

Steering Committee

REMINDER: please print your own hard copies of meeting materials

Meeting Date: Wednesday, March 12, 2008
Time: 2:00 pm to 4:00 pm
Location: 931 Spring Street, Conference Room

Committee Members: Greg Bergner, MD, John Bachman PhD, Dick Derby, Jim Ellsworth, Gayle Erb-Hamlin MPA, Jon Lehrman MD, Shannon Truesdell MPA RN, Chuck Wiesen

Invited Guests: Sandra Dunn MSc, Dana Davies, MPH, Rob Quadri, Maria Chaves, Kim Dickson,

<u>Time</u>	<u>Topic</u>	<u>Outcome</u>	<u>page</u>
2:05	1. Welcome, Introductions and Agenda Review		
2:10	2. Changes or additions to minutes from February 13, 2008	• Decision: approve, modify or reject	
2:15	3. EMPI Update - <i>Maria Chaves</i>	• Review	handout
2:30	4. Care Pathways iREACH go live - <i>Kim Dickson</i>	• Review	handout
2:45	5. Staff Updates - <i>Sandra</i> A. Policies B. Grants • CHCF Specialty Care Initiative planning grant • UHC -PacifiCare application	• A. Decision: approve, modify or reject • B. Review	
3:00	6. 2008 - 2010 Workplan - <i>Dana</i>	• Review, understand • Prepare for future review of resource implications	attached
3:20	7. Member updates - <i>all</i> • Round robin to share news and plans	• Common understanding	
3:55	8. Wrap Up, next meeting		

Facilitator: Dana Davies
Action items from last meeting: Final review of Program Manual Change Policy, Exhibit I.
Next meeting: Wednesday, April 9, 2008, 2:00 - 4:00 PM

Staff Report (March 2008)

California HealthCare Foundation Specialty Care Grant

- Attended CHCF-Kaiser grantee LA meeting on grantor specialty assessment goals & desired data
- Working w/ Provider Capacity workgroup & clinic’s referral specialist to ascertain what specialty referral data is possible to secure retrospectively or prospectively (see letter)
- Research will commence on alternative practice models
- David O’Neal from CHCF would like to attend SC meeting

PacificCare/United Healthcare Grant - submitted

Purpose & Scope

This proposal seeks to substantially advance two promising Health Information Technology (HIT) strategies that ACCEL is initiating in 2008: Cross-agency, jointly developed, clinical practice guidelines (Care Pathways with a clinical focus) and health information exchange (HIE). When built into electronic medical record systems, embedded practice guidelines allow clinicians to follow decision trees for specific conditions, based on the needs of their patients. Our proposal plans to take clinical guidelines to the next level -- to share Complex Clinical Pathways between otherwise separated care partners. HIE allows sharing of key clinical results and jointly developed clinical guidelines. Taken together, these activities provide a unique focus around which to implement our HIE, while creating best practices across providers, and improving access for underinsured populations. Building on the capabilities established with access Pathways we have in place, we propose to implement one or more complex clinical care pathways to synergistically combine the practice guideline approach with health information exchange We will choose a complex clinical condition that requires coordination between both generalists and specialists. Focus on a complex clinical condition that will provide an immediately practical application for the HIE, and it will define needed data elements to be shared for a common purpose.

Pain Management Illustration

Opportunities for HIE enabled clinical care pathways

Connect Settings	Bridge Barriers	Link Providers	Improve Outcomes
<ul style="list-style-type: none"> • Clinic • MD Office 	<ul style="list-style-type: none"> • MD knowledge/abili 	<ul style="list-style-type: none"> • Primary Care • Mental 	<ul style="list-style-type: none"> • Access • Treatment

<ul style="list-style-type: none"> ED 	<ul style="list-style-type: none"> ty to treat special condition Ability to rule out substance abuse with access to master Rx history Ability to see testing & treatment received Integrated, cohesive care plan 	<ul style="list-style-type: none"> Health services Social services Pain and other specialists 	<ul style="list-style-type: none"> plan compliance Clinical monitoring and surveillance Quality of care
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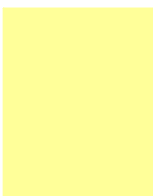
Use of Funds

The two (2) Project Deliverables are, I. **Clinical Care Pathway**, builds upon existing successful cross agency case management method and technology; II. **HIE Strategic Work** formalizes HIE procurement and amendments to existing governance agreements and policies.

