Safety Net Clinic Coalition Medical Directors

Thursday, January 13, 2022
12 PM - 2 PM

@hip_scc

Health Improvement Partnership of Santa Cruz County


HEALTH IMPROVEMENT PARTNERSHIP of SANTA CRUZ COUNTY
SAFETY NET CLINIC COALITION MEETING
common themes
WOW!
Salud
Encompass
Dientes @ SCCH
NOW 2023
HOW
Headlines...
"Salud is our community healthcare provider!"
Stories Create the Future
Engaging ppl. EARLY and in SCHOOLS
Grow Our Own
Diversity
Foster Development
Provider-Vision
Building an Org'n
Upstream Focus
Serve
Premier Provider
Featured in Health Affairs Journal
Shifting burden of svcs. from the client to the system
"Health starts in our families schools neighborhoods"
Integrated services so that No Community Needs go unmet
Be the BEST trauma-informed system
Multiple Shared Svcs & Spaces
3.6 acre CAMPUS!
Our Goal is: Culturally Responsive Justice
Responding to Comm'y Needs
Economic Development
200 NEW JOBS!
Case Mgt... from Cradle to Career
Building is adapted for future Health Crises.
Warm and welcoming
Beautiful outdoor Plaza
Clinic opened in 2022
Housing open 2023
Story Excerpts & Themes
Thursday, Jan 21, 2021
Facilitated by Maritza Lara and Vicki Amon-Higa
w/ graphic Recording by Leslie Salmon-Zhu
(P1 of 2)

SNCC asks...

In your role, what is one goal you would like to advance this year?

Meeting Agenda

- Welcome & Introductions
- Partner Announcements
- CalAIM Enhanced Care Management & Community Support Services
- 2022 Care-Based Incentive (CBI) Program Updates
- Stretch Break
- CBI Quality Measure Presentations & Discussion

Planning Committee

Maritza Lara
Population Health Director

Jen Hastings
Physician Consultant

Amy Mancia
Senior Population Health Program Coordinator

Laura Wishart
Population Health Program Coordinator

Priscila Bacio
Population Health Program Assistant

New HIP Members!

Welcome

Hayley Mears
Workforce Development Program Manager

Welcome

Gustavo Indarose
Population Health Program Coordinator

Welcome

María Estela Jerezano
Population Health Program Assistant

Welcome

Mason Flanagan
Population Health Program Assistant

Welcome new SNCC members & guests!

CommonSpirit

CCAH Santa Cruz Collaboration

January 13, 2022

CommonSpirit™

High Priority Focus Areas & Metrics - Opportunities

- ED Utilization
- Readmissions

Who Are These Patients – Where Do They Live?

Medical Group	Number of Attributed Lives
Santa Cruz Community Health	10,764
Salud Para La Gente	12,546
Santa Cruz County Clinics	11,655
Dignity Health	4,682
Total	39,647

What I’ve learned

Great things happen “sometimes”

HIE is a key in this market

Communication is sometimes difficult across the continuum

MAT program with the County Clinics is a strong connection and maybe something to build upon

In general the readmission rates in this market are pretty good

Transitions of Care as a focus

- What do we have in place today?
- What are the gaps?
- How do we standardize this process better

Partner Announcements

Please send any materials you would like to share to Amy Mancia at amy@hipscc.org

Enhanced Care Management & Community Support Services

Dale Bishop, MD
Chief Medical Officer

ECM and Community Support Services

AGENDA:

1. Background CalAIM
2. Enhanced Care Management
3. Community Support Services
4. Summary

WHAT IS **Cal-AIM?**

A multi-year set of proposals to improve the quality of life and health outcomes for people with Medi-Cal, from birth to end of life, guided by key principles.

- *Improve member experience*
- *Deliver person-centered care*
- *Align funding, data reporting, quality and infrastructure*
- *Data-driven population health management strategy*
- *Identify and mitigate social determinants of health and reduce disparities or inequities*
- *Transform system: value and outcomes*
- *Eliminate or reduce variation and recognize local innovation*
- *Support community activation and engagement*
- *Reduce administrative burden to improve plan/provider experience*
- *Reduce per-capita cost through system transformation*

CalAIM: ENHANCED CARE MANAGEMENT AND COMMUNITY SUPPORTS

- Key feature is the addition of an Enhanced Care Management (ECM) benefit.
- Allows MCPs to offer Community Support services which can serve as cost-effective alternatives to covered Medi-Cal covered services.
- Medi-Cal Managed Care Plans (MCPs) will be responsible for administering both ECM and Community Support services (CS).
- Financial support for the programs including payments for ECM and incentives for infrastructure development are being developed by DHCS.

