HWS HOUSING AND WORKFORCE SOLUTIONS

ENGAGE. ENCOURAGE. EQUIP.

"Chronic Conditions"

Multidisciplinary Approaches to End Homelessness

A Continuum of Care Division Webinar Series

Please sign in by typing your full name, title, and organization into the webinar chat box.

About the Webinar Series

Purpose

These webinars provide an opportunity to engage with local and regional experts on best practices, advocacy tools and resources available to prevent and end homelessness in Riverside County.

Recorded Webinars

After the live webinar has taken place, the recording will be added to our website.

Upcoming Webinars

We are working on securing speakers for future webinars and would love to feature you or your agency.

Email CoC@rivco.org if interested.

Please sign in by typing your full name, title, and organization into the webinar chat box.

Agenda for Today

10:00 - 10:05 AM	Welcome	HWS – Continuum of Care Staff: Emma Perez-Singh, Administrative Services Manager
10:05 – 10:30 AM	IEHP	Ben Jauregui, Manager, Behavioral Health & Care Management Support Services
10:30 – 10:55 AM	Molina Healthcare of CA	Nadine Khan, Program Director - Enhanced Care Management (ECM)
10:55 – 11:00 AM	Q&A: Please type your questions in the chat box. We will answer as many questions as possible at the end of the webinar.	

Please sign in by typing your full name, title, and organization into the webinar chat box.

“Could a greater miracle take place
than for us to look through each other’s eyes
for an instant?”

Services for People with Chronic Conditions

Ben Jauregui, MPA, CCM
Manager, BH&CM Support Services

Inland Empire Health Plan

Riverside and San Bernardino County created Inland Empire Health Plan in 1996 as a Public Entity to provide Medi-Cal benefits, programs, and services in the Inland Empire.

IEHP Governing Board is comprised of 4 County Board of Supervisors and 3 appointed members of the public.

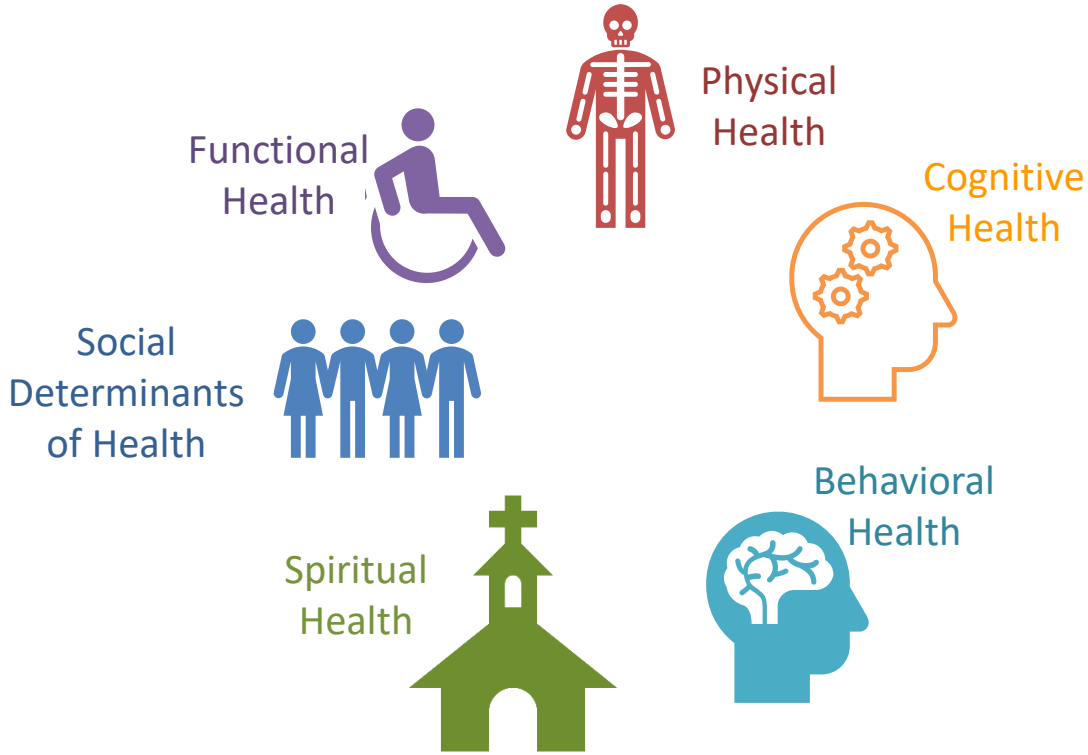
Membership =

Medi-Cal Members = 1,500,000

Medi-Cal-Medicare = 31,000

Behavioral Health & Care Management

The goal of the IEHP BH&CM department is to improve the coordination and management of medical, behavioral, and social services.



