was decided to leave the indicator as it was, with each Plan specifying its definition of "homelessness." • Deletions – All agreed to delete 3 indicators that were not included in Health Homes. • Secondary data pull to include all Health Homes criteria? The consensus was no. Next Steps – The agreed-upon parameters will be incorporated into the next data pull. Data period: January 1 – June 30, 2017. County staff will send instructions and a revised template to Plans. Data will be due on November 30, and will be presented at the meeting on December 4. Care Coordination Guides – Each Plan submitted information to update their respective Care Coordination Guides. If Molina has changes in its programs, we will need the new information. We will also have a Guide for Kaiser that will be produced at a later date. Staff will work on standardizing the format, and then post on the website. The Care Coordination Guides are valuable resources for providers and navigators.
Public Comment	The following provided public comment: • **Kristie Brown, Kaiser Health Plan:** Kristie asked whether the Work Group had considered using OSHPD to pull homeless individuals. When hospitals submit inpatient and ED data, they enter "ZZZZZ" for the zip code of homeless individuals. She stated they should be able to pull based on the zip code, and everyone

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Public Comment	has access to OSHPD. Sandy responded that the group will take it under advisement since some believed OSHPD does not report plan data. • **Robyn Alongi, County Public Health, Dental Transformation Initiative:** Robyn requested hospital systems sort the Emergency Department utilization data by dental services. As they get started with the Dental Transformation Initiative, it would be helpful to know how many individuals go in for a dental emergency. Tory Starr responded that the hospitals would need the specific ICD-9/10 codes. • **Beau Hennemann, Anthem Blue Cross:** Beau's role is working on implementation of Health Homes, Whole Person Care pilot, and Palliative Care. Health Homes is in Phase 1 in San Francisco County. It is not completely decided, but they are leaning toward using the HUD definition of homelessness. The State has not provided a definition. With regard to the All Plan Letter on Health Risk Assessment for SPDs, the majority is not new guidance. It is a refresh of an existing APL. There are probably few changes to risk stratification. Most of the changes are related to Long Term Services and Supports and would only apply to Coordinated Care Initiative counties.	
Closing Remarks and Adjourn	Next Meetings – Sandy Damiano announced: Medi-Cal Managed Care Committee Meeting on October 23 will focus on Part 2 of the Split Mental Health Benefit. Plans and County Mental Health Plan will present on how they are operationalizing the split benefit, including the use of a bi-directional tool they have been working on. Care Coordination Work Group Meeting on December 4 will focus on the high utilizer data for the first half of 2017, based on the revised data parameters. Note: *The meeting is off-cycle due to the holidays*. Sandy thanked the Plans and Hospital Systems for their presentations and for providing data to guide strategies. Sandy 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, October 23, 2017 / 3:00 – 5:00 PM	**Location:** DHHS Admin Building Conference Room 1 7001A East Parkway
	Care Coordination Work Group Meeting Monday, December 4, 2017 / 3:00 – 5:00 PM – Note: Meeting is off-cycle	