# LONG TERM CARE COORDINATING COUNCIL

*Guiding the development of an integrated network of home, community-based, and institutional services for older adults and adults with disabilities*

**DATE: THURSDAY, March 10, 2016**
**TIME: 1:00 p.m. to 3:00 p.m.**
**LOCATION: 1650 Mission Street**
**4th floor, Planning Department conference room**

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**Present:** Abbie Yant, Amie Haltman-Carson, Anne Quaintance, Benson Nadell, Bernadette Navarro-Simeon, Bill Hirsh, Cathy Davis, Cathy Spensley, Chip Supanich, Dan Kaplan, Eileen Kunz, Jacy Cohen, Jennifer Walsh, Jeremy Wallenberg, Jessica Lehman, Kelly Dearman, Kelly Hiramoto, Margaret Baran, Samantha Hogg, Sandy Mori, Traci Dobronravova, Valorie Villela, Shireen McSpadden, Anne Romero, Carla Johnson, Cindy Kauffman, Marie Jobling, Mivic Hirose, Noah Lopez, Victoria Tedder

**Absent:** Akiko Takeshita, Jonathan Cheng, Ken Hornby, Tom Ryan, Twima Earley, Marlene Hunn, Ramona Davies

**Guests:** Eric Mar, Tom Nolan, Vince Crisostomo, Mark Burns, Valerie Coleman, Cassandra Chan, Rose Johns, Rick Appleby, Catherine Omalev, Luke Fuller, Julian Metcalf, Latoya McDonald, Krista Blyth-Gaeta, Raquel Redondiez, Katherine Kelly, Giuliana Milanese, Michael Pulizzano

**DAAS:** Melissa McGee

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## WELCOME & INTRODUCTIONS

## ROLL CALL – ATTENDANCE

**ACTION –**
MOTION: That the LTCCC meeting minutes of February 11, 2016 be approved.
Vote: All in favor, with no changes.

**ANNOUNCEMENTS –**
The sign-up sheet for the Board of Supervisor visits is available for member to indicate which Supervisor they will visit.
The San Francisco Chronicle has published an article written by health reporter Erin Allday about long term HIV survivors called "Last Men Standing." In addition, a documentary will be screened at the Castro Theater on April 8.

**WORKGROUP UPDATES –**
Send written workgroup updates to Melissa to be included with the minutes.

**PRESENTATION – Long Term Care Population Analysis –**
Dan Kaplan introduced the report to the Council. The Finance and Policy workgroup of the LTCCC continues to look at those who do not qualify for public programs but are in an income situation that hinders their ability to afford long term supports and services as they age and needs increase. Catherine Omalev from the Controller's Office and Rose Johns from HSA Planning presented a PowerPoint on "Long Term Care Middle Income Population Demographic Analysis."

The PowerPoint is attached.

**PRESENTATION – In-Home Care for Seniors –**

Supervisor Eric Mar introduced the report to the Council. This information is relevant to a discussion about a pilot program for home care.
Julian Metcalf and Latoya McDonald from the Budget and Legislative Analyst's Office presented a PowerPoint on "In-Home Care for Seniors."
The PowerPoint is attached.
Additionally, the Policy Analysis Report requested by Supervisor Mar is attached.

**PRESENTATION – Home Care Subsidy Pilot –**

Jessica Lehman and Krista Blyth-Gaeta presented a pilot proposal for home care.
The proposal is attached.
The planning group started meeting in February of this year, and have named their project "Support at Home Program." The group has developed a rough proposal for a pilot program, which would include a form of subsidy that would go directly to the consumer to purchase home care services. The goal is to subsidize a portion of the care. There is discussion about using a sliding scale to provide the subsidy, as the pilot targets individuals with some resources.
The timeline for this pilot is to put the basics together quickly with the hope for the funds in this budget cycle. The group is asking for 2 million dollars to get started. They will first ask the Mayor, then the Board of Supervisors.
A question was asked on how this fits with dignity fund discussions. Jessica pointed out that this is separate from the dignity fund, and the group wants the Mayor and Board of Supervisors to know this is a separate request. The goal is to get this started now, and the dignity fund will take time to start once approved.
A suggestion was presented of using the method of "cash and counseling" as this can be used by the consumer for a variety of services, not only home care. It can be used for broader purposes that may be more relevant to the consumer, and therefore offers options to consumers.
There was discussion on paying the subsidy directly to the consumer, and through a community-based organization. When a CBO pays an independent provider directly, employment requirements are triggered, such as taxes. A comment is made that there is a need to address the possibility of abuse. The group is currently looking at wage issues. There is a comment that the pilot is very broad, and this should be explored. There is a need to decide whether this is just for home care or whether it is broader and may include areas like home modifications and food.
There is a suggestion to be cognizant of the size of the pilot, and to keep it smaller to serve a group of consumers and evaluate effectiveness. If the pilot is too broad, it is hard to carry forward.
Sandy Mori thanked Supervisor Mar, and informed him this is the first time an elected official has come to Council to ask for input.

