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ascent

June 21,20

Agenda

- Introductions
- CalAIM Overview
- Community Supports Housing
- Challenges| Opportunities
- Synergies with NY State 1115 Waiver
- Questions

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Intrepid Ascent *Who We Are*

Intrepid Ascent is a team committed to improving health outcomes one community at a time through effective data sharing and use.

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To learn more about Intrepid Ascent, see: https://intrepidascent.com/

Intrepid Ascent *What We Do*

Technology Strategy

- Leverage technology to support community goals and systems of care integrations linking health and human services through cross-sector data exchange

Policy Innovation

- Help navigate policies and governance associated with the landscape of data sharing
- Use novel approaches and industry best practices to design policies and support implementations

Community Change

- Utilize a range of collaboration tools like design thinking and quality improvement to increase stakeholder engagement and collaboration
- Foster positive and sustainable community change

CalAIM and Community Supports Overview

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Familiarity with CalAIM?

California Landscape – *Transforming Medicaid*

Over 14 million Californians, or **one in three**, rely on the Medi-Cal program for health coverage

By 2023, MCPs will be responsible for the care of **> 90%** of Medi-Cal beneficiaries across the state = **12.6 million residents**

Why?

Because of **CalAIM**!

CalAIM = **Cal**ifornia **A**dvancing and **I**nnovating **M**edi-Cal

Healthcare reform initiative to transform and strengthen Medi-Cal, by offering more equitable, coordinated, and person-centered care

Source: CHCF, Medi-Cal Facts and Figures

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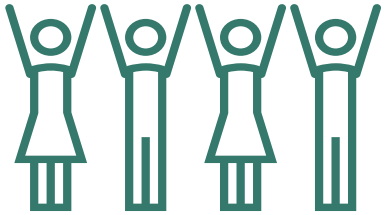
CalAIM – *Advancing Population Health*



Improve whole person health for Medi-Cal enrollees	Make meaningful advances in quality	Reduce health disparities
CalAIM will put people in the center, with a focus on prevention, wellness, and care coordination services.	DHCS will establish targets and benchmarks to measure quality, with a focus on preventive care and wellness.	DHCS will establish targets and benchmarks to measure quality, with a focus on preventive care and wellness.

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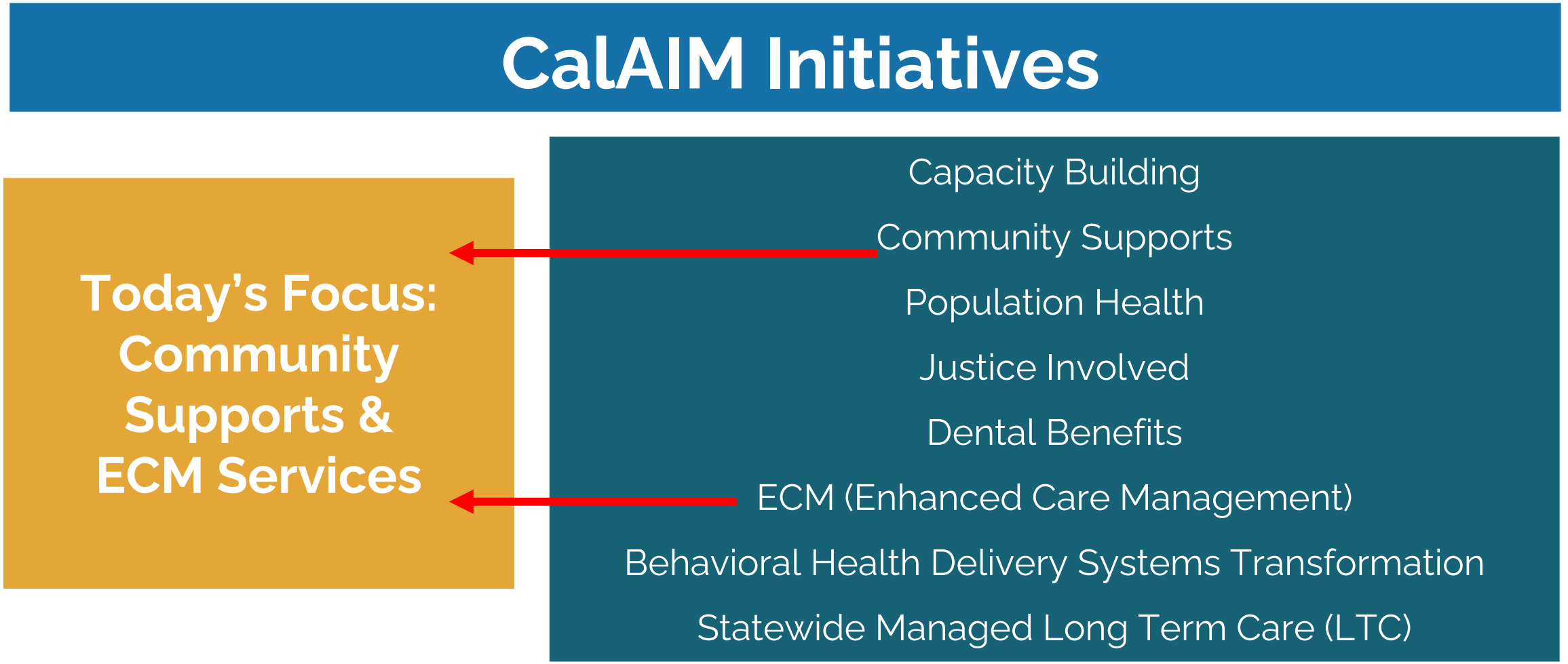
Snapshot: CalAIM Initiatives