ECM IMPLEMENTATION

Enhanced Care Management is a Medi-Cal ***benefit*** as of January 1, 2022.

ECM is available to high need members in 7 defined populations of focus and addresses clinical and non-clinical needs through in-person, community based care management.

The Alliance will hold contracts with ECM providers who will deliver services to members.

Population of Focus	Implementation Date
Individual and Families Experiencing Homelessness	January 1, 2022 (SC/MTY) July 1, 2022 (Merced)
Adult High Utilizers	
Adults with SMI/SUD	
Incarcerated and Transitioning to Community	January 2023
At-Risk for Institutionalization and Eligible for LTC	
Nursing Facility Residents Transitioning to the Community	
Children and Youth	July 2023

ECM GOALS

- Improving care coordination
- Integrating services
- Facilitating community resources
- Improving health outcomes
- Addressing social determinants of health
- Decreasing inappropriate medical utilization

ECM CORE SERVICES

1. Outreach
2. Comprehensive Assessment and Care Management Plan
3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Supports
7. Coordination of and Referral to Community and Support Services

COMMUNITY SUPPORT SERVICES OVERVIEW

- According to Federal Medicaid program rules, Community Supports services (CS) are medically appropriate and cost-effective alternatives to services that can be covered if:
  - ✔ Services are focused on medical/social determinants of health as a substitute for, or to avoid, hospital/nursing facility admissions, discharge delays, and avoidable emergency department use.
  - ✔ Each service will have defined eligible populations, code sets, potential providers, restrictions, and limitations.
  - ✔ Services are optional for the managed care plan to provide.
  - ✔ Plans will not receive reimbursement for CS.

COMMUNITY SUPPORTS **IMPLEMENTATION**

Community Supports Available Services	Preliminary Go Live Target
Housing Transition and Navigation	Jan. 2022
Housing Deposits	Jan. 2022
Housing Tenancy and Sustaining Services	Jan. 2022
Sobering Centers (Monterey)	Jan. 2022
Medically Tailored Meals/Meals	Jan. 2022
Recuperative Care	July 2022
Short Term Post Hospitalization Housing	July 2022
Respite Services	TBD
Day Habilitation Services	TBD
Nursing Facility to RCFE/ARF	TBD
Community Transition Services/ Nursing Home to Home	TBD
Personal Care and Homemaker Services	TBD
Environmental Accessibility	TBD
Asthma Remediation	TBD

Previously called *In Lieu of Services or ILOS*, are not benefits, but are *services* plans *may* offer as of January 1, 2022 *in lieu of* a benefit and, if accepted by the member.

The Alliance will phase in CS based on populations of focus and, as is financially feasible.

The Alliance will contract with CS providers to provide relevant services, and may add additional CS on a periodic bases for the duration of the CalAIM initiative.

SUMMARY

A significant effort is underway to establish a new Enhanced Care Management (ECM) benefit and to offer selected Community Support (CS) services under the new California Advancing and Innovating Medi-Cal (CalAIM initiative) with the goal to improve the quality of life and result in equitable health outcomes for Alliance members.

Questions?

TIMELINE FOR ECM AND CS

ECM and Community Support Services - Go-Live Timeline			
ECM Population of Focus	**Santa Cruz County**	**Monterey County**	**Merced County**
1. Individuals and Families experiencing Homelessness	January 1, 2022	January 1, 2022	July 1, 2022
2. Adult High Utilizers	January 1, 2022	January 1, 2022	July 1, 2022
3. Adults with Serious Mental Illness SMI/Substance Use Disorder (SUD)	January 1, 2022	January 1, 2022	July 1, 2022
4. Incarcerated and Transitioning to the Community	January 1, 2023	January 1, 2023	January 1, 2023
5. At Risk for Institutionalization and Eligible for LTC	January 1, 2023	January 1, 2023	January 1, 2023
6. Nursing Facility Residents Transitioning to the Community	January 1, 2023	January 1, 2023	January 1, 2023
7. Children/Youth Populations of Focus	July 1, 2023	July 1, 2023	July 1, 2023
Community Supports	**Santa Cruz County**	**Monterey County**	**Merced County**
1. Housing Transition Navigation Services	January 1, 2022	January 1, 2022	
2. Housing Deposits	January 1, 2022	January 1, 2022	
3. Housing Tenancy and Sustaining Services	January 1, 2022	January 1, 2022	
4. Medically Tailored Meals	January 1, 2022	January 1, 2022	January 1, 2022
5. Sobering Centers		January 1, 2022	
6. Recuperative Care	July 1, 2022	July 1, 2022	July 1, 2022
7. Short-Term Post Hospitalization Housing (Note: Go-live change from 1/1/2023)	July 1, 2022	July 1, 2022	July 1, 2022

