

**Community partnership** - The San Diego County Long Term Care Integration Project (LTCIP) is part of a multi-county initiative launched by the California legislature (AB 1040) to stimulate community-based long term care (LTC) innovation. The specific focus is to encourage better systems of care for aged and disabled Medi-Cal beneficiaries with special attention to those eligible for Medicare and MediCal (dual eligibles). Since 1999, San Diego County has received several small planning grants from the State Office of Long Term Care (OLTC) in recognition of its leadership potential. This support has resulted in extensive stakeholder input and commitment to pursuing this goal. It is estimated LTCIP stakeholders have dedicated over 10,000 hours to project activity, as documented on the LTCIP website: [www.sdcountry.ca.gov/cnty/cntydepts/health/ais/ltc/](http://www.sdcountry.ca.gov/cnty/cntydepts/health/ais/ltc/).

Through this consensus development process the LTCIP stakeholders (including over 500 consumers, caregivers, and health and social service providers) have developed a shared “vision” that balances community interests and concerns. It involves the following incremental strategies designed to be complementary components of an improved system of care for aged and disabled populations: **Strategy 1, Network of Care (NoC)**, will systematically test, build, and improve upon a web-based, community-wide information and referral database for health and social information and services for elderly and disabled individuals that is in use in San Diego (SD) and numerous other California counties. **Strategy 2, Physician Strategy**, builds upon Managed Fee-For-Service (MFFS) models that have begun to emerge in other states as a step toward integrating social and health services. This strategy will test pilots in several physician groups designed to improve care through coordination of Medicare and Medi-Cal services and community-based health and social services. **Strategy 3, Health Plan Pilots**, will test voluntary, fully integrated acute and long term care pilots with combined Medi-Cal and Medicare capitated funding to health plans.

These three strategies are responsive to the varying levels of interest and support for integrated acute and LTC in SD. They serve as complementary components that will improve upon the current LTC service environment in SD and represent an intertwined strategy that allows continued progress toward full integration of acute and LTC. At the core of this vision is the need for a unified and reliable source of information that supports the integration of both the medical and social aspects of chronic care in a way that helps

consumers and providers support self-directed care. This grant will focus on the NoC strategy as the vehicle to accomplish that core component of the SD LTCIP vision.

**Target Population** - Based on previous and on-going research and feedback from the LTCIP's Physician Strategy Workgroup, the NoC Strategy will target all county residents, with a special focus on consumers with chronic conditions requiring LTC support and caregivers & providers with vested interests in serving those with chronic care needs. The following four target groups have been identified for formalized testing, as they are seen as key constituency representatives in the LTC system: 1) Consumers with chronic conditions and/or disabilities, including many ethnically diverse sub-populations that are typically underserved, as well as those with physical, mental health, and/or developmental disabilities 2) Caregivers and potential caregivers of all individuals in these groups 3) Providers of health and social services, including physicians offices, health systems, home health agencies, senior centers, personal care providers, and other long term care community-based providers and 4) Information and referral specialists at local Call Centers, including Aging & Independence Services and other community-based organizations. This will permit SD to address one of its key implementation steps in achieving LTCI—refining and enhancing a coordinated system for I&R, assistance, assessment, education, chronic care management and communication across consumer and provider groups.

The fourth largest U.S. county and California's second most populous, SD is home to 2.96 million residents, with growth projected to reach four million by 2030. The senior population in SD County continues to grow at a faster pace than the county's total population. There are approximately 426,000 older adults 60+ currently living in SD, making up 14% of the population. By the year 2030, the total population of people aged 60+ is predicted to be 795,000, or approximately 25% of the total population. SD's population age 85+ is our fastest growing age group and is also the one most likely to need long term care assistance. Also important to consider are the many SD County seniors that are low income and/or live alone and. According to Census 2000 data, of SD County's 313,750 older adults age 65+, 20,561 lived below the poverty line; 78, 509 lived alone. The NoC Strategy will make efforts to outreach to these seniors as they are less likely to be aware of or have access to appropriate long term care support.

SD County is an increasing ethnically diverse community, which means that the NoC Strategy must be responsive to the growing and unique needs of many subpopulations and cultures. Approximately 19% of the county's population is immigrants who come from other

countries and speak 68 different languages. SD's population is 60% White, 24% Hispanic, 9% Asian, 6% Black, and 1% Native American. The county has 18 Native American Tribal reservations, more than any other single county in the country. Between 1995 and 2020, SD's Hispanic population will more than double, comprising one-third of the total population. Project staff will work in conjunction with community partners serving minority groups to focus on individuals who are underserved or under-utilizing social services and LTC resources.

**LTC infrastructure** - The nature of chronic disease requires ongoing monitoring, management, and reconfiguration of health services to maximize functioning, stabilize individuals at their highest level of independence and ensure appropriate and effective utilization and coordination of health and social services. SD County may be "service rich" compared to many other large counties, but stakeholders identified as early as 5 years ago (Aging Summit of 1998) that the long term care system is highly fragmented, difficult to access and navigate, and characterized by unnecessary duplication, cost shifting and other inefficiencies. The most vulnerable aged and disabled persons with multiple chronic illnesses often see three or four home care staff following hospital discharge. These service workers all ask similar questions to establish eligibility, to assess level of need, and to develop a plan of care, in addition to the physician's discharge plan. Income and asset levels, types of diagnosis/illness, and availability of community resources often set barriers to a comprehensive system of care for these individuals. Cost-shifting incentives between Medicare and Medi-Cal adversely impact this population. Institutionalization is too often the outcome.

