Medical Care Coordination (MCC):
Implementing the Medical Home Concept in Los Angeles County

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Coordination and Linkages: **RWA #491**
August 23, 2010

Medical Care Coordination (MCC):
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LEARNING OBJECTIVES

Learning Objective #1: The audience will learn why LA County's Planning Council and Grantee decided to migrate from the case management to medical home model, and the EMA's projected outcomes and benefits from medical care coordination services.

Medical Care Coordination (MCC):
Implementing the Medical Home Concept

LEARNING OBJECTIVES *(cont.)*

Learning Objective #2: For LA's migration to medical care coordination services to be successful, it requires almost near consensus. Workshop participants will learn the strategies used to educate and invest multiple stake-holder constituencies in the process: consumers, providers, the Board of Supervisors and other interests.

Medical Care Coordination (MCC):
Implementing the Medical Home Concept

LEARNING OBJECTIVES *(cont.)*

Learning Objective #3: The audience will gain an understanding of the lessons learned in such a significant migration of LA's HIV services—where planning and implementation have been most challenged, from initial opposition and model specifics, through concerns about the financial and consumer impact to transition issues.

MCC Planning:
Reasons and Justification

- Following development of standards of care, Commission found that:
  - Psychosocial case management did not necessarily facilitate patient access into medical care;
  - Points of entry into continuum were not clearly defined;
  - Case conferencing was not used consistently; and
  - Weak links between psychosocial/medical case management.
- Significant redundancy/duplication of case management services and cost-inefficiency

MCC Planning:
Reasons and Justification *(cont.)*

- Barriers in the two services hindered patient access
- Other models of care had more successfully integrated the psychosocial/medical components of care:
  - Integrated care, disease management, chronic care, and care coordination
  - All used the “medical home” concept more effectively
- State’s home-based case management program relied on medical home construct
  - Interest in creating “seamless” transition between the two types of care management systems

MCC Planning:
Reasons and Justification *(cont.)*

- More funding allocated locally to psychosocial case management than medical case management
  - Core medical services threshold necessitates shifting funds to more medically oriented services
- "Handwriting on the Wall"—movement at the Federal level:
  - HIV services becoming more "medicalized"
  - HRSA focusing more attention on accountability, achieving health outcomes
  - "Medical home" concept increasingly integrated into Federal health care initiatives

MCC Planning:
Reconfiguring Case Management

- Research and Literature Review
- Principles and Priorities
- Development of a Care Coordination Framework
- Communication with Stakeholders
- Expert Review Panels (ERPs)
- Development of a New Standard of Care
- Cost / Fiscal Impact Study

MCC Planning:
Principles and Priorities

- Coordination services should help patients access medical care / adhere to treatment regimens
- Coordination services should reduce barriers and improve patient access into medical care
- Other services (psychosocial) were designed to help patients meet the first two goals (above)
- Seamless medical / psychosocial service delivery
- Reduce service duplication / improve cost-effectiveness

