

Issue Brief No. 1*

A Promising Collaboration: Care1st Health Plan and Access to Independence (A2i), San Diego, California

This Issue Brief is the first in a series of three that explores how collaborations between Independent Living Centers (ILs)—community-based, cross-disability, non-profit organizations that are designed and operated by people with disabilities¹, —and one or more community partners can improve health, reduce unnecessary emergency department (ED) visits and hospital admissions, and promote safe and stable community living for people with disabilities and older adults while also reducing costs.² IL community partners in these promising collaborations include Managed Care Organizations (MCOs), Aging and Disability Resource Centers (ADRCs), medical and behavioral health care providers, and other community-based service organizations. (Visit dredf.org/healthcare-access/ to read the series.)

Context for Collaboration

The healthcare system in the United States is in a state of transition, as innovations spurred by the Affordable Care Act (ACA) disrupt longstanding practices and move healthcare providers toward shared accountability for health outcomes and value. New payment structures are spreading financial risk more widely, for example, by introducing new forms of capitation and incentive payments for reduced utilization, patient satisfaction, and positive health outcomes. Now, payers and providers who perhaps never gave much thought to patients' lives outside the formal healthcare system are beginning to see reflected in their own bottom lines the impact of social and environmental factors on health

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and access to care. In addition, there is an increasing focus on better care for people in high-risk situations, to both improve outcomes and reduce avoidable costs. In light of this changing environment, collaborations like the one between Access to Independence and Care1st Health Plan illustrate both the potential benefit for people with disabilities and older adults and opportunities for reducing healthcare costs.

Many states also are turning to MCOs to provide acute health care services under the Medicaid program and some are also incorporating Long Term Services and Supports (LTSS) into their clinical care systems. While MCOs have a long history of coordinating care and managing financial risks associated with health care, many do not have experience providing LTSS for people who have significant disabilities and who depend on LTSS to remain functional, safe and integrated in their communities. As LTSS is increasingly included as a component of managed healthcare, MCOs have the unique opportunity to gain the expertise they require by partnering with community-based organizations, including ILs that have extensive experience providing such services for people with disabilities and older adults.³

A Seven-Month Case Management Pilot

This Issue Brief reports promising preliminary results of a seven-month case management pilot project designed by the MCO, Care1st Health Plan, an affiliate of Blue Shield of California, and Access to Independence (A2i), an IL operating in San Diego County, California. The overarching goals were to stabilize housing and increase access to regular primary care for a select group of low income people with disabilities and older adults, some of whom were dually eligible for both Medicare and Medicaid and who were also homeless. The pilot hoped to improve overall health for members of this group, reduce their dependency on EDs for basic clinical services over the long term, reduce hospital readmissions for the same condition within 30 days of discharge, and reduce hospitalizations.

By mid-2012, 34,963 low-income seniors and people with disabilities living in the San Diego County, California area were passively enrolled in a managed care plan in order to receive health care under the Medicaid program (Medi-Cal in California). Over 8,000 of these beneficiaries were enrolled in Care1st Health Plan, one of the MCOs serving San Diego County.

TABLE: 1**Seniors and People with Disabilities: Medi-Cal Beneficiaries Passively Enrolled in Care1st—2012**

Medi-Cal-Only: People with Disabilities	5783
Medi-Cal Only: Seniors	992
Medicare and Medicaid Dually Eligible Seniors	243
Medicare and Medicaid Dually Eligible People with Disabilities	1039
TOTAL ENROLLEES	8057

As Care1st became acquainted with the new enrollees, they discovered that some members were homeless or transient and a significant number of people had mental health or substance use disorders. Even locating some of the new members presented challenges. Care1st soon realized that many of their new members needed temporary housing while permanent solutions were sought even as they also lacked access to regular sources of food and transportation. Some did not have current identification. Few had ready access to primary care, regularly using ED services instead when a health care need arose. Overuse of the ED is exemplified by one member—a person with a disability—who had sought medical help from various EDs around the area approximately 135 times in a one year period.

While Care1st was responsible only for providing clinical care to these new members, plan staff recognized that many of them also needed diverse LTSS that were not readily available through Medi-Cal. Moreover, a new demonstration intended to align care for people who were dually eligible for Medicare and Medicaid was slated to roll out soon in the county and that program would combine both clinical and LTSS for these beneficiaries. Care1st anticipated that these prospective members were likely to have many of the same clinical and services and supports needs as the newly enrolled group of older adults and people with disabilities, some of whom were themselves also dually eligible for Medicare and Medicaid. The pressing immediate and anticipated needs of the new members spurred creation of the innovative pilot project led by Care1st and A2i.

