MEETING MINUTES

COMMITTEE NAME: ADULT SERVICES POLICY COUNCIL

Meeting Purpose(s): Working together to meet the health and human service needs of adults and seniors. Our vision is safe and supported adults and seniors with access to a full continuum of resources and independence wherever they reside.

Leader: Paulina Flores Jimenez	Meeting Called By: Paulina Flores Jimenez
Facilitator: Paulina Flores Jimenez	Time: From: 9:00 AM To: 11:00 AM
Recorder: Danielle Raiss	Date: November 1st, 2024

Location: 3433 Higuera St, San Luis Obispo, CA 93401 Conference Room #101

Members Present:

Danielle Raiss – DSS	Jean Raymond – SLO Health Counts / Dignity Health
Sally Kruger – SLO Village	Nicki Edwards – SLO Village
Alex Morris – Geriatric Care	Kim Chartrand – Hospice SLO County
Rod Brown – Geriatric Care	Jerry Mihaic – ILRC
Madison Griffin – 24 Hour Home Care	Gisela Taboada – CenCal Health
April Lewallen – Pathpoint	Becca Carsel – Carsel Consulting
Linda Beck – SLOMPA Advisory Committee	Clint Weirick – Office of Sen. Laird
Tara Davis – SLO Food Bank	Juliane McAdam – Meals that Connect
Cathy Slaughter – CenCal Health	Paul Garth – VASH
Mark Shaffer – UCP / RideOn	Francine Levin – SLO Public Health
Karen Jones – LTCO	Isabelle Hagwood – SLO Public Health
Jeffrey Smith – TMHA	Sue Gibson – SLG Senior Care
Lilah Harvey – Alzheimer's Association	Nell Bennett – Coast Caregiver Resource Center
Violeta Vallin – Los Osos Cares	Kristen Grasso – Wilshire Community Services
Jen Miller – SLO Public Health	Laura DeLoye – Alzheimer's Association
Sarah Reinhart – SLO Public Health	

AGENDA ITEMS	COMMENTS/CONCLUSIONS/ACTIONS (IF ANY)
Introductions	
Public Comment	JERRY MIHAIC • ILRC IS RE-BRANDING SOON TO ACC KIM CHARTRAND • ANNUAL FUNDRAISER UPCOMING FRANCINE LEVIN • JOINING MEALS THAT CONNECT AT SEVERAL MEAL SITES TO PROVIDE HEALTHY AGING SERIES ROD BROWN • SENIOR RESOURCE FAIR ON DECEMBER 19TH (SLOCOUNTYRESOURCE.COM) CLINT WEIRICK • NEXT LEGISLATIVE SESSION STARTS JANUARY 6TH AND GOVERNOR'S BUDGET COMES OUT SHORTLY AFTER THAT
Member Spotlight	N/A
Guest Speakers	**CALAIM PRESENTATION PANEL** **CALAIM ON THE CENTRAL COAST – GISELA TABOADA & CATHY SLAUGHTER** • COMPOSED OF MORE THAN 240,000 MEDI-CAL MEMBERS (1 IN 3 SANTA BARBARA RESIDENTS AND 1 IN 4 SAN LUIS OBISPO COUNTY) • MISSION: TO IMPROVE THE HEALTH AND WELL-BEING OF THE COMMUNITIES WE SERVE BY PROVIDING ACCESS TO HIGH QUALITY HEALTH SERVICES, ALONG WITH EDUCATION AND OUTREACH, FOR OUR MEMBERSHIP • VISION: TO BE A TRUSTED LEADER IN ADVANCING HEALTH EQUITY SO THAT OUR COMMUNITIES THRIVE AND ACHIEVE OPTIMAL HEALTH TOGETHER. • GOALS: o IDENTIFY AND MANAGE MEMBER RISK AND NEED THROUGH WHOLE PERSON CARE APPROACHES AND ADDRESSING SOCIAL DETERMINANTS OF HEALTH o MOVE MEDI-CAL TO A MORE CONSISTENT AND SEAMLESS SYSTEM BY REDUCING COMPLEXITY AND INCREASING FLEXIBILITY o IMPROVE QUALITY OUTCOMES, REDUCE HEALTH DISPARITIES, AND DRIVE DELIVERY SYSTEM TRANSFORMATION AND INNOVATION THROUGH VALUE-BASED INITIATIVES, MODERNIZATION OF SYSTEMS, AND PAYMENT REFORM • SOCIAL DETERMINANTS / DRIVERS OF HEALTH: THE CONDITIONS IN WHICH PEOPLE ARE BORN, GROW, LIVE, LEARN, WORK, PLAY, WORSHIP AND AGE THAT SHAPE EVERYDAY LIFE CONDITIONS INCLUDING HEALTH OUTCOMES AND RISKS. CATEGORIES INCLUDE: EDUCATION/LITERACY, EMPLOYMENT, OCCUPATIONAL EXPOSURE TO RISK FACTORS, HOUSING AND ECONOMIC CIRCUMSTANCES, SOCIAL ENVIRONMENT, UPBRINGING, PRIMARY SUPPORT GROUP / FAMILY CIRCUMSTANCES, PSYCHOSOCIAL CIRCUMSTANCES • CALAIM TIMELINE: o 2022:

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	▪ CenCal Health goes live with ECM and 2 community supports (MTM and Recuperative Care) o 2023: ▪ CenCal Health goes live with an additional 4 community housing supports ▪ CenCal Health is funded for SBHIP ▪ CenCal Health has awarded $8.3 million in HHIP funds and $14.6 Million in IPP funds to support local providers o 2024 ▪ CenCal Health has served 1,575 members through ECM and 2,424 members through community supports services ▪ CenCal Health implements additional 4 community supports ▪ Addiitonal 4 community supports launched o 2026: CenCal will offer a dual special needs plan • Enhanced Care Management: ECM is person-centered, community-based care management provided to the highest-need Medi-Cal enrollees, primarily through in-person engagement where enrollees live, seek care, and choose to access services. Enrollees with complex needs have their care coordinated by a Lead Care Manager knowledgeable of community resources and services available to coordinate care addressing both medical and social drivers of health. ECM is California's first statewide effort to address complex care management, leveraging the promising results from California counties' Health Homes Program and Whole Person Care Pilots. • ECM Populations of Focus: o Individuals and families experiencing homelessness o individuals at risk for avoidable hospital or emergency utilization o individuals with serious mental health or substance abuse disorder o adults living in the community and at risk for long term care institutionalization o individuals transitioning from incarceration o children and youth enrolled in CCS with additional needs beyond CCS condition o children and youth involved in child welfare o individuals with intellectual or developmental disabilities • ECM Core Service Components: Outreach and engagement, comprehensive assessment and care management plan, enhanced coordination of care, health promotion, comprehensive transitional care, member and family supports, coordination and referral to community and social support services • Referring a member to ECM: Providers can refer qualified members to CenCal health by calling ECM 805-562-1698 or using secure link https://gateway.cencalhealth.org/form/ecm • Community Supports Services, a pivotal component of CalAIM, integrates into population health strategies by providing alternatives to services such as hospital admissions or delays in discharge. These services complement Enhanced Care Management for high-risk members and are optional for beneficiaries, allowing CenCal Health members to choose their participation. • Housing Transition/Navigation: Assists individuals who are homeless or at risk of

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	HOMELESSNESS IN FINDING SHELTER AND SECURING STABLE HOUSING. • HOUSING DEPOSITS: PROVIDES FINANCIAL ASSISTANCE FOR SECURITY DEPOSITS AND INITIAL UTILITY COSTS TO HELP INDIVIDUALS SECURE HOUSING. • HOUSING TENANCY & SUSTAINING SERVICES: OFFERS EDUCATION AND SUPPORT FOR MAINTAINING STABLE HOUSING, INCLUDING BUDGET PLANNING AND LANDLORD/PROPERTY MANAGEMENT RELATIONS. • RECUPERATIVE SERVICES: o SHORT-TERM POST-HOSPITALIZATION HOUSING: PROVIDES IMMEDIATE HOUSING FOR MEMBERS WITHOUT A RESIDENCE, FOCUSING ON THOSE WITH HIGH MEDICAL OR BEHAVIORAL HEALTH NEEDS FOLLOWING HOSPITAL DISCHARGE OR FROM OTHER FACILITIES LIKE SUBSTANCE USE TREATMENT OR CORRECTIONAL FACILITIES. THE GOAL IS TO SUPPORT RECOVERY AND STABILITY DURING CRITICAL TRANSITIONS. o RECUPERATIVE CARE (MEDICAL RESPITE): PROVIDES SHORT-TERM RESIDENTIAL CARE FOR INDIVIDUALS RECOVERING FROM ILLNESS OR INJURY, INCLUDING BEHAVIORAL HEALTH CONDITIONS, WHO DO NOT REQUIRE HOSPITALIZATION BUT NEED A STABLE ENVIRONMENT TO HEAL. o RESPITE SERVICES FOR CAREGIVERS: OFFERS SHORT-TERM, NON-MEDICAL SUPERVISION FOR CAREGIVERS WHO NEED TEMPORARY RELIEF FROM THEIR CAREGIVING DUTIES. THIS SERVICE PROVIDES ESSENTIAL SUPPORT TO CAREGIVERS, ENSURING THEY CAN CONTINUE TO PROVIDE EFFECTIVE CARE TO THEIR LOVED ONES. o SOBERING CENTERS: PROVIDES A SAFE ENVIRONMENT FOR MEMBERS FOUND PUBLICLY INTOXICATED, OFFERING MEDICAL TRIAGE, TEMPORARY BEDS, MEALS, SUBSTANCE USE EDUCATION, COUNSELING, AND CONNECTIONS TO HEALTHCARE SERVICES. THE GOAL IS TO MITIGATE EMERGENCY DEPARTMENT VISITS OR INCARCERATION BY OFFERING SUPPORTIVE SOBERING SERVICES WITHIN 24 HOURS. • SERVICES FOR LONG-TERM WELL-BEING IN HOME-LIKE SETTINGS SERVICES AIMED TO COORDINATE CARE SEAMLESSLY DURING SIGNIFICANT LIFE CHANGES: o ASTHMA REMEDIATION: OFFERS PHYSICAL MODIFICATIONS TO HOMES TO PREVENT ASTHMA EPISODES TRIGGERED BY ENVIRONMENTAL FACTORS SUCH AS MOLD. THIS INCLUDES FILTERED VACUUMS, DEHUMIDIFIERS, AIR FILTERS, AND VENTILATION IMPROVEMENTS TO ENHANCE HOME AIR QUALITY AND REDUCE EMERGENCY VISITS RELATED TO ASTHMA FLARE-UPS. o COMMUNITY TRANSITION SERVICES/NURSING FACILITY TRANSITION TO A HOME: SUPPORTS INDIVIDUALS MOVING FROM NURSING FACILITIES TO PRIVATE RESIDENCES. SERVICES INCLUDE FINANCIAL ASSISTANCE FOR SECURITY DEPOSITS, UTILITY SET-UP FEES, AND HEALTH-RELATED APPLIANCES LIKE AIR CONDITIONERS OR HOSPITAL BEDS. THIS SUPPORT AIMS TO PROMOTE A HEALTHY LIVING ENVIRONMENT AND PHYSICAL WELL-BEING, REDUCING STRESS LEVELS PARTICULARLY CRITICAL FOR INDIVIDUALS WITH CONDITIONS LIKE HYPERTENSION. o DAY HABILITATION PROGRAMS: OFFERS SUPPORT FOR PERSONAL AND SOCIAL NEEDS, HELPING MEMBERS DEVELOP ADAPTIVE SKILLS CRUCIAL FOR SUCCESSFUL LIVING. SERVICES MAY INCLUDE TRAINING IN USING PUBLIC TRANSPORTATION, CONFLICT RESOLUTION, AND DAILY ACTIVITIES LIKE COOKING AND SHOPPING. **IMPROVING COMMUNITY HEALTH: AN OVERVIEW OF SLO COUNTY PUBLIC HEALTH'S ECM PROGRAM – SARH REINHART** • THE ECM PROGRAM IS DESIGNED TO MAKE HEALTHCARE MORE ACCESSIBLE AND COORDINATED BY ASSIGNING EACH CLIENT A LEAD CARE MANAGER WHO MEETS THEM WHEREVER THEY ARE—WHETHER THAT'S ON THE STREET, IN A SHELTER, AT A PROVIDER'S OFFICE, OR AT HOME. THE PROGRAM PROVIDES PERSONALIZED SUPPORT, COORDINATING CARE TO FIT INDIVIDUAL NEEDS. THIS INCLUDES MEDICATION MANAGEMENT, SCHEDULING MEDICAL APPOINTMENTS, AND CONNECTING CLIENTS WITH ESSENTIAL COMMUNITY SERVICES. • THE KEY COMPONENTS OF ECM ARE:

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	○ 1. Outreach and Engagement – Our ECM providers connect with clients in-person, by phone or mail, with the goal of building trust and engagement. ○ 2. Comprehensive Assessment and Care Management Plan – One a client is enrolled the LCM complete an assessment is to determine both clinical and non-clinical needs, creating a flexible care plan that adapts as the client's situation changes. ○ 3. Enhanced Coordination of Care - Regular, in-person contact with the member and their support network (family, guardians, caregivers) ensures everyone is aligned in supporting the client's needs. ○ 4. Health Promotion - Encourages clients to adopt healthier lifestyle choices, helping them manage their health more effectively. ○ 5. Comprehensive Transitional Care - Provides support for clients and their families during transitions from hospital or institutional care back into the community. ○ 6. Member and Family Supports - Ensures that clients and their families understand health conditions and treatment plans, improving adherence to care and medication management. • Public Health ECM Program is supported by a multidisciplinary team dedicated to meeting the needs of our clients. As the program manager, I oversee the program's administration and compliance. We have a Community Health Worker focused on outreach and engagement, connecting and enrolling clients to our program and helping them access needed services. Our team also includes two nurses who serve as Lead Care Managers; they bring valuable expertise in working with clients who have complex medical needs. Additionally, we have a behavioral health specialist who provides essential support for clients facing behavioral health challenges and also serves as a Lead Care Manager. Together, our team takes a holistic approach to care, addressing both physical and mental health needs to provide well-rounded support. • program is primarily serving individuals who fall into one of these populations of focus: individuals experiencing homelessness, individuals at risk of avoidable hospitalizations and individuals transitioning from incarceration. **CalAIM Personal Care, Homemaker & Respite Services – Madison Griffin** • Goal: To educate about new funding available for the managed Medi-Cal population and identify how to refer eligible members to receive personal care, homemaker or respite services • Current Challenges: ○ Complex health and social needs elevate Medi-Cal Hospitalization and initializing risk and cost ○ Over 65% of Medi-Cal enrollees are from diverse communities, tackling social determinants is crucial for health equity ○ IHSS Caps hours, long application delays limit care access ○ licensing, wages, and market factors create workforce shortage • CalAIM implements a whole-person care approach and address social drivers of health, improve quality outcomes, reduce health disparities, drive delivery system transformation, create a consistent & Efficient medi-cal system • CalAIM Community supports (ILOS) ○ Housing Stability Supports: Housing transition, Housing deposits, housing tenancy, short-term post hospitalization housing

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	○ TRANSITION SUPPORTS: NURSING FACILITY TRANSITION AND COMMUNITY TRANSITION SERVICES ○ LONG TERM CARE SUPPORTS: RESPITE SERVICES, PERSONAL CARE AND HOMEMAKER, RECUPERATIVE CARE, DAY HABILITATION, MEDICALLY TAILORED MEALS ○ AUXILIARY SUPPORTS: ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS, SOBERING CENTERS, ASTHMA REMEDIATION • 24 HOUR HOME CARE: ○ FOUNDED IN 2008, SYNERGISTIC CARE MODEL FOR SENIORS AND INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES ○ LARGEST NON-MEDICAL HOME CARE IN THE SOUTHWEST USA ○ IN 2023, 6.66MM HOURS OF CARE PROVIDED • PERSONAL CARE AND HOMEMAKER: ○ GOAL: SUPPORT TO MANAGE HEALTHY CONDITIONS AT HOME INSTEAD OF HIGH COST FACILITY SETTING ○ SERVICES: PERSONAL CARE, MEAL PREPARATION, MEDICATION REMINDERS, SUPERVISION, LIGHT HOUSEKEEPING ○ SERVICE LIMITATIONS: NOT A REPLACEMENT TO IHSS, CANNOT EXCEED 24/7, MUST BE COST EFFECTIVE ○ ELIGIBILITY REQUIREMENTS: ABOVE MAXIMUM IHSS HOURS, WAITING FOR IHSS DECISION, IF NOT IHSS ELIGIBLE, UP TO 60 DAYS TO AVOID SNF • RESPITE ○ GOAL: TO PROVIDE A BREAK TO THE PRIMARY CARETAKER ON AN INTERMITTENT OR TEMPORARY BASIS, NON-MEDICAL ASSISTANCE ON AS NEEDED BASIS TO SUPPLEMENT CARE, UP TO 336 HOURS ANNUALLY BUT MAY NOT EXCEED 24/7 COMBINED WITH OTHER SERVICES ○ ELIGIBILITY: NO IHSS CONNECTION REQUIRED, REQUIRE CAREGIVER RELIEF TO AVOID INSTITUTIONAL PLACEMENT • MODEL OF CARE ○ FOSTERS HEALTH EQUITY BY EMPOWERING PEOPLE TO SELF SELECT TRUSTED CAREGIVERS, TRAINED THROUGH PROFESSIONAL HOME CARE AGENCIES, PROMOTING CULTURAL COMPETENCE, AND INCREASING CARE UTILIZATION IN UNDERSERVED DEMOGRAPHICS. ○ SUSTAINABLE STAFFING REQUIREMENTS: • ELIGIBLE PLANS FOR AGENCY STAFFING • CARE NEEDS OF 20+ HOURS PER WEEK • 4 HOURS PER DAY AT A MINIMUM • LENGTH OF STAY EXPECTED FOR 2+ MONTHS – *FOR KAISER PERMANENTE MEMBERS, LENGTH OF STAY EXPECTED FOR 30+ DAYS ○ AGENCY STAFFING IS APPROPRIATE WHEN THE MEMBER DOES NOT HAVE AN AWC WORKER AND MEETS OUR SUSTAINABLE STAFFING REQUIREMENTS. • REFERRAL: SUBMIT REFERRAL FORM TO THE PLAN AND CC: 24 HOUR HOME CARE OR DIRECTLY TO 24 HOUR HOME CARE VIA FORM BELOW IF YOU DON'T HAVE ACCESS TO THE PLAN PORTAL OR OTHER METHOD HTTP://WWW.24HRCARES.COM/REFER
Corrections/Additions to the Synopsis	• SYNOPSIS ACCEPTED WITH NOTED CORRECTIONS.
Action Items	N/A

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Committee Updates as Needed	HEALTHY BRAIN INITIATIVE • One goal being pioneered currently by Paulina who gave a talk last week in Cambria in Spanish. It is difficult to reach Latinx community members so this is a success. • Action plan has been completed and identified community needs, priority populations, purpose, community served, and HBI priorities such as increase community partnerships, increase public knowledge, enhance caregiver support, increase knowledge, and train healthcare professionals. They also identified actions needed moving forward as well as aligning HBI activities with the SLO County community Health Improvement Plan and national-level Healthy Brain Initiative. Especial attention was placed on the need for more adult day centers. Since the MPA process is ongoing this action plan can be considered as a living document subject to change. • HBI team solicited ASPC feedback on what would be critical for inclusion on the website and its respective category as a dementia-friendly resource. SLOMPA • Appeared before Board of Supervisors on October 8th. The consultants have identified four pillars: housing, healthcare, connection, and caregiving. The current plan is to have a draft ready for internal distribution by the end of this year and eventual rollout in the first quarter of 2025. COMMISSION ON AGING • Presentation was given by HICAP and discussed changes of how a rural county may be restricted in options in medical plans. Medicare for 2024 was reviewed and information for 2025 is as yet unreleased.

The next meeting is: December 6th, 2024 **Time**: 9:00 AM

Location: 3433 South Higuera St, San Luis Obispo, CA 93401 Conference Room #101