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ACCESS TO INDEPENDENCE AND CARE1ST HEALTH PLAN

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>> Mary Lou Breslin: Hello, everybody. Welcome to this third Webinar in a series entitled, “Promising Practice,” collaborations between Independent Living Centers, ADRCs, Area Agencies on Aging, Managed Care plans, healthcare providers and other partners.

Before we begin, please note that if you want to access captioning for this Webinar, Mac users should click on the" media viewer "which is located in the lower right‑hand corner of your Webinar window. Windows users should click on the media viewer in the upper right‑hand corner of the Webinar window. You can read a transcript of the Webinar there in realtime. On the bottom right‑hand corner of your screen, click show/hide header.

If during the event another window might cause the media viewer to collapse, then click the media viewer icon in the upper right‑hand corner which brings the window back. We will be taking questions following presentations by Pamela Mokler and Louis Frick. You can type your questions in the chat box. We'll answer as any questions as type permits. A transcript for the Webinar along with the sides will be posted on the DREDF Web site which is dredf.org within one week of the presentation.

So we are just going to get started now. My name is Mary Lou Breslin, and I would like to welcome you all to the third in a series of Webinars featuring promises collaborations between Independent Living Centers, aging and disability resource centers, Area Agencies on Aging, Medicaid Managed Care plans, healthcare providers and other partners. The Disability Rights Education & Defense Fund is pleased to be presenting these webinars in collaboration with Aging and Disability partnership for managing long-term support and services established by the National Association of Area Agencies on Aging as part of a project funded by the Administration for Community Living. The project partners include the National Disability Rights Network, Justice of Aging, Disability Rights Education & Defense Fund, and Health Management Associates.

The goal of the aging and disability partnership for managing long-term support and services is to leverage the Aging and Disability network’s extensive infrastructure, service capacity, and expertise to ensure delivery of high‑quality managed long-term support and services to seniors and people with disabilities. The purpose of this webinar series is to share promising practices and collaborations between Independent Living Centers, ADRCs, AAAs, Managed Care plans healthcare providers and other partners.

The third Webinar in this series being presented today features a collaboration between Access to Independence, and Care1st Health Plan which is a managed care plan in the area of San Diego, California.

Our goals in presenting these Webinars are to illustrate how collaborations between these groups and organizations have the potential to infuse the independent living philosophy and services into long‑term services and supports and managed long‑term services and supports to increase community living for older adults and people with disabilities. Such collaborations may also have some potential cost savings.

Presenters for our Webinar today are Pamela Mokler, vice president of long‑term services and supports for Care1st Health Plan and Louis Frick, executive director for Access to Independence, an independent living center in San Diego, California. They will present preliminary outcomes from a collaboration between the two organizations to reduce hospitalizations for a group of homeless people with disabilities and seniors identified as repeat high users of emergency care.

Silvia Yee, senior attorney with DREDF, will conclude the Webinar with a discussion of the policy implications for this program.

I'd like to extend our deep appreciation to our presenters for working with us to bring us our Webinar to you.

With that, I will turn it over to Pam.

>> Pamela Mokler: Okay. Good morning. Thank you so much for the opportunity to present. And pretty excited to talk about this pilot that we launched in 2012.

I have to advance the slides. Excuse me.

Okay. We will get this straight here.

What we are going to talk about today is a pilot we launched in San Diego to provide services for homeless members who were transitioned to us in 2012 as part of the SPD transition. We had ‑‑ at that time, we had a little over 8,000 people with disabilities that were transitioned to us from the state of California to manage their medical care. So at that time, we were only responsible for the medical care.

What we began to see were that many of our members were a revolving door in and out of the emergency room and so we started looking into the numbers and we realized that out of the 8,000, only 992 were seniors. Out of those 243 were seniors with both Medicare and Medicaid. 5,783 were individuals with disabilities. And out of those, 1,039 were disabilities or both, dual. That gives you a breakdown on home were duals and how many were MediCal. We were managing their MediCal only. This was a high priority for us.

We began to look at the numbers and we discovered that many of our members were homeless or transient. And we were not able to find them. In fact, the state identified homeless ‑‑ and we'll go to those numbers in a minute.

Along with the homelessness and people being transient, there was a high percentage that had mental health and substance abuse disorder issues, including mental illness. There was, as I mentioned, high emergency room utilization. In fact, one of those members, an individual with disabilities, was in and out of the emergency room in and around San Diego County approximately 135 times in one year. So the emergency room utilization with this population was very high.

Priority needs were these individuals needed emergency shelter, transitional or temporary housing. Permanent housing was the ultimate goal, but they needed things like food and transportation. Many of them didn't even have any identification. They didn't even know their name.

And then also there were a lot of long‑term services and supports and supportive services needs, but because the population was transitioned to us for medical purposes only, we were only able to pay for medical services.

So we ‑‑ so we decided to test a pilot. In fact, at about the same time that I had a conversation with our C.E.O., Anna, she was very concerned about the population in San Diego and wanted us to set something up that was going to meet their needs. We had previously conducted a pilot in Arizona and did an integration of the area agency on aging in Maricopa County with a plan that resulted in a high ‑‑ resulted in very positive outcomes between a 47 and 59% per member per month reduction in cost. So we began to look at what could we do, especially for the homeless population in San Diego, that was transitioned to us. At the time we were looking for solutions, I met Amy Calivas from Access to Independence, at a Gerontological Society of America conference, and she began to tell us about some work they had been doing. We immediately set up a meeting with Louis Frick to talk about how we might work together.