Care1st Pilot Objectives

- Test and develop a working model to prepare for the dually eligible beneficiary demonstration in San Diego County
- Test impact of housing placement for homeless people with disabilities and older adults on health care utilization
- Build institutional knowledge and capacity at Care1st by fostering awareness about issues affecting people with disabilities and older adults who are homeless

The pilot project was a natural outgrowth of work begun by A2i in 2006 focused on helping people with disabilities transition from nursing homes to the community, which provided a foundation for the project that was deeply rooted in the Independent Living philosophy.⁴

Care1st and A2i entered into a collaborative case management agreement in late 2012 for a sub-group of the newly enrolled members in order to launch the pilot project. Possible pilot participants were identified according to specific selection criteria: 1) the person was a member of Care1st as of April 2013, 2) the person could not be reached by telephone, 3) the person was identified as homeless in documents provided by the state, and 4) the person had used more than \$10,000 in healthcare services and more than \$5,000 in ED services during the previous six months. A2i agreed to help locate eligible individuals and with their permission, conduct Independent Living and health risk assessments. A2i was also empowered to recruit members of this group to join the pilot project.

Pilot Project--Timeframe

- December 2012: Initial Care1st meeting with Access to Independence (A2i)
- February 2013:
 - Care1st staff hired
 - Contract with A2i for external case management (ECM)
- March—April 2013:
 - Clinical systems developed
 - Test cases identified
 - Web portal developed and launched
- May—November 2013: 7-month pilot
- Post pilot: Four-month pilot follow on and preliminary evaluation

Launching the Pilot Project

Using pilot participant selection criteria, Care1st identified 293 possible participants. However, because most of these individuals were homeless, it was difficult to locate them and conduct the required health risk assessment. Louis Frick, A2i Executive Director recalls the processes A2i used to locate some of these members:

Our goal was to get to people within 24 hours because...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... so many of these folks are homeless...A lot of our initial meetings with people were held under bridges, in parking lots of Burger King, [and] other places like that. (Louis Frick, Executive Director, Access to Independence)

Frick notes that face-to-face interaction with these individuals was especially important, so making contact quickly when people were being treated in the ED or other facility helped establish the trust required for an ongoing relationship. During these encounters, A2i also focused on identifying what was important to the individual rather than only conveying the message that the contact was being made in order to get something from them.

Upon locating a prospective pilot participant, A2i obtained consent from that person to collect required information and then completed both the Independent Living plan and the health risk assessment. These documents helped identify the healthcare needs of the person as well as any other supports and services she or he might need. A care transition plan was also completed for members in skilled nursing and rehabilitation facilities, as well as acute care hospitals. Those who agreed were also enrolled in the pilot program at the same time.

Within 30 days of locating the person, A2i uploaded the health risk assessments and Independent Living plan to a web portal Care1st designed specifically for the pilot. The portal made it easier to share documents and also triggered payment when monthly updates were received. After enrollment in the pilot, A2i and the Care1st member worked together to set short-term goals, and progress toward meeting those goals was recorded and uploaded monthly to the web portal. A2i staff also participated in Care1st care coordination and interdisciplinary care team meetings. The information that A2i obtained related to member needs and goals was integrated into the member's care plan, which sets out problems,

interventions and goals for that person. A2i also coordinated closely with Care1st social services and participated in weekly case conferences with the Care1st Medical Director and

Vice President of Medical Management. A2i also helped Care1st understand why they should approve certain member benefits and services, such as transportation.

Sixty-Six Care1st Members Enrolled in Pilot Program

Sixty-six Care1st members were identified, recruited and enrolled in the pilot program. Among these, 48 were located during a period of hospitalization and referred to A2i while A2i located 18 others through skip tracing—a process of locating a person's whereabouts—and other means. Fifty-one members completed the pilot. Following the pilot, A2i continued to provide case management for 23 people who also remained Care1st-eligible members. While these numbers might appear modest, they are larger than might be expected in that this group typically is transient, frequently moving in and out of managed care plans thus interrupting continuity of care and making follow up difficult or impossible.

