Aging & Independence Services (AIS)
Long Term Care Integration Project (LTCIP)
Update for the Health Services Advisory Board (HSAB)
March 9, 2017

The goal of the Long Term Care Integration Project (LTCIP) is to improve the delivery of health care and long term services and supports for older adults and persons with disabilities. This report includes updates on some key LTCIP activities.

Aging and Disability Resource Connection (ADRC):

Background: The Aging and Disability Resource Connection (ADRC) is a partnership between AIS and Access to Independence. Between the two agencies, the ADRC provides persons of all ages, abilities, and incomes, their caregivers, and service providers with free, comprehensive information about long term services and supports (e.g., personal care, household chores, meals, transportation, home modification, etc.) in San Diego County and delivers care transition support, care management, and options counseling. The ADRC Advisory Committee gives input on community needs and how the ADRC agencies can improve these services.

Update: Members are currently considering various ways to structure our ADRC Advisory Committee meetings in order to make them most meaningful and helpful for guiding the services of the ADRC. Contact Kristen Smith if you are interested in being part of this group. (kristen.smith@sdcounty.ca.gov).

Community-based Care Transitions Program (CCTP):

Background: CCTP was established under Section 3026 of the Affordable Care Act (ACA) in 2011 as a 5-year demonstration to link community based organizations with hospitals to improve care that high-risk Medicare patients receive as they transition across different care settings, reduce the readmission rate for high risk patients and reduce Medicare spending. The San Diego Care Transitions Partnership (SDCTP), a partnership between AIS and Palomar Health, Scripps Health, Sharp HealthCare and the UCSD Health System (13 hospitals) has provided comprehensive, person-centered, health care and social services to over 57,000 high-risk, fee-for-service (FFS) Medicare patients across thirteen participating hospitals since its inception in January 2013. Over the past three years SDCTP has reduced the 30 day, all-cause readmission rate from 21.2% to 10.5% resulting in an estimated $13,793,462 in Medicare savings. The SDCTP's success has resulted in several extensions.

Update: The program enrolled patients until January 31, 2017, and closed the final cases at the beginning of March. Final participation numbers will be reported in April. AIS and Palomar Health have executed a contract for AIS to serve Palomar patients beyond the CCTP, and AIS has begun to provide services for some patients via this contract. AIS and the hospitals will continue to meet twice a year to share best practices regarding Care Transitions.

Coordinated Care Initiative (CCI):

Background: San Diego County is one of seven counties in California selected to implement the Coordinated Care Initiative (CCI), an improved delivery system that provides coordinated health care and long term services and supports (LTSS) to dual eligible and Medi-Cal only beneficiaries in the county. Begun in 2014, CCI consists of two components: 1) mandatory enrollment of dual eligible beneficiaries into managed care for all of their Medi-Cal benefits, including LTSS, and 2) the dual demonstration project, Cal MediConnect (CMC), which provides dual eligible beneficiaries the option of selecting one managed care plan to administer and coordinate both their Medicare (acute medical care and hospitalizations) and Medi-Cal benefits. Those duals who do not choose this option continue to receive fee-for-service Medicare. CCI health plans are required to offer four types of LTSS: MSSP, IHSS, adult day healthcare and skilled nursing care. In San Diego County, health plans must partner with AIS for the administration of MSSP and IHSS. CMC health plans may offer other discretionary LTSS known as Care Plan Options (CPO), which include a wide array of a la carte services and support, and also offer transportation and vision benefits. According to the recent enrollment figures published by the Department of Health Care Services (DHCS), there were 14,690 San Diego County duals actively enrolled in Cal

MediConnect (CMC) as of February 1, 2017. However, CMC enrollment in San Diego County continues to hold at 33%, meaning that 67% of have either opted-out or have disenrolled from CMC. That said, the opt-out/disenrollment rate from CMC slowed over the second half of 2016 and with DHCS' recent implementation a new comprehensive strategy to improve CCI, there may be an avenue to increased, sustainable enrollment.

Update: The Governor's proposed budget and the changes to the CCI were discussed at the quarterly CCI Advisory Committee meeting held on Wednesday, February 1, 2017. The California Department of Finance determined that the CCI program is not cost effective, prompting a process that ceases all statutory provisions related to CCI as of January 1, 2018. This year DHCS will be restructuring parts of the program in an effort to make it cost effective. While the CCI has been technically "discontinued," most components remain the same and beneficiaries will not experience changes in service. The main changes are the following:

- The cost of the In-Home Supportive Services program will be removed from the Health Plans' bundled, capitation rates and will be reverted back to prior state-county share of cost arrangements and IHSS will also return to being a fee-for service benefit.
- Although the funding for IHSS will no longer be included in the Medi-Cal managed care capitation rates, the Governor's proposed budget "encourages" Medi-Cal managed care plans and counties to continue "collaborating" on care coordination.
- The seven CCI counties will also regain collective bargaining responsibilities for IHSS workers' wages and benefits.
- The transition of MSSP from community-based providers (i.e., AIS for San Diego County) to the Health Plans that was to be effective as of January 1, 2018, is now being postponed to January 1, 2020.