DESIGN AND IMPLEMENT ECM AND CS LIFECYCLE

Two project subgroups:

Whole Person Care (WPC) Pilot Transition to ECM/CS.

- Meets biweekly with WPC County leadership.
- Member Transition List preparation.
- Co-Branding of Member Notice of the Transition.
- Warm hand off contingency.

Design and Implement ECM and CS Lifecycle

- Design pathways to assure that the seven core clinical services of ECM and the activities assigned for CS can be tracked to completion and evaluated on outcomes for members.
- Includes interface with the data/systems project around assuring that business requirements are identified accurately for system configuration.
- Work flows are being reviewed to assure alignment with business requirements as additional information is received from DHCS and further development of care coordination platform is designed.
- Additional work is underway to further refine member assignment and align understanding across departments.

PROVIDER NETWORK DEVELOPMENT

Developing contract templates, credentialing pathways, and appropriate policies and procedures which will support contracting with ECM and CS entities

- Approved by DHCS in early October.
- Finalizing payment language.
- Preparing to send contracts out in late October for review and execution by interested and qualified entities.
- As of October 12, 2021, 32 organizations have expressed interest in the provision of ECM or CS services.

Alliance sent detailed questionnaires to potential ECM and CS entities

- In the process of reviewing submissions.
- Determining which organizations are ready to proceed towards a January start date.
- Current efforts focused on ensuring ECM capacity in Santa Cruz and Monterey and CS capacity needed for the WPC transition.
- Subsequent efforts in 2022 and beyond will ensure that capacity and contracted organizations expand to support all future eligible populations of focus.

DATA SUPPORTS AND SHARING

- Operationalizing system readiness and integrating with new applications to support closed loop referral and seamless care coordination around Community Based-Organizations (CBOs).
- Providing access to member-specific data to support care teams in providing person-centric care.
- Procuring necessary social referral and care coordination platforms across our service areas.
- Assessing available data sources of social determinants of health (SDOH).
- Acquiring and integrating SDOH into the Alliance data repository to support robust member and population health management.

ECM AND CS INCENTIVE PROJECT TEAM

- Planning new investments in:
  - Care Management capabilities
  - ECM and community supports infrastructure
  - Information technology and data exchange
  - Workforce capacity
- DHCS will make incentive payments over three program years from January 2022 through June 2024.
  - The Alliance will submit an incentive plan to DHCS in December 2021 comprised of:
    - Measures and Reporting Plan.
    - Gap Filling Plan, which outlines measures and activities by county for program year one (2022).
    - The first 50% payment would be received in February 2022 based on plan approval.
    - The second 50% payment would be received in December 2022 based on progress reporting.
    - Staff are awaiting the final incentive amount determination from DHCS, currently estimated at $21.66M total for the Alliance's three counties for program year one.
    - The incentive amount is based on a calculation of 50/50 blend for enrollment and revenue and a 15% increase to non-WPC/HHP county (Merced County).
- Staff are currently:
  - Conducting a gap analysis for the Alliance and the ECM/CS provider network
  - Drafting the incentive plan in three priority areas:
    - Delivery System Infrastructure
    - ECM Provider Capacity Building
    - ILOS Provider Capacity Building & MCP Take-Up

2022 Care-Based Incentive

Kristen Rohlf, MPH
Quality Improvement Program Advisor IV

2022
CARE-BASED
INCENTIVE

Provider Incentives

AGENDA:

1. CBI Program Measures
2. New Measures
3. Modified Measure
4. Exploratory Measures
5. Retired Measures

Measure Type	Measure
Care Coordination Access	Application of Dental Fluoride Varnish
	Developmental Screening in the First Three Years
	Initial Health Assessment
	Post-Discharge Care
	Unhealthy Alcohol Use in Adolescents and Adults
Care Coordination Hospital & Outpatient	Ambulatory Care Sensitive Admissions
	Plan All-Cause Readmissions
	Preventable Emergency Visits
Quality of Care	Asthma Medication Ratio
	BMI Assessment: Children & Adolescents
	Breast Cancer Screening
	Cervical Cancer Screening
	Child and Adolescent Well-Care Visits
	Screening for Depression and Follow-up Plan
	Diabetic HbA1c Poor Control >9.0%