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Enhanced Care Management

Designed to improve Medi-Cal for people with complex needs and who are facing difficult life and health circumstances:

- Focusing on breaking down traditional walls of health care – extending beyond hospitals and health care settings into communities
- Statewide Medi-Cal benefit available to select “Populations of Focus" that will address clinical and non-clinical needs of highest-need enrollees
- Intensive coordination of services
- Meeting beneficiaries wherever they are – on the street, in a shelter, in doctor's office, or at home.
- Single Lead Care Manager who coordinates care and services among physical, behavioral, dental, developmental, and social services delivery systems (right care at the right time)

Source: DHCS Website

What are Community Supports?
(In Lieu of Services)

Pre-Approved DHCS Community Supports

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations
12. Meals/Medically-Tailored Meals or Medically-Supportive Foods
13. Sobering Centers
14. Asthma Remediation

- Services to address the social drivers of health.
- Medically appropriate, cost-effective alternative services
- Optional benefits by MCP (plans can offer different combinations of Community Supports)

Source: DHCS Website

Housing Support Services

What is the level of New York Infrastructure Support? Current providers? Interest and planning?

Support to Reach Long-Term Housing:

Housing Transition Navigation

Housing Deposits

Housing Tenancy & Sustaining

Recovery- Focused Housing:

Short-Term Post-Hospitalization

Recuperative Care (Medical Respite)

Sources: https://DHCS Community Supports Policy Guide and ECM and CS Data Guidance Webinar

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Homelessness & Housing

California accounts for more than half off all unsheltered people in the U.S., with more than 161,000 Californians facing homelessness each night.

Who is Experiencing Homelessness in California

51,785 are individuals experiencing chronic homelessness (Jan 2020)[1]

44% are individuals experiencing chronic substance abuse (2019)[2]

42% are individuals experiencing untreated mental health conditions (2019)[2]

Common Characteristics of People Experiencing Homelessness in the U.S.

Compared with the general population, unsheltered individuals:

Have higher rates of **hypertension**, **diabetes**, and **HIV**[3]

Have 4 to 10 times higher **mortality rates**[3]

Experience more frequent and longer **hospital stays**, and are three times more likely to be readmitted[3]

Source: DHCS Webinar

Housing Transition

Housing Transition Navigation:

Assist members in obtaining housing, including tenant screening and housing assessment, developing an individualized support plan, searching for housing, and landlord education/ engagement (service duration can be as long as necessary)

Housing Deposits:

Assist identifying, coordinating, securing, or funding **one-time services** and modifications necessary to enable a person to establish a basic household that does not constitute room and board

Source: DHCS Website

Housing Transition Navigation Services

Titanium Healthcare organization provides primary care and wrap-around support. As a hybrid organization, Titanium provides housing support services to eligible individuals, helping them to navigate the complex housing landscape in the Bay Area of California.

