CCI Stakeholder Advisory Committee Meeting
Thursday, October 22, 2015
1:00 pm – 3:00 pm
Meeting Minutes

Welcome and Introductions
Gretchen Brown, Senior Director of Medicare Programs, L.A. Care Health Plan

Ms. Brown welcomed the group and stated that in the interest of time, the group would forgo introductions.

DHCS Update
Ryan McDonald, Deputy Director of Strategic Communications & Outreach Harbage Consulting

Enrollment Data
Mr. McDonald presented the State DHCS Cal MediConnect enrollment data, including total active enrollments and opt-out data as of September 1, 2015 (http://www.calduals.org/wp-content/uploads/2015/10/CMC-Sept-Enrollment-Dashboard.pdf). In addition, CMC enrollment projections for upcoming months were also reviewed. Harbage Consulting announced the release of updated data for Cal MediConnect Health Risk Assessment (HRA) dashboard and informed the attendees that the data was based on information received by participating plans from April 2014 through June 2015. In addition, Mr. McDonald updated the group on the MSSP transition, as well as the transition from passive to voluntary enrollment in Los Angeles County.

The Interdisciplinary Care Team (ICT)
Dr. Rafael Gonzalez- Amezcua, MD, Medical Director-Medicare, L.A. Care Health Plan

Dr. Amezcua provided a general overview of the integration of Interdisciplinary Care Teams (ICT) in the work Cal MediConnect health plans are conducting with members. He described the requirements, definitions and literature that support plans utilizing ICTs to assist in the identification and coordination of health services for dual eligible populations.

Panel: Interdisciplinary Care Team
Dr. Rafael Gonzalez- Amezcua, MD, Medical Director-Medicare, L.A. Care Health Plan

Dr. Amezcua introduced the L.A Care Health Plan panel members, who were:

- **Karen Gonzales,** Manager, Medical Management, Medicare Medical Management,
- **Michelle Parrella , LCSW,** Lead, MLTSS Social Worker
- **Dr. Edwin Poon,** Director, Behavioral Health Clinical Services

The Panel fielded questions regarding ICTs, the way in which they function as a team to ensure members get the best possible care to suit their individual needs.

Dr. Amezcua then followed up by outlining some challenges that the ICT faces on an ongoing basis.

Future Meetings

CCI Stakeholder Advisory Committee Meeting

- January 20, 2016 (1 – 3 p.m.)
- Cathedral of Our Lady of the Angels
- Heath Net (Hosting)

Q&A Session for ICT Panelists:

Q: (Karen Widerynski) L.A. Care described how the plan identifies who requires an ICT meeting, but of the scope of members you have, how many are being managed through the ICT right now?
A: Approximately 5% of the LA Care CMC members are being managed at LA Care who are high risk, including the development of an ICT for each of those members.

Q:(Lourdes with Health Net) On creating the team culture, how do you go about doing that to ensure that participants have equal power within the team, and who takes the lead on the cases?
A: The case managers take the lead when discussing member cases during the ICT.

Q: What kind of ratio (case load) do they (case managers) have typically?
A: For our high risk members, the case managers manage from 55-60 cases, and we also have complex case managers and they manage caseloads from 45-50.

Q: And then on team culture?
A: Dr. Amezcua: More often than not the provider feels the inclination to lead, and when that happens, not everyone speaks, or if they do speak, they get vetoed by the provider. So I think at L.A. Care, it is very important that everyone has a voice, everyone should have a voice. There's a culture of respect, there's a culture of "everyone says their piece", and there may not be agreement, but the person that has an opinion based on their expertise, it gets said. We work very hard at that, to make sure there is a meaningful dialogue toward what the member wants. Also, because we invite members and families, their perspective and their goals are important, front and center, as well.

Q: (Maria Lackner) Can you speak to what occurs when a member or a participant doesn't wish to participate in the ICT, how the team deals with that?
Dr. Amezcua: First and foremost there's a respect for how they want to participate. It can be daunting for some folks, very scary, but the care manager has already interviewed the member, has reviewed the HRA, has reviewed the medical records, and a plan has been developed, incorporating the member's wishes. It gets presented at the ICT and then we formulate or fine tune the plan, and then the care manager reaches back out to the member for the fine-tuned planned.