**DISCUSSION AND ACTION – BOS Budget Asks Talking Points –**

The budget asks that are being discussed are for the Mayor and the Board of Supervisors. The goal is to see these requests in the Mayor's budget or addbacks from the BOS.
All members were previously sent the identified budget asks from last month's meeting. The document included details about the ask, as well as number of votes received.
Bill Hirsh made a motion to accept the top four items on the list as the priority requests to the Mayor and Board of Supervisors. The top four items are:

- Prevent evictions and homelessness through tenant outreach and education, and legal services
- Expand housing subsidies
- Create a housing modifications fund
- Develop a home care subsidy pilot program

It is noted that in all discussions the group needs to identify that the LTCCC supports the efforts of the Age and Disability workgroup of the council.
Sandy points out that as the Mayor's advisory council, we are asking him to support our recommendations. The first 3 asks fit with the Mayor's goals on housing and homelessness.
There was discussion on the home-delivered meal waiting list, and it is felt that the LTCCC needs to acknowledge food security.
There was discussion on coordination of services, and encouraging the Mayor to leverage other departments to meet housing needs for older adults and adults with disabilities. Housing is critical and the underpinning of everything else.
Benson suggested adding to the motion, and adding food insecurity as a priority.
Bill Hirsh amended his motion to accept the top four items on the list and food insecurity as the priority requests to the Mayor and Board of Supervisors.
A vote was taken, and all in favor. Motion passes.
Talking points will be developed by members. Bill Hirsh will develop the three housing related items, Jessica Lehman will develop the home care subsidy item, and Anne Quaintance will develop the food insecurity item.

**ADJOURNED at 3:00pm.**

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**NEXT MEETING: Thursday, April 14, 2016, 1:00 – 3:00pm**

## Regional Coalition Webinar Summary
## Thursday, March 3, 2016 – 9:30 to 10:30 AM

**Welcome and Webinar Details**
If you missed the roll call, you can send Jack Neeley a note at jack.neeley@gacinstitute.org.

9:35 **Transition Services, Challenges, and Local Opportunities**
Rebecca Schupp, Joseph Billingsley, and Karli Holkko, DHCS, HCBS Advisory Workgroup
Pat Blaisdell, California Hospital Association (CHA), hospital perspective on transition and transition planning
Martha Tasinga, M.D., Care 1st and California Association of Health Plans, health plan perspective

Pat Blaisdell, VP for the Continuum of Care at CHA provided an overview

- With all the changes in discharge planning, there is a critical need for all of the key stakeholders to be working together and branching out. Here is some context for the discharge planning process (transition from hospital to home) …
    - Within our hospital members, I support what we call the post-acute care services, which includes: inpatient rehabilitation hospital units, Long Term Acute Care hospitals (Kindred Healthcare), hospital based Skilled Nursing Facilities (SNFs), home health agencies owned by hospitals, and hospital based case managers who are most involved with facilitating hospital-to-home transitions.
    - I stress for people to think of it as a process. It is something that occurs over time and in different settings, depending on needs and recovery time. Once someone is hospitalized, more than likely, they will need further care, rehabilitation, and/or help in self-care.
- Two kinds of things that happen in a SNF: (1) they might go for just a few days/weeks; (2) it might be long term residential care.
    - Hospitals always prefer to send patients directly home, but they need to be in the process so patients go to a setting where they can continue medical/functional recovery as well as being safe.
    - Example: If a patient has suffered a stroke, they may be medically well enough to leave the hospital, but they require post-acute care (rehab hospital or SNF).
    - We arrange for the other services a patient might need at home, but if that does not work, the hospital will find another facility to continue recovery/care.
- The point here is that it is the hospital's responsibility to match the patient to the right level of post-acute care, with the ultimate goal of returning to the most independent setting possible. There has been an increased and necessary focus on the entire episode of care. At this time, there are lots of

challenges to make that transition. We hope that working with all of you will address these challenges.
    - There are huge reimbursement changes in healthcare/Medicare. A patient may have surgery, the hospital and doctors get paid, and the patient goes home/home health/SNF. Traditionally, the next facility would collect their dues and everything was separate.
- In post-acute hospitals, if the patient uses too much service once they leave the hospital, the hospital will pay Medicare back. The hospitals are really starting to look at establishing partnerships to manage the utilization and the cost of care for up to 90 days after leaving the hospital.
    - Readmissions. If a patient went home and got readmitted, the hospital would get paid twice. Now there is a penalty for readmissions.
    - The case manager along with the medical team, hospital, and caregivers are supposed to help make the best decision. We have a problem with the ability to access SNF care in particular for LT Residential services and in particular for patients who have behavioral issues including advanced Dementia. Because some patients require supervision, they end up getting "stuck" in a hospital or SNF.
    - There has been an increase focused at the federal level on providing adequate support for caregivers. The hospitals are actively doing this in their process.

Overview from the Department of Health Care Services (DHCS) - Rebecca Schupp, Director, DHCS

- For our California Community Transition (CCT) project and the Assisted Living Waiver (ALW), we have contacted providers, non-profits, and home health agencies. For our CCT, we contract specifically with providers to perform transitions. They work with SNFs/hospitals/managed care plans to find beneficiaries who are appropriate for transitioning. There are a number of services that are reimbursable through our CCT program.
    - Some transition coordination providers under our assisted living waiver work with both programs because CCP and the assisted living waiver program work hand in hand.
    - Challenges: lack of support with family/friends, necessity to get them set up with power of attorney (goes through county if power of attorney is not clear)
- For the ALW, care coordination agencies which can be home health or other Home & Community Based Services (HCBSs) are responsible for identifying the individual's placement in assisted living, assessing needs, completing application package, and facilitating enrollment into an

approved SNF. Varieties of settings include Residential Care Facilities for the Elderly (RCFEs), adult residential facilities, and public housing projects. There is crossover between CCT and assisted living care coordination agencies.

- Ways that the regional coalitions can learn more and provide input, through our HCBS workgroup series …
    - Initiated last June, we have a series of five workgroups. The first was for CCT delivery. In the next meeting, we will focus on fielding the longevity of institutional transition to HCBS settings. This is funded through MFP grants (not targeted), so the grant funding has an expiration date (2020).
    - We want to set up core groups of 12-13 members (home health/IHSS/housing reps, case management providers, managed care reps, and mental health consumers and advocates). We encourage strong public participation. We will be posting the statement of reason for this workgroup on our website http://www.dhcs.ca.gov/services/ltc/Pages/HCBS_Advisory_Workgroup_Series.aspx
- I would add that the workgroup is also exploring how the CCT model can be adapted into an existing infrastructure (managed care plan, existing waiver services, hospital to home transition program). How can we build a long term transition program while building off of the CCT model?

Health Plan Perspective: Dr. Martha Tasinga (LA Care):

- One challenge we have is finding facilities willing to accept members from acute hospitals. Member had to have spent 90 days in an institution.
    - Karli Hokko (DHCS): CCT has that as a limitation. It is only open to Medical beneficiaries who have been in a facility for more than 90 days. My sense would be that – with the implementation of the CCI – the hope is that plans that are responsible for the full continuum of care might develop similar services. Hopefully, we can show success of the CCT to the plans to show cost efficiency. There is opportunity to utilize the managed care plan. We do have assisted living waiver program where children facility and transition out and there is no 90 day requirement.
- Dr. Tasinga: I am involved in CCT. If we don't have a place for the member to stay, it is very difficult. I think housing is something to look at.
    - Jack Hailey: Regional coalitions may want to put transitions and housing on their agendas and report to us how the discussions proceed… especially if there are actions determined.

Discussion:

- Ana Acton (Nevada): For Pat Blaisdell, some of us are engaging in care transition models to reduce hospital readmissions. We are bringing the University of Colorado to Sacramento on June 7/8 for care transition and intervention training (will send you an announcement). Are you familiar with the Eric Coleman model? What do you think our role is as RC members with working with hospitals for transition programs? Has anyone successfully billed Medi-Cal directly for that model?
    - Pat Blaisdell: Reimbursement has not caught up yet with new models. There are models that might allow for reimbursement. There are individual hospitals partnering with other entities (formal clinicians or HCBSs). There is definitely a role there. We can talk more offline.

**TSF Update,** Kali Peterson
Team leaders are listed in bold on the new regional coalition contact list, circulated today. Team leaders can send additions and corrections to DCheng@thescanfoundation.org

- We have sent out contact lists as well as a profile document on each coalition. The contact list as of today will be emailed to the coalition leaders. Leaders will provide important contacts for each RC.
    - Outlook appointments mostly included leaders. Please feel free to share the appointments for monthly calls as well as the meeting in September.
    - David and Kali are updating the webpage on the Community of Constituents. The profile documents will be used to update that page, as well as a 22 page document that includes the CCLTSS.
- Committees:
    - Webinar planning group ("Ad-Hoc Planning Group") – dates are listed on agenda/outlook appointment
    - Regional Meeting Planning – successfully held the SoCal regional meeting (Feb 24th). NorCal regional meeting will be on March 14th
    - Conference Planning – not yet engaged, but GACI will contact members of that planning group. Sept 13th is date for the Community of Constituents conference. Sept 14th is the date of the TSF Summit for LTSS. It will be announced next week. If you are not already a member of TSF's list serve, I strongly encourage you to sign up on our website.
    - If you have not met with Kali to go over the grant administration guide, please respond to Kali or Karen to finalize your contract.

- If you are a Part B grantee, you will have a report due in the middle of April.

**Collaborative Update**, Jack Hailey, GACI

- Collaborative meeting schedule (2nd and 4th Friday mornings at 9 a.m.) In general, government programs, such as the CCI, are discussed on the 2nd Friday and preparing California for coming demographic changes is a part of 4th-Friday discussions.
    - Anyone is welcome to attend these meetings. I try to keep track of which issues different RCs are interested in and invite them to meetings that address those issues. If you have questions, please feel free to email or call me.

- How to connect to the Collaborative – with questions or the need for information: contact Jack Hailey jack@gacinstitute.org
- Once regional coalition profiles are complete, GACI staff can let coalition leaders know when a Collaborative agenda item intersects a regional coalition's focus.
- Upcoming Collaborative discussions
    - March 11: health homes, CCI activities, and potential interaction.
    - March 25, April 15, and April 29: to be announced.

FAQs about the webinar format

- How to connect audio? Please make sure you are signed up (its free!) with WebEx to take advantage of all of the functions. Once you join the call through the WebEx app on your smartphone or computer, you may connect via phone or through your computer's microphone.
- How to raise hand or get the facilitators attention? –For future webinars, please use the "Chat" box on the WebEx application on your smartphone or computer to let the facilitator of the call know if you have a question or comment. The "raise hand" function was available on previous versions of WebEx, but is no longer available. We apologize for any confusion. These instructions will be updated on future agendas.
- How to mute/unmute audio and activate/deactivate video? – There are audio and video buttons next to your name in the "Participants" box. Unless you have spoken with the facilitator prior to the call, please disable your video feed. The facilitator can and will mute those who create background noise; please mute your line if you don't plan on speaking.

10:25 **Webinar Experiences and Final Roll Call**

10:30 **Adjourn**

**Notes:**
This year's webinars, first Thursdays of the month, from 9:30 to 10:30:

- *April 7*
- *May 5*
- *No Webinar on first Thursday of June*
- *July 7*
- *August 4*
- *No Webinar on first Thursday of September*
- *October 6*
- *November 3*
- *December 1*

Agendas go out two days before each webinar. *Regional coalitions are welcome to include additional members, whenever topics are of interest.*

*Participants*
Guests:
Patricia Blaisdell, California Hospital Association
Rebecca Schupp, DHCS
Joseph Billingsley, DHCS
Karli Holkko, DHCS
Martha Tasinga, MD, Care 1st (for California Association of Health Plans)

Coalition Members and Staff:
Lake/Mendocino: Corrina Avila, Tanner Silva-Parker, Kathy Johnson
Santa Clara: Cara Sansonia, Marilou Cristina, Nayana Shaw (or another person from Silicon Valley ILC), Wendy Ho
Bay Area Sr. Health Policy: Katherine Kelly, Vic Gellon, Cassandra Chan
Central Coast: Jennifer Griffin, Barbara Finch, Eduardo Medel
Central Valley: Donald Fischer and Camille Valentine
Nevada County: Ana Acton, Mike Ruggles, Valerie Lenwell, Christine Norwood, Carly Packard
CoCoCo: Debbie Toth, Gerald Richards
DAR (Chico):
Kern: Jan Lemucchi and Harvey Clowers
Inland Empire: Renee Dar-Khan
LAAAC: Sherry Revord, Anwar Zoueihid, Jason Moore, and Rita Chakrian
Monterey Bay: Elsa Quezada
San Mateo: Michelle Makino, Cristina Ugaitafa, Marilyn Baker-Venturini, and Deborah Owdom

Orange County: Christine Chow
Placer: Eldon Luce
San Diego: Elizabeth Lee, Jenel Lim, and Louis Frick
S.F.: Melissa McGee, Cindy Kauffman
Stanislaus: Dianna Olsen, Erlinda Bourcier
Alameda: Wendy Peterson, Jordan Lindsey, and Patricia Osage
Ventura: Blair Craddock, Joseph Durazo, and Bonnie Subira
Yolo: Sheila Allen, Fran Smith, and Valerie Olson
TSF: Kali Peterson, Rene Seidel, Megan Juring, and David Cheng
GACI: Jack Hailey and Jack Neeley

Other attendees, coalition unknown: Please let Jack Hailey or Jack Neeley know which coalition these individuals are part of. Thank you.
Cecille Luna
Family Caregiver Resource Center
Kathy Kelly (may be the same as Family Caregiver Resource Center)
Felix Su
Helen Jung
Joni Ruiz
Kelly Chang
Laura Watkins
Laura Zarate
Martha Tasinga
Melissa_____
T. Bennett
Teri Helton
Eddy Moreno
Jamie Ueoka