Cal MediConnect: Health System Response Key Findings and Recommendations

Brooke Hollister,[1] Carrie Graham,[1,2,3] Charlene Harrington,[3] Alice Wong,[3] Luke O'Shea,[1] Elaine Kurtovich,[2] Brenda Nussey,[1] and Pi-Ju Liu[1]

Cal MediConnect (CMC), a demonstration launched in 2014, seeks to align the financing and administration of Medi-Cal (California's Medicaid program) and Medicare services in seven counties for dually eligible beneficiaries through capitated managed care plans. CMC integrates benefits from Medi-Cal and Medicare, including medical care, behavioral health care, and long-term services and supports (LTSS). It also provides new benefits like care coordination, transportation, and expanded vision and dental services. CMC represents a significant shift in health care delivery, and successful implementation of the demonstration and positive outcomes could possibly result in further expansion.

Between July 2015 and February 2016, researchers at the University of California conducted 36 interviews with 58 key informants (KIs) about the health system response to CMC. Efforts were made to interview participants from across CMC counties and representing a variety of stakeholder groups, including: CMC plans, participating provider groups (PPGs), long-term care (LTC) facilities, In-Home Supportive Services (IHSS), Multipurpose Senior Services Programs (MSSP), Community Based Adult Services (CBAS), hospitals, state and federal government, and community-based organizations (CBOs). This first phase of KI interviews relied heavily on information from CMC plan KIs to provide a foundation of understanding about CMC and plan practices that will guide a second phase of interviews beginning in 2017.

The aims of the health system response study are to: (1) examine organizational impacts and health system responses to the demonstration; and (2) identify challenges, promising practices, and recommendations to improve the coordination of care across sites for dual beneficiaries. A summary of key findings and recommendations are provided here along with a response from the Department of Health Care Services (DHCS). Additional findings and details can be found in the full report.[4]

KEY FINDINGS AND RECOMMENDATIONS

Health System Response Varied by Region and Plan

Health systems across California vary greatly by county in terms of their history of managed care; the capacity of their provider groups; the availability of a qualified workforce; the volume of beneficiaries they serve; the geographic spread of their beneficiaries; and the integration of their medical, behavioral, LTSS, and social care services. These variations were notably apparent in how CMC plans built their network of providers, how they delegated services, how contracts and payments were structured, and how health system stakeholders collaborated. There was a broad recognition among KIs that what worked well for one CMC plan may not have worked well for another plan in the same region (or even the same plan in another region). For example, County Organized Health Systems (COHS) experienced a more seamless transition to CMC due to the fact that they were the single Medi-Cal plan in their county, their plan networks were already well developed, and most beneficiaries were already part of their Medicaid Managed Care (MMC) plan or Dual Eligible Special Needs Plan (D-SNP). Conversely, in southern California there was a very high level of delegation of medical care, authorization of services, and care coordination to PPGs. While this allowed plans to serve larger numbers of beneficiaries, it also reduced the extent to which the plans had control over the services provided. There was also a great deal of variation around how care coordination programs were implemented, with many plans creating innovative programs unique to their county and the needs of their beneficiaries. The integration of behavioral health varied, too, including one CMC health plan that was fully integrating behavioral health by building behavioral health capacity directly into the plan. KIs noted that current data reporting systems are challenged to capture the variability and complexity of practices across regions and plans.

> *Recommendation: DHCS or CMS should develop reporting systems that capture the regional and CMC plan variation in delegation and care coordination practices in order to assess their relative strengths and challenges.*

CMC Education and Outreach Was a Challenge

Many KIs were critical of outreach efforts and educational materials provided to beneficiaries and other stakeholders. Notification materials especially could have used more detailed descriptions outlining the potential benefits of the program for beneficiaries and the providers who serve them. While some efforts have been made to improve CMC materials for beneficiaries, several KIs noted that many providers were still not well informed about the potential benefits of CMC. As beneficiaries' decisions about enrollment

are strongly influenced by their providers, educating providers is imperative to sustaining adequate beneficiary participation in CMC.

