Connecting the Dots: New Medi-Cal Services to Support Safe Living in the Home

July 9, 2024

Health Plans We Support

Agenda

- Welcome and Introductions
- Learning Objectives
- Overview of Enhanced Care Management (ECM) and Community Supports (CS) Services
- Understanding the Referral Pathway
- Guest Speakers
- Wrap Up

Welcome and Housekeeping

- This webinar is being recorded
- Attendance will be tracked via log-in
- Send a message to the host if you cannot hear or see the slides
- After the webinar you will get a link to the PowerPoint and recording
- Participants are automatically MUTED. Please communicate via the chat
- If we are unable to address your questions in today's webinar, we will address your questions in an upcoming forum

Welcome and Introductions

Introductions

Nancy Wongvipat Kalev, MPH, Health Net

Senior Director, Systems of Care

Today's Presenters

Flint Michels, RN, MBA, MHSA
Health Management Associates

Anthony Federico, MA, MPA
Health Management Associates

Our Provider Speakers

Gavin Ward
Director of Strategic Partnerships
24 Hour Home Care

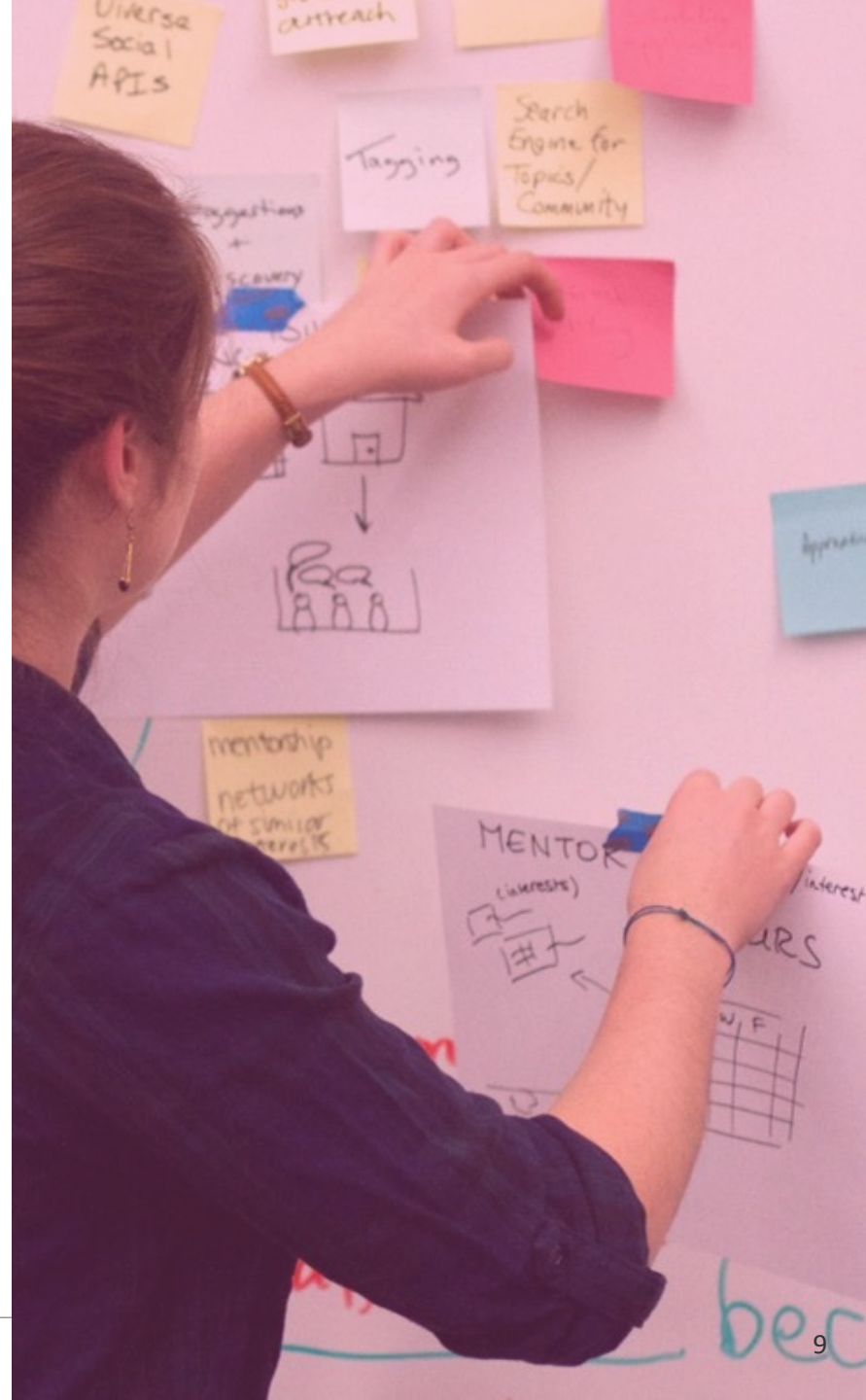
Lena Haroutunian
Program Director
New Sunrise ADHC