BH&CM Services

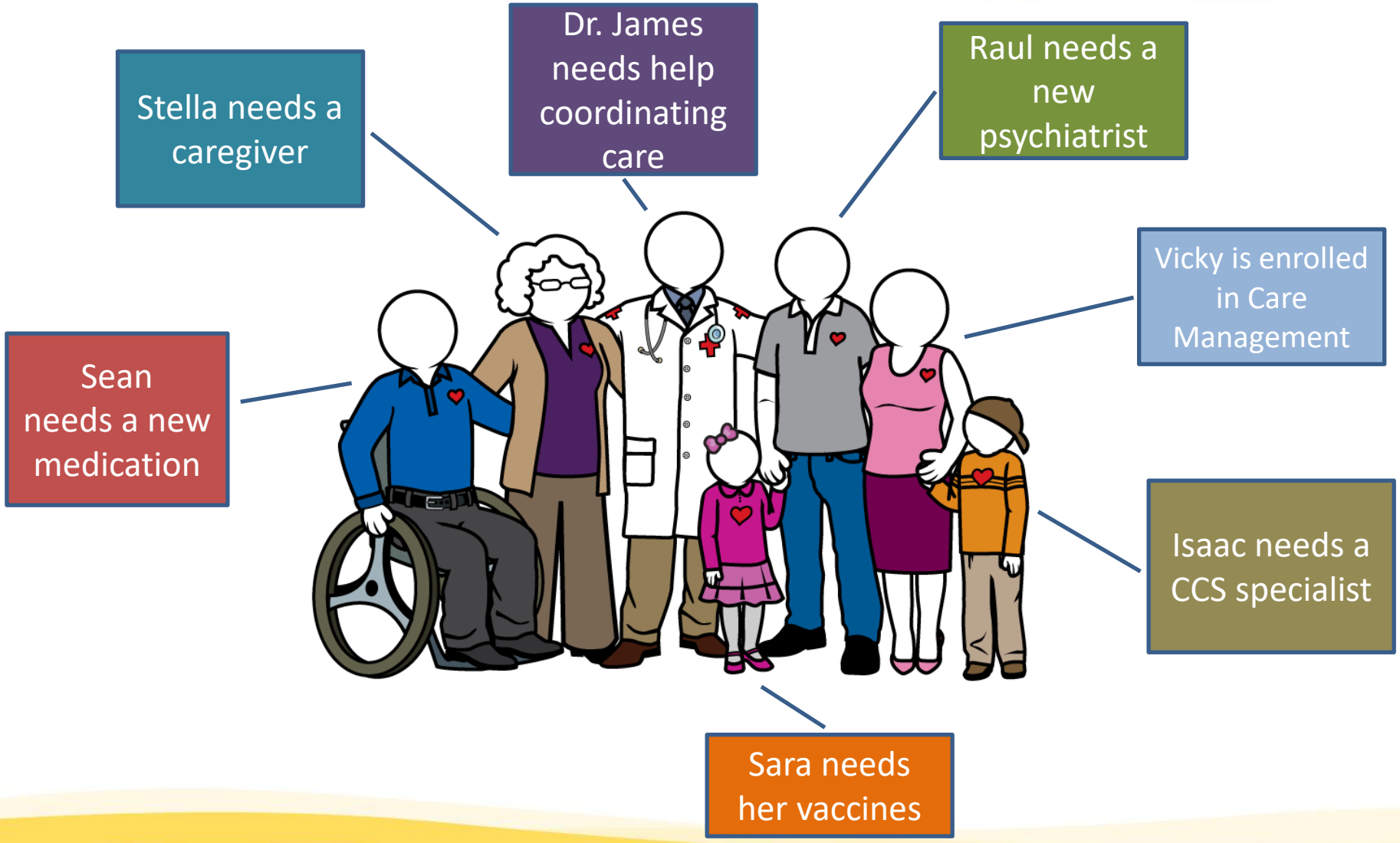
Programs, Services, and Interventions

- Care Management
- Behavioral Health Care Management
- Crisis Call Triage and Intervention
- BH Utilization
  - Inpatient, outpatient, intensive outpatient, partial hospitalization, SNF, ECT, Detox, Eating Disorder admissions
- Health Risk Assessment/Health Information Form
- Interdisciplinary Care Case Conferences
- BH Hospital Triage and Transition of Care
- Community Supports – see next slide
- Long-Term Services and Supports
- Coordination for Pain Management, Eating Disorders, or Behavioral Health Treatment.

New Community Supports

- Support Services
  - Housing Transition and Navigation Services – help finding a place to live
  - Housing Tenancy and Sustaining Services – case management
  - Housing Deposits – does not pay rent
  - Recuperative Care
  - Post-Hospitalization Housing,
  - Nursing Facility Transitions/Diversions to RCFE/ARF
  - Community Transitions to independent living
  - Sobering Centers
  - Environmental Accessibility Adaptation –minor home modifications
  - Asthma Remediation

Programs and Services



How do we coordinate care?

We can help coordinate services or enroll those Member's that meet criteria into a Care Management program that includes the following:

- Care Coordination includes:
  - help with navigating health and social services