Karen Gonzalez: Very early on in the engagement process, the ICT and ICP process is explained to our members and our case managers conduct all reviews and assessments. Members are

encouraged to participate in the ICT. Every single member (and/or their caretaker or family member) is invited to join the ICT, but attendance is not required. If a member chooses to not participate in the ICT than the case managers advocate and speak at the ICT team on their behalf, in presenting the case. After the meeting, the case manager calls the member to update them on the recommendations of the team, as well as the PCPs. In that sense, we ensure that the member is represented at some level during the ICT.

Dr. Chau: I just want to make sure the folks understand the team dynamic is very important because in addition to the four disciplines on the panel today, we also have a pharmacist, a registered dietician, health education, disease management, and sometimes the care coordinators, the ones who do the linkage, involved. So you've got a lot of people sitting on the team, and a lot of the time, the case manager presenting the case is doing so in front of all their colleagues. We do know that there are some managers who get really nervous about doing that because it's new for them. At L.A. Care, we are moving towards a team approach in terms of taking care of a member. So it is a *team* taking care of a member, not just a single case manager taking care of them.

Q: (Denny Chan, Justice in Aging) Regarding PCP participation, I notice that you said they're invited to participate in the ICT. I'm wondering what sort of experience and challenges you have had getting PCPs to participate during the ICT.
A: (Dr. Amezcua) We have approximately a 16% PCP participation in the ICT, which is an improvement from when we first started. We work very hard to ensure their participation is based on a schedule that is effective and convenient to them to help maximize the provider's participation. We recognize providers have busy schedules and participating in 45 minutes ICTs is not always appropriate for them in their business. At LA Care we are striving to make the ICT discussions efficient and effective within 15 minute time slots. We invite a provider and we say, "We would like to have you join us at 10:00, and on the dot." We will call the provider at that time and the goal is that we have the communication be so effective that we don't end up taking 20 minutes of their time, but that it is the shortest amount of time possible without taking away from the quality and the effectiveness of the ICT. Ultimately we would like to give the PCP actionable data so they can say, "This member is being well cared for, and rest assured they will get what they need." It doesn't add an additional burden to them. So I think those are characteristics that will help us engage more PCPs, and I think that we have goals in place to grow that participation and satisfaction.

Q: (Denny Chan) At the last stakeholder meeting, DPSS shared a little bit about how there are formal ICTs and informal ICTs, and I'm wondering how the informal ICT interplays with the operational workings.
A: (Karen G) The formal ICT is the weekly ICT all the disciplines attend and the member of course is always invited to participate. The formal ICTs occur twice a week for 2 hours.
The informal ICT's are conducted by care coordinators or care managers. They are usually ad hoc and conducted on a case by case basis and do not require all the disciplines participation. It is usually a tool to assist in gathering information or authorizing care when a member's health condition changes suddenly.
Dr. Poon: Whenever there is a change in the condition of the member, we'll have a follow-up ICT event if one had just occurred, so that any updates can be shared with the entire ICT team. Ad Hoc ICTs are most common among our members with behavioral health needs.

Q: (Denny Chan) Earlier you said that about 5% of members at the plan level that you're doing ICTs for. Do you have a sense of what that number might be at the delegated level?
A: (Michelle Parrella) High risk members are not delegated, for those who are delegated ICT's can vary from PPG to PPG. L.A. Care does participate in those whenever possible, so we continue to monitor our delegated groups in terms of how often they are conducting the ICTs, but remember there is no current requirement for an ICT to be conducted for every single member, so it is conducted on a case-by-case basis or as needed.

Comment: (Brenda Primo) I love the presentation. One of the cautions I want to make, though, is in Cal MediConnect about 80% are seniors and 20% are younger, in Medi-Cal SPD, of those about 75% are under the age of 65. These populations are not separated by their conditions; they're separated by these artificial rules created by these two programs. They may have functional limitations but these people are not necessarily frail. They may be a 24-year-old quadriplegics who plays soccer. So it's important to remember that we're dealing with a range of populations. The other reason I'm concerned is how we decide what to get them in regards to durable medical equipment or in-home modifications. We think differently about "sick, frail" people than we do about healthy people. You may want a power wheelchair to get on the bus to go somewhere because they're very fast and you need to get there. If someone thinks you're frail, they're not going to give it to you.

