L.A. COUNTY COORDINATED CARE INITIATIVE (CCI)
Stakeholder Workgroup
Meeting Minutes

July 15, 2015; 1-3p.m.
The California Endowment
1000 Alameda Street, Los Angeles, CA 90012
CHC Yosemite B-LA (Multi-Purpose Room)
Web Conference:
Go to: https://molina.webex.com/molina/j.php?J=804614248
Telephone Dial-In: Call 855-665-4629

TIME	TOPIC	PRESENTER
	Attachments:	

1:00 – 1:15 p.m.	**Welcome & Introductions**
	• Approval of April 15, 2015 Meeting Minutes
	  • No corrections to minutes
	  • Minutes approved by committee
		James Novello
		Chief Operations Officer
		Molina Healthcare of California

1:15 – 1:30 p.m.	**LTC Report: California Community Transitions (Money Follows the Person)**
	• **Purpose of CCT**
	  o CCT developed because of the Olmstead Decision. People should have the opportunity to live in their communities, not facilities.
	  o Rebalance Medi-Cal spending (previously 45% of spending was on facility care).
	• **History of CCT**
	  o The Olmstead Decision took place in 1999 and then CMS released the Money Follows the Person Demonstration Grant (MFP). California used the MFP grant to develop and implement the CCT program.
	  o The CCT program will continue through 2016 with the ACA extension of the grant.
	  o There were approximately 500 transitions last year. To date, 2,307 people have been transitioned out of facilities and into the community setting of their choice.
	• **Guiding principles:**
	  o Everyone has the right to Self-determination, independence, and choice.
	  o Ensure consumers have the full range of services necessary to live in their community when such services are appropriate.
	• **Eligibility criteria for CCT:**
	  o CCT can be utilized by people of any age
	  o To qualify individuals must have Medi-Cal for at least one day, be in a SNF for at least 90 days, and still need the same level of care as they did while in the facility they're transitioning out of.
	• **Process - Lead Organizations**
	  o Transition coordinator goes to facilities for pre- transition preparations. They secure money for first and last month's rent,
		Rebecca Malberg von Loewenfeldt
		Director of HCBS Integration
		Harbage Consulting

	furniture, transitional personal care before IHSS is in place, vehicle modifications and more. o With the implantation of CCI, now CCT can coordinate with the consumer's health plan. This allows for ongoing case management by coordinator after the transition o The coordinator also connects consumers with resources, including help with employment resources. • **CCT goals** o Focus on the "Whole Person Approach" and identify early risk. o CCT aims to coordinate with Health Plan and be involved in member ICTs. o Primary care and specialty care should be set up before the transition happens to allow for a smoother transition. o The Health Plan connecting with local lead organization to help get their members to get CCT assistance. • **Future of CCT:** o Ensure that services and supports are in place so that the consumer doesn't end up back in a facility. • **Q & A Session** **Question:** Ashlee - How is this part of the Medicaid waiver? • **Answer:** Rebecca - I can't answer this but will take the question back to the State • **Answer:** Pam @ Care first - Has successful CCT referrals and transitions and mentions differences with CMC and Medi-Cal process. **Question:** Denny - Q: what kind of communication and infrastructure is in place for the Health Plan and the Transitions coordinator? • **Answer:** Rebecca – this is a better question for the plans. • **Answer:** Pam: Note there have been many successful transitions. Mentions several of the providers who are involved. It's a work in progress and it's a lot of communication. • Rebecca – It's important to remember that front end communication **Question:** Lisa Hayes- How long for waiver, does it sunset in 2015? • **Answer:** The grant was extended and will continue through the end of 2016. **Comment:** Lisa states consumers can be in CCT & a CMC health plan. • Pam M. notes cannot have CCT & the assisted living waiver while with a CMC plan.	
1:30 - 1:50 p.m.	**IHSS and Health Plan Coordination** How ICT's with DPSS & Health Plans work together to help members • Terrance Henson speaks about IHSS and Health Plan Coordination. He will talk about what he does and how the program helps improve lives of consumers. • IHSS: o There was preparation before CCI took effect including ensuring that the social model of IHSS stays intact. This means the consumer stays in charge as the employer of their provider and	Terrance Henson, Manager LTSS *Molina Healthcare of California* Marla Pearson, HSAI, LA DPSS Phyllis Crawford, SW LA DPSS

the focus remains on person centered care.