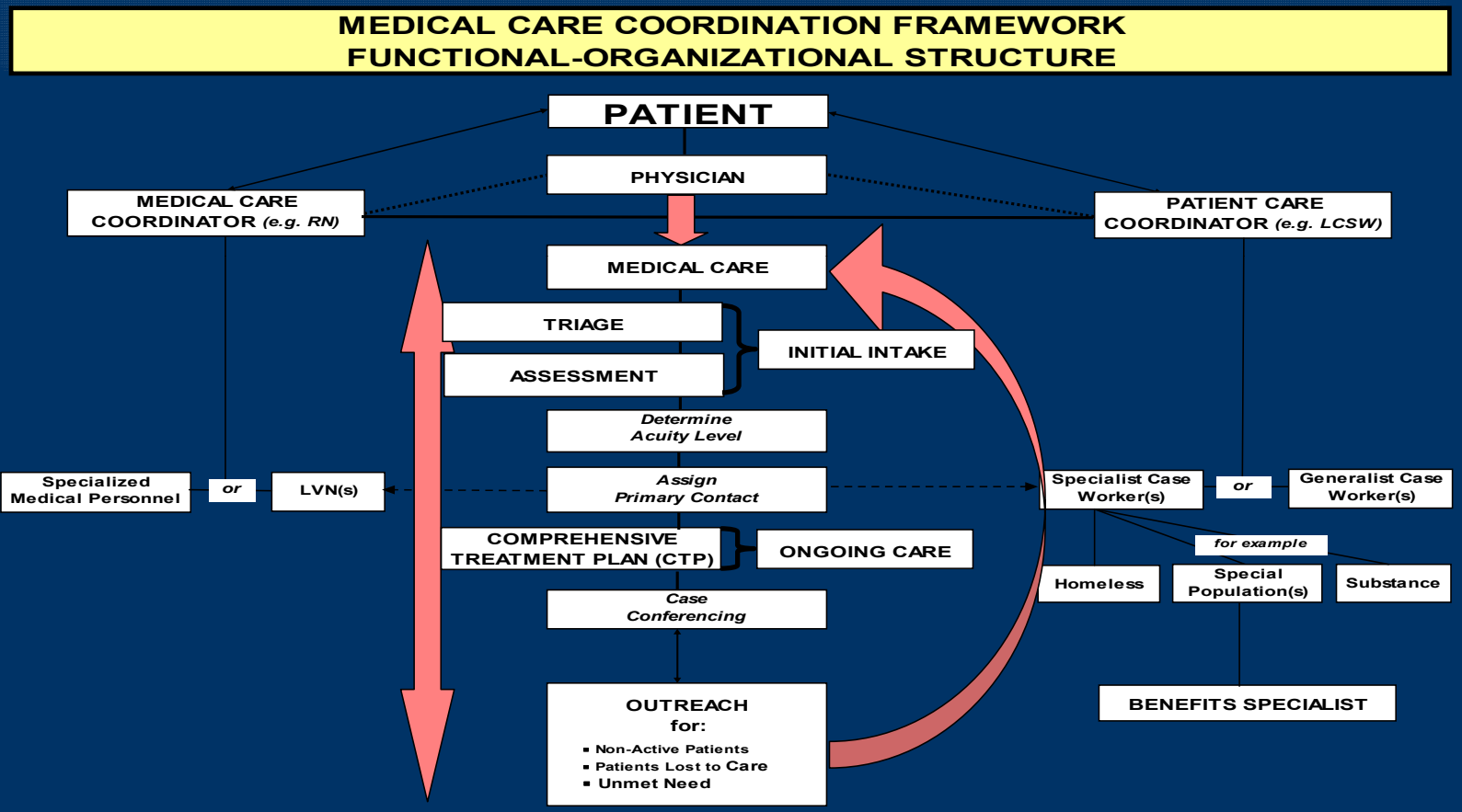
MCC Planning:
Framework Development

- Outlined key MCC components:
  - "Single Program" vs. single agency
  - Coordinated care, inside and out of RW-funded care system
  - Comprehensive treatment plans
  - "Primary Contact" for patients / clients
  - Case conferencing, made more difficult with patients receiving care outside of RW-funded medical services
  - Acuity levels needing services
  - Outreach for unmet need
- Convened focus groups: 2 for providers/ 1 consumer

MCC Planning:
Framework Development *(cont.)*

- Approved unanimously by Commission at Annual Meeting to guide development of standard of care
- Twelve (12) recommendations for implementation
  - Create standardized assessment forms
  - Conduct fiscal analysis
  - “Beta-test” simulation alongside existing services
  - Consider a variable rate reimbursement structure
  - Allocating funds equal to CM + NCM on medical outpatient contracts + MCC costs
  - Allocate additional funds for outreach / unmet need activities
  - Provide technical assistance to migrate to MCC

MCC Planning:
MCC Service Model



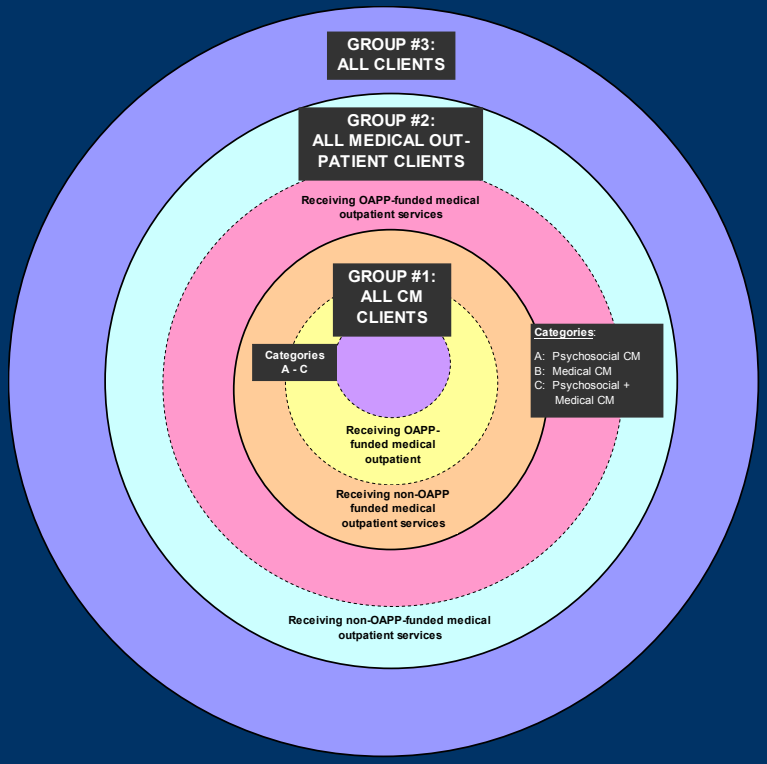
MCC Planning:
Standard of Care Development