My second comment is regarding language being used. We're not "managed." I'm not "managed." Part of what we have to remember is that the consumer should be able to be in charge when they can be, but they won't be able to be if we don't speak in everyday language about whatever it is that we're going to talk about when they're there to make decisions for their lives. Now the question I had is: My primary care doctor is a pharmacist and a low-vision optometrist. I have a general practitioner, but I rarely see him. For those who have a disability, they may use their specialists or their mental health providers more than their primary doctor.

Q: (Brenda) How do we ensure that the wide range of specialists is involved in the ICT process?
A: (Dr. Amezcua) That's precisely the purpose for the ICT, to have these multiple disciplines come together after initial evaluation has taken place with the goal to identify the needs of the patient. Providers caring for the member, including specialists are asked to participate in order to have them present the scope of the care they are providing for this member.

Michelle: At the start the ICT was very medically centered, but as a health plan and as a community we've had to evolve. We really have to take a look and be honest about the fact that these are our members and they're not just facing medical issues. As a team, as Dr. Amezcua has referenced, we meet the member where they're at and we let them dictate what their wishes are. That may be that they don't want to do the ICT or they only want to talk to the nurse, or I only want to talk to the housing specialist, but we always start with that individual and they're the center of the plan.

Q: I'm really glad to know that even the health education team is integrated as part of the ICT team. Can you elaborate a little on what their role looks like? I imagine a lot of it may be health literacy education or information around chronic diseases overlaps with the dietician or what the care manager says. Also, does the health education team have touch points with the member whether on the phone, in the community, or in the clinical setting with the doctors?
A: (Karen G) Yes, the health education team is part of the overall team as well as they too have direct touch points with our members. As an example, health educators conduct calls to our members, per

the recommendation of the ICT team. They work closely with dietitians to ensure a complete assessment and evaluation when prescribing or recommending an intervention. For example, with a member that is hypertensive, non-compliant with medications, we could provide educational materials, but we could also have a dietician call this member, work with the member to make dietary modifications, almost like a health coach.

Q: Do case managers work in the same way for nursing home residents?
A: (Dr. Amezcua) Nursing home residents are considered high risk members. As such, they are managed within the health plan and yes, the case management works very similar with the twist that we are working more closely with the facility doctors and nurses. We have also provided SNFs with information about best practices in discharge planning so they can develop plans of care for their patients.

Q: (Jennifer Schlesinger, Alzheimer's association) When you have a member with dementia, have you found opportunities to use your trained dementia care specialists on the team, and what does that workflow look like? Also, are there opportunities for community agencies to be part of an ICT, if there's an identified need?
A: (Karen G) Yes, definitely. We do invite people out in the community who are working closely with the member if the member agrees to have them participate. It's the member's ICT, and they choose who they wish to be part of that team. Michelle Parrella who is a dementia specialist participates as well during the ICT. Through our work with other stakeholders we are also focusing on caregivers to make sure that they are not experiencing caregiver burnout.

Q: (Maria Lackner) I wanted to ask each of the panelists to share what, if any, positive impacts you've seen as this process has evolved through the implementation of the CCI (Coordinated Care Initiative) and CMC (Cal MediConnect)?
A: (Karen G) There's been a *lot* of positive impact for our members. One that is very important is timely access to care. . As part of IHSS participation during the ICT we have been able to evaluate and reassess IHSS hours for our members. We've helped eliminated duplication of services.

Dr. Poon: Navigating the behavioral health system is very challenging, given that we have a two-level system. One at DMH level and the behavioral health services. What the ICTs bring is the integration of care between mental health and physical health services. In the past you'd often see members who may be receiving services from DMH but that information was not being shared with physicians. With the ICT, we connect the mental health providers at the DMH level, we collect their treatment plans, and identify services the members are receiving and then bringing that back to the ICTs so that we may share that if necessary with the PCP's. This can help our PCPs understand how to better manage the members physical health and vice versa. There has been positive feedback from DMH and from the health plan, which ultimately benefits how we care for our members.

Michelle: The most prominent positive effect I've seen is moving away from medically-driven care to the individual driving their care and the integration across departments and disciplines. Because we have to collaborate and work together, within L.A. Care we function less in silos. Each department works with one another, and *knows* one another.

Dr. Amezcua: The ICT's have expedited numerous visits to physicians, clarification for medications, and referrals to specialists. It has also expedited DME requests, referrals to IHSS and CBAS, and numerous instances where we helped the family member or caretaker better understand the work being done in support of the patient. But the music to my ears is when a member says at the end of a discussion, "Thank you so much." To me that is the best indicator of success.