Measure Type	Measure
Quality of Care Continued	Immunization: Adolescents (Combo 2)
	Immunizations: Children (Combo 10)
	Well-Child Visits First 15 months of Life
Performance Target	Performance Improvement
	Member Reassignment Threshold
Fee-For-Service	Behavioral Health Integration
	Patient Centered Medical Home (PCMH) Recognition
Exploratory	90-Day Referral Completion
	Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents
	Chlamydia Screening in Women
	Controlling High Blood Pressure
	Health Plan Health Disparity
	Immunization: Adults
	Lead Screening in Children
	Tuberculosis (TB) Risk Assessment

NEW MEASURES

Breast Cancer Screening

Measure

The percentage of women 50 – 74 years of age who had a mammogram to screen for breast cancer on or between October 1 two years prior to the measurement period and the end of the measurement period.

Eligible Codes:

- Mammogram – CPT: 77061, 77062, 77063 (TAR required if under 40), 77065, 77066, 77067.
- Bilateral Mastectomy – ICD-10: Z90.13.

Data Collection: Claims, DHCS FFS encounter data, Data Submission Tool (DST) for mastectomies and mammography.

NEW MEASURES

Screening for Depression and Follow-up Plan

Measure

Members aged 18 and older screened for depression on the date of the visit using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Eligible Codes:

- **G8431** – Screening for depression is documented as being positive and a follow-up plan is documented.
- **G8510** - Screening for depression is documented as negative, a follow-up plan is not required.

Data Collection: Claims.

MODIFIED MEASURES

Behavioral Health Integration

Measure

CBI Groups who have achieved the NCQA Distinction in Behavioral Health, after completion of the NCQA Patient Centered Medical Home (PCMH) recognition.

Required Achievement

- NCQA Distinction in Behavioral Health Integration.
- NCQA PCMH recognition.

Removes

- TJC PCMH Certification as a standalone qualifier.

Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents

Measure

Members 1 – 21 years of age who are screened for Adverse Childhood Experiences (ACEs) annually using a standardized screening tool.

Eligible Codes

- **G9919** – Screening performed – Providers must bill this HCPCS code when the member's ACE score is 4 or greater (high risk), results are positive.
- **G9920** - Screening performed – Providers must bill this HCPCS code when the member's ACE score is between 0 – 3 (lower risk), results are negative.

EXPLORATORY MEASURES

Health Plan Health Disparity Measure

Measure

Determine whether different ethnic groups had or did not have equal access to primary care, relative to our largest member population.

Metric

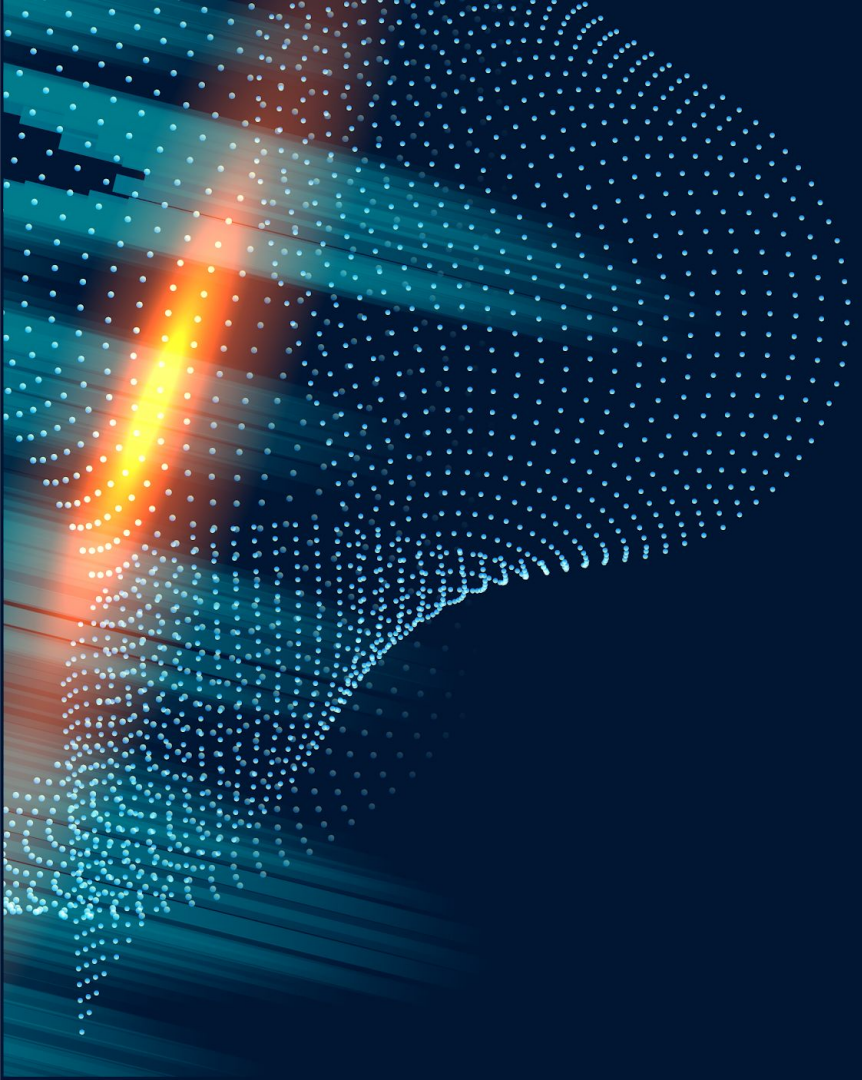
NCQA HEDIS Child and Adolescent Well-Care Visit.

