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How CalOptima Supports the Delivery of Quality, Person-Centered Care

CalOptima Informational Series
June 9, 2017

Agenda

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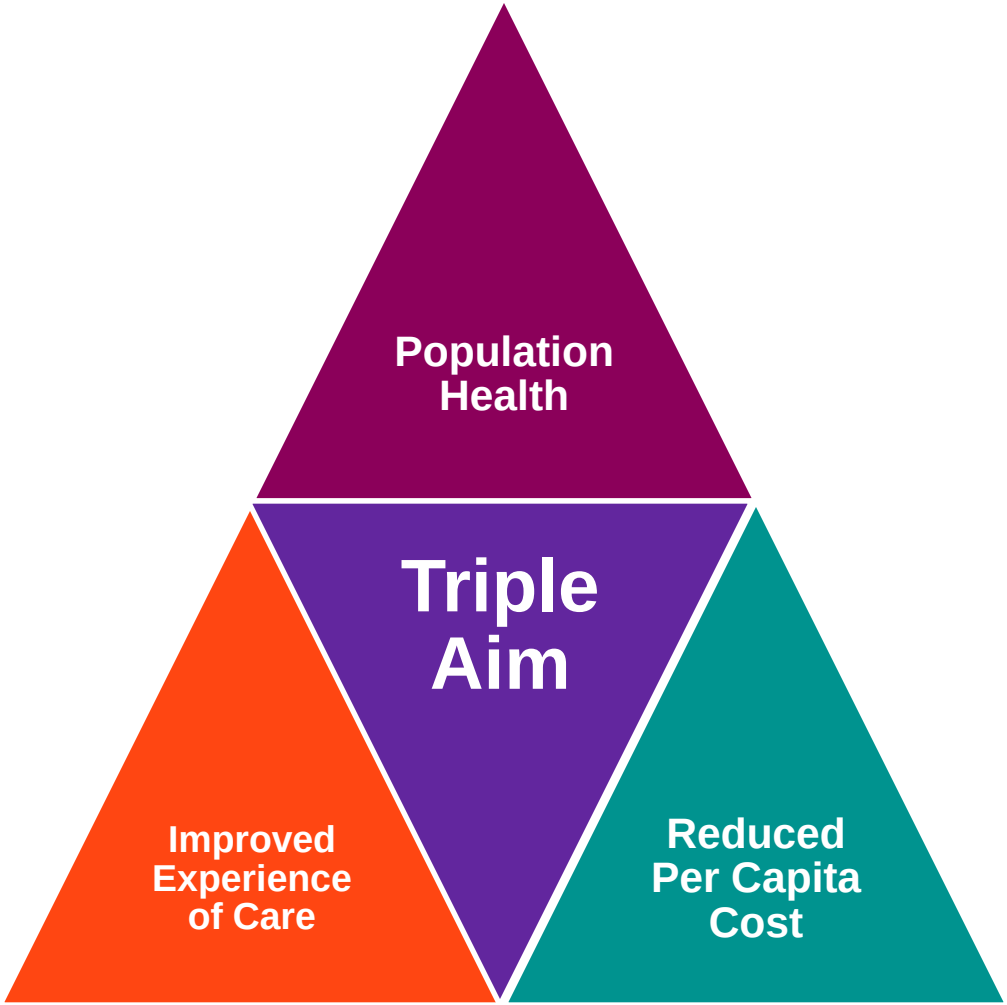
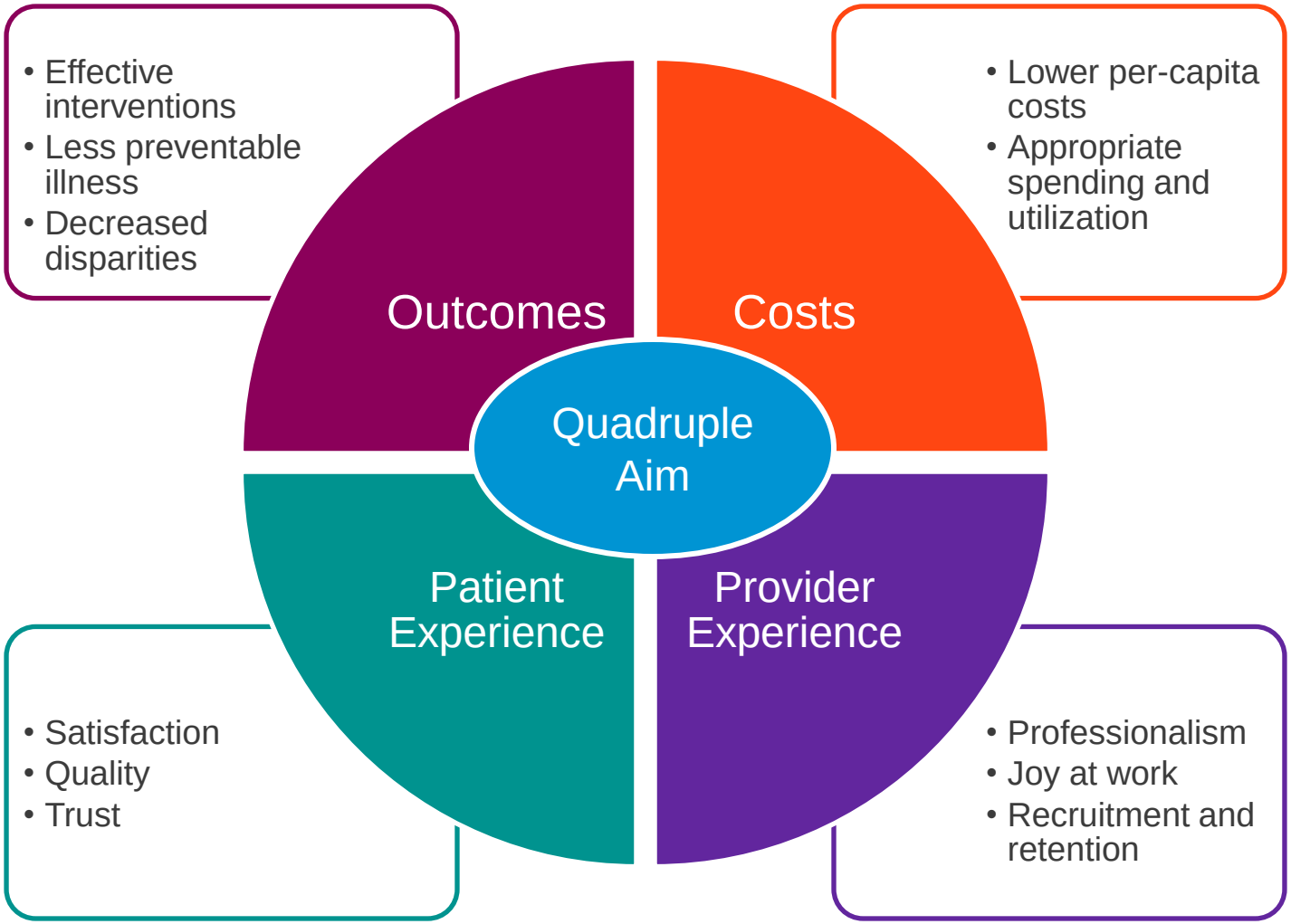
   - James Sharkoff, M.D.
4. Quality Monitoring and Outcomes
   - Caryn Ireland, Executive Director, Quality and Analytics
5. Questions and Answers
6. Closing