- Drafted new standard guided by approved framework, case management standards, contracts and literature
- Convened four Expert Review Panels (ERPs) to review/comment/revise draft:
  - Over 40 providers/consumers/experts participated
  - All CM providers had an opportunity to send a representative
- Development of the standard followed the same course as development of all other standards
- Commission approves MCC standard six months later

MCC Planning:
Fiscal Impact Study / Analysis

- Purpose:
  - to determine possible cost impact, and
  - provide a tool for Grantee use in implementation
- Created a financial simulation model
  - A means of analyzing cost impacts in various scenarios
  - Not a rate study, an operations study or a definitive answer on exact costs
- Cost Drivers—
  - Weighted average service unit: service units + frequency
  - Cost per service unit

MCC Planning:
Fiscal Impact Study / Analysis *(cont.)*



	Current Number of Patients by Current Case Management and Medical Outpatient Status	Medical Outpatient from OAPP	Medical Outpatient outside OAPP	No Medical Outpatient	Total Patients by Care Mgmt Status
A	Psychosocial Case Management only	2,883	362	1,085	4,330
B	Medical Case Management only	487	8	0	495
C	Both Psychosocial & Medical Case Manag	246	44	0	290
	No Case Management from OAPP	9,886	500	1,500	11,886
	Total Patients by Medical Outpatient Statu	13,502	914	2,585	17,001

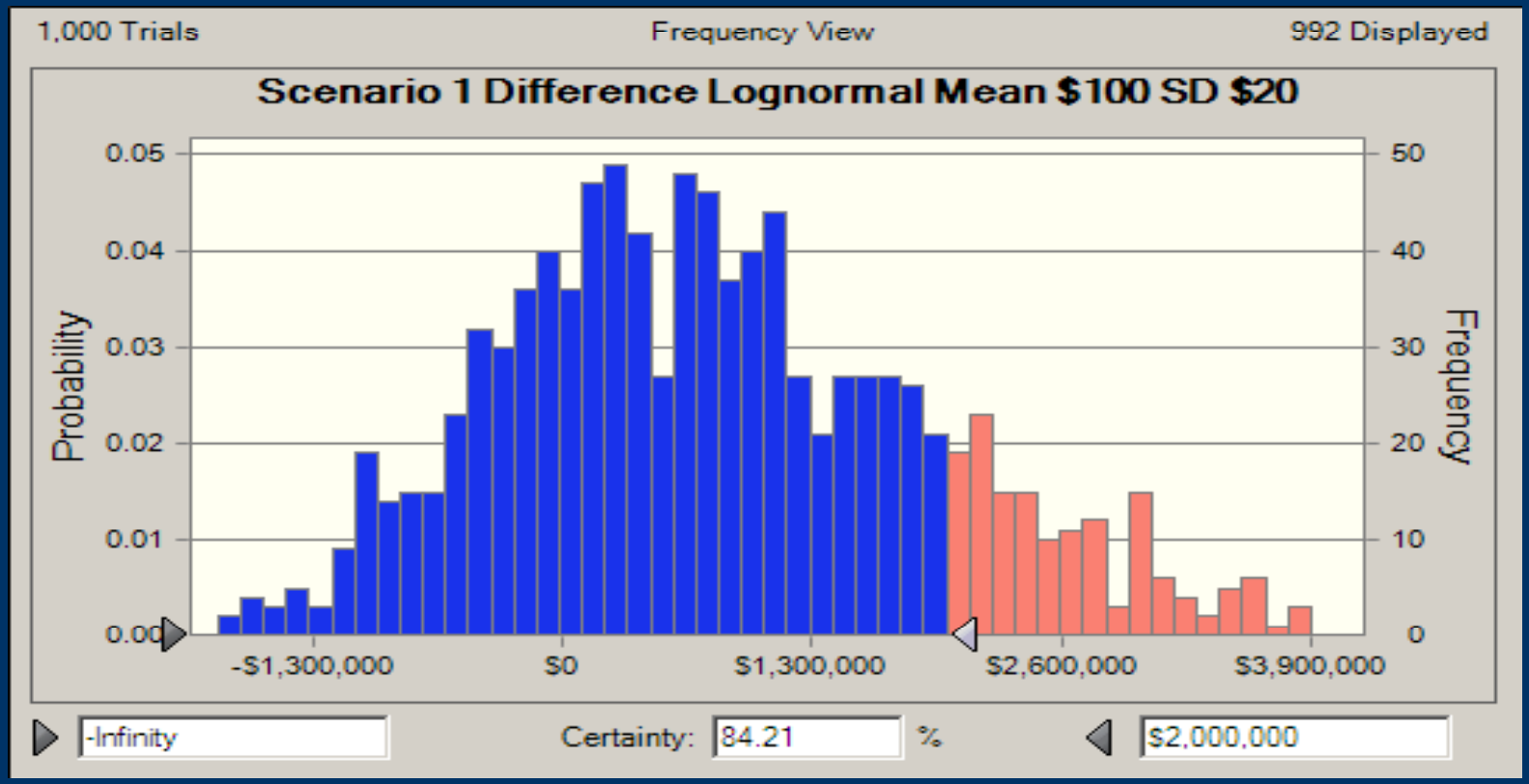
MCC Planning:
Fiscal Impact Study / Analysis *(cont.)*