  - accessing services, products, or procedures.
- Care Management includes:
  - intake, assessment, care planning, and interventions until goal is met.
  - outreach calls annually, semi annually, quarterly, monthly, or as needed.
  - Educating Members on disease process so they can manage it better.

  Members need to meet criteria, i.e., chronic condition that need needs coordinated interventions.

Chronic Care Pilot Programs

Congestive Heart Failure Pilot:

100 Members with heart failure identified to participate in a 6-month pilot program to improve their health and well-being.

Program components:

- Medically tailored meals for 3 months (3/day)
- Registered Dietician coaching
- New weight scale
- Frequent outreach from IEHP Care Managers
- All Members screened for Food Insecurity and helped with resources
- Delivered 25,000 meals, 1,300 coolers, 1,200 Safety Checks, 75 Nutritional Counseling Sessions, delivered over 700 Produce & Pantry boxes.

Chronic Care Pilot Programs

Homebound Pilot

Program Interventions:

- Care Coordination Outreach: **(Every two weeks)**
- NCM assistance as needed **(NCM Leads assisting with immediate Member needs)**
- Complete Homebound Program Assessment upon enrollment into program
- Assist with overall Care Coordination needs.
- Complete Care-Taker burnout screening
- Food insecurity Screening **(Every six months)**
- Birthday Greeting announcement

