Beyond CCI: A Multi-Agency Commitment to Care Coordination

Program Abstract (200 words)

A three-year demonstration project known as the Coordinated Care Initiative (CCI), was established to address the fundamental lack of coordinated care services for higher-risk elderly and disabled adults throughout California. Riverside County was one of seven counties that participated in this statewide initiative and launched its collaborative partnership in April 2014 with the two Managed Care Health Plans (Inland Empire Health Plan [IEHP] and Molina) in the County, to increase and improve services to vulnerable populations.

Fiscal year 2016-17 marked the end of California's CCI demonstration project; however, in 2018, Riverside County and the Health Plans signed a new MOU to solidify and sustain the enhanced care coordination that was established with CCI during its initial three-year period. Riverside County and the Health Plans were committed to continuing care coordination to some of the most vulnerable and medically frail populations with the primary goal of avoiding unnecessary hospitalizations and institutionalization placements among elderly and disabled adults with complex health care needs. The extension of CCI beyond the State's termination date, has enhanced the way medical care, behavioral health and long-term services and supports are delivered to low-income older adults and persons with disabilities in Riverside County.

THE PROBLEM OR NEED FOR THE PROGRAM (1/4 PAGE)

In 2014, California launched the Coordinated Care Initiative (CCI) to improve care coordination for individuals with Medicare and Medi-Cal (California's Medicaid). Prior to CCI, programs worked in silos. There was confusion regarding payer sources and a fundamental lack of coordinated care creating inefficiencies in the system, thus hindering the coordination of care services for higher-risk elderly and disabled adults throughout the State. In Riverside County, working lines of communication between social services and medical and behavioral health care systems did not exist. Specifically, the disconnect between the County and the Health Plans led to many individuals with multiple medical conditions and severe functional impairments experiencing fragmented care and gaps in service likely to lead to costly negative outcomes such as emergency department visits, avoidable hospitalizations and skilled nursing facility stays.

CCI became operational on April 1, 2014 and Riverside County was one of seven counties that became part of this statewide initiative and launched its collaborative partnership with the two Managed Medi-Cal Health Plans in the County, Inland Empire Health Plan (IEHP) and Molina to increase and improve services to vulnerable populations including low-income, disabled adults and elderly residents. In 2017, Governor Brown enacted policy changes ending the CCI demonstration project in California between county In-Home Supportive Services (IHSS) programs and the local Medi-Cal Health Plans. All contractual obligations of the CCI demonstration project were considered terminated.

Riverside County's elderly population is expected to continue to grow significantly and much faster than younger population groups. The county is projected to have the second largest increase of older adults in California through 2060. This growth will increase the demand for services and drive changes in geriatric service delivery for this population. This continued rapid

growth of the aging population has prompted Adult Services Division to seek innovative and sustainable ways of providing quality and efficient care for its elderly, high-risk and vulnerable clients. In spite of the official termination of CCI, Riverside County Adult Services Division (ASD) and the Health Plans, IEHP and Molina, were committed to the continuation and strengthening of the collaborative partnership that was initially established to continue providing care coordination to medically fragile populations.

DESCRIPTION OF THE PROGRAM (2 ½ PAGES)

Although fiscal year 2016-17 marked the end of California's CCI demonstration project, Riverside County and the Health Plans remained committed to continuing and strengthening the collaborative partnership established. The County and the Health Plans continue to share care coordination functions to collectively serve clients through coordinated person-centered care. The integrated approach provides quality, efficient care for joint clients with complex medical and behavioral health needs, including those in need of long-term services and supports (LTSS). The overarching goal of this collaboration is to provide enhanced care coordination and avoid unnecessary hospitalizations and institutionalization placements among elderly and disabled adults with complex health and social needs.

To respond to the continued need for CCI services for ASD's In-Home Supportive Services (IHSS) and Adult Protective Services (APS) clients, Riverside County designated and trained 19 social services supervisors as CCI liaisons in ten (10) district offices throughout the County. The main function of the CCI liaisons is to communicate the needs of IHSS and APS clients to the Health Plan LTSS coordinators and case managers. The CCI liaisons also assist the Health Plans with expediting the process of obtaining In-Home-Supportive-Services (IHSS) for their members. The County has trained the Health Plan's case managers on the IHSS program and the Health Plans have trained County social services staff on managed care concepts. This mutual understanding of each other's programs ensures efficient and effective access and utilization for clients.

