# Health Care Reform at the Local Level: Contra Costa County Care Coordination Program

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## EXECUTIVE SUMMARY

The conditions of the U.S. health care system have driven policymakers, administrators, and health care leaders to pursue the implementation of health care reform concepts and policies. California has partnered with the Centers for Medicare and Medicaid (CMS) to deliver a demonstration pilot, named Cal MediConnect, to coordinate the care of individuals who are eligible for both Medicare and Medicaid (i.e. Medi-Cal). Dually eligible individuals have very complex needs and health conditions, making it challenging and costly to manage their health in the current fee-for-service health care delivery model. Cal MediConnect will serve approximately 456,000 individuals in eight pilot counties beginning April 1, 2014. If the pilot is effective, Cal MediConnect will become a permanent program in all 58 counties, and the lessons learned about care coordination for high-risk/high-need populations will be transferrable to other similar care coordination models at both the state and local levels.

This case study examines Contra Costa County's Care Coordination Program, which is a smaller, county-driven pilot that facilitates care coordination by using a multidisciplinary team model for shared client case discussion between the Contra Costa Health Plan and the Contra Costa County Employment and Human Services In-Home Supportive Services Program. This program demonstrates that health reform concepts, such as care coordination and patient-centered care, are implementable at the local level, and that improving the local health care system in counties will require developing partnerships outside the traditional concept of health.

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## Introduction

Rising health care costs, health disparities, and increases in chronic health condition rates in the United States have served as the impetus for reformation of the current health care service delivery model. Health care costs account for 17 percent of the nation's gross domestic product (GDP), ranking the U.S. as one of top spenders among industrialized nations.[1] Although U.S. health care costs are increasing, the quality of care and better health outcomes for the U.S. population continue to decline. The World Health Organization (WHO) ranks the United States 37th out of 191 nations in overall health status and 13th among other industrialized nations in health outcomes such as low birth weight, infant mortality, and life expectancy at age 40. Moreover, health outcomes continue to vary within the U.S. population based upon socioeconomic status, ethnicity, and gender. For example, in 2009, African American women were 10% less likely than non-Hispanic white women to be diagnosed with breast cancer and 40% more likely to die from breast cancer than non-Hispanic white women.[2] The uninsured rate among poor nonelderly adults is more than twice as high as the national rate;[3] and those living in more affluent neighborhoods can live up to 15 years longer than those who live in impoverished neighborhoods.[4]

The Institute of Healthcare Improvement has developed a framework to address the issues found in the U.S. health care system. The triple aim approach proposes that policymakers and health care industry leaders focus reformation efforts on (1) lowering health care costs, (2) improving the quality of care, and (3) improving the health of populations. The triple aim approach has been influential in the creation of several health care policies, including the recent federal health care reform law, the Patient Protection and the Affordable Care Act of 2010 (ACA). The ACA has made the most significant changes to the national health care system since the creation of the 1965 Medicaid program by President Lyndon B. Johnson. The ACA implements aspects of the triple aim approach, including access to quality care by requiring health plans to offer a set of comprehensive health benefits; lowering costs by requiring all U.S. citizens and legal permanent residents to have insurance if it is affordable, so as to reduce systemic costs related to serving the uninsured in hospitals and emergency rooms; and improving the health of populations by providing additional funding for prevention activities in disparate populations.

In addition, the ACA led to the creation of the Centers for Medicare and Medicaid Innovation (CMMI), a branch of CMS that tests health care payment methods and health care delivery models across the country. The State of California has partnered with CMMI to pilot several demonstrations

1. Centers for Medicare and Medicaid, Office of the Actuary; National Healthcare Expenditure Projections 2010-2020; https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2010.pdf.

2. U.S. Department of Health and Human Services, Office of Minority Health; African American Profile; http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlID=51&ID=2826; retrieved April 15, 2014.

3. Henry J. Kaiser Family Foundation; *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*; http://kff.org/report-section/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/#endnote_link_107292-1; retrieved April 15, 2014.

4. Unnatural Causes; *Health Equity Quiz Answers*; http://www.unnaturalcauses.org/assets/uploads/file/quiz_answers_only.pdf; retrieved May 1, 2014.

related to health care payment reform and care coordination. Recently, California received funding to pilot the duals demonstration. Dually-eligible beneficiaries are individuals who qualify to receive health care benefits from Medicare and Medicaid. The dually-eligible population is typically described as a high-need, high-risk population, with many suffering from co-occurring chronic health conditions. California has nearly 1.1 million dually-eligible individuals, with the majority of this population being seniors 65 or older with incomes less than $10,000 a year.[5,6] The CMS snapshot of California's dually-eligible population indicated that nearly 70% suffered from five of more chronic health conditions and relied heavily upon an array of long-term services and supports programs.