*Titanium is transforming healthcare with a model that leaves **no one behind**. Every day we are using our unique expertise and backgrounds to shape a healthcare model that allows everyone, everywhere to have the kind of compassionate, coordinated care they deserve.*

Source: Titanium Healthcare

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Housing Tenancy & Sustaining

Help individuals maintain safe and stable tenancy once housing is secured

+ Early identification/intervention for behaviors that may jeopardize housing
+ Education on tenant and landlord rights/responsibilities and coaching on maintaining relationships with landlords/property managers
+ Working with landlord/case manager to address issues that could impact housing
+ Assistance to resolve landlord/neighbor disputes to reduce eviction risk
+ Assistance with benefits, housing recertification, and resources to prevent eviction
+ Working with Member to review/update/modify housing support and crisis plan
+ Health and safety visits, and providing independent living and life skills training
+ Continuing assistance with lease compliance

Source: DHCS Website

Short-Term Post-Hospitalization Housing (STPHH)

Housing for individuals who don't have a residence and who have high medical, behavioral health needs. Allows continuation of recovery immediately after discharge w/ goal of gaining (or regaining) ability to perform daily living activities

- Must coordinate/offer Housing Transition Navigation (including housing assessment and housing support plan to identify preferences/barriers)
- Only available once in an individual's lifetime
- Not to exceed duration of six (6) months
- Only available to enrollee unable to meet such an expense.
- These services supplement/not supplant services received by individual through other State, local, or federally-funded programs

Source: DHCS Website

Recuperative Care (Medical Respite)

Short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.

- Primarily used for those experiencing homelessness or with unstable living situations - too ill/frail to recover from illness/injury in usual living environment; but are not ill enough to be hospitalized
- Allow individuals to continue recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management, and other supportive social services (transportation, food, and housing).
- At minimum, the service will include interim housing (w/ bed, meals, and ongoing monitoring of health condition

Source: DHCS Website

Short Term Housing | Recuperative Care

Across California, PATH helps people find permanent housing and provide case management, medical and mental healthcare, benefits advocacy, employment training, and other services to help them maintain their homes stably. Since 2013, we have connected more than 9,000 people to permanent homes.

In 1983, PATH started supporting homeless population by distributing food and clothing to people living on the streets. As homelessness continued to grow nationwide, research revealed that Housing First—a best practice model that first connects people to permanent housing and then focuses on stabilization through voluntary supportive services, proved more effective.

Now, over thirty years later, PATH provides services in more than 150 cities in five regions, and has more than 1,500 units of permanent supportive housing completed or in the pipeline.

Source: PATH Website

Housing Eligibility

Eligibility for Short-Term Housing:

RECUPERATIVE CARE

Recuperative Care is allowable for members if the support is necessary to achieve or maintain medical stability and prevent hospital admission or readmission.

In addition, members must meet specific eligibility criteria outlined in the Community Supports Policy Guide.

STPHH

Members must have medical/behavioral health needs such that experiencing homelessness upon discharge would likely result in hospitalization, rehospitalization, or institutional readmission

In addition, members must meet specific eligibility criteria outlined in the Community Supports Policy Guide. Members exiting recuperative care may be eligible for this Community Support.

Source: DHCS Website

Housing Eligibility

Eligibility for Long-Term Housing:

Eligible members for Transition Navigation Services, Deposits, Tenancy and Sustaining Services include members who:

1. Are prioritized for a permanent supportive housing unit/subsidy through the local Coordinated Entry System or similar system

OR

2. Meet the HUD definition of homelessness or of being at risk of homelessness
and have 1+ serious chronic condition/SMI or are at risk of institutionalization or overdose or are requiring residential services because of SUD or are receiving ECM

See policy guide for additional eligibility details by Community Support.

Source: DHCS Website

Housing Supports In Action

NEWS > LOCAL NEWS

Formerly homeless woman moves into new apartment with help from local organization & state program

PATH San Diego and CalAIM helped woman get into Chula Vista apartment.

Retention Rate	People Served	Communities
90%	800+	36

Source: Local News Story More about Organization: https://epath.org/

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Challenges & Opportunities

Variability by MCP (Eligibility, Referral, Authorization, Billing)

Reimbursement Sustainability

- Capacity to stand up and then to maintain

PATH CPI Collaboration

- PATH =Providing Access and Transforming Health Initiative
- CPI = Collaborative Planning and Implementation

Navigating Different State/Federal Initiatives –State Regs and Certification

Data Sharing, Standardization, Reporting Requirements

Sources: https://DHCS Community Supports Policy Guide and ECM and CS Data Guidance Webinar

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Discussion!

What stands out? Where are there connections with NY's 1115 Waiver?