- Terrance notes the county is still in charge of eligibility and hours determination
- **Health Plan Collaboration:**
  - LA Care leads a workgroup for collaboration. This allows for open communication between Health Plans.
  - Health plans have contacts within IHSS to assist members quickly.
- **Liaison process**
  - Streamlined communication with a central point of contact, making it easier to get an IHSS representative present at an ICT meeting.
- **Expedited referrals**
  - Health plans work together with IHSS and this makes it possible to get services to members faster who are need of services. Health assessments are done while the member is still in the facility so this works well with CCT. It allows for IHSS to be set up before the member transitions back into the community.
- **Data Sharing**
  - We receive state data that includes the number of hours, the types of services they receive, and when next reassessment is due are communicated. Helps us to understand how we can best serve our members.
- **Care Coordination** – This is what we do on a day to day basis. There is a streamlined process for IHSS referrals and these can come directly for the health plan. To do this the health plan submits a request on behalf of the member to the intake unit at IHSS. Following that, the Health Plan can help the member complete the Health Certification Form. Open communication between all parties involved is key.
  - **Redetermination of hours** – If the member's health status changes, their health plan can request reassessment for more IHSS hours.
  - **Member updates -** IHSS needs to have up to date contact information, and be advised of hospitalizations/SNF care. Open communication gets this information to all the relevant parties to allow for better coordination.
  - **Caregiver assistance** – Health plan can refer them help them connect with an appropriate caregiver. Health Plans can help work with caregiver to solve issues that may arise, such as lost timecards.
- **Interdisciplinary Care Teams (ICT)**
  - It's a person Centered Model of care. A care plan is developed with a case manager and they're member and is based on the most important health goals that the member wants to reach. Then the case manager brings that information to the ICT and everyone works together to help them achieve those goals. ICTs have medical directors, pharmacists, social workers, nurses, and the IHSS Social Workers. Other such as LTSS social workers, caregivers can be at the ICT, but only with the member's discretion.
  - Most importantly the member can be a part of their ICT.
  - Formal ICTs take place on a regular basis and Ad Hoc ICTs occur when a need arises.

Meeting interrupted to evacuate the space due to a strong natural gas odor. Meeting attendees are moved to a nearby conference room and then the meeting continues.

Terrance continues:

- Terrance tells member stories - See slides
  - **Success story 1:** Member is a 70 year old male Cal MediConnect member who had Diabetes. The member was authorized for IHSS in November of 2014 for 85.5 hours per month. Related to the diabetes, the member had his left foot amputated in February of this year. After the surgery, the member was presented in ICT in with IHSS present. During the ICT, IHSS was notified of the amputation as they were not aware of this change in his condition. IHSS conducted a reassessment based on the significant change. The member was awarded additional hours for ambulation, bathing and transportation to medical appointments.
  - **Success Story 2:** 42 year old female who developed gangrene in both of her hands and was at risk for amputation. The member was unable to use her hands and required assistance with all ADL's and IADL's. The member could no longer care for herself or her family. Molina LTSS Liaison worked with IHSS to expedite an IHSS referral. CM gathered signatures for the Health Certification Form. IHSS assessed the member and approved her case. Assessment was completed within 14 days from the start of application.
  - **Success Story 3:** Husband and wife, 82 year old female and 85 year old male Cal MediConnect members. Molina CM noticed the wife's cognitive ability was deteriorating related to a Dementia diagnosis. The wife already had IHSS and needed additional services. CM and Molina LTSS Liaison worked with IHSS and member to establish Protective Supervision. The members number of approved hours changed from 51 hours to 283 (the IHSS max amount).
    The husband was denied services the year before, however, due to decreased functional ability, the CM and Molina Liaison worked with the member to re-apply and submit the SOC 873, Health Certification Form. Member was approved for 29 hours per month. Molina CM also made MSSP referrals for both members and they are now enrolled in the program.
- These aren't special cases; this is what we do on a day to day basis.

Marla Pearson Speaks

- Marla tell us she's going to give an overview how IHSS and health plan care coordinators work together at ICTs.
- ICT is a group of professionals brought together along with DPSS involvement when it's determined that there is a need for care coordination. DPSS works with all five CMC Health plans in LA County.
- When it's determined the ICT is needed the plan contacts the ICT liaison. The appropriate people are contacted at DPSS in order to gather necessary information about the member.
- The ICT takes place and then the DPSS representative takes that information back to the case social work. The social worker then does a new assessment and most of the time hours are increased. Very rarely are hours decreased, but that only takes place DPSS learns that there are other services in place for that member, thus decreasing the need for the same amount of hours.
- The outcome is reported to the Liaison

- Requests for ICTs are on the rise – these started in January 2015. 247 ICTs have taken place, in 34 cases the hours have been increased and in only 3 cases have hours been decreased.

