

Vision Statement

A coordinated healthcare delivery system through which Orange County's uninsured and medically vulnerable populations are linked with a patient-centered medical home that is clinically effective, improves health status, and avoids unnecessary costs.

MSC Meetings

- July 1, 2009
- September 2, 2009
- November 3, 2009
- January 4, 2010
- May 10, 2010
- September 13, 2010: Go – No Go

Steering Committee Members

Name	Role	Agency
Mr. Ed Kacic	Co-Chair	Irvine Health Foundation
Dr. Eric Handler	Co-Chair	Orange County Health Care Agency
Dr. Richard Afable	Member	Hoag Memorial Hospital Presbyterian
Mr. Barry Arbuckle	Member	Memorial Care Medical Centers
Mr. Terry Belmont	Member	University of California, Irvine Medical Center
Dr. Gregory Buchert	Member	CalOptima
Mr. Richard Chambers	Member	CalOptima
Ms. Kimberly Cripe	Member	Children's Hospital of Orange County
Mr. Jeffery Flocken	Member	Tenet Health Care
Mr. Robert Gates	Member	Orange County Health Care Agency
Mr. James Lott	Member	Hospital Association of Southern California
Ms. Julie Miller-Phipps	Member	Kaiser Permanente
Ms. Deborah Proctor	Member	St. Joseph Health System
Mr. Lex Reddy	Member	Prime Healthcare Management, Inc.
Mr. David Riley	Member	Orange County Health Care Agency
Mr. Ken Westbrook	Member	Integrated Healthcare Holdings, Inc.

Steering Committee Members

Michael Sugarman MD, Heritage Medical Group

Gloria Mayer, Institute for Healthcare Advancement

Gale Gascho, AHMC Healthcare Inc.

Castulo de la Rocha JD, AltaMed Health Services Corporation

Peter Anderson MD, Emergency Physician

Michael Stephens, Consultant



Network Development Members

Nick Anas, M.D., CHOC

Peter Anderson, M.D.

Barry Arbuckle, Memorial Care

Isabel Becerra, Coalition of OC Community Clinics

Dan Castillo, OC Health Care Agency

Jay Cohen, M.D., Monarch IPA

Cástulo de la Rocha, AltaMed

Bob Gates, OC Health Care Agency

Eric Handler, M.D., OC Health Care Agency

John Heydt, M.D., UCI University Phys & Surgeons

Pamela Honsberger, M.D.,

Kaiser Permanente

Michael Hurwitz, M.D., OCMA –
Past President

Russ Inghis, IHHI, Inc.

Ajay Meka, M.D.

Maria Miñon, M.D., CHOC

Mary Paul, Consultant & Patient
Advocate

Margarita Pereyda, M.D., SOS
Clinic

Mark Refowitz, M.D., OC
Health Care Agency

Javier Sanchez, CalOptima

Ericka Waidley, Access OC

Vision of the Managed System of Care

- Cares for medically vulnerable populations
- Geographically and culturally accessible
- Clinically effective to improve the health status of the population
- Efficient, directing resources effectively to diminish unnecessary costs

