AGING & INDEPENDENCE SERVICES
COUNTY OF SAN DIEGO ■ HEALTH AND HUMAN SERVICES AGENCY
LONG TERM CARE INTEGRATION PROJECT

Aging & Independence Services (AIS)
San Diego Long Term Care Integration Project (LTCIP)
Update for the Health Services Advisory Board (HSAB)
May 2013

The goal of the Long Term Care Integration Project (LTCIP) is to improve service delivery for older adults and persons with disabilities. To achieve this goal, three incremental strategies were established: (1) The Aging and Disability Resource Connection (ADRC) (2) TEAM SAN DIEGO and (3) An Integrated Acute and Long Term Care Service Delivery Model (Coordinated Care Initiative which includes Cal MediConnect).

Aging and Disability Resource Connection (ADRC)

The Community-based Care Transitions Program (CCTP)

On November 14, 2012, the Health and Human Services Agency (HHSA), Aging & Independence Services (AIS) entered into a Program Agreement with the Centers for Medicare and Medicaid Services (CMS) to implement CCTP in partnership with Palomar Health, Scripps Health, Sharp HealthCare, and the University of California San Diego (UCSD) Health System. CCTP is funded under Section 3026 of the Affordable Care Act (ACA). CCTP will target up to 21,390 high-risk, fee-for-service Medicare patients each year in 13 hospitals.

CCTP has been implemented in all partnering hospitals except Scripps Mercy Chula Vista, which is expected to begin providing CCTP services later this month. Since CCTP began on January 22, 2013, AIS invoiced CMS for 357 fee-for-service Medicare patients who received one or more interventions to reduce their risk for a readmission. AIS enrolled 85 UCSD and Palomar patients into the Care Transitions Intervention (CTI) Program and 27 patients into the CTI Care Enhancement Program across the partnering hospitals.

The Beacon CTI Program

The Care Transitions Intervention (CTI) Program which was funded by the San Diego Beacon Community Collaborative began in December 2011 at UC San Diego Medical Center and in February 2012 at Scripps Mercy Hospital San Diego and Sharp Memorial Hospital Through one hospital visit and one home visit, and a series of follow-up phone calls by a trained Transitions Coach employed by AIS whose primary role was "to coach, not do," 426 patients with chronic health conditions developed improved capacity in the areas of medication management, personal health record keeping, knowledge of "Red Flags," and follow-up care with primary care providers and specialists.

The patients who participated in this program were primarily unfunded; self pay, Low Income Health Plan (LIHP), County Medical Services (CMS), or Medi-Cal and were under the age of 65. These patients were often homeless, had multiple unmanaged chronic health conditions and were at significant risk for a readmission. Several months after the program began, a Social Worker and a Spanish Language Interpreter, also employed by AIS, were added to the Beacon CTI Team to support the Transition Coaches (Registered Nurses) who were often providing coaching in the back of a pick-up truck, a shelter or wherever the patient happened to reside at the time a home visit could be scheduled. Early on in the program, it became evident that coaching alone was not going to prevent a readmission if the patient had no home, no money for food and medications, and no Medical Home. The Beacon CTI Team met both the complex health and social service needs for these patients, and this was key to preventing readmissions.

The Beacon CTI Program proved to be quite effective in reducing the all-cause, 30 day hospital readmission rate for patients who completed CTI when compared to the all-cause readmission rate for an equivalence sample of patients. Although 426 patients completed the CTI program across the three participating hospitals when the

program ended on March 31, 2013, the data that was used to evaluate the program represents 298 patients, a subset of the total number of patients served through the program. The enrollment cut off for inclusion in the analysis was different for each hospital (August, September, or October of 2012). The equivalence sample was obtained from the Office of Statewide Health Planning and Development (OSHPD), which included all inpatient discharges in 2010 from each of the three hospitals participating in the CTI Program.

The readmission rate of 12.4% that was achieved for these 298 very medically and socially complex patients was considerably lower than the estimated 21.2% readmission rate for an equivalence sample of patients that was used for comparison. Based on the estimated readmission rate for the equivalence sample of patients if these 298 patients had not completed CTI, we would have expected to have 63 (298 x 21.2%) readmissions. Among those who were provided CTI, only 37 patients were readmitted, resulting in an estimated 26 (63 - 37) prevented readmissions.

TEAM SAN DIEGO

No updates at this time.

Demonstration to Integrate Care for Dual Eligible Individuals

The Memorandum of Agreement (MOA) between the Department of Health Care Services' (DHCS) and the Center for Medicare and Medicaid Innovation (CMMI) for the Coordinated Care Initiative (CCI): State Demonstration to Integrate Care for Dual Eligible Individuals was signed on March 27th. The CCI and the Dual Eligible demonstration project component, now called Cal MediConnect, is now scheduled to begin no sooner than January 1, 2014 and will end December 31, 2016, unless extended. Duals receiving Long Term Services and Supports (LTSS) including IHSS, SNF, MSSP and CBAS will be enrolled in CCI in their birth month. The Dual Eligible beneficiary can opt out of Cal MediConnect by electing to remain in FFS Medicare; however, they must remain in CCI to receive the LTSS identified previously.

AIS, Public Authority, and Behavioral Health staff have been meeting regularly with the health plans for the past two years to discuss plans for integration and to develop MOUs. The draft MOUs between the County and the health plans for Behavioral Health services, IHSS and Public Authority were submitted by the health plans to the State as required, in preparation for the health plans' readiness reviews.

Over the past year, AIS has also provided assistance to the health plans in administering the CCI Advisory Committee. The CCI Advisory Committee formed a CCI Communication Workgroup that will work with the State's outreach and communication contractor, Jaime Mulligan from Harbage Consulting, to develop a strategic outreach and education plan for San Diego that specifically addresses the needs of the diverse stakeholders in our community. The workgroup's goal is to ensure that outreach to impacted individuals is done in a comprehensive consumer-centered fashion, utilizing communication channels already in place within our county.

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