Marla notes that Phyllis will now speak and that she is one of the social workers present during the ICTs.

- **Phyllis Crawford** Speaks - At ICTs DPSS learns more because of ICTs. Normally they only see the client once a year and the client could need of more hours before their next annual assessment. Health plans can notify us about the need for reassessment prior to next annual assessment. Otherwise we wouldn't have known about it. It's beneficial for all when DPSS works with the health plans.

Q&A Session:

Question: Stephanie Lee with CMC Ombudsman – were additional staff hired prior to CCI implementation? Were there existing staff put in place as Liaisons or did you hire new people? What kind of ongoing evaluations are happening to assess how this ICT process with the health plans is going?

Answer: Marla– We are hiring new staff to meet the needs. The health plans have a list of Regional Liaisons to contact when there's an issue.

Comment: Pam M. – ICTs have been very positive experiences. She has received quick turn-around times with few issues. There's a lot of communication between the health plan and IHSS social workers

Question: Denny – References the chart displayed and asks if the data represents each individual request or if it represents individual people with multiple requests– If the same person has two requests for reassessment, are they counted once or twice in this data?

Answer: Marla – We count these manually and do not have a way of identifying whether or not it's the same individual. It's really the number of requests we receive.

Question: Denny - Do you have a sense of how many IHSS consumers are enrolled in CMC.

Answer: DHCS has not shared that with DPSS.

Question: David from CMC Ombudsman - Does your office contact HP when there's a consumer issue

Answer: Marla - Does not have data in order to do this. The consumer has to contact the health plan or DPSS.

Question: Dulce from PASC peers - As a consumer, what can be done for traveling when my provider can't join me? Can you find me a provider in another state?

Answer: Marla- IHSS does not hire providers but can offer resources and referrals for out of state travel. IHSS will pay while you're on vacation for a limited amount of time.

	Question: Jennifer S. from Alzheimer's association: What about people with cognitive disabilities? Do your systems identify family members or informal caregivers who are providing IHSS services, and if that information is communicated to health plan? **Answer:** Marla - When the initial assessment is done at home, usually a family member will be present as the authorized representative for a person with cognitive disabilities (or a guardian or conservator). Health plans are notified of guardians and conservators by data provided by the state. **Question**: Stakeholder - What is the typical timeframe from the initial request for ICT and what the determination outcome. **Answer-** Sonia Perez – Within two weeks determinations will be made from the time of the ICT. **Comment:** Terrance from Molina – To clarify: State data provided to the health plan is limited on the conservator information provided to the health plan. We're not told whether it's a parent, sibling etc. - just that there is a conservator or guardian for that member.	
2:40p.m.	**Panel Discussion – LA PASC Peers:** **Lisa Hayes speaks:** The focus of the meeting today is on IHSS and all things around IHSS. There is high % of opt out rates for CMC. We have an opportunity to talk to PASC peers who communicate with other IHSS consumers. We did this at our internal meetings. Feedback was so insightful we thought that the entire group should hear what they have to say. Introduces Panel from PASC Peers and invites them to the panel table: Randi Bardeaux Jorge Chuc Ducle Garcia Bertha Poole Emphasizes how important this discussion is for health plans to hear. **1. Why opt out? What are the issues IHSS consumers are saying?** • **Randy Bardeaux -** Approximately 190,000 IHSS consumers in LA County and 68 % are seniors. When we started having discussion groups with the IHSS consumers, the first response we got from the seniors was an earnest "NO. We don't trust the government". As we told them what the concept was – to coordinate all of their health care, and to get a coordination team they were interested in the concept. Once the program got underway, we found that the concept wasn't followed up on and that the care coordination was not complete. Consumers complaining that prescriptions weren't followed through during the transition, procedures started weren't carried on in a timely manner; they are experiencing lengthier wait times to get in to see a provider. From the beginning many did not want to changes their doctor and knew that with CMC they may lose	**Moderator:** **Lisa Hayes,** Director Disability & Senior Access *Molina Healthcare of California* **PASC Panelists:** 1) Randi Bardeaux 2) Jorge Chuc 3) Dulce Garcia 4) Bertha Poole

the doctor that they liked. We had some other concerns that are continuing. When a CMC doctor feels that a IHSS recipient could benefit form more hours, they aren't getting those hours. It's really a thrill to see the success stories up on the slides, but I'm hearing the people who are complaining about the program. The biggest problem is the smooth integration between Medicare and Medi-Cal processes for CMC enrollees.

