HPSM: Partnering to Enable Community Living

May 5, 2016

About HPSM

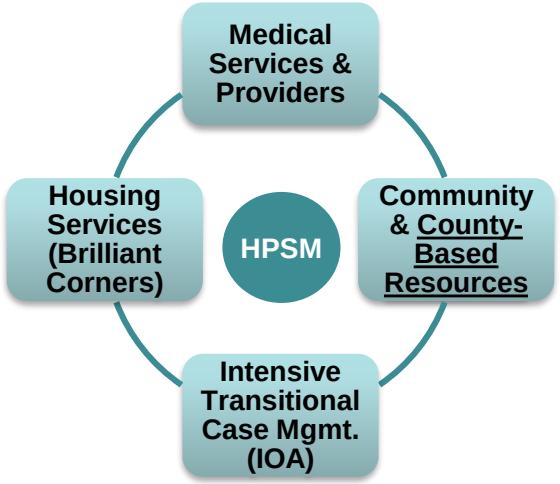
- Established in 1987 as the sole Medi-Cal MCP for San Mateo County (COHS)
  - D-SNP in 2007, for dually-eligible members
  - Duals Demonstration Project CMC activated 4/1/14 and 1/1/2015 included enrollment from DSNP to CMC
- Membership (~146,400)
  - D-SNP/Cal MediConnect 10,500
  - Medi-Cal Only 113,500
  - Local Coverage 19,000
  - Other 3,000

HPSM has been working towards long-term care integration for more than 20 years

What is the Pilot?

- LTCI has been a goal in San Mateo County for more than 20 years, finally becoming a reality
  - San Mateo Health System has been the key partner in this process
- The Community Care Settings Pilot (CCSP) is HPSM's highest intensity care management program
- Project operations:

  - Overseen by a 25+ member multi-disciplinary Core Group
  - Leverages numerous resources, including: IHSS, CBAS, waiver programs, benefits & CPO services



Goal: help members migrate out of, or avoid, LTC residency

Care Management & Housing Strategies

- IOA Intensive Care Management program includes:
  - 1:15 Case management ratio
    - Extensive face-to-face contact and phone support
  - Deployment of any necessary services and supports, including purchase of service
  - Phased approach:

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

- Housing services are one of the unique elements of CCSP, delivered by Brilliant Corners:

Person-centered housing search	Housing portfolio management	Affordable housing waitlist management	On-call/ 24-hour response
Owner-resident liaison	Lease subsidy, if necessary	Unit repairs and modifications	Unit Habitability and wellness checks

Targeting Participants

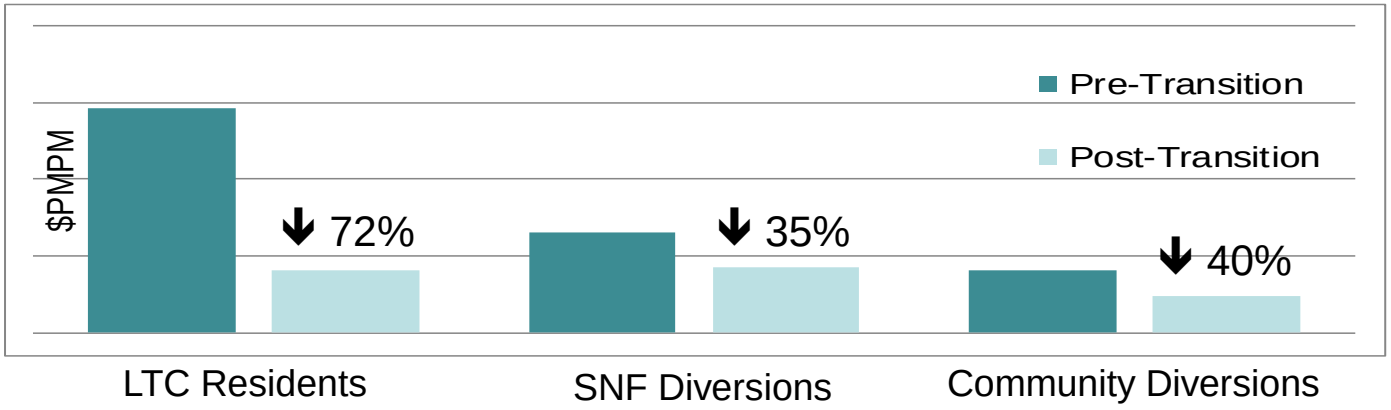
- Population segmenting: member groupings best fit to pilot goals & services

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

- ~900 participants to be enrolled over 5 years
- Participants tend to be highly complex: poly-chronic conditions, behavioral health, substance use, history of homelessness…

Early Program Outcomes

- Total cost by population six months pre- and post-transition (Dec.'15):



- Mix of services utilized shifting from acute/ED/SNF to MLTSS/HCBS
- System improvement in accessing services and coordinating care
- Members served so far: 129 enrolled, 82 transitioned
  - 59% LTC-R, 18% SNF-D, 23% Com-D
  - Member satisfaction: 100% satisfied with Care Manager, 86% see program delivering quality of life and allowing community living

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