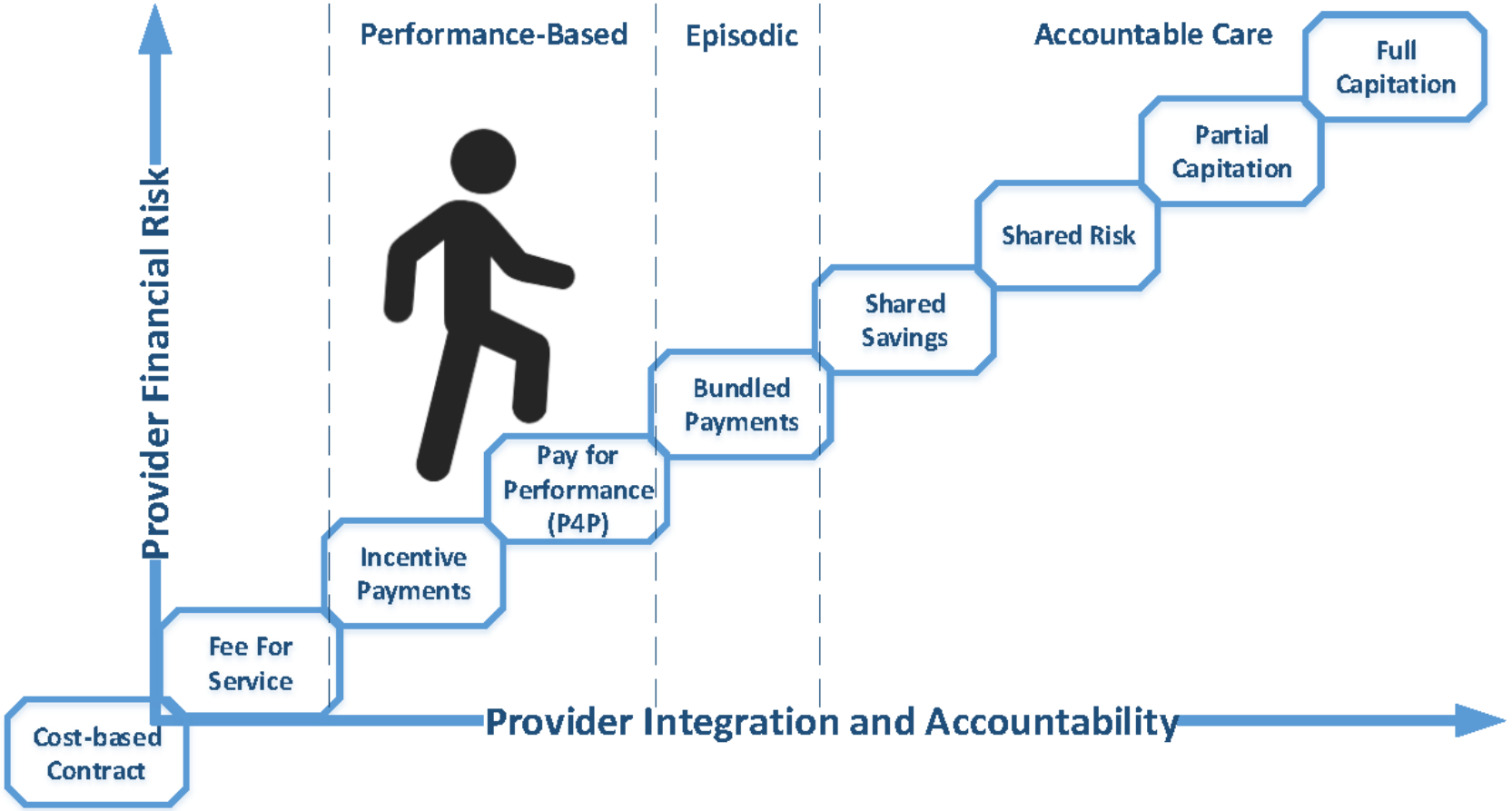
Triple Aim


Population Health
Triple Aim
Improved Experience of Care
Reduced Per Capita Cost

Quadruple Aim



Evolution of Managed Care

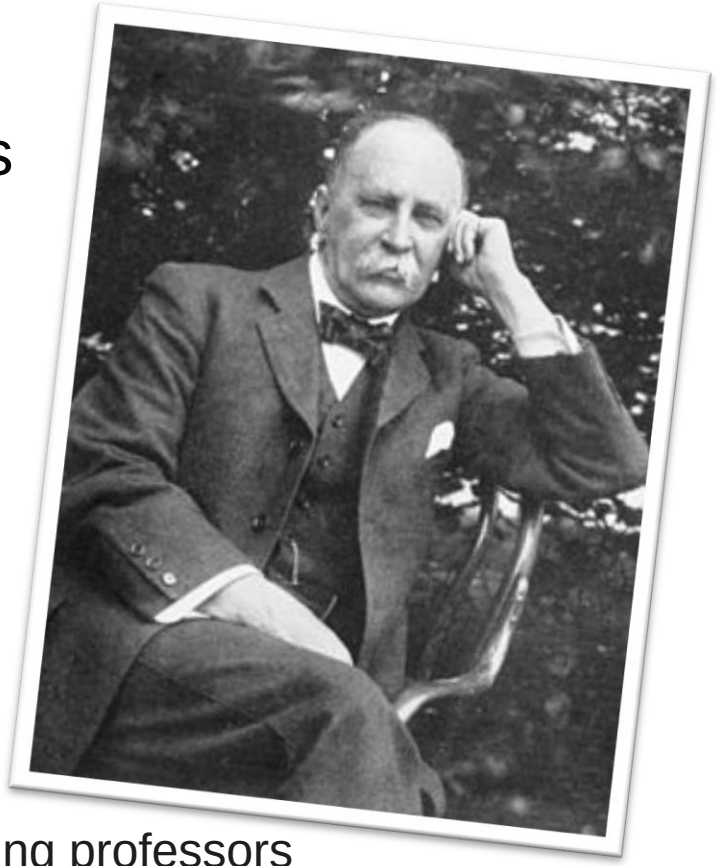


Source: Health Management Associates

Everything Old Is New Again

- "It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has."