So, Louis, do you want to provide some comments at this time?

>> Louis Frick: Absolutely. Thanks, Pam.

Yeah. Sometimes it's about timing. And it really ‑‑ the timing was perfect, as Pam said, when she met Amy who works with me. And we had been starting in 2010 very aggressively focusing on doing nursing on transition and working in the healthcare world and understanding that the people that we served had significant needs and that they're a means of acquiring healthcare was changing radically with the shift to managed care.

And so we really had done a lot of work to position ourselves to serve that population, homeless or otherwise. Actually going back to 2006, which is when we actively began doing nursing home transition work. And so we had done a lot of work in that arena. We've worked a lot with people that were homeless. And we were really well‑prepared to jump in and work on this project.

I think an important component that we brought to Care1st right away was talking to them about our independent living philosophy and the concept that we would help people but we would help them to help themselves. And so the context within which we worked in this project was to go to homeless shelters. A lot of our work really required us to track people down. We tried skip tracing, a number of other ways, to interact with people. But ultimately we really were just ‑‑ we had done a lot of this work. We were known to the community. And people were willing to work with us. And so I think our philosophy was and remains appealing to people with disabilities and seniors because what we're about is helping them finding out what's important to them, not what is important to somebody else.

So that philosophy, I think, was really a key component of why people were willing to work with us and why we were prepared to work with them.

>> Pamela Mokler: Okay, thank you, Louis.

>> Louis Frick: Sure.

>> Pamela Mokler: So what Care1st decided to do was to test and develop a working model to prepare for the dually eligible demonstration. For the work that we were doing in 2012, we knew that we needed to get our ducks in a row and learn how to take care of this population before we jumped into the duals demonstration which we had already been hearing about in 2012.

We wanted to test the impact of housing placement for homeless people with disabilities and seniors on our healthcare utilization. So that was on hospitalization, emergency room utilization. And to build institutional knowledge and capacity of Care1st by fostering institutional knowledge about people with disabilities and seniors who are homeless. So I'm a gerontologist and knew about seniors but I knew nothing about the homeless. We learned a lot from Access to Independence.

Just to give you the time frame of the pilot, our initial meeting was in December of 2012. By February, we had hired staff on our side. We needed case management staff that wore be coordinating care with the Access to Independence staff. We contracted with Access to Independence for external case management. We were able to pay them for the external case management. We were not able to pay for services. So we'll kind of go into that as to what our restrictions were under the SPD model.

And by March and April, we were testing our clinical systems and the workflow. We had kick‑off meetings. And we did some test cases. And we also developed a Web portal. So I want to mention at this time, Dr. Michael Griffith who at the time was the medical director for Care1st in San Diego ‑‑ he's now corporate medical director ‑‑ he really was, you know, the individual on our team that drove this pilot. And we had quite a few staff in San Diego that were very involved as well. And so the pilot ‑‑ we decided ‑‑ we started out as a six‑month and then we continued another month because there were individuals that had needs, that needed us to continue it. So it was from May to November of 2013. And then we did a preliminary evaluation which you are going to hear about today.

So we developed a pilot participant selection criteria. And so we looked at our membership as of April in 2013. Those we could not reach by phone, we were in the process of conducting health risk assessment force this population. And so there was, you know, an amazingly large number of people that we could not reach because we didn't know where they were. And, of course, the homeless, most of them don't have phones.

The state had listed people who were homeless in the address field and had things like sleeps across the street from Denny's or is under the bridge. So there were interesting addresses in the address field that indicated for us that they were homeless.

So 293 people were identified by their six‑month healthcare utilization thresholds which meant that they had greater than 10% ‑‑ and $10,000 and up total that had been spent on hospitalization and healthcare costs and greater than $5,000 that were spent on emergency room utilization in the six months.

And then we had the chore of finding these people. And so we literally sent a list of almost 300 people to Access to Independence. And the way we set up our contract, that we would pay them a fee to attempt to find our member. We would pay them a fee if they found the member and were able to conduct a face‑to‑face assessment. And then we went into paying them a monthly capitation for whatever was needed for that member. So we were able to identify the majority of them in the hospital.

So 58% were identified. Out of the 66% that ended up being participants in the pilot, 58% were identified during hospital stays. 19% had been identified during emergency room visits. I have to mention here that Access to Independence, we would get the information that the individual was in the hospital or the emergency room. And they would immediately go to conduct the face‑to‑face assessment because this is a population that if they got discharged, they would be back on the street and we couldn't find them.

And then 16% were identified via their total utilization of all different services.

And 7% didn't meet the above criteria, but they were identified via our case management activities and by providers as an at‑risk ‑‑ potential population at risk for placement.

So, Louis, I don't know if you want to share something else at the time about what you went through to try to find them and what you did.

>> Louis Frick: Absolutely. I think what Pam said is regards to those percentages, you know, 58% were located during the hospital stay or that 19% during emergency room visits. It was either 24 hours or 48 hours. Our goal was to get two people within 24 hours because as Pam said, if somebody was in the hospital ‑‑ if they were in a facility, obviously the clock was ticking so we needed to get to them while they were there because, as Pam also was saying, so many of these folks are homeless. I mean, a lot of our initial meetings with people were held under bridges, in parking lots of Burger King, other places like that.

