

# **CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY (“Authority”)**

## **California Health Access Model Program (“CHAMP”) (Information Item)**

**May 25, 2017**

### **BACKGROUND**

The California Health Access Model Program (“CHAMP”) was authorized by Assembly Bill 1467 in June of 2012. 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. Regulations for the program can be found in California Code of Regulations, title 4, sections 7100-7112.

CHAMP allows the Authority to, in the first phase, award grants to one or more demonstration projects up to a combined total amount of \$1.5 million. If the demonstration project is determined successful, the Authority may launch the second phase of CHAMP to support additional “replication” projects with grants up to a combined total amount of \$5 million. In the second phase, other California communities may implement the same model of delivering improved services. Any grant funds not expended by January 1, 2020 will revert back to the CHFFA fund.

### **AWARD AND DEMONSTRATION PROJECT**

On January 30, 2014, CHFFA awarded a CHAMP demonstration grant in the amount of \$1,426,089 to the San Francisco Health Plan (“SFHP”) 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 the cost of delivering care. SFHP is a public Medi-Cal managed care plan serving San Francisco County with over 94,000 members, which constitutes more than 17% of the entire population in San Francisco.

The existing pilot, known as Community Based Care Management (“CBCM”), had demonstrated promising results and savings of Medi-Cal related expenses. The CHAMP grant allowed SFHP to expand its existing pilot program to serve an additional 300 high-risk, high-utilizing SFHP members and to more rigorously evaluate the impact on clinical outcomes, member experience and the costs between a treatment cohort to a comparison cohort. The CHAMP grant funds went towards funding the following:

- Five community coordinator positions
- One social work supervisor position
- One project manager position
- Contractor costs
- Program and enrollee expenses

Community coordinators, within the CBCM model, are bachelor-level social workers/outreach workers, each with 30-35 member caseloads who provided tailored, patient-centered services and outreach to members by cell phone or in person where the members may live, hangout, or congregate (shelters, bus stops, coffee shops, and community agencies). They are trained to leave no corner unturned in attempting to locate eligible members. The social work supervisor provides clinical guidance and oversight to the five community coordinators. The program manager is responsible for overall program operations. The contractor costs include a psychiatrist, data analyst, and biostatistician. Program expenses included training and equipment. Enrollee expenses include local travel (via public transportation or taxis), incentives (e.g., food, pill boxes, and pill cutters), and temporary housing to stabilize a member after hospitalization.

## **RESULTS AND ANALYSIS**

SFHP administered the CBCM from June 1, 2014 to June 30, 2016. Within the two-year project period, SFHP expanded and evaluated the impact of CBCM on 292 Medi-Cal members. It appears SFHP achieved three of its four key objectives:

- Improve the overall health of the members, including connecting them to preventive and maintenance health services.
- Show the program to be cost neutral.
- Provide key data elements and success measures for program replication.

However, SFHP was unsuccessful in providing significant data to show a reduction in members' use of the emergency department and inpatient hospital services. SFHP conducted a statistical regression analysis to "evaluate the main outcome variables and determine whether the CBCM intervention impacted utilization of specific healthcare services over time."

SFHP's data findings and evaluation were based on a study of 292 SFHP members. The project had a treatment cohort of 144 members who received CBCM services, and a comparison cohort of 148 members who did not receive CBCM services. Data was collected for six months prior to engagement, which is also known as the initial delivery of CBCM services, and for 12 months after engagement.

### **SFHP's Key Findings:**

- Significant increases in the number of primary care physician appointments for the treatment cohort.
- Significant reduction in the number of long hospital stays for treatment cohort.
- Non-significant decrease in total inpatient bed days between cohorts.
- Non-significant change in emergency department visits between cohorts.
- Increase provisions of preventative maintenance services (e.g. durable medical equipment, enrollment in dialysis) for treatment cohort.
- Program cost 97% covered by reductions in spending on inpatient hospital stays.

