

# Extending Health Care into Community Settings

## HPSM Community Care Settings Pilot

**DHCS 1115 Waiver Renewal - Housing Workgroup**  
January 14, 2015

**the  
healthy  
fight.**



**HealthPlan  
OF SAN MATEO**

# About HPSM

---

- Established in 1987 as the sole Medi-Cal MCP for San Mateo County (COHS)
  - Added CareAdvantage D-SNP in 2007
- Duals Demonstration Project CMC activated 4/1/14
- Membership:

Total (All LOB)	CareAdvantage	Other CCI	MCE
136,285	CMC: 10,350 D-SNP: 847	Other Medicare Primary: 5,379 SPDs/Partial Duals: 8,692	28,714

**\*HPSM CCI 1/2015**

# Serving Vulnerable Populations

LTC Residents, SNF Diversion, and Community At-Risk

---

- Primary focus is the Community Care Settings Pilot
  - A coordinated approach to delivering existing and incremental services to vulnerable members
  - Partnerships to deliver critical project elements:

**Intensive Transitional  
Case Management**  
(Institute on Aging)

**Housing Services &  
Retention**  
(Brilliant Corners)

- Other Initiatives:
  - IHSS CCI Enhanced Case Management partnership with San Mateo County
  - Reorganization of Health Services Care Coordination based on member acuity and existing member relationships

# The Opportunity

Why We Developed the Community Care Settings Pilot

---

## Challenges

**Inflexibility of Existing Resources**

**Fragmentation of Programs & Resources**

**Developing and Organizing New Plan Capabilities**

**Shrinking LTC/SNF Beds**

## Opportunities

**Duals Demonstration Project & Long-term Care Integration**

**Affordable Care Act**

**Local Funding**

## Pilot

**The Community Care Settings Pilot**

Vehicle to increase speed and precision of change

**The pilot will serve as an important proving ground and innovation lab for new care delivery concepts**

# Target Populations

---

- High-risk sub-populations:

## LTC Residents Needs Assessment

- ~10% of LTC residents able to migrate to LLOC
- Identify community housing options and support transitions

## SNF Diversions LTC Avoidance

- Acute health incidents prompting change in health status
- Stabilize and support to reduce readmissions

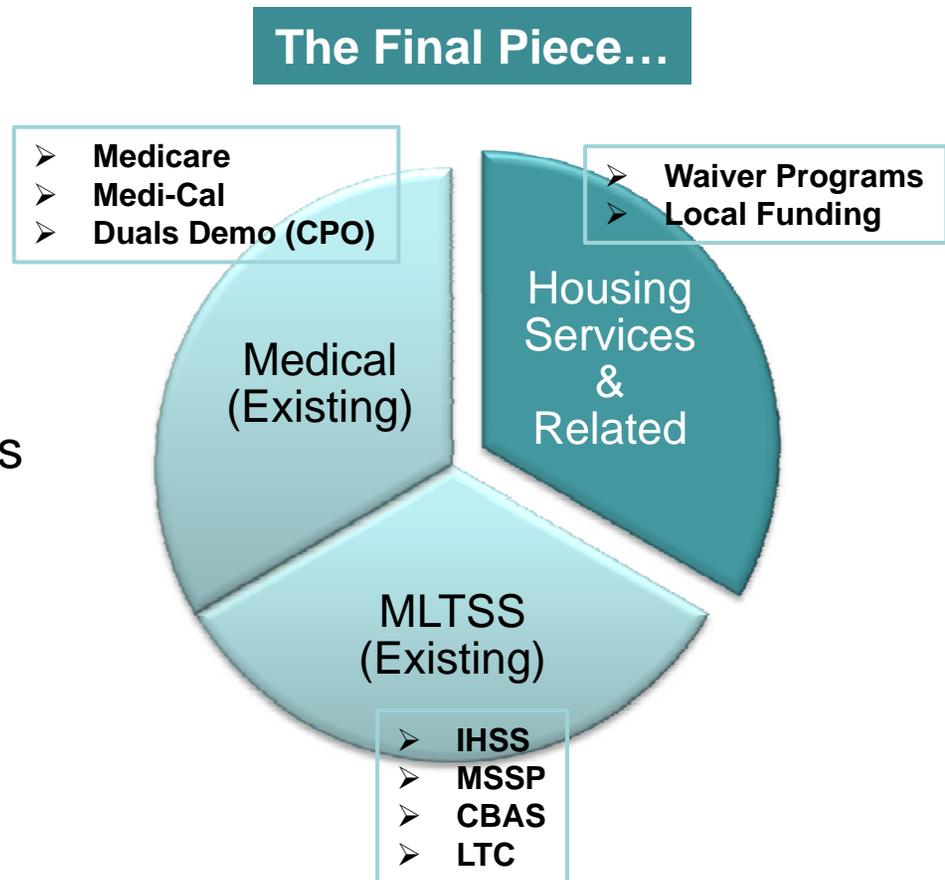
## Community Diversions Extending Independence