> *Recommendations: Education and outreach efforts should continue with both beneficiaries and providers along with clear dissemination plans developed by DHCS. Special efforts should be made with physicians serving diverse communities, providers with high proportions of opt-outs, and IHSS social workers and care workers. Moving forward, outreach and education tools should be updated to include outcome data and examples of CMC success.*

CMC Impacted the Health System Workforce

One common theme across KI interviews was that CMC required an adjustment to the health system workforce. Major adjustments to workforce infrastructure occurred in areas such as enhanced specialty provider networks; recruiting and training of adequate and qualified care coordinators; and expanded contractual, legal, and administrative staff. Though expanding the workforce can be a challenge, many of the changes have led to positive results. For example, the "evolution" of nurse and social work care coordinators often had a positive impact on care. As the health system workforce expands and diversifies, the importance of adequate data systems becomes more essential, especially in their ability to collect, report, and share data both within and across organizations; convene interdisciplinary care teams (ICTs); monitor services provided; and facilitate administrative processes.

> *Recommendations: Shifting health system workforce needs and challenges should be closely monitored, predicted, and addressed by CMC Plans and DHCS to meet the evolving needs of health systems and beneficiaries. DHCS should also encourage the adoption of adequate data systems that enable data sharing and foster collaboration both within and across stakeholder organizations.*

CMC Strained the Financial and Administrative Capacity of Some Stakeholders

The administrative burden on health system stakeholders reportedly increased substantially as a result of CMC's data collection and reporting requirements. Although some CMC plan KIs reported simplified billing as a potential benefit of CMC, provider and LTSS KIs often reported challenges early in implementation with establishing and/or managing contracts, navigating variable processes across plans, adjusting to provider payment rates, and adapting to lags in cash-flow that were a result of denied claims. These

challenges may have been especially burdensome on smaller PPGs or LTC facilities that were less able to adapt to these changes or withstand any disruptions in cash-flow.

> ***Recommendations: DHCS should continue to monitor CMC's financial and administrative impacts, especially on independent providers, and small PPGs or LTC facilities. DHCS could also encourage plans to standardize processes in order to alleviate administrative burden on stakeholders that work with multiple plans.***

Health Systems Reported Challenges with Competing Pressures to Invest and Save

Most health plan KIs were positive about CMC and committed to its continuation. They were, however, concerned about the pressure to cut costs while simultaneously investing significantly in new systems of care, an expanded workforce, and innovative programs. Health plan KIs reported that the savings targets in CMC were ambitious and that additional time would be needed for cost savings to be realized. Similarly, most CMC plan KIs felt rates were too low and that quality withholds (i.e., the portion of the CMC rate that is withheld from the plan until quality benchmarks are met) were more punitive than incentivizing. Plan KIs also reported that they were not given the flexibility in determining CMC payment structures that they would need to succeed.

> ***Recommendation: Evaluations of CMC effectiveness, particularly around cost savings, should take into account likely lag times between investment and savings.***

CMC Encouraged Collaboration Across Health System Stakeholders

CMC led to increased levels of collaboration between health plans and multiple stakeholders and providers serving dually eligible beneficiaries. Statewide and regional meetings (called "collaboratives") that were formed as part of the CMC implementation process were a key factor in successfully promoting shared learning, enhanced communication, and collaboration across health system stakeholders. This was especially true in large counties where the multiple plans and high numbers of CBOs have historically made collaboration and communication more difficult. Collaborations between health plans and IHSS, a key requirement of the demonstration, were strengthened using strategies such as co-locating staff and developing portals to share data and were reported as effective in improving services for beneficiaries. In an effort to address beneficiaries' non-medical needs, several CMC plans developed promising partnerships with CBOs.[5] There were also many challenges due to lack of, or ineffective collaborations in CMC counties. Challenges arose when health system stakeholders were not adequately informed about each other's roles, limitations, and capacities. Collaborating and communicating across the health

system, especially between health plans, LTSS and behavioral health is a mandate of the CCI legislation. Though a great deal of progress has been made, additional investment in communication systems and collaboration across stakeholders will be essential over time for advances to be maintained and improved.

> *Promising Practices: Some CMC plans reported building new collaborative relationships, such as with Alzheimer's disease organizations to train their care coordinators, improve identification and diagnosis of their beneficiaries with Alzheimer's disease or related dementias, and expand access to services and supports for beneficiaries with dementia and their caregivers.*

> *Recommendation: CMC plans should continue to invest in communications and collaboration across health system stakeholders to meet the needs of their beneficiaries and share promising practices.*