A lot of people ‑‑ I don't know if we came up with this term or somebody else did. The term service resistant we started to use.

A lot of these people were resistant to get services. Again, back to the independent living philosophy, that approach is really what drew some people in because our approach is to find out what's important to the individual. And that was a really valuable component of us being able to connect with people and it still is because when people realize that you're there to provide assistance to them, you are not just trying to get something from them, they are more receptive. So we were very quick to respond when we got a call from Care1st, whether the person was in the ER ‑‑ in the emergency room or some other facility because we had such a short time. And then once we could make that initial contact, even if they ended up back in a homeless situation or understand the bridge, wherever it might be, we would be able to work with them.

So it was just a matter of really being nimble and being able to respond quickly at a time when it was required because so many of these folks would disappear if you didn't get to them right away. So we did our very best to connect with them in the hospital. Our skip tracing efforts were somewhat successful but really tracking people down and getting that face‑to‑face contact is really what made the difference, connecting with that person one‑on‑one is really what continues to make a difference to people is that one‑on‑one contact.

And in their environment as well, that is a particularly important concept as well. To work with them where they are in a way and time and place that's meaningful and that works for the individual.

>> Pamela Mokler: Thank you, Louis. So I can't say enough about the fact that Access to Independence was able to shift their business model to fit what we needed. Managed health plans are used to responding very quickly. We have a lot of experience having contracts with home health organizations that, you know, are able to very quickly get to the member, conduct the assessment. So I would like to say to the independent living industry and the aging network, that that's one of the things that, you know, managed health plans as we begin to integrate these different models together, that we have a little bit more of an urgency than some of the programs that haven't had to move so quickly. So we very much appreciated that from Access to Independence.

So quickly to kind of just go through the workflow, we would send a referral to Access to Independence and ask them to find a member, to conduct an assessment. They also had to obtain consent. And then in the first 30 days, within the first 30 days, we had set up this. We built this very specialized Web portal. Herbert Wu on our team who is VP of I.T. and Dr. Michael Griffith worked very hard on getting this model so everything would be uploaded. All the documents that Access to Independence completed would be uploaded.

So they had 30 days from the date of finding the member and conducting the assessment to upload the assessment that was conducted, the pilot HRA, the independent living plan which is different than what we are used to. We do care plans. But we wanted Access to Independence to use the same assessment tool that they used for all of their clients so that they were able to follow what they needed to follow to be able to leverage other funds that they received from the Department of Rehab.

And they also did a care transition plan for members in the SNFs rehab and acute care hospitals.

Step three, within months two to six which really ended up two to seven, every single month we had this set up that a payment would be generated if the documents were uploaded. So they were really in a position where they had to upload the updates to the independent living plan every single month in order to get paid for that month. So they got really good at uploading the documents and we were able to keep on track with the timing and able to meet our requirements that we had to in terms of case management. And they participated in our care coordination meetings. Some of you know that there are interdisciplinary care team meetings. So individuals on both sides with Access to Independence and with Care1st would contribute.

And then also kind of on our side, we were required to conduct an initial health risk assessment. So actually what Access to Independence was doing for us is fulfilling that need for the people that they were able to find that were homeless. We are also required to do an individualized care plan. So a lot of the information that they obtained and put into the independent living plan could be part of our care plan. And what we're responsible to do for our members, the case management, is identify ‑‑ a lot of it is referred to as PIGs, problems, interventions and goals.

We also had to coordinate ‑‑ Access to Independence coordinated for those members to get their medical carat St. Vincent's de Paul which is a clinics in downtown San Diego. They are very specialized and their expertise is in treating the homework. That became the medical provider as well as other FQHCs in San Diego.

And then also Access to Independence would coordinate with us on obtaining authorizations for services that were part of our benefits, healthcare‑related, and transportation. We have a social services department as well that would review the independent living plan and coordinate with Access to Independence. And then there were also weekly case conferences between Dr. Michael Griffith, our medical director, and Josie Wong who is our VP of medical management in San Diego. So this pilot was ‑‑ had not only the blessings but the top level people in our San Diego office were very involved in this and both Dr. Griffith and Josie Wong and her team were involved with this on a daily basis.

Okay. So in terms of our identifying the people with disabilities and senior pilot participants ‑‑ and this is ‑‑ so out of the 66 who were identified, recruited, enrolled in the pilot, 48 were found in hospitals. 18 were found by Access to Independence. 51 completed the pilot. So these are small numbers. Ten received their care through St. Vincent DePaul and 41 received care through primary care providers or federally qualified health centers that are contracted with us in San Diego County.

23 of the 51 who completed the pilot continued to be case managed by Access to Independence following the pilot and were still eligible as a Care1st member. I should mention that this is a population that's very transient. They were able to move in and out of plans on a monthly basis. And so, you know, it can be difficult to really try to wrap your arms around trying to help meet their needs if they are going to be moving out of plans or they don't respond to the MediCal recertification and then they fall off and no longer eligible and have to be reenrolled. I know Access to Independence did a lot to help with that.

Okay. Now in terms of housing placements for the pilot participant ‑‑ the ultimate goal was to try to get these people housed. 45% of the 66, 49 people were placed in housing. And I'm going to turn this over to Louis in a second so he can tell you about the relationships of housing providers.

Okay. And out of the 23 still eligible after the pilot, 15 of those were placed in housing. So that's going to be significant in a minute when I kind of talk about the results.