Chronic Care Pilot Programs

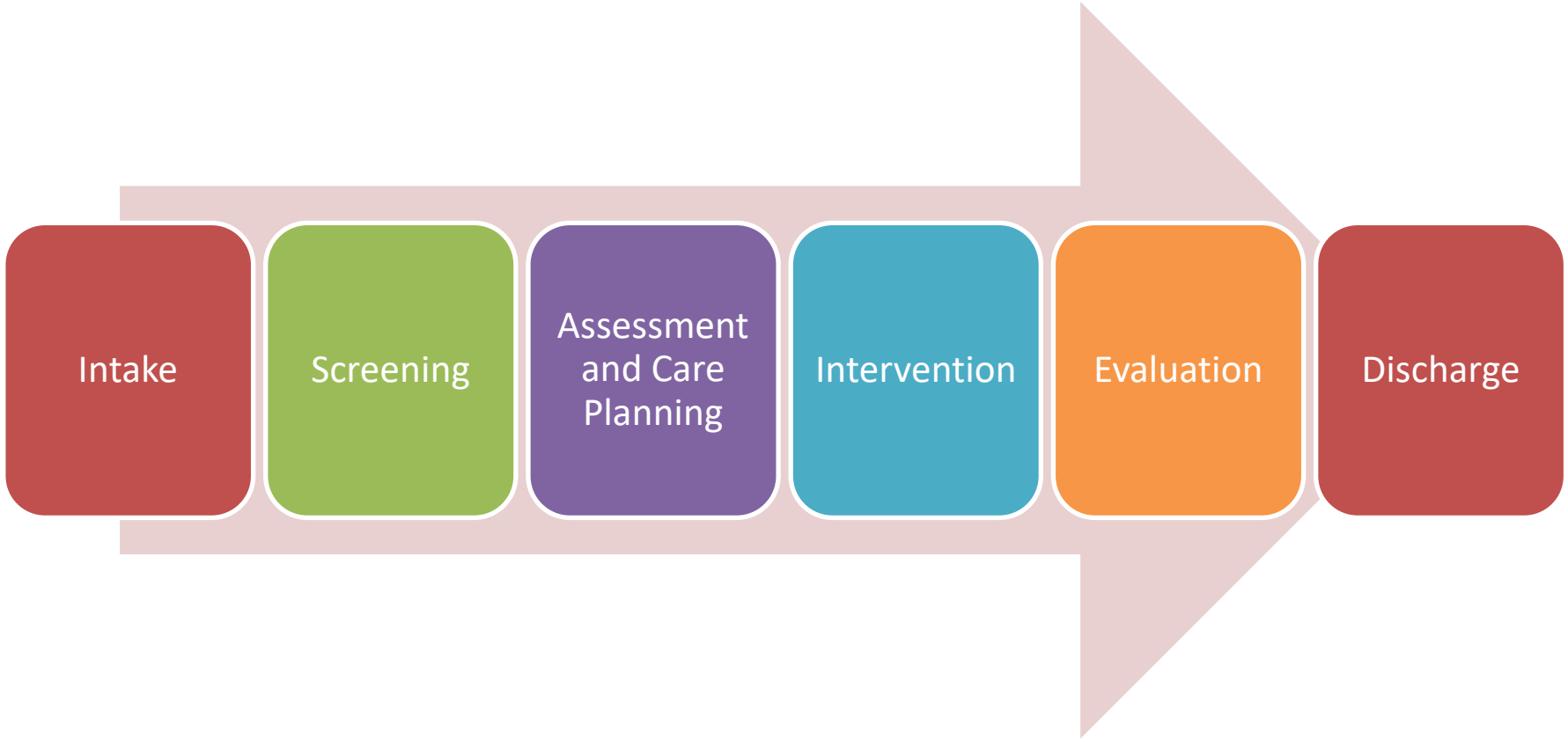
End-Stage Renal Disease:

- Total of 70 Active Members, goal is 75 active members.
- Members engaged are being assessed for their understanding of and educated on ESRD Disease Process.
- ESRD Education Flyer & Vital Sign Monitoring logs mailed to Members.
- All Members screened for Food Insecurity and helped with resources
- Frequent outreach from IEHP Care Managers
- Coordination with dialysis centers

Multidisciplinary Team

- Member
- Member’s caregiver/designee
- Care Coordinators
- Community and Housing Navigators
- Community Health Workers
- Behavioral Health Specialists
- Care Managers
  - Licensed Vocational Nurse
  - Registered Nurse
  - Master of Social Work
  - Licensed Marriage and Family Therapist
  - Licensed Clinical Social Workers

Care Management Process



Coordination with External Partners

- Providers, Specialty Providers and IPAs
- Inland Regional Center (IRC)
- State Contracted Medi-Cal Waiver Agencies
- County Departments
  - Homeless Services, Housing Authority
  - Behavioral Health
    - Mental Health Services
    - Substance Abuse Services
  - Aging and Adult Services
    - Multipurpose Senior Services Program (MSSP)
    - In-Home Supportive Services (IHSS)
  - Children and Family Services
  - Public Health
    - California Children's Services (CCS)
    - Targeted Case Management

Behavioral Health & Care Management

Questions
or Comments?