HRAs and Other Assessments Were Challenging but Valuable

CMC health plans were required to conduct a health risk assessment (HRA) for all new members, but many experienced serious challenges due to the difficulty of reaching beneficiaries with outdated contact information from DHCS. Many beneficiaries were also reportedly reluctant to participate in an assessment. As of March 2016, only 88 percent of CMC beneficiaries have completed an HRA overall, with the percentage of completion varying by plan from 56 percent to 100 percent.[6] CMC health plans conducted HRAs in a variety of ways, with many KIs noting the value of CMC plans conducting in-home assessments, especially with complex or high-risk beneficiaries. Although HRAs were expected to meet certain criteria established by CMS and DHCS, each CMC health plan's assessment form was propriety and unique. Due to this, there was concern that HRAs were not adequately assessing non-medical or social needs, and were therefore not triggering referral to appropriate care coordination or LTSS. CMC health plans felt that HRAs were important because they were a first step in providing person-centered care to beneficiaries, a mandate of the demonstration. However, some KIs expressed concern that HRAs may not do enough to identify the care goals and priorities of beneficiaries.

> *Promising Practices: CMC plan KIs described developing additional assessment protocols that were triggered as a result of HRA or utilization data. For example, one CMC plan used a caregiver strain question in their assessment if a caregiver was identified in the HRA.*

> *Recommendation: DHCS should more clearly define person-centered care for CMC health plans, and ensure that beneficiaries' goals are elicited in the HRA process.[7]*

The development, piloting, and adoption of a universal screening assessment tool and procedures by DHCS, with guidance from plans, could address this challenge.

CMC Plans Varied in How They Implemented ICPs and ICTs

As part of the assessment and care coordination processes in CMC, plan KIs reported completion of, or intention to complete, individualized care plans (ICPs) for all CMC beneficiaries. However, there was a great deal of variation across plans in how ICPs were implemented, ranging from ICPs that were created solely from utilization data to ICPs that were *"living documents"* created and adjusted through interdisciplinary care teams (ICTs) and shared with all relevant parties. Similarly, the implementation of ICTs varied, from ICTs that existed solely on paper with no formal meeting to ICTs that included multiple members meeting weekly. CMC plan KIs noted the importance of organization and expediency in arranging and holding ICTs to make the best use of, and encourage the participation of, all ICT members. While, many KIs pointed out that not all CMC beneficiaries needed an intensive ICP and ICT, more information is needed from plans about their ICP and ICT implementation.

Recommendations: DHCS should establish a reporting process on ICP and ICT implementation. Best practices in organizing and conducting ICTs should be identified, replicated across CMC plans, and integrated into future CMC plan requirements.[8]

Care Coordination Holds Promise

CMC required health plans to develop and expand care coordination programs. CMC plan KIs reported significant investments in care coordination workforce, specialized trainings, expanded collaborations, and sometimes even an evolution in their internal culture of care. Several KIs reported innovative approaches to care coordination in CMC, such as specialized complex care departments or care coordinators specially trained in care transitions or to serve LTSS beneficiaries. Some plans also reported different levels of care coordination, with more extensive support for higher-risk beneficiaries. Most CMC plans employed a variety of credentialed care coordinators including registered nurses and social workers, who were sometimes supported by non-credentialed "care navigators" or "community connectors." Most CMC plan KIs were able to provide numerous anecdotes of successful care coordination, expanding upon existing literature on the promise of care coordination.[9] While all plans reported conducting care coordination activities, they varied greatly in the volume of beneficiaries receiving these services from 100 percent in one plan to only 10 percent in another. This variation suggests CMC plans may define care

coordination differently, with some equating basic utilization review or completion of an HRA as care coordination.

> *Recommendations: DHCS should work with CMC plans to more clearly define levels of care coordination and improve data collection and reporting on care coordination practices in order to better assess their impact. DHCS should also make efforts to ensure that beneficiaries understand care coordination and its potential benefits.*

CMC Encouraged Efforts to Avoid Unnecessary Utilization and Cost

The CMC demonstration is designed with many pathways and potential strategies to control costs. CMC plans reported efforts to avoid unnecessary utilization of medical services including: intensive care coordination for at-risk members, enhanced support for members and caregivers, improved transitions across sites of care, and attempts to mitigate financial incentives that encourage LTC facilities to re-hospitalize residents. A key area where CMC health plans might achieve cost reductions is in the transition of beneficiaries from institutional care to lower cost home and community-based services. Though most CMC plans were interested in facilitating the transition of willing LTC residents back to the community, only a couple plans reported success in doing so. Efficacy of these efforts may depend on adequate community resources, including the availability of accessible and affordable housing options; the effective provision of home- and community-based services; and cooperation of LTC facilities and LTSS providers.