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

Learning Objectives

- Articulate the broad set of services available to support members healthy living at home.
- Present the healthy living statistics for living at home.
- Express the referral model for someone needing additional support to maintain save living at home.

Please answer the poll questions so we can get to know you!



“Home is where the heart is…” (J.T. Bickford (Novel: Scandal))

What words or images come to **your** mind when you think of “Home”?

Food
Comfort
Stability
Memories
Routine
Warmth

Can home be an unsafe environment as well?

Familiarity
Family
Ease of use
Safety
Sleep
Healthy living!

The primary care model focuses more on acute needs than long-term healthy living at home.

The CalAIM model is designed to wrap services and supports to maximize a person's well being in community settings.

Vignettes

Even if their health is not perfect, most individuals prefer to be in their own home environment to sleep, eat, and live to their fullest happiness.

Services such as Recuperative Care have been directly linked to positive health outcomes. (Study Link)

Three vignettes will show how providers can identify different member needs and link them to services that enable them to continue living a safe and healthy life at home.

health net

CalViva HEALTH

Community Health Plan OF IMPERIAL VALLEY

Vignette #1: Meet *Julie*

Julie lives alone in an apartment.

She just got discharged from the hospital.

She has to use a crutch now and at least for another month. (Prosthesis timing tbd)

She was referred for Medically Tailored Meals (MTM) due to diabetes and difficulties with meal planning (and her recovery prevents her from shopping and cooking like she used to)

Xavier, MTM provider, delivers first meal to Julie.

Notices the lack of a rail going up the 12 steps to her apartment.

Tremendous risk of fall, injury, and hospitalization.

What does Xavier do?

Call to Action!

Eyes open! Look for risk factors impacted your clients.

Talk to your clients about issues identified and offer support gently.

Offer support via information and resources.

Use FindHelp to refer client for support services!

OR, ask your client if you can have a local agency contact them directly to evaluate their needs.

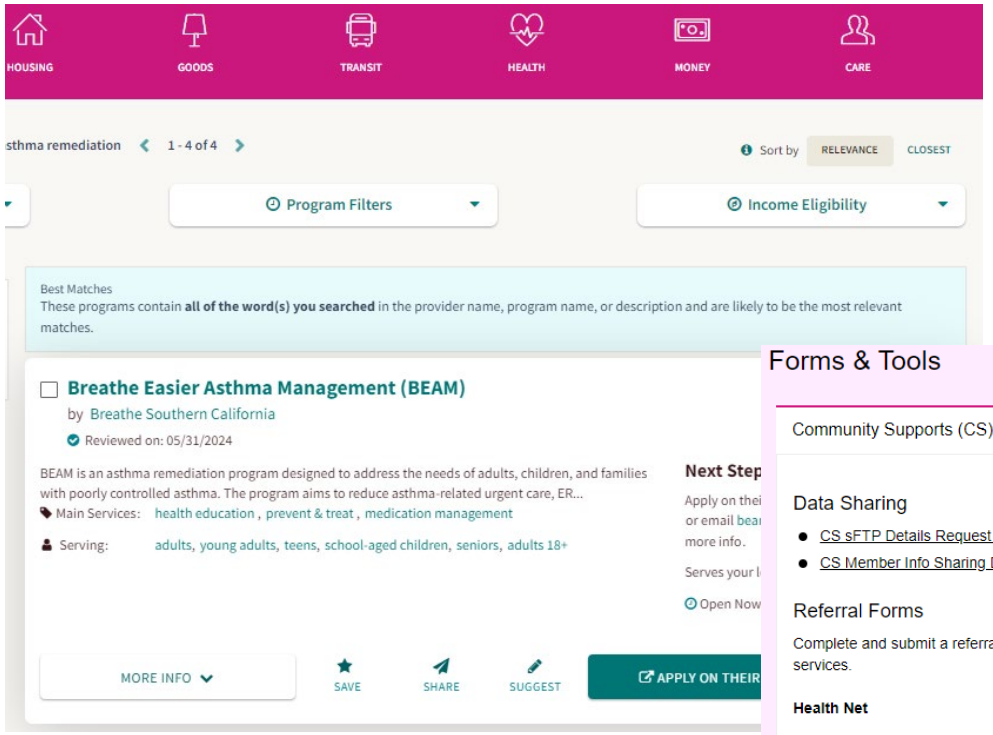
Opportunity to ‘Connect the Dots’

