Extending Health Care into Community Settings

HPSM Community Care Settings Pilot

DHCS 1115 Waiver Renewal - Housing Workgroup

January 14, 2015

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

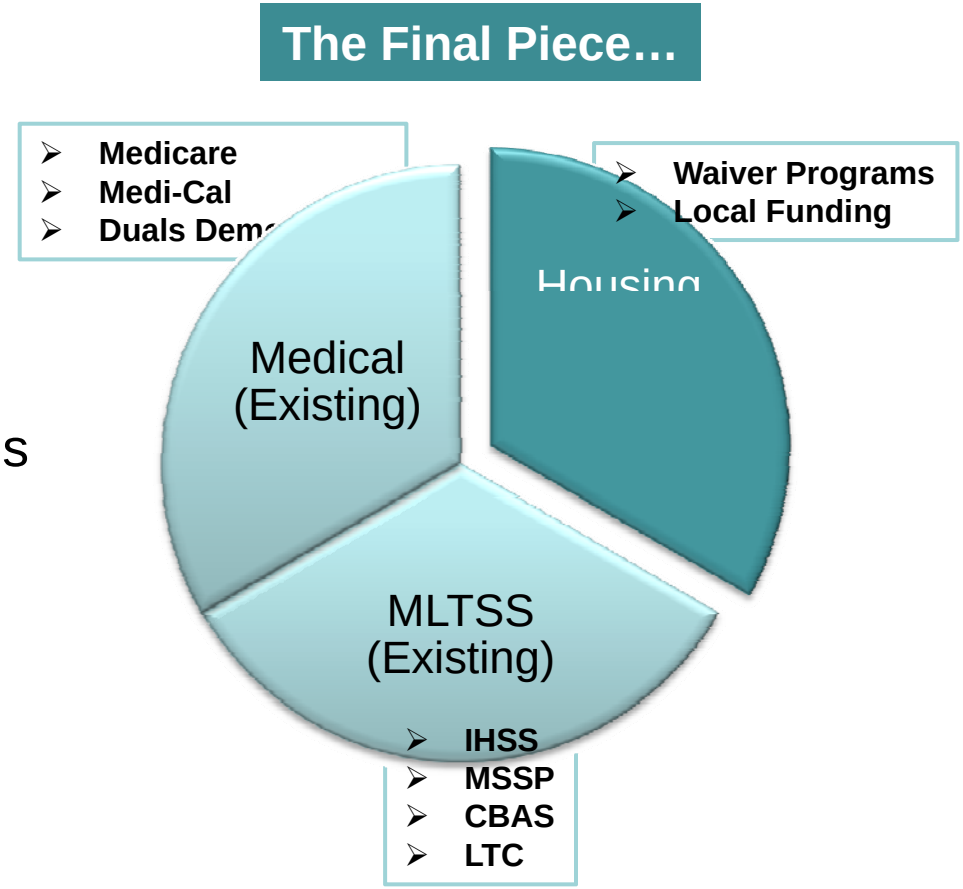
- High-risk sub-populations:

LTC Residents Needs Assessment	SNF Diversions LTC Avoidance	Community Diversions Extending Independence
• ~10% of LTC residents able to migrate to LLOC • Identify community housing options and support transitions	• Acute health incidents prompting change in health status • Stabilize and support to reduce readmissions	• 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 housing retention and HPSM care coordination
- 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**	
Target Population	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
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%*
HPSM Line of Business	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
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%*
Referral Source	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
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%*
Anticipated Housing Need	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
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%*
Reasons for Deferral/Closure	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
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