> *Recommendation: Best practices in avoiding unnecessary utilization of medical services should be identified, replicated, and integrated into future CMC policy reform efforts.*

Better Tracking of CPOs and Referrals to Community-Based Organizations Is Needed to Document Their Return on Investment

CMC allows plans to provide optional services, beyond plan benefits and supplemental services, to beneficiaries, called care plan options (CPOs). These CPOs are intended to give CMC plans the flexibility to provide services not otherwise covered to beneficiaries to help them avoid higher levels of care. CMC plan KIs reported providing a variety of CPOs including: cell phones, home modifications, home appliances, socialization programs, personal care services, and housing support. Once an "actionable need" was identified, CMC plans either identified available resources and services through community organizations, or they provided the resource or service as a CPO. The documentation of CPOs provided to beneficiaries is inconsistent across plans, with only a few plans reporting efforts to track

their return on investment. The CMC plans that were tracking CPOs reported tracking only the services they paid for, excluding the services that were provided through community organizations' existing services. The lack of consistency in the tracking of CPOs makes it difficult to assess their return on investment. Furthermore, community organizations that provide free services to CMC beneficiaries want to make sure that their role in the demonstration, their contribution to cost savings, and the positive impact they are having on CMC beneficiaries are captured and taken into account as policymakers decide how the program may be structured in the future.

Recommendations: CMC plans should enhance efforts to track the provision of CPOs as well as resources or services provided by community organizations in order to determine their return on investment. Such data should be used to identify promising practices for expanded replication.

CMC Could Improve Access to LTSS

Several CMC plan KIs reported efforts to improve access to LTSS for CMC beneficiaries, especially in the area of referral to IHSS, CBAS and MSSP, or advocating for re-assessments of current IHSS recipients to increase their hours. Despite this, some organizations that provide home and community-based services raised concerns about the lack of referrals from CMC plans, and some were disappointed in the extent to which the CMC health plans were contracting for their services. They expressed skepticism about the capacity of CMC plans to adequately provide LTSS without leveraging the expertise of stakeholders that have a long history of providing these services to dually eligible beneficiaries. The duplication of care coordination services was especially concerning, especially in situations where the CMC plan and the LTSS provider had not developed a collaborative relationship.

Promising Practices: CMC plan KIs reported efforts to 1) increase referrals to IHSS, CBAS, and MSSP; 2) enroll informal caregivers as IHSS workers; 3) request re-assessments and additional services; and 4) pay for certain LTSS services as care plan options to avoid delays in access or gaps in care.

Recommendations: CMC plans should share promising practices in expanding access to LTSS. DHCS should continue to encourage CMC plans to collaborate with LTSS providers, especially around the provision of care coordination.

CMC Has Impacted Coordination Between IHSS and Plans

While the county Social Services Department retained control over the assessment and authorization of IHSS hours for CMC beneficiaries, CMC plans paid for and coordinated services. Though this limited the ability of CMC plans to directly influence the provision of

IHSS to their beneficiaries, KIs did report that the level of communication and coordination between IHSS and plans had improved tremendously. CMC health plans worked to communicate more effectively with IHSS social workers, sometimes co-locating staff or creating data systems to enhance communication. IHSS and CMC plan KIs also reported arranging education and outreach sessions with IHSS social workers, care workers, and beneficiaries. Many CMC plan KIs expressed an interest in IHSS care worker's involvement in their beneficiary's care planning and ICTs. However, some KIs were concerned that this could happen without the beneficiaries consent, risking the consumer-directed nature of IHSS.

> *Recommendations: DHCS should monitor CMC plans' efforts to engage IHSS care workers in care planning and ICTs, and ensure that the consumer-directed foundation of IHSS is upheld.*

Plans Responded to the Challenge of Serving Some Populations

While not unique to CMC, KIs noted challenges in serving particular CMC beneficiaries, especially homeless beneficiaries, those with severe mental illness or substance use disorders, and those that are "unknown" and at risk. A large number of beneficiaries fall under one or more of these categories, further compounding the challenge of serving them. However, with CMC's additional benefits and flexibility, some plans were developing innovative approaches to address the challenge. While some CMC plans were able to patch together community resources or multiple funding streams to meet the needs of these challenging populations, other plans reported that they didn't have the same resources in their communities. This disparity in community-based resources to supplement the benefits and services provided by the CMC plan could lead to variable CMC outcomes regarding the ability to serve challenging populations.