Project Deliverable	Population Served	Geography	Description	Cost
I. Clinical Care Pathway	Safety-Net	County wide	Enlist clinical resources & toolset for cross agency patient management	\$ 283,533
II. HIE Strategic Work	County residents	County wide	Vendor procurement & ACCEL structural work	\$ 203,667

Budget Summary*

Category Expense	
Personnel	\$ 53,710



Contractual	
\$321,434	
Other Direct Costs	\$ 40,000
Capital	
\$ 58,000	
Indirect Costs (personnel + Other Direct \$))	\$
14,057	
TOTAL	
\$487,201	

AHRQ

- Carry Over Fund request - still awaiting outcome
- Quarterly report submitted

CalRHIO

- Updated ACCEL profile (available on their website)

NPP & iREACH Go live Dates

- February 19, 2008 – PHD, MHD, Marshall (NPP only)
- March 4, 2008 – EDCCHC
- March 21, 2008 – Barton
- Tribal – shortly (actual date TBD)

Dear Safety Net Provider Referral Specialist,

Project Access for El Dorado County (ACCEL) was awarded a planning grant from the California HealthCare Foundation (CHCF) to improve residents’ access to specialty care. As part of this project, ACCEL must assess the county’s need for specialty care and providers’ capacity to meet these demands. The SPHERE Institute, ACCEL’s evaluator, will conduct this needs assessment.

CHCF has provided ACCEL and SPHERE with an ambitious list of needs assessment indicators and several tools for data collection. However, we want to ensure that the needs assessment does not place undue burden on providers. Therefore, to better understand provider data collection capability, SPHERE participated in the ACCEL Provider Capacity Workgroup on February 26, 2008. Members suggested that SPHERE contact referral specialists within their agencies to get a better sense of what referral data is collected and how.

If you are able to participate in a brief phone conversation from March 4 – 7, please contact Ellie Coombs, ecoombs@sphereinstitute.org, with the days and times of your availability. As a reference, the questions that we would like to address during our conversation

are attached to this letter. Thank you for your support, and we look forward to hearing from you soon.

Sincerely,

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 The SPHERE Institute
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Questions on Specialty Care Referral Data

1. How is referral data collected (e.g. referral log)?
2. Are data collection systems electronic or paper based?
3. For an individual client, which of the following data elements are collected?:
 - a. Date of specialty care referral request
 - b. Recipient of referral request
 - c. Type of specialty care requested
 - d. Payer source
 - e. If the request is accepted, date of specialty care appointment
 - f. If the request is not accepted, reason for rejected referral

Steering Committee Review & Approval Calendar for ACCEL Program Manual

	SC Approval		
	Method	Target	Actual
I. Definitions	SC	12-10-07	12-10-07
II. Insurance			12-10-07
• Required Insurance	SC	12-10-07	“
• Evidence of Coverage	SC	12-10-07	“
III. Services			
• EMPI			
• Technology	SC mtg	4-9-08	
• Data Synchronization	SC mtg	4-9-08	
• Care Pathways	SC mtg	2-13-08	2-13-08
Technology	SC mtg	2-13-08	2-13-08
• Securing Health Care Coverage	SC mtg	2-13-08	2-13-08

• Obtaining a Medical Home	SC mtg	2-13-08	2-13-08
• (Newborns) Utilizing a Medical Home	SC mtg	2-13-08	2-13-08
• Pediatric Mental Health Consults	SC mtg	2-13-08	2-13-08
IV. Privacy & Security			
Notification of Privacy Practices			
• General Requirements	SC mtg	10-12-07	11-16-07
• NPP Simple Language	SC mtg	10-12-07	11-16-07
• Fact Sheet	SC mtg	10-12-07	11-16-07
• Opt Out Form	SC mtg	10-12-07	11-16-07
• Talking Points	SC mtg	10-12-07	11-16-07
• User Set Up			
• Confidentiality Agreement	SC mtg	12-10-07	12-10-07
• Confidentiality Patient Information	SC mtg	12-10-07	“
• User Set Up Application	SC mtg	12-10-07	“
• Auditing & Reporting	SC mtg	12-15-07	12-10-07
User access			
○ Authorizing & Requesting Access	SC mtg	12-10-07	“
○ Access Removal	SC mtg	12-10-07	“
○ User passwords	SC mtg	12-10-07	“
Emergency Access			
Patient Data Request			
V. Steering Committee			
• Charter	SC mtg	Summer '07	09-04-07
• Governance Agreement	SC mtg	12-10-07 01-09-07	1-9-07
• Changes to Program Manual	SC mtg	02-13-08	2-13-08
○ Modifying, Amending or Updating	SC mtg	02-13-08	
VI. Technical Support			
• Unique User Identification & Password Management Policy	SC mtg	1-9-08	1-9-08
• Security Awareness & Training Policy	e-vote	3-12-08	
• Risk Analysis Policy	e-vote	3-12-08	
• Data Transmission Security Policy	SC mtg	1-9-08	1-9-08
• Data Back Up Policy	SC mtg	1-9-08	1-9-08
• Data Custodian Roles & Responsibilities	SC mtg	1-9-08	1-9-08
• Disaster Recovery Policy	SC mtg	1-9-08	1-9-08
• Firewall Use Policy	e-vote	3-12-08	
• Information System Activity Review and Reporting Policy	e-vote	3-12-08	