And then 14% received services other than housing. And I'll turn this over to Louis so we can talk about, you know, what they've got going on with the housing providers and how they were able to leverage funds that they get for services that is we were not able to provide.

>> Louis Frick: Sure, Pam.

First, with regards to housing, housing is ‑‑ everywhere you go in the country, housing is the biggest barrier to independence for people with disabilities, period, because so many people are on fixed income. And whether you live in San Diego which is obviously a very expensive place to live or if you live in, you name it, wherever you live it's almost certainly going to be too expensive. But here in San Diego, we work really diligently to develop close relationships with property managers and apartment complex owners, single‑room occupancies and really aggressively work with them so that they would use their units for people that needed them.

There are a lot of places that have senior housing or senior and disabled housing where some of the units are acceptable. But some years ago what we found is that those units were going to the next person on the list, not necessarily someone that needed an accessible unit. So we worked with these housing providers so that they would call us when they had a vacancy of an accessible unit.

And through that process of working with them over time, we got to the point where the housing providers are now calling us when they have a vacancy of an accessible unit. That way we can help them, the housing provider, by getting that unit filled and serving our purposes, in this case Care1st numbers, by getting them into an accessible unit. So our work there has really paid off in terms of housing.

We've also done a lot of work to determine the levels of accessibility of various apartment complexes so that we have information for our members, our consumers and can tell them where an accessible place to stay would be.

So in addition to our work with regards to housing, we also, as Pam talked about, provided other services. And in addition to housing, services like peer counseling and independent living skills training, and assistive technology can be just a few.

In addition to that, we also have access to funding that we can use to pay for Items, basic needs that people need, especially when they're getting moved into a new house or their new home.

Particularly so for somebody that was in an institution for any length of time, if you have been in a nursing whom for months or years, you likely don't have those basic needs like a bed and linens and pots and pans, things like that. We have access to funding that we can use to purchase those basic needs and much of that money is available to centers around the state of California through the California Department of Rehabilitation.

But in addition to those funds, Access to Independence is continually building up funds through donations, through small foundation grants and other funding sources so that we constantly are kind of replenishing our pool of funding to be able to provide those basic needs.

It's not just things like a bed, linens, pots and pans. Sometimes it's a bus pass or clothing for someone to go do an interview, groceries, you name it. There are so many basic needs that people have that, again, when they're coming out of a facility or if they are on limited income, they just don't have the means to purchase those items.

And, again, the difference between getting out and not getting out is sometimes that basic need being met. So being able to have good rapport with our housing providers and really being able to get people in stable housing as well as being able to draw on our funds to make those basic needs available to Care1st members were really critical components in making a difference for those folks that were in this pilot project.

Back to you, Pam.

>> Pamela Mokler: Thank you, Louis.

Now we're going to get into some of the data. I have to mention that this is a preliminary analysis. The numbers are very small. So we can't say they were statistically significant. But you'll begin to see the benefits as we go along. So one of the things that happened, out of the 51 who completed the pilot, we did a preliminary analysis looking at the utilization prepilot and the utilization post‑pilot. And so of the hospitalization lengths of stay, prepilot the average length of stay was 4.88 and one hospital. During the seven months of the pilot, utilization went up significantly. And so we feel that was because of the increased services following the health risk assessment and access to independent living plan. All of a sudden somebody was paying attention, so there were a lot of unmet medical needs that needed to be cared for.

A lot of these folks did end up going back to the hospital 2.88 times during the seven months and had an average length of stay of almost nine days. And then after the pilot for all participants, it went back down again a little bit before the prepilot.

And so if you look at the hospitalization and length of stay for the 15 people who were placed in housing, out of the 23 who were still eligible at the end of the pilot, we have a little bit different result.

The prepilot number of hospitalizations at 1.53 times and an average length of stay, 6.67 days.

During the pilot for those people, it went up significantly during the pilot. So there were 3.2 hospitalizations and for those 15 and the average length of stay was almost 16 days.

After the pilot, it went down significantly. So we followed these people for the four months after the pilot and as you can see, the number of hospitalizations were .25 and average length of stay of .5 days. So, again, we think the increased utilization was because of the pent‑up need of having a lot of different medical needs taken care of. We were working very closely with Access to Independence to do that.

If we look at the readmissions to the hospital for the 15 members placed in housing ‑‑ this is the same population we were just looking at but this is readmissions, before the pilot, the number of members who were readmitted is two. The number of members that were readmitted and the readmissions were five.

During the pilot, four people were placed in the hospital and 12 were readmitted. So, again, an increase in utilization during the pilot and then after the pilot, it went down to lower than before the pilot, the number of members ‑‑ only one person went into the hospital and one was readmitted.

The emergency room visits for the 51 members who completed the pilot ‑‑ so this is going back to the total population that completed prepilot, the number of ER visits of 2.63. During the pilot, it went up to 4.11. And then post‑pilot it went down lower than the prepilot to 1.70.

Emergency room visits for the 23 who were Care1st members at the end of the pilot ‑‑ so these people stayed as Care1st members so we had prepilot, the number of emergency room visits, 2.41, a significant rise again during the pilot, and then post‑pilot, the number of ER visits decreased to 1.70.

But the real ‑‑ the most important finding, I think, preliminary find something that the emergency room visits among the 15 of the 23 that were ‑‑ remained members of the Care1st following the pilot and were placed in housing prepilot, the number of emergency room visits was 4.36. During the pilot, again, the significant increase, 6.85.