Current Number of Patients by Current Case Management & Medical Outpatient Status	Currently Receiving OAPP-Funded Medical Outpatient	Currently Receiving Other-Funded Medical Outpatient	Not Currently Receiving Medical Outpatient	Total Patients by Care Mgmt Status
Currently Receiving Psychosocial Case Management only				
Currently Receiving Medical Case Management only				
Currently Receiving Both Psychosocial & Medical Case Management				
Currently Receiving No OAPP-Funded Case Management				
Total Patients by Medical Outpatient Status				

MCC Planning:
Fiscal Impact Study / Analysis *(cont.)*

Acuity Distribution Input Table Estimated Percent of Patients by Acuity	Currently Receiving CAPP-Funded Medical Outpatient [Crisis%+High%+Med%+Low%+Self-Managed%=100%]					Currently Receiving Other-Funded Medical Outpatient [Crisis%+High%+Med%+Low%+Self-Managed%=100%]					Not Currently Receiving Medical Outpatient [Crisis%+High%+Med%+Low%+Self-Managed%=100%]				
Acuity of Service Need	5 Crisis Acuity	4 High Acuity	3 Med Acuity	2 Low Acuity	1 Self-Managed	5 Crisis Acuity	4 High Acuity	3 Med Acuity	2 Low Acuity	1 Self-Managed	5 Crisis Acuity	4 High Acuity	3 Med Acuity	2 Low Acuity	1 Self-Managed
Currently Receiving Psychosocial Case Management only	5%	45%	35%	8%	7%	5%	45%	35%	8%	7%	5%	45%	35%	8%	7%
Currently Receiving Medical Case Management only	2%	48%	21%	14%	15%	2%	48%	21%	14%	15%	2%	48%	21%	14%	15%
Currently Receiving Both Psychosocial & Medical Case Management	5%	45%	35%	8%	7%	5%	45%	35%	8%	7%	5%	45%	35%	8%	7%
Currently Receiving No CAPP-Funded Case Management	5%	45%	35%	8%	7%	5%	45%	35%	8%	7%	5%	45%	35%	8%	7%

MCC Planning:
Fiscal Impact Study / Analysis *(cont.)*



MCC Planning:
Fiscal Impact Study / Analysis *(cont.)*

- Scenario Results:
  - Projected for patients currently in CM: -$650,000
  - For all medical outpatients: $8,270,000
  - For all patients/clients in RW-funded services: $10,400,000
- Simulation Results:
  - 85% chance that the migration will cost less than an additional $2 million; within the Commission's comfort zone
- Commission approves going forward with migration
  - Allocated to MCC for FY 2011

Medical Care Coordination:
Stakeholder Communications

- Presentations to all 8 Service Planning Areas (SPAs) when framework approved
- Elongated public comment periods for the framework and the standard of care
- Presentations of standard and cost impact analysis to all 8 Service Planning Areas (SPAs) when approved:
  - Additional presentations to Task Forces,
  - Consumer groups,
  - Board of Supervisors / County Chief Executive Officer

