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)
May 21, 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).

Aging and Disability Resource Connection (ADRC)
San Diego County's Aging and Disability Resource Connection (ADRC) is a shared, core partnership between Aging & Independence Services (AIS) and Access to Independence, the local Independent Living Center (ILC). 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 (LTSS); a no wrong door access to important programs, resources, services, planning and communication tools; care transition services; and application assistance for entitlement programs.

The San Diego County ADRC is a member of the Administration on Community Living's (ACL) learning collaborative initiative for Targeted Technical Assistance to build the *Business Capacity of Community-Based Aging and Disability Organizations for Integrated Services Partnerships*. The ACL held a two-day, in person learning collaborative meeting on April 15-16th in Alexandria, VA to build the foundation for a business model that will support sustainability of key programs. Over the two-day meeting, collaborative members developed action plans around 3 business capacity areas: Knowing Your Market, Developing Service Packages, and Structuring Your Network. AIS was invited to present on our journey toward developing an array of services that AIS can provide to medically and socially complex patients and health plan members, and to share our insights and lessons learned from working and contracting with healthcare payers and providers. The goal of the technical assistance that is provided by ACL consultants throughout the project is to help awarded community-based organizations to establish at least one new contract with an integrated care entity to provide community-based, long-term services and supports by the end of the initiative. AIS has already met that goal by executing a contract in April with Molina Healthcare of California to deliver complex case management services to their high-risk members.

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 (CCTP) on January 1, 2015. The SDCTP will target over 19,000 high-risk, fee-for-service (FFS) Medicare patients across the thirteen participating hospitals this year. The SDCTP began the year strong serving close to 4,500 high risk, FFS Medicare patients since January 1, 2015. Since the program began in January 2013, 30,324 patients received specialized care that included support from transitional care nurses, licensed pharmacists, healthcare coaches and social workers.

Having reduced the readmission rate for patients who participated in CCTP by 65.6%, the SDCTP continues to leverage best practices to streamline and improve care transition practices. Additionally, AIS continues to demonstrate the importance of addressing the social determinants of health to reduce the risk for an avoidable readmission. By expediting enrollment in essential social service programs and purchasing services for patients at high risk for a readmission until permanent solutions are in place, AIS has prevented readmissions and contributed to the significant overall savings to Medicare of over $2M

achieved by the SDCTP. On May 4, 2015, AIS Director, Ellen Schmeding, met with Dennis Wagner and Dr. Paul McGann, Co-Directors of the Partnership for Patients Initiative at the Centers for Medicare & Medicaid Services (CMS) Innovation Center (CMMI). Both were extremely complimentary of the SDCTP's incredible hard work, the visionary leadership that brought the project into being, and the acknowledged the difference that the SDCTP has made to the Medicare beneficiaries in our region.

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 actively supported the rollout of the Coordinated Care Initiative (CCI) in San Diego County by assisting with both the CCI Advisory Committee and the CCI Communication Workgroup. At the May 6, 2015 meeting, the CCI Advisory Committee was joined by Department of Health Care Services' (DHCS) new CCI Leadership: Claudia Crist, Deputy Director, Health Care Delivery Systems and Hannah Katch, Assistant Deputy Director Health Care Delivery Systems who shared their vision for CCI/Cal MediConnect moving forward now that the focus has shifted from passive enrollment to new enrollment and member retention. The CCI Advisory Committee also welcomed Hilary Haycock, president of Harbage Consulting, DHCS' contractor supporting CCI stakeholder engagement, policy development and program operations. Together they engaged the Advisory Committee in a meaningful discussion on how we can work together to increase participation in Cal MediConnect and how the committee could capitalize on our successes and address our challenges through future provider and beneficiary outreach.

As of April 1, 2015, 19,242 San Diegans were actively enrolled in Cal MediConnect (CMC). Passive enrollment into CMC was set to end in March; however, there are 210 pending enrollments for the month of May. According to DHCS, the 210 pending enrollments are dual eligible beneficiaries who enrolled in a CMC Dual Special Needs Plan (D-SNP) after October 2014 (when notices went out for January enrollment). Since these beneficiaries did not receive timely notice about having to either enroll in CMC or return to fee-for-service Medicare, there passive enrollment was extended to May. The main challenge that continues to impact beneficiaries enrolled in CCI is continuity of care, more specifically the insufficiency of the 30-day retroactivity requirement. Furthermore, balanced billing is beginning to occur more frequently among beneficiaries who opted out of CMC because some physicians refuse to work with their patient's managed care health plan and are shifting the financial burden to the patient. In San Diego County, the overall opt-out/disenrollment rate in CMC continues to hover around 62%.

Brenda Schmitthenner, MPA, Aging Program Administrator
Health and Human Services Agency, Aging & Independence Services (AIS)
Manager of the Long Term Care Integration Project (LTCIP)