Connecting the Dots:
Promoting Community-Based Services to Avoid Hospitalizations and Institutional Care

August 13, 2024

Health Plans We Support

Welcome and Introductions

Introductions

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Senior Director, Systems of Care

Today's Presenters

Flint Michels, RN, MBA, MHSA
Health Management Associates

Karen Hill, PhD, MSN ANP-C
Health Management Associates

Our Provider Speakers

Alex Fajardo
Executive Director
El Sol Neighborhood Educational Center

David Zarka
Technical Development Specialist
El Sol Neighborhood Educational Center

Dr. Sonali Saluja
VP and Medical Director of Population Health
Healthcare in Action

Please say hello in the chat with your role and organization!

Learning Objectives

- Describe the benefit of Community Health Workers (CHWs), Street Medicine Providers, and Recuperative Care.
- Explain how CHWs, Street Medicine Providers, and Recuperative Care supports can help avoid unnecessary hospitalization and institutional care services.
- Provide an example of how an at-risk homeless member would receive these services.
- Articulate the eligibility criteria and referral pathways for these services.

Street Medicine
A Broader Continuum of Medical Outreach

Case Study: Matthew

35 year old Caucasian man living with paranoid schizophrenia and alcohol use disorder

- Currently experiencing homelessness and unwilling to use the shelter system
- Is estranged from his family
- Frequent visits to ED: abscess, tooth pain and various ambulatory sensitive issues
- He frequents the local park where the Street Medicine team conducts outreach
- Today his back molar is “acting up”

Consider ways that CHWs, Street Medicine, and/or Recuperative Care services could support Matthew as we move through the presentation.

Background

- On any given night in California, **171,521** individuals are unsheltered or experiencing homelessness.
- **51%** of the nation's unhoused population is in California.
- The homeless population disproportionately includes **Black, Brown, and Indigenous persons** and families.
- Contributing factors include **systemic racism, biases, poverty, childhood trauma, objectification**, and **dehumanization**.
- Health systems are designed in ways that make it **nearly impossible** for the unhoused to access care.
- There is a **high prevalence of chronic diseases** among the homeless, including high blood pressure, diabetes, asthma, substance use disorders, and mental health concerns.
- The frequent use of emergency department visits and exacerbated chronic issues contribute to **skyrocketing healthcare costs**.
- Mortality rates among the homeless are significantly higher, with morbidity and **all-cause mortality rates being 10 times higher than those of the housed population.**

Street Medicine Institute - Defined

The fundamental approach of street medicine is to **engage people** experiencing homelessness **exactly where they are** and on their own terms to maximally reduce or eliminate barriers to care access and follow through.

California Department of Health Care Services (DHCS) All Plan Letter 22-023 & APL 24-001: **Street Medicine Provider: Definitions and Participation in Managed Care**

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Street Medicine Overview

Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment through street medicine providers in the role of the Member's assigned Primary Care Provider (PCP), through a direct contract with the Plan, as an ECM Provider, as a Community Supports Provider, or as a referring or treating contracted Provider.

Street Medicine Provider: Refers to a licensed medical provider (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas).

Primary Care Provider (PCP): Providers can elect to serve as PCPs. In order to serve as a PCP, the street medicine Provider must meet the Plan eligibility criteria for being a PCP, be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice and agree to serve in a PCP role.

Street Medicine Services

Street Medicine Providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, including but not limited to:

- Basic Case Management (with transition to Basic Population Health Management when effective);
- Care coordination and health promotion;
- Support for Members, their families, and their authorized representatives;
- Referral to Specialists, including behavioral health
- Referrals to long-term services and supports, community-based organizations, and social support services, when needed;
- The use of Health Information Technology to link services, as feasible and appropriate; and
- Provision of primary and preventative services to assigned Members.

Additional Information

Please note that mobile units/RVs that go to the individual experiencing unsheltered homelessness in their lived environment (“on the street”) is considered street medicine

For a non-physician medical practitioner (PA, NP, and CNM), MCPs must ensure compliance with state law and Contract requirements regarding physician supervision of non-physician medical practitioners. Additionally, given the unique and specialized nature of street medicine, a supervising Physician must be a practicing street medicine provider, with knowledge of and experience in street medicine clinical guidelines and protocols.

