CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY (the "Authority")

California Health Access Model Program ("CHAMP")

Resolution Approving Award of Demonstration Project Grant to the San Francisco Health Plan

Resolution No. 2014-01

January 30, 2014

Summary of Recommendation:

Staff recommends approval of a California Health Access Model Program (CHAMP) demonstration project grant for the San Francisco Health Plan (SF Health Plan) in the amount of $1,426,089 to expand and evaluate an existing pilot program for high-risk, high-cost patients to improve their health outcomes and experience of care, as well as to lower costs. SF Health Plan is a public Medi-Cal managed care plan serving San Francisco County with over 94,000 members - more than 17% of the entire population of San Francisco.

SF Health Plan's Community-Based Care Management pilot program ("Program") known as "CareSupport" serves vulnerable SF Health Plan members who are high utilizers of hospital inpatient and emergency departments and at extremely high risk for mortality and morbidity due to factors such as housing instability, mental illness, and addiction[1]. Care managers, called community coordinators, are trained bachelor-level social workers or outreach workers and each have a panel of 30-35 members who they directly engage in the community where the members tend to live or congregate (shelters, bus stops, coffee shops, community agencies, and by cell phone) to help them improve their health and navigate through the health care and social services systems.

Community coordinators facilitate supportive housing, behavioral health treatment, access to food resources and access to primary care. The Program first piloted in the fall of 2012 as a small team of six staff (five coordinators and one social worker), and preliminary data from the pilot phase is trending towards decreased hospitalizations and emergency department visits. Currently, the staffing is 10 coordinators and two social workers.

Funding this grant will allow the SF Health Plan to expand its existing pilot to serve an additional 300 high-risk, high-utilizing SF Health Plan members and to more rigorously evaluate the impact on clinical outcomes, member experience and costs through comparison with a control group. The grant will also allow SF Health Plan to develop materials to support the replication of the model by other public and nonprofit Medi-Cal managed care plans in California. The model appears to have promising sustainability: SF Health Plan reports that the cost of one saved hospital day per member per year, for 30 members, would cover the annual cost of a community coordinator.

The program is modeled after a successful New York City program focused on high-risk, high-cost patients and evaluation of the program is being led by the same physician, Dr. Maria Raven, who led the successful New York City effort. This excerpt from the application nicely explains how the Program seeks to make a difference:

[1] The SF Health Plan reports that 3% of its members use over 60% of hospital resources yet they face poorer outcomes.

> The model thinks about healthcare differently. What makes the difference between health and sickness, survival or early death, is not just the care that happens within the four walls of a health care system. For our population, it is what happens *between* touch-points in the healthcare system that really matter. Triggers can occur at any time – a psychiatric crisis, relapse into addiction, threat to housing, hunger, confusion about medication – and a timely, supportive intervention from a Community Coordinator can help prevent that trigger from turning into an emergency visit or hospitalization. Our staff bridges the critical gap between the health care delivery system and the communities where our members reside.

A successful demonstration of the model may have significant implications in terms of improved outcomes, enhanced patient experiences, improved safety net coordination and cost savings for the San Francisco Department of Public Health, the City and County of San Francisco and the State of California's Medi-Cal program.

History of CHAMP

CHAMP was authorized by Assembly Bill 1467, signed into law by the Governor on June 28, 2012 and added to the Government Code as Section 15438.10. Regulations for the program, effective February 7, 2013 can be found in Title 4, California Code of Regulations, sections 7100-7112.

CHAMP's purpose is to support innovative methods of delivering health care services more effectively, and to improve access and health outcomes for vulnerable populations and communities by bringing services, including preventive services, to individuals where they live or congregate.

CHAMP allows the Authority to, in its first phase, award grants to one or more demonstration projects up to a combined total of $1.5 million. If the evaluation of a completed demonstration project proves successful, the Authority may launch a second phase of the CHAMP grant program to support additional grants up to a combined total of $5 million so other California communities may replicate and implement the same improved ways of delivering services.

Authority Process and Scoring

Once authorized by AB 1467, the Authority solicited letters of interest for a demonstration project grant and then, based on those letters, invited full grant applications from the twelve that met eligibility requirements. Thereafter, the Authority timely received eleven applications from the twelve invitees (two of the invitees decided to combine their efforts into one application).

Two analysts evaluated each application according to criteria and scoring defined in the regulations, and top scoring applications were then subject to additional review, both by a third analyst and the program's steering committee made up of the Authority's executive director, one of the Authority's program managers and legal counsel to the Authority. Staff then calculated the average for all reviews of the top scoring applications and the SF Health Plan achieved the highest average score.

Thereafter, staff visited the SF Health Plan at its San Francisco office and met with the authors of the application, including SF Health Plan's Chief Medical Officer, the Program's principal investigator and a community coordinator. The site visit reinforced the strengths of the model being demonstrated, and the commitment, competence and dedication of the applicant to the success of the model and its replication.

Description of Applicant

SF Health Plan was created in 1994 as one of California's Local Health Plans in an initiative to provide affordable health coverage to low and moderate-income families residing in San Francisco. It now provides affordable health care coverage to over 80,000 ethnically diverse, low-income members, including families and seniors, and people with disabilities. Members have access to a full spectrum of medical services including preventive care, specialty care, hospitalization, prescription drugs, and all needed medical services. SF Health Plan's network includes over 2,300 primary care providers and specialists, six hospitals, and 200 pharmacies.

Medi-Cal beneficiaries in San Francisco are served by two competing Medi-Cal managed care plans: the public SF Health Plan and the private Anthem Blue Cross. According to SF Health Plan, it serves over 75% of low-income families, seniors and persons with disabilities in San Francisco. SF Health Plan is wholly governed by San Francisco's safety net providers, including the San Francisco Department of Public Health, the San Francisco General Hospital, the San Francisco Community Clinic Consortium and the University of California, San Francisco.

SF Health Plan avers and, our own due diligence confirms that SF Health Plan appears to have a track record of success in coordinating and managing grant-funded projects, and leading successful projects and partnerships designed to change systems and policies to improve health care delivery.

Scoring Factors

Based on the review of the application, staff evaluated the SF Health Plan's Program using the five scoring factors identified in the regulations.

Factor1: Likelihood of success of the Demonstration project in improving access cost effectively and/or enhancing healthcare outcomes for the identified vulnerable populations or communities

The SF Health Plan specifically designed its Program to improve access and healthcare outcomes for its high-risk, high-cost members and the Program appears to be achieving success. Well-trained, street-savvy, out-of-the-box thinking community coordinators facilitate member access to primary and preventive care, behavioral health treatment, food resources, and supportive housing by meeting these members wherever they live or congregate, assessing member needs and then formulating creative solutions to connect the member to needed services, including mitigating social and economic barriers to accessing care.

The program operates from a holistic, patient-centered approach and functions to bridge the gap between the existing health and social care systems for these high-risk, high-cost members. Community coordinators build and individualize relationships with each assigned member and combine all social and medical needs into one treatment plan. They schedule, remind and accompany patients to appointments, make home visits, and assist patients in accessing needed services, including entitlements and housing.

The following grid provided by the SF Health Plan demonstrates how the Program's community-based case management model differs from the more traditional health plan case management model:

	Traditional Health Plan Case Management	Community-Based Case Management
Engagement	Short-term (3 months)	Longitudinal (6 months or more)
Communication	Phone	In-person, in the community – at shelters, bus stops, coffee shops, community agencies, or by cell phone
Case load	50-100 members	30-35 member panel, allowing intensive personal contact and time to build trust
Accountability	Productivity expectations	Held accountable for triple-aim outcomes (quarterly report with clinical stats, utilization, satisfaction)
Staffing	Nurses; each FTE over $100,000	Social work model (bachelor-level social worker or outreach worker); each FTE $45,000
Model	Medical model, focus on disease management; often disconnected from community resources	Navigation and "connect the dots model" – working closely with member to identify community resources (housing, mental health resources, food, entitlement applications) and help the member navigate through the system
Planning of intervention	Designed by health plan leadership	Consumer-directed, holistic where individual drives the path toward better health outcomes

SF Health Plan anticipates that by employing less expensive, but more appropriately trained staff, as well as by connecting vulnerable members more effectively to primary and preventive care, to social, community and behavioral resources, it will reduce the rate of and consequently, the cost for their acute care services. And importantly, SF Health Plan reports that preliminary data from the current pilot is showing the pilot has saved Medi-Cal costs, above the costs of the intervention. A person that has access to a community care coordinator whom they trust can have their social and non-urgent medical needs met, without having to constantly access the emergency department. SF Health Plan reports that decreasing hospitalizations by an average of just one hospital day per member per year, for 30 members, will cover the salary of a bachelor-level, trained community coordinator.

The following anecdotes provided by SF Health Plan show how the Program works to improve access and healthcare outcomes:

- A member complained that his nebulizer (a machine to deliver medication to the lungs, especially for asthma) was broken, but because it was so new, he was having a hard time getting a replacement approved. When the community coordinator visited the member at his home, the community coordinator discovered that the member's home was infested with cockroaches (which can aggravate asthma) and the nebulizer itself had been broken by a cockroach which had inserted itself into the nebulizer. The coordinator assisted the member with getting his room treated to eliminate the infestation and getting his nebulizer replaced. The care coordinator's discovery and subsequent assistance may markedly reduce flare-ups of this member's chronic disease.

- A homeless member was denied admission by more than 25 skilled nursing facilities for acute rehabilitation associated with the amputation of his leg. The member had a prior history of amputation and a behavioral reaction to the amputation that resulted in his discharge before he could heal and get a prosthetic device. With the community coordinator's help and changed narrative with and about him, the member was finally admitted to a skilled nursing facility.

The coordinator's engagement skills, flexibility and willingness to meet the member where he was, led to a successful outcome for this member. Now, the member has received a life-saving procedure and is in a clean, safe environment to recover.

- When working with a member who was trying to stop drinking, a community coordinator asked the member to recall the last occasion he had fun without alcohol. The member replied that it was the last time he went fishing. The coordinator conducted a community visit with the member at Pier 17, where they fished and processed what it was like to have the experience sober.

Factor 2: The likelihood of success in replication of the service delivery model

The Program appears to offer a significant likelihood of success in replication throughout California. Safety net providers and Medi-Cal health plans across California are struggling with the same challenges: how to deliver high-quality, cost-effective care to members with high morbidity and mortality rates despite heavy use of medical resources. A successful Program will benefit not only the high-risk patients who are served, but also San Francisco's safety net, and equally as important, will provide a model for all other non-profit and public Medi-Cal managed care plans across the state.

In 2013 there were 8.5 million people enrolled in Medi-Cal, California's Medicaid program for low-income Californians, including children, pregnant women, seniors, and persons with disabilities. Under the Affordable Care Act (ACA), Medi-Cal eligibility expanded January 1, 2014 to single adults without children making one to two million people newly eligible. Medi-Cal provides health care services through two distinctive health care delivery systems: the managed care system and the traditional fee-for-service system. Prior to 2014, the Medi-Cal managed care program served approximately 5 million in 30 counties. In November 2013 the state completed the planned expansion of managed care services to more than 274,000 members in rural counties, bringing Medi-Cal managed care to all of California's 58 counties. This double expansion of Medi-Cal managed care and the corresponding increased burden on managed care plans increases the potential for the model to be attractive to other nonprofit and public Medi-Cal managed care plans, and that there will be a demand for replication grants, if the evaluation of the Program warrants replication.

In order to successfully serve the expanded adult Medi-Cal population, health plans will need to understand how to successfully engage its highest need, vulnerable members. Health plan based case management is traditionally a system-centric approach, requiring patients to be available during health plan hours and on health plan terms (by phone or by appointment). A patient-centric approach like that modeled in SF Health Plan's Program, has the potential to result in improved outcomes, particularly for vulnerable members with complex medical, behavioral and social needs. As one of SF Health Plan's members noted, "I am worried about sleeping safe and my next meal. The last thing I need is some social worker telling me to be someplace three weeks from now that will take me two buses and a lot of walking."

As part of the project, SF Health Plan will develop a comprehensive, user-friendly replication manual that will include a guide to essential and preferred program features, including a hiring guide (including what are the best skills and experience to seek, and interview questions that will elicit the right information to assess candidates), a training guide, a budget guide with cost justification methodology, a guide to developing key partnerships (including sample memoranda of understanding), and a guide on how to gather and report on key data elements to measure success and sustainability.

Since the model has upfront costs, SF Health Plan will not only report changes in service use and costs, it will also determine whether these changes cover the costs of the program itself and thereby indicate long-term sustainability. Considering the existing pilot and proposed Program hold the promise for savings of relevance to Medi-Cal managed care, it will be clear for potential adopters whether results are achievable within their payment structure, or if certain aspects of the program need to be changed. The project is flexible and can be adjusted and tailored to meet differing local needs and resources, which makes replication easier.

SF Health Plan's Chief Medical Officer, Kelly Pfeifer (MD), leads a quarterly peer group of Medi-Cal managed care directors, and they are interested in learning about the Program and its impact. Other national organizations such as the Corporation for Supportive Housing, the Center for Health Care Strategies, and America's Essential Hospitals have also expressed interest.

Factor 3: The level of expertise and resources of the applicant and its partners

SF Health Plan's partners in this demonstration project include the San Francisco Department of Public Health (SFDPH) and San Francisco General Hospital and Trauma Center (SFGH). All three partners have a high level of expertise and resources in protecting and promoting the health of all San Franciscans.

SF Health Plan states that through sharing best practices and technical assistance for providers, and providing outreach and incentives for members, SF Health Plan has become one of the leading community health plans in the state. For the past six consecutive years, SF Health Plan has been the recipient of the Gold Award for Excellence in Quality Care from the California Department of Health Care Services. SF Health Plan has also been successful in implementing many grant-funded programs, and has formed strong partnerships aimed at changing policies and improving health care delivery. Examples of some of these efforts include programs like Strength in Numbers, SF Quality Culture Series, Patient Experience Collaborative, 10 Building Blocks coaching programs, among others.

SFDPH directly operates 16 primary care sites, an acute care hospital and trauma center, a skilled nursing and rehabilitation center, mental health and substance use services, housing programs and jail health. It has a $1.5 billion budget, approximately 7,000 employees and is the largest safety net provider in San Francisco. SFGH is the city's public safety-net hospital and serves over 100,000 patients each year, with a full complement of inpatient, outpatient, emergency, diagnostic and psychiatric services for adults and children 24-hours a day. SFGH is also an academic medical center, collaborating with the University of California, San Francisco School of Medicine since 1872 and is home to more than 20 UCSF research centers, affiliated institutes, and major laboratories, and over 160 UCSF principal investigators conduct research through programs based at the hospital campus, with an annual budget of over $170 million.

The role of each partner in the demonstration project is to provide access and information in coordinating the health care and community services needed for the members enrolled in the program.

Factor 4: The quality of the evaluation and research component of the Demonstration project

SF Health Plan has clearly identified their target population and the outcomes they seek to measure. SF Health Plan has also provided a detailed plan for accomplishing that evaluation based on sound methodology and data. And their effort appears to be supported by prior research.

The evaluation of the demonstration project is intended to answer the question, "Can we achieve better triple-aim outcomes (improved care, improved patient experience, at lower cost) for our most vulnerable members, through a member-centered, community-based care management intervention, compared to standard health plan case management?" With the additional funds provided though a CHAMP grant, SF Health Plan will be able to expand the evaluation to include a comparison or "control group." A control group is important, according to SF Health Plan, because prior research has shown that with heavy users of health care services, there is a "regression to the mean," which means that utilization of services decreases naturally over time in some participants, even without an intervention. The "control group" will address this limitation by randomizing SF Health Plan members with a minimum of two hospitalizations in the prior year and assigning them to either the Program or to the control group using a standard "every other" technique.

SF Health Plan anticipates that hospital admissions, including 30-day readmission rates, inpatient hospital days and emergency department visits will decrease at a higher rate for the Program enrollee group compared to the control group. Additionally, in order to demonstrate potential future costs savings from avoided medical complications, SF Health Plan aims to analyze whether improvements in clinical measures of chronic diseases for their members occur after enrollment in the Program. They expect to see improvements in clinical measures and patient satisfaction. The evaluation will also determine whether the Program reduces costs for the delivery system more than it costs to implement and sustain the Program. This is essential to determine whether the program is sustainable and worth replicating by other Medi-Cal health plans.

Maria Raven (MD, MPH, MSc), the physician who successfully led the New York City program on which this program is modeled is the principal investigator for the evaluation, and is providing expertise in the program development and implementation. Dr. Raven is an Assistant Professor of Emergency Medicine at UCSF and a practicing emergency room physician.

Factor 5: The level of commitment from other entities, including funding, personnel, and other resources

The commitment of SF Health Plan and its partners is significant. SF Health Plan is requesting this grant funding in order to expand and evaluate a model that it piloted on a small scale with internal funds in 2012. Those internal funds will continue to be utilized during the grant period. In addition to SF Health Plan internal funds, the grant leverages in-kind support from the Program's partners and a $559,817 grant from the Corporation for Supportive Housing to San Francisco Department of Public Health for supportive housing for some of the members served by the program.

Sources of Funds		Uses of Funds	
In-Kind Funding	$2,003,067	Two-Year Personnel Costs	$2,499,946
CHAMP Funding	1,426,089	Two-Year Non-Personnel Costs	929,210
TOTAL	**$3,429,156**	**TOTAL**	**$3,429,156**

Legal Review

No information was disclosed to question the financial viability or legal integrity of the applicant or its partners.