"There is a “no wrong door” approach with the referral process. Health Net accepts referrals from ECM providers, other providers, other entities serving members, family member(s), guardian, caregiver, and/or other support person(s).

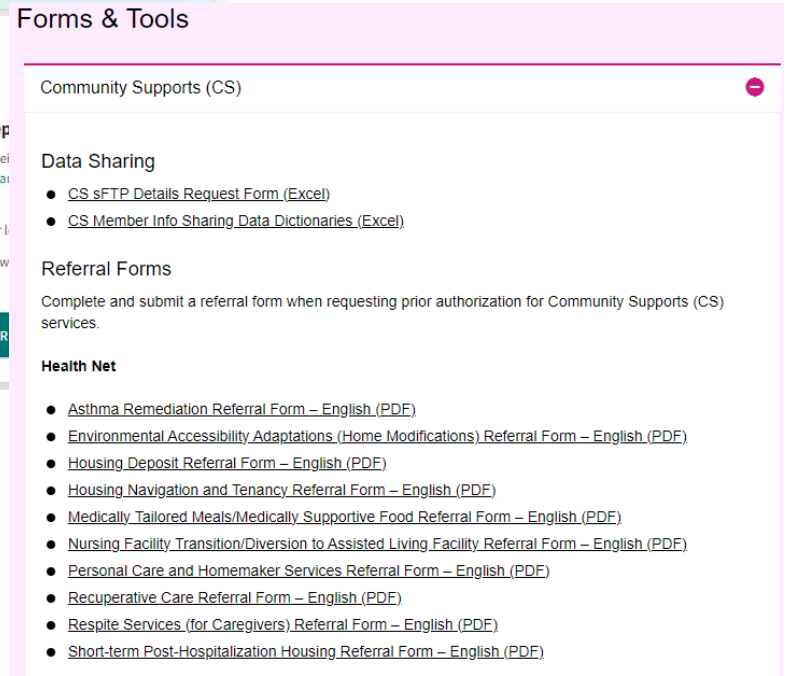
There are several ways a referral can be made to CS providers. Processes for identifying and referring members to CS services electronically, through findhelp, or manually, are contained in the Health Net CS Reference Guide

- https://www.Health Net.com/content/dam/centene/Health Net/pdfs/provider/ca/provider-library/hn-medi-cal-provider-cs-reference-guide.pdf

1 Health Net's findhelp Provider Directory



2 CalAIM Resources for Providers, including CS Reference Guide



3 Referral Form

ASTHMA REMEDIATION REFERRAL FORM

Environmental asthma trigger remediations are physical modifications to a home environment that are necessary to ensure the health, welfare and safety of the individual or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. The services are available in a home that is owned, rented, leased or occupied by the member or their caregiver. For more information, review the Asthma Remediation Authorization Guide.

Complete and submit this referral form with the *Medi-Cal – Prior Authorization Request Form – Outpatient* either online (recommended) at **provider.healthnetcalifornia.com** or by **fax at 800-743-1655**.