Street Medicine to Enhanced Care Management or Community Supports Handoff Process

Referring Street Medicine Provider

Enhanced Care Management or Community Supports Provider Receiving Referral

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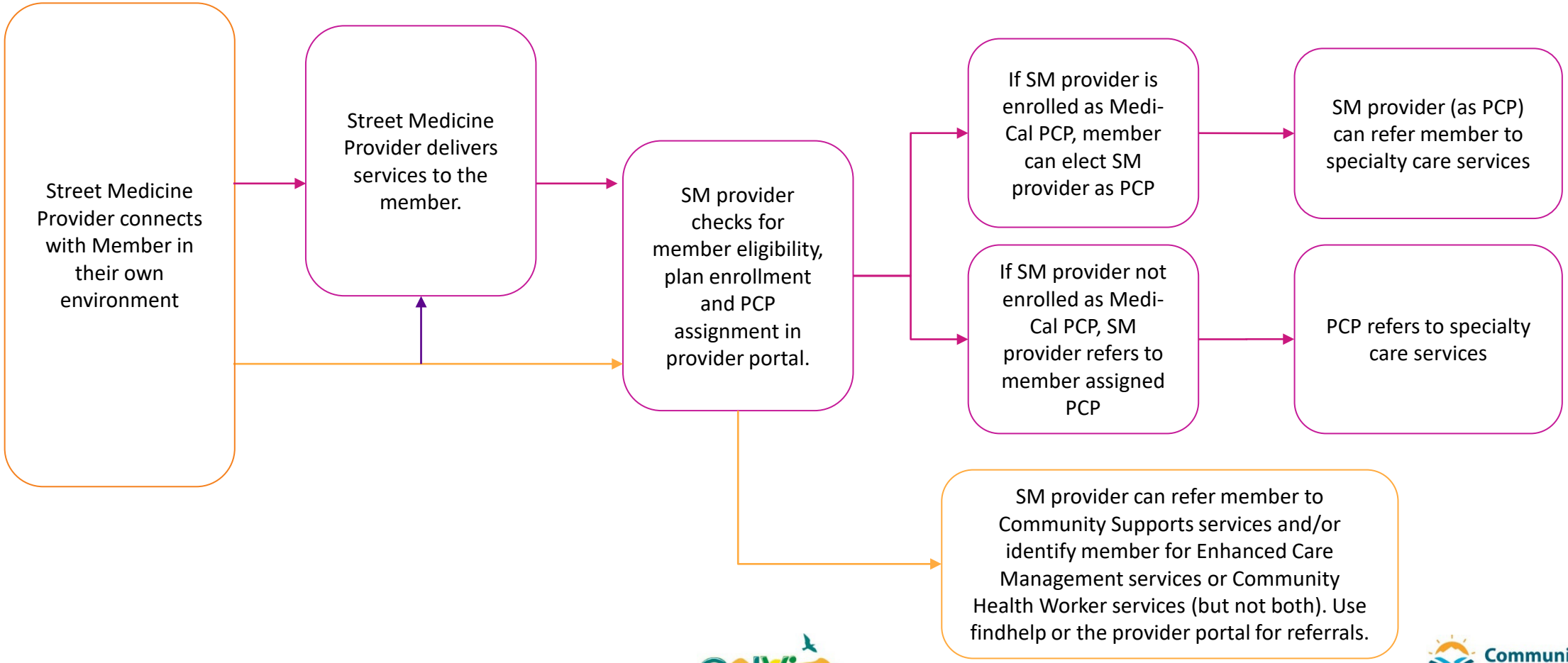
Health Net Authorization Guides

Street Medicine Referral Pathway to Specialists and other Services



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In Summary

- More street medicine teams should be created, and current teams scaled and optimized, to meet the existing needs on the street
- Street Medicine start-ups will need funding for capacity building and growth.
- Street medicine services and teams are opportunities to record unmet needs of the unhoused
- The impact of street medicine and other models of care for people experiencing unsheltered homelessness must be evaluated to establish best practices and inform where limited resources should be directed.
- Technical assistance and training will be a growing need as more Street medicine teams are created

Community Health Worker
Navigational Support for a Complex System

Case Study: Matthew

35 year old, Caucasian man living with paranoid schizophrenia and alcohol use disorder

- Currently experiencing homelessness and unwilling to use the shelter system
- Is estranged from his family
- Frequent visits to ED: abscess, tooth pain and various ambulatory sensitive issues
- He frequents the local park where the Street Medicine team conducts outreach
- His back molar has really been “acting up”
- **Today he is very worried he may have to go to the hospital**

How might a CHW support Matthew in navigating through the various services that may be of benefit to him?

Community Health Worker - Defined

A community health worker is a **frontline** public health worker who is a **trusted member of and/or has an unusually close understanding of the community served**. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and **cultural competence of service delivery**.

Community Health Workers (apha.org)

CHW Role and Services

A CHW provides culturally congruent, person-centered services that bridge different health and social services systems and improve the health and well-being of the people they serve.

Serve as **trusted community members** with lived experience and have a long history of connecting those not well served by the traditional health care system with culturally competent health and social services.

Source: CHCF, Advancing California's Community Health Worker and & Promotor Workforce in Medi-Cal
https://www.chcf.org/wp-content/uploads/2021/09/AdvancingCAsCHWPWorkforceInMediCal.pdf

What is the value of CHWs?

Numerous studies have demonstrated the value and impact of CHWs as part of a care team, such as:

- Spent 34% less time in the hospital than those not under the care of a CHW
- Were twice as likely to report that their care was high quality

Massive anecdotal evidence of the value and benefit of CHWs.

CHW Benefit Overview

CHWs can provide preventive health services working directly with individuals under the supervision of licensed practitioner.

- ***All enrolled Medi-Cal beneficiaries, whether in managed care or fee-for-service, who have been recommended for CHW preventive services by a recognized licensed physician can receive CHW-eligible services. Recommendation is required to be submitted to MCPs, but prior authorization is not required.***
- **Reimbursable services:**
  - **Health education** to promote the beneficiary's health or address barriers to physical and mental health care
  - **Health navigation** to provide information, training, referrals or support to assist beneficiaries in accessing care
  - **Screening and assessment** that does not require a license and that assists a beneficiary in connecting to appropriate services to improve their health.
  - **Individual support or advocacy** that assists a beneficiary in preventing the onset or exacerbation of a health condition or prevent injury or violence.

Source: Medi-Cal Manual for the community health worker benefit, https://files.medi- cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/chwprev.pdf

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CHW Benefit Overview (cont.)

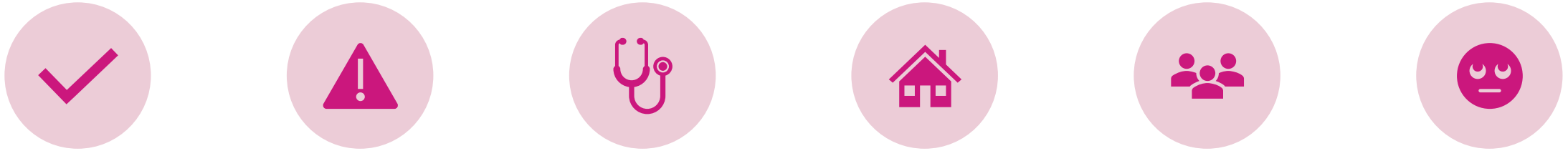
Additional Information

- CHW services **do not** include case management, care management or direct client services or supports.
- CHWs **must be under a supervising provider** who submits claims for services provided by CHWs. Supervising provider can be a licensed provider, a hospital, an outpatient clinic, a local health jurisdiction or a community-based organization.
- CHW services **require written recommendation by a physician or other licensed practitioner of the healing arts**. Written **plan of care** is required for continued CHW services after 12 units of care per beneficiary in a single year, with the exception of services provided in the ED.

Training Requirements

- A CHW **providing services other than violence prevention** shall **demonstrate qualification** through either Certificate Pathway or Work Experience Pathway. All CHWs must complete 6 hours minimum of continuing education training annually.
- A CHW providing violence prevention services must have a Violence Prevention Professional (VPP) Certification issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute.

WHEN is it a good time to evaluate someone's need for ECM and/or Community Supports?



ANY TRANSITION EVENT

ANY SIGNIFICANT CHANGE IN CONDITION

ANY NEWLY DIAGNOSED CONDITION

ANY CHANGE IN HOUSING

ANY CHANGE IN SUPPORT STRUCTURE

ANY KNOWN HIGH-STRESS EVENTS

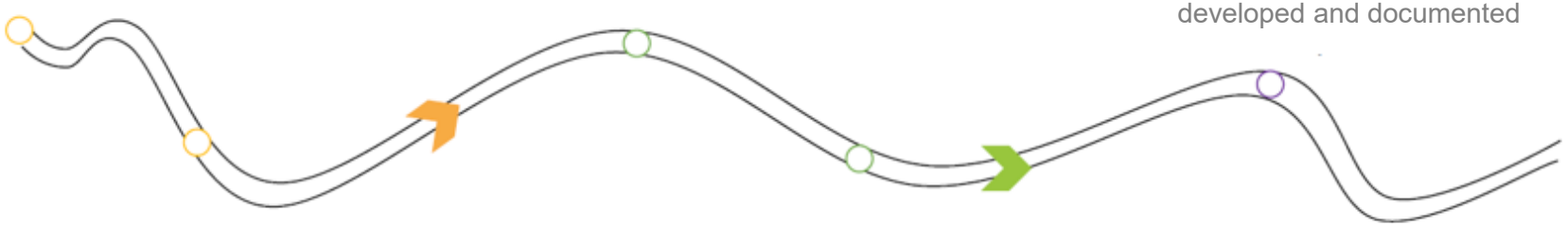
Member Journey

Identification and Eligibility	CHW Services	Care Plan

Eligibility
((Based on DHCS Criteria)

Determine Assistance Needed
Identify needs from Member

***Care Plan**
(only if support is needed beyond 12 units)
*Supervising provider needs to attest that a care plan has been developed and documented



Written Recommendation
Providers should submit these written recommendations on HN's provider portal

Individual Support
Begin linkage to other services and service providers (ex: CS Housing Suite and other community supports as identified)

When might an individual need a CHW for short-term needs?

“I’m struggling to get to my provider appointments.”

“I’m confused about my health condition(s) or when or how or where to get treatment.”

“I’m not sure how to get services I need.”

“I’m really stressed out and need more help”, including for things outside of typical healthcare needs. (Housing, meals, supports)

“I feel unsafe in my current situation.”

“I was just diagnosed and I’m really worried and confused.”

“My (x condition) has gotten really worse and I’m not sure how to manage.

“My friend/spouse/helper is struggling to help me.”

“I’ve been to the ED a lot and am struggling to manage my health.”

“I would like to talk to someone who has “walked in my shoes” and can help guide me.”

“These applications confuse me; I need help.”

CHW as Part of the Model of Care

How can CHWs support individuals in their access to healthcare and related services?

Recuperative Care
Transitional Support to Better Health at Home

Case Study: Matthew

35 year old Caucasian man living with paranoid schizophrenia and alcohol use disorder

- Currently experiencing homelessness and unwilling to use the shelter system
- Is estranged from his family
- Frequent visits to ED: abscess, tooth pain and various ambulatory sensitive issues
- He frequents the local park where the Street Medicine team conducts outreach

Matthew was admitted to the hospital due to his infections and other issues. Ready for discharge now.

How might Recuperative Care services support Matthew's needs?

Recuperative Care – Defined

Also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but **still need to heal** from an injury or illness (including behavioral health conditions) and whose **condition would be exacerbated by an unstable living** environment.

It allows individuals to **continue their recovery** and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management, and other supportive social services.

Recuperative Care - Definition

*"A community health worker is a **frontline** public health worker who is a **trusted member of and/or has an unusually close understanding of the community served**. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and **cultural competence of service delivery**."*

Community Health Workers (apha.org)

Recuperative Care Expedited Referral Process

*Members who are in need of recuperative care are granted **presumptive eligibility** and can be admitted directly to a recuperative care facility from the hospital.*

Step 1	Step 2	Step 3
Confirm member eligibility for the Plan in the provider portal.	Contact the recuperative care provider directly. Use the Provider Directory if needed	Transfer the member to recuperative care facility. **No authorization is required prior to transfer**. Notify the concurrent review nurse of the transfer to approve the authorization.

RECUPERATIVE CARE SERVICES

Based on individual needs, services may include:

- **Assessment and referrals** to community supports or connect the individual to any other on-going services
- **Limited or short-term assistance** with Instrumental Activities of Daily Living &/or ADLs
- **Coordination of transportation** to post-discharge appointments
- **Connection to any other on-going services** an individual may require including mental health and substance use disorder services
- **Support in accessing** benefits and housing
- **Gaining stability** with case management relationships and programs
- Recuperative Care can be for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury

Recuperative Care – Additional Information

Eligibility:

1. Medi-Cal Eligibility
2. Homeless or unstable housing
3. Need to heal from injury or illness (including BH) that would be made unstable if discharged to the street

Timespan: 30-day increments, up to 90 days total if authorized

Exclusions: BH instability, high levels of care, combative, infectious diseases

- Recuperative Care sites are **not** skilled license facilities like a nursing home!
- Individuals must be able to manage their own Activities of Daily Living
- Small wound care and IV's – with caution
- Each site is a bit different in services provided
- May be better for individual to transfer to skilled facility if extensive ADL or other support is needed

Goal of Recuperative Care is to **reduce risk of re-hospitalization or ED visits if an individual is at risk due to lack of support/unstable home environment and additional support needs**

Provider Spotlight and Q&A

Provider Spotlight – **Dr. Saluja Sonali**
VP and Medical Director of Population Health
Healthcare in Action

Discussion Questions:

Walk us through what it is like for an individual to be served by Healthcare in Action. What services do you provide to them?

How do you partner with CHW's, ECM and Community Supports providers, such as Recuperative Care providers, to serve the individuals you work with? (both internal to Healthcare in Action and outside providers)

What is your biggest challenge to being a Street Medicine Provider?

Provider Spotlight – **David Zarka**
Technical Development Specialist and **Alex Fajardo**
Executive Director
El Sol Neighborhood Educational Center

Discussion Questions:

Walk us through what it is like for an individual to be served by El Sol. What services do you provide to them?

How do you partner with CHW's, ECM and Community Supports providers, such as Recuperative Care providers, to serve the individuals you work with? (both internal to El Sol and outside providers)

What is your biggest challenge to providing your services?

What are the key differences between a CHW role within an ECM model versus a CHW as a short term isolated benefit?

Questions?

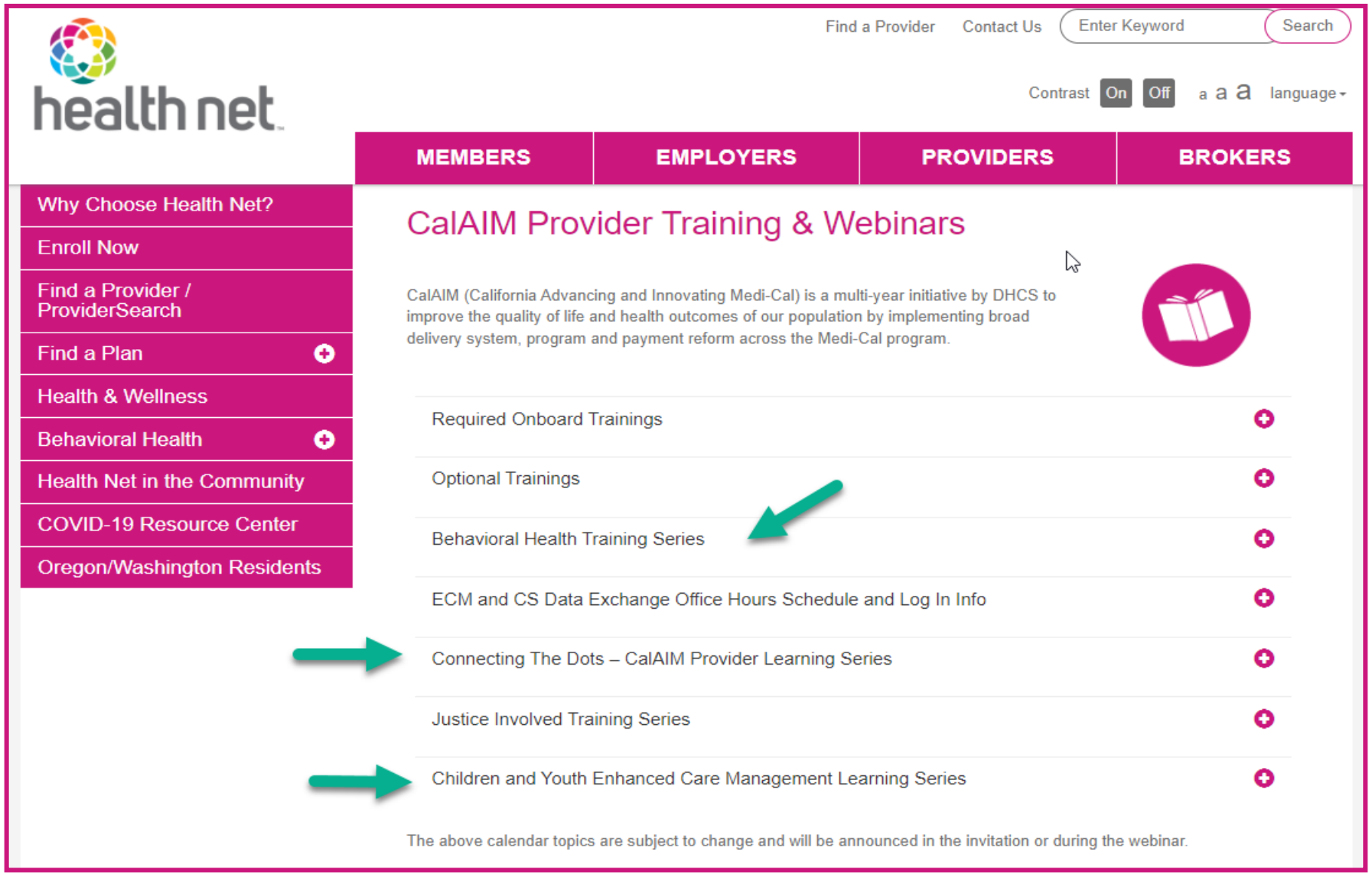
if time allows

Reminders about past Webinars and where to find them

- Connecting the Dots: **Children and Youth Involved in Child Welfare** (February 13, 2024)
- Connecting the Dots: **How to Refer your Client to Enhanced Care Management (ECM) and Community Supports (CS)** (March 12, 2024)
- Connecting the Dots: **New Services to Support Children and Youth with Complex Behavioral Health Needs** (April 9, 2024)
- Connecting the Dots: **New Services to Support Families and Youth Experiencing Homelessness** (May 14, 2024)
- Connecting the Dots: **New Services to Improve Maternal and Infant Health** (June 11, 2024)
- Connecting the Dots: **New Medi-Cal Services to Support Safe Living in the Home** (July 9, 2024)

View past webinars and recordings:
https://www.healthnet.com/content/healthnet/en_us/providers/support/calaim-resources/training-webinars.html

Scroll down the page to locate "Connecting the Dots – CalAIM Provider Learning Series"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Find a Provider
Contact Us
Enter Keyword
Search
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language
MEMBERS
EMPLOYERS
PROVIDERS
BROKERS
Why Choose Health Net?
Enroll Now
Find a Provider / ProviderSearch
Find a Plan
Health & Wellness
Behavioral Health
Health Net in the Community
COVID-19 Resource Center
Oregon/Washington Residents
CalAIM Provider Training & Webinars
CalAIM (California Advancing and Innovating Medi-Cal) is a multi-year initiative by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reform across the Medi-Cal program.
Required Onboard Trainings
Optional Trainings
Behavioral Health Training Series
ECM and CS Data Exchange Office Hours Schedule and Log In Info
Connecting The Dots – CalAIM Provider Learning Series
Justice Involved Training Series
Children and Youth Enhanced Care Management Learning Series
The above calendar topics are subject to change and will be announced in the invitation or during the webinar.

THANK YOU!!!!
Before You Go…

Please Complete the Evaluation of Today's Session

Once the webinar has concluded, the survey will pop-up in a separate browser.

This is the LAST of the live webinars!!!!

Thank you to all those that have contributed and to those that attended.

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Health Net Provides all 14 Community Supports Services

Community Support Service	Health Net
Housing Transition/Navigation	✓
Housing Deposits	✓
Housing Tenancy & Sustaining Services	✓
Short-Term Post-Hospitalization Housing	✓
Recuperative Care (Medical Respite)	✓
Day Habilitation Programs	✓
Nursing Facility Transition/ Diversion	✓
Community Transition Services/Nursing Facility Transition to a Home	✓
Personal Care and Homemaker Services	✓
Respite Services for Caregivers	✓
Environmental Accessibility Adaptations	✓
Medically Supportive Food/ Meals/ Medically Tailored Meals	✓
Sobering Centers	✓
Asthma Remediation	✓

Glossary of Terms

- CS – Community Supports
- DC - Discharge
- EAA – Environmental Accessibility Adaptions
- ECM – Enhanced Care Management
- HHSS – Housing Support Services
- MCP – Managed Care Plan (Health Plan)
- PCP – Primary Care Provider
- STPHH – Short Term Post-Hospitalization Housing