Medical Care Coordination:
Lessons Learned

- The larger the change, the more the resistance:
  - Fears of the unknown
  - Need for status quo
  - Personal agendas
  - Insecurity
- Resistance is rarely characterized as a desire “to keep things the way they are,” or “don’t want to work at it”:
  - Opponents will find other ways to express their resistance

Medical Care Coordination:
Lessons Learned *(cont.)*

- The three most common ways opponents will resist:
  - Question the data
  - Claim that it costs too much
  - Assert the need for pilot-testing
- In response:
  - Have sound, valid, reliable data
  - Have/plan for cost estimates / impact analyses
  - Build pilot-testing into the plans, or have inarguable reasons that a plan cannot be pilot-tested

Medical Care Coordination:
Lessons Learned *(cont.)*

- Grantee / planning council relationship(s):
  - Regardless who starts the process, collaboration between the two is needed
  - If one fails, they both fail
  - Grantee / PC discord makes helps stakeholders rationalize their resistance

MCC Implementation:
Implementation Process

- Request TA consultant from HRSA
- Form Transition Advisory Group (TAG)
- Develop implementation plan
- Formulate TAG recommendations
- Design transition plan
- Work on implementation activities

MCC Implementation:
HRSA Technical Assistance

- Expertise and experience implementing service model changes for system improvement; specialty in case management services
- Meeting facilitation
  - Transition Advisory Group (TAG)
  - Administrative Agency internal workgroup
- Transition plan development
- Service descriptions and scope of work for RFP

MCC Implementation:
Transition Advisory Group (TAG)

- Intense Planning Council interest in seeing through MCC implementation
- Involve stakeholders in the beginning of process
- Gauge expectations and concerns from the community
- Expertise from other health care systems

MCC Implementation:
TAG Membership

- Planning Council SOC Committee co-chairs
- Planning Council staff
- Registered Nurse
- Social Worker
- CBO medical provider
- County DHS medical provider

MCC Implementation:
TAG Membership *(cont.)*

- Social service provider
- HIV-positive consumer
- Other public health care systems
  - Chronic disease management
  - Maternal, child, and adolescent health
  - County safety-net and other public health programs
- Administrative Agency staff

MCC Implementation:
TAG Process

- Monthly meetings for 7 months; one Consumer Caucus meeting
- Agree on guiding values and principles
- Identify implementation/transition issues
- Issue report of recommendations
- Transition plan review and comment
- Re-convene as needed thereafter

MCC Implementation:
Guiding Values and Principles

- Increase ease of access for patients
- Do not lose patients because of transition
- Reduce administrative and programmatic redundancies
- Sensitivity to client perspective

MCC Implementation:
MCC Implementation Team

- Office of Planning
  - Planning Council, TAG, HRSA TA liaison
  - System planning (include IT)
  - Project management
  - RFP and contract development
  - Care data analysis
  - Community engagement

MCC Implementation:
MCC Implementation Team *(cont.)*

- Care services
  - Program development (guidelines, protocol, tools)
  - RFP and contract development
  - Program management and monitoring
  - Provider training and TA
- Office of Medical Director
  - Quality assurance and quality management
  - Performance evaluation
  - Clinical direction and oversight