  —*Sir William Osler, 1892*



Sir William Osler was one of the four founding professors of Johns Hopkins Hospital. He is frequently described as the "Father of Modern Medicine" and one of the "greatest diagnosticians ever to wield a stethoscope."

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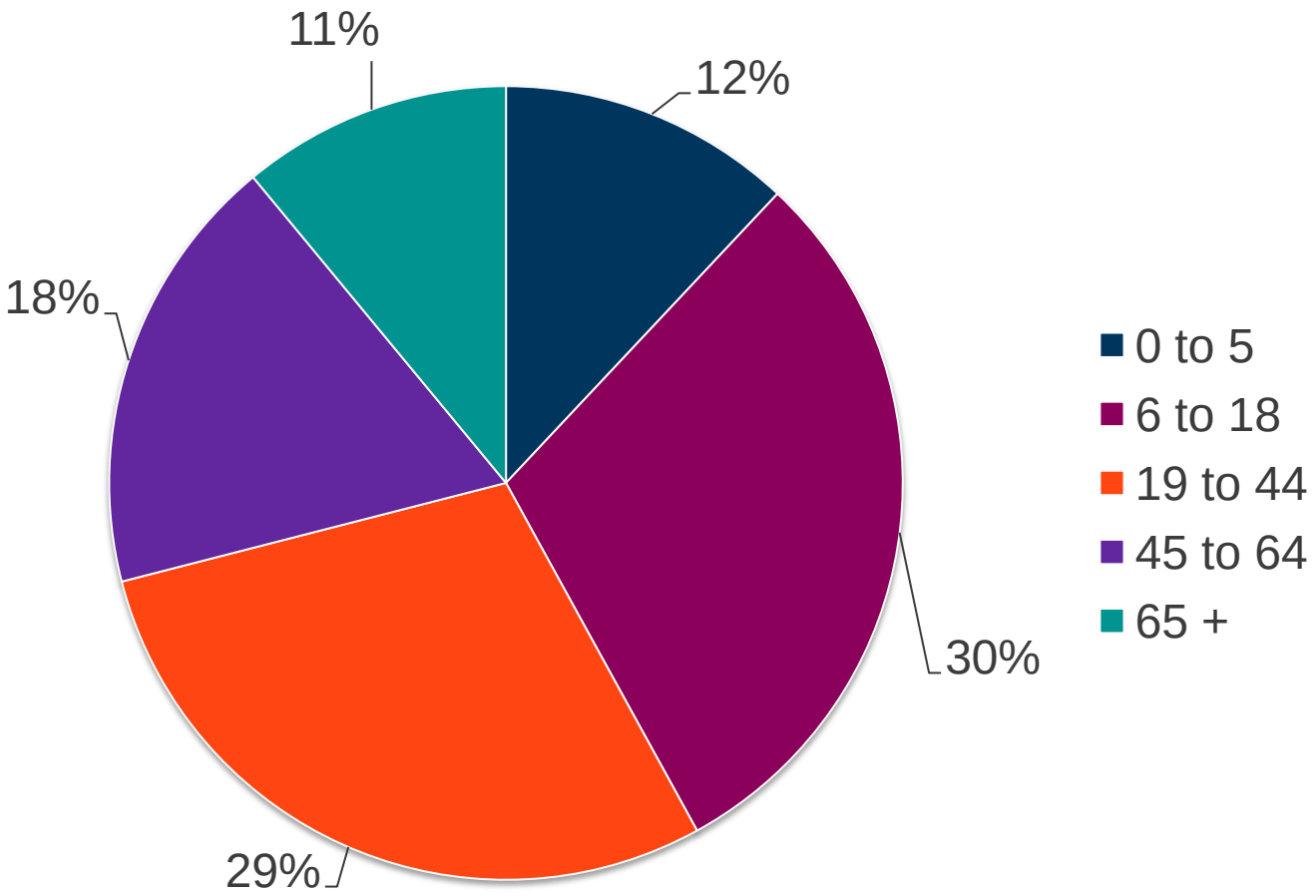
Care Management Overview and Components of Person-Centered Care