California's dual eligible demonstration (renamed Cal MediConnect) provides care coordination for approximately 456,000 dually-eligible beneficiaries in eight pilot counties beginning April 1, 2014. Medi-Cal Managed Care health plans will manage the benefits for the Cal MediConnect participants, including medical care, behavioral health services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), the Multipurpose Senior Services Program, and nursing facility services. With better care coordination, it is anticipated that this vulnerable population will have the opportunity to stay in their homes and out of skilled nursing facilities longer, reducing the overall costs of health care and improving their quality of life. Cal MediConnect will be expanded to all 58 counties if the program is successful, and the lessons learned about care coordination for high-risk/high-need populations will provide critical knowledge for the development of other care coordination programs at both the state and local levels. The Cal MediConnect program has captured the attention of many counties and low-income managed care health plans across the state. In attempting to provide care coordination for such a fragile and complex population, the program epitomizes the complexities associated with implementing health care reform policies at a granular level.

## Background

Compared to other regions across the state, Contra Costa County has a sizable dually-eligible population of approximately 22,000 individuals.[7] However, Anthem Blue Cross (the other health plan serving low-income residents in Contra Costa County) was not in a position at the time to participate in the pilot program. To implement the demonstration in a two-plan model county (e.g. Contra Costa County), both plans had to consent to participating. Contra Costa County elected to move forward with a smaller care coordination pilot, which included the Contra Costa Health Plan (CCHP) and the Contra Costa County Employment & Human Services Department Aging & Adult Services Bureau In-Home Supportive Services program. The Care Coordination pilot prepares Contra Costa County for the possible rollout of the Cal MediConnect program in the near future; the pilot began in September 2012, and adopted as a permanent program within a year.

## Key Elements of Program

The Care Coordination Program aims to effectively coordinate the care of shared clients between CCHP case management and the county IHSS program through utilization of the multi-disciplinary team (MDT) model. The MDT model is a team-based approach to managing and coordinating the health of individuals. MDTs are becoming widely used as a reformation tool in health care, bridging the chasm between behavioral health and physical health care to improve the health outcomes of individuals with co-occurring health conditions. The Care Coordination Program expands on the MDT model by

5. California Department of Health Care Services. *Medi-Cal's Dual Eligible Population Demographics, Health Characteristics, and Costs of Health Care Services*. Research and Analytics Studies Section; 2009.

6. Henry J. Kaiser Family Foundation. *Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries*. Kaiser Commission on Medicaid Facts; May 2011. http://www.kff.org/medicaid/upload/4091-08.pdf

7. Contra Costa Health Plan; Contra Costa Health Plan Response to California's Dual Eligible Demonstration Request for Solutions; http://www.dhcs.ca.gov/provgovpart/Documents/Duals/RFS%20Applications/Contra%20Costa.pdf; pg. 4; retrieved April 15, 2014.

incorporating team members from not only physical and behavioral health, but also from traditional social services programs. The Contra Costa County Care Team is comprised of an IHSS program analyst, IHSS supervisors, IHSS social workers, the CCHP director of case management, a CCHP nurse case manager, and a public health nurse. This approach provides CCHP and IHSS a broader view of the individual's needs, which helps to improve the quality of care for shared clients.

Periodically, CCHP case management provides a list of high risk clients to Contra Costa County Employment & Human Services Department (EHSD). High-risk clients are classified as individuals who have frequent hospitalizations and/or emergency room visits. EHSD reviews the list to identify individuals who are receiving IHSS services, and provides a list of client matches to IHSS social workers. The IHSS social workers then review the list and recommend individuals to the Care Team for review.

The Care Team meets every other month for 1.5 hours to review one or two cases. Meetings are held throughout Contra Costa County, rotating among the East, Central and West county districts. The recommended cases are reviewed, and minutes for the meeting are recorded and disseminated to the Care Team. Decisions made during the Care Team meeting regarding services to improve the client's health are given to the client or their caregiver through nurse case managers and, when appropriate, the IHSS social worker. However, clients do not attend the Care Team meetings.

## Successes

The Care Coordination Program is an innovative design that allows counties to better understand how health reform policies and concepts can be implemented effectively at the local level. By expanding on the MDT model to incorporate experts from social services, Contra Costa County broadens the definition of quality care and increases the chances of improving the health of individuals. The major success of this program is the increased and improved communication between CCHP and EHSD about shared clients, and finding ways to partner with the intent to improve health outcomes for individuals. The MDT model allows Contra Costa County to see that health care reformation is comprehensive, and requires partnerships outside the realm of traditional health to implement. The increased opportunities for communication have also mitigated the social versus medical model controversy, in which county IHSS programs and IHSS advocates have expressed concern that moving a program like IHSS into a healthcare managed care model would limit its valuable social aspects (e.g. helping with food preparation and grocery shopping for clients). The Care Coordination Program has demonstrated the opposite, and further reinforced the interdependence associated with both models. CCHP case managers contact IHSS social workers regularly outside the formal Care Team meetings to identify social barriers for clients that impede the client's recovery and stabilization, and vice versa. There is a mutual respect and appreciation for each other's expertise.