The continued partnership and collaboration between the County and the Managed Care Health Plans was formally established by creating a new Memorandum of Understanding (MOU) in 2018. The MOU sets the platform to continue and improve the coordination of care for shared clients, to share data to assist with the care coordination, and to participate in Coordinated Care Team (CCT) meetings to address the multiple needs of complex high-risk clients.

Open Communication between Social Workers and Health Plan Case Managers

The MOU continues the collaboration between agencies establishing the provision of two-way communication for the early identification of, and intervention with, clients at risk of institutional placement. This two-way communication is the critical link to preventing premature and undesirable institutional placement. It is this collaborative effort that allows the managed health care plans to identify, assess, and refer appropriate clients to IHSS and in turn, allows the County to identify vulnerable IHSS and APS clients and coordinate care with the health plan's case managers for clients in need of medical, behavioral health, and LTSS. The County's social workers and the health plan's case managers work directly to ensure lines of communication are

fluid, coordination is intact, and clients are linked to the appropriate services. A key factor in the continued success of CCI in Riverside County is the direct contact the IHSS and APS social workers have with the health plan's case managers. This direct line of communication allows for an expedited response to both health plan member's and County IHSS/APS client's requests for services. The collaboration assures appropriate access to both in-home caregiver services and health care services.

Information/Data Sharing

The new MOU allows for the mutual sharing of confidential information to promote a holistic understanding of a client's needs assuring appropriate access to IHSS, health care services, behavioral health services, and other long-term services and supports. In addition, IHSS applications for Health Plan members are expedited and the Health Plans assist clients with obtaining the required Health Care Certification form to ensure IHSS services are approved in as efficient a manner as possible. The Health Plans also notify IHSS staff of changes in a client's condition, which may require a reassessment of the scope of authorized IHSS services prior to the regularly scheduled annual reassessment.

Coordinated Care Team Meetings

To address the needs of complex and high-risk clients, Riverside County and the Health Plans participate jointly in Care Coordinated Team (CCT) meetings; also referred to as Interdisciplinary Care Team (ICT) meetings. The CCTs emphasize care coordination across disciplines and different systems of care, including long-term and other non-medical settings. This care coordination unites a team of providers to meet the individual needs of clients, address gaps in services, improve health care access and outcomes, and synchronize the variety of services needed.

The unique partnership between Riverside County and the Health Plans also allows the involvement of social workers, as members of the CCTs to help meet the social support needs of clients who have multiple co-morbidities, diabetes, frailty, dementia, or depression and other mental health needs. Social workers are also able to work with the Health Plan case managers during the CCTs to discuss plans to ensure smooth and successful transitions of clients from a hospital or a skilled nursing facility (SNF) to their home. In optimal situations, the CCTs would include the participation of the client as well as his or her caregiver or other support person, thus emphasizing the client-centered approach of care coordination.

The CCT meetings maximize resources and enhance a structured communication and documentation process among the various agncies to establish, prioritize and achieve individualized care plans for complex IHSS or APS clients with multiple chronic conditions who are at higher risk of adverse health outcomes or worsening of their health and functional status.

Multi-Agency Collaboration

The MOU established with the Health Plans with the Adult Services Division (ASD) IHSS and APS programs, also extends to Riverside County's IHSS Public Authority (PA) and Office on

Aging (OoA). Similar to the MOU with ASD, establishing MOUs with the PA and OoA allow for streamlined communications between these entities and the Health Plans. When caregiver issues arise the Health Plans have the ability to reach out directly to the PA in order to efficiently mitigate such issues. Likewise, when senior members of the Health Plans need additional resources, open communication exists between the Health Plans and the OoA allowing for successful linkage to the appropriate community resources.