- **Jorge Chuc-** You're not doing good enough outreach, things were not clear in the beginning. Transportation is a big issue. A consumer changed plans because of the transportation and access issues with medication. This message is circulating and IHSS consumers who are about to turn 65 are hearing that and saying no I'm not going to enroll in [the CMC] program.

- **Bertha Poole –** My experience with those who opt-out of CMC is fear of the unknown. Many IHSS consumers are struggling with their caregiver. That one of the biggest issues – a cg in times in times of emergency or having caregivers in the hospital. When they go into a facility. Say the consumer is in the hospital, so many of them wind up with caregivers coming to help met their needs without pay while the consumer is in the facility. This is an imposition on both consumer and provider, there's stress and discomfort for the provider and the provider works without pay. If there was a way for the provider for to be paid, even for fewer hours, so those needs could still be met while the consumer. This would be an enormous burden lifted. Another area is in cases of emergency. PASC has a backup program for urgent care, should you find out that you'll be without a provider and you have time to prepare. This is not for an emergency; there is no backup system unless you have one of your own. Many people don't live with their providers, if something were to happen in an emergency where their provider was incapacitated or otherwise, where would they be? Like me, you can't get out of bed, you can't get dressed. If you can help with that, maybe this would help. It is a concern, not always present struggle, but a constant concern. How can you help me with this? A longer transition period would help. Many of us have found doctors we are comfortable with and 6 months is not that long. When you have allergies and other needs – this would help with CMC enrollment rates.

- **Dulce Garcia–** We don't want to change these aspects of our lives. It takes us years sometimes to find the right doctor who understand our needs and works with you. Then you have panel of doctors – an umbrella. I have 8-10 doctors who work on me every three months. I'm continuously getting certain tests because of my diagnosis. I opted out because of that. How am I going to go in there when I haven't had the help prior? I have reached out and haven't got any of the responses that I requested or needed. I have to throw a fit to be heard. You feel like you're just a case number and not a person. A lot of it has to do with how they've been approached in the past. For myself, I was not ambulatory but I got denied for IHSS. I don't know why. (Panel member is very emotional about this). It's a big concern for a lot of consumers, if I don't have someone to get me out of bed, how am I going to get out of bed? How am I going to be turned in bed? How am I going to take my medications if there's no one to bring them to me? I called in for an assessment because my condition became worse than what it was before. I got my hours cut and then I

had an additional 6 hours cut. The person assessing said that the previous office that had assessed me before was very lenient with hours. Now they are going to review the hours according to protocol. They said I'm sorry but we have to go by the book. So I cut my hours cut. And that's the problem that so many IHSS consumers face. It makes no sense. Then you reach out for help and you get the cold shoulder or a scripted response. It's basically saying "I've answered your question It is what it is, suck it up".

Lisa asks if the panelists all live on their own.

Dulce responds, "No I had to move in with my family because of that."

2. What would need to change to get consumers to voluntarily enroll?

- **Randi Bardeaux** – I think one of the main issues is for the doctors to be on board with this and too many [doctors] are not. And the doctors who are in the program are very frustrated with e current computer system and when they try to coordinate with the rest of their care team members, they believe in this concept. The technology is so antiquated and very frustrating to be able to communicate with their team. I've been talking with a lot of doctors who are in Cal MediConnect program. They say because of the paper work that's required of them and the computer system they have, now 90% of their work is spent on paperwork. They spend less time with patients. This has been very frustrating for the doctors. Were we get more consumers, we need to get the doctors fully supported and help them encourage our consumers to join the program.

- **Jorge Chuc**- The program is there to help us. We're told to sign papers, and until then, nothing happens. We need to educate the doctors and the community.

- **Bertha Poole-** Anything that will facilitate a smoother transition and give exemptions when needed. This is often an issue with medications. Another thing that would help is the outreach. If people knew that these services are available. During Terrance's presentation, I noticed that one of my neighbors could have been helped by an interdisciplinary care team. The Medical Certification Form was a big problem for one of my neighbors. It ended up with her case being closed. Her, provider, out of the goodness of her heart refused to leave her stranded and worked unpaid for several months. Just someone who could have notified her that her doctor had not submitted the Medical Certification form could have stopped all of that from happening. So there are benefits to ICTs - it's just the consumers need to know.