In addition to increased communication, the Care Coordination Program is positioned to collect meaningful data to track and monitor its effectiveness in improving health outcomes for certain high-risk/high-need IHSS populations in Contra Costa County. In other counties, the exchange of client information with its low-income health plan can be complicated due to state and federal privacy regulations and other local restrictions. Contra Costa County is unique; CCHP is a part of the county's organizational structure. This provides Contra Costa County increased flexibility to share client information without violating state or federal privacy laws. Overall health measures such as decreased emergency room visits and decreased concurrent hospitalizations could be captured through the program. Qualitative data about the client's experience pre- and post-assignment to the Care Coordination Program could be obtained readily without breaching state and federal regulations. Contra Costa County hopes to take advantage of this opportunity for the Care Coordination Program in the near future.

## Obstacles (Recommendations for Contra Costa County)

Data collection and setting overall performance measures are the next logical steps for the Care Coordination Program. The available data is anecdotal, which creates a sense of ambiguity about the direction and effectiveness of the program. Gathering data would create accountability and reinforce the importance of the program among Care Team members. Moreover, establishing formal processes would further strengthen the program. The current case selection process has not been formalized. In some instances the IHSS supervisor, not the social workers, selects the cases for review during the Care Team meetings. Establishing written guidelines for the Care Coordination Program would encourage the IHSS social workers to become more invested in the case selection process, which may increase the number of cases discussed at Care Team meetings and subsequently increase the impact the Care Coordination Program could have on the population. Suggested written guidelines include:

- Formal screening or assessment tool to determine which CCHP case management clients are considered high-risk/high-need (e.g. having two or more emergency room visits, four or more concurrent hospitalizations, or a combination of both).
- How often CCHP will provide the case management high-risk client list to EHSD (monthly, quarterly, annually, etc).
- The timeframe in which EHSD will generate the revised list of CCHP case management clients who receive IHSS benefits and provide that list to IHSS social workers for review.
- Formal screening or assessment tool for IHSS social workers to select clients from the CCHP list (including limited mobility of client, number of authorized hours, etc).
- Timeframe in which IHSS social workers select cases for Care Team meetings discussion.
- Development of a regular schedule for Care Team meeting dates. This will allow more opportunities for IHSS social workers to adjust their schedules to attend the Care Team meetings more regularly.

Lastly, the program should provide opportunities to include client voice in the decision-making process regarding their health. This population has several barriers to participating in the Care Team meetings including mobility and compromised cognitive ability due to their illnesses. Possible solutions include:

- Establishing a written wellness plan after the Care Team meeting and discussing the plan with the client or the client's caregiver;
- Reviewing the wellness plan with the client or the client's caregiver regularly to make modifications and to determine the status of the implementation of recommendations; and
- Reaching out to include the client and/or the client's caregiver in the discussion, whenever possible. [Note: EHSD and CCHP are currently developing further integration of the IHSS client and their IHSS provider into the Care Team as part of their participation in a federal Health Care Innovation Grant funded by CMS/Center for Medicare and Medicaid Innovation (CMMI). They will leverage appropriate lessons from this grant into ongoing care coordination efforts going forward.]

## Conclusion – Implications for Napa County

Implementation of a similar care coordination program for IHSS recipients in Napa County is not recommended at this time. In 1997, Napa County selected Partnership HealthPlan of California to operate the Medi-Cal managed care plan for Napa County residents. Partnership HealthPlan of California is a separate entity from the counties it serves, which makes it quite difficult for the exchange of data for shared clients. This will require the development of complex formal agreements between the involved entities that delineate acceptable sharing of client information within federal and state laws and regulations. Also, data reflecting the Contra Costa

County Care Coordination Program's effectiveness is not readily available. This information is crucial prior to pursuing the use of Napa County resources.

However, the Care Coordination Program presents a valuable lesson about implementing health care reform policies and concepts at the local level. Napa County Health and Human Services Agency (HHSA) has deployed similar care coordination and integration programs to address issues related to health care costs, quality of care, and improving health outcomes. HHSA should continue to use the MDT model for these programs, and whenever possible, expand the model to include social services program experts to increase the likelihood of improving health outcomes for program participants. Health is multi-faceted, and therefore reformation of the local health care system will require a multi-faceted approach.

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