☐ Initial request ☐ Extension request
☐ Member consented to asthma remediation referral

Type of Request (check all that apply)	
☐ Allergen-impermeable mattress and pillow dustcovers	☐ Other moisture-controlling interventions
☐ High-efficiency particulate air (HEPA) filtered vacuums	☐ Minor mold removal and remediation services
☐ Integrated Pest Management (IPM) services	☐ Ventilation improvements
☐ De-humidifiers	☐ Asthma-friendly cleaning products and supplies
☐ Air filters	☐ Other interventions identified to be medically appropriate and cost effective

Eligibility Criteria

Individuals with poorly controlled asthma as determined by a licensed health care provider who has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits or other high-cost services, including:

☐ An emergency department visit or hospitalization.
OR
☐ Two sick or urgent care visits in the past 12 months.
OR
☐ A score of 19 or lower on the asthma control test.

Member Information

Member name:		**Date of birth (DOB):**
Medi-Cal ID:	**Phone number:**	**Preferred language:**
Home address:		
Contact name: (if different than member)		**Relationship:**
Phone number:		**Preferred language:**
Member height:		**Member weight:**
Member's diagnosis (*related to asthma remediation need*):		

23-1139/FRM122515OEH02w (9/23)

Additional Connections to Care

Thanks to Xavier, Julie is now receiving MTM, and a handrail is being installed along her staircase.

Julie is getting what she needs to complete her recovery and stay safe and healthy in her home.

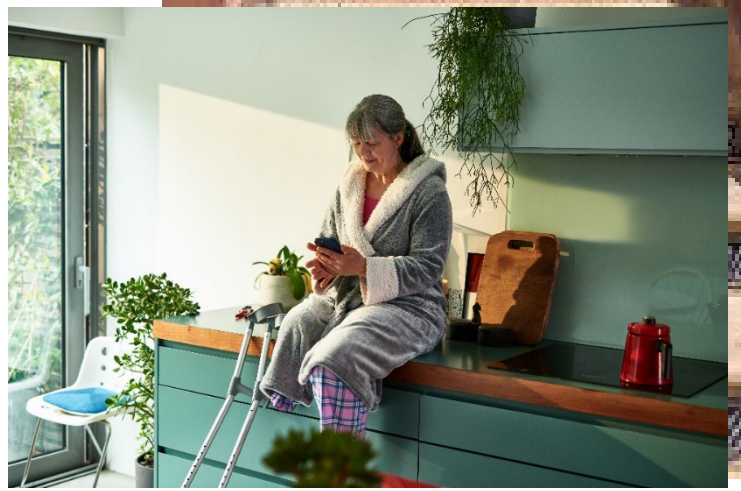
On his next visit, Xavier notices her coughing and wheezing. Julie says she has gone to the ED because of acute asthma episodes in the past.

What can Xavier do?

Makes Julie aware of resources available through Health Net – which in this case, is … ? The Asthma Remediation Community Support!

Xavier makes the referral.

Result: an Asthma Remediation provider reaches out to Julie and provides an air filter and mold remediation. Julie is now healthier and living safely at home.



Vignette #2: Meet *Anthony*

Anthony is experiencing homelessness and receives help from a housing navigator (Theresa) in Health Net's provider network.

She helped him find a suitable apartment, complete an application, and move-in.

They celebrated together!

Anthony's landlord came around without notice to inspect the apartment and said that his neighbors objected to Anthony playing his guitar loudly. The conflict escalated and the two began shouting.

This conflict is putting Anthony's housing at risk.

Anthony calls Theresa, exasperated.

What can Theresa do?

Opportunity for Linkages to Additional Care

Once again…

- Provider notices client needs in other domains of health and social care
- Engages clients (respecting privacy and not making assumptions) to see if needs are being addressed
- Makes the individual aware of resources available through Health Net
- Works with Health Net, Findhelp, and other resources (i.e., ECM if enrolled) to determine eligibility, make a referral, and provide access to care.
- Housing is at risk – he could return to homelessness
- "Can you share more about what happened? I want to see you keep this apartment."
- "I know a program that could talk to you and the landlord to resolve this. Can I see if you're eligible?"
- Identifies Housing Stabilization provider and makes warm handoff – begins engaging with member and landlord.
- *Result: Anthony and the landlord commit to respecting the lease: the landlord will give advance notice when inspecting the apartment, and Anthony won't play music after 8pm.*
- *Thanks to Housing Stabilization, the conflict is resolved. Anthony is no longer at risk of losing his housing.*

More Needs Emerge

Anthony remains housed, thanks to Theresa coordinating care and being proactive.