Eligible Codes: CPT: 99382-99385, 99392-99395; ICD-10 Z00.00-Z00.01, Z00.121, Z00.129.

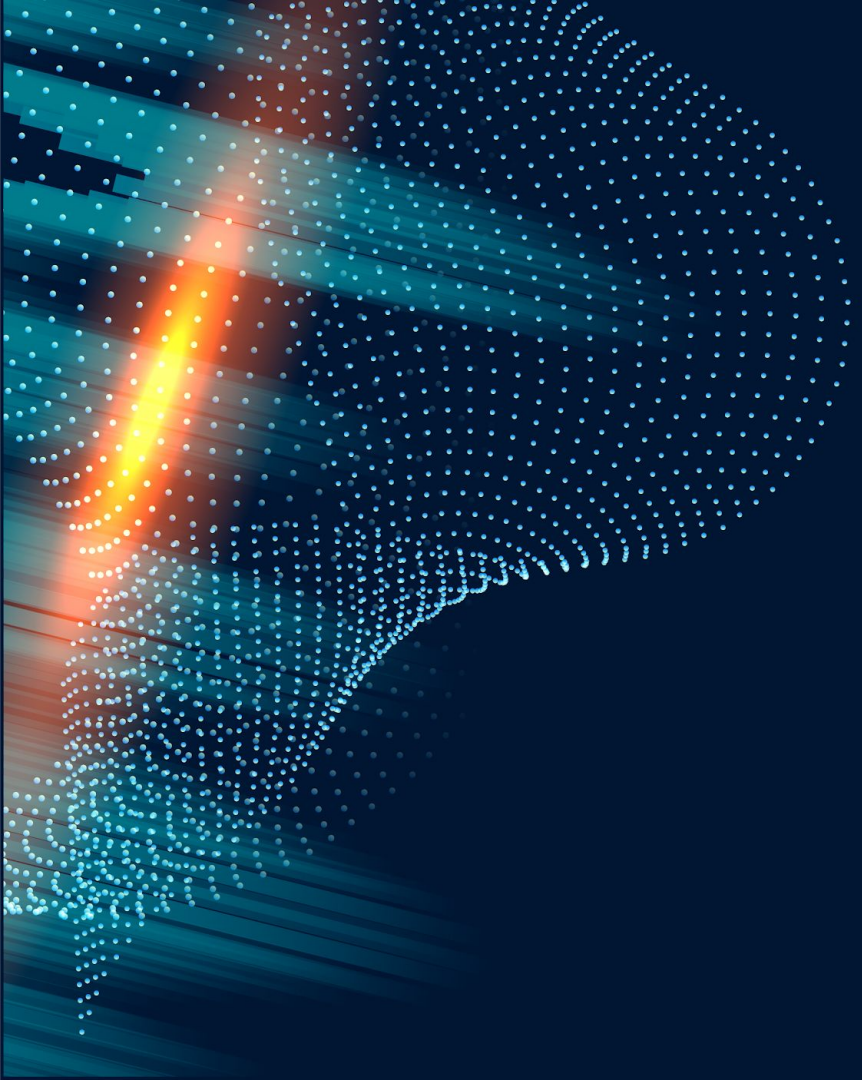
RETIRED MEASURES

- Maternity Care-Post Partum Visit.
- Maternity Care-Prenatal.
- Antidepressant Medication Management.
- X-License (Buprenorphine).