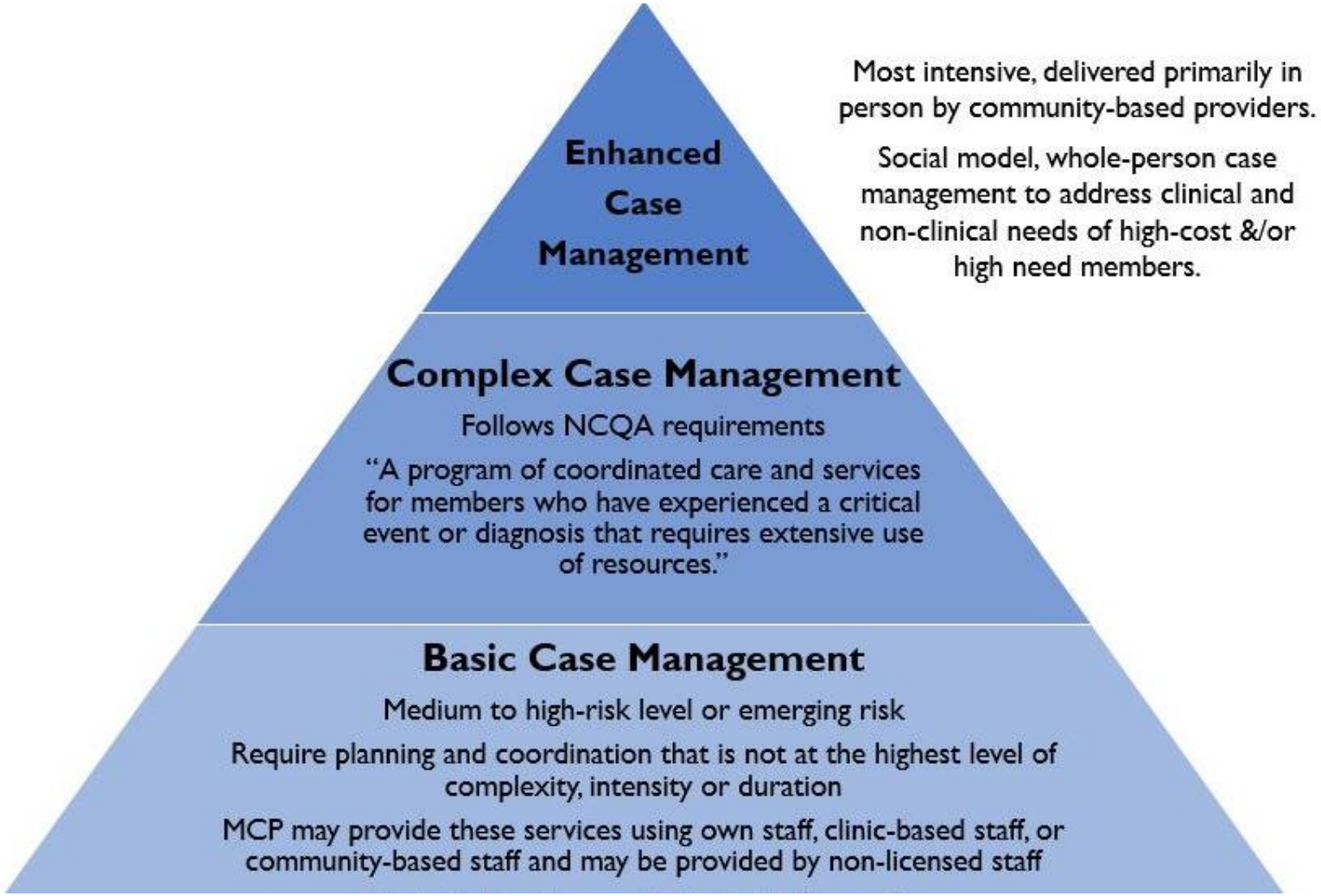
Enhanced Care Management & Community Supports Benefits for Homelessness