San Diego has over 350,000 Medicare beneficiaries, with about 60,000 of those individuals dually eligible to Medi-Cal. In CY 1999, there were approximately 95,000 Medi-Cal recipients in the Aged, Blind, and Disabled aid categories. Total Medi-Cal expenditures for CY 1999 for persons in these aide codes were \$543 Million. At a legislative hearing in Sacramento in March 2003, the Legislative Analysts Office announced the new projections of Medi-Cal long term care costs: the \$5 Billion being spent this fiscal year is projected at \$11 Billion in 2010 if measures are not taken to change the current system. The NoC Strategy presents an opportunity for such change.

**Project description** - In September 2002, San Diego County unveiled the local Network of Care (NoC) web site ([www.networkofcare.org](http://www.networkofcare.org)), based on the NoC product developed under the CA Department of Aging-sponsored Innovation Grant initiative. The NoC web site is currently

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being used by Call Center staff and includes the following features: 1) A resource finder to locate services, facilities, and assistive devices; 2) Consumer-entered health information that can be shared with providers and family members, personalized notes, links, and a personal “Hot List”; 3) Consumer-focused information on health conditions, risk-factors, treatments, and health behaviors; and 4) Caregiver support options (message board, chat, articles). It is a great resource but its potential has yet to be systematically examined and exploited in the context of chronic care management where the strengths of community-based organizations are partnered with primary care practices.

The LTCIP NoC strategy proposed in this application will be designed to grow and enhance the current NoC web site resource from an I&R database into a coordinated and streamlined system of chronic care management that includes both web-based and personal interaction to assure access to services meeting the full array of consumer, caregiver, and provider needs. The goal is to make the NoC a valuable component of both the Physician Strategy and the Health Plan Pilot LTCIP efforts. The request of \$150,000 from RWJ is to formulate and perform chronic care management testing with the four target groups outlined on page 2. This task will be planned and accomplished through the collaboration of LTCIP Project staff, stakeholder groups and a national expert consultant, Dr. Mark Meiners, National Program Director for the RWJ Medicare Medicaid Integration Program. The San Diego Association of Nonprofits, a member of the LTCIP Planning Committee, represents a coalition of community-based providers and will facilitate the group’s assessment and planning to meet their technical assistance needs to participate in the NoC strategy; examine the current capacity and user-friendliness of the NoC website; identify areas for improvement; and develop a work plan for implementing necessary system improvements. The Southern Caregiver Resource Center will provide the same type of activity for caregivers and consumers. AIS will work with Dr. Meiners to complete like activity to assess and plan with Call Center staff both within the agency and throughout the community.

**Work Plan** - The estimated timeline for Phase I planning and development is 12-18 months. The findings and outcomes of Phase I will lay the groundwork for integrating the NoC strategy with the Physician Strategy and the Health Plan Pilots for which additional resources may be sought in the subsequent implementation application. Major objectives for Phase I planning and development include testing current NoC capacity and responsiveness, identifying problem

areas, making suggestions for improvements, and developing a plan for enhancing NoC as a communication tool and community resource instrument. A consensus development process will be undertaken to synthesize the various perspectives. Eventually, the physician, consumer/caregiver, and community-based service provider focus groups or representatives will meet together to disclose their recommendations in the broader context of mutual understanding and within the goal of improved chronic care. Recommendations on information transfer and encouragement of the consumer to state their preferences and be supported across settings will be forwarded for the implementation plan.

**Applicant Agency** - This grant application has been developed through a partnership between the County of San Diego's LTCIP, representing the 500+ LTCIP consumers, caregivers and health and social service providers, and the Southern Caregiver Resource Center (SCRC), who will serve as the applicant agency and community liaison coordinator representing a large coalition of consumers and caregivers. LTCIP will oversee the proposed project. As the applicant agency, the SCRC will have the ability to maximize available grant resources due to its low overhead costs as a private, non-profit agency and its established position within the community's aging network. Other key LTCIP member groups will be involved in planning and developing activities, as described in the Project Description section of this grant. The proposal reflects the combined strengths of these organizations and the LTCIP stakeholders who have supported them in developing this proposal.

**Technical Assistance** – The San Diego LTCIP has a long history of soliciting input from consumers, providers, and other stakeholders in its various planning & development efforts. Technical expertise from the local community will be sought as a direct outcome of the focus groups. This process insures stakeholder buy-in, a product that meets community need, and sustainability due to “ownership” by many who assisted in developing a worthwhile project. AIS will continue to take the lead in convening and facilitating periodic stakeholder meetings to update community members on the NoC Strategy and will use its website to share knowledge and information related to the project. The NoC strategy will be shared by all as it offers both San Diego and California the opportunity to evolve and expand the NoC into an enhanced communication and coordination tool meeting the full array of consumer, caregiver and provider needs.