CENTENNIAL CARE NEXT PHASE
1115 Waiver Renewal Subcommittee
November 18, 2016
Agenda

- Introductions  8:30 – 8:40
- Feedback from October meeting  8:40 – 8:45
- Care coordination continued  8:45 – 10:00
- Break  10:00 – 10:10
- Population health  10:10 – 11:20
- Public comment  11:20 – 11:35
- Wrap up  11:35 – 11:45
Renewal Waiver
Areas of Focus

- Refine care coordination
- Expand value based purchasing
- Continue efforts for BH & PH integration
- Address social determinants of health
- Opportunities to enhance long term services and supports
- Provider adequacy
- Benefit alignment and member responsibility
Care Coordination
Care Coordination
Opportunities/Goals

- Improve transitions of care: The movement of a member from one setting of care (examples: inpatient facilities, rehabilitation settings, skilled settings and after incarceration) to another setting or home.
- Focus on higher need populations
- Provider’s role in care coordination

1 Adapted from CMS’ definition of terms, Eligible Professional Meaningful Use Menu Set of Measures; Measure 7 of 9; Stage 1 (2014 Definition) updated: May 2014. retrieved: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downl
# Improve Transitions of Care

<table>
<thead>
<tr>
<th>Feedback</th>
<th>Concepts</th>
<th>Further Discussion</th>
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<tbody>
<tr>
<td>➢ Communication across health providers and managed care is a challenge</td>
<td>➢ Identify funding to focus on facilities improving discharge planning</td>
<td>1. Are there ideas here that will have more impact than others?</td>
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<td>➢ Real time information is critical to transitions</td>
<td>➢ Enhanced care coordination as part of transitions (short-term):</td>
<td>2. What are good measures for defining a successful discharge?</td>
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<td>➢ Care Coordinator’s access in hospitals is challenging</td>
<td>➢ Jail release</td>
<td>3. Carrot or stick for adherence to discharge plan?</td>
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<td>➢ Inpatient stay</td>
<td>4. Any other at-risk populations we should address?</td>
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<td>➢ Nursing facility to community</td>
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<td>➢ Children in residential facilities</td>
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<td>➢ Incentives for outcomes of a successful discharge:</td>
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<td>➢ Attend follow up PCP visit</td>
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<td></td>
<td>➢ No unnecessary ED visit post discharge for 30–days</td>
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<td>➢ No preventable readmission post discharge for 30–days</td>
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<td>➢ Filling medications</td>
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<td>➢ Completing medication reconciliation (provider)</td>
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<td>➢ Incentives for member adherence to recommended follow–up:</td>
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<td>➢ member rewards</td>
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## Focus on Higher Needs Populations

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| Improve education to members about use of public health services<br> Increase member education and use of community supports such as public health services:  
  - Community Health Workers / Certified Peer Support Worker (CPSW)<br>  - School-based health centers<br>  - Expand Health homes | Improved engagement of family and other community supports:  
  - Family/caregiver role<br>  - Increase use of community health workers / CPSWs<br> Promote creative approaches by MCOs to support unique high needs populations.<br> Focused education and interventions that are condition or location specific:  
  - Areas with fewer providers, transportation issues and/or specific cultural aspects<br>  - Areas with high risk pregnancies, with high prevalence of diabetes, COPD and other chronic diseases<br> Use of Community Health Workers for more intensive "touch" for these members<br> Expand health homes<br> Use of population health information to develop targeted education and interventions | 1. How can we incentivize member participation in care coordination? In their healthcare? In preventative care?  
2. How can we use Community Health Workers and others as resources for a more intensive role for these members?  
3. What are some interventions to engage hard to reach members?  
4. Who are higher need populations we should consider?  

## Provider’s Role in Care Coordination

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| - Information sharing with local providers is key.  
- Need for further definition of care coordination roles based on where a member is receiving care (FQHC, Senior Center, Jail, ER)  
- Need to increase consistent use of terms (case management, care coordination, care management)  
- Increase use of local/community supports to support MCO care coordination. More use of CPSW, peer navigator:  
  - Teen parents, cancer center | - Consider pilot opportunities for MCOs to incorporate local supports (regional systems, homeless, family members) into care coordination  
- MCOs could share dollars with local programs for direct linkages to members  
- MCO and Provider Incentives for outcomes  
- Value-based payment approaches mean more responsibility for providers to provide care coordination to meet value based payment goals  
- Value-based payment approaches will involve / delegate care coordination to providers | 1. How do we build capacity and readiness in the provider community?  
2. Where should care coordination be provided (physical location)?  
3. How do you avoid duplication of efforts between MCO care coordination and provider level?  
4. How do you promote communication and coordination between the MCO and provider level care coordination? |
Population Health
Population Health

Key Terms

- Population Health
  “A population–based approach to health care and preventative services improves health outcomes for all populations and helps individuals achieve their highest health–related quality of life”  

- Social Determinants of Health
  Factors that enhance quality of life and can have a significant influence on population health outcomes. Examples include safe and affordable housing, access to education, a safe environment, availability of healthy foods, local emergency and health services, and environments free of life–threatening toxins  

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Population Health Overview

- Data
  - Define populations (location, condition, setting of care).
  - Identify data points for social determinants of health (cultural, social, environmental).

- Care Coordination
  - Assess physical, mental health conditions and other factors that impact outcomes.
  - Identify inequities that negatively impact health and address them.

- Medicaid & Non Medicaid Services
  - Address environmental, transportation or other needs needs through services in benefits package.
  - Improve access to non-Medicaid services such as food banks, rent assistance, supported employment.

- Patient Centered Models
  - Focus on specific populations by geography, condition or other factors and target interventions.
  - Consider: high-risk pregnancy, homeless, incarcerated, high/low utilizers.
# Population Health
## Starting the Discussion

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<tr>
<td>➢ Food</td>
<td>➢ Chronic disease monitoring and education</td>
<td>1. What population(s) should we target? Why?</td>
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<td>➢ Housing</td>
<td>➢ Health assessments and data collection</td>
<td>2. Which factors/determinants impact outcomes for this population? How could Medicaid address those factors?</td>
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<td>➢ Transportation (work, school, social needs)</td>
<td>➢ Medication compliance</td>
<td>3. How do we move the organization to population-based analysis? Do we have necessary data or analytical capability?</td>
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<td>➢ Employment</td>
<td>➢ Condition or region specific initiatives funding and outcomes goals</td>
<td>4. How do we create a nimble system that can respond to factors that impact population health?</td>
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<td>➢ Housing</td>
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<td>➢ Job coaching and support.</td>
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<td>➢ Food pharmacies</td>
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<td>➢ Linkages to community resources and supports beyond health services</td>
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Subcommittee Meetings
Timeframe for Discussion

October 14, 2016
- Goals & objectives
- Waiver background
- Care coordination

November 18, 2016
- Care coordination
- Population health

December 16, 2016
- BH-PH integration
- Long term services and supports

January 13, 2017
- Value based purchasing
- Personal responsibility

February 10, 2017
- Benefit and eligibility review