The CBCM model data provided positive results that support the improvement of the overall health of high-need members; however, less than 1% of SFHP members were measured in this study. SFHP included a total of 450 members in the overall study, but only 292 members' data were captured and evaluated because the data set was incomplete due to a high "churn" rate (disenrollment and reenrollment) in and out of Medi-Cal. SFHP concluded that significant data indicated members in the treatment cohort who received CBCM services made 1.24x more visits to their primary care physicians than members in the comparison cohort who did not receive CBCM services. Although the outcome was positive and showed more use of preventative services, 1.24x does not appear to be a significant difference. Of the remaining utilization data collected, SFHP concluded that there was a non-significant, but encouraging, reduction in total inpatient bed days. SFHP noted that the data that they are continuing to collect would include a larger number of members' data, which may provide more compelling results not reflected in the current evaluation.

SFHP determined its CBCM model could be "adoptable either in its entirety, or by selecting key components of the community-based approach," to meet the needs of any community. SFHP has acknowledged that more rural localities may need to tailor the CBCM model to meet the needs of their target populations. SFHP believes the CBCM model is flexible and has room for changes and has discussed potential barriers and lessons learned in the study that would need to be addressed for replication and sustainability of the CBCM model by other programs.

SFHP stressed the importance of hiring and retaining the "right" staff for a successful CBCM; attracting and retaining committed and experienced staff can be a barrier to program replication and sustainability. SFHP stressed the importance of eliminating member selection bias and that staff must attempt to locate members, including the most difficult to reach members, and not solely those who are available by phone or housed continuously in a single location. Another barrier to evaluating program effectiveness is missing health services data. SFHP mentioned that "unless comprehensive data are included in the program evaluation, results can be difficult to trust and thus difficult to spread". SFHP was able to overcome the barrier of collecting comprehensive data because it receives all hospital and utilization data (e.g., Emergency Department visits inpatient admissions, primary care visits, etc.) for its members. In addition, state and local policymakers and stakeholders must be part of the program development and be informed on the program's progress. This "buy in" and satisfaction with staff, members, stakeholders, policymakers, and the other departments are essential to implementation, adoption, and sustainability.

SFHP has continued to collect and evaluate its data through the end of calendar year 2016 to further determine if the results are significant and can be replicable. SFHP has offered to provide an extended evaluation to the Authority; however, the data analysis is taking longer than anticipated and not yet shared with the Authority.

There are community based infrastructure needs that must be recognized in replicating the CBCM model that may not have been fully recognized in the evaluation. A few of these unique qualities that may have contributed to SFHP's project outcomes include the following:

- Monetary resources for homelessness and members in poverty (i.e. shelters, food vouchers, free clothing donations).
- Transportation accessibility (i.e. mobile phone applications such as Flywheel for taxis and cabs, clipper cards for Bay Area Rapid Transit (BART), and city buses).
- The sophistication and ability of SFHP's database to collect data of Medi-Cal members from any health facility receiving Medi-Cal reimbursements from SFHP.
- Access to in-kind funding and resources.

## **NEXT STEPS**

At this time, Authority staff cannot conclude if SFHP's final evaluation has provided enough data to support successful replication of the CBCM demonstration project. With additional data being collected and analyzed by SFHP, Authority staff believes it is too early to make a recommendation. Based on the information shared by SFHP, there are a number of requirements and thresholds as well as a cultural environment needed to ensure successful replication that Authority staff is not sure is available in other managed care health plans or organizations. Staff will continue to work with SFHP to get a more complete data set, get a better understanding of the community based infrastructure and cultural environment needed, as well as the requirements and thresholds that need to be met to successfully replicate the CBCM project outside of San Francisco.

Staff has begun to survey other managed health care plans on their ability to replicate the SFHP CBCM model and their interest in replicating the model. To date, staff has reached out to four Medi-Cal Managed Health Care Plans ("Managed Health Plan") regarding their ability to replicate the CBCM project. One Managed Health Plan was already engaged in a similar activity and showed great interest but expressed the need for funds to purchase a facility, which may be problematic. The Authority did not grant SFHP any funds for facility purchases and the requirements for replication would need to be similar to that of SFHP. A second Managed Health Plan showed interest but expressed that they cannot take on the workload of the project at this time. Although the other two Managed Health Plans have not yet responded, staff will continue to engage and solicit interest.

Before making any recommendation, Authority staff would like greater comfort that replication will be successful. Staff will update the Authority members as staff obtains new information.