How Participants Were Found

- 58 percent identified during hospital stays
- 19 percent identified during emergency room visits
- 16 percent Identified via total utilization of all services
- (7 percent did not strictly meet pilot participant criteria but were identified through case management activities and providers because they were at potential risk for institutional placement)

Connecting with Primary Care

Stable and ready access to primary care has long been shown as a key to reducing use of the ED for ongoing, non-emergent clinical care needs. Care1st recognized the importance of facilitating referrals to primary care practitioners and clinics with the capacity to accept these new patients and provide timely follow up care as it was required. Among those who completed the pilot, ten were referred to St. Vincent de Paul's homeless clinic where they each established an ongoing relationship with primary care provider teams. Arrangements were made for 41 people to be seen either by Care1st primary care network providers or by providers from various Federally Qualified Health Centers (FQHCs). Such arrangements were especially important in order to strengthen availability of consistent care, which could potentially contribute long-term to reducing ED visits, hospitalizations and readmissions.

Housing

It is widely accepted that housing insecurity is one of the most pervasive barriers to healthy community living for low-income people with disabilities.⁵ A central goal of the pilot therefore was to secure stable housing for the pilot participants who needed it. Among 66 participants, the pilot project facilitated placement of 29 people in some type of stable housing including their own apartments, sober living environments, single residence occupancy (SRO) units and with family members. In addition, 23 people who completed the pilot were still eligible for A2i services after the pilot ended and among these 23 people, 15 were placed in housing during the active phase of the project. Among the 66 pilot participants, 14 percent also received housing related assistance such as groceries, rent, environmental adaptations, furniture, bed linens and pots and pans. A2i has access to funding from the California Department of Rehabilitation, a state agency that helps pay for basic items that people with disabilities might need when they move into housing after being homeless. Such practical support eases the transition to permanent housing and can work to stabilize the housing solution going forward.

The pilot succeeded in placing many of the participants in housing because A2i has worked for many years to build close ties with affordable housing providers for older adults and persons with disabilities in the San Diego area. In some cases, A2i was able to arrange for an affordable wheelchair accessible unit within a particular complex to be made available to a person with a disability, rather than being given to the next person on the waiting list even if they did not require accessibility. A2i has also surveyed accessibility for numerous apartment complexes and SRO buildings in the San Diego area. This hard-to get information makes the difficult search for housing somewhat easier for people who require basic mobility accessibility and who would otherwise have to contact each prospective housing provider separately. Pilot participants also benefited directly from A2i staff familiarity and contacts with these diverse housing resources in the area.

TABLE: 2
Housing Placements for Pilot Participants

Total Pilot Participants	Number Placed in Housing	Percentage Placed in Housing
66	29	45 percent

Promising Preliminary Results

The 15 individuals who were placed in housing during the pilot, and who also remained with Care1st and A2i after the pilot, appear to have experienced the greatest benefit in terms of reduced ED visits, hospitalizations and re-hospitalizations. While further study is needed to fully understand the factors that influenced these outcomes, the preliminary results suggest that people with disabilities benefit when clinical care and IL supports and services are integrated through coordinated case management. Moreover, they experience fewer ED visits and hospitalizations, which results in cost savings for healthcare organizations.

Hospitalizations and Lengths of Stay for All Participants

TABLE 3:
Hospitalizations and Length of Stay Pre-, During and Post Pilot—All Participants

	Hospitalizations	Average Length of Stay
Pre-Pilot (four months)	1	4.88 days
Pilot (seven months)	2.88	8.96 days
Post Pilot (four months)	1.13	4.43 days

One of the goals of the pilot was to reduce hospitalizations among the pilot participants over the long term. Not unexpectedly, the program itself triggered increased hospitalizations and lengths-of-stay for all participants while the pilot was underway. Moreover, they experienced slightly more hospitalizations during the four months following the pilot as compared with the four months before the pilot was launched. Average length of hospitalization was only slightly reduced during the four-month period following the pilot as compared with the four months before it began. These results could be explained by the extensive pent up need for clinical care and other services that was triggered following completion of the health risk assessment and creation and implementation of the Independent Living plan for pilot participants. More

study is required in order to determine long-term outcomes for the pilot participants and whether or not hospitalizations and lengths of stay further decreased over time.