The Governor and DHCS are committed to improving the coordination of care for dual-eligible individuals and DHCS will continue to work with stakeholders, health plans and providers to make Cal MediConnect a cost effective program that enhances the quality of care.

National Committee on Quality Assurance:

Background: In November 2015, AIS was one of ten organizations chosen from across the United States to participate in the National Committee on Quality Assurance's (NCQA) 18-month long program: *Piloting Standards to Support Coordination of Long Term Services and Supports (LTSS) Learning Collaborative*. NCQA's new Case Management Accreditation for LTSS is a comprehensive accreditation program dedicated to quality improvement. To prepare for accreditation, AIS created a standardized training academy for our social workers, developed an comprehensive assessment tool that is reflective of person-centered care (PCC), and we are establishing a Policies and Procedures manual that focuses on person-centered care and NCQA case management standards for LTSS. The timeline for the accreditation process is over 1 year, so we hope to gain accreditation in early 2018. NCQA staff conducted a site visit in October. The purpose of the site visit was for NCQA to evaluate their own process of developing the new standards. Although the NCQA visitors were not the same staff as the future accreditation survey evaluators, they provided very helpful feedback.

Update: AIS has submitted our application for participating in the accreditation survey. We anticipate that period of program file review will be March or April 2017 through September 2017.

The Alzheimer's Project:

Background: In 2014, under the leadership of Supervisor Dianne Jacob, the County launched The Alzheimer's Project, an unprecedented regional initiative that has united ADRD stakeholders from multiple community sectors to address the toll the disease is taking on our families, communities, and local health care systems. The Board of Supervisors, in March 2015, approved a comprehensive regional strategy with short and long-term recommendations, developed by roundtable groups working under the umbrella of The Alzheimer's Project. This strategy encompasses four key areas: the search for a cure (Cure Roundtable/Collaboration4Cure (C4C)), clinical diagnosis and disease management (Clinical Roundtable), care for San Diegans living with ADRD and their caregivers (Care Roundtable), and public education (Public Outreach and Awareness Roundtable). The Alzheimer's Project also supports legislation and pursues funding opportunities that advance the regional strategy. This year Kristin Gaspar, San Diego County's newest Supervisor representing District 3, joins Chairwoman

Dianne Jacob in leadership of this ambitious regional initiative. AIS plays a key role in several aspects of The Alzheimer's Project, including creating Annual Reports, maintaining the project's website, and supporting the Care Roundtable. The Care Roundtable's recommendations are linked to the Long Term Care Integration Project, in that there is a shared vision of better connected health and social services.

Update: Two Care Roundtable recent projects that help further the goal of integrating long term care include:

1) In September 2016, AIS was awarded a three year, $1 million grant to improve the dementia-capability of the local service system. Through the grant, AIS will implement the FIRST project (First Identify and Refer, then *Serve* and Track) to conduct the following activities:

    - Increase identification of individuals with dementia through brief screening and referrals for diagnosis.
    - As a partner in the FIRST initiative, Alzheimer's San Diego will expand their respite services with a voucher program.
    - Alzheimer's San Diego will train AIS social workers and nurses to deliver an evidence-informed behavioral symptom management program to family caregivers in the home.
    - AIS will administer *Serve*, a dementia-specific case management program, which will include respite care and behavioral symptom management training.
    - Best practices and trainings developed under the FIRST initiative will be expanded and made available to community partners.

2) The Care Roundtable began work on its long term recommendation to increase the availability and affordability of care options (e.g., adult day care/adult day healthcare, assisted living, and in-home care). To this end, AIS worked with several state departments, along with HHSA's new division, Housing and Community Development, to host two forums on potential ways to use state and federal mechanisms, such as the Assisted Living Waiver, Project Rental Assistance 8II grant awards, the Nursing Facility/Acute Hospital Waiver and the No Place Like Home Program. Approximately 200 professionals from the housing and senior service fields participated in the forums and now that these diverse sectors are connected, work can begin on finding ways to increase affordable supportive housing in order to avoid or transition out of nursing homes.

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