Shasta Community Health Center – Redding, California

Dual RFI Response Summary

Improving Care through Integrated Medicare and Medi-Cal Delivery Models

Stakeholder Meeting
August 30, 2011

SHASTA COMMUNITY HEALTH CENTER

Organization Background

- Shasta CHC is a multi-specialty primary care practice and Federally Qualified Health Center with five sites in Shasta County, CA.
- Shasta CHC cares for 40,000 patients, 95% living below federal poverty lines. About a quarter of the pop. of Shasta County.
- There are about 8,000 dual eligibles in Shasta County; Shasta CHC has 3,500 of them in its practice.

Existing Problems this Proposal Addresses

- Our Medi-Medi patients are medically complex, often with underlying behavioral and social issues/needs that could be better addressed in a coordinated way.
- Our community has no private or public managed care plans to build/learn from.
- Our patients require more care coordination/case management than our primary care model can afford to provide right now.

Existing Problems this Proposal Addresses

- Our non-profit community providers/partners, like Adult Day Health Centers, are in distress but this program could help stabilize these community services and care for frail seniors.

- While we have excellent relationships with our two regional hospitals, care coordination between the ER, hospital inpatient services and our ambulatory setting could be greatly improved.

Overview: Proposed Integrated Care Plan

- Service Area/location: The I-5 corridor through Shasta County that includes the communities of Anderson, Redding and Shasta Lake City.

- January 2011 data shows the following Medi-Medi eligible pop. in Shasta County: (0-21) 40; (22-64) 4,344; (65 & up) 3,332.

- We propose to serve 3,500 Medi-Medi patients with a majority of those in the 22-64 grouping.

Overview: Proposed Integrated Care Plan

- Provider Network Basics: Shasta CHC employs over 30 primary care clinicians and contracts with 25 local/regional specialists to undertake clinics at its Redding location.

- Financial Structure (who is taking on the risk): With no real managed care experience, SCHC is proposing that funders take downside risk. Therefore we are proposing a FQHC FFS and Case Management capitation structure with some shared savings incentives.

Key Points: Proposed Integrated Care Model

- This would be a primary care case management model.
- SCHC is in the process of certifying itself as a Tier 3 Patient Centered Medical Home under NCQA over the next three years.
- All patients assigned a permanent primary care clinician or clinical team (e.g. MD/FNP/RN).

Key Points: Proposed Integrated Care Model

- A case manager would be assigned to each team to assist with coordination of care for Dual Eligible patients with special needs.

- Sub-contracts with community agencies (e.g. ADHC) would allow for patients to remain in their homes.

- Close coordination of the primary care teams and the hospital staff/programs will decrease unnecessary utilization of hospital services.

Specific Care Integration Challenges

- Mental & Behavioral Health Care: Shasta CHC has an integrated neuro-psychiatry and counseling program working with the primary care team. Some additional resources could be helpful in hiring 1-2 LCSWs/case managers for this population.
- Long Term Care: Our primary care clinical teams including our case managers would work closely with LTC providers and community agencies, perhaps using sub-contracts, to ensure appropriate and cost effective services.

Measures for Success

- Is there a measurable reduction in the use of inpatient services – i.e. bed days and costs?
- Is there a measurable reduction in the use of ER services – i.e. ER visits and costs?
- What level (FTEs or other measures) of case management is necessary to achieve a reduction in the use of inpatient/ER services?
- Are all stakeholders (hospitals, specialists, etc.) on board with the program?
- Note: To measure this requires a somewhat complicated data exchange to measure costs/outcomes.

Information Needed from CMS and the State

- What CMS/Medi-Cal utilization and cost data can be provided? Is this current? Can it be used to measure savings from one period to the other?

- The primary issue is access to information, hopefully on-line/help desk services that is responsive to inquiries and provides a fast turnaround time.

- Probably need technical assistance support in areas such as effective ER diversion and case management services for non-managed care communities.