Care Coordination Advisory Committee
Meeting Summary: 9/6/2018

The Department of Health Care Services (DHCS) held the third of six Care Coordination Advisory Committee meetings on September 6, 2018. The meeting was attended by invited committee members, staff from other state agencies and the Legislature, and members of the public. Jacey Cooper, Assistant Deputy Director of Health Care Delivery Systems facilitated the meeting, with support from other DHCS leadership and staff.

This meeting focused on the following topics:

- Transitions of care
- Point of care and community-based care management
- Social determinants of health

Key Discussion

- The meeting began with a presentation from Jennifer Clancy from Inland Empire Health Plan (IEHP) on IEHP's population health framework. A full slide deck is available here.

  The presentation focused on IEHP's approach to population health management to keep members healthy and manage members with emerging risk and multiple chronic conditions. The presentation emphasized: 1) the importance of collaboration with counties, community organizations, and provider organizations, 2) targeting care management to specific populations, 3) developing multi-disciplinary care teams, and 4) developing a population care management framework.

  Key committee members questions and comments focused on challenges surrounding collecting data on social determinants of health and integrating other social services (e.g. Cal Fresh) into patient care. Members were also interested in how IEHP measured outcomes, to which IEHP explained they aim to meet HEDIS and CAHPS, but also consider patient experience, staff experience, and impacts on social determinants of health.

- Following IEHP's presentation, Los Angeles County (LA) presented on their Whole Person Care Pilot. A full slide deck is available here. Clemens Hong and Debra Duran shared how LA is building county-wide infrastructure and community capacity to meet the needs of individuals who have traditionally fallen through the cracks. Clemens explained LA's effort to meet the patient where they are through extensive 'on-the-ground' efforts and a 'no wrong door' approach aimed at ensuring no one falls through the cracks.

  Debra Duran from LA County then presented on how LA is using transitional care management across entire care teams to meet the needs of complex populations. She described how LA is using ELM Care Management software to identify high risk patients, conduct risk stratification, and manage care plans across their patient population. LA includes questions about social conditions and ensures that the patient is engaged with care plan development.

  The committee provided comments following LA's presentation. Key comments focused on the importance of building a pathway to develop a coordination pipeline between counties, health plans, and providers and engaging plans and care teams. One member mentioned

the importance of aligning with the Drug Medi-Cal Organized Delivery System pilot efforts and SUD providers in general.

- DHCS discussed transitions in care, guided by this summary document. The discussion focused on discharge planning and the use of non-billable services to address the needs of high-need individuals. Many comments on this topic centered around challenges beneficiaries face in transitioning from the hospital to Skilled Nursing Facilities (SNFs) due to SNFs unwillingness to take Medi-Cal patients because of low Fee-For-Services (FFS) reimbursement rates, their inability to provide sufficient resources for beneficiaries with mental health or substance use disorders or who are children, and workforce challenges. Other comments focused on the importance of including families and caregivers in transitions and taking advantage of available resources in the community.

  The committee also discussed how they are or would like to address these challenges, including:
  - The need to consider financing 'in lieu of' services to allow flexibility to address transition of care challenges.
  - Placing social workers with the patient from the time of admission through post discharge.
  - Hiring 'sitters' to go with patients to SNFs to alleviate some of the SNF's concerns and resource limitations and help get the patient out of the hospital more quickly.
- DHCS also addressed point of care and community-based care management, guided by this summary document. Discussion on this topic focused on who should take the lead in providing care coordination services: the health plan, the county, or a community-based organization, and whether that person should vary based on the beneficiaries' needs at a point in time. Committee members had concerns about being able to share data and communicate effectively and efficiently enough to enable one system or person to hold care coordination responsibilities. Members were also concerned about how each system would be able to meet their care coordination responsibilities if the care coordinator lies in a different system.

  Committee members reinforced the importance of having 'boots on the ground' in the communities and being creative to address challenges caused by geography and resource limitations. Members also spoke to the importance of developing strong partnerships and co-locating services in probation departments and jails.

- The final topic of the day was how to address social determinants of health. DHCS began the conversation by introducing this summary document. This topic resulted in many comments from the committee. Key discussion points focused on health plans needing the resources to address social determinants and concern about requiring them to meet specific metrics or outcomes in a short period of time, considering that it takes significant time and data collection to see outcomes impacted by social determinants. Other comments focused on the importance of leveraging community resources, public health departments, schools,

cultural hubs and, especially, the on-the-ground learnings of behavioral health providers to address social determinants.

Committee members noted that addressing social determinants is not a new idea for health plans, and they have been trying to address member needs through various social determinants-focused pilots for years. The challenge is having enough resources to really address members social needs, which requires immense time and administrative commitments. Plans are currently paying for this out of their own pocket. Some comments focused on the importance of modernizing the rate setting process to account for savings realized through addressing social determinants.

DHCS Next Steps

DHCS will carefully consider all committee comments. The next meeting will focus on the organized delivery system and eligibility.