- Individuals struggling at home, at-risk of acute incident or LTC admission
- Potential for inclusion of homeless populations

**Investigating opportunities to support targeting of chronic homeless and other populations**

# Organizing Resources

- Key incremental resource: Local funding as an agent for start up costs
- Critical to organize and optimize full range of funding sources/uses
- Understanding opportunities of existing programs
  - ~6-8 State HCBS programs
  - Example: ALW



**Confusing array of resources requires alignment and coordination across programs and among partners**

# Care Management & Housing Strategies

---

- Identify and screen potential participants
- Engage in person-centered care management model
  - MSWs and LCSWs serve as member advocates
  - Support from housing specialists, RNs, OTs, Psychologists
- Phased Transition Process
  - 9-12 months of intensive transitional case management is initiated
  - Identify and secure appropriate housing upon enrollment:

Existing Home	Affordable Supportive Housing	Scattered-Site Housing	RCFE/ ARF Assisted Living (IOA)
---------------	-------------------------------	------------------------	---------------------------------

- Ongoing housing retention services and return to high-risk HPSM care coordination
- Multi-agency Core Group oversees project and participants
  - Provides immediate access to services (IHSS, behavioral health...)
  - Promotes multi-disciplinary case discussion and planning

# Key Learnings

---

- Rate determination does not recognize housing services in subsequent rate payments to Plan
- Targeting and screening participants requires new tools and extensive testing (Prioritization Factors & Case Mix Index)
- Successful placements require 3-6 months of pre-work
- Affordable housing partners are keenly interested in connecting with health care services (set-asides)
- Resource alignment and Health Plan role definition is key to delivering incremental services
- Building new network with non-traditional partners requires significant coordination
- Finding hard-to-reach members has required community partner participation (HRA's, etc.)

**Ultimate goal of project sustainability/scalability through proven cost savings and member health outcomes**

# Appendix A – Caseload Projections

---

- Began enrollments August 2014, with annual projected caseloads:

Caseload	Year 1	Year 2	Year 3	Year 4	Year 5
Intensive Care Management	120	154	200	200	200

- Transitioned enrollees remain connected to
- Projected to serve 874 enrollees over five years

# Appendix B – Project Pipeline

	Prospects		Waitlisted		Enrolled		Transitioned		Closed		Deferred	
Totals	27		15		36		4		5		11	
<b>Target Population</b>	#	%	#	%	#	%	#	%	#	%	#	%
LTC Resident	26	96%	2	13%	26	72%	2	50%	0	0%	3	27%
SNF Diversion	0	0%	3	20%	4	11%	2	50%	2	40%	0	0%
Community Diversion	1	4%	10	67%	6	17%	0	0%	3	60%	8	73%
<b>HPSM Line of Business</b>	#	%	#	%	#	%	#	%	#	%	#	%
Care Advantage/CMC	13	48%	6	40%	19	53%	3	75%	3	60%	4	36%
Medi-Cal Only (No Medicare)	10	37%	8	53%	9	25%	1	25%	2	40%	6	55%
Medi-Cal Only (Medicare Primary not HPSM)	4	15%	1	7%	8	22%	0	0%	0	0%	1	9%
<b>Referral Source</b>	#	%	#	%	#	%	#	%	#	%	#	%
SNF	0	0%	5	33%	26	72%	2	50%	1	20%	2	18%
Community	0	0%	10	67%	5	14%	1	25%	2	40%	8	73%
HPSM	27	100%	0	0%	5	14%	1	25%	2	40%	1	9%
<b>Anticipated Housing Need</b>	#	%	#	%	#	%	#	%	#	%	#	%
Scattered Site			6	40%	14	39%	0	0%	0	0%	0	0%
RCFE	N/A		3	20%	15	42%	0	0%	0	0%	0	0%
Other			1	7%	3	8%	2	50%	0	0%	0	0%
None			5	33%	4	11%	2	50%	5	100%	11	100%
<b>Reasons for Deferral/Closure</b>	#	%	#	%	#	%	#	%	#	%	#	%
Member declined services									2	40%	1	9%
Death/hospice									1	20%	2	18%
Needs met by other CM provider	N/A		N/A		N/A		N/A		0	0%	3	27%
No longer needs services									1	20%	1	9%
Not appropriate for program									1	20%	4	36%

**Prospects** = Individuals identified by name as potential referrals but no referral received

**Waitlisted** = Referral received but no CM assigned

**Enrolled** = Includes new referrals being assessed and individuals completely enrolled

**Transitioned** = Total number of individuals transitioned to lower or alternate level of care

**Closed** = Individuals who have been closed to CCSP Case Management services

**Deferred** = Individuals referred to CCSP but not enrolled or waitlisted