HUMAN SERVICES
DEPARTMENT

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

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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

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Care Coordination

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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*[1]
- 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

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Improve Transitions of Care

Feedback	Concepts	Further Discussion

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

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Focus on Higher Needs Populations

Feedback	Concepts	Further Discussion

➢ Improve education to members about use of public health services
➢ Increase member education and use of community supports such as public health services:
  ➢ Community Health Workers / Certified Peer Support Worker (CPSW)
  ➢ School-based health centers
  ➢ Expand Health homes
	➢ Improved engagement of family and other community supports:
	  ➢ Family/caregiver role
	  ➢ Increase use of community health workers / CPSWs
	➢ Promote creative approaches by MCOs to support unique high needs populations.
	➢ Focused education and interventions that are condition or location specific:
	  ➢ Areas with fewer providers, transportation issues and/or specific cultural aspects
	  ➢ Areas with high risk pregnancies, with high prevalence of diabetes, COPD and other chronic diseases
	➢ Use of Community Health Workers for more intensive "touch" for these members
	➢ Expand health homes
	➢ 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?

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Provider's Role in Care Coordination

Feedback	Concepts	Further Discussion
➢ 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?

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Population Health

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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" [2]

- 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 [3]

[2] Centers for Medicaid and Medicare, CMS Strategy: The Road Forward (2013-2017); retrieved: https://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf

[3] Adapted from :Office of Disease Prevention and Health Promotion, Health People 2020; 2020 Topics and Objectives: Social Determinants of Health. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

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Population Health

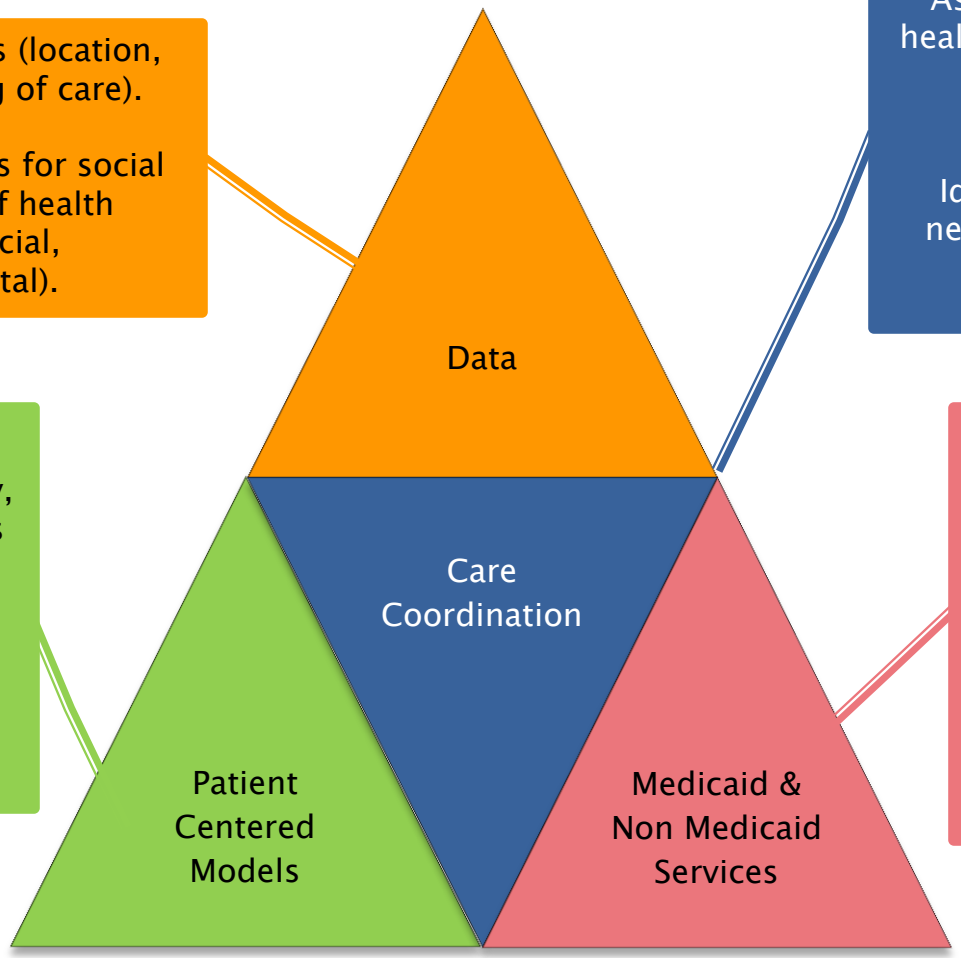
Overview

Define populations (location, condition, setting of care).

