Partnering to Enable Community Living

HPSM Community Care Settings Pilot Update

January 26, 2016

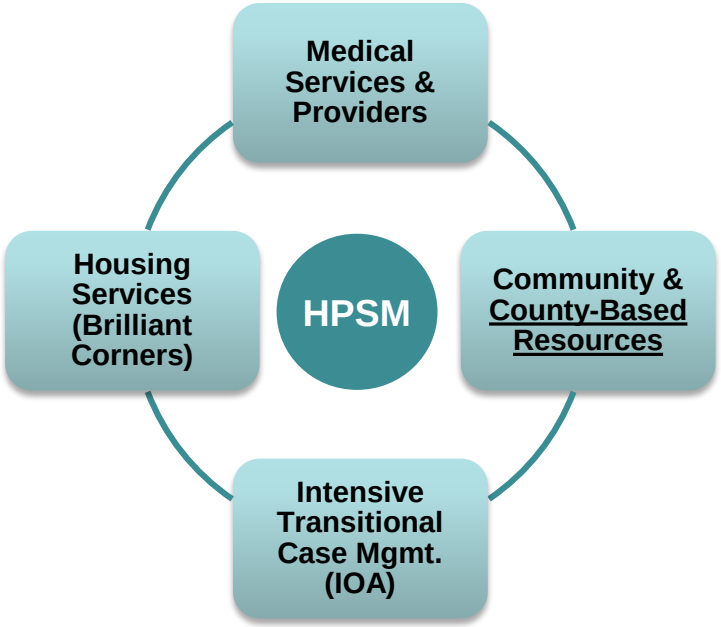
What is the Pilot?

- The Community Care Settings Pilot (CCSP) is HPSM's highest intensity care management program
  - Focused on deinstitutionalization and promoting community living for vulnerable members
  - Test-bed for incremental services and tools
- Unique features for members include:
  - 1:20 case management (MSW/LCSW)
    - Significant face-to-face contact
  - Housing services & retention
  - Multi-disciplinary Core Group care planning & oversight
    - 25+ participants including County agencies, contractors, HPSM staff and physicians

For appropriate members, CCSP will deploy whatever services are necessary to migrate out of, or avoid, LTC residency

Pilot Structure

- Operated in partnership with two community-based organizations selected through an RFP:
  - Institute on Aging (IOA): case management and oversight
  - Brilliant Corners: housing services and retention



CCSP Leverages a Number of Resources to support operations:

- County programs (IHSS, CBAS, MSSP)
- Other programs (ALW, CCT, IHO)
- Health benefits and Care Plan Optional (CPO) services
- Local funding

Targeting Participants

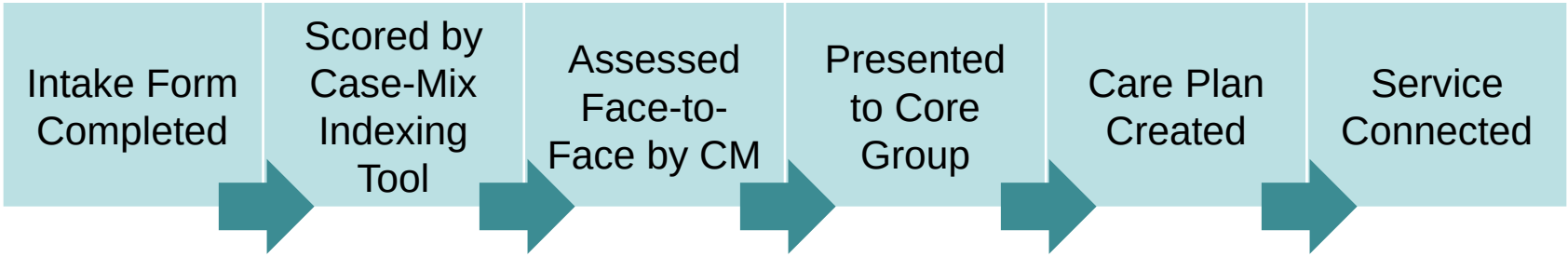
- Population segmenting: member groupings best fit to pilot goals & services

LTC Residents Needs Assessment	SNF Diversions LTC Avoidance	Community Diversions Extending Independence
• ~10-30% of LTC residents able to migrate to lower level of care	• Acute health incidents prompting change in health or functional status	• Individuals struggling in the community, at-risk of acute incident or LTC admission

- Targeting LTC supports community lack of NF bed capacity
- Case-mix indexing tool utilized to determine eligibility and population fit

Participant Engagement

- Once participants are identified, prep work begins:



- Stepped case management phases:
  - Once service is connected, participants receive intensive CCSP case management for 9-12 months:

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

- Members are transitioned to a different CM tier
  - Brilliant Corners housing retention services continue

Housing Strategy

- Housing services are one of the unique elements of CCSP, delivering a range of supports for project participants:

Owner-resident liaison	Housing portfolio management	Unit Habitability and wellness checks	On-call/ 24-hour response

- Targeted residential settings:

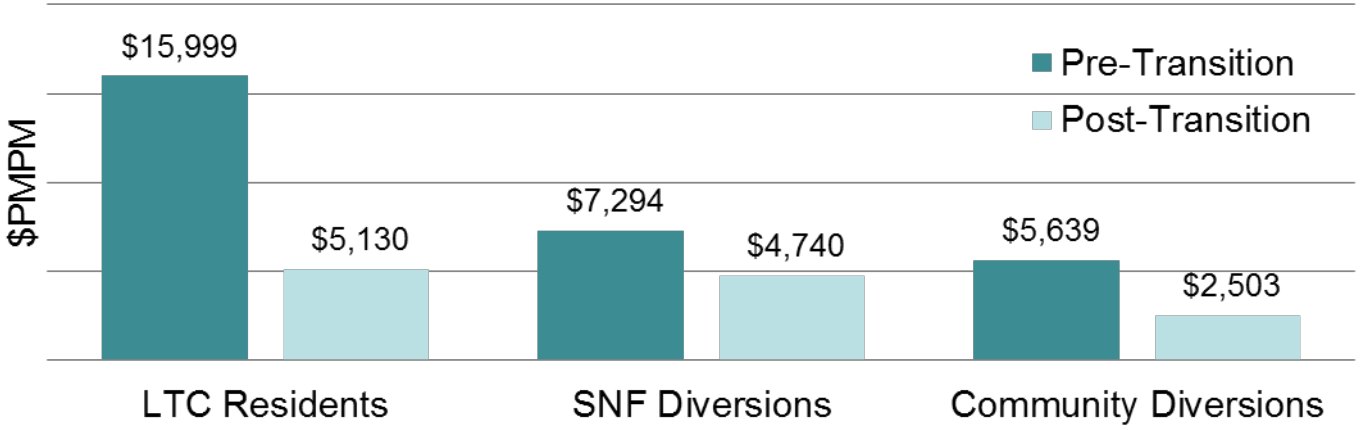
Existing Home	Affordable Supportive Housing	Scattered-Site Housing	RCFE/ ARF Assisted Living

- Partnership with County Department of Housing and Housing Authority for set-asides (Half Moon Village) and waitlist management

Housing has been the main barrier to LTC discharge for many members, our goal is to remove that barrier

Early Program Impacts

- Total cost by population six months pre- and post-transition:



- Member stories:

Stroke Patient **SNF (1 Year) → Affordable Apt.**	**Stroke, Vision Loss, Diabetes** **SNF (2 Years) → RCFE**	**Shoulder Replacement** **SNF (1 Year) → Section 8 Apt.**
• Eviction prevented • CBAS 5x per week, 4 other supportive services • Socially engaged in community	• Bonded with 'house' dog at RCFE • Volunteering with the SPCA • Self-managing diabetes	• Lost apt. while in SNF • Brilliant Corners secured new section 8 unit • Overjoyed to be back in the community

- Improvement in the system – efficiency in service connection, incremental services, enhanced coordination

Operational Update

- Current project status – 15 months since launch
  - Operating successfully within original scope
    - Biweekly core group and administrative meetings
    - Growing range of services and supports
    - Barriers to community living being eliminated
  - 146 members enrolled, 71 transitioned
    - Three ‘pathways’: SNF residents (60%), SNF diversions (20%), community diversions (20%)
    - Referral pipeline and waitlist growing
    - Below projections for transitions
  - Budget: Actual expenses 30% below FY16 targets

Phase two: opportunity to grow the impact of CCSP

Phase Two Proposals

- Seven initiatives identified to grow impact of CCSP:
  - Enhance case manager capability
  - Dedicated project manager
  - Augment scope of program intake criteria
  - Leverage affordable housing partnerships
  - Operationalize CCSP elements within larger HPSM programming
  - Implement peer mentoring program
  - Deploy project MD to engage providers

Appendix A: Participant Dashboard

			Enrolled to IOA CM				*Closed to IOA CM*					
	Waitlisted		**Pre-transition**		**Transitioned**		**Transitioned**		**No Transition**		**Deferred**	
Totals	**108**		**49**		**53**		**18**		**26**		**50**	
Target Population	#	%	#	%	#	%	#	%	#	%	#	%
LTC Resident	39	*36%*	36	*73%*	37	*70%*	4	*22%*	17	*65%*	22	*44%*
SNF Diversion	23	*21%*	10	*20%*	9	*17%*	6	*33%*	4	*15%*	4	*8%*
Community Diversion	46	*43%*	3	*6%*	7	*13%*	8	*44%*	5	*19%*	24	*48%*
HPSM Line of Business	#	%	#	%	#	%	#	%	#	%	#	%
Care Advantage/CMC	51	*47%*	16	*33%*	34	*64%*	9	*50%*	11	*42%*	23	*46%*
Medi-Cal Only (No Medicare)	21	*19%*	12	*24%*	10	*19%*	3	*17%*	6	*23%*	13	*26%*
Medi-Cal Only (Medicare opt out)	36	*33%*	21	*43%*	9	*17%*	6	*33%*	9	*35%*	14	*28%*
Referral Source	#	%	#	%	#	%	#	%	#	%	#	%
SNF	52	*48%*	39	*80%*	37	*70%*	7	*39%*	15	*58%*	25	*50%*
Community	51	*47%*	7	*14%*	12	*23%*	10	*56%*	5	*19%*	22	*44%*
HPSM	5	*5%*	3	*6%*	4	*8%*	1	*6%*	6	*23%*	3	*6%*
Anticipated Housing Need	#	%	#	%	#	%	#	%	#	%	#	%
Scattered Site	26	*24%*	10	*20%*	9	*17%*	3	*17%*	8	*31%*	13	*26%*
RCFE	47	*44%*	26	*53%*	29	*55%*	4	*22%*	13	*50%*	25	*50%*
Other	16	*15%*	7	*14%*	11	*21%*	2	*11%*	4	*15%*	3	*6%*
None	19	*18%*	6	*12%*	4	*8%*	9	*50%*	1	*4%*	9	*18%*
Reasons for Deferral/Closure	#	%	#	%	#	%	#	%	#	%	#	%
Member declined services							0	*0%*	13	*50%*	19	*38%*
Death/hospice							4	*22%*	5	*19%*	7	*14%*
Needs met by other CM provider	N/A		N/A		N/A		2	*11%*	2	*8%*	2	*4%*
No longer needs services							12	*67%*	4	*15%*	10	*20%*
Not appropriate for program							0	*0%*	2	*8%*	12	*24%*

Appendix B: Case-Mix Indexing Tool

Best Case Scenario 10-12 points

SNF Resident

Line of Business		Target Population		Prioritization Factors	
Cal MediConnect or Care Advantage	+3	SNF Resident	+3	Primary barrier to discharge is housing	+1
				Expressed preference and motivation to return to community	+1
				Behaviors unlikely to jeopardize potential placement	+1
				Client income source expected to support community living	+1
Medi-Cal only	+1			Formal or informal supports motivated to assist client	+1
				Current placement >90 days	+1

Cal MediConnect or Care Advantage **12 pts**

Medi-Cal only **10 pts**

SNF Diversion

Line of Business		Target Population		Prioritization Factors	
Cal MediConnect or Care Advantage	+3	SNF Diversion	+2	Primary barrier to discharge is housing	+1
				Expressed preference and motivation to return to community	+1
				Behaviors unlikely to jeopardize potential placement	+1
				Client income source expected to support community living	+1
Medi-Cal only	+1			Formal or informal supports motivated to assist client	+1
				DxCG score > 75th percentile of HPSM members	+1

Cal MediConnect or Care Advantage **11 pts**

Medi-Cal only **9 pts**

Alternative Case Scenario 8 points

Community

Line of Business		Target Population		Prioritization Factors	
Cal MediConnect or Care Advantage	+3	Community Diversion	+1	Current housing at risk and/or accessibility issues identified	+1
				Recent history of missing multiple primary or specialty care appts	+1
				Recent history of lack of engagement with service providers	+1
				Case management needs exceed those available in community	+1
Medi-Cal only	+1			Formal or informal supports in need of support to assist client	+1
				DxCG score > 75th percentile of HPSM members	+1

Cal MediConnect or Care Advantage **10 pts**

Medi-Cal only **8 pts**

Appendix C: ***Phase Two Proposals***

Initiative	Description	Anticipated Impact	Cost Projections
Case Management	• Add IOA staff: 2 senior SW, 2 SW, 0.5 SW aide, 0.5 clinical supervisor, 0.2 intake specialist	• Decrease lead time from referral to transition for enrollees • Increase total IOA max caseload from 120 to 200	• Staffing and related variable costs increase by $____ annually • For FY16, fits within existing total budget • Shifts housing costs earlier in budget cycle via increased placement flow
Project Management	• Dedicated CCSP project manager	• Improve oversight and reporting procedures • Organize implementation of new initiatives and program growth • Drive systematization of CCSP elements	• TBD annual costs (salary plus benefits)
Intake Criteria	• Expand beyond initial targeted populations • Focus on acute discharges • Consider further populations: behavioral health, chronic homeless	• Develop deeper partnerships with acute facilities to reduce burden on inpatient system • Reduce inpatient utilization • Prevent social admissions to LTC facilities	• No cost directly associated with change in intake criteria • Supported by growth in case management program

Appendix C: ***Phase Two Proposals***

Initiative	Description	Anticipated Impact	Cost Projections
Affordable Housing Partnerships	• Deploy service packages on-site at select properties • Scope based on RFI responses	• Promote aging in place in lowest cost residential setting • Efficiency in service deployment due to high concentration of members	• Cost will depend on scope of services and number of selected properties (supported by RFI and data)
Integration of CCSP Services	• Health Services manages CCSP among array of CM programs • Other CM programs access certain CCSP elements	• More effective targeting of CCSP and other programs to appropriate members • Standardize processes and procedures across programs • Increase service delivery	• Cost to be determined based on services offered
Peer Mentorship Program	• Provide peer supports to CCSP participants for both social and informational purposes	• Increase socialization for deinstitutionalized members adjusting to community settings • Improve member independent living skills	• Potential to partner with existing programs to deliver peer programming at no or little cost
MD Engagement	• Utilize contracted CCSP physician to engage and train facility and community physicians	• Improve quality of care in facilities, including the safety of discharge procedures	• TBD per month for contract staff costs