

Strategic Models Implementation

Dr. Mark Meiners has assisted San Diego stakeholders in identifying three strategies to move us closer to our goal of fully integrated care. These strategies serve as stand alone components which will improve upon the current long term care service environment in San Diego. Taken together, they serve as an intertwined strategy that allows continued progress toward full integration of acute and long term care. Workgroups have self-selected to participate in brainstorming sessions and the strategy workgroup names will be used to describe the three strategy ideas. Workgroup structure looks like this:



Strategy 1: Network of Care

The County of San Diego has purchased a software product created with grant funds from the California Department of Aging called the "Network of Care". It was designed and developed in Alameda County as a web-based approach to user-friendly information gathering on long term care services for consumers and caregivers. It has many practical applications such as the ability to build your own library of services or health-related information from a number of linked resources.

The program also offers an individual a place to maintain a personal medical record, including items like his/her medical history, medication list, and Durable Power of Attorney for Healthcare. Family and professional staff can then be provided the password by the individual to access the record. There is also a link to the California Legislature's web site for the purpose of advocacy with local lawmakers.

The LTCIP strategy for the Network of Care is to procure resources to formulate and perform beta testing with consumers and caregivers in San Diego.

Additionally, this testing would be expanded to several groups: information and referral specialist who are County Call Center staff as well as information and referral staff in the broader community; and health and social service providers.

The goal is to develop a continuous quality improvement program that will allow all

stakeholders in San Diego access to a set of resources that is consistently accurate and meets the needs of all users.

Resources needed for this strategy include ???

Strategy 2: Socio-Medical Care Management

Managed Fee-for-Service has long been identified as an improvement over no management of care for persons with chronic diseases. Managed Fee-for-Service activities often include prior authorization, concurrent review, provider selection, provider and consumer education, coordination between Medicare and Medicaid benefits, and demand management to improve care for persons with chronic disease.

Fee-for-Service healthcare delivery to aged and disabled Medi-Cal recipients in San Diego has resulted in poor elderly with multiple chronic illnesses presenting to the Medi-Cal waiver program (Multipurpose Senior Services Program) with up to 8 physicians and 20 prescription medications, all of which are unknown to any of the physicians.

The strategy for Socio-Medical Care Management is to identify and engage and incentivize local physicians/groups who serve elderly and disabled persons with chronic disease and to provide them care management team resources to improve patient outcomes in the community. "After office" services will become part of the physician treatment plan as the care manager links the physician and his/her staff to community-based care and communication across the health and social service continuum.

Value added items for physician/physician groups will include: training in geriatric/chronic disease protocol; training for office staff on use of the Network of Care as a resource for staff and patients; and pharmacy benefit management and/or consultation. A small group of San Diego physicians have stated that access to care management resources would also free more of their time for medically oriented activities.

The target population to be served will be dually eligible elderly and disabled individuals identified as having chronic disease that impacts their independence in activities of daily living. The goals of this strategy include:

1. Engagement of the physician community in evaluating for/coordinating with community-based services to support the health care treatment plan for persons with chronic disease;
2. Improvement in the quality of care and outcomes for persons with chronic disease;
3. Maintaining maximum beneficiary independence and choice within current physician relationships rather than moving to a full managed care model; and

4. Reduction in the fragmentation between health and community-based care, with management of costs and services for beneficiaries across Medi-Cal and Medicare programs.

Resources needed for this strategy include physician identification, recruitment and training, care management dollars, possibly an incentive payment for physicians, and an evaluation of the quality, effectiveness, and implications for future system development.

Strategy 3: Health Plans/Pilots

In order to test more fully-integrated models and their effectiveness in managing care and improving outcomes for persons with chronic disease, two voluntary pilots will be developed and implemented in conjunction with the State Office of Long Term Care. The Healthy San Diego Health Plans Pilot will develop a plan centered around the current Medi-Cal managed care program expanding expertise and service array to implement the integrated delivery of health, social, and supportive services for a capitated rate from the state.

1. The target population will be individuals who are: dually eligible to Medicare and Medi-Cal, receiving In-Home Supportive Services, at a skilled nursing facility level of care, residing in the community or in a facility. Care management will coordinate services across the health and social service continuum. Care managers will administer multi-dimensional assessments and develop a consumer-centered care plan in conjunction with other members of the care team—physician, consumer, family, caregiver(s), providers. This strategy will demonstrate the capacity of the existing Medi-Cal managed care environment to provide a continuum of care to frail elderly and disabled persons who are dually eligible.

Resources are needed for planning activities, coordination among health plans and with the Office of Long Term Care, actuarial analysis, network development assistance, and evaluation of this strategy, its quality and effectiveness, and implications for future system development.

The second health plan pilot will be one proposed by Lifemark Evercare, a national leader in integration, with current projects in Arizona, Texas, Florida, and other states. Lifemark Evercare proposes to contract with the state Office of Long Term Care for a capitated rate to provide an integrated continuum of health and social services for individuals on Medi-Cal who are at a skilled nursing facility level of care living in a community setting. In-Home Supportive Services, and its funding, is proposed to be included. Inclusion of this target population will be on a voluntary basis.

Lifemark Evercare has not requested resources to implement this pilot, but resources will be needed for the evaluation of the pilot, its quality and effectiveness, and implications for future system development.

The goals of both pilots are:

- To improve the quality of care and outcomes through management of health and social services for dually eligible Medicare and Medi-Cal recipients from a single entity;
- To maintain individuals in the least restrictive setting including home and community settings;
- To comply with the provisions set forth in the Olmstead Decision; and
- To move incentives and resources to community-based care as a deterrent and replacement for higher level acuity care, including repeated emergency room and hospital use.