MOLINA HEALTHCARE

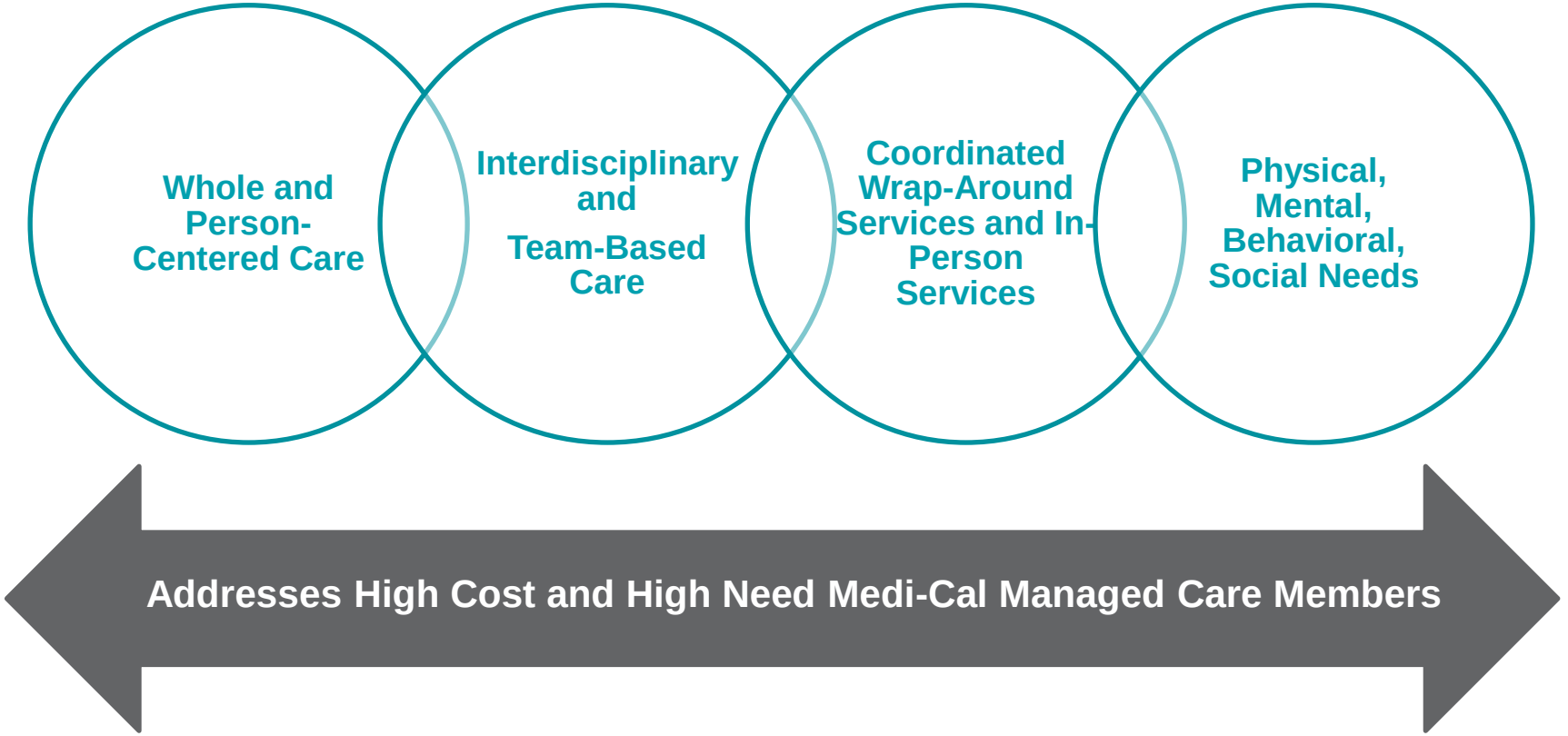
What is ECM?

A statewide enhanced care management (ECM) benefit that provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. The ECM benefit builds on the current Health Homes (HH) Program and Whole Person Care (WPC) Pilots.

