Community Transitions

Health Plan of San Mateo

Medi-Cal Advisory Group Stakeholders Meeting
December 8, 2016
Care Coordination at HPSM

**Tiered Intensity of Care**

- **Intensive**
  - Community Care Settings Pilot (CCSP)
  - Landmark Health Home-based Complexivist Care Team
- **Advanced**
  - Home Based Care Coordination
  - IHSS-CCI
  - MSSP
  - ESRD Case Management
  - OASIS
- **Standard**
  - HPSM Care Coordination Team
  - Phone-based Complex Case Management
  - Care Transitions Short-Term
  - Hospital and SNF Discharge Support
Vehicle for Transitions
The Community Care Settings Pilot

- **Features**
  - Housing Services
  - Intensive Case Management

- **Enablers**
  - Shared vision of LTCI with County Health System
  - Cal MediConnect/Coordinated Care Initiative
    - Integration of (Social/Behavioral/Medical)
  - HPSM’s Role (Coordinating Entity)
    - Convener
    - Resource Aggregator
    - Disrupter

**Goal:** Support Community Living
How did we get here?

Opportunities and Challenges
• Address Community Needs (Access to SNF/NF Beds)
• Leverage Reforms (ACA)
• Create a Proving Ground for Innovation/Build Capabilities
• Inefficient Health Care Systems (Barriers)

Milestones/Timeline (It takes time)
• 8/2013 – RFP for Intensive Case Management/Housing Svcs
• 8/2014 – First enrollees served/intake
• 6/2016 – First 100 enrollees transitioned
• 9/2016 – New budgets approved (+40%)
• 1/2017 – Integrate with Whole Person Care

Building community awareness and alignment is key
Housing Strategy

• Delivered by Brilliant Corners
• Includes an array of services focused on safe transition and longevity in the community:

<table>
<thead>
<tr>
<th>Person-centered housing search</th>
<th>Housing portfolio management</th>
<th>Affordable housing waitlist management</th>
<th>On-call/ 24-hour response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owner-resident liaison</td>
<td>Lease arrangement</td>
<td>Unit repairs and modifications</td>
<td>Unit Habitability and wellness checks</td>
</tr>
</tbody>
</table>

• BC also manages relationship with County Housing Department and Housing Authority
• Project leverages a wide array of residential settings as on the next slide
## Facilitating Multiple Housing Channels

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Market Rate Corporate Lease</th>
<th>Market Rate Housing Authority Voucher</th>
<th>Affordable General Pool</th>
<th>Affordable Set-Asides</th>
<th>RCFE Assisted Living</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad rent ranges, increasing market rates</td>
<td>Bypass barriers in rental criteria</td>
<td>Affordable for member &amp; program Member holds their own lease</td>
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<td>24/7 Supervision More frequent redirection for dementia-related behaviors</td>
</tr>
<tr>
<td>Limited accessible floorplans</td>
<td>More widely available</td>
<td>Member holds their own lease</td>
<td>Member holds their own lease</td>
<td>Member holds their own lease</td>
<td>Provides potential ‘step down’ path from SNF</td>
</tr>
<tr>
<td></td>
<td>Immediate housing access</td>
<td>Additional onsite supports</td>
<td>Additional onsite supports</td>
<td>Bypass standard waitlist process</td>
<td>Immediate access</td>
</tr>
<tr>
<td></td>
<td>Limitation of landlord participation</td>
<td>Difficulty accessing due to lengthy or closed housing waitlists</td>
<td>Requires sometimes lengthy negotiation and planning</td>
<td>Short window of opportunity to put in place</td>
<td>Shortage of facilities skilled in managing more difficult behaviors</td>
</tr>
<tr>
<td></td>
<td>Limited accessible floorplans</td>
<td></td>
<td></td>
<td></td>
<td>Assisted Living Waiver Rates notably below market &amp; state approval process cumbersome</td>
</tr>
</tbody>
</table>
Care Management Strategy

- Care management delivered by the Institute on Aging
- IOA Intensive Care Management program includes:
  - Primary Care Management for 1-2 months pre-transition and 9-12 months post-transition
    - 1:15 -18 Case management ratio
  - Assessment and facilitation of needed goods and services (care plan option services) to support the transition and/or prevent unnecessary institutionalization
  - Integration of medical/social/behavioral services and supports
  - Phased approach includes the following:

**Implementation Phase**
- Successful discharge
- Frequent home visits
- PCP engagement
- Home setup

**Stabilization Phase**
- Problem solving
- Regular contact
- Skills development
- Crisis intervention

**Transition Phase**
- Resolve unmet goals
- Promote independence
- Ensure safety
- Transfer of case
Targeting Participants

- Population segmenting: member groupings best fit to pilot goals & services

  **LTC Residents**
  - Needs Assessment
  - ~10-30% of LTC residents able to migrate to lower level of care

  **SNF Diversions**
  - LTC Avoidance
  - Acute health incidents prompting change in health or functional status

  **Community Diversions**
  - Extending Independence
  - Individuals struggling in the community, at-risk of acute incident or LTC admission

- Participants tend to be highly complex: poly-chronic conditions, behavioral health, substance use, history of homelessness...

- Through ~24 months of pilot operations...
  - 130 members transitioned as of November 1, 2016
  - 335 members have been touched by the program
  - +20 members have opted into CA CMC after CCSP enrollment
  - Total enrollment and waitlist are both growing steadily
2016 Program Outcomes

- Total cost by population six months pre- and post-transition:
  - Note: only enrollees with six full months of post-transition data are included, therefore the N for each population remains small.

<table>
<thead>
<tr>
<th></th>
<th>Pre-Transition</th>
<th>Post-Transition</th>
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</thead>
<tbody>
<tr>
<td>LTC Residents</td>
<td>$PMPM ▼ 61%</td>
<td>$PMPM ▲ 8%</td>
</tr>
<tr>
<td>N = 56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF Diversions</td>
<td>$PMPM ▲ 8%</td>
<td>$PMPM ▲ 34%</td>
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<tr>
<td>N = 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Diversions</td>
<td>$PMPM ▲ 34%</td>
<td>$PMPM ▲ 34%</td>
</tr>
<tr>
<td>N = 10</td>
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</tbody>
</table>

- Mix of services utilized shifting from Medical to Social & Behavioral
- 97% of enrollees with 6+ months of community residency have remained in place
- System improvement in accessing services and coordinating care
- High levels of member satisfaction in initial participant survey
Keys to Success / Lessons Learned

- Serving as single accountable entity
- Filling systemic gaps and breaking down barriers to support transitions or community longevity
- Leveraging and coordinating an array of resources
- Maintaining organizational alignment in an evolving landscape
- Focused, flexible housing approach
Project Outlook

- Targeting new populations including homeless and dementia/cognitive impairment
- Growing base of referral sources across the community
- Testing new care/delivery models such as rapid service connection and housing deployment
- Exploring new residential opportunities
- Adding case management capacity/variety to grow overall project enrollment
- Connecting CCSP services into standard operations serving larger HPSM population

Eventual Integration with Whole Person Care....
Appendix - Raising Awareness Nationally

Recent articles featuring CCSP:

- Center for Health Care Strategies – see below - [http://www.chcs.org/media/HPSM-CCS-Pilot-Profile-032916.pdf](http://www.chcs.org/media/HPSM-CCS-Pilot-Profile-032916.pdf)
- Bipartisan Policy Center – Healthy Aging Begins at Home - [http://bipartisanpolicy.org/library/recommendations-for-healthy-aging/](http://bipartisanpolicy.org/library/recommendations-for-healthy-aging/)