Questions?



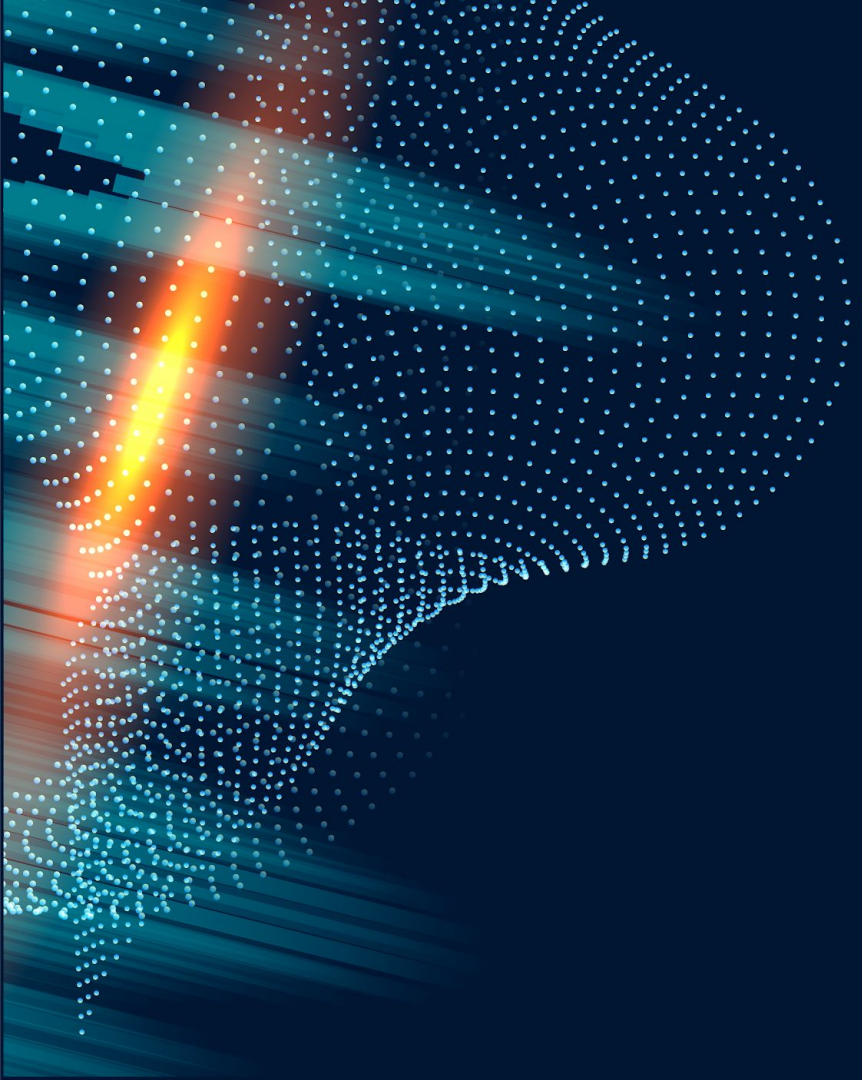
Stretch Break



CBI Quality Measure Presentations

Facilitated by:

Jen Hastings, MD
Physician Consultant
Health Improvement Partnership
of Santa Cruz County



Well Child Visits

Presented by:

Devon Francis, MD
Director of Pediatrics
Assistant Chief Medical Officer

Salud Para La Gente

Working Together for a Healthy Community

Preventable ED Visits

Presented by:

Casey KirkHart, DO
Chief Medical Officer

SANTA CRUZ COMMUNITY HEALTH

Diabetic HbA1c Poor Control >9%

Presented by:

Danielle Harik, DO
Staff Physician

Planned Parenthood Mar Monte

SNCC CBI MEASURE HBA1C

Danielle Harik, DO

Planned Parenthood Mar Monte

Jan 13, 2021

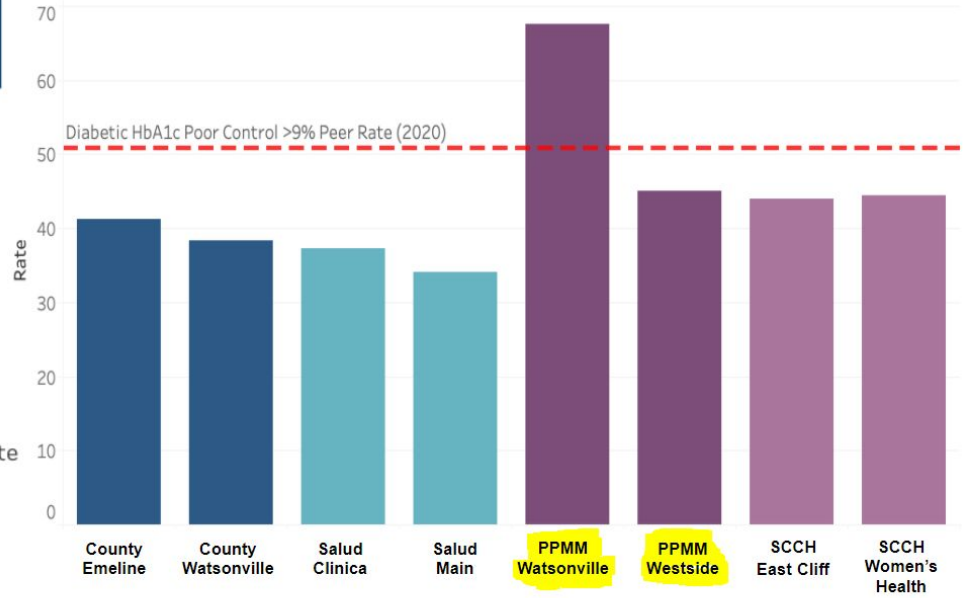
Objectives

- Review old data
- Discuss changes
- Review new data
- Current difficulties
- Next steps

SNCC CBI Data 2020

Diabetic HbA1c Poor Control >9% (2020)