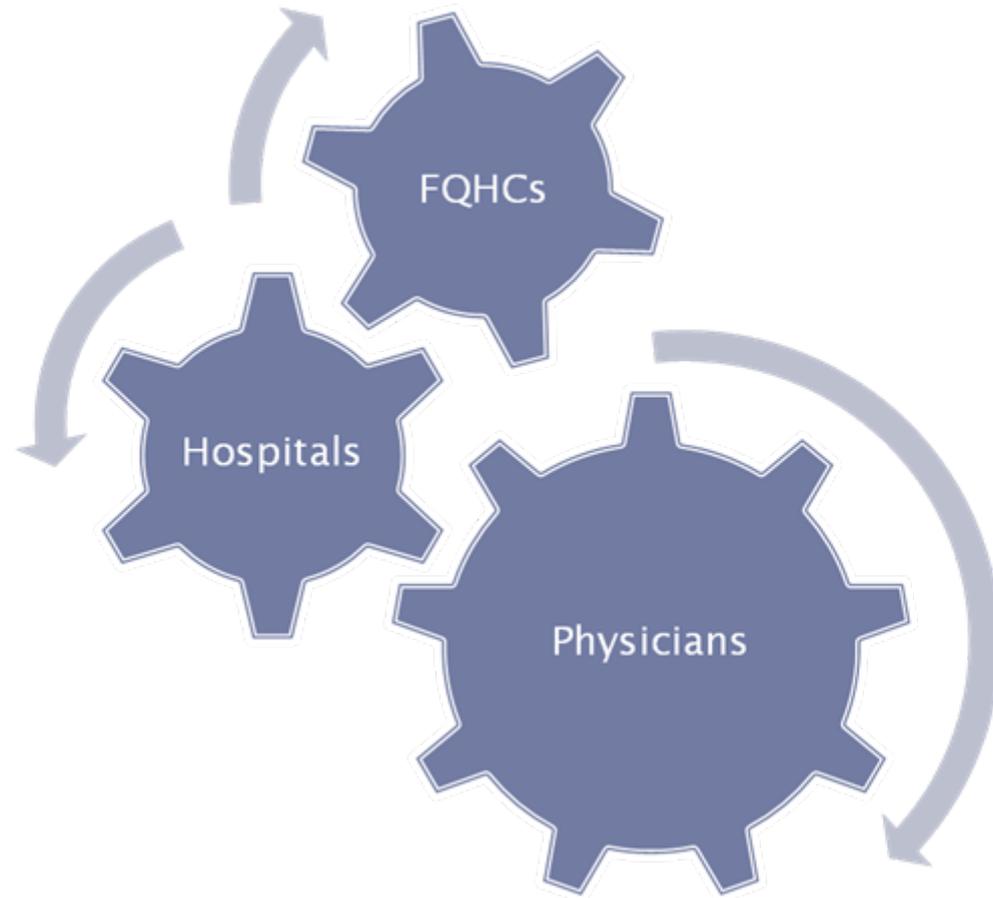
Vision of the Managed System of Care

- Utilizes the innovative efforts already in place to serve the uninsured and Medi-Cal populations
- Maximizes available funding opportunities and resources
- Is designed and organized with knowledge of likely changes due to the California Medicaid waiver renewal

Initial Target Population

- Those with incomes under 133% of the federal poverty level
- Chronically ill and high utilizers of services

Who Will Form the Network?



System Components

- Primary Care
- Specialty Outpatient Care
- Emergency/Urgent Care Services
- Inpatient Care
- Managing the Population

Network Model

- Patient Centered Medical Home
- Call Centers
- Urgent Care Centers
- Specialty Referrals
- Care Management
- Health Information Technology

Network Elements

- ▶ Designated medical home for all members
 - ▶ Integration of behavioral & physical health
 - ▶ IT tools and the infrastructure to facilitate seamless care and early identification of chronic conditions
 - ▶ Case management and care coordination
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Medical Home – Coordinated Care

- ▶ Meeting NCQA standards for Patient–Centered Medical Home (PCMH) requires significant time and capital
- ▶ For Near–Term: Give contracting priority to PCPs who:
 - Agree to pursue PCMH designation
 - Consistently work with care/case manager
 - Agree to provide access to clinical call center should one be made available
 - Use HER or are taking significant steps to adopt one

Medical Home – Coordinated Care

- ▶ **Care/Case Management (CM) should be:**
 - Tiered, so patients with greatest need get most CM
 - Uniformly–applied (i.e., patient gets CM irrespective of which medical home assigned to)
 - Delivered in a timely manner
 - Embedded within the medical home so fosters patient/provider relationship
 - Technologically interconnected with key sectors of the healthcare delivery system

Medical Home – Coordinated Care

- ▶ **Practice-based Health Information Technology Recommendations:**
 - Participating providers have adequate support to adopt EHR technology
 - All patients have an Electronic Health Record (EHR)
 - Patient-allowed information is available to all MSC-participating providers in real-time

Medical Home – Coordinated Care

▶ Clinical Call Center

- Provides triage and health information services to members or provider practices
- New clinical call center could be created or could explore contracting with existing vendor
- CalOptima member & provider call center is operations-oriented, not clinical

