Road to Home

Long Term Care at Home
Community Based and Service Provider Convening

Presented by

Health Plan of San Joaquin

Health Net®

Welcome and Acknowledgements

Michael Schrader, Chief Executive Officer

Health Plan of San Joaquin

Purpose of Today

Lizeth Granados, Chief Operations Officer

Health Plan of San Joaquin

Agenda

HPSJ and HealthNet Overview (25 mins)

Dr. Ramiro Zuniga, CMO- HealthNet
Dr. Lakshmi Dhanvanthari, CMO-HPSJ

Introduction of Community Resources (70 mins)

Jason West- Central Valley PACE
Jenna Silva- Star Nursing Inc.
Yanine Arias- Libertana
Sima Semmel- Libertana **(TBC)**
Renee Smith- SJC HCS
Stephanie Naverette- Stanislaus County
Lenore Gotelli- Active Live Adult Day Health Care Center
Sandra Maple- Gospel Center Rescue Mission
Greg Diederich, Agency Director-
San Joaquin County Health Care Services
Alissa Bettis, Assistant Director of Quality and Planning
Ruben Imperial, Director- Behavioral Health Services
Stanislaus County Health Services Agency and Behavioral Health Services

Questions and Remarks

Closing (15 mins)

Lizeth Granados
Michael Schrader
Follow up on any actions (Next Steps)
Recognize and thank participants
Final comments

Overview: HealthNet

Ramiro Zuniga, MD

Vice President, Medical Director, Medi-Cal

Health Net, LLC and California Health & Wellness

Health Net®

Medi-Cal Program

No Cost and Low-Cost Coverage

Coverage for every stage of life™

Medi-Cal Benefits

The following is a summary of the services covered under Medi-Cal. Not all benefits are covered by health plans but may be accessed through Medi-Cal fee-for-service.

- Physician Services (primary and specialty care)
- Hospital Services (inpatient and outpatient)
- Prescribed Medicines
- Laboratory and X-ray Services
- Maternity Care
- Newborn Care
- Family Planning Services
- 24-hour Emergency Services
- Durable Medical Equipment (e.g., crutches, wheelchairs)
- Optometry
- Podiatry
- Audiology
- Medical and non-medical transportation
- Physical, Occupational and Speech Therapy
- Prosthetic Devices (artificial limbs and braces)
- Home Health Care Services
- Skilled Nursing Facility Care
- Blood and Blood Plasma
- Preventive Care (e.g., immunizations and routine health screening, and special programs, such as smoking cessation and wellness programs)
- Dental Services
- Mental Health Services
- In-Home Supportive Services
- Palliative Care
- Waiver Care Services (subject to eligibility)

Medi-Cal Managed Care Carve-outs and Exclusions

- **Carve-outs:** Specific services that the DHCS has excluded from the Medi-Cal managed care organization's capitated rate. "Carve-out" services are typically provided within the Medi-Cal benefit package but delivered exclusively by a designated provider or group through fee-for-service Medi-Cal. To administer a carve-out, separate utilization review and pre-certification entities are involved as well as different payers and providers.
- **Exclusions:** Services excluded from the Medi-Cal benefit package; not a reimbursable Medi-Cal benefit.

Carve-Out Services

- Long-Term Care (unless in a CCI county)
- California Children's Services (CCS)
- Regional Center Services
- Child Health & Disability Prevention
- Women, Infants, Children Program
- Pediatric Day Health Care
- Major Organ Transplants (except kidney)
- Special services for American Indians
- Targeted Case Management
- Substance Use Disorder Services
- Severe Mental Illness Services

Exclusions

- Routine Circumcisions
- Services to reverse surgically-induced infertility
- Personal comfort/convenience items
- Mental Health services for relationships
- Custodial Care
- Experimental and investigational services
- Infertility
- Optical lenses and frames for members +21

California Medi-Cal Waiver Programs

- Medi-Cal waivers are programs that provide additional services to specific groups of individuals, limit services to specific geographic areas of the state, and provide medical coverage to individuals who may not otherwise be eligible under traditional Medicaid rules.

- The Department of Health Care Services (DHCS) has a number of Medi-Cal waiver programs that provide home and community-based services, family planning services, specialty mental health services, and managed care to specific groups of eligible individuals.

- Participation in any waiver, requires the establishment of Medi-Cal eligibility.

