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

Aging & Independence Services (AIS)
Long Term Care Integration Project (LTCIP)
Update for the Health Services Advisory Board (HSAB)
March 19, 2015

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 (the Coordinated Care Initiative, which includes Cal MediConnect).

The LTCIP Quarterly Stakeholder meeting was held on Friday, March 13, 2015 from 8:30 to 10:00am at Aging & Independence Services. This quarter, we were joined by Megan Burke, Policy Analyst from The SCAN Foundation and Blanca Castro-Paszinski, Advocacy Manager at AARP-California who provided an overview of the second edition of the State Long Term Care Performance Report titled *Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers.* Their presentation detailed California's Scorecard results and outlined the policy implications and opportunities that will help our state to better meet the needs of the aging population. A recording of the meeting along with the meeting materials can be found on the Long Term Care Integration Project website at www.sdltcip.org under the LTCIP meeting materials tab.

The Community-based Care Transitions Program (CCTP) 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) began year three of the Community-based Care Transitions Program (CTTP) on January 1, 2015. The SDCTP will serve over 19,000 high-risk, fee-for-service (FFS) Medicare patients across the thirteen participating hospitals this year. The SDCTP has begun the year strong serving 1,556 high risk, FFS Medicare patients in January. Since the program began, 27,390 patients have received specialized care that included support from transitional care nurses, licensed pharmacists, healthcare coaches and social workers.

The Centers for Medicare and Medicaid Services (CMS) has identified San Diego's CCTP as a top performer and has been particularly impressed by the SDCTP's use of technology to support comprehensive care transition services and program administration. On Feb 19th, Carol Castillon, CCTP's Operation Manager, and Deborah Marquette, CCTP's Principal Analyst, were invited to present how the SDCTP leverages technology on a webinar to more than thirty staff within the Administration on Community Living (ACL), CMS, and the Office of the National Coordinator (ONC). Ms. Castillon and Ms. Marquette educated webinar participants about the number of different technologies that are used by the SDCTP to support the exchange of patient information, billing and performance data. The use of technology has been one of the cornerstones of the SDCTP's success.

Among CCTP sites, it is rare that a community-based organization's staff has access to the partnering hospitals' Electronic Medical Record (EMR) systems. In the SDCTP, all AIS nurses, social workers, their supervisor, and manager have access to the EMR systems, which include Epic, Cerner, Midas and Clarity. Through the EMR, AIS' CCTP staff complete chart reviews, track a patient's health status, and upon the patient's discharge from the hospital verify discharge orders and follow up care. EMR access has improved the accuracy of information that is communicated across the care continuum. AIS' CCTP staff also have mobile access to the hospitals' electronic case management system, Allscripts. Through Allscripts, AIS staff can securely access patient referrals from the hospitals via their mobile devices, and document in-home, patient assessments. Real-time documentation facilities timely and effective

communication between AIS and the hospitals about the patient's home environment and psychosocial needs, and supports comprehensive care coordination. Customized, ad-hoc reports from Allscripts allow the SDCTP to monitor the progress of the program and implement rapid process improvements.

To support the administration of the CCTP, a Microsoft CRM application, ALEX, was designed by the SDCTP and is used to manage the day-to-day invoicing, data collection, monitoring and reporting. SDCTP hospital staff can directly enter patients who received CCTP services into the system, as well as review the status of existing patients. AIS' CCTP staff use Alex to create and edit invoices, update patient/hospitalization information, create ad-hoc reports, and manage user access.

The Coordinated Care Initiative (CCI)

As the Regional Aging and Disability Service and Advocacy Coalition for San Diego County funded by The SCAN Foundation, the LTCIP has been actively supporting the Coordinated Care Initiative (CCI) managed care health plans to ensure a successful implementation of CCI in San Diego County by assisting with both the CCI Advisory Committee and CCI Communication Workgroup. At the March 4, 2015 meeting of the CCI Advisory Committee, updates on consumer experience were provided by key stakeholders. The committee discussed its changing focus from rollout to implementation in San Diego County as March marks the last month of passive enrollment in Cal MediConnect. The Advisory Committees' efforts over the past year prioritized consumer outreach and provider education, which resulted in the development of numerous educational materials, the establishment of a CCI Virtual Toolkit on the LTCIP website, and a successful Tele Town Hall meeting that targeted IHSS beneficiaries. As passive enrollment comes to an end, the Advisory Committee will concentrate on the evaluation and growth of the program. As of February 1, 2015, 19,942 San Diegans were actively enrolled in Cal MediConnect and another 1,792 beneficiaries are projected to enroll in March 2015. According to the Assembly Budget Subcommittee, the IHSS opt-out rate in San Diego County is hovering around 53%, and the disenrolled rate is about 17%. A significant number of San Diegan IHSS recipients are dual eligibles and hence these figures highlight the need for more targeted messaging relating to the benefits of Cal MediConnect as well as learning more from this population about what the barriers to enrollment are and strategizing how we can overcome them.

The hallmark of the Cal MediConnect program for dual eligibles is the delivery of coordinated medical, behavioral health, long-term institutional and home and community-based services through a single health plan. The Health Risk Assessment (HRA) is a survey conducted by the health plan that evaluates a beneficiary's current health status, The HRA serves as the foundation of the beneficiary's individual care plan that will ensure that the beneficiary is connected to the right services, at the right time and in the right setting. Cal MediConnect plans must conduct an HRA within *at least* 90 days for all beneficiaries. The Department of Health Care Services (DHCS) has released a new dashboard that tracks the HRA completion rates of all Cal MediConnect plans. Locating members and convincing them to participate in the HRA has been a challenge. The dashboard will be published quarterly on the CalDuals website (www.calduals.org).

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