Seeing Double?

Duplication of Care Coordination Services in Medi-Cal: Lessons from Whole Person Care

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Care Coordination Duplication

Overview

- Evidence of a complex system
- Case studies from Whole Person Care pilots (WPC)
- Early lessons
- How can DHCS help

Conclusion

- Fragmented systems, in terms of program requirements and billing, are a major driver of duplication and care coordination challenges
- Solutions are complex and will require a collaborative, multi-level framework that involves all stakeholders
- Solutions need to offer flexibility, align billing and program requirements, and be supported with data

Care Coordination Duplication

System perspective

- Multiple programs and financing streams
- Multiple care coordinators and/or case manager roles attempting to manage the same patients at different and/or overlapping points in time

Patient perspective

- Confusion when different care coordinators and/or case managers reach out without knowing about the other pieces – leads to negative patient experience

System Perspective: Fragmentation

Health Plan contracts require plans to coordinate with at least 16 other Medi-Cal services

- Targeted Case Management (TCM)
- Specialty MH
- SUD
- CSHN
- CCS
- DD
- Early intervention services
- LEAs
- School-linked CHDP services
- HIV/AIDS
- Dental
-
- Direct observed therapy for TB
- WIC
- LTC
- Organ Transplants
- HBCS waiver programs

Source: Two-plan model boilerplate contract, Exhibit A, Attachment 11

System Perspective: County Services

One county identified 22 different care coordinator or care/case manager roles that serve Medi-Cal beneficiaries

- County Social Services
  - Medi-Cal
  - APS
  - CPS
  - HIS
- CCS
- Office on Aging
- Medical Center
  - SW
  - RN CM
- FQHCs
  - SW
  - RN CM
  - Care Coordinators
  - CHWs
- Department of Behavioral Health
  - SUD Support
  - Peer Support
  - Transitional Age Youth
  - Elder Clients
- Coordinated Entry System for Homeless
- Community Housing/Shelter
- Economic Development Agency/Housing Authority CM
- Detention Health
  - Physical Health CM
  - Behavioral Health Personnel
- Probation Officers

Whole Person Care

- Address the fragmentation, multitude of care coordinators/case managers

- Examples of WPC activities
  - Care coordination mapping
  - Creation of a single care plan
  - Data sharing
  - Hiring people to do individual outreach (Community Health Workers)
  - Collaborative planning

- Case examples: Contra Costa and San Mateo

WPC Case Study #1: Organizing Care Coordination (Contra Costa)

- Mapping exercise
  - 22+ individual roles providing care coordination services
  - 3-4 meetings to map out duties and responsibilities
- Not a lot of duplication, but differences in length of time services provided
  - Lots of short term/crisis intervention (90 days max)
  - WPC is providing long-term coordination (1 year)
- Difference in approaches
  - Medical model (plan) vs. addressing more social determinants (WPC)
  - WPC is providing mental health, SUD, homeless specialists
- A lot of effort (1:1 conversations) required to increase capacity across all programs
  - All of the existing capacity was needed, but it needed to be better coordinated, streamlined

WPC Case Study #1: Contra Costa (cont.)

- Data integration is critical
  - EHR integrates hospitals/clinic, behavioral health, detention, public health, health plan, housing on EPIC, with additional view-only or other arrangements as the partnerships extend out in the community
  - Everyone can see who the care team is, and how to contact the case manager

- Clarity with plan on who has which patients
  - Plan had some similar complex-care capabilities, but shorter term (max 90 days) and less capacity
  - Contra Costa Health Plan (CCHP) manages about 500 patients
  - WPC manages about 14,400 patients
  - A significant number of WPC patients are not in CCHP at all: they are FFS duals (Contra Costa is not a CCI county).

WPC Case Study #2:
Coordination between the county and plan (San Mateo)

- Coordination with the plan
  - Attends complex case conferences
  - Hired WPC Manager, Nurse Case Manager
  - Provides underlying support for care coordination that occurs through the WPC care teams

- Plan supports for WPC teams
  - Telephonic outreach
  - Client service use, claims data, eligibility data
  - Contract for intensive services for complex clients (5+ chronic conditions)
  - Advocate for access to specific services to be included at service sites (e.g., Vivitrol in a FQHC)

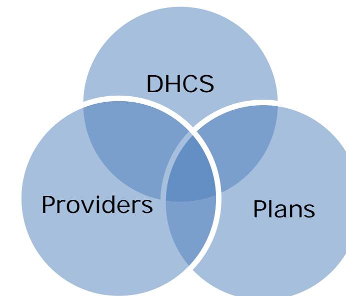
- County preparing for a 6-week LEAN (performance improvement process) body of work on shared care plans

Early Lessons

- Critical to have a single care coordinator, and for long duration
  - Multiple case managers many still be appropriate; some duplication may exist, but it's also about coordination. Need to stop passing the baton, and instead offer sustained coordination.
- Complex care coordination happens best when closest to the patient with a trusted individual
  - Plan has strengths to bring to the table vis-à-vis the care team, esp. with data
- Flexibility is key
  - Flexibility in WPC (both in funding and in what could be covered) allowed counties to provide what was needed
  - Contrast with TCM, where roles and services are very clearly defined, but the rigidity makes it hard to administer, creates audit fears
- Work is happening because there is funding
- Data, data, data
  - Need to define what the data is for, how it is being used

Where can DHCS help?

- Flexibility: what is best for the patient?
  - Encourage crossing of boundaries
  - Ensure payment and rules allow for creative solutions
  - Monitor and measure care coordination in ways that are streamlined and minimize reporting burden
- Ensure new frameworks are collaborative and multi-level
  - State ⟷ Plans
  - Plans ⟷ Provider



Where can DHCS help, cont.?

- How we do coordination and how we pay for coordination are not separate issues; solutions must look at the issues together, create alignment
- Data
  - Invest in care management systems and/or platforms for data sharing
  - Provide guidance and continued support on privacy and data sharing
- Provide robust rollout and messaging support

Questions

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