

**Master Plan for Aging:
LeadingAge California Recommendations
Integrated Services Delivery System**

December 13, 2019

Instructions for submitting recommendation: *To submit your recommendation, please fill out as many of the fields as you can, but it is fine to leave some blank. Recommendations can be submitted at engage@aging.ca.gov. Initial recommendations are requested to be submitted by December 13, but continue to be welcome.*

Goal #1: We will live where we choose as we age and have the help we and our families need to do so.

Objective 1.1: Californians will have access to the help we need to live in the homes and communities we choose as we age.

Issue Statement:

Older adults over age 65 and those with disabilities will have access to an integrated service delivery system that provides robust care coordination. The current service delivery system offers little guidance to older adults and their families as they attempt to navigate and manage our complex and fragmented system of medical care and long-term services and supports (LTSS). When families tackle this overwhelming challenge alone, it often results in unmet needs, inefficient use of available dollars, and poor outcomes.

Recommendation:

Develop and support a comprehensive and coordinated integrated service delivery model pilot that addresses the needs of older adults in a holistic fashion, using available public and private funding resources more efficiently and improved health outcomes.

Detailed Recommendations:

Recommendation 1: Adopt a large scale, statewide demonstration to test and refine a statewide integrated service delivery model.

Recommendation 2: Establish Hub Provider networks across the state that incorporate care management, home and community-based services, hospitals, skilled nursing facilities, non-emergency medical transportation, wellness and socialization services.

Recommendation 3: Adopt framework for Service Facilitator through direct and indirect methods (in office and cloud based telecommunications) to maintain strong and ongoing care coordination.

Recommendation 4: Assure access to non-emergency transportation to aid in maintaining wellness, increasing mobility and socialization, and reducing social isolation.

Description:

Holistic, integrated service models will be piloted to explore a variety of different approaches to care coordination and information sharing in the service delivery system.

Integrated service model pilots will incorporate the following key elements:

- **Pooled Funding and Risk Sharing:** Success of the integrated service model depends on the ability of “Hub Providers” to pool all sources of funding (public and private) and offer a full range of coordinated services and supports designed to help an individual maintain health and achieve personal goals. Hub Providers will assume a portion of risk for outcomes and total cost of care.
- **Hub Providers as Central Coordinating Bodies:** The Hub Provider will be a central coordinating body for a group of individuals and/or a region. There will be multiple Hub Providers throughout the state. As the central coordinating body, the Hub Provider will house Service Facilitators, an interdisciplinary care team and others, and be responsible for a network that incorporates care management, home and community-based services, hospitals, skilled nursing facilities, non-emergency medical transportation, wellness and socialization services.
- **Single Point of Contact:** A single “Service Facilitator” will work with the older adult, his or her family, and the Hub Provider’s interdisciplinary care team to answer questions, identify and coordinate needed services, supports and resources across settings. The Service Facilitator will serve as a liaison between the individual, family and Hub Provider.
- **Assessment and Universal Aging Service Plan:** The Hub Provider’s interdisciplinary team will conduct a comprehensive assessment of each older adult, and use its findings to develop a Universal Aging Service Plan in collaboration with the older adult, family and all identified home and community based and long-term care providers within the Hub Provider. The Universal Aging Service Plan will address all of the older adult’s needs for services and supports, not just his or her medical needs. To meet this broad range of needs, the Hub Provider will pool Medicare funds with a variety of other available dollars – such as Medicaid, U.S. Housing and Urban Development, Older Americans’ Act and personal funds – to offer any service or support that optimizes health or functional status for beneficiaries, as long as those services meet needs identified in the Universal Aging Service Plan.
- **Comprehensive Service Coordination:** Comprehensive service coordination will be a key strategy for improving outcomes for the older adult, and enhancing the effectiveness of the Hub Provider. To facilitate this coordination, Hub Providers, Service Facilitators, older adults and families will have real-time access to individual health information and the Universal Aging Service Plan. Cloud-based and telecommunication tools will be used to share information, improve access to services and supports such as care management and non-emergency transportation, enhance wellness and independence, and facilitate predictive modeling to improve outcomes and identify best practices.
- **Quality Assurance:** The integrated service framework will define measures of quality that gauge the outcomes and satisfaction of the older adult and his or her caregivers. Quality measures will also be tied to achievement of the individual’s goals, as identified in the Universal Aging Service Plan.