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Observation in Best Practices

New York State	California
SHIN-NY Framework • SHIN-NY connects 100% of hospitals in New York State • Over 100,000 healthcare professionals • Some health and social data exchange	DataExchangeFramework • Develops framework for health/social service data exchange • Requires **most** health care organizations to start exchanging data by 2024 • Encourages social service organizations to sign data sharing agreement
1115 Waiver • Funding available for increased service providers – specific to short-term housing transition/ medical respite --- where additional housing structures are not required	CalAIM Community Supports • Medicaid population with complex needs • Addresses social drivers of health • Connects social service organizations INTO the healthcare system • MCP-driven

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Thank you!

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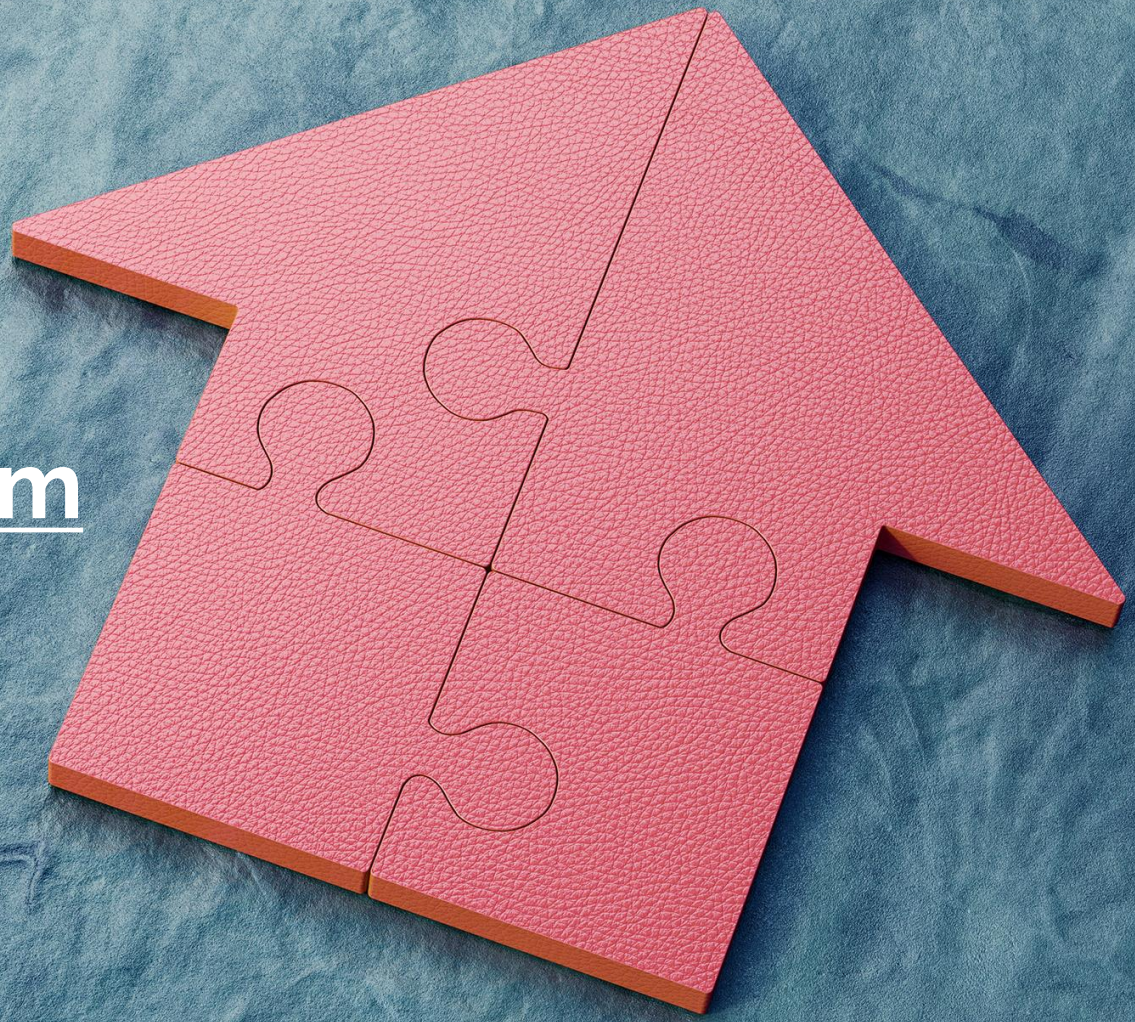