However, Anthony's chronic conditions worsen, and he struggles to bathe, dress, and prepare meals independently.

He has a pending application for IHSS (homecare support), but in the meantime he has no help.

What can Theresa do?

Opportunity for Linkages to Additional Care

- Anthony is feeling less independent; wants to avoid institutional care
- Educate about the Personal Care and Homemaker Services (PCHS) Community Support
- “While your IHSS application is pending, there is a program that may be able to help you in the meantime, here in your home.”
- Initiates a referral
- *Anthony gets home-based PCHS services for his ADL needs*
- *Result: Anthony gets the support he needs to continue living safely and happily in his home*

Vignette #3: Meet *Quinn*

Quinn lives in an apartment. She has complex, acute medical needs, and uses feeding tubes and a wheelchair.

She is supported by her sister, Ray, who lives nearby and visits three times per day to provide companionship and support Quinn's ADLs and IADLs.

Ray is exhausted from these caregiver responsibilities. Plus, she has an upcoming medical procedure and will need one week of dedicated recovery.

Caregiver burnout is a serious problem. The situation is not sustainable, and Quinn's ongoing care at risk.

What supports are available for Quinn and Ray?

The **Respite Services** Community Support provides a caregiver with temporarily relief.

A provider is located using findhelp; Health Net referral form is submitted.

Result: A Respite Services provider supports Quinn for the week that Ray is recovering, and for one hour per day thereafter, relieving Ray and creating a sustainable caregiver schedule.

Quinn: More Needs Emerge

Quinn's condition worsens, and she needs assistance with injections and catheter care. Ray is unable to provide this support.

Quinn may have to move to a Skilled Nursing Facility, but she would prefer a more independent/less institutional environment, if there is one that can meet her needs.

Ray and Quinn have heard of Assisted Living Facilities and there are several nearby, but want information about what they are and how to access them.

What is the **Nursing Facility Transition/Diversion to Assisted Living Facilities** Community Support?

When a member meets the nursing home level of care prevents them from continuing to live independently, Assisted Living may be a desirable alternative.

This Community Support assists members in locating, applying for, and moving into an Assisted Living Facility as a more independent and cost-effective alternative to institutional care.

A provider is located using findhelp; Health Net referral form is submitted.

Result: Quinn moves into a nearby Adult Residential Facility, stays out of institutional care, and sees Ray and other family frequently.

Vignette #4: Meet *Rosa*

Rosa was also referred for Medically Tailored Meals (MTM) due to diabetes and difficulties with meal planning.

Xavier, her MTM provider, notices Rosa struggling with a **lot** of healthcare issues. He informs his supervisor.

The data file from Health Net does NOT show Rosa working with an ECM provider.

The MTM provider contacts Health Net to make a referral for ECM.

Result: Rosa receives a comprehensive assessment and other services to support her needs and is able to maintain a healthier lifestyle, albeit with ups and downs in her overall health.

ECM Populations of Focus (PoFs) – Complex, right?

ECM Populations of Focus (PoFs)	Adults	Children
Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	●	
Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	●	●
Individuals At Risk for Avoidable Hospital or ED Utilization *(Formerly "High Utilizers")*	●	●
Individuals with Serious Mental Health and/or SUD Needs	●	●
Individuals Transitioning from Incarceration	●	●
Adults Living in the Community and At Risk for LTC Institutionalization	●	
Adult Nursing Facility Residents Transitioning to the Community	●	
Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		●
Children and Youth Involved in Child Welfare		●
Birth Equity Population of Focus	●	●

Provider Spotlight and Dialogue

Gavin Ward
Director of Strategic Partnerships
24 Hour Home Care

Lena Haroutunian
Program Director
New Sunrise ADHC

Discussion Questions

- How do you envision using the new CS's to meet the holistic needs of the individuals and families you are serving?
- How do you identify the need of individuals you serve that are outside of your scope (e.g., asthma, behavioral health needs)?
- You also make referrals to other CS providers. How have you built and managed those relationships?
- Many providers and case managers (including ECMs and CHWs) are coordinating care and making referrals to CalAIM Community Supports. What do you want them to know about working with your organizations?

Questions?

if time allows

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	✓

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.

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