Staff Recommendation:

Staff recommends the Authority approve Resolution No. 2014-01 for the SF Health Plan to provide a grant not to exceed $1,426,089 for the expansion and evaluation of its Community Based Care Management program and to develop materials to support replication of the model, subject to all requirements of the California Health Access Model Program.

RESOLUTION NO. 2014-01

A RESOLUTION OF THE
CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY
APPROVING GRANT FUNDING FOR THE
CALIFORNIA HEALTH ACCESS MODEL PROGRAM OF 2012

WHEREAS, the California Health Access Model Program, established by Assembly Bill 1467, signed into law by the Governor on June 28, 2012 and codified under Government Code section 15438.10 (hereafter the "Statute"), authorizes the California Health Facilities Financing Authority (the "Authority") to, in its first phase, award grants to one or more demonstration projects, up to a combined total of $1.5 million, to support innovative methods of delivering health care services more effectively and improving access and health outcomes for vulnerable populations and communities by bringing services, including preventive services, to individuals where they live or congregate; and

WHEREAS, the Statute authorizes the Authority to award grants, subject to the limitations of the Statute and to further the purpose of the Statute, to demonstrate new or enhanced cost-effective methods of delivering quality health care services that are effective at enhancing health outcomes and improving access to quality health care and preventive services for vulnerable populations or communities, or both; and

WHEREAS, Authority staff has reviewed the applications, according to criteria specified in the regulations for evaluation of demonstration project grant applications and selected the San Francisco Health Plan's application as the application that best meets the criteria;

NOW THEREFORE BE IT RESOLVED by the California Health Facilities Financing Authority, as follows;

Section 1. The Authority hereby approves a grant of **$1,426,089** to **San Francisco Health Plan** ("Grantee") to complete the demonstration project as described in the Grantee's California Health Access Model Program application (hereafter "Application") and Exhibit A to this Resolution (Exhibit A is hereby incorporated by reference) with a project period that ends on June 30, 2016.

Section 2. The Executive Director and Deputy Executive Director are each hereby authorized, for and on behalf of the Authority, to determine the final amount of the grant approved pursuant to Section 1 hereof, and to approve any changes in the Project described in the Application as said officer or officers shall deem appropriate and authorized under the regulations (provided that the amount of the grant may not be increased above the amount approved by the Authority). Nothing in this Resolution shall be construed to require the Authority to obtain any additional funding, even if more grant funds are approved than there is available funding or than the Executive Director or Deputy Executive Director determines shall be funded by the California Health Access Model Program. Any notice to the Grantee shall indicate that the Authority shall not be liable to the Grantee in any manner whatsoever should such funding not be completed for any reason whatsoever.

Section 3. The Executive Director and Deputy Executive Director are each hereby authorized and directed, for and on behalf of the Authority, to draw money from the California Health Access Model Program Fund not to exceed those amounts approved by the Authority for the Grantee in Section 1. The Executive Director and Deputy Executive Director are each further authorized and directed, for and on behalf of the Authority, to execute and deliver to the Grantee any and all documents necessary to complete the transfer of funds.

Section 4. The Authority hereby finds that the grant approved in Section 1 is for a Demonstration Project eligible for financing pursuant to provisions in the regulations.

Section 5. The Executive Director and Deputy Executive Director are each hereby authorized and directed, to do any and all things and to execute and deliver any and all documents which said officer or officers deem necessary or advisable in order to effectuate the purposes of this Resolution and the transactions contemplated hereby, and which have heretofore been approved as to form by the Authority. The Executive Director and Deputy Executive Director may jointly or severally exercise any authority or directive under this Resolution.

Section 6. This Resolution expires June 30, 2016.

Date Approved: _____

EXHIBIT A

PROJECT DESCRIPTION

The proceeds of the grant will be used by San Francisco Health Plan (SF Health Plan) to expand and evaluate the existing Community-Based Care Management program known as "CareSupport," which serves vulnerable SF Health Plan members who are high utilizers of hospital inpatient and emergency departments and at extremely high risk for mortality and morbidity due to factors such as housing instability, mental illness, and addiction.

Care managers, called community coordinators, facilitate supportive housing, behavioral health treatment, and access to food resources and primary care. Providing these necessary services in an integrated manner through one point of contact improves the member's access to services and is both cost-efficient and effective.

To assist with replication of the model if replication is warranted by the evaluation, SF Health Plan will also develop a comprehensive, user-friendly replication manual that will include a guide to essential and preferred program features, a hiring guide, a training guide, a budget guide with cost justification methodology, a guide to developing key partnerships, and a guide on how to gather and report on key data elements to measure success and sustainability.