But after the pilot, it was a very big drop down to .38. So that was actually one of the most important findings for us, to see that after they were found and after their needs were attended to, then their utilization decreased significantly.

So some of the reflections and observations, I should say right up front that we're now looking into going back and doing more analysis of these numbers and these members and especially for those who continue to be Care1st members, the pilot results definitely need further study to look at why the utilization increased during the pilot, also to study long‑term outcomes of individuals still Care1st members that participated in the pilot.

Benefits that were derived from housing placement and case management, these are people who had a lot of unmet needs and it wasn't just the medical. They had behavioral health and substance abuse and needed a lot of assistance. These were people with disabilities who, you know, as Louis said, some of them lived under a bridge, definitely on the street. So we were thrilled to be able to find them and to begin providing services.

Lessons were learned about this member population, which I can't say enough about because we learned so much from Access to Independence about what we needed to do for the dual‑eligible demonstration which we are participating in in both San Diego and L.A. Counties. This pilot helped us along with the pilot we did with the area agency on aging in Maricopa County, Arizona.

Both of those pilots really gave us a jump start and we were able to hit the ground rounding with the initiatives and demonstration. This created a commitment by both Care1st and Access to Independence to continuing the collaboration. We have a strong partnership with Access to Independence. They are really our VIP primary provider for all of our members in the CCI and Cal Medi Connect that have disabilities. More important outcomes, the intervention worked for those placed in housing who remained a Care1st member at the end of the pilot. So I know Access to Independence continued to provide services to many of those people.

We found that you can't just do the intervention. You need to, number one, conduct an assessment to ask them what they need, develop an independent living plan which is very empowering versus a care plan for this population. We learned a lot from Access to Independence about how you need to build on their strengths and not create dependencies. And, again, this strong partnership between Care1st and Access to Independence that we are still working with today and we expect this is going to be a long, successful relationship going forward.

So, Louis, I don't know if you have some reflections and observations you want to make at this time.

>> Louis Frick: Yeah. Well, first of all, I'll echo what Pam said and kind of turn it around. We learned a lot in the process working with Care1st. As Pam said early on, we really had to change our business model and we really have already been in the process of doing that. What I mean specifically is most of our work is really going to where people are. Most of the people we serve lived ‑‑ we're serving them where they live, whether it's in a shelter, under a bridge, in the single room occupancy, or renting a two‑bedroom apartment, whatever it might be.

Most of our work is going to where people are. And I think that's an important component that serves this kind of a partnership very well because ‑‑ pardon me ‑‑ we have had to go out and really get connected to people in the community and where they are. It's been a great ability for us as an organization to build our revenue stream so we're not just depending on state and federal funds but we're able to generate revenue through a contract, in this case with Care1st, to expand the services that we provide.

We've known all along that independent living services could have a significant impact on health outcomes. But this is really the first data that I've ever seen. While it's not significant numbers, I think it's significant that Care1st has taken the time and made the effort to really take this data and analyze it and break it down. And I think the more of that that's done, the more likelihood of independent living centers partnering with managed care organizations and other healthcare entities because I just think there's so much value. And you can see especially when referring people that got the housing that they needed, that that is such a key component that housing is just critical. But in addition to that, it's those other services and it's that connection with the individual that makes a difference.

So we continue to be really aggressive in our efforts to work with managed care organizations. We're working on finalizing a contract with another one in our community and hope that there are other opportunities because I think this is the wave of the future. And it's a huge opportunity ultimately to serve people that are not getting what they need.

The people in this pilot were the high utilizers, the frequent flyers. They are people with co‑occurring disabilities, most often with mental health diagnoses as well. For us at least as an independent living center, that's really our wheelhouse. Those people that are high users with co‑occurring disabilities, that's really our strength, is working with those individuals.

I think this pilot has really been a great opportunity for us to expand our efforts. And I hope it's just the beginning of this becoming more the norm around the county ‑‑ excuse me, around the state and the country. So I just think it's been a great opportunity. And I appreciate the ability or the opportunity here to share with you all what we're doing and happy to answer any questions about it.

>> Pamela Mokler: Okay. Thank you very much, Louis.

I'm now going to turn this over to Silvia for questions and answers.

>> Louis Frick: Silvia, I see a question.

>> Silvia Yee: I'm sorry. My apologies, I had my mic on mute. Up here you see the questions. I will bring up a few of the questions that have been raised during Pamela and Louis' presentation.

I'll just go through a few of them and give them a chance to answer. Again, my apologies about that.

One of the questions here is for Louis and it was a question about what kinds of characteristics and experience did you seek in the outreach that you employed in this project and were they trained in independent living philosophy?

>> Louis Frick: Were our staff trained in independent living philosophy? Can you repeat the question, please?

>> Silvia Yee: For this particular project, the staff that were working on it, what kinds of characteristics and experience did they have?

>> Louis Frick: Well, the person that spearheads our work in this area has a master's degree in social work. But we also ‑‑ the manager of that program has a master's degree in rehabilitation counseling. But many of our staff are engaged in this type of work. Some of them have degrees. Some of them do not have degrees. All of our staff that are involved in this activity, especially this pilot project where people were very well‑versed in the independent living philosophy and thoroughly understand the programs and services that we offer and the means in which we provide those services.

So it really was people that are very skilled as we call them service coordinators, independent living service coordinators and people that were well‑versed in working with those that had mental health diagnoses in particular as well as staff that were familiar with going out into the community and engaging people where they happen to be.

>> Silvia Yee: Thank you. I had another question here for Louis about whether any of the 51 in the project needed ‑‑ do they need or get referred for home care? And specifically was durable medical equipment an issue for anyone?

>> Louis Frick: Yes is the answer to the second part of that question. Some of the people that we assisted in that regard did need durable medical equipment. We have some equipment that we have as donations that we either can loan or give away. In some cases, we provided those services directly to the individual. In other cases, you know, we referred out.

I don't recall, the first part of that question had to do with home healthcare?

>> Silvia Yee: I think so. They just said home care which I might be IHSS. I'm not sure.

>> Louis Frick: If it was IHSS, then, yes, our staff is familiar with programs. One particular staff member focuses in that area. So we would certainly have worked with people in particular that had been in nursing homes and would not be IHSS recipients because their benefits would be going to the nursing home.

We also have two staff that are financial benefit counsels trained on Social Security trained benefits counselors. They would have worked with staff ‑‑ excuse me, those staff members would have worked with consumers to help them to acquire their inhome supportive services.

If it was a nursing home transition as an example, there are a whole bunch of things that have to line up and timing is very important. Housing is critical in terms of when they're going to be able to rent a place. But also are they going to be able to get their inhome supportive services available in time when they transition out.

So a lot of it is a very complex timing issue that has to do with those issues, particularly with regards to housing and in home supportive services.

>> Silvia Yee: Right, of course.

I guess kind of a follow‑up question for both Pam and Louis is: How much in individual members' case were there times when the Access to Independence coordinator and the Care1st coordinator would be working especially closely together?

>> Pamela Mokler: Yeah, absolutely. This is Pam.

There was ‑‑ I know that Access to Independence was the primary coordinator of the services. They were ‑‑ they had the expertise. We did not have the inhome supportive services expertise at that time. We certainly have now that we're involved in the CCI. But much of that, it was ‑‑ I'm told, Louis, that there were, you know ‑‑ that a lot of this communication was taking place on a daily basis.

And so we were able to pay for what we were able to pay on the medical side. We didn't have the benefit like with CalMedi Connect and being able to pay for incidentals. That's what Access to Independence paid for. But we did coordinate with them.

>> Silvia Yee: Okay.

>> Louis Frick: Very regular communication. I know our staff and Care1st staff had weekly meetings. But if we had a situation where, again, we were talking during the presentation where we might have to respond within 24 hours, if our staff got a call and said, hey, look, we got somebody in a nursing home. They're going to be discharged tomorrow at 4:00 p.m. or whatever, then, you know, our staff would be on it.

So in addition to the regular call we had, staff would be on the phone between our organizations on a daily basis, if needed for a particular case or given a situation.

>> Silvia Yee: Okay, thank you.

I have just a couple more questions that have come in. There's a question here for Pam. It looks ‑‑ this is a question. It looks like the ER visit numbers for the pilot are for a seven‑month period compared to a four‑month periods for before and after. So unless they are visits per month, they would be expected to be higher just because of the length of time. Is that correct?

>> Pamela Mokler: I didn't do the analysis so I can't necessarily speak to that. But I do know that we did approximately four months prior look and afterlook. This is one of the things that I know Dr. Michael Griffith has said we are very interested in going back and looking at the numbers and trying to drill down a little bit deeper to really find out what caused the increase in the visits and then the decrease obviously where we think it was because of the services that Access to Independence was providing and the fact that they finally had a roof over their head and their medical needs as well as social needs were taken care of.

But in terms of some of these ‑‑ to tease out some of these differences, we haven't had a chance to do that yet. And we are hopeful that we're going to be able to come back and look at this because we still are providing services to even some of the people that were a member back in 2013 when we did the pilot, some of them are still a Care1st member. It's a lot easier to look forward than it is to look back.

>> Silvia Yee: Okay.

We have a question here asking whether either of you has data on the types of chronic conditions that folks in the pilot program reported.

>> Pamela Mokler: No, we don't. I don't have that data in front of me. But I'm sure we've got the information somewhere.

>> Silvia Yee: Okay.

And one more has come in. I think it's a question around housing and housing especially for those making $800 a month or less, that question seems to be whether some are still living in their cars. I think the question is around what is housing that's available to them.

>> Louis Frick: Silvia, I see two questions. One was about how do we create housing relationships, and then the other with regards to the dollar amount. Yeah, there are still a number of people living in their cars if they even have cars because there's so little income and housing is such a steep cost here.

We also try to do things like shared housing and getting people to share a place. For example, one of the folks we worked with from Care1st had a disability. And he had a friend who also had a disability, and they both needed care. They ended up ‑‑ we ended up helping them rent a three‑bedroom house where the two guys with disabilities had rooms and the third room was used by the caregiver. We were able to kind of put these together in that manner. But I don't know if that answers the question specifically or not.

>> Silvia Yee: Right. I think it gives a lot of ‑‑ oh, here. I think it did answer the question.

Have just a couple of more. One of the questions is for Pam. Did the Care1st employees and providers also use the members' independent living plan? Was it a useful tool for Care1st as well?

>> Pamela Mokler: Yes, yes. The information was shared back and forth. There was a two‑way street with communication because they needed ‑‑ the Access to Independence folks needed to know about the medical conditions. And we definitely used the independent living plan to inform us as to the services that were needed.

>> Silvia Yee: Great. A question for Louis. The individuals that were received through this project in this demo, were they ‑‑ I don't know if you know this. But were they individuals that you ever had served before or that you think ‑‑ do you think you would have reached them in your normal course of business as an independent living center?

>> Louis Frick: Some, yes. Some, no. The first thing we did was when we got the list that Pam talked, is we ran that list through our current database and we did find. We did get some hits. So if some of the people that were on that list were already people that we had been working with, that was a fairly small number. So many of the people that we worked with through Care1st are people we would not have reached if we had not been involved in the pilot. So some were already consumers of others but most were not. We had already since 2011, we have been tracking people's healthcare providers. So we have asked that question for some time now. I guess the answer is we served a few people we had already been serving, that many people in the pilot we would not have otherwise served if we had not done a pilot with Care1st.

>> Silvia Yee: Maybe one final question looking a little bit into the future that someone has asked. As you move forward and you have committed to continuing a relationship and working with one another, how do you feel this ‑‑ how do you see your work expanding? What are the individuals and members that you think that you will be identifying as potential participants in the work you do together?

>> Louis Frick: If I could jump in first, if that's okay, Pam. I'll just give you my two cents. The work that we're doing is still ongoing and I hope that continues. I know Pam and I are both big fans of this. Maybe now that Care1st is officially part of Blue Shield we can get back to officially cranking this up.

What I would love to see is there are so many people in skilled nursing facilities that don't need to be there, we have a proven model that we reduce the cost of people living in shared housing and other housing options as opposed to living in nursing homes. My sincere hope is we significantly expand our hope to serve people who are in nursing homes that don't need to be there. I think that is the biggest area of low‑hanging fruit for both us and for Care1st. And my significant hope is that we can really aggressively work together to change the dynamic there. I'm absolutely certain we can reduce the cost for those individuals that are in skilled nursing facilities that don't need to be there.

>> Pamela Mokler: So, Silvia, this is Pam. We definitely see Access to Independence as an extension of our case management model. They are ‑‑ we pay them for extended case management services, for our members that need assistance and especially those persons with disabilities.

My department, I'm vice president of long‑term services and supports in San Diego and LA. I personally have been going out to nursing homes in both counties, probably about 40 in the last two months, training my staff on how to identify people who might be potentially able to move back into the community. And while Access to Independence is not a California‑community transitions provider, they do have funding that they can leverage. And we absolutely see Access to Independence as one of our primary providers that can help us, especially for people with disabilities because they do a lot of peer support and mentoring. And our members that have disabilities really respond to Louis' team and, you know, the holistic way in which they treat them.

So we see this just growing, not shrinking. And Louis mentioned, yes, we were purchased by Blue Shield of California recently. We are very excited about that and do expect that that is going to help us to be able to do more in the community and certainly more with Access to Independence. So we expect this partnership to grow and continue to evolve long‑term.

>> Silvia Yee: That's great. Thank you for answering the questions. The plans for the future sound very exciting and obviously the thought of helping individuals back to independent lives in the community is supported.

I will move forward a little bit to talk about the Medicaid managed care role. While I'm doing so, everyone should continue to ask questions through chat either of Louis or Pam or of myself and we will see if there is a little bit of time at the end to get to any of them.

So just to set a little of context, San Diego County is a mandatory Medicaid managed care county. It has been required mandatory managed care for seniors and people with disabilities from 2012 to 2020. And those dually included since 2014. San Diego is one of only two counties that offer a choice of several MediCal managed care organizations. Through the Coordinated Care Initiative that Pam has mentioned, San Diego also has long‑term services and supports integrated within mandatory MediCal. As a MediCal member in San Diego, if you want IHSS services at this point ‑‑ for pretty well most MediCal members if you want IHSS services or CBAS or other long‑term services and supports through MediCal, you need to join a managed care plan.

So against this context, on July 1st, the centers for Medicare and Medicaid produced major revision of its managed care. It hasn't touched the rule since 2002. Since that time, Medicaid has grown substantially. The managed care has grown. There is significant managed long‑term services and supports. In July 1st, there was a 60‑day comment period and that period is now closed. But there are a lot of very interesting things to note about this plan, about the rule. And the rule has implications for projects, innovative projects such as Care1st and Access to Independence have spoken about during this Webinar.

Just a couple of quick facts about Medicaid managed care, back in 1991, Medicaid Managed Care covered 2.7 million, only about 10% of Medicaid beneficiaries.

By 2016, it's projected to cover about 75% of what will likely be over 70 million Medicaid beneficiaries. So that's a very, very significant leap in a 25‑year period.

Today managed care organizations operate in 39 states. And their Medicaid revenues account for over 31% of federal and state Medicaid spending in 2013. That's just to give you a little bit of a picture.

As we look at the rule itself, the proposed rule ‑‑ one important thing to note about it is the proposed rule incorporates 2013 guidance from CMS that established 10 managed long‑term services and supports principles. And included a recognition of the Supreme Court's Olmstead decision and the importance of home and community‑based services. The rule also talked about person‑centered needs assessment and service planning. So that ‑‑ CMS' vision for managed Medicaid, managed MediCal is for a service that acknowledges the right to live in the community and the right to have services integrated with one's life in the community.