> *Promising Practices: CMC plan KIs described efforts to integrate behavioral health care into primary care, develop innovative pain management health homes, utilize recuperative care services, and identify housing resources.*

> *Recommendations: CMC plans should share promising practices in serving challenging populations to be shared by DHCS. DHCS should also monitor disparities in serving challenging populations across CMC plans and counties, and seek to address these challenges in future reform efforts.*

CMC Encouraged Quality Oversight

CMC policy included several incentives to improve quality of care, such as increased collection and reporting of quality metrics, quality withholds, and person-centered care

requirements. However, KIs also reported an incentive for CMC plans to conduct quality oversight. This interest in ensuring quality of the care provided to their beneficiaries seemed to be especially important in newer areas of plan responsibility – LTC and LTSS.

> ***Promising Practices: CMC plan KIs reported efforts to: 1) tie payments and shared savings arrangements to quality outcomes, 2) assess the quality of LTC facilities and LTSS using rating systems,[10] and 3) enforce quality through partnerships with oversight agencies, such as the LTC Ombudsman Program.[11]***

More details about these and other findings can be found in the *Evaluation of Cal MediConnect: Health System Response Full Report at*
http://www.theSCANFoundation.org/sites/default/files/cal_mediconnect_health_system_full_report.pdf

---

California Department of Health Care Services (DHCS) Response

California's Coordinated Care Initiative (CCI) is a historic undertaking to help improve the lives of low-income seniors and people with disabilities. DHCS appreciates the various evaluation efforts supported by The SCAN Foundation, and is encouraged by early evaluation data[a] that shows beneficiaries in Cal MediConnect (CMC) health plans are confident in and satisfied with their care. DHCS also recognizes the challenges that come with trying to integrate different health care systems in a way that provides improved and coordinated care to beneficiaries. Throughout the history of the CCI, DHCS has worked with CMC plans and other stakeholders to address issues and improve and strengthen the program. DHCS is implementing program improvement strategies[b] developed to target the areas identified in the evaluations to date, and will continue to use data-driven quality improvement strategies as program implementation continues.

DHCS is currently working on a number of projects within the CCI to continue improving collaboration across health system stakeholders. For example:

- DHCS is working with the California Hospital Association and the CMC plans on a hospital case manager toolkit[c] that will help facilitate smoother care transitions for CMC members during hospital admissions and discharges. DHCS is working with the plans and CCI counties around a similar toolkit or best practices white paper on how the plans, their delegates and the county behavioral health agencies and providers can continue to strengthen care coordination for CMC members.
- DHCS has begun convening best practices meetings with CMC plans to target specific topics for quality improvement, such as strengthening data collection and reporting or care coordination for patients with dementia.
- DHCS has worked closely with the plans and providers to improve communication and resolve billing, authorization and contract challenges, particularly during the initial transition period in implementation. DHCS facilitated a number of meetings between

Continued…

plans and specific provider groups to resolve these issues, as well as hosting several large provider summits designed to strengthen communication within CMC networks.

- The DHCS-CMS contract management teams continue to work closely one-on-one with the CMC plans to resolve challenges as they are identified.

DHCS is also taking several steps to encourage broader use of LTSS services. DHCS is working with stakeholders to standardize the HRA questions designed to prompt referrals for non-medical or long term services and supports (LTSS) needs.[d] These new questions will reflect best practices developed by plans with high rates of LTSS referrals. Additionally, DHCS is strengthening data collection around LTSS referrals to better track how effectively plans are linking beneficiaries to needed services. This will enable a better understanding of how and why CMC plans are identifying a need for LTSS and services to which they are providing referrals. DHCS has also recently proposed that CMC plans clarify the extent to which ICPs and ICTs are being completed, utilized, and executed.

DHCS is also working to ensure that eligible beneficiaries and their providers understand the promise of CMC. DHCS has also developed new materials for beneficiaries; the Cal MediConnect Beneficiary Toolkit[e] has been developed to support beneficiaries, their key supports, and options counselors in choosing the best option for the beneficiary, in addition to the formal notices and guidebooks. DHCS has also created a Guidebook[f] for new dual eligibles. The Beneficiary Toolkit and new Guidebook have undergone stakeholder review and beneficiary user testing with Health Research for Action at the UC Berkeley School of Public Health. They will be finalized by the end of July and then shared broadly.