Cal-Medi Connect Outreach

Cal Medi-Connect members (i.e., dual beneficiaries with Medicare and Medi-Cal) are assigned a Health Plan case manager responsible for care coordination of services for that member. This includes linking the Cal Medi-Connect (CMC) member with social services and long-term services and supports such as IHSS. The Cal Medi-Connect program eliminates the fragmentation of Medicare fee-for-service and allows the member to voluntarily have both their Medicare and Medi-Cal enrolled in their health plan. ASD takes a proactive approach to assist dual eligible IHSS and APS clients to become CMC members with the Health Plans. ASD developed and led a series of division-wide trainings for social services staff at all district offices on care coordination with the health plans and the services associated with and benefits of becoming a CMC member. The training also included information on how social workers can guide and assist IHSS and APS clients with the process of becoming a CMC member, thus, linking them with enhanced care coordination services.

THE COST OF THE PROGRAM (3/4 TO 1 PAGE)

The total cost associated with the continuation of CCI is $0. Nineteen social services supervisors are assigned the role of CCI liaisons at the district offices and one program specialist is assigned the role of CCI administrative liaison. Each of these staff have other primary job responsibilities, which cover their salaries/expenses. The health plans and community partners who participate in the Stakeholder meetings and coordination of care activities do so voluntarily or as part of their existing professional capacity, and therefore do not result in any additional expense.

THE RESULTS/SUCCESS OF THE PROGRAM (3/4 TO 1 PAGE)

The collaboration between Riverside County and the Health Plans has resulted in the achievement of several significant outcomes. These have included improved coordinated care for vulnerable populations, immediate access to Health Plan liaisons and county social workers, efficiencies in the application process for In-Home Supportive Services for health plan members, and increased linkages to medical and behavioral health services and other long-term services & supports. Other outcomes include reduced hospitalization and institutionalization of populations that traditionally would be placed in a long-term care facility. The extension of the Coordinated Care Initiative beyond the state's termination date, changed the way medical care, behavioral health and long-term services and supports were delivered to 691 low-income older adults and persons with disabilities in Riverside County during 2018.

In addition, 184 CCT meetings occurred in 2018, addressing the multiple and complex needs of high-risk clients linking them with an array of medical, behavioral health, and long-term services and supports. As of result of the continued care coordination, it is estimated that more than two-thirds of these clients were linked with services which kept them safe and independent in their homes and communities in lieu of potential negative outcomes such as emergency department visits, other hospitalizations, or skilled-nursing facility stays.

Navigating the managed care system is complex and intimidating for many IHSS and APS clients. Becoming a CMC member aided clients in the navigation of this system. Riverside County's focused efforts to educate and enroll dual beneficiary IHSS and APS clients in the Cal Medi-Connect Program also demonstrated success. While the total "opt" out rate (i.e., members that did not enroll their Medicare with the Managed Care Health Plans) for California in 2017 was 50%, Riverside County had a much lower opt out rate that same year at 37%.

WORTHINESS OF AWARD (1/4 TO ½ PAGE)

A new MOU signed in 2018 extended care coordination beyond the scope of the three-year statewide CCI demonstration project. The continued collaboration between Riverside County and the Managed Care Health Plans is rooted in the mutual understanding of and commitment to preventing, diverting or delaying institutional placement utilizing an enhanced, holistic, and person-centered care coordination approach.

The MOU not only solidified what was established with CCI during the initial three-year period, but it has sustained the goals of the Initiative to the residents of Riverside County. This is due to the pledge of both the County and the Health Plans to continue to provide care coordination to some of the most vulnerable and frail populations, such as elderly and disabled adults with physical, cognitive and emotional impairments; the abused elderly; those that are dealing with multiple medical and mental health conditions; and, those at-risk of becoming abused, homeless, hospitalized, or institutionalized.

The extension of CCI in Riverside County has standardized what was initially considered an innovative approach. CCI has strengthened the relationships between the Health Plans and Riverside County's IHSS and APS programs, the IHSS Public Authority, and the County Office on Aging to provide better coordination and response to the healthcare needs of elderly and disabled adults. What was once considered a disconnection of the various care systems is now an improved patient-centered care coordination approach inclusive of enhanced case management. This extension of California's CCI in Riverside County is unique in comparison to the other CCI counties that initially participated in the three-year demonstration project. The agencies commitment to care coordination, beyond CCIs initial three-year contract, provides quality and efficient care, continues to address gaps in services, and eliminates access barriers to healthcare services for some of the most vulnerable populations in the County. Collaborating with IEHP and Molina has proven that care coordination for older and disabled adults is a critical link to improved health care.