Care Management Model
DHCS Proposal



Enhanced Care Management Framework Review



ECM Eligibility and Exclusions

1915 c Waivers	Services Carved Out of Managed Care Plans	Services Carved into Managed Care Plans	Duals	Other
Multipurpose Senior Services Program (MSSP)	California Children's Services (CCS)	CCS Whole Child Model	Dual Eligible Special Needs Plans (D-SNPs) [from 2023]	AIDS Healthcare Foundation Plans
Assisted Living Waiver (ALW)	Genetically Handicapped Person's Program (GHPP)	Basic Case Management	D-SNP look-alike plans	California Community Transitions (CCT) Money Follows the Person (MFTP)
Home and Community-Based Alternatives (HCBA) Waiver	County-based Targeted Case Management (TCM)	Complex Case Management	Other Medicare Advantage Plans	Mosaic Family Services
HIV/AIDS Waiver	Specialty Mental Health (SMHS) TCM	Community-Based Adult Services (CBAS)	Medicare FFS	Hospice
HCBS Waiver for Individuals with Developmental Disabilities (DD)	SMHS Intensive Care Coordination for children (ICC)		Cal MediConnect	
Self-Determination Program for Individuals with I/DD	Drug Medi-Cal Organized Delivery Systems (DMC-ODS)		Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)	
			Program for All-Inclusive Care for the Elderly (PACE)	

Per DHCS, Members will not be able to obtain both Health Plan Case Management and ECM services as that is considered duplicative

1. ECM as a "wrap"	MCP Members can be enrolled in both ECM and the other program. ECM enhances and/or coordinates across the case/care management available in the other program. MCP must ensure non-duplication of services between ECM and the other program.
2. Either ECM or the other program	MCP Members can be enrolled in ECM or in the other program, not in both at the same time.
3. Excluded from ECM	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM.

ECM Populations of Focus

Jan 1, 2022

1. Individuals experiencing homelessness
2. High utilizers with frequent hospital or ER visits/admissions
3. Individuals with Serious Mental Illness (SMI) or substance use disorder (SUD) and other health needs
4. Individuals transitioning from incarceration (Riverside ONLY)

Additional POFs including children or youth will go live starting in Jan 2023

Homelessness

Individuals **Experiencing Homelessness** AND

- has a **complex condition** with **inability to successfully self-manage**
- for whom **coordination of services** would likely result in improved health outcomes
- AND/OR **decreased utilization** of high-cost services

Definition of *Homelessness*

DHCS defines homelessness as one of the following. An Individual or family:

- who lacks adequate nighttime residence
- with a primary residence that is a public or private place not designed for or ordinarily used for habitation
- living in a shelter
- exiting an institution to homelessness
- who will imminently lose housing in next 30 days
- Unaccompanied youth and homeless families and children and youth defined as homeless under other Federal statutes
- Victims fleeing domestic violence

Transitioning from Incarceration (Riverside 1/1/2022)

Youth & Adults Transitioning from Incarceration AND

- **Have at least one of the following conditions**
  1. Chronic mental illness (SMI)
  2. Substance Use Disorder (SUD)
  3. Chronic disease (e.g., hepatitis C, diabetes)
  4. Intellectual or developmental disability
  5. Traumatic brain injury
  6. HIV/AIDS
  7. Pregnancy

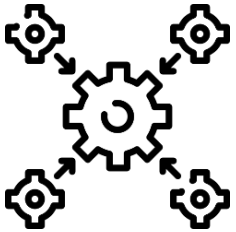
Grandfathering Existing HHP and WPC Members

Ensure Continuity

- Members enrolled in HHP and WPC as of 12/31/21 are automatically enrolled in ECM on 1/1/2022
  - Including those in process of enrolling on 12/31/21
- These “Grandfathered” members are not required to meet the ECM Four Populations of Focus
- Members received a notification letter in December
- Grandfathered members are re-assessed in 6 months for continued enrollment in ECM

Community Supports (CS)

Purpose and Administration of Community Supports



Medi-Cal managed care plans will have the option to integrate Community Supports into their population health management plans – often in combination with the new enhanced care management benefit

Community Supports would be focused on addressing combined medical and social determinants of health needs and avoiding higher levels of care or other future health care costs

Community Supports must be cost effective. For example, Community Supports might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays and emergency department use

MOLINA HEALTHCARE

DHCS MENU OF OPTIONS

THE 14 COMMUNITY SUPPORTS

MOLINA HEALTHCARE

MOLINA'S COMMUNITY SUPPORTS

	Riverside	San Bernardino
Housing Transition Navigation Services	X	X
Housing Deposits	X	X
Housing Tenancy and Sustaining Services	X	X
Recuperative Care (Medical Respite)	X	X
Community Transition Services/Nursing Facility Transition to a Home	X	X
Personal Care and Homemaker Services	X	X
Medically Tailored Meals	X	X
Sobering Centers	X	
Asthma Remediation	X	X