Evidence that supports the recommendation:

- *Integrated Service Delivery: A LeadingAge Vision for America’s Aging Population*
https://leadingage.org/sites/default/files/Integrated%20Service%20Paper_2017.pdf

Target Population and Numbers: All Californians over age 65, people with disabilities and families in need of long-term services and supports.

Examples of local, state or national examples:

- The Health Plan of San Mateo “Whole Person Care Pilot Program”
- There may be similarities to other pilots such as, the Coordinated Care Initiative, and CalAIM

Implementation: State Agencies/Departments : A variety of state agencies, including but not limited to: Department of Health Care Services, California Department of Public Health, California Department of Social Services, California Department of Aging and Housing and Community Development, as well as the federal Centers for Medicare and Medicaid will be utilized for demonstration projects for integrated service delivery pilots.

- **State Legislature:** Developing a pilot program may require legislation or a budget request to implement and appropriate necessary funding.
- **Local Government:** Counties organized with comprehensive and integrated health plans and services will be looked to for expansion pilot programs.
- **Federal Government:** Collaboration will be required with the CMS for federal dollars to help serve dually eligible individuals.
- **Private Sector:** Private-sector partnerships will be required with managed care plans, providers and caregivers.
- **Community Based Organizations:** Partnerships among community-based organizations will be needed to create Hub Provider networks to ensure the needs of older Californians are met.

Person-Centered Metrics: Success will be measured by:

- Growth from baseline established in 2021 in the percentage of California’s older adult population over age 65 and those with disabilities using a Service Facilitator for care coordination in 2025 and 2030.
- Growth from baseline established in 2021 in the percentage of California’s older adult population over age 65 and those with disabilities with access to non-emergency medical transportation in 2025 and 2030.
- Growth from baseline established in 2021 in the number of California’s older adult population over age 65 and those with disabilities who are enrolled in a Provider Hub in 2025 and 2030.
- Tracking, maintaining and improving key health indicators and quality measures in 2021, 2025, and 2030.
- Tracking and reducing unnecessary hospitalizations in 2021, 2025 and 2030.

Evaluation:

- Short term: By 2021, modify existing framework or develop a new framework for a statewide integrated service delivery system pilot program.
- Mid-term: By 2025, a statewide integrated service delivery system program will have been piloted and analyzed to measure outcomes.
- Long term: By 2030, the state will implement a statewide-integrated service delivery model throughout the state.

Person Centered measure: Older adults over age 65 and those with disabilities will have access to an integrated service delivery system that provides robust care coordination.

Data sources:

- Existing data sources:
- Suggestions for data collection to evaluate implementation of this goal when no data sources exist:
 - https://www.leadingage.org/sites/default/files/Integrated%20Service%20Paper_2017.pdf
 - <https://aspe.hhs.gov/pdf-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>
 - http://www.nhpf.org/library/background-papers/BP84_FamilyCaregiving_01-11-13.pdf
 - <http://www.ltqa.org/wp-content/themes/LtqaMain/custom/images/LTSS-Integration-Working-Paper.pdf>
 - <https://altarum.org/publications/medicaring-communities-getting-what-we-want-and-need-frail-old-age-affordable-cost>
 - <https://bipartisanpolicy.org/report/improving-care-for-high-need-high-cost-medicare-patients/>
 - http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2015/Improving-Diagnosis/DiagnosticError_ReportBrief.pdf
 - <https://www.ncbi.nlm.nih.gov/pubmed/25077248>
 - <https://tandem365.com/>
 - <http://tandem365.com/wp-content/uploads/2014/01/T365-PlanteMoran-Report.pdf>
 - <https://www.ajmc.com/journals/issue/2013/2013-1-vol19-n5/effects-of-integrated-delivery-system-on-cost-and-quality>
 - <https://www.hpsm.org/about-us/quality-programs/quality-assessment>

Potential Costs/Savings: Savings have been demonstrated in pilots with elements of care coordination and integration with housing and community based services such as the San Mateo Health Plan. Potential cost savings for a state-wide integrated service delivery system will be determined through the pilot demonstration, where we will collect enough data to accurately project cost savings in future years.

Name of person(s)/organization submitting recommendation:

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Date of recommendation submission: 12/13/19

Prioritization: High. This issue affects all older adults, people with disabilities and caregivers who cannot access services they need in a streamlined, timely manner.