Hospitalizations and Length of Stays, and Re-hospitalizations Before, During and After the Pilot for 15 Participants Placed in Housing

Preliminary information collected before, during and after the pilot suggest that when people who are homeless can secure stable housing along with responsive primary care, hospitalizations, readmissions and lengths of stay can potentially be reduced. For example, hospital admissions and length of stay information was collected for 15 participants who were placed in stable housing during the pilot and who were among 23 participants still eligible for managed care through Care1st and Independent Living services through A2i when the pilot ended. During the four months prior to the launch of the pilot, there were 1.53 hospitalizations among this group with an average length of stay of 6.67 days. During the seven-month pilot, there were 3.2 hospitalizations among the group and an average length of stay of 15.87 days. Following the pilot, however, the number of hospitalizations fell to 0.25 and lengths of stay fell to 0.5.

**TABLE 4:
Hospitalizations for 15 Pilot Participants Placed in Housing**

	Hospitalizations	Average Length of Stay
Pre – Pilot (four months)	1.53	6.67
Pilot (seven months)	3.2	15.87
Post – Pilot (four months)	0.25	0.5

Hospital readmissions within 30 days of discharge for the group of 15 followed a similar arc. Two participants among 15 had been readmitted to the hospital for a total of five readmissions during the four months leading up to the pilot. Four participants were involved

with a total of 12 readmissions during the pilot. However, only one person was readmitted one time during the four months following the pilot.

It appears that when pilot participants had access to stable housing that is augmented with ongoing primary care access, coordinated case management, and support services, problems potentially could be identified and resolved before they lead to the need for hospital care.

TABLE: 5
Readmissions to Hospital Within 30 Days of Discharge
for 15 Pilot Participants Placed in Housing

	Number of Members	Readmissions
Pre – Pilot (four months)	2	5
Pilot (seven months)	4	12
Post – Pilot (four months)	1	1

Emergency Department Visits

Again, while 51 participants who completed the pilot increased their use of emergency departments during the seven months the pilot was underway, those visits decreased for this group during the four months following the completion of the pilot and were fewer than during the four months before it began. While more research is needed to understand exactly why participants visited the ED more times during the pilot than during the four months leading up to it, this could be explained as an outcome of the same pent-up demand for services and healthcare that is reflected in increased hospitalizations for all participants during the same period. The reduction in ED visits during the four months following the pilot suggests that care coordination involving both clinical and Independent Living services might contribute to

reducing ED visits generally and that the services and supports designed and carried out by Care1st and A2i, namely stabilizing personal and living situations and streamlining participants' access to primary clinical care, also played a role.

Similarly, the 23 participants who remained with Care1st at the end of the program also experienced an increase in ED visits during the pilot, however they visited the ED fewer times during the four months following the pilot as compared with the four months leading up to it. Among these 23 participants, 15 were provided housing during the pilot. They also experienced increased ED visits during the pilot, but they visited the ED significantly less during the four months following the pilot than they did during four months before it began. While further study also needs to be carried out with each of these groups, the most promising preliminary results are seen among the 15 pilot participants who were placed in stable housing during the pilot and remained with Care1st after it ended.

TABLE: 5**Emergency Department Visits**

	15 Placed in Housing	23 Care1st Members at end of Pilot	51 Care1st Members who Completed Pilot
Pre – Pilot (four months)	4.36	2.41	2.63
Pilot (seven months)	6.85	4.09	4.11
Post – Pilot (four months)	0.38	1.70	1.70

Lessons Learned

Preliminary information regarding pilot participants' utilization of healthcare services suggests that benefits can be derived from housing placement and coordinated clinical and Independent Living case management for people with disabilities who are homeless and who might also have mental health and substance use disorders. More study is required to understand why healthcare utilization increased during the pilot and decreased for the period following the pilot for certain subsets of the participant group. Research is also needed to understand how participants, themselves, experienced the pilot and what worked and didn't work for them.

While pilot program outcomes are preliminary, Care1st nonetheless garnered important benefits from the pilot experience including a deeper awareness and understanding about the barriers to health and health care that members with disabilities who are homeless experience. The pilot also helped build the foundation for Care1st's involvement in Cal MediConnect, the demonstration in California intended to align benefits and services for beneficiaries who are dually eligible for Medicare and Medicaid.

Finally, the pilot also reinforced the value of a strong partnership between Care1st and community organizations serving the disability community such as A2i, a relationship that continues beyond the pilot. Pam Mokler, Vice President for Long-Term Services and Supports with Care1st during the pilot observed:

We found that you can't just do the intervention. You need to, number one, conduct an assessment to ask [members] what they need, develop an Independent Living plan, which is very empowering, versus only a care plan for individuals with disabilities.