• Media Re-Use Disposal Policy	e-vote	3-12-08	
• Automatic log off policy	e-vote	3-12-08	
• Data Integrity and Authentication Control Policy	e-vote	3-12-08	
• Support Model			
VII. Steering Committee Evaluation	SC mtg	01-9-08	1-9-08

- Items in yellow are for Steering Committee e-vote by 3/13/08
- Items in blue are being drafted

ATTACHMENT 1

TITLE: Changes to Program Manual

Category:	Policy Number:
Original Effective Date:	Current Revision Effective Date:

ACCEL may change (amend, repeal, or replace) the approved Policies and Procedures in the Program Manual at any time as deemed necessary.

Development and Dissemination of Changes

ACCEL is solely responsible for the development of the Policies and Procedures, and may amend, repeal or replace them at any time with approval from the ACCEL Steering Committee. ACCEL shall **determine the timeline for notification and** provide notice to all Participants of any changes to Policies and Procedures. ~~with at least (30) days prior to the effective date of change. (COMMENT – assuming these are reviewed by the SC, who else needs to be notified?)~~

ACCEL shall notify Participants immediately ~~in the event~~ **when notified** of a change required to comply with applicable laws and regulations. However, if ~~the~~ **urgent** change is required in order for ACCEL or Participants to comply with applicable laws or regulations, ACCEL’s principal staff may implement the change within a shorter period of time as ~~ACCEL determines~~ **d** appropriate under the circumstances. ~~(COMMENT: Who will approve this and how?).~~ **Such urgent changes will be brought to the Steering Committee for validation at a later date.** ~~ACCEL shall notify Participants immediately in the event~~ **when notified** of a change required to comply with applicable laws and regulations.

Participant Request for Reconsideration

Each Participant has the right to request reconsideration of a change. If a Participant objects to a change that has been approved by the Steering Committee, that Participant may, within (30) days following the ACCEL ~~notice~~ **approval** of change make a request to Steering Committee for reconsideration, noting the reasons for the objection. During this period, ~~the implementation of the disputed change is not required to be implemented by~~ of the Participant requesting reconsideration **and that Participant accepts responsibility for any and all consequences that may arise from not enacting recommended change.**

MEMORANDUM OF UNDERSTANDING
Regarding
PARTICIPATION IN CARE PATHWAYS PROGRAM

Exhibit 1

Description of ACCEL, the Program and Care Pathways Services

ACCEL is a county-wide health collaborative dedicated to improving El Dorado County residents access to and quality of health care, in part by building transparent patient program linkages cross agencies.

The Program. Care Pathways is a cross-agency case management program to ensure that a residents needs are attended to throughout many encounters in the health access and delivery process. Each pathway defines the problem to be addressed, the desired positive outcome, and the key intervention steps required to achieve the outcome. The program provides a standardized accountable structure to shift the focus towards defined, outcomes. It is a patient-centric process that addresses one health care issue at a time. As work steps are completed, they are defined by a measurable outcome.

Pathways can address administrative access or clinical issues. To date, [six](#) Care Pathways have been implemented: Securing Health Care Coverage, Obtaining a Medical Home, (Newborns) Utilizing a Medical Home Appropriately, (Newborns) Securing Health Care Coverage, Pediatric Mental Health Consult, [and Annual Eligibility Review](#). Community Health Workers (CHW) assists and monitors the person/patient progress through a Pathway. Care Pathways were developed as a paper process to enable clear cross-agency patient referrals with ‘transparent’ interactive work process definition. Automation of the paper processes was always envisioned to increase efficiencies, accurate timely communication and improved patient outcomes. ACCEL Participants automation of the paper processes will occur over time. Therefore it is expected that Care Pathway paper process for one ACCEL Participant will continue for the foreseeable future.

Although the Care Pathways electronic solution (iReach) will be accessible by Participant users at different sites and organizations, it is a stand alone product that does not exchange information with any other systems. The implementation of a county-wide Master Patient Identifier (EMPI) used with the Care Pathways electronic solution will support Participants exchange and update of demographic patient information and provide a match on patients at the different Participant delivery stations.

Care Pathways Services.

- Attachment I: Securing Health Care Coverage
- Attachment II: Obtaining a Medical Home
- Attachment III: (Newborns) Utilizing a Medical Home Appropriately
- Attachment IV: (Newborns) Securing Health Care Coverage
- Attachment V: Pediatric Mental Health Consult
- [Attachment VI: Annual Eligibility Review](#)

Attachment I: Securing Health Care Coverage

The Securing Health Care Coverage Pathway works to provide health insurance to children (infants through 18 years of age) from families of moderate to low income. Several insurance options are available, Medi-Cal, Healthy Families, Healthy Kids, California Kids, and Kaiser. Client determination of the appropriate insurance option is based upon meeting pre determined qualifying criteria. Client referrals to this ACCEL Care Pathway come from various agencies throughout the county, including but not limited to hospitals, clinics, County Mental Health Department, schools.

Community Health Worker's (CHW) assist clients in assessing the appropriate insurance option, completing the application packet, and compiling the necessary documents to ensure a successful insurance coverage outcome. This pathway is considered successful when the child has obtained health care coverage.

Attachment 2: Obtaining a Medical Home

This ACCEL Care Pathway is designed to assist families in obtaining a Medical Home, otherwise known as having their own doctor / clinic to receive ongoing primary care. Through a countywide partnership, this pathway is able to offer families a "permanent" doctor / clinic for their child, when they would otherwise use the Emergency Room for their Medical Home. The ER refers children to ACCEL who present at the ER for non-urgent care and who do not have a primary care physician. The CHW initially assesses if the child has Health Care Coverage, routes them through the Securing Health Care Coverage Pathway if necessary, and then pairs them with doctors based on client location, insurance type, and preference. Meanwhile the CHW seeks to provide education to the client on the benefits to a consistent medical home, preparing for a physician visit, while also identifying and working through any barriers that might inhibit the client from successfully establishing their own medical home.

Attachment III. (Newborns) Using Medical Home Appropriately

Maneuvering through newborn checks, immunizations, and common illnesses can be daunting. This ACCEL Care Pathway strives to come alongside mothers of newborns on Medi-Cal, and assist them in a successful first year of life for their child. For eight months, the CHW assists in: establishing a medical home for the newborn, providing health education to the mother, and overcoming barriers that may inhibit the mother from accessing appropriate medical care for her child. Well Baby checks and immunizations schedules are monitored by the CHW, who reminds the mother of appointments and problem solves with the mother when appointments are missed.

Attachment IV. (Newborns) Securing Health Care Coverage

This ACCEL Care Pathway is designed to assist mothers whose births were funded through Medi-Cal in adding their child to the mother's Medi-Cal coverage. At one year of age, the CHW will reassess what type of health care coverage the child is eligible for and begin the Securing Health Care Coverage Pathway for the child.

Attachment V: Pediatric Mental Health Consult

This ACCEL Care Pathway allows primary care providers to make direct referrals to the County Mental Health Department for Medi-Cal or Healthy Families children. The Mental Health Department provides an assessment, and if necessary, treatment for the child. Both the Mental Health Department's primary assessment and final assessment are sent to the referring physician. The Community Health Worker plays the unique role of advocate for the child, interceding

between the physician's office, the Mental Health Department, and the client - reminding the client of appointments, informing the different entities of client barriers, or provider delays.

Attachment VI: Annual Eligibility Review (AER)

This ACCEL Care pathway picks up where the Securing Health Care Coverage and Newborn Securing Healthcare Coverage Pathways end. Nine months after children are successfully enrolled in insurance, the Public Health Department Community Health Workers are alerted through the iREACH system, to review the client information. The CHW then contacts the client and assists the client in retaining or enrolling in the appropriate insurance for the coming year.