Current Medi-Cal Waiver Programs;

- 1115(a) Waiver – Medi-Cal 2020 Demonstration
- 1093(i) 4 Superior Systems Waiver (SSW)
- 1903(w)(3)(B) and (C) MCO Tax
- 1903(w)(3)(B) and (C) Hospital Quality Assurance Fee Program (HGAF) Phase IV
- 1903(w)(3)(B) and (C) Freestanding Skilled Nursing Facility Quality Assurance Fee Program (SNF QAF) 2019 – 20
- 1915(b) Medi-Cal Specialty Mental Health Services Waiver
- 1915(c) Home and Community-Vases Services (HCBS) Waivers

Health Net Programs

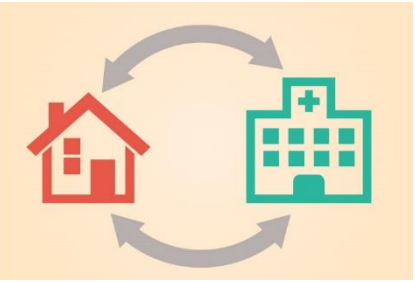
Health Net Medi-Cal members have access to these programs and services at no cost

Telehealth	Behavioral Health	Health Education	Disease Management	Weight Control	Smoking Cessation	Pregnancy Education	Mental Health	Social Media
babylon	MHN						myStrength	T2X
▪ Symptom Checker ▪ Chat Bot ▪ Live Chat ▪ Virtual Visits	Mental health services and substance use disorder treatment	▪ Health education materials ▪ Health education classes	Be in Charge! disease management program	Fit Families for Life – Be in Charge! weight control program	California Smokers' Helpline	Pregnancy Matters! pregnancy education and support program	myStrength Program – Online tool to improve mental health	T2X – Social media website for teens and adults

Community Transitions

Health Net works collaboratively with Acute & SNF partners to safely and appropriately transitions members to a lower level of care or community setting.

- **Community Based Adult Services**
- **Meal Delivery Programs**
- **Project Roomkey/Homeless Services**
- **Lead Organization/CCT**
- **Home Modifications**
- **IHSS and Respite Support**



Acute Hospital to Community

- ❑ If Medical Groups/PPG is delegated, they will take the lead on transitions
- ❑ If additional support is needed, please reach out to Health Net Utilization Management nurses for assistance
- ❑ Out of area transitions on occasion

SNF to Community

- ❑ If Medical Groups/PPG is delegated, they will take the lead on transitions
- ❑ Contact the Health Net Concurrent Review nurse for assistance
- ❑ Provide updated copy of MDS and Social Service Assessments

Health Net Provider Network by County

County	Medi-Cal	CommunityCare
Fresno	• 1,302 doctors • 7 hospitals, • 88 medical groups	
Kings	• 217 doctors • 1 hospital (Adventist Medical Center- Hanford) • 26 medical groups	
Madera	• 509 doctors • 2 hospitals (Madera Community & Valley Children's) • 15 medical groups	
Tulare	• 484 doctors • 2 hospitals (Kaweah Delta District & Sierra View District) • 72 medical groups	
Kern	• 592 doctors • 10 hospitals, • 60 medical groups	• 518 doctors • 5 hospitals • 20 medical groups
San Joaquin	• 517 doctors • 6 hospitals • 32 medical groups	
Stanislaus	• 585 doctors • 5 hospitals • 58 medical groups	

Provider Search Tip

To find Medi-Cal providers on the Health Net provider directory (website), filter by type of Plan/Network

Go to **State Health Plan** section and select **Medi-Cal**

*data as of 6/23/2020

Telehealth Services During the COVID 19 Crisis and Beyond

Envolve Nurse Advice Line	Babylon*	myStrength	Aunt Bertha	ConferMed* eConsults
• Health Net Medi-Cal • CalViva Health	• Health Net Medi-Cal • CalViva Health	• Health Net Medi-Cal • CalViva Health	• Health Net Medi-Cal • CalViva Health	• Health Net Medi-Cal (FFS) • CalViva Health (FFS)

- **24/7 Nurse Advise Line**
- **Babylon -** remote consultations with medical and behavioral health doctors and health care professionals via a secure, HIPAA-compliant video-conferencing platform within its Apple/Android mobile application. Offers an Artificial Intelