

COMMUNITY CARE SETTINGS PILOT (CCSP)

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Agenda

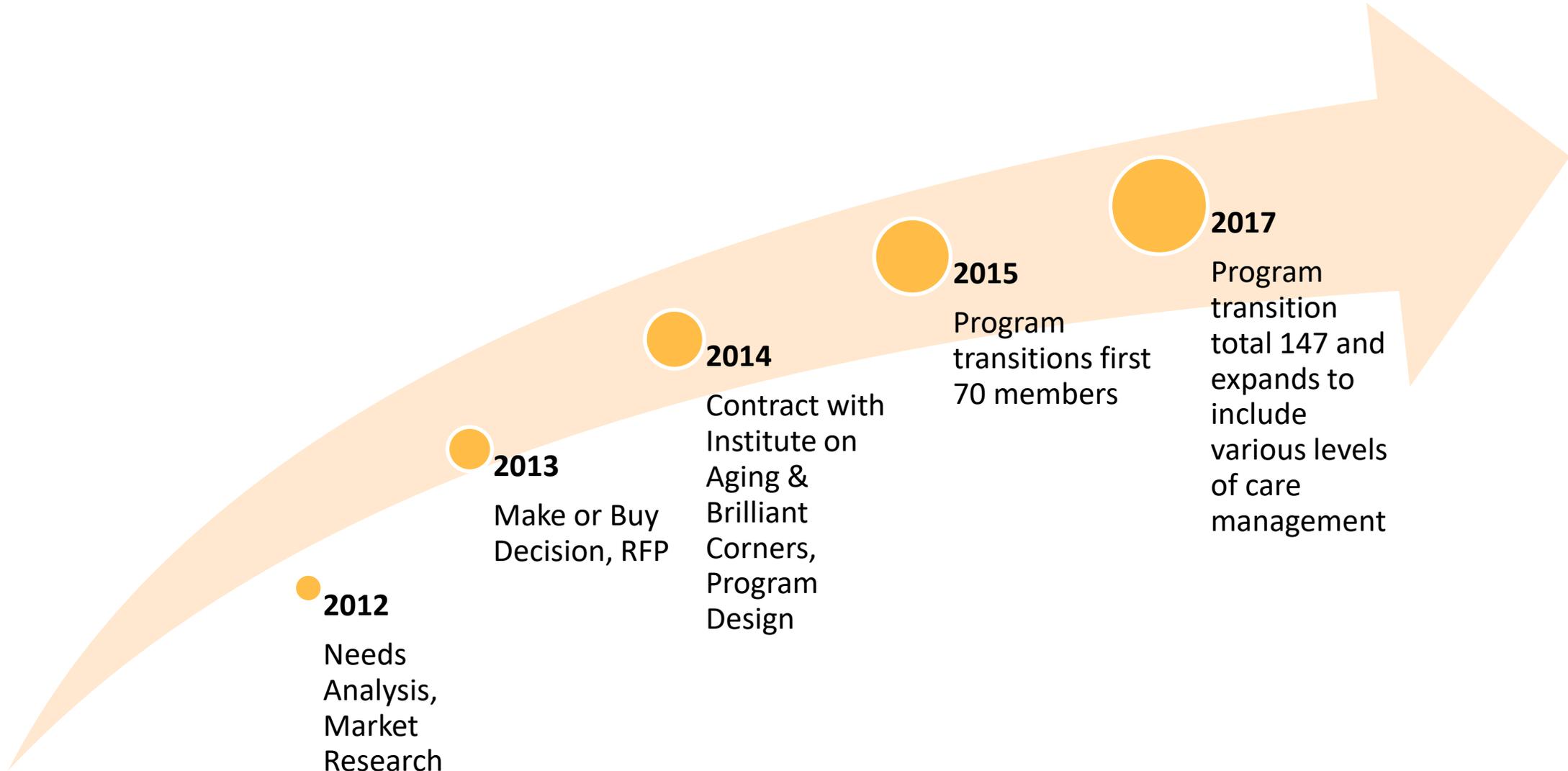
- California's Duals Demonstration
- Understanding Health Plan of San Mateo (HPSM), Institute on Aging (IOA), Brilliant Corners, and the partnership created to form CCSP
- Community Care Settings Pilot (CCSP)
- CCSP membership
- Integrating Clinical Systems
- Program and Client specific information

California's Coordinated Care Initiative: The Duals Demonstration

- A partnership between California's Medi-Cal and the Medicare programs promoting coordinated health care delivery for beneficiaries who are dually eligible for both Medicare and Medi-Cal, "dual eligible beneficiaries.
- The duals demonstration is part of California's larger Coordinated Care Initiative (CCI) that was enacted in July 2012. CCI was implemented in 7 counties in California; San Mateo County was one of them.
- **Duals Demonstration Goals:**
 1. Coordinate State and Federal benefits to improve continuity of care and use a person-centered approach.
 2. Maximize the ability of dual eligible beneficiaries to remain in their homes and communities.
 3. Increase the availability and access to home-and community-based alternatives.
 4. Preserve and enhance the ability of consumers to self-direct their care and receive high quality care.
 5. Optimize the use of Medicare, Medi-Cal and other State/County resources.

• http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal_CCI.aspx

Identifying Partner Organizations



Introducing the Community Care Settings Pilot

Program Objectives

- Develop Community-Based Alternatives to Nursing Home Placement for 10-30% of HPSM's LTC Population
- Integrate Housing, Home & Community Based Services into Health Plan System of Care
- Fill systemic gaps and breakdown unnecessary barriers in accessing long term supports & services.



Community Care Settings Pilot

For many years, older adults and younger adults with disabilities have found it difficult, if not impossible, to access the services necessary to allow them to continue living independently in their homes, or to return to community living from institutional placement.

The Community Care Settings Pilot (CCSP) connects clients with home and community-based services, or a combination of goods and services, that help individuals who are currently or at risk of being institutionalized.

Three-Pronged Program Approach:

1. **Coordinated case management** – CCSP connects clients to community services such as transportation, meals, personal care, housing assistance, etc.
2. **Purchase of services** – CCSP provides the needed resources and services, not available through any other mechanism, to Health Plan of San Mateo members. CCSP is considered the payer of last resort.
3. **Housing retention and placement** – CCSP identifies, secures, and maintains appropriate community based housing.

Groups Served:

- Individuals living in long term care facilities who are willing and able to return to living in the community with additional supports and services.
- Individuals in acute care hospitals or short term rehab settings being recommended for long term placement, but are willing and able to live in the community.
- Individuals in the community determined to be at imminent risk of institutionalization, who are willing and able to remain living in the community.

Eligibility Criteria:

- Be 18 years and older
- Be a Health Plan of San Mateo Member
- Be willing and able to live in the community with appropriate supports.
- Have demonstrated a need for a service and/or resource that will serve to prevent institutionalization or enable community living.
- Assistance needed with at least 2 activities of daily living (ADLs) or 3 instrumental activities of daily living (IADLs).
- Medical conditions must be able to be managed in the community.

Just call Institute on Aging **415.750.4111** or **650.424.1411** or visit **www.ioaging.org**



How does it fit together

- Health Plan of San Mateo (HPSM) – a local non-profit Medicaid and Medicare/Medicaid Managed Care Plan
 - Serving all of San Mateo County
- Institute on Aging – non-profit organization with expertise in care management
 - Primary Care Management Responsibilities for 1-3 months pre-transition and 6-12 months post-transition
 - Assess and facilitate purchase of needed goods and services (care plan option services) to support the transition and/or prevent unnecessary institutionalization
 - Primary point of entry for intake and referral, waitlist management, and initial assessment
 - Develop Community Living Plans for CCSP enrollees
 - Facilitate Core Group meetings (bi-monthly interdisciplinary, multi-agency meetings that make housing recommendations, oversee care coordination, and ensure access to needed services)
 - Develop and manage Residential Care Facility network
- Brilliant Corners – non-profit housing search and housing retention services organization
 - Housing search, assistance with affordable housing applications
 - Housing retention services

Who are CCSP members?

	Transitions	March 2017 Case Mix %
LTC Resident	79	56%
SNF Diversion	38	27%
Community Diversion	22	17%

*Includes CCSP Transitions through March 1, 2017

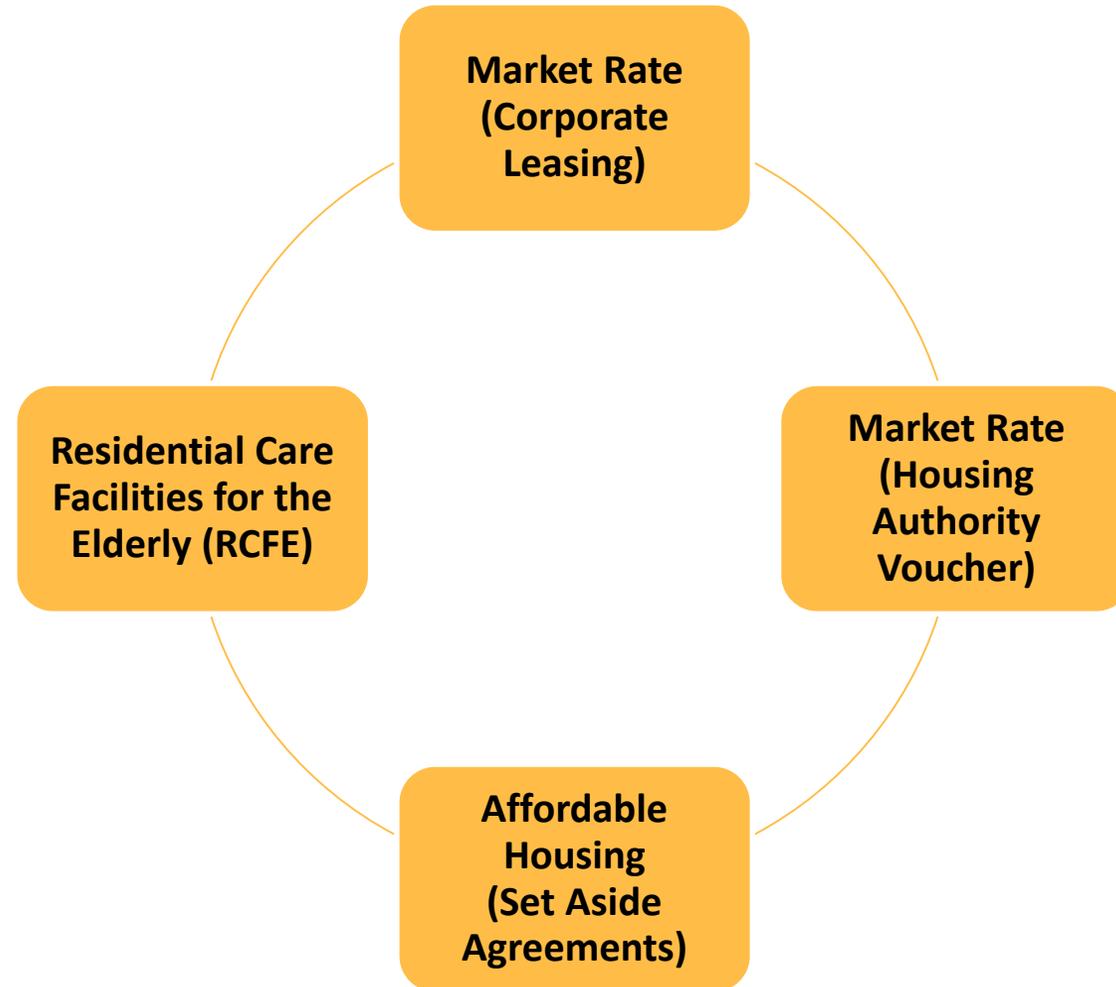
LTC Residents – *Individuals living in long term care facilities that could return to living in the community with additional long term supports and services.*

SNF Diversions – *Individuals in acute care or short term rehab settings being recommended for long term placement.*

Community Diversions – *Individuals in the community determined to be at imminent risk of long term placement.*

- *The average age of CCSP members is 72 years old. 40% are under the age of 65, 10% are over the age of 90.*
- *53% of CCSP members identify as male, 47% as female*
- *51% of CCSP members identify as Caucasian, 16% Asian, 14% African American, 9% Latino*

Current Housing Channels



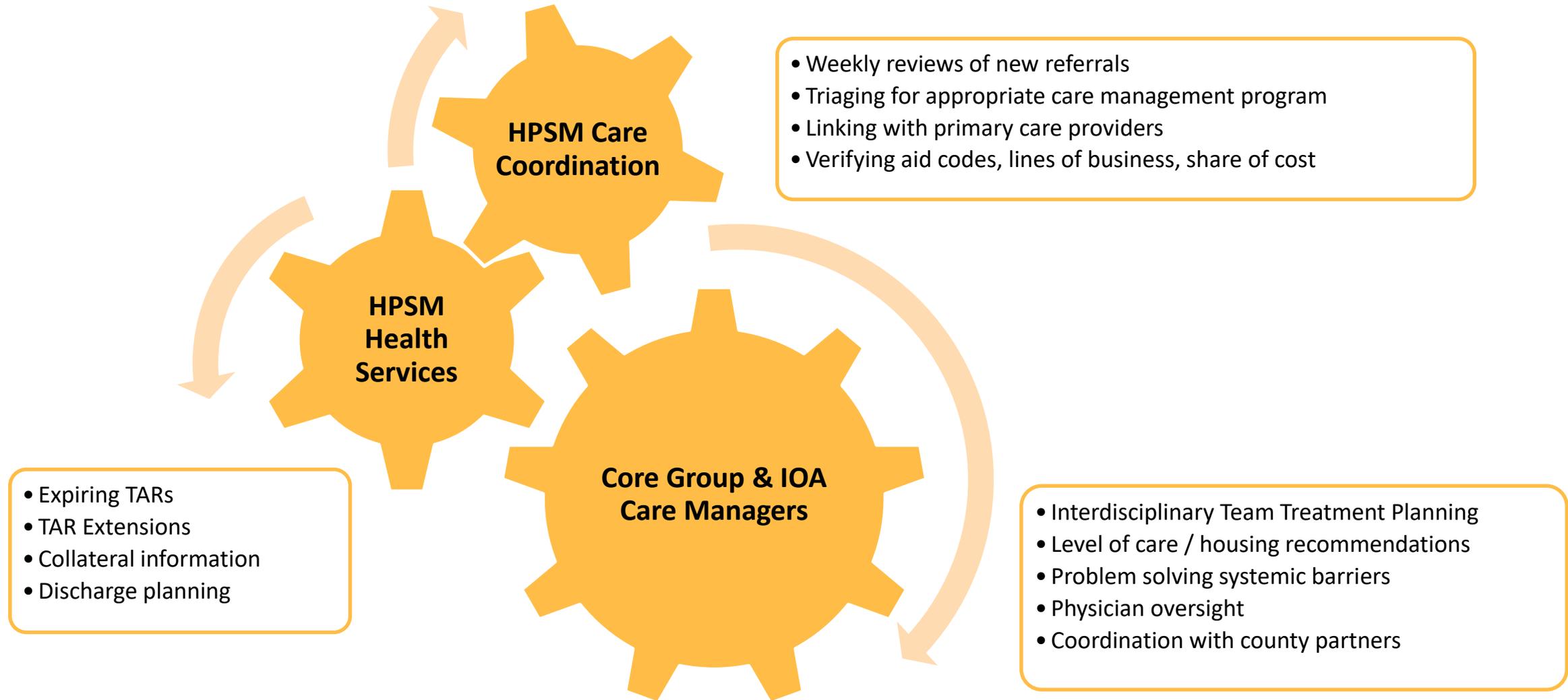
Transitions by Housing Channel

	Transitions	Case Mix %
Scattered Site	11	8%
RCFE	81	56%
Other (Section 8 Voucher, Set Asides, etc.)	27	19%
No Housing Need	24	17%

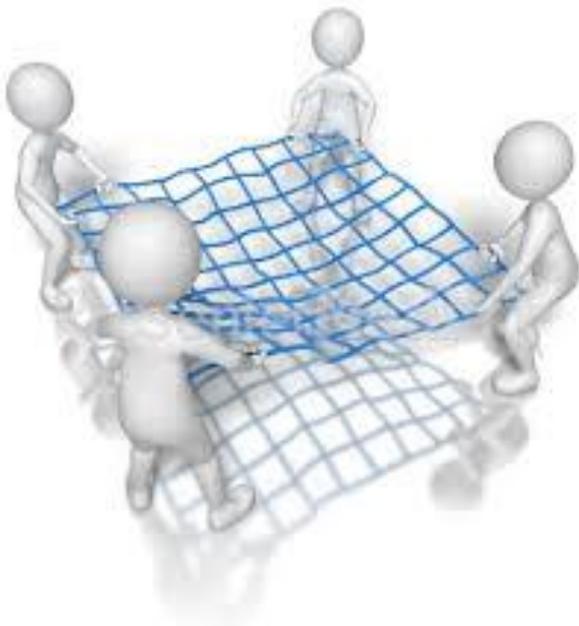
*Includes CCSP Transitions through March 1, 2017

- *Housing channel recommendations are made by the Core Group.*
- *Nine individuals have ‘stepped down’ from one housing channel to another (e.g. RCFE to Scattered Site, Scattered Site to Affordable Housing)*

Integrating Clinical Systems



Filling Gaps in the 'System'



IHSS expedited referrals

- Member assessed for hours in SNF prior to transition
- IHSS Contract Provider notified at time of IHSS assessment
- IOA purchases homecare hours until IHSS on board

Outpatient Behavioral Health expedited referrals

- Members are approved for services prior to first appointment; same-day appointment requirement removed
- Rep payee services approved prior to first appointment

Community Based Adult Services enrollment begins pre-transition

- Ensures services start on day one, assists members to manage ambivalence or apprehension re: transition

Member Experience

- Member experience surveys were completed in July 2016. The surveys are phone-based and conducted across all IOA programs annually. The response rate for CCSP was 85%. A complete report is available for further review. A few highlights:
- **84%** of all members responded that they were satisfied or very satisfied with the services provided
- **90%** of all members responded that their CCSP care manager had the knowledge and skills needed to help them
- **85%** of all members responded that CCSP services maintained or improved their quality of life.
- **90%** of all members responded that they would recommend the service to their family or friends
- **Areas for Improvement** identified included accessing service more quickly and improved communication.



THE PROMISE OF COORDINATED CARE

A Place to Call Home

"Living at home, my goal is to stay as healthy as I am today, or even improve my health."

— Josephine, age 75

Josephine has had a dream for many years to call the Northern California coast home. "I had been trying to move to the coast side for 23 years," she says. Josephine now lives in an assisted living community where she has an attendant to help her with personal care needs, a care manager to help coordinate things such as medical appointments and referrals to community services, meals in a dining room, and transportation. She also has behavioral health services from a psychiatrist and social worker who visit her home once a month. This is a big change from where she used to live — a two-year stay in a nursing home. Josephine says her new environment, "feels like freedom."

While in the nursing home, Josephine enrolled in Cal MediConnect, a new program in California designed to connect the financing and delivery of medical care and long-term services and supports. This program gave Josephine access to an interdisciplinary care team that helped her determine it was time to find a home where she could be independent and participate in the everyday activities she once took for granted — and that being her joy. It took four months of planning, help with filing out financial and housing applications, and multiple team meetings to bring all the pieces together. Josephine was finally able to move to assisted living — what happened to be on the coast.

What is life like today for Josephine? She feels independent, safe, knows she is not alone. Recently she fell and instead of calling 911, Josephine first called her care manager, saw the doctor quickly, and immediately followed up with an MRI. Josephine was in control of her plan of care, unlike before when in the nursing home as in the exhausting cycle of emergency room visits and hospitalizations.

A coordinated care experience for Josephine means a partnership between a health plan and a community-based organization that align systems to support her independence, well-being and living in the place she calls home.

COORDINATED CARE MAKES A DIFFERENCE

Prevents avoidable hospital re-admissions

Transitions people out of institutional settings

Helps people thrive in their communities



Supported by a grant from the San Francisco Area Agency on Aging, this project was a pilot program to test the effectiveness of a coordinated care model in the San Francisco Bay Area.

Member story

- Ms. B is a 75 year old, Caucasian, widowed female who was admitted to a SNF for short stay rehab following multiple falls in the community and diagnosis of failure to thrive. Prior to SNF admission, she was living in a hotel and not caring for herself. Ms. B has a diagnosis of Bipolar Disorder and has a long history of hospital admissions for failure to thrive and falls. Core Group's recommendation was for RCFE placement. The CCSP CM worked to get Ms. B re-linked with County Behavioral Health's home visiting program and set her up with transportation services via paratransit. Ms. B transitioned to an RCFE in June 2015 and has done extremely well. She regularly socializes with other residents and the resident dog. She has been successful in arranging transportation independently and consistently attending all medical appointments. Ms. B is relieved that she no longer has to manage her own medications in the RCFE and that she has people to "check on her" regularly to ensure that she is able to maintain her independence; she also recently started an exercise program at the RCFE based on what she learned from PT at the SNF.

Member story

- Mr. C is a 92 year old, Latino, divorced male who was admitted to the SNF in February 2015 after his family found him down in his apartment following a fall. Prior to admission, Mr. C was living independently in a low income senior apartment in the community. He had some caregiver coverage, but did not have anyone available to help him overnight. Mr. C's dementia has progressed to a point where falls and wandering were common overnight. Initially, family was hesitant to have him return home, but CCSP CM (in conjunction with IHSS), was able to obtain protective supervision hours (the maximum caregiving hours available) for Mr. C and worked with the family to develop an overnight schedule. In addition to family providing the care, Mr. C currently has an outside provider as well to provide much needed respite to the family. Along with the family, CCSP was able to purchase a pull-out sofa for the family members who were staying overnight to provide care. Mr. C has been very successful in the community, has started attending the Memory Care Program at CBAS, has attended all medical appointments, and has had no episodes of wandering or falls.

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>
 - Bipartisan Policy Center – Healthy Aging Begins at Home - <http://bipartisanpolicy.org/library/recommendations-for-healthy-aging/>

CHCS Center for
Health Care Strategies, Inc.

PROFILE | MARCH 2016

Housing Options for High-Need Dually Eligible Individuals: Health Plan of San Mateo Pilot

*By Brianna Ensslin and Deborah Brodsky, Center for Health Care Strategies**

IN BRIEF

Many individuals with long-term services and supports (LTSS) needs either reside in institutions or are at risk for institutionalization. Rebalancing care to provide LTSS in the community is one goal of the federal