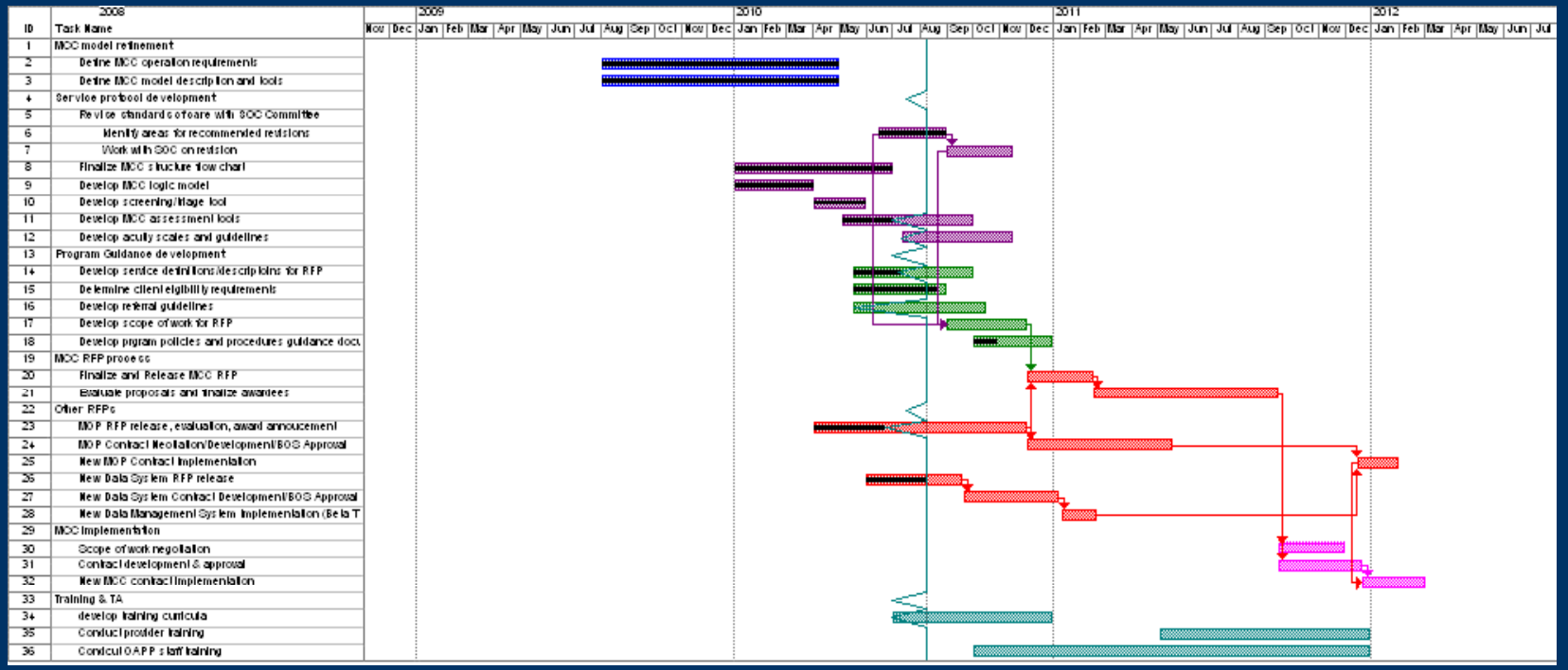
MCC Implementation:
MCC Implementation Plan

- Updated after TAG recommendations
- Define MCC model operation requirements
- Develop service protocol/program guidance (screening and assessment tools, acuity scales and guidelines, eligibility requirement, referral guidelines, SOC revision, etc.)
- Develop RFP, release and evaluate

MCC Implementation:
MCC Implementation Plan *(cont.)*

- Implement MCC contracts
- Training and education (provider, consumer, staff)
- Stakeholder communication
  - Planning Council, consumers, all HIV service providers, medical providers, County leadership, program staff, other advisory groups/task forces
- Evaluation

