A CBO Perspective on HCBS Investment

Partners in Care FOUNDATION

Driving alignment between social care & health care.

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President & CEO
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CAHP

PARTNERS IN CARE FOUNDATION

A Mission-Driven Organization

Our Mission

Partners aligns social care and health care to address the social determinants of health and equity disparities affecting diverse, under-served and vulnerable populations.

Portfolio of Medi-Cal & LTSS Services

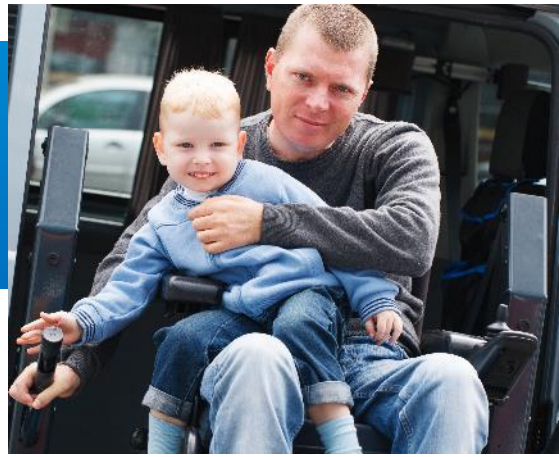
HCBS services expand options for long-term care service delivery, offering participants a choice of where they age and recover.

- Multipurpose Senior Services Program (MSSP)
- Home & Community Based Alternatives Waiver (HCBA)
- Health Homes Program (HHP)
- Assisted Living Waiver (ALW)
- Health Risk Assessments (HRA)
- Face to Face CBAS Eligibility Determination Services
- Care Plan Options (CPO)
- California Community Transitions (CCT)

The Value of Home & Community Based Waiver Programs

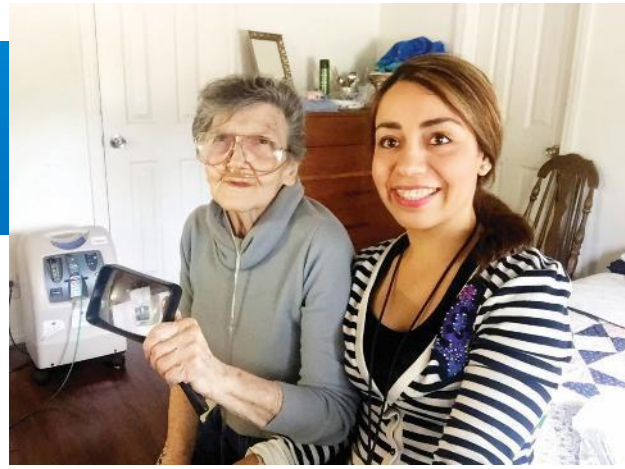
- CA is boldly moving from a fragmented program approach to a more comprehensive HCBS approach to statewide Benefits.
- SDOH/social factors drive health outcomes – the point of CalAIM
- In FY 2018, CA's HCBS programs served ~ 1.2 million Medi-Cal members, spending approximately $17.6 billion.
- To get optimum results from that investment requires targeting, which is part of the distinctive CBO knowledge and skill base at helping people succeed in community living.
- Locating and engaging with a member is crucial. CBOs have ability to locate and engage by:
  - Performing home visits
  - Intensive outreach for homeless
  - Comprehensive assessments