The percentage of members eligible/members screened: **Lower is Better**



*New measure → previously Hba1c Good Control <8.0%

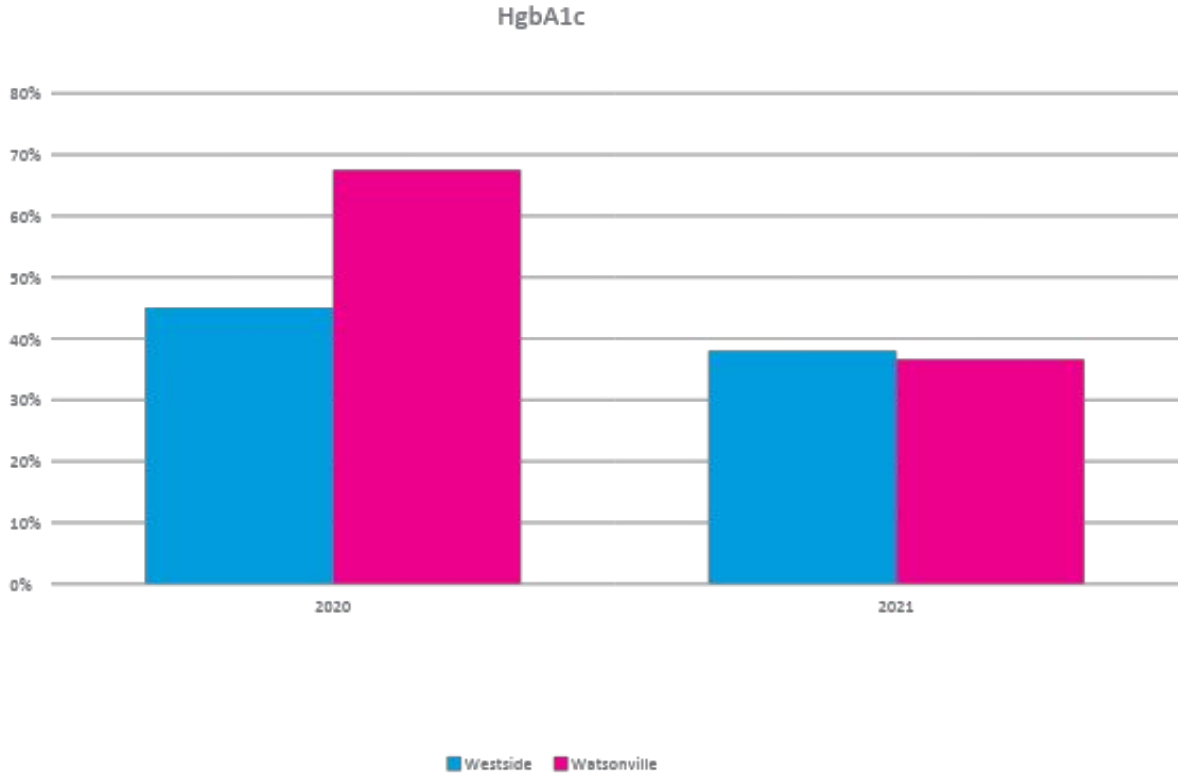
SNCC CBI Data 2020

- Percentage of people with A1c > 9%
- Age 18-75
- Diabetes mellitus type 1 or 2
- Excluded: GDM, dementia medications, advanced illness
- Watsonville: 67.5%
- Westside (Santa Cruz): 45%
- Goal: <50%

Changes

- Curbside testing
- Primary care outreach
  - Missed appointments
  - Overdue for labs
  - Overdue for DM follow up

2021 vs 2020 Data



2021 Data

- Data pulled from DRVS, not EMR
- Westside
  - 38% A1c > 9
  - 14% not within 3 months
  - 14% A1c < 6.5
- Watsonville
  - 36.67% A1c > 9
  - 20% not within 3 months
  - 16.67% A1c < 6.5

Difficulties

- Clinic hesitancy
- Transition in care teams
- Other clinic priorities
- Patients lost to follow up
- Physical location of the “curb”

Next steps

- Continue curbside testing
- Added other curbside services
  - Immunizations
  - Other labs
  - Vital signs
- Transition in care teams – new RN team
  - Outreach
  - Diabetic counseling

THANK YOU!


HIP
HEALTH IMPROVEMENT PARTNERSHIP of SANTA CRUZ COUNTY
SAFETY NET CLINIC COALITION MEETING
common themes
We/you are all Change Agents!
WOW!
Headlines...
"SALUD IS OUR COMM'S HEALTHCARE PROVIDER!"
Salud
Encompass
Dientes @ SCCH
ONE STOP ACCESS
CELEBRATE 50 yrs of BUILDING COMMUNITY Resilience
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MULTIPLE SHARED SVCS & SPACES
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200 NEW JOBS!
Case Mgt...from Cradle to Career
STORIES Create the FUTURE
"NOW" 2023
OUR STORIES FROM 2023
Focusing on care for whole family / community
engaging ppl.
Grow Our Own
EARLY and in SCHOOLS
HOW
FOSTER DEVELOP'T
DIVERSITY
PROVIDER VISION
the FUTURE
BUILDING an ORG'N
SO THAT... In College... pursuing educ. in Health Sciences, then work@Salud
We RECRUIT our healthcare providers who really REFLECT this COMMUNITY w/ a commitment to serve
engage our pts.
UPSTREAM FOCUS
A PHOENIX... Rising from the ashes
POST-COVID: Engaged COVID pts. in CARE
Premier Provider
Featured in HEALTH AFFAIRS JOURNAL
High quality
Shifting burden of svcs. from the clinic TO the system
"Adapted to meet the demands... to provide best quality svcs..."
"Health STARTS in our families schools neighborhoods"
The Main Door of all Community Needs
Be the BEST Trauma-informed system
Integrated services so that NO Community Needs go unmet
We have All
Responding to Comm'y Needs
dental
Comp. space
pharmacy
housing
pediatric
Optometry
psychiatry
changes in funding?
SOURCES of FUNDING
Collaboration
$10m + 6m = $16m
Significant fundraising campaign
Housing Expert Healthcare
The Building is adapted for future Health Crises.
Warm and welcoming
Beautiful outdoor Plaza
County Punch Agreement
CLINIC opened in 2022
HOUSING open 2023
STORY EXCERPTS & Themes
THURSDAY, Jan. 21, 2021
(P1 of 2)
Facilitated by Maritza Lara and Vicki Amon-Higa
w/ graphic recording by Leslie Salmon-Zhu

Discussion questions...

Can we intentionally design for equity?

How do we identify and then integrate demographic data gaps in our data collection?

How can we build in identifying and addressing health disparities?

Thank you for joining!

Please send any materials you would like to share to Amy Mancia at amy@hipscc.org

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Health Improvement Partnership of Santa Cruz County