MCC Implementation:
MCC Implementation Plan *(cont.)*

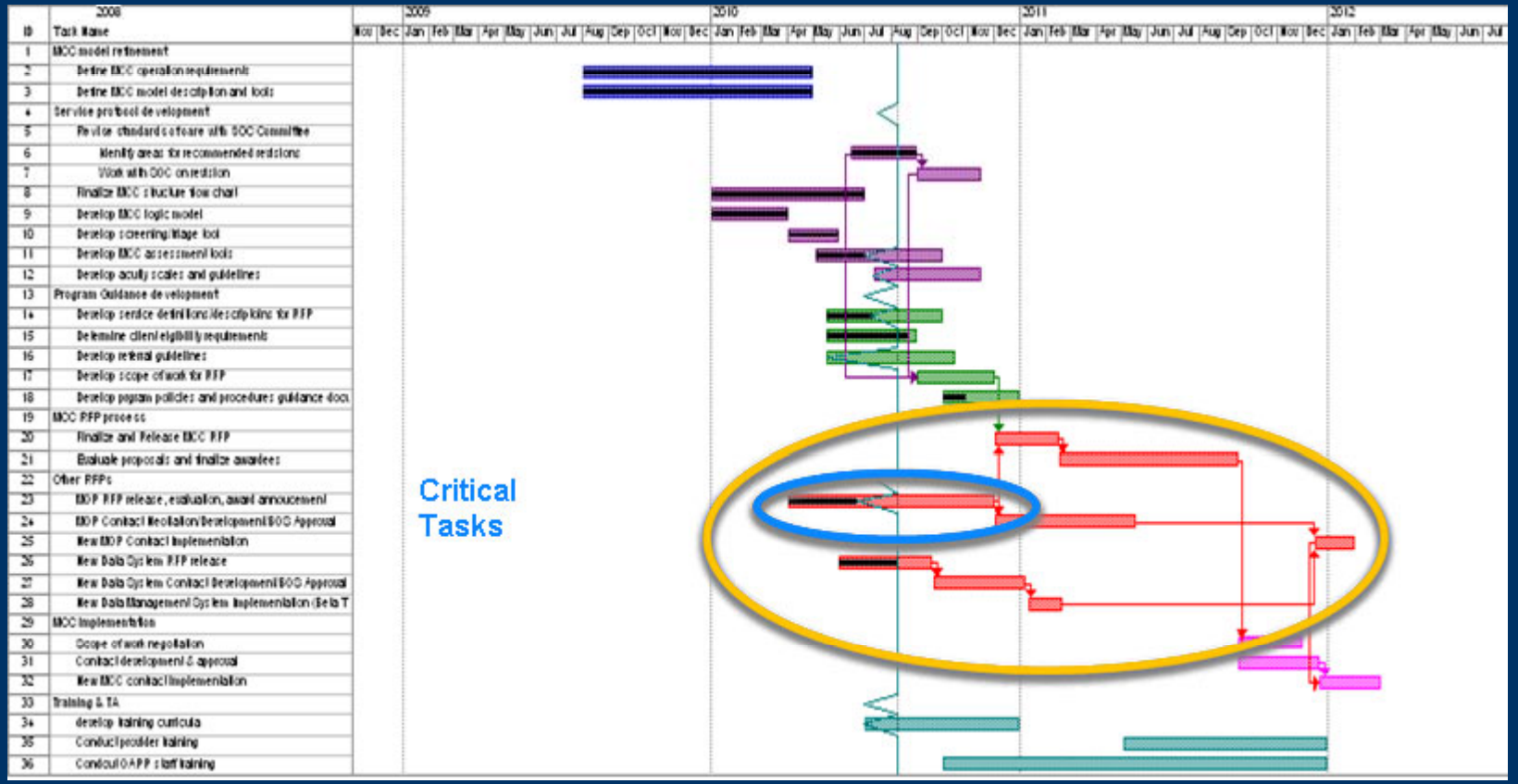


ID	Task Name
1	MCC model refinement
2	Define MCC operation requirements
3	Define MCC model description and tools
4	Service protocol development
5	Revise standard software with SOC Committee
6	Identify areas for recommended revisions
7	Work with SOC on revision
8	Finalize MCC structure flow chart
9	Develop MCC logic model
10	Develop screening/triage tool
11	Develop MCC assessment tools
12	Develop acuity scales and guidelines
13	Program Guidance development
14	Develop service definitions/descriptions for RFP
15	Determine client eligibility requirements
16	Develop referral guidelines
17	Develop scope of work for RFP
18	Develop program policies and procedures guidance docu
19	MCC RFP process
20	Finalize and Release MCC RFP
21	Evaluate proposals and finalize awardees
22	Other RFPs
23	MOP RFP release, evaluation, award announcement
24	MOP Contract Negotiation/Development/BOS Approval
25	New MOP Contract Implementation
26	New Data System RFP release
27	New Data System Contract Development/BOS Approval
28	New Data Management System Implementation (Beta T
29	MCC Implementation
30	Scope of work negotiation
31	Contract development & approval
32	New MCC contract implementation
33	Training & TA
34	develop training curricula
35	Conduct provider training
36	Conduct OAPP staff training

MCC Implementation:
MCC Implementation Challenges

- Multiple major initiatives to be carried out around the same time → affecting decisions already made because new factors come into play
- Initiatives have inter-dependent relationships with each other → MCC implementation timeline constantly a moving target when other processes delay