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Co-authors: Mary Lou Breslin, DREDF Senior Policy Advisor, Louis Frick, Executive Director, Access to Independence, Pamela Mokler, Vice President, Long-Term Services and Supports, Care 1st Health Plan, Josie Wong, Vice President, Medical Services, Care1st Health Plan, and Herbert Woo, Vice President of Management Information Services, Care1st Health Plan

FOR MORE INFORMATION

Mary Lou Breslin
Senior Policy Advisor
Disability Rights Education and Defense Fund
Berkeley, CA 94703
mlbreslin@dredf.org
www.dredf.org

Louis Frick, MS, CC
Executive Director
Access to Independence
8885 Rio San Diego Drive, Suite 131
San Diego, CA 92108
LFrick@a2isd.org
www.a2isd.org

Pamela Mokler, MSG
Vice President of Long Term Services and Supports
Care1st Health Plan
pmokler@care1st.com
www.care1st.com

Josie Wong, RN
Vice President of Medical Services
Care1st Health Plan
San Diego, CA 92108
Jwong@care1st.com
www.care1st.com

Herbert Woo
Vice President of Management Information Services
Care1st Health Plan
Monterey Park, CA 91755
hwoo@care1st.com
www.care1st.com

ABOUT DREDF

The Disability Rights Education and Defense Fund (DREDF) is a national law and policy center dedicated to advancing the civil and human rights of people with disabilities through legal advocacy, training, education and public policy and legislative development.

Our Health Care Work

We advocate for state and federal laws and policies that chip away at the complex barriers people with disabilities experience when they try to access health care. We also conduct research, author journal articles, comment on federal and state health care regulations, train diverse health care stakeholders, develop model policies for accommodating people with disabilities in medical settings, and build alliances with colleagues in the health policy and aging fields.

Disability Rights Education and Defense Fund (DREDF)
Ed Roberts Campus
3075 Adeline Street, Suite 210
Berkeley, CA 94703
510.644.2555
tty/fax 510.841.8645
www.dredf.org

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On [facebook.com/DREDF.org](https://www.facebook.com/DREDF.org)
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Endnotes

¹ National Council on Independent Living. Website: <http://www.ncil.org/about/aboutil/>. Accessed June 23, 2016. Such organizations include Independent Living Center (ILs/CILs), community-based, cross-disability, non-profit organizations that are designed and operated by people with disabilities. ILs are unique in that they operate according to a strict philosophy of consumer control, wherein people with all types of disabilities directly govern and staff the organization. ILs help people with disabilities acquire the skills necessary to recruit, train, hire, and manage personal assistance services (PAS) workers.

² This issue brief summarizes material presented in the webinar, A Promising Collaboration: Access to Independence and Care1st Health Plan San Diego, California, organized by the Disability Rights Education and Defense Fund on October 15, 2015. The webinar along with a transcript and slides can be accessed at <http://dredf.org/healthcare-access/training-policy-briefs-presentations/>

³ U.S. Department of Health and Human Services, Administration on Aging (AoA), Aging and Disability Resource Center Program. Website: http://www.aoa.gov/AoA_programs/HCLTC/ADRC/ADRC_Program.aspx. Accessed July 8, 2016. The Aging and Disability Networks have a long history of assisting older adults and people with disabilities by assessing and coordinating their social care needs, as well as effectively delivering quality LTSS, care transitions programs and chronic disease self-care management trainings.

⁴ National Council on Independent Living. Website: <http://www.ncil.org/about/aboutil/>. Accessed July 5, 2016. Independent Living philosophy emphasizes the idea that people with disabilities are the best experts on their own needs, possess crucial perspective, and deserve the opportunity to decide how to live, work, and take part in their communities, especially regarding services that powerfully affect their day-to-day lives and access to independence.

⁵ Stahre, M., VanEenwyk, J., Siegel, P., & Njai, R. Housing Insecurity and the Association With Health Outcomes and Unhealthy Behaviors, Washington State, 2011. *Preventing Chronic Disease* 2015;12:140511. DOI: <http://dx.doi.org/10.5888/pcd12.140511>. Vallas, R., Fremstad, S., Ekman, L. A Fair Shot for Workers with Disabilities. Center for American Progress. January 28, 2015.