Richard Helmer, M.D., Chief Medical Officer

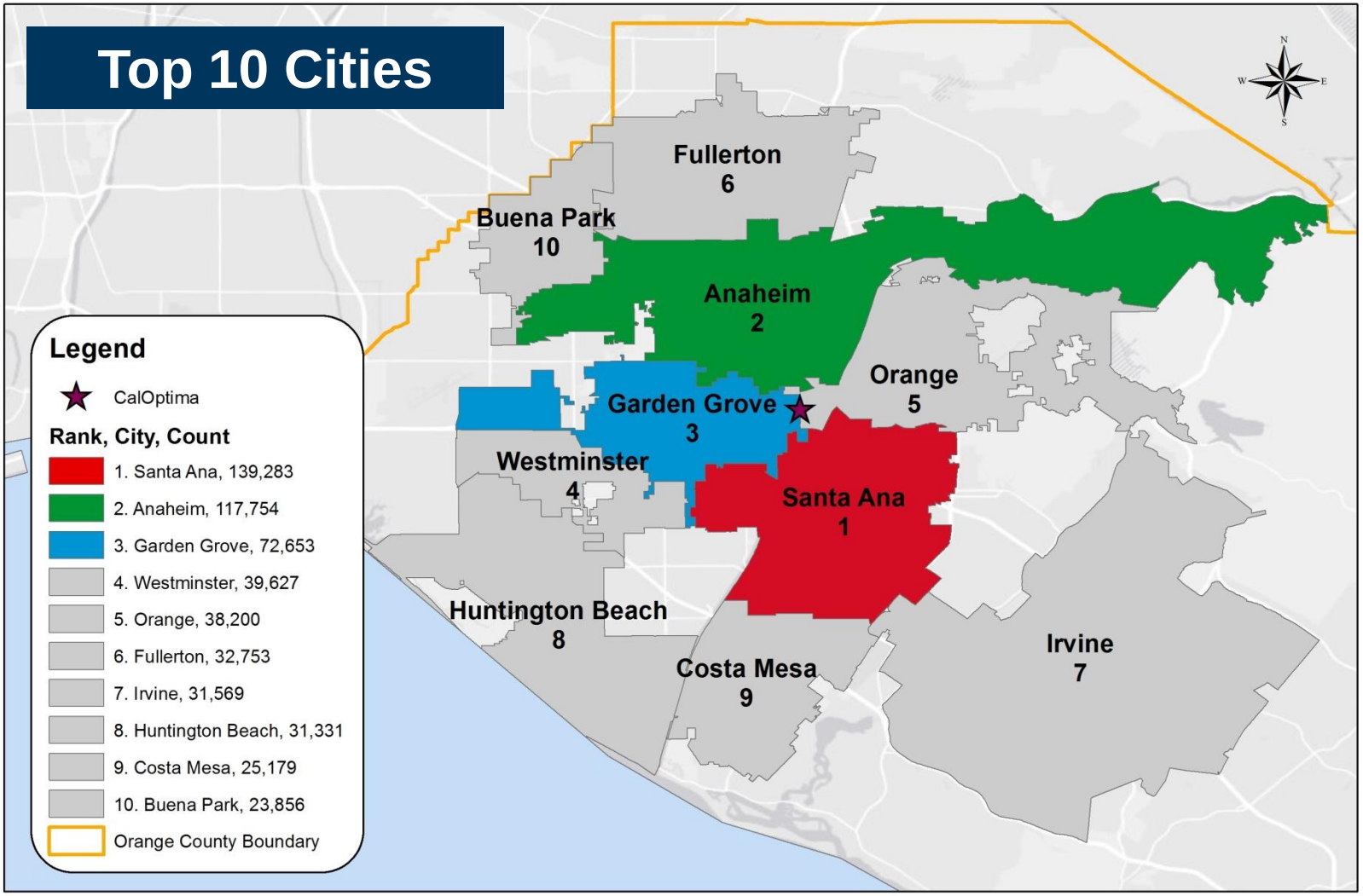
Caryn Ireland, Executive Director, Quality and Analytics