As the evaluation efforts have shown, written materials are not always sufficient to effectively educate beneficiaries about the program and its potential benefits. DHCS is continuing to work on-the-ground in CCI counties with other stakeholders and partners to reach and educate dual eligibles about the program, including targeted and culturally competent outreach in diverse communities. DHCS is also working with the CMC plans to encourage appropriate education and marketing efforts towards duals who may benefit from the program.

As the evaluation notes, providers are a key source of information for dual eligibles. DHCS has conducted a detailed analysis of beneficiaries who have opted out of the program and their most frequently used providers in an effort to more effectively focus provider education and outreach activities, in partnership with the health plans. This work will include language-specific outreach and activities focused at physicians who serve diverse communities.

DHCS will continue to work with CMC plan partners and stakeholders to identify areas to improve the program and ensure that more eligible beneficiaries know how Cal MediConnect can improve their health and quality of life.

Continued…

REFERENCES

[a] DHCS (2016). Latest Survey Results Finds Cal MediConnect Enrollees Are Expressing Increased Satisfaction. Retrieved from http://www.calduals.org/2016/06/16/latest-survey-results-finds-cal-mediconnect-enrollees-are-expressing-increased-satisfaction/.

[b] DHCS (2016). Cal MediConnect Voluntary Enrollment Strategy. Retreived from http://www.calduals.org/wp-content/uploads/2016/06/DRAFT-Cal-MediConnect-Voluntary-Enrollment-Strategy-2016-06-30-16.pdf .

[c] DHCS (2016). Cal MediConnect Hospital Case Manager Toolkit. Retrieved from www.calduals.org/wp-content/uploads/2016/03/Case-Manager-Toolkit_-3-3-16.pdf.

[d] DHCS (2016). Standardized Health Risk Assessment (HRA) Long-term Services and Supports (LTSS) Referral Questions. Retrieved from http://www.calduals.org/wp-content/uploads/2016/05/HRA-LTSS-Questions-5.5.16.pdf.

[e] DHCS (2016). Beneficiary Toolkit. Retrieved from http://www.calduals.org/2015/11/24/for-review-new-toolkit-for-dual-eligible-beneficiaries/.

[f] DHCS (2015). Revised Managed Care Guide and Choice Book for New Dual Eligible Beneficiaries in CCI Counties. Retrieved from http://www.calduals.org/2015/09/21/for-review-revised-managed-care-guide-and-choice-book-for-new-dual-eligible-beneficiaries-in-cci-counties/.

REFERENCES

[1] Institute for Health and Aging, UC San Francisco
[2] Health Research for Action, UC Berkeley
[3] Community Living Policy Center, UC San Francisco
[4] Hollister, B., Graham, C., Harrington, C., Wong, A., O'Shea, L., Kurtovich, E., Nussey, B., Liu, P-J. (2016). Cal MediConnect: How Have Health Systems Responded? Long Beach, CA: The SCAN Foundation. Retrieved from http://www.theSCANFoundation.org/sites/default/files/cal_mediconnect_health_system_full_report.pdf.
[5] The SCAN Foundation: Linkage Lab Initiative. Retrieved from http://www.thescanfoundation.org/linkage-lab-initiative.
[6] DHCS (2016). Cal MediConnect Performance Dashboard. Retrieved from http://www.calduals.org/enrollment-information/enrollment-data/cal-mediconnect-performance-dashboard/.
[7] The SCAN Foundation: Person-Centered Care. Retrieved from http://www.thescanfoundation.org/our-goals/person-centered-care.
[8] Philip, A., & Herman Soper, M. (2016). Interdisciplinary Care Teams for Medicare-Medicaid Enrollees: Considerations for States. Retrieved from http://www.thescanfoundation.org/sites/default/files/chcs_icts_for_medicare-medicaid_enrollees_012216.pdf.
[9] The SCAN Foundation: The Promise of Coordinated Care. Retrieved from http://www.thescanfoundation.org/promise-coordinated-care.
[10] CalQualityCare.org-Your Guide to Quality Health Care in California. Retrieved from http://www.calqualitycare.org/.
[11] Hollister, B., Davies, M., Mokler, P.M. & Graham, C. (2016). Yes, Collaboration Can Happen—and Means Better Quality of Life for LTC Residents. Retrieved from http://asaging.org/blog/yes-collaboration-can-happen-and-means-better-quality-life-ltc-residents.