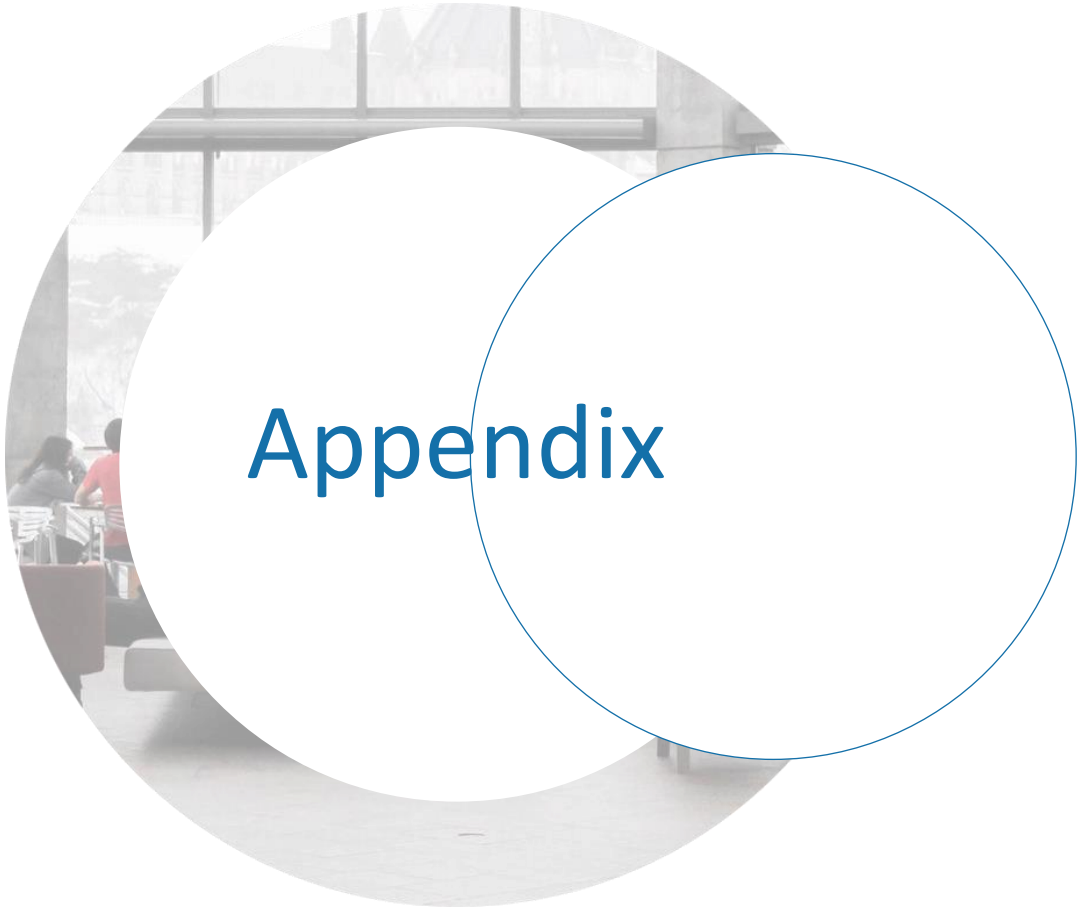

Appendix

Homelessness & Housing

State and County Housing-Related Programs

California has invested billions of dollars and undertaken a multi-agency effort to address housing and homelessness across the state.

California State Agency	Housing-Related Programs
Business, Consumer Services and Housing Agency (BCSH)	Homeless Housing Assistance and Prevention (HHAP)
Department of Housing and Community Development (HCD)	Homekey, Housing for a Healthy CA, No Place like Home Program, Veterans Housing
Department of Social Services (CDSS)	CalWORKS Housing Support Program, Housing and Disability Advocacy Program, Home Safe
Department of Health Care Services (DHCS)	CalAIM ECM & Community Supports, HHIP, BHBH