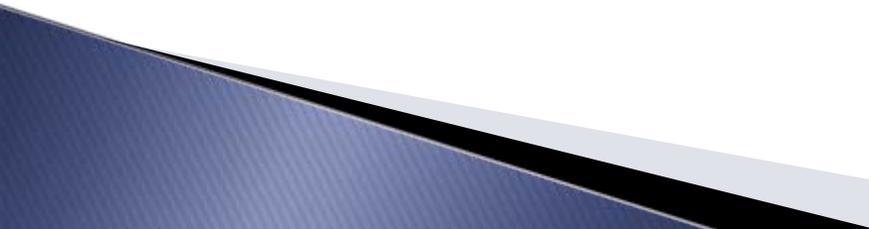
Specialty Care

- ▶ Link specialists to medical homes based on geography and equitable distribution of members
 - ▶ Compensate specialists at a level that ensures a sustainable network
 - ▶ Embed specialty care within FQHCs to serve Medi-Cal and uninsured
 - ▶ Develop strategy for integration, coordination of hospitals, medical homes & specialists
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Urgent Care

- ▶ Can be cost-effective means of decreasing ED visits for nonemergency care but should not replace or duplicate medical home
- ▶ Many centers in OC but need to be contracted and expanded to serve the indigent
- ▶ Support expansion of services & afterhours operations at FQHCs, other clinics

Acute/ Tertiary Care

- ▶ **Community & tertiary hospitals need to collaborate to use OC facilities when possible**
 - ▶ **Service list by hospital should be created & shared**
 - ▶ **Contracts with ambulatory surgical center that are agreeable to fair rate could expand access to services, contain costs**
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Other Key Services

- ▶ Ancillary: Must develop county-wide network (therapists, lab, radiology, etc.)
- ▶ Pharmacy: Essential to provide reasonable benefit and access to network of pharmacies; system will need to be managed & monitored closely to prevent costs from rising unduly

Benefit Design – Guiding Principles

- ▶ Reward patients for compliance with preventive care
 - ▶ Prepare potentially eligible individuals for participation in Medi-Cal or statewide health insurance exchange in 2014
 - ▶ Leverage existing preventive care programs when possible
 - ▶ Promote use of an electronic personal health record to encourage individual responsibility for health
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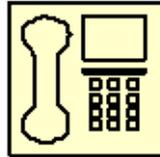
Orange County Managed System of Care for the Low-Income Uninsured



Professional Services

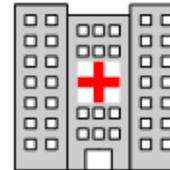
(Physician and Allied Health)

1. Primary Care + Care Management + EHR (or contract w/REC for EHR) = Medical Home (NCQA certification not required at this time)
2. Pilot with select providers from MSI/ CalOptima networks who meet criteria
3. Enhance access to high-demand / hard-to-find specialists



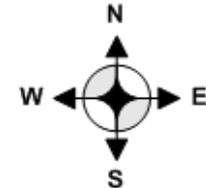
After Hours Triage & Treatment

1. Contract with urgent care centers and/or develop urgent care capacity among community clinics
2. Ensure all MSC members have access to a MSC-contracted clinical call center via medical home for afterhours services at medical home discretion



Facilities

1. Work with hospitals to ensure MSC members have consistent and reliable access to acute and tertiary care
2. Contract with skilled nursing facilities for subacute care



MSC Governing Entity

(Independent Not-for-Profit contracting with MSO)

1. Raises capital
2. Provides policy direction
3. Oversees program evaluation
4. Provides technical assistance and capacity building (PCMH, FQHCs)
5. Incubates ideas
6. Serves as neutral broker
7. Measures clinical quality and patient/provider satisfaction
8. Monitors access and capacity



Work Toward Shared Health Information Technology for Increased Connectivity, Coordination of Care and “Systemness”

Implementation Timeline

Potential Scope by Year

Year 1	<ul style="list-style-type: none">•Expand services to enroll uninsured into existing programs•Purchase coverage for uninsured from existing, affordable plan•Secure funding for new benefit program to address remaining gaps•Campaign to expand FQHCs to serve those with no payer source
Year 2	<ul style="list-style-type: none">•Roll out new plan
Year 3	<ul style="list-style-type: none">•Support transition of Medi-Cal eligible to CalOptima•Support transition of Health Insurance Exchange-eligible members•Review Yr1 & Yr2 data and consider future investments

Questions?



LINK to HMA REPORT

<http://www.healthmanatement.com/files/OC%20Report-Final.pdf>