Population Variables: Age

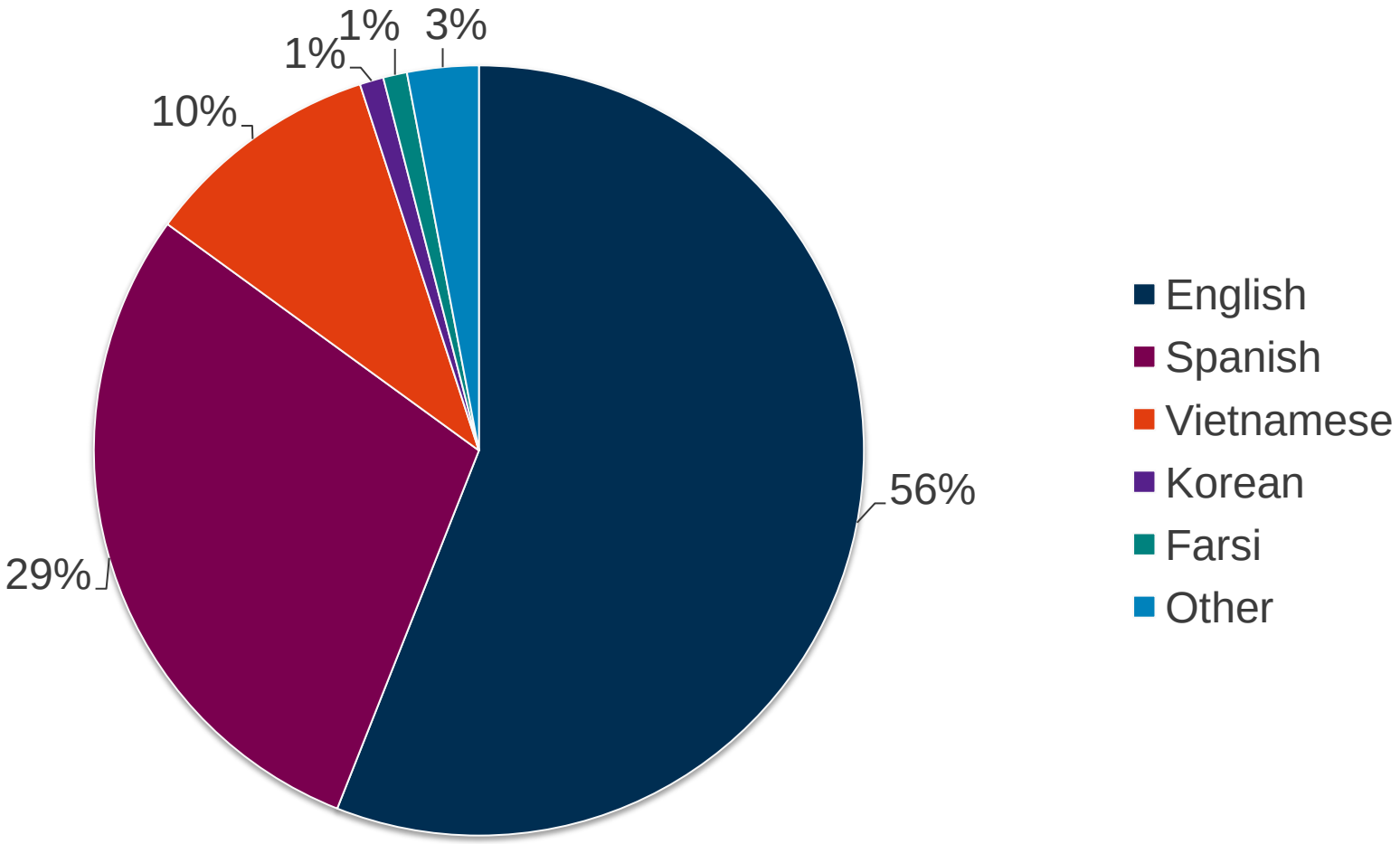


Source: Fast Facts, June 2017

Population Variables: Geography



Population Variables: Language

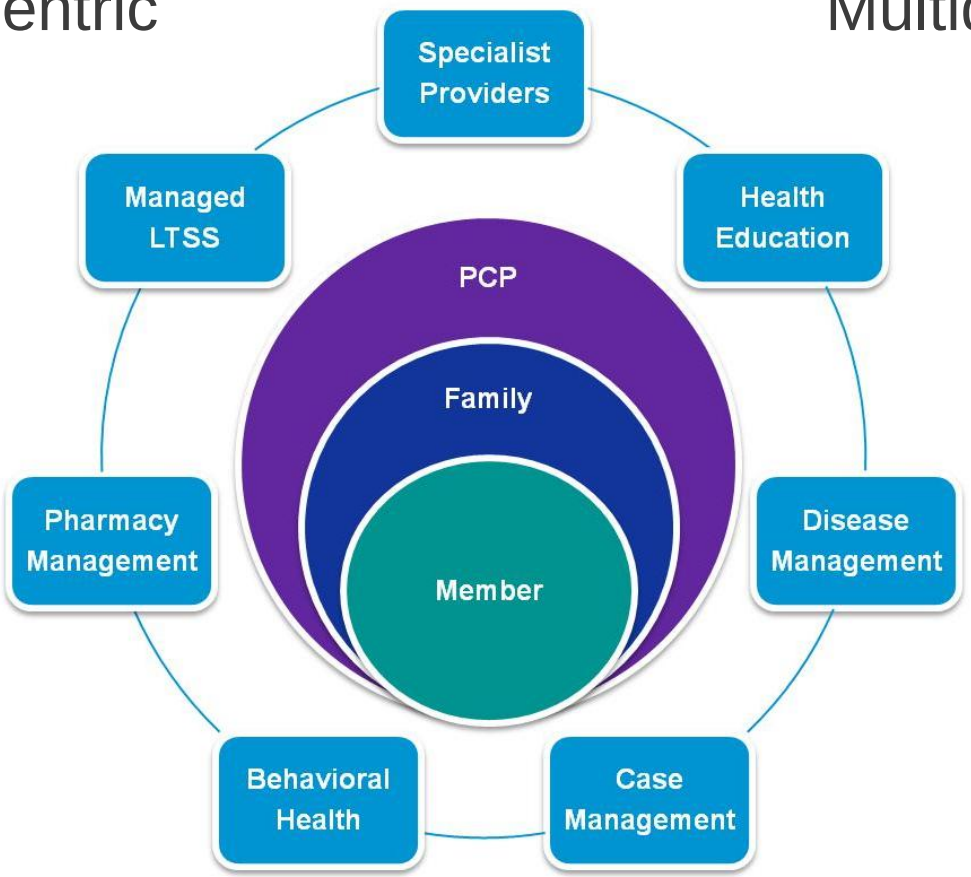


Source: Fast Facts, June 2017

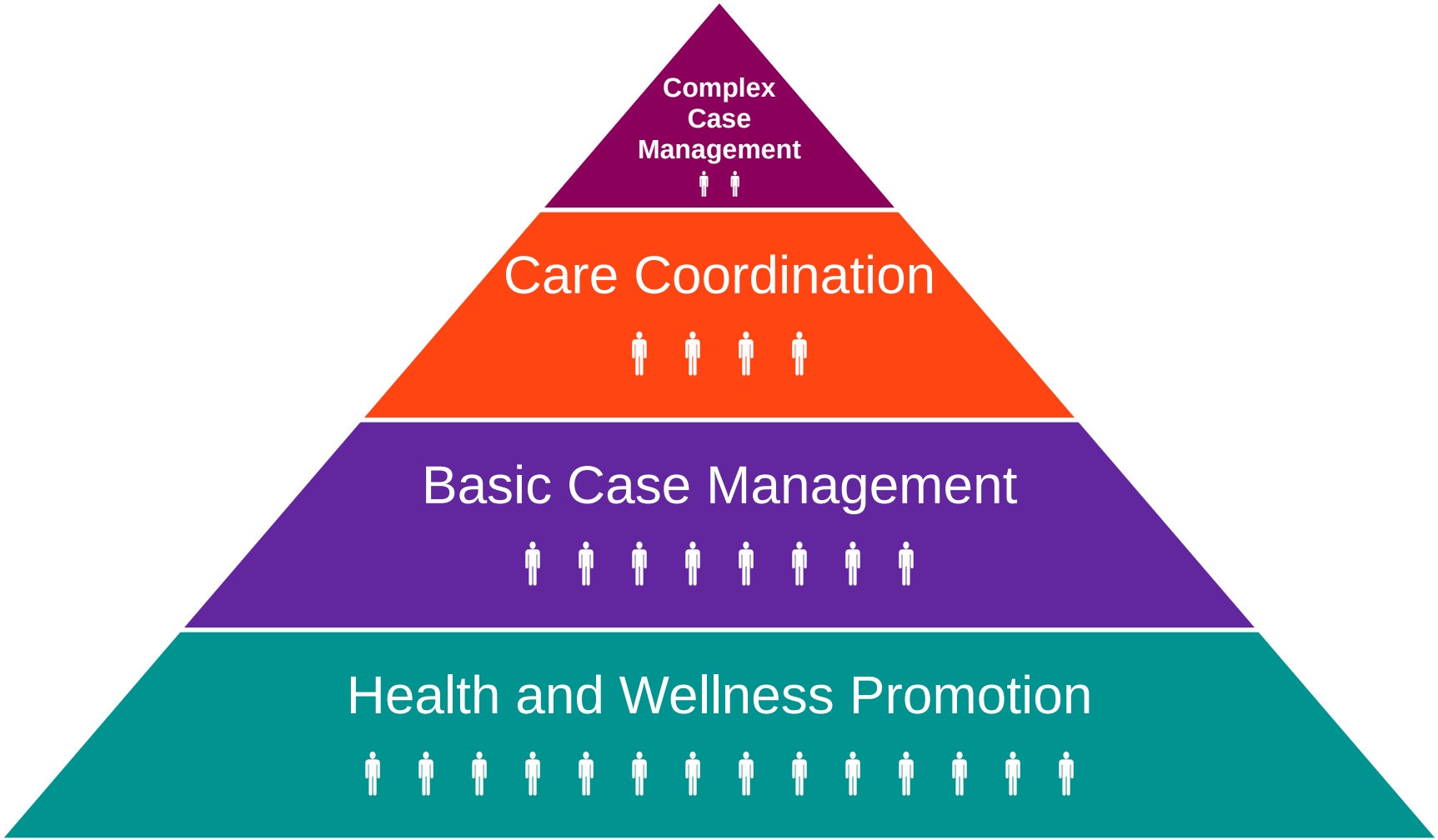
Population Variables: Medical Needs

Member-Centric

Multidisciplinary



Population Health



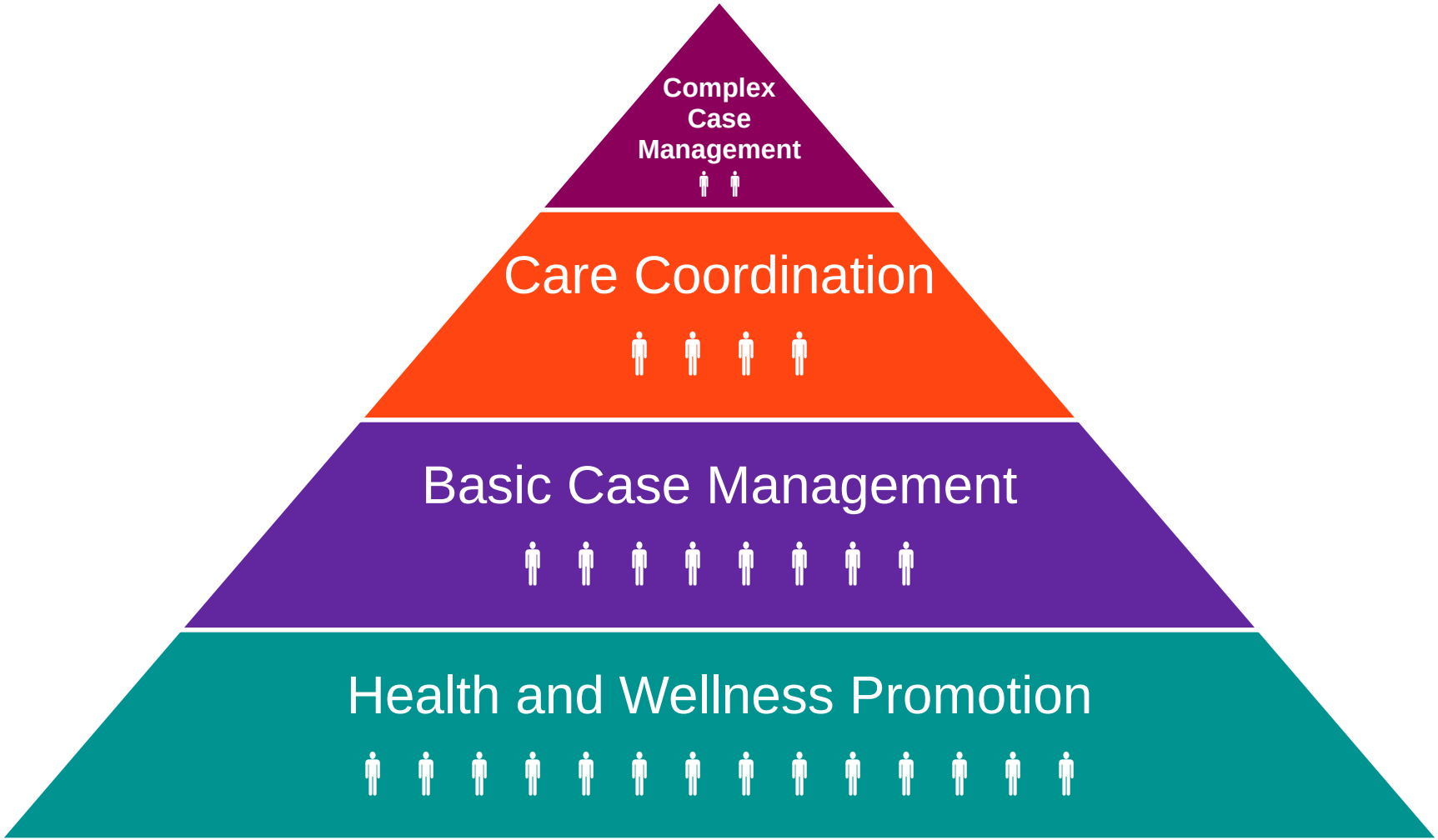
Member Is Generally Healthy

Health and Wellness Promotion

- Primary care provider (PCP) partners with the member to manage health care needs
  - Occasional need for specialty care

- CalOptima programs include:
  - Member newsletters
  - Member incentives for preventive care
  - Health education materials to support self-management

Population Health



Member Is Medically Stable

Basic Case Management

- PCP manages member's health care
  - May have additional needs for specialty care
  - Assistance from Personal Care Coordinator (PCC)

- Additional CalOptima programs include:
  - Disease management
  - Long-Term Services and Supports
  - Community referrals
  - Social worker consultation

Member Has Chronic Conditions

Care Coordination

- PCP manages member's health care in collaboration with specialist(s)
  - Increased interaction with PCP
  - Plan of care developed by multidisciplinary team
  - Care coordinated by nurse case manager
  - Assistance from PCC
- Additional CalOptima support includes:
  - Pharmacist medication review
  - Behavioral Health integration

Member Has Acute Medical Needs

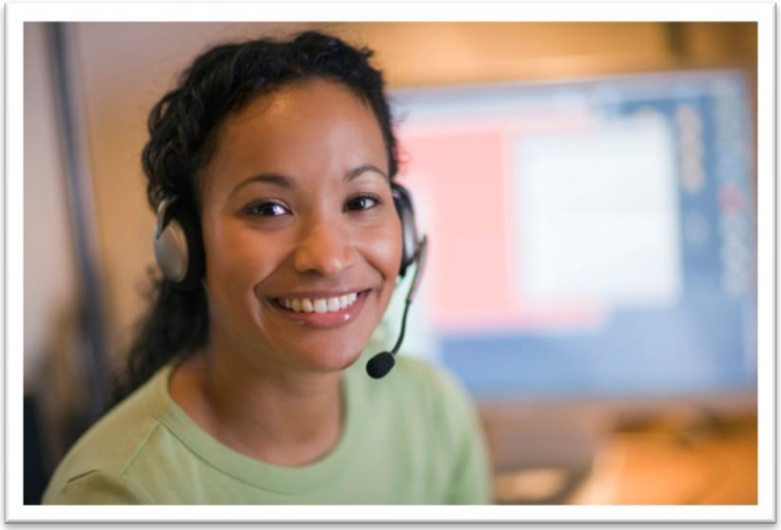
Complex Case Management

- PCP manages member's health care in collaboration with specialist(s)
  - Intensive coordination by nurse case manager
  - Plan of care developed by multidisciplinary team
  - Assistance from PCC
- Additional CalOptima support includes:
  - Increased level of assistance from the health care team
  - Additional coordination with ancillary services
  - Ensuring effective delivery of highly complex care