CS Eligibility Criteria

Medi-Cal only and Partial Dual Members (Medicare Part B and/or D)

Completed referrals must be submitted to the CA HCS Community Supports/LTSS team for review

CS services require authorization (except Sobering Centers)

Each CS has specific qualifying criteria in order for members to be approved for the service. The request will be reviewed and decisioned by the HCS Community Supports team.

Duplication of services are not permitted – the member cannot be receiving these services through another avenue, such as a state or county funded program.

Housing Transition Navigation Services

Assists with obtaining stable housing for members experiencing homelessness.

Interventions include:

- Tenant screening and housing assessment
- Individualized housing support plan
- Assistance with housing search/application completion
- Coordination with landlords
- Benefits advocacy
- Securing housing resources for subsided rent and housing expenses
- Coordination with landlords
- Ensuring living environment is safe and ready for move-in
- Assistance with arranging for and supporting details of the move

Housing Tenancy and Sustaining Services

Assists with maintaining safe and stable tenancy for members who were previously experiencing homelessness and newly housed.

- Services provided in-person/telephone/video
- Interventions include:
  - Early identification and behavioral interventions to support stable housing including
    - Financial literacy and timely rental payment
    - Maintaining successful relationships with landlord (e.g. landlord disputes, etc.)
- Education on rights and responsibilities of tenant and landlord
- Linkage to community resources to prevent eviction
- Assists with annual housing recertification process
- Continuing assistance with lease compliance
- Health and safety visits, including unit habitability inspections
- Review and update member's housing support and crisis plan

Only available for a single duration in the member's lifetime

- **Services may be approved one additional time with documentation supporting change of conditions**

Housing Deposits

Assist members experiencing homelessness with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board such as providing security deposits.

Criteria is as follows:

Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or members who meet the Housing and Urban Development (HUD) definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder

Services and resources are maxed at a total lifetime maximum amount of $5,000

- **Services may be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt.**

Community Transition Services/ Nursing Facility Transition to a Home

Helps members who have been living in a skilled nursing facility to live in the community and avoid further institutionalization by supporting members with becoming newly housed and covering nonrecurring setup expenses.

Criteria is as follows:

- Is currently receiving medically necessary nursing facility level of care (LOC) services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and
- Has lived 60+ days in a nursing home and/or Medical Respite setting; and
- Is interested in moving back to the community; and
- Is able to reside safely in the community with appropriate and cost-effective supports and services.

Services and resources are maxed at a total lifetime maximum amount of $7,500

  - Services may be approved one additional time if the Member is compelled to move from a Provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.

Sobering Centers
Riverside Only

Sobering Centers are alternative destinations for members who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail.

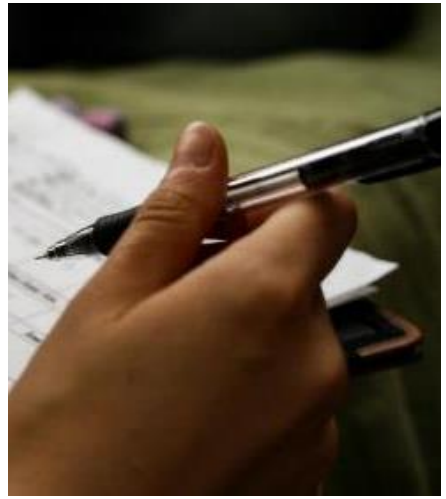
Criteria is as follows:

Individuals aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

How to Refer a Member

- **CS Referrals**
  - Submit referral form to MHC_CS@molinahealthcare.com
  - IE Molina HN members – Health Net's contact center

- **ECM Referrals**
  - Submit referral form to MHC_ECM@Molinahealthcare.com
  - IE Molina HN members – Health Net's contact center



Q&A

Thank you!

Questions and Comments

Next Webinar: Case Management
March 17, 2022