Also, for the first time, the rule provided a definition ‑‑ proposed definition of long‑term services and supports. And it's a pretty broad definition. The definition is: Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice which may include the individual's home, a provider‑owned or controlled residential setting, a nursing facility, or other institutional setting.

So it is meant to encompass many, many different kinds of services as well as recognize the individual's choice of where they want to live and how they want to live. And it's also interesting that it encompasses work and not just residence.

So one of the things from the rule, something that Pam and Louis have talked a lot about is care coordination. There has been ‑‑ the proposed rule expands managed care coordination obligations. It requires coordination between care settings and with services, even with services that the managed care organization doesn't directly provide including, for example, fee form service Medicaid benefits such as long‑term services and supports.

Under the CCI in California, Care1st actually is ‑‑ does have integrated long‑term services and supports. Those are managed. But the CCI in California currently encompasses seven counties. There are counties outside of those seven counties. Other California counties that don't currently have long‑term services and supports under their control, under their administrative control.

Nonetheless, for managed care organizations operating in those counties, there is an obligation to coordinate. As well there's potentially an additional standard to require community or social supportive services. So the proposed rule talks about, well, should there be an obligation on managed care organizations to link to ‑‑ or provide services through different community‑based organizations, a variety of organizations, either providers or organizations such as the protection and advocacy organizations, the Disability Rights California organizations, aging and disability resource centers, so there's been a lot of comment on that. And it something potentially that could be incorporated within a final rule.

There's another important part of the rule, talks about network adequacy. This is an important change. The rule requires states to develop standards on the adequacy of Medicaid managed care organization provider networks. And where the managed care organization has long‑term services and supports providers such as nursing homes or home and community‑based providers, et cetera, they also have to have standards for that. The state is supposed to develop standards on network adequacy.

So currently the state has time and distance standards. And those apply to primarily to will medical providers so that when consumers travel, they are supposed to be able to reach a provider within a certain time or it has to be within a certain distance. So the rule proposes when we are talking about long‑term services provider, time and distance standards will apply if the consumer has to travel to the provider, the long‑term services provider such as a CBAS provider, a community‑based adult services provider.

The state is supposed to have other kinds of standards when the long‑term supportive services provider travels to the consumer. This is a ‑‑ it's not entirely clear what those standards will be, and there's going to be an interesting conversation, I think, upon ‑‑ on how that will actually roll out, in fact.

And, finally, I just wanted to bring up the fact that the rule does propose a credentialing and recredentialing requirement for providers that enter managed care organizations contracts or participation agreements. And this would apply also as written up in the rule currently, this would apply also to long‑term services and supports providers. They would apply to all the home and community‑based providers that comes to a new individual's home. It would apply to behavioral and substance abuse disorder providers.

This rule which is a change would have a big potential impact on community‑based long‑term services and supports providers who work with Medicaid now and want to continue to do so under managed care. So those are among the pretty substantial changes that are going to take place when the managed care rule comes into effect. We don't know exactly when that will happen. All comments have been submitted. It's possible to look at the rule still. Of course, it's only. And also to look at comments that have been submitted by various stakeholders. Exactly when it's going to come into play is something of an open question obviously the changes I outlined would be significant and in many ways would support the pioneering work that Pam and Louis have been ‑‑ have outlined through this Webinar.

So I'm just going to turn it back quickly to Mary Lou to close up our session for you today.

>> Mary Lou Breslin: Thanks very much, Silvia. Actually, I think we have one question perhaps you can answer for us. Would the independent living organizations have to be credentialed under the new ‑‑ the proposed rule in order to contract with managed care organizations?

>> Silvia Yee: That is a possibility. I think this credentialing requirement is something that I imagine that CMS received a lot of different comments about this. And I know that the state itself, the state of California submitted comments and really asked for ‑‑ basically, asked for flexibility how the state would do credentialing, whether the state would do credentialing. The rule itself does leave a lot of flexibility to the states. One thing for managed care organizations to note as currently written, the rule doesn't require the state, for example, to set up a really clear state‑administered credentials by which the state would set up criteria, the state would administer tests, and the state would handle licenses. It potentially could be much more hands‑off than that and the state could, for example, say, well, we want a community‑based organization to have such and such characteristics. Managed care organizations, you take care of it. You just make sure it's done. I think for managed care organizations, there's a desire to have as much uniformity as possible and to have certainty.

For community‑based organizations such as independent living centers, I mean, I think it's tough. It's hard to ‑‑ you don't know what those criteria might be. It might well be an additional burden on community‑based organizations who are already running a pretty tight ship.

So all these questions are a little bit up in the air. At the same time, everyone wants to have providers who have certain experience, have a certain knowledge, and are capable of doing the job they are supposed to be doing.

So I think those are all the different factors that CMS has to weigh. But at this time, there's no reason to think that the independent living organizations would be any different from other long‑term services and supports providers if they are actively involved in care coordination.

>> Mary Lou Breslin: All right, great. Thank you very much.

I'd like to thank everyone who joined us for this Webinar today, especially Louis Frick and Pam Mokler for their terrific presentations and for the work that you're doing.

For more information, please contact DREDF at our Web site, dredf.org, and the Aging and Disability Partnership and the link is posted on this last slide.

I just want to make sure that everyone remembers that these Webinars in this series will be posted on the DREDF Web site along with transcripts. So look for this most recent Webinar within the next week. The previous two Webinars are already posted. And we thank everyone very much for joining us today.

(Webinar has concluded.)