How to Best Address Social Factors & Provide Social Care



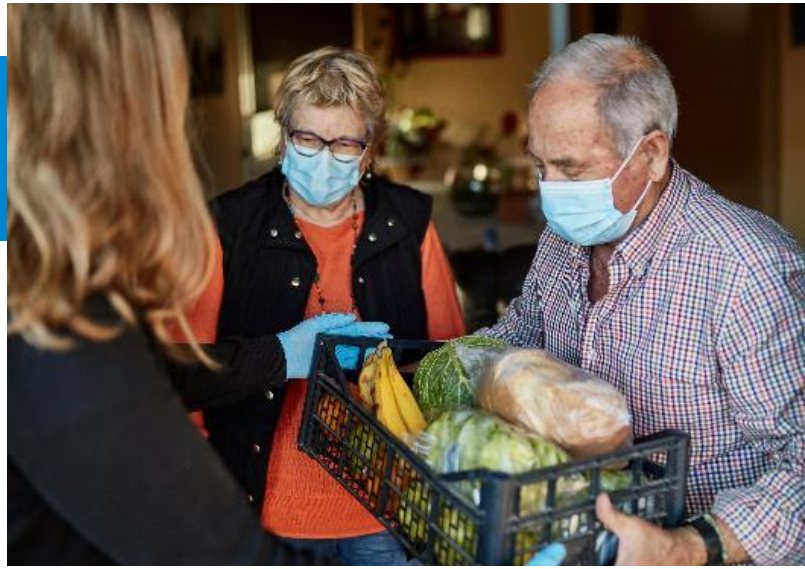
- CalAIM relies on CBOs, FQHCs, Home Health and various others to provide social care
- In the MediCal Waivers, CBOs have played a leading role in providing the care management and overseeing comprehensive HCBS services, which includes the coordination of social and clinical needs.
- ECM will need to determine how to assure full and systematic identification of HCBS needs – **clear targeting criteria, clear kinds of interventions, clarifying workforce qualified for this work.**
- We are switching from reactive care to proactive care - this requires targeting, locating those in need (outreach) and engagement strategies.
- As we move forward this very positive but disruptive set of innovations to serve the most complex and costly populations really requires solid new methods.

The *Partners* /CBO Approach to Success



- CBOs should get socially & medically complex who are difficult to engage and require ongoing and intensive social care coordination.
- CBOs are best equipped to handle outreach, engagement and addressing the Social Factors driving health outcomes:
  - Coordinating community services, and
  - Navigation of medical care.
- CBOs are experts at transitioning people from SNF or diverting from placement and supporting safe community living as demonstrated through their leadership of the various HCBS waiver services, including MSSP & HCBA.
- Similarly, for homeless or near homeless and socially complex, the expertise in community settings is what is most needed.
- Arranging safe stable community living through temporary and permanent housing, security deposits, furnishings, and vocational guidance.

The Challenge?



How to best connect medical and social care:

- Community organizations (CBOs) that are essential must be paid properly.
- Are provided enough volume so they can function as “systems” of care”.
- Referring for community services must be highly structured so it is a system that can be sustained and maximize quality, outcomes and full and effective medical partnerships.

Establishing HCBS Standardized Outcomes

Partners has established standardized outcome measures to show the collective impact of ECM interventions. Data can be stratified by population, geography, or agency for further analysis on impact. Potential outcome measures may include:

- Locating and Engaging members
- Care transitions (emergency admissions, hospitalizations, nursing home admission, and returns to community settings);
- Primary care/health specialist visits and follow-ups;
- Medication management interventions;
- Consumer empowerment for self-care management;
- Achievement of member-identified health goals;
- Management of chronic conditions; and
- Identification and utilization of community supports and other services.

How this alignment between health care/social care could work

- Health Net and *Partners* are working together to reach the hardest to reach
- *Partners'* Team used our Engagement Center to begin process
  - Called individuals on list for enrollment
- For those we couldn't reach on phone we identified alternative means of tracking:
  - Mass Mailings
  - Alternative Contact Information Search – using CHIP, HMIS, Collective Medical
  - SMS & Secure SMS Texting
  - Home visits
  - **Group outreach in community for unannounced visits**
- Results were outstanding with an average outreach & engagement success rate of 21%
- THE LESSON: **CBOs aren't tied to a physical setting and have the flexibility to go to where an individual may be.**

In Closing

- CBOs are important partners for DHCS, managed care organizations, and medical providers to address the social determinants of health.
- We encourage DHCS and MCOs to **continue engaging CBOs as partners** in this work.
- CBOs should serve as thought partners to co-design and build systemic solutions that are participant and community-centered.
- **CBOs should be engaged from the start** of planning through implementation to be meaningful partners in building systems that don't reinvent the wheel but instead leverage lessons learned from the social services and care field.
- We are looking forward to our continued partnership to improve care and services for all Californians.

Thank You!

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