Identify data points for social determinants of health (cultural, social, environmental).

Assess physical, mental health conditions and other factors that impact outcomes.

Identify inequities that negatively impact health and address them.



Focus on specific populations by geography, condition or other factors and target interventions.

Consider: high-risk pregnancy, homeless, incarcerated, high/low utilizers.

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.

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Population Health
Starting the Discussion

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

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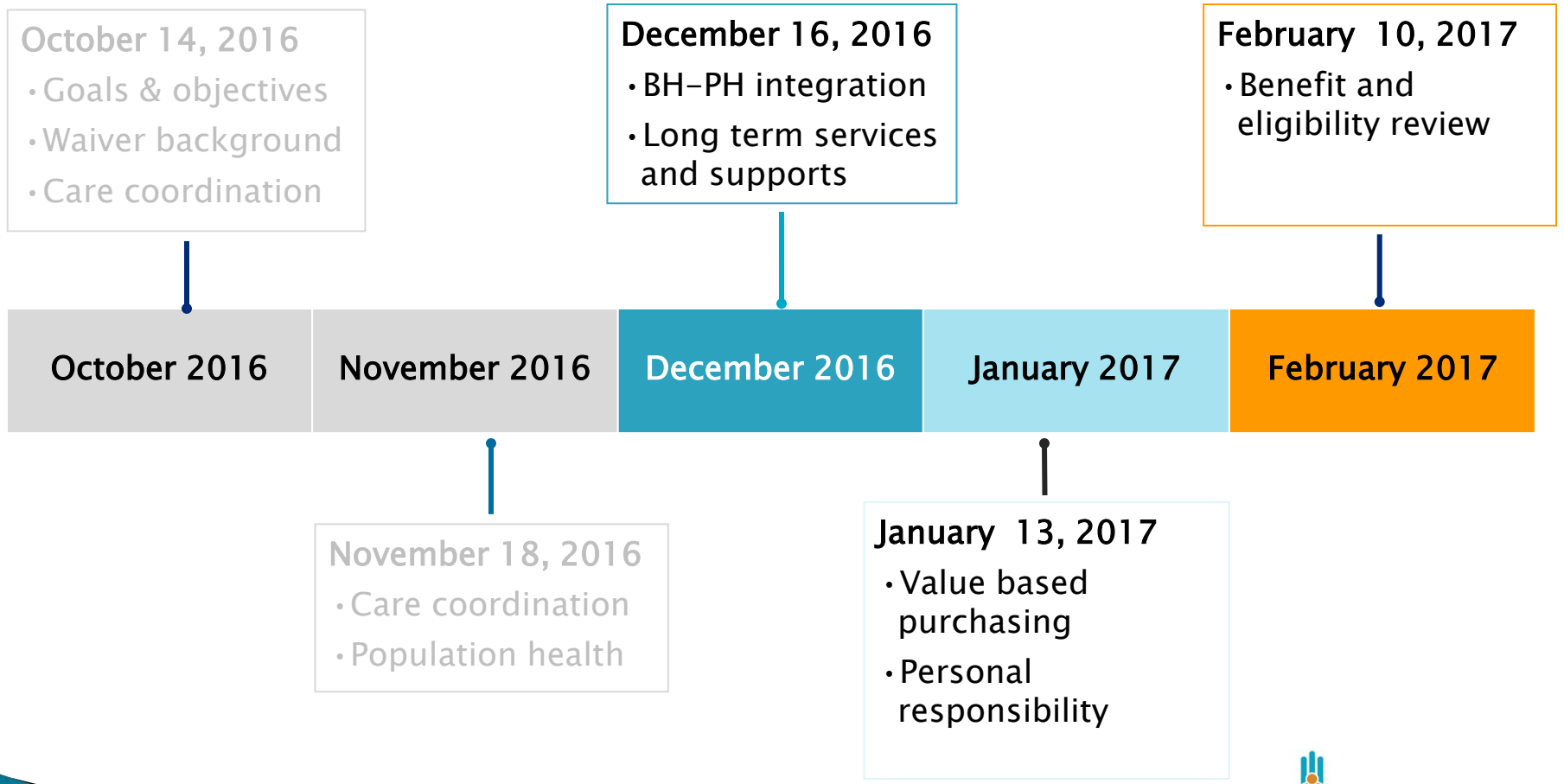
Subcommittee Meetings

Timeframe for Discussion



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