Source: DHCS Webinar

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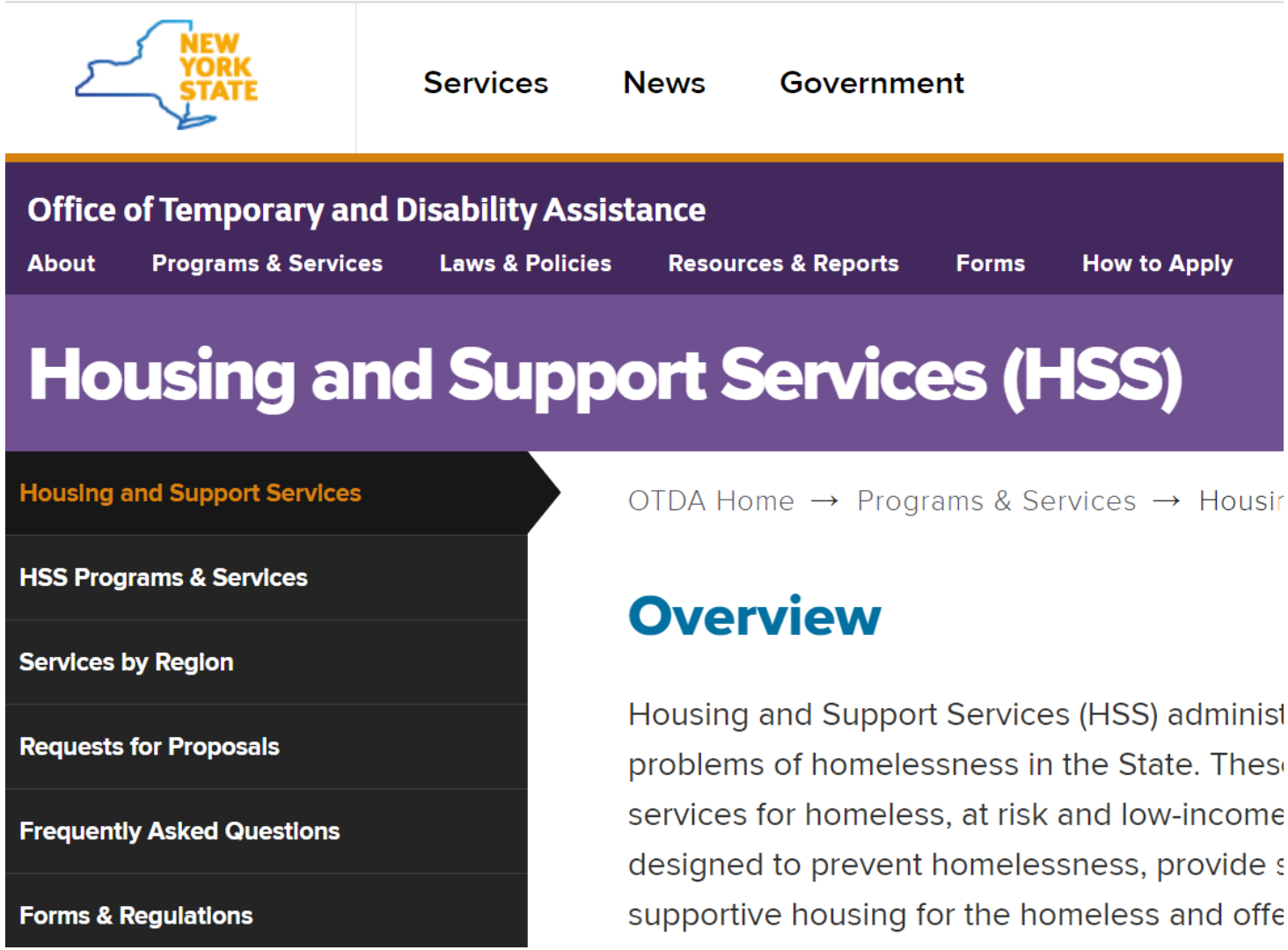
Homelessness & Housing



NY Resources:

- What exists today?

Source: https://otda.ny.gov/programs/housing/

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Homelessness & Housing

Medical Respite Pilot to Prioritize High-Needs Regions

Pilot Geographic Regions

- The NYS medical respite pilot will include medical respite programs operating in the **Capital Region, Finger Lakes, New York City, Long Island,** and **Western** regions
- DOH selected the pilot regions based on an assessment of homeless populations and inpatient spending by region
- DOH anticipates it will expand access to medical respite services statewide after the pilot program ends

2022 proof of concept **Overview of New York State Medical Respite Medicaid Pilot:** https://www.youtube.com/watch?v=ipVpOfE2yJk

Source: https://otda.ny.gov/programs/housing/

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