Care Management Levels

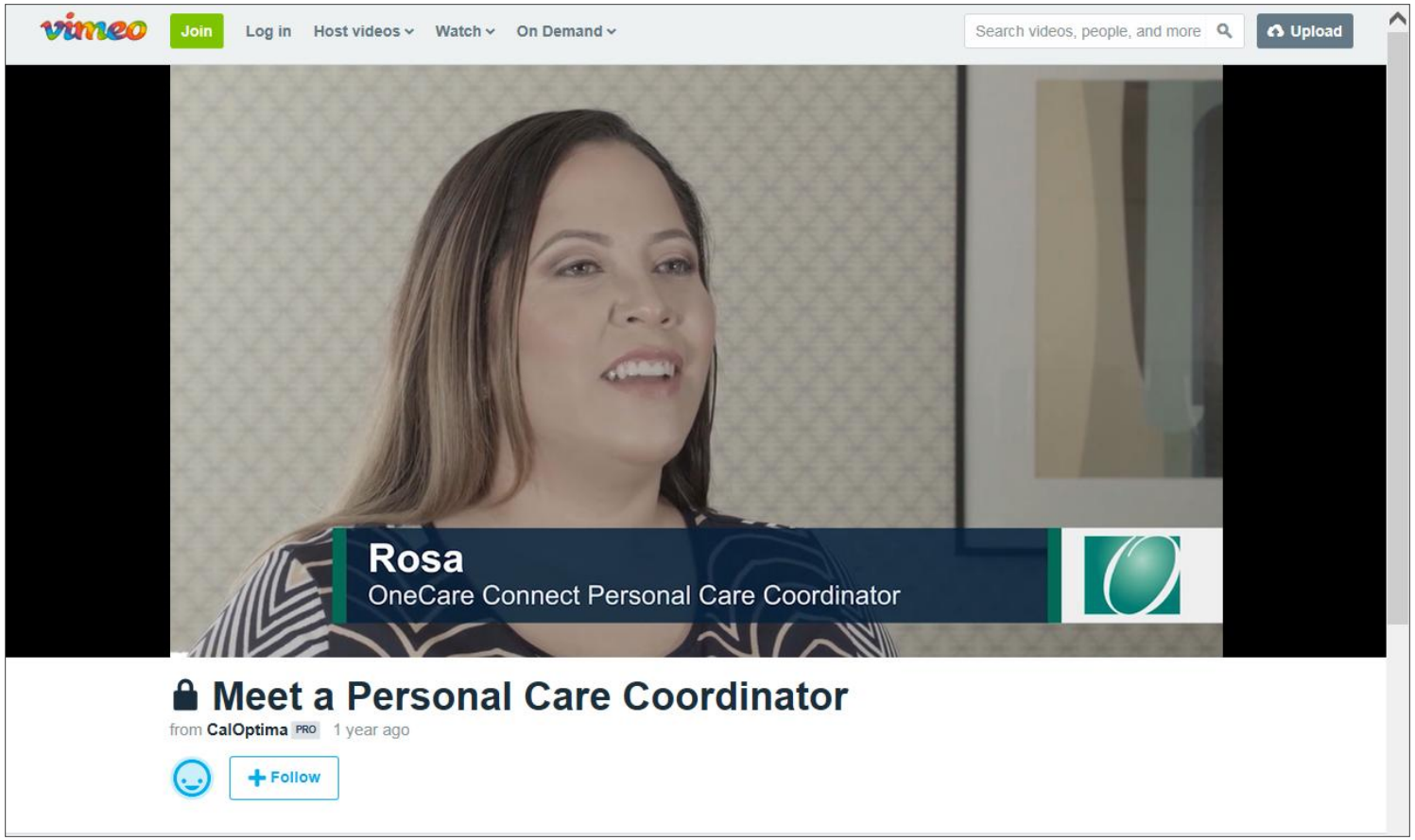
- Basic Case Management
  - Medically stable
  - Community well
- Care Coordination
  - Chronic conditions
  - Significant coordination of services
- Complex Case Management
  - Acute medical need
  - Requires complex case management
  - Less than 5 percent of population

Personal Care Coordinator (PCC)



- Facilitate completion of the health risk assessment
- Answer general health plan questions
- Help member with problem solving
- Identify member's preference for communication (language, alternative format, etc.)
- Facilitate warm transfers to case managers
- Identify care advocate and facilitate approval of protected health information (PHI) exchange

PCC Video



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Health Risk Assessment (HRA)

- Comprehensive questionnaire
  - Actionable health concerns
  - Activities of Daily Living (ADLs)
  - Behavioral health
  - Chronic conditions
  - Community resource needs
- Separate outreach process for members in long-term care
- Initial risk stratification to prioritize outreach time frames (high/low)
- Risk assessment algorithm used to identify care management levels:
  - Basic Case Management, Care Coordination or Complex Case Management

Benefits of the HRA Information

- Based on member responses, CalOptima creates a plan to address needs, which may include:
  - Memory or home safety evaluation
  - Referrals to Disease Management, Health Education or Pharmacist
  - Assessment of nutritional needs/exercise evaluation
  - Identification of preventive care and early disease detection needs
  - Additional assessment for behavioral health needs
  - Long-term services and supports referral
  - Access to community resources
  - Coordination of care among providers

Sharing Information

- CalOptima shares the following information with the health network and primary care provider
  - Completed HRA
  - Initial Care Plan (iCP) based on HRA
    - Recommended care management level
    - Recommended ICT participants
  - Recommended interventions list
    - Actionable items separated by PCC, PCP, RN case manager
    - Identification of actions already taken on behalf of member
  - Age-appropriate medication review tool