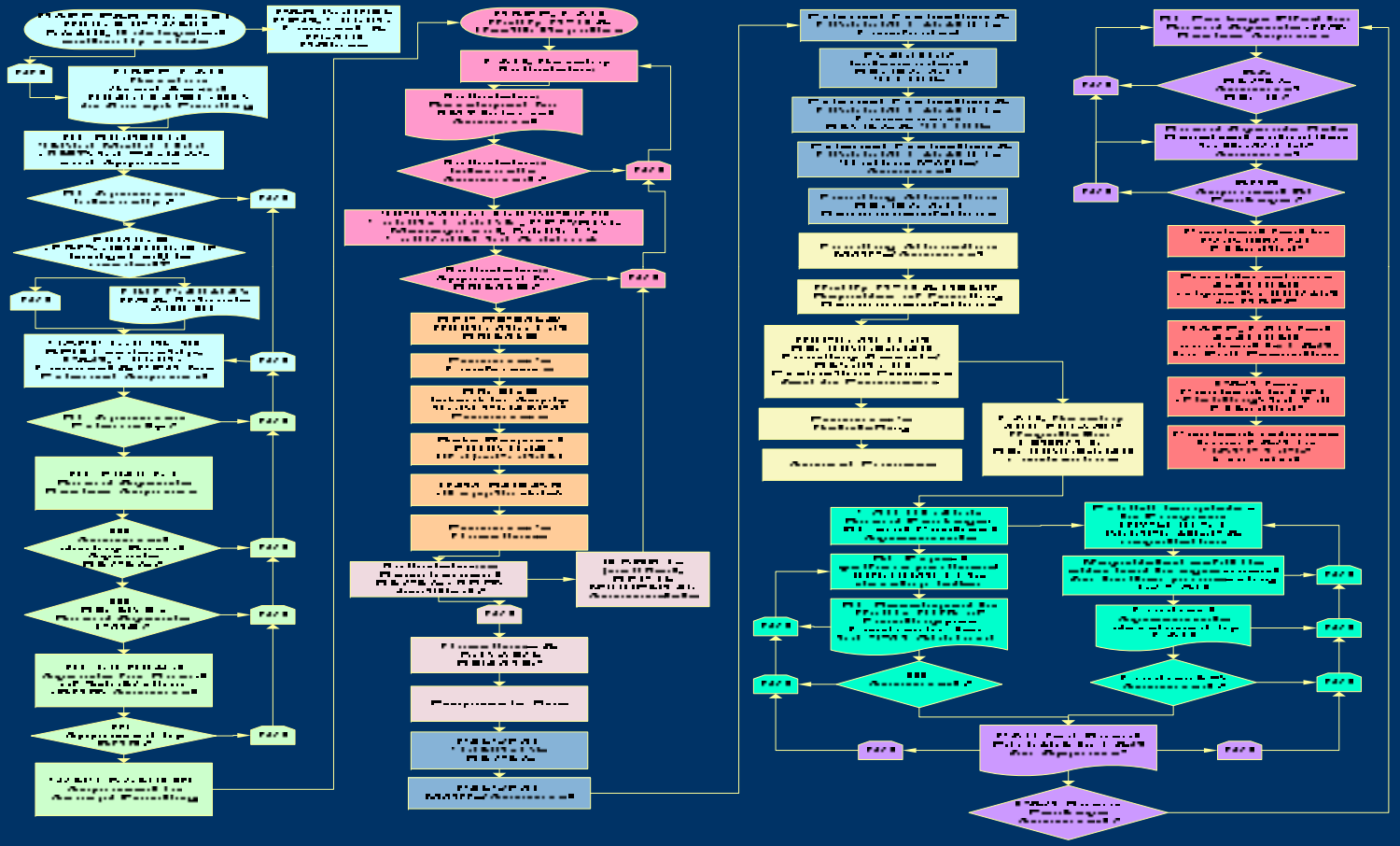
MCC Implementation:
MCC Implementation Challenges *(cont.)*



MCC Implementation:
MCC Implementation Challenges *(cont.)*

- Prolonged County solicitation and contracting process adds to unpredictable timeline delay
- County hiring freeze due to budget cuts affect ability of County facilities to implement required staffing for MCC
- Nursing shortage remains a key factor that may influence MCC implementation

MCC Implementation:
MCC Implementation Challenges *(cont.)*



MCC Implementation:
Lessons Learned

- Is a third-party TA needed to implement MCC?
  - TA from HRSA was valuable
  - Reduced tension by providing objective guidance from experience
  - Provides resources and guidance so that you don't need to "re-invent the wheel"

MCC Implementation:
Lessons Learned *(cont.)*

- Is Transition Advisory Group necessary?
  - Community participation from beginning of process
  - Particularly important when the initiative comes from the community
  - Invite experts outside of HIV field for specific topics rather than the entire process
  - Engagement of high-level Administrative Agency staff important
  - Recommendations largely echo internal plan

MCC Implementation:
Lessons Learned *(cont.)*

- About the implementation process . . .
  - No opportunity or resource for piloting creates an atmosphere of over-planning
  - Too many moving targets from multiple initiatives results in unwanted delays
    - Affect staff momentum and motivation
    - Create potential tension with Planning Council
  - Plenty of lessons still to be learned after roll-out
    - Will have information based on MCC data

MCC Planning / Implementation:
Question of the Day

- Who should initiate a system change: the Planning Council or the Grantee?
  - Tension between Planning Council and Administrative Agency exists with either approach
    - You are more on the same page than you think
    - Timing is key
    - Work together from the beginning
  - Different expectations of implementation timeline
    - Pressure to implement MCC amidst other major initiatives

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