  Comment: Terrance – Wants to go back to first question where bertha talks about assist with hiring a caregiver or getting someone out their in an emergency situation. Is your idea only to be emergency situations or a more of a combined model where the either the IHSS consumer can hire their own provider or if the consumer wants, allow the health plan to hire someone on their behalf. Not that it has to be one way or other, just to give the option.

  Response: Bertha – I don't like the idea of someone else hiring the caregiver because the self-directed model. Finding

their own their own caregivers is very important to IHSS consumers and if you talk about shutting that down there's nothing else you could say that they would listen to.

Comment: Terrance – So just in an emergency situation?

Response: Bertha- Yes just in an emergency situation. We need a plan B. Just one emergency can be so terrible, its always in the back of our minds. It would be very reassuring to know that that kind of assistance was available.

Question: Pam M with Care1st – The health plans have the ability to contract with homecare providers for those types of situations, so you really just need your contact at the health plan in those types of situations. So you're not getting the names and phone numbers of the people who are your contacts at the health plans?

Response: Bertha – Most of the people I know opted out. Those are very real concerns. If they were to know that this kind of help was available that would help. The responsibility to hire our providers is taken very seriously. But anything can happen, and when anything does happen the consequence can be so severe. There was an emergency and my neighbor had to be hospitalized. They didn't give her the appropriate type of care and when she came home her providers were horrified to find that she had a stage 1 pressure sore. These are things that make us not want to even consider enrolling in a managed care plan, because we might get lost in the cracks and fall right through.

Question: Joyce furlough with CareMore – I just wanted to thank you for coming to share your feedback with health plans. I understand the comment about fear and I understand it. I don't think it's unique to any type of person; life changes create fear and it sounds like having that provider engaged and working with us will take care of some of that fear. Set aside the provider issue, what could we communicate better to help people make a decision about managed care. What can we explain better or provide more information on?

Lisa notes this is a great segue to our next question, summarizes the concerns noted already, and then transition into asking the next question.

3. What recommendations can you give the state and/or the plans on messaging to IHSS consumers?

- **Randi Bardeaux** – One of the most beneficial things would be to have a panel like this one, but include consumers and doctors who are part of CMC. Have them describe the successes. It was wonderful seeing the slides but we don't hear about them. You need panel discussions to in for the public and consumers, share that there are success stories, that people are happy with the program and what the benefits are.

- **Jorge Chuc** – We want to hear what's really happening in the plans. Accommodations are important to us. Molina came out with a pamphlet that describes what accommodations they have so I took

	that back and can really show other consumers what they can get. Then he discusses how he waited for an appointment for 2 months but couldn't get the appropriate accommodations for transportation. The transportation could not actually transport him so he had to miss his appointment and wait an additional two months for another appointment. States "I didn't know the health plans were responsible for this. I can take this [the pamphlet] and say this is what's happening." • **Bertha Poole** – I think it's so important when dealing with IHSS consumers that you reassure use that you have our back's, AND that our autonomy will not be compromised. In an emergency, that we won't get hurt or lost in the system. If that can be conveyed without compromising our autonomy, that is the key to IHSS consumers. • **Dulce Garcia**– Education is powerful thing, don't just educate the doctors and nurses, education the patients. I'm with L.A. Care and I get so much mail that I don't read it. Find a way to that's not just sending out papers to convey the message to consumers. Invite them to come out to an event and show them what's happening. As for transportation, it's not just saying "we have transportation". I received transportation from my health plans for years and it was good but recently they changed contracted transportation providers. I had a driver show up and tell me to go up a ramp while he held it down. It was not safe. I've been left behind 5 times and missed appointments. This is not just a matter of just offering transportation, but following through with it. Real change, not a cosmetic change.	
3:00p.m.	**Closing Remarks** • **Dr. Cruz notes that this has been an illuminating discussion and thanks panel for sharing their insight. Asks for any additional questions.** **<u>Stakeholder Question:</u>** States that credentialing was very time consuming for he and his staff. The process is a little cumbersome. Is there some way you can make that easier **<u>Answer:</u>** Dr. Cruz - There are some things that are required by NCQA, but I can definitely check to see if there are ways to streamline. **<u>Stakeholder Comment:</u>** Janet with PASC – Thanks the peers and opening their ideas. Thanks the plans for setting up this meeting. It would be wonderful to figure out how to improve communication with consumers so they can make choices based on facts and not fear. • **Next Meeting: October 22, 2015 at the California Endowment – L.A. Care will host.**	**James Cruz, MD** **Chief Medical Office** *Molina Healthcare of California*