Medication Review Tool

- Generates prescription drug data based on claims
- Includes age-appropriate indicators
- Produces medication list
- Helps identify:
  - Duplications in therapy
  - Drug-drug interactions
  - Drugs to avoid in the elderly
  - Drug disease interactions in elderly
  - Identification of prescriber
  - Cited references (NCQA/HEDIS, CMS, Lexicomp)

Interdisciplinary Care Team (ICT)

- ICT composition determined by member needs
- ICT meeting results in a finalized individual care plan with the member's prioritized goals and documentation of discussion of care goals with member

Interdisciplinary Care Team	
Core Participants	**Additional Participants**
Member (or authorized rep)	Medical Director
PCP	Pharmacist
Specialist (as indicated)	Behavioral Health Specialist
Case Manager	Social Worker
PCC	Dietitian
	LTSS Coordinator
	Therapists
	Community-Based Organization Rep

Individual Care Plan (ICP)

- ICP developed by appropriate licensed professional
- PCP/health network use evidence-based guidelines to develop ICP goals
- Health network ensures ICP is disseminated to the member, caregiver or authorized representative (member-friendly version), PCP, participants of the ICT and member's health care team
- Health network ensures that ICP interventions are implemented and goals are achieved

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Provider Success Stories

James Sharkoff, M.D.

Pueblo Family Medical Center

Community Physician Perspective

It can be lonely working in a small clinic

James Sharkoff, M.D.
Pueblo Family Medical Center, Stanton

Community Physician

- It feels like patients are not taking their medications
- It feels like they do not care about their diet
- It feels like they do not care to follow up
- It feels like you are not making a difference

Community Physicians Need Help. What Would Help?

- A nurse to do a home visit
- A case manager to help arrange for home services
- A pharmacist to help coordinate medication
- An in-home health assistant to help patient with diet and medication

Solution

- Bring all allied providers together
- Complete a home visit
- Conduct a patient interview at home
- Formulate a care plan with all providers to solve the problem of in-home complex care

Patient M.A.

- 70-year obese Hispanic female with poorly controlled diabetes and hypertension
- At clinic visit, she states she is taking all medication as prescribed and following diet, yet there is no weight loss, poor control of diabetes and no change in hypertension

Nurse Practitioner Home Visit

- Patient is not taking medication
  - Fear of hypoglycemia
  - Not willing to tell doctor that she cannot read
- Patient not going to referred specialist
  - Does not have a ride with family members

Outcome for M.A.

- Improved education about medication and hypoglycemia
- Improved compliance with diet with better education
- Health plan provided rides to specialist

- END RESULT: Better glycemic and hypertension control, and better patient compliance

Takeaway Message

- Low-income patients have complicated problems that are both medical and social
- Physicians cannot solve these problems by themselves
- There's value in a system that brings patients and all providers together
  - Each player sees what they can bring to the table
    - Education
    - Transportation
    - In-home care
- It is not a perfect system, but it does make it better

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Quality Monitoring and Outcomes

Caryn Ireland

Executive Director, Quality and Analytics

Quality Monitoring

- ICT/ICP
- Quality Measures (including LTSS)
  - Access to care/network management
  - Coordination of care
  - Utilization of services
  - Prevention and chronic diseases measures
    - Key HEDIS measures
  - Member satisfaction, complaints and grievances
- Regular review of metrics
- A key component of our overall Quality Improvement Program

Monitoring of ICT/ICP

Interdisciplinary Care Team (ICT)	Complex Case Management/ Care Coordination	Basic Case Management
Member or representative invited OR attended	✓	
PCP invited OR attended	✓	
Appropriate discipline/pertinent specialist invited OR attended	✓	

Individual Care Plan (ICP)		
ICP developed within 30 days of HRA completion	✓	✓
PCP visit and evidence of care planning within 120 days	✓	✓
Addressed all HRA-identified issues	✓	✓
Documented discussion of care goals with member	✓	✓
Signed by PCP	✓	✓
Signed by licensed care manager	✓	
Member version provided with date/mail documentation	✓	✓
Member version provided in preferred language/format	✓	✓

Monitoring Quality Measures

Quality of Clinical Care
Adult Access to Care
Adult BMI Assessment
Controlling Blood Pressure
Breast Cancer Screening/Colorectal Cancer Screening
Diabetes Care (A1C Control, Retinal Eye Exam, Kidney Disease Monitoring)
Depression Screening
Rheumatoid Arthritis and Osteoporosis Management
Utilization (ER Visits, Hospital Stays, Readmissions)

Quality of Service
Getting Needed Care, Getting Care Quickly
Care Coordination
Getting Needed Prescription Drugs

Key Attributes of the Model of Care

- Member-centric and multidisciplinary
- Crucial PCC role
  - Sole focus is on care coordination
  - Non-licensed, highly trained
- Strong member and PCP engagement
- Essential tools
  - HRAs
  - ICPs
  - Medication Review Tool
  - Quality Score “Report Card”
- Robust ICT discussions

Person-Centered Care Model

- Focused on coordination
- Multidisciplinary
- Integrated — we're not chasing a measure; rather, we're focusing on health needs and improvement
- We're still learning…

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Questions and Answers

Caryn Ireland
Executive Director, Quality and Analytics

Questions and Answers

Q&A

Upcoming Events

- **Community Alliances Forum**
  - Location: Delhi Community Center, 505 E. Central Ave., Santa Ana
  - Topic: Enhancing the Aging Experience Together: The Orange County Strategic Plan for Aging
    - Wednesday, June 14, 9–11 a.m.
  - RSVP: Wilbur Sham, 657-900-1303, wsham@caloptima.org
- **Community Health Education Seminars**
  - Location: CalOptima Satellite Office
    - 15496 Magnolia Ave., Suite 111, Westminster
  - Topic: Long-Term Services and Supports for Seniors and People With Disabilities
    - June 9, 9–10 a.m. (English)
    - June 16, 9–10 a.m. (Spanish)
    - June 30, 11 a.m.–12 p.m. (Vietnamese)

Upcoming Events (Cont.)

- **CalOptima CME Workshop**
  - Location: DoubleTree Hotel, Orange
  - Topic: Diabetes Update 2017
    - Wednesday, June 28, 6:30–8:30 p.m.
  - RSVP: Ashley Young, 714-246-8690 or continuingeducation@caloptima.org

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner


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Medi-Cal
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OneCare (HMO SNP)
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OneCare Connect
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PACE
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