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SPEAKERS

Hilary Haycock
Anastasia Dodson
Carrie Graham
Jack Dailey
Maya Altman

Hilary Haycock:

So welcome to our fourth Managed Long-Term Services and Supports (MLTSS) and Duals Integration CalAIM Workgroup. We are so thrilled to have you all here, and we are thrilled to have some great speakers with us today. We are joined as always by Anastasia Dodson with DHCS. We also have with us today Carrie Graham, who is the director of LTSS at the Center for Health Care Strategies, Jack Dailey, from the Cal MediConnect Ombudsman, and Maya Altman from the Health Plan of San Mateo. And so, they're going to be joining us today for our conversation on lessons learned in care coordination from Cal MediConnect. And so, I'm not sure we could have three more knowledgeable and great speakers to join us today. So, thanks to folks for joining us.

Hilary Haycock:

A few meeting management items before we begin. All participants will be on mute during the presentation, so please feel free to submit any questions you might have for the speakers using the chat function. We'll be monitoring that throughout the morning's presentations and discussion. And so, if you want to ask a question or provide comments or any feedback, please use the chat, or you can always raise your hand and during the discussion periods, we will unmute folks and call on them who have raised their hands, who want to participate in the discussion section.

Hilary Haycock:

All the PowerPoint slides and all meeting materials will be available shortly after the workgroup on the CalAIM website. And you can find a link to where we post the materials in the Zoom chat. We will be posting those links periodically, so that they'll keep popping up to the top of the thread, so feel free to go check those out at the end, in the next couple of days, we'll get those posted, all meeting materials will be made public. We are asking that folks add their organization to their Zoom names so that we know who has joined us. So please take a minute now to do so. You can click the "Participants" icon. You go to the three little dots, click on that, and say "Rename," and please add your organization after your name so we know who else is here. Everyone has access to the participants list. So, you can click that button on Zoom and see who all has joined us today.

Hilary Haycock:

All right, with that, I am going to hand it over to Anastasia to kick us off and thank you very much.

Anastasia Dodson:

Okay, great. Thank you, Hilary. Good morning, everyone. I'm really pleased to be here, really pleased to have this meeting here today. The workgroup purpose, we've talked about this in previous meetings, that this is a collaboration hub for CalAIM MLTSS for integrated care for dual eligible beneficiaries and the transition of Cal MediConnect and the Coordinated Care Initiative. We want stakeholders to give as much feedback as possible around policy operations and strategy. There are a lot of upcoming changes, both for Medicare and Medi-Cal for dual eligibles and for Medi-Cal only in California and in CalAIM, so there's a lot of topics that we can talk about, so we've tried to make sure the meeting is as open as possible. We have a lot of people who've dialed in and we're trying to get dialogue and feedback from as many of you as we can. We have a charter posted, but we really do value our partnership with all of you. All right, next slide.

Anastasia Dodson:

So today I'm just briefly going to talk about the DHCS vision on coordinated care and integrated care, and we have a panel and then breakout group, and then we're going to have the panel reaction to the breakout group comments, so we've consulted with some key stakeholders in the design of the meeting. Hopefully, this is a good design, and we know that sometimes we have a lot of information for DHCS to present, but many times we want to hear from all of you and hear the conversations that you have with each other, because that is a really important part of both learning and then developing policy going forward. All right, next slide.

Anastasia Dodson:

Okay. So, I'm just going to speak for a few minutes about our vision for care coordination and integrated care for duals. Next slide.

Anastasia Dodson:

These are the CalAIM goals. You've probably seen these several times, but again, we're trying to identify and manage member risk through whole person care approaches and addressing the social determinants of health. We have, of course, ECM and In Lieu of Services. That's already under way, you've probably seen the materials and attended the webinars there, but population health management, other aspects of CalAIM are also addressing those issues as is our work here today. Moving Medi-Cal to a more seamless and consistent system by reducing complexity, having all dual eligibles enrolled in Medi-Cal managed care, and then having D-SNP aligned enrollment statewide. That's our goal, to have a consistent system and then improving quality outcomes and reducing disparities. Those are important goals and even more so of course, with the pandemic and all of the important concerns that have been re-raised again too, all of us are well aware that health equity is an important and imperative effort that we must continue to undertake throughout all of this work. All right, next slide.

Anastasia Dodson:

So around long-term services and supports, our CalAIM initiative is reaching for improved care integration across all of the different partners, providers that are medical and LTSS providers, having person-centered care so that whether it's through information sharing or through a joint care plan, that there is a focus on what does the individual need, what are their goals and how can the care team work together on those goals? We have a robust array of home- and community-based service providers and programs in California, although there are some areas of the state where there are gaps, but we want to bring everybody to the table for long-term services and support, so that we're really leveraging all the local resources. And when I say we, yes, that's the big picture goal, but at the local level, at the health plan level, at the provider level, we want everyone to work together and again, leverage the resources that are already out there.

Anastasia Dodson:

Building on lessons and success of Cal MediConnect and CCI, which we have talked about in some previous meetings, but want to get to in more specifics today, Governor's Master Plan for Aging, and then better link home- and community-based services, those providers to the managed care plans and the Medicare D-SNP plans. And that's been an interesting topic we've been thinking about here at DHCS, but as we proceed in the coming months, we want to continue to think about that because if there's help that we can do at the state level, or if there's local strategies that you all want to share, we're interested in that as well. Next slide.

Anastasia Dodson:

So as far as the care coordination and integrated care, we want to ensure that our Medicare D-SNPs and our Medi-Cal Managed Care Plans have clear requirements for integrated coordinated care, particularly in the aligned plans where it's the same plan that's managing both the Medi-Cal and the Medicare benefits. So, the requirements will be in the SMAC. We've talked about that as the contract that is between the state and the D-SNP Medicare plan. And I think in the next slide, we're going to talk maybe a little bit more about the particular standards and where those requirements are. But anyway, we want those requirements to be clear, and we want to improve data sharing between plans and providers. In our May revision, we've proposed a population health management structure that will help with that data sharing, but in the meantime, there may be strategies already going on at the local level, and that's extremely important. And we want to create more robust connections between the managed care plans and the carved-out delivery systems such as IHSS, as well as specialty mental health and any other programs that are carved out such as MSSP. Next slide.

Anastasia Dodson:

Okay. So, a little bit more detail, and then we'll get very shortly to our presenters. So, the care coordination standards in Cal MediConnect, those were based on Medi-Cal managed care requirements, as well as California state statutes and even D-SNP Model of Care requirements. I want to mention that on our website, there is a one-page document that goes through at a very high level the Cal MediConnect care coordination standards, and if you're able to on your screen, you might want to hop over and look at that briefly, just as a reminder of all that we have done in Cal MediConnect and the requirements that we have for plans, and for the ways that, whether it's direct staff of the plan or providers that they contract with, but for care coordination, to make sure that there's a health assessment, there's individual care plans, there's interdisciplinary care teams, and there's ongoing care management. And these are strategies that are evidence-based, they've been longstanding goals of many care coordination efforts across the nation, but those are built into Cal MediConnect already.

Anastasia Dodson:

So, the D-SNP requirements, for Medicare, for our upcoming expansion of D-SNPs in California, those D-SNP requirements reflect the CMS Model of Care requirements, as well as our SMAC coordination requirements. So, this slide is really just intended to help us think, okay, there are requirements in Cal MediConnect. There are requirements in the D-SNP SMAC around care coordination. In this D-SNP there's a Model of Care that's a basic framework outlining care measures, and then there's also the Medi-Cal managed care requirements, which also includes a Model of Care. And they're in the process of being updated for 2022 to reflect enhanced care management and In Lieu of Services and in future years for population health management.

Anastasia Dodson:

So as we think about all three of those: what we already have in Cal MediConnect, what we have and what we will have in the D-SNP SMAC, and then what's in our Medi-Cal managed care requirements, we want to over the next few months, starting with this conversation and going forward, work with you all to put the requirements in the SMAC that need to be there for 2023. That SMAC document, by the way, for 2022 is posted on the DHCS website, on that MLTSS page, so that you can see we've made some changes to the 2022 SMAC to reflect the feedback that we got. And then we're really looking forward to working with all of you on the 2023 SMAC to bring in any additional requirements from Cal MediConnect strategies, and then carefully and thoughtfully think about what's in the Medi-Cal managed care requirements, and how do those intersect with the D-SNP Model of Care?

Anastasia Dodson:

And we don't need to tackle all of that today, but it's just wanting you to know the framework that we're thinking about for our care coordination standards, and that we want to put meaningful standards in. We don't want to just copy and paste, we want to do it thoughtfully. And we want to set this up in such a way that it really serves the needs of individuals. Again, person-centered, that we're not necessarily looking at just high-level requirements, but thinking about how these will meet the needs of individuals. All right, next slide.

Anastasia Dodson:

And this is a helpful slide to just visually think about the care coordination elements of Cal MediConnect and D-SNPs. A reminder that the D-SNP Model of Care requirements are less prescriptive than Cal MediConnect, but we can establish whatever requirements we want at the state level for D-SNPs. Now, I say, "whatever we want." Of course, it needs to be reasonable. It should be focused on achieving the outcomes that we want. And again, there's a balance between how prescriptive do we want to be versus how flexible, and again, looking to all of you to help us navigate that for the 2023 SMAC. All right. And you can see there's similar requirements in Cal MediConnect and D-SNP Model of Care. So, we just need to think about how detailed do we want to put those requirements in our SMAC? Okay. Next slide. Great. So, I'm going to hand it back to Hilary and the panel, and then really looking forward to the discussion. Thank you all.

Hilary Haycock:

Great. Thank you, Anastasia for getting us started with that excellent background and overview from DHCS. So now I'm going to reintroduce our panelists. We have Carrie Graham, director of long-term services and supports at the Center for Health Care Strategies, Jack Dailey, with Health Consumer Alliance coordination, and the director of policy and training for the Cal MediConnect Ombudsman Services Program, and Maya Altman, the CEO at the Health Plan of San Mateo. So first up, we've got Carrie Graham. And so, Carrie, I'm going to hand it over to you to talk about some of the key takeaways from the Cal MediConnect evaluation that you led.

Carrie Graham:

Thanks, Hilary. Good morning, everyone, and thanks for having me here. As Hilary said, I'm Carrie Graham. I was the principal investigator of the evaluation of Cal MediConnect that was funded by The SCAN Foundation. It was a team of researchers from both UCSF, the Institute for Health and Aging, and the UC Berkeley School of Public Health. And we also worked very closely with DHCS and a stakeholder advisory group that probably many of the people in the audience today were part of, and we worked really closely with DHCS and the advisory group to help us formulate our research questions and interpret the data that we gleaned from the evaluation. So, what we did was we started with focus groups with beneficiaries, because we always want to start every evaluation with the voices of beneficiaries and their experiences. We also conducted a longitudinal telephone survey where we surveyed folks soon after they got into the Cal MediConnect plan, as well as a group that opted out and then surveyed them again a year later. We conducted a lot of key informant interviews with many people, probably many of you. These came from interviews were with DHCS, with plans, with providers, with advocates to get their input on how things were going, and again, just continue to work with our stakeholder advisory group to review findings.

Carrie Graham:

So, I'm going to talk about a few findings of the care coordination portion today. And so, in our survey, just some results: only about 30% of beneficiaries self-reported that they got care coordination from the Cal MediConnect plan. And you would think that this would correlate with people who had higher levels of acuity, who had more functional impairment or lower self-rated health, but it didn't. We did not see that people who had more complex care were getting care coordination. So that was an interesting finding in and of itself and brings up questions about health risk assessments and how plans were finding people and getting care coordination to the right people.

Carrie Graham:

Another piece- But we do know that people who did get care coordination through Cal MediConnect plans were really satisfied with it, and they reported that these care coordinators did help them get access to lots of services, to appointments with providers, to DME, to prescription drugs. So, there were some promising findings. Another interesting finding is that we saw that people who had care coordination, who had IHSS did tend to have significantly higher hours, self-reported hours, the second time we surveyed them. It wasn't that more people got IHSS, but those who had it in the first survey reported increase in hours and we think that's because of the collaboration between plans and IHSS, especially when IHSS were required to participate in interdisciplinary care teams.

Carrie Graham:

So, one of the really- I think anyone who knows about Cal MediConnect will tell you one of the best things about it were the new collaborations. There were all these regional collective collaborations, where we found that plans were meeting with home- and community-based services providers, IHSS, senior service agencies for the first time, and were really just making those relationships to be able to work together. And I think that that was a really important result. We saw some plans that were very successful. We're working with what we call home- and community-based services brokers, or HUBs, that helped them to collaborate more and create contracts with home- and community-based service providers in their regions. So that was really a promising practice that we hope to see more of. We also saw some plans, especially with the carve-in of skilled nursing facility care, working with long-term care ombudsman offices to do joint visits to nursing homes, to look at who might be needing to have the capacity to transition out of the facility, to identify areas where quality of care might not have been great, or where people weren't getting their needs met.

Carrie Graham:

So those kinds of collaborations, we also saw a collaboration with the Alzheimer's Association to train providers that were in the plan networks for dementia care. So that was great. We did see that some plans, not all plans were successful in getting some people out of institutional care to home- and community-based services. These tended to be plans in regions that had community care transitions pilots, and who worked with these HUBs to really collaborate and coordinate services. But it was very, very difficult, especially because there was not adequate housing, a big barrier was being able to find adequate accessible and affordable housing for people.

Carrie Graham:

Another barrier was sort of beneficiary and provider knowledge. We saw that the notifications that people got in Cal MediConnect, everyone knows that a lot of people opted out of Cal MediConnect and one plan key informant described it like this: they got a notification at 90 days that said, "You're going to be put into this thing. You have 90 days to get out." And then 30 days later, they'd get another notification. "Now you only have 60 days to get out." And it was that the notifications did not really highlight any of the benefits of the Cal MediConnect plan, like the care coordination benefit, like the transportation benefit or anything positive about the plans and our focus groups with beneficiaries, we talked to them about care coordination. Most of them didn't know it was a benefit, and many of them said that they would have liked to hear about that as well as providers being, we know that providers probably were not bought into the program and recommended people opt out, and providers weren't really bought in or educated about what care coordination could do or the transportation benefit could do for their patients.

Carrie Graham:

Finally, I would just say data sharing on a stage, you already talked about this. I've done a lot of different evaluations of transitions of seniors and people with disabilities into managed care, and it seems like data sharing just has been sort of an age-old issue. Plans were saying they weren't getting the right data from DHCS, providers weren't getting the right data from plans, medical doctors weren't being able to share information with behavioral health providers, so that certainly was a big rub. So, these are just a few different highlights and lessons learned from the Cal MediConnect evaluation. We just published a paper in the Generations Journal called Care Coordination and Managed Care World that highlights a lot of these lessons learned, and there's also summaries of our evaluation on The SCAN Foundation website. So, I'll stop there.

Hilary Haycock:

Great. Thank you so much, Carrie, for that helpful overview. We will now hear from Jack Dailey with the Cal MediConnect Ombuds.

Jack Dailey:

Great. Thank you, Hilary, to the rest of our team, and to DHCS. We definitely appreciate the ongoing stakeholder engagement, the opportunity to contribute to this discussion, and to provide insights from the collective experiences of the CMC Ombuds and each of our seven demonstration counties.

Jack Dailey:

Throughout this demonstration project, the CMC demonstration, the Ombuds have advocated for a meaningful and consistent care coordination benefit that engages members in a truly patient centered manner. In practice, “patient centered” (I put that in quotes) really works best when members are met where they're at and with their individual care and engagement needs being met. And engagement needs include consideration of the appropriate accommodations and meeting cultural and linguistic needs of individual members, and I think that's an important component as we saw different take up rates of Cal MediConnect vary across various cultural communities in the demonstration counties. So that's definitely one of the things that we wanted to highlight.

Jack Dailey:

As the Ombudsman, of course, I want to just flag and I think I flagged this in many of my conversations, that we only become involved when something goes wrong. So, when things are hunky-dory and consumers are receiving great care coordination and accessing the services they need, they're often not looking to reach out for help and don't come across our service. However, but through that process of helping people and helping people navigate problems that they've encountered, we have gained insights as to what that effective care coordination process would look like for our consumers, especially for those that are facing barriers or other challenges.

Jack Dailey:

So, from our experience, care coordination typically works at its core, and I think Carrie mentioned this, but at its core, when members have awareness of the care coordinator, the care coordination benefit, and the care coordinator's role. Many consumers that were reaching out to us unfortunately had little or no knowledge of their care coordinator and what their role was. And thus, in our role, we then acted as a facilitator to help engage that care coordinator and connect them to the member and help identify what those individual's needs were in that particular moment.

Jack Dailey:

Similarly, care coordination really works when members knew how and when to engage their care coordinator, and I think just as important and sometimes even more important when to expect engagement. So, for example, when members we interacted with were unaware of the phone number or the name of the care coordinator, or if they had it, they sometimes felt that when they reached out, the staff maybe wasn't as responsive as they would hope, and it only takes a couple of those interactions to really create a sense of distrust or lack of credibility and that whole benefit and people stop asking for help.

Jack Dailey:

We learned that basically when members understood the role of the care coordinator and the expectation of when that care coordinator would be involved, the member was more engaged in communicating with the care coordinator. The member knew when to reach out, knew when to rely on the care coordinator, and also when the care coordinator maybe they felt the care coordinator should have been involved because they had that expectation, they were assertive about reaching out, and sometimes that would include contacting us or sometimes it would just include navigating on their own with the plan, which is what we always want to see, that empowerment to handle issues and address issues on their own.

Jack Dailey:

Members had successful care coordination when there was meaningful engagement to either access plan and non-plan or carved out services. It was often a difficult situation when members would reach out to us when they had fallen through the cracks, trying to access kind of carved out behavioral health or IHSS or dental services for which a care coordinator really could have been an important aide to help support facilitation and support. So we want to emphasize that as we look at what worked in the past and then as we think about what to ask of the D-SNP plans in the future, I think this is a really important element to think about because there are a number of services that at the moment are not a part of the plan's responsibility, but as a care coordinator they still have that capability and role to help support folks access the needed services. Because ultimately that's a better outcome for everyone in the process, better health outcomes for the member most importantly.

Jack Dailey:

From the perspective of a care coordinator, we saw really incredible care coordination efforts on behalf of our consumers at times and at other times not so much. But when it was really effective, it was effective when those care coordinators engaged with members early and often. Care coordinators that regularly checked in and affirmatively worked to identify areas that they could be of support were often the most effective and consumers felt they had the resources they need to access care and navigate the system.

Jack Dailey:

Coordinators that really had established clear lines of communication for members and that those lines of communication worked had better engagement, had better success in supporting our clients, but also had established that trust and credibility that I think is so important for consumers as they reach out for help. So, I think one of the things we'll want to think about is how do we make sure that consumers are aware of that information, that contact information going forward, because I think sometimes consumers didn't have that information readily available.

Jack Dailey:

This last one is an important one and it relates to of course what I think is the bread and butter of the Cal MediConnect program, really this is the heart of why we have care coordination, and that is to help support these LTSS care transitions and discharge support. When these cases came up, we often had to spend an inordinate amount of time with members to help them overcome these barriers. Folks that have experienced delays or other barriers during these vital care transitions for a variety of different reasons, but importantly, we at times found that there was little to no involvement or engagement from their care coordinator, and that was the most challenging for us to comprehend, because this was just the heart of why the care coordinator would be involved. I talk to plans and plan reps all the time locally and in other areas, and I know that on the whole care coordination in this really key moment is happening, absolutely happening, and they're doing a good job.

Jack Dailey:

I also talked to our advocates and I think in every one of our Ombuds staff in every single region has had stories like this, has had case examples like this, has had stories like this where someone is facing either hospital's nursing facility or it's a community discharge or nursing facility to community discharge, and the care coordinator was just not engaged, and in worst cases, when we contacted those care coordinators, we actually had to convince them that they had a role in that process, and we've had to actually educate and help advocate to have coordinators understand that role and engage them in the process.

Jack Dailey:

I think from talking to providers in the hospital in the LTC world, the experience, and the availability of that type of sort sometimes can be a surprise, that the plans have more of a role than just providing a list of network facilities. So, it's not something that I think is... I think probably the rule, however, when it does come up and when there are those gaps, it is a huge problem for consumers, and we have really terrible examples of consumers staying on unit at a hospital in 90, 100, 120 days unnecessarily due to delays in placement, and I think that that really is impactful to that member and to their family and their overall health outcomes.

Jack Dailey:

So really the most effective care coordination in these key moments truly collaborated with members, their family, the hospital, and facility discharge workers, who by the way, have statutory obligations to handle that discharge process. I don't want to pretend that the plans have all this responsibility. Absolutely the hospital discharge workers have those roles, but the plan care coordinators provide really important support to the members and their families during that process and help smooth out the wrinkles of that really important transition process.

Jack Dailey:

So, we really are looking forward to continuing to work with DHCS and plans and other stakeholders to help support meaningful care coordination, not only throughout the rest of the CMC demonstration, however, but in the future D-SNP model of care. So really thank you for the opportunity to present today and I'm looking forward to the conversation as we go forward. Thank you.

Hilary Haycock:

Thanks so much, Jack. It was really helpful. All right, we'll go to our last panelist before we go into our breakouts, and we have everybody have a chance to have a conversation about the presentations and what we've all learned together. Maya Altman, chief executive officer for the Health Plan of San Mateo.

Maya Altman:

Okay. Thank you, Hilary, and hello everybody. And thank you for the opportunity to speak to you all for a few minutes today. I just wanted to start off with a reminder of I know most of you know this, but who the Medicare, Medi-Cal beneficiaries are. They tend to be people with the most complex issues. Many have a serious mental health illness. In fact, that's how they qualify for Medicare. They're more likely to be people who face inequities in our health system, and they're also very diverse in other ways. That includes people with developmental disabilities, with Alzheimer's, with physical disabilities or with other multiple chronic medical conditions. So, any care coordination that we develop to address these many issues, it's challenging to set up and do well and requires practice, it requires different approaches, trying different approaches, adjusting as needed. So, I think all the plans have been learning throughout this period.

Maya Altman:

I think one of the biggest challenges, and others have alluded to this, is how to customize and keep the focus on a unique individual and their goals while bringing care coordination to scale for really thousands of people. And then finally making it seamless for the member or participant despite all the complexity. They should not see that complexity. It should be simple for the participant.

Maya Altman:

So, with that, the first of my lessons or takeaways from Cal MediConnect is the importance of partnership. Because of the complex issues faced by our members, they also interact with a broad range of health and other providers, community organizations, and county agencies, but more care coordination is not always better care coordination. Again, back to simplicity and not confusing people unnecessarily. So, our staff and planned staff have to figure out how to work with each partner, how to develop a team, develop relationships, develop trust, and agree on who's the care coordination leader or quarterback in each instance. It may be in some cases it doesn't make sense for the plan to be the lead coordinator. For example, if someone has a serious mental health illness.

Maya Altman:

Again, this takes time and practice. One example, I think many of you know, we've had at the Health Plan of San Mateo, Community Care Settings Program, a transition program where we help people leave nursing homes or help them avoid nursing homes, and that involves working with a whole lot of partners, including IHSS, CBAS and other LTSS providers, medical providers, behavioral health, hospital and nursing home discharge folks, and housing people.

Maya Altman:

The second takeaway or lesson is the importance of an integrated approach. In the beginning, we had a very nurse-heavy staff. Over time, we've added increasing numbers of social workers, behavioral specialists, and unlicensed staff. We also started off with separate teams for LTSS and behavior health, for example. We found this was creating new silos just within our organization. So now we have integrated teams of social workers, behavioral health specialists, nurses, and other staff.

Maya Altman:

Another example of kind of an organizational or staff integration that really worked well for us is we had an IHSS MSSP unit on our site, in those days when we worked on a site, working closely with plan staff, and focusing on folks with the greatest complexity and risk. While our county has been able to sustain this focus and continue working with us, unfortunately, the funding to support IHSS social workers to collaborate with plans was pulled when IHSS was pulled out of CCI. So, it's difficult, it's hard to expect busy IHSS social to collaborate with plans when there's no funding or support to do so.

Maya Altman:

So, the final lesson I want to touch on is the importance of robust and shared information and Carrie talked about this. Data really helps us know who to focus on and guides us to reach the people who we may not know about, because they're not reaching out to us, but they really are the folks who may need the most help.

Maya Altman:

This data information includes not just medical data, but functional behavioral health, social determinant data such as information about homelessness or who lives alone, and who the caregiver is. It's critical to share that information across all the partners and with the member if the member wants it. And it's also critical to have data that is timely and actionable, such as shared care plans, as well as enough data that we can do effective reporting on outcome information that all of us can benefit from evaluation from how our members are doing and how these programs are working or not working.

Maya Altman:

Again, the data, as Carrie said, this has been going on for years. We are making progress, but it's still very much a work in progress at our health plan. I know it is for our partners too. To have the capacity to deal with all this data is another challenge. So, I think from my perspective, over the last many years, I've seen a lot of improvements, both in our own health plan and with our fellow health plans, but we all have a lot to continue to learn and care coordination continues to evolve to be the best possible help for all the people we serve and care about. Thank you. I'll turn it back to Hilary.

Hilary Haycock:

Thanks so much, Maya. I appreciate it. All right. So, we're excited. We're doing something new this time. We are going to do some breakout room discussions. So, we have assigned folks somewhat randomly to breakout sessions. We're going to be meeting until 11:10, and then we will bring folks back. You'll be automatically placed in a breakout room. Each breakout room will be staffed with a note taker, who is going to help pose the questions that we want folks to discuss and take notes on the discussion. Every breakout room will need to choose someone to report out to the larger group. We're going to try to get through as many of our breakout sessions as possible, but there are 16 of them. And so, we may not get through everyone, but we'll do our best.

Hilary Haycock:

And for that reason, we also want folks to write down your key takeaways, the top three lessons learned from Cal MediConnect and the top three opportunities that we see to improve moving forward. So, we want to make sure that folks record those things that you discussed in your breakout room, and that you will enter them in the chat when we come back so we can make sure that we are capturing all of the feedback from what I hope will be very rich discussions in our breakout sessions, whether we get to hear from you verbally or not.

Hilary Haycock:

So here are the three... Here are the things that we're hoping to have you discuss in your breakout room. Additional lessons learned on care coordination and Cal MediConnect, opportunities to improve, and so we want you to try to have a robust discussion and try to identify what you think the top three of each are to share back out with the broader group.

Hilary Haycock:

So, with that, I'll stop yammering so we can get into our breakout sessions and have hopefully a great rich discussion that we can bring back to the group at 11:10.

Hilary Haycock:

All right. Getting folks coming back. All right. So, we are going to do a couple things to hear from our breakout groups. It would be great for folks to put their lessons learned and opportunities into the chat to share with the rest of the group. I am going to go ahead and lead off from our group our lessons learned and opportunities, and we would love to hear from some of the groups. So, if you are interested in doing a report out from your group, please go ahead and raise your hand and we will go ahead and call on you.

Hilary Haycock:

We are going to be saving everything that has been... All of the notes from the breakout sessions, as well as the lessons learned and opportunities that folks are putting in the chat. All of this is going to be saved and synthesized by the department. It is going to 100% inform both policy development and worker topics moving forward, so we're very excited to hear from folks. And with that, we will-

Anastasia Dodson:

Hilary, can I?

Hilary Haycock:

Yeah.

Anastasia Dodson:

Hilary, can I just say one thing too, that in our breakout group, I realized when we just... This is assumed, but I want to be explicit about it that the other efforts that the department has around Population Health Management, In Lieu of Services, Enhanced Care Management, all of those different efforts, we will share these notes with those teams as well. So, it's not just for this, it's great feedback that impacts a lot of areas of the department and we will share.

Hilary Haycock:

Great. All right. So, for our first report out, I am going to unmute Cynthia Jackson.

Cynthia Jackson:

Hello, everybody. I'm glad to be here today. And I am really just going to go over the notes that you probably see in the chat. We talked about member education to improve understanding of what the benefit entails and how to access it. Because sometimes that felt like there wasn't quite as much understanding as needed, re-education of care coordinators, using community organizations to provide training and using 211 to identify resources. And then care coordinators needing some tailored training given the population. I commented extensively about the SMI sub-population that the benefits, I don't know if they felt limited, but felt like they weren't practical with that population, and it worked better for the FSP program itself to manage the care coordination. The health plan coordination felt like another layer to kind of deal with the billing and deal with all that as opposed to super supportive. And then lessons learned from other programs on number three. I'm not sure what WPC stands for, I'm sorry, and then housing navigation and support what would be important.

Hilary Haycock:

Great. So, keeping things all connected in and making sure we've got the right folks, quarterbacking the care coordination. I think we heard that from Maya as well, thank you. Does anybody else want to raise their hand and report out from their group? Otherwise, I can start... Oh, awesome. All right, Sarah Steenhausen.

Sarah Steenhausen:

Great. Well thank you, Hilary. It was really a fun breakout because we had Christina from United Healthcare who actually has transitioned to California from New York, so she was able to share some best practices from New York and their kind of Medicaid reform that they've undergone. And we also had representative somebody from Tulare County who could speak to some of the challenges in a rural area. We had James from LA care, who's the CBAS manager. So, we learned – kind of thought about some of the program issues and care coordination.

Sarah Steenhausen:

And then we had Mary Woods who is with Kaiser, but on their Medicare side. So, a really interesting cross section of people in our group. And I would say three main themes emerged as best practices and challenges at the same time. The first one builds off a lot of what Maya had talked about in her presentation initially, which is the importance of data. I mean, with care coordination you can have data, but you have to be able to share it across the provider groups. And something that New York state did is that they developed one common data platform statewide that providers were able to share information on the care... The individuals, with the individuals consent. But that enabled a much more streamlined service delivery system. And I know that's something that's on the state's radar and that there are different approaches to that at different local levels through different platforms, but also something that has really helped kind of de tangle the web of who's coordinating the care coordinators, which is a real challenge often in our system.

Sarah Steenhausen:

The second best practice is just at the program level, a benefit of the Cal MediConnect care coordination approach was this idea of the one point of contact. So that assuming that the individual enrolling knew who their care coordinator was, it was really helpful to have that person as the key contact to help troubleshoot, to develop plan of care and to help that individual access services that weren't necessarily just within the scope of the Cal MediConnect program, so that they could really connect to the range of needs across the system, for a more kind of person driven approach.

Sarah Steenhausen:

And then the third lesson learned again, was something that Christina brought to us in terms of workforce approach. We all are very aware of the challenge of workforce issues, and this is particularly prominent in our rural areas, but really statewide. And what New York state did was they developed these kinds of cross sector partnerships. So instead of individually trying to go and find the workforce that they needed, they worked together to grow the workforce. So, one, understanding that a lot of the people that could serve this population didn't have a GED so they worked with the local community system to develop education, to address transportation issues and really develop the workforce that is needed for a successful delivery system. So, I will pause there in case anybody from our group wanted to clarify any of those points.

Hilary Haycock:

Great. It sounds like you guys had a very robust conversation. That's wonderful. Thank you for sharing with the group. Hanh? If I'm pronouncing that correctly.

Hanh Truong:

Hi, can everyone hear me?

Hilary Haycock:

Yes great. Go right ahead.

Hanh Truong:

Okay, thank you. So, thank you for the opportunity to share, we are from group number three. I appreciate all the comments that just mentioned. So, I'm trying not to repeat some of the things that are already said. Just want to point out really quick. Some of the information from what we have and then group member can add onto it. But the first thing we talk about is data sharing. There is a process, and we need to work on having that process more mainstream and more meaningful to us, to the member and to the services being provided. So that's one, the other one we did talk about in term of less is more and it was just mentioned earlier, so we called a one-stop shop. And we wanted coordinate better services for members so I'm just going to be brief with that. But some of the thing that we found that it's important is, we need to take a person center approach, meaning that we need to know what our member needs, not what we need or not what other agency wanted to provide or how they provided the services.

Hanh Truong:

So basically, what we talked about was that we have a good intention to provide services, but sometimes we are the very barrier to access of help. So, we need to understand that, and we need to refocus on what our member needs are. We need to do whatever it takes or integrated services in a way that's meaningful and applicable to the member. The other part that we talked about have to do with understanding the culture. So, when we talk about culture there are different aspects or different perspectives. In this perspective we're talking specifically to be a culture of mental health services, the culture, the policy, the way different agency doing their work. So, once we understand that, we can correct down the communication barrier. And we need to look at how to benefit the member best to overcome those culture issue and focus really on the member and their needs.

Hanh Truong:

Finally, we did talk about the concept of collaboration. It's very important and meaningful, but how to put that in practice. So, we give an example working with the hospital, as mentioned earlier in the presentation that it is the responsibility of the hospital to discharge planning, and we are here to help. But many times, it become our responsibility to do that and then we see that cases have been in the hospital for weeks, sometimes months. So, they have plenty of time to do discharge planning, but upon the time that the member after they're discharged was so inadequate. Family member was not informed, or the different conversation and input was not being carry out. And unfortunately, there were time that member was discharged to self, meaning they was dumped outside in the street.

Hanh Truong:

So, I think we all agreed that collaboration is important, and we need to clarify, and we need to hold different people responsible for their role. So thereby we can really find and clarify our own role and responsibility in helping member. Otherwise, it's just a lot of agencies working together and we just going in different direction. So that would be something that I get from the group, I don't know if group members want to add something more to that?

Hilary Haycock:

Great. Thank you. All right. I'm going to go to Lisa Hayes as having her hand up next to share.

Lisa Hayes:

Thanks Hilary. We did also have a very awesome discussion and I apologize; I don't know what group number we were in. It was Mallika’s group. So, we talked about the challenges of delegating care management. If we're delegating care management to providers, providers really don't get or don't understand the big picture. There are challenges with coordinating ICTs. This presented a lot of challenges and so we would recommend that care management not be delegated at all. We do, because there's a lot of great work going on with the independent living centers and the AAA that delegating long-term supports and services to the ADRCs would be a really good suggestion. It's work that we've been doing, really good at. And it would really, I think, present some really great outcomes if we could do that.

Lisa Hayes:

We talked about the data, absolutely is critical. And knowing that, that has been a challenge for the Health Plans to get but it also should include LTSS community-based organizations and what's going on because you really need to know what's happening with the community with that person. We really took a lot of heart to Maya's quarterback response because that is an issue. You don't always know who is driving the train here with... And I can tell you from an independent living center's perspective and trying to request ICTs and trying to find out who is the health plan designated or who does that? It is really, really challenging. And I love the comments. And we talked about person centered and really having a clear understanding of what person-centered planning is. Not necessarily what you think is good for that person but it's what that individual, what that member, what that consumer is right for them. What do they want?

Lisa Hayes:

We talked about not having a medical model, especially as it pertains to home and community-based services and long-term supports and services. We talked about the increased number, expected number of seniors within the next 10 years and a lot of our counties. And we really need to focus on what we're going to be doing and how we're going to be coordinating keeping members into the community and living as productive... Being as productive as they can. So that was pretty much what our group... If I missed anything, please y'all speak up.

Hilary Haycock:

Thank you. That's great. Lots of great points there. It seems like we've got some good lessons learned, really rising to the surface. I'm going to go to Gretchen Alkema, next.

Gretchen Alkema:

Great. Thanks so much, Hilary and thanks to everyone for a great day and series of discussions. I was in Alisa's group, and I don't know what number we were. Alisa, I'm having a hard time copying and pasting so if you'd be so kind as to copy and paste our summary and put it in the chat for everyone, that would be awesome. A couple of themes that haven't been a part of this discussion already that I will elevate. One is ensuring that there are opportunities to identify people who have cognitive impairment as well as opportunities for people to self-identify for care coordination. So that both, what are the data pathways to help identify, can elevate some of those pieces and some of those trends. Maybe using AI and as part of that and some of the health plans that are operationalizing that data in that way. But just making mechanisms for people who maybe have trouble identifying or aren't always recognized as people with cognitive impairment and as well as those who wish to identify can have pathways into getting access to care coordination.

Gretchen Alkema:

Also wanted to elevate the idea that when these evaluation modalities came into being, there was not any meaningful use of tele-health or other virtual care technologies. And given all of the changes at the federal and state landscape, just wanting to make sure that virtual care was incorporated as a pathway and a modality to provide care coordination for duals. And that includes making sure that people have access to these modalities so that health plans can be part of closing the digital divide, helping people get access to appropriate technologies and the connectivity to be on the superhighway. We had discussions about making sure that people's health benefits were coordinated in a seamless way and that includes things like if people are coming close to challenges of maintaining their eligibility that, that information is ported to the plan to help keep people in continuous eligibility where appropriate. And then also being able to help people know that if Medicare doesn't cover something, maybe Medi-Cal does and not just stopping at that place where it's only about the Medicare side or the Medi-Cal side and making sure people have that connectivity.

Gretchen Alkema:

And then I think the last thing that hasn't been brought up already is just that there's a whole series of quality measures that are being developed by NCQA through a variety of different tools that puts the person's voice really at the center of the care process, measuring what matters through person reported measure sets and the LTSS distinction. And so, we just want to elevate that this is a consideration as part of the larger quality measurement that care coordination is a center point on is to orient care and the quality measurement for that care around persons reported outcome measures. So, thanks so much.

Hilary Haycock:

Thanks. Appreciate you broadening out the discussion to some really important elements. We're going to keep going with some report outs, these are so great. Christina Dimas-Kahn, you're next.

Christina Dimas-Kahn:

Great. Hi, I'm the HICAP program manager for San Mateo County and also representative for CHA. And I'm not sure what group I was in, but I was in Melissa Cohen's group, and I know Susan and I had a lot to input. And so, for accomplishments and successes, one of the primary successes that I've seen in San Mateo County is long-term care population were brought home to live independently, which was huge because previously they were living in skilled nursing facility care homes. So that was amazing. Also, seamless coordination between SNFs, ADCs and mental health, as well as community partners with the type of care that members needed. As well as responding quickly to our public emergency, COVID, by having a concentrated effort to get members vaccinated, as well as making sure they had food and other supplies needed during shelter in place.

Christina Dimas-Kahn:

So those were just some of the accomplishments that we discussed. And achievements, opportunities for improvements, prescription drug coordination, especially with medications and the pills and supporting primary care providers, especially single owner operated practices for the mom and pod medical doctor offices. So, we talked about the support that's needed because they have to meet a lot of quality measures that are implemented by CMC. And to make sure that's done to have a provider ombudsman office and geographical areas, not just one, but have several of them that could help support the mom and pop doctor's offices. As well as having a central database available, excuse me, for some of these providers.

Christina Dimas-Kahn:

And one of the things that could be done differently is changing the language in terms that we use as professionals to make it more relatable for clients. And we'll just give you an example, like discharge planner, some bilingual or monolingual clients don't know what a discharge planner is. So, changing that term, writing it out so they understand what that means. And so, these are some of the opportunities for improvements. I'm going to also reach out to Susan and Melissa in case I missed anything. Thank you.

Hilary Haycock:

Thank you. Appreciate that. Great. All right, we'll keep going. Ryan Caceres? If I'm saying that correctly, you are next.

Ryan Caceres:

Yep. You got it correct, thank you. I'm a representative from Tulare County's Mental Health Plan and I'll go over a few opportunities for improvement we discussed, as well as best practices. So, when multiple stakeholders are coming to the table and a true carve-out environment, identifying the lead would be an important improvement that can be made. It would be beneficial to have an entity designated as being responsible to monitor the overall care coordination and that everything is going smoothly for the beneficiary. We also talked about the nature of reporting requirements imposed on providers, which can be improved where possible. The reporting should be closely aligned with their focus, which is more on diagnostic trends, interventions, and outcomes, as opposed to metrics such as just how many HRAs have you completed, et cetera.

Ryan Caceres:

If the reporting requirements are on a more relatable level than the engagement would be more increased. Their communication barriers, around things like the 90, 60, 30-day transition. And there's a general sense that a more robust plan for communication would be helpful and a best practice for that would be to create some standardized talking points. So, to highlight the specific benefits of opting in. And then from those talking points, health plans and providers can create their own media or their own outreach to expand on it, but it would be helpful to have that standardized approach that everybody can go off of for a more uniformed communication plan.

Hilary Haycock:

Great. Thank you. All right, we'll go to Grace. You are, there we go.

Grace Kotoyan:

All right, everyone. I'm Grace with Health Net's Long-Term Care intake team. Thank you everyone for your suggestions, there were some real interesting information shared. I will try to keep it short for opportunities and improvement. I think we need to establish better relationships or better public relations and incentives with our contracted providers early on, extend perks to them so that they can in turn sell the product to our members. We should focus on all of the MLTSS options instead of just CMC for better outcomes, better relationship between insurance companies and providers such as data sharing, identifying high-risk members for an effective and more member focused care coordination, and regular outreach to our members so that we can provide them with the support they need in order for them to be able to find their way through the system, instead of just opting out. That's about all I had.

Hilary Haycock:

Great.

Grace Kotoyan:

Thank you.

Hilary Haycock:

Wonderful. All right, so we all right, so we're going to try to unmute Anna. Sasha thinks she's got a solution and then that'll be our last report out and we'll see if we get some-

Anna Edwards:

Hello?

Hilary Haycock:

There ya are.

Anna Edwards:

Wow. Well thank you, I felt a little bit trapped in a box there. I am Anna Edwards, and I'm one of the directors at Inland Empire Health Plan. Thank you so much, I've learned so much from everybody. I was in Group 9, which is a lovely group and some of the lessons learned were talking about serving families, really being as a central goal. I think to an example of that, if we look at food insecurity, at Inland Empire what we're doing is when we're talking to a member, we're also looking at the family, cause we're improving the health of all. One of the other things is, we would need to make sure that care coordination or a care coordinator is really clearly defined and having some uniformity, because we want to make sure that everyone understands. Obviously, the data presented early, around 30% of people didn't know that they had a care coordinator, or this was available to them. So, it's going to be really important in the future that that's clearly defined and understandable.

Anna Edwards:

One of the lessons or the opportunities I really liked, I think what Ryan said, is that we have to take a look at the reporting. So, we know that we all want to do well and really the focus should be is on great care coordination and care management, right? But with such a heavy emphasis on the reporting requirements, oftentimes that can become this primary focus, right? We don't want to dilute the excellent efforts and the resources that we have hired to help support the members. Particularly I think of our ICP requirements, if we are going to be in the future, requiring everybody to have an ICP, is that really where we want to be going? I think there's a lot of opportunity there and we love serving the duals and all the opportunities to collaborate. A great group: does anyone want to chime in for my group to share anything else?

Hilary Haycock:

Great, thanks. All right well, I don't see any other hands raised, so I think now we're going to, I'm going to ask the panel to turn your videos back on, Carrie, Jack, and Maya, and see if you guys have any sort of reflections on themes you heard. I know it seems like there's a lot of, we really need to get the members engaged in the care coordination. We need to figure out ways to make it be person centered. We need to think through who's on that care team, which care coordinators, who is that quarterback, which I think Maya brought up.

Maya Altman:

Yeah, I would just add, adding onto the who's, somebody brought up how layers of care coordinators sometimes don't add value. I think they were talking about; I don't remember who it was, but they were talking about behavior health. For example, the plan wasn't really adding any value.

Maya Altman:

I think one thing I think about is I think the plan has a role to play as maybe a convener, but at different times, there are different people that would take the lead and just layering on another level of care coordination isn't necessarily helpful. But I think when you have, sometimes I think what works well is when you have a group, they can learn how to hold each other accountable. And so, there's, I think just building on that, I think there's just so much work to be done to improve care coordination. Again, when you're, especially when you have such diversity of people that we're working with in terms of beneficiaries and partners. I think another theme was housing, big emphasis, and I think, certainly CalAIM tries to build in a lot more with housing and it's definitely needed I'll stop there. There's a lot, there's so much there. It was really rich conversation. Thank you.

Hilary Haycock:

Yeah, sure.

Carrie Graham:

Sorry. So, we were in breakout room 18, it was a great conversation. I think something that came up in our group that was, has not been mentioned yet is the importance of collaborating across Medicare, Medi-Cal, and the VA and how veterans fall through the cracks. Veterans have, some veterans get HCPS through VA, some don't. And so, a focus on, I thought that was a really important point.

Carrie Graham:

Someone in our group, not me, mentioned the importance of evaluation framework and sending that data ahead of time. I loved that comment because, we can talk about data and data sharing, but if we don't have the data collected as baseline, reported out, it's hard to evaluate. And I think just, the other theme I think I heard throughout was kind of this difference between the medical model and the social model of disability and how, in health risk assessments, we know in CCI first people were kind of, the plans were collecting a lot of medical information, but the importance of collecting information, that health plans address the social determinants of health. Asking about social isolation, asking about food insecurity, hunger, housing conditions, those kinds of things, just a really important opportunity for the plans. So, I will stop there and hand it over to Jack.

Jack Dailey:

Sorry, now I can unmute myself, all right. This was a really great conversation, so many great points and thoughts. My head is exploding with thoughts. I mean really common theme, we keep hearing, you know, patient centered patient centered. And I think if we kind of keep that as our core principle, it speaks to a lot of the issues and ideas that were shared.

Jack Dailey:

The communication, I heard single point of contact and also in a separate vein, but also related, workforce. I think those really are important pieces to tie together. You can have a single point of contact but if that single point of contact has 500 members they're assigned to, that is not going to be effective single point of contact. So, I think as we look towards accountability measures and reporting, I think looking towards some best practices' standards with regards to patient ratios and care coordinator will be really, really great.

Jack Dailey:

Heard a lot about data sharing and I'm 100 percent in agreement that the care coordinator can't be the last person that learns about hospitalization or an LTSS transition. So, to be effective, they have to have data information. However, I want to tie that back to patient-centered data sharing and what that means is that these are patient's information that we're sharing amongst many players, and that should always come back to what that patient is comfortable with and remains at the center of those decisions to share data and information about their care. And I think in some ways that I, that also relates to engaging family members, we, in our group, we talked about the importance of family members and how they often will be the first person that learns of a problem that the member's calling the family member, not necessarily the plan, and as where a family member where a patient rather is okay with sharing that information involving a family member, that absolutely should do the case. But again, that starts with the patient and really honoring the patient's wishes with regards to that sharing of the data.

Jack Dailey:

I love the discussion of which also kind of fits into this theme of really starting with patient centered as the main concept here but the theme of engaging mental health and behavioral health consumers effectively, and ensuring that their care needs, whether they're carved in, carved out are being met and being addressed and incorporated into the larger care package that they're receiving. I think that's really important. And recognizing also that, non-medical model of care approach to care coordination may be an absolutely, should be considered when considering that all of these other social determinants impact a member's overall health. So, broadening that approach to care coordination to really include those nonmedical models, I think is really also really important.

Jack Dailey:

Also, virtual care, we learned a lot about virtual care. Many folks love it. As long as that is opted into by the patient, I'm 100 percent in support of that, but I think that's just, again, coming back to the idea that we're keeping the patient in charge and at the center of these care decisions and that virtual or Telecare is not being thrust upon a patient that either isn't comfortable with it and isn't comfortable with it in maybe one treatment area or what is in another. So, I'm gonna stop there for a moment because I could go on, there's so many great things. I really appreciate the discussion.

Maya Altman:

Can I just add a couple other things? Is there time, Hilary?

Hilary Haycock:

Yeah, absolutely.

Maya Altman:

Lisa brought up the, that it's not just a medical model and Jack you too, and how to bring in kind of the non-traditional, providers, the LTSS providers like ADRC and ILC, independent living centers. And what I struggle with as we prepare for CalAIM, is that in a way we're already medicalizing everybody, cause we're asking everybody to be able to submit encounters. And I get that because we need information to evaluate these programs and to make sure, we need to know what went into making, developing a certain outcome. But at the same time, all these providers, they're not used to doing this kind of work, and it's the massive change in their approach. I feel a little queasy about it too, but I don't know how else to get at the data piece. So that's just something I struggle with.

Maya Altman:

And then I just wanted to say on that, I fully support the single point of contact, but I don't want to lose the importance of teamwork and that people are able to follow people through their journey. I mean, they'd be maybe in a high-risk area, and they moved to a low-risk, you know, more low-risk and vice versa, and you want to have a single person who's working with them during that journey, but they also have to take advantage of the strength of a team because people leave. They leave their jobs, or they're not there that day. And so, you really need that team support as well. I don't want to lose that.

Hilary Haycock:

Great. So, looks like we were getting some comments in the chat. One about sort of really wanting to make sure that we're communicating well with members during this transition, which I think ties back to kind of where we started the conversation really with that with some of the findings the carrier reported out that others, that members, it's great when members are engaged. That's how care coordination works, right? It's not something that can be done to someone or completely on their behalf, but it has to be, I think, to your point, Maya, it's that teamwork and having the members be part of the team and making sure that we're communicating well, and folks are staying engaged with their integrated care.

Jack Dailey:

Can I just add onto Maya’s point? I think that is the point about bringing kind of the medical model, the encounter model, to areas that never have used that model. I think we learned that being an ODS-DMC county and bringing SUDs providers into the realm of managed care and adopting a medical model, I think that there were some real growing pains in that process. And so I think as policy decision-makers, there has to be a lot of thought about how, when you open up that model and bring in these other model providers into that discussion and you want to start tracking encounter data, you really have to allot for the resources and time and energy to bring those other provider types up to speed with what's gonna be expected of them and the data sharing, the charting. The concept of charting is something that I think is sometimes taken for granted in the medical model, of course, but in non-medical models, it's a newer concept and the depth and the detail and the rigor of the charting.

Jack Dailey:

So, I just wanted to kind of lift that up at that point, because that does take significant resources to bring nonmedical providers into the realm of this care coordination provider loop and to ensure accountability and quality measures going forward. That always has to be considered as well.

Hilary Haycock:

Yeah, I think those are good points.

Hilary Haycock:

I just think that, so we've got a comment from, from Marty Lynch, wanting to push back a little, the distinction between medical and social model of case management is false.

Hilary Haycock:

At a patient level they need to be ones that all needs are met, and you have to integrate that care manager or the primary care team. I think there were some other comments too, about how, that really a goal should be to make this seem seamless to patients, right? That there should be no wrong door. Patients shouldn't be tracking what's, ideally patients wouldn't be tracking what's covered by Medicare, what's covered by Medi-Cal, but that a patient kind of knows how to, that there's someone who's gonna help get their needs met. That there's a team to get their needs met. So, I don't know, that's a, how do you make that happen? I think is the challenge that lies ahead.

Hilary Haycock:

Lots of comments about data, which I think is, comes back to that as well. I think that transition to the encounter data is, is a challenge for folks that are new to the system. We talked about this in my group. You can't do care coordination unless you're sharing data; it's got to be bi-directional, it's got to go flow between the providers and the plans and everybody who needs to be involved and LTSS, and the medical side of the house. So, another, I think, important point to be thinking through how that works.

Hilary Haycock:

All right, well, I would just want to really thank our panelists for offering such thoughtful comments and wisdom to help us wrap this conversation up and wanted to invite Anastasia in to see if you, if there was anything you wanted to comment on as we close out our time together today.

Anastasia Dodson:

Thanks Hilary. Yeah, as we have listened to all of the wonderful feedback, I think we're wanting to take it all in and appreciate what it means at the individual level and at the local level, but then also at DHCS, we want to, at the same time carry into how should we adjust the SMAC contract? It's, we're going from the sublime to kind of a nitty gritty thing, but we do want to keep our eye on that ball as well and think about what is appropriate for state requirements, and what's appropriate more for either local collaboration, raising up best practices. What should we be doing as far as data sharing? How can we support that? And then how can we have outcomes or reporting that we can post on our website, that we can share back with plans.

Anastasia Dodson:

A lot of different topics there, but we will, as I said, share this all with the teams here at DHCS, and then think about for our next meetings, how can we put sort of a strategic approach for the next few meetings?

Anastasia Dodson:

Thinking about all these topics, quality reporting, data sharing, beneficiary communications, and then as we, we'll have the budget wrapped up, hopefully we'll have trailer bill wrapped up. All those things will give us a more certain landscape then, for our July meeting and we can think about again with care coordination, is there something that we should absolutely put in the SMAC? Absolutely not put in the SMAC? And then look ahead to all of the other intersecting transitions coming up in 2022 and then in 2023. So, we'll, and I appreciate also everyone's participation in this new format because we want to get your opinions and we want to give you a voice and make sure that we're hearing from a diverse group of folks. So, all of those things are happening all at the same time, and we really, very much appreciate your participation in this meeting. And we'll look forward to seeing you in July.

Hilary Haycock:

Great. Thank you, Anastasia, and many thanks to the department for creating this, I think, very valuable forum. Thanks again. And I will echo thank you everyone for your robust participation. We have a lot to take back and synthesize and communicate back out. So, thank you again, and we'll give folks a couple of minutes back for a passing period.

Hilary Haycock:

Have a wonderful rest of your day, and we'll see you Thursday, July 15th at 10:00 AM. And if folks are interested, we're having our quarterly CCI stakeholder webinar, Wednesday, June 30th at noon. So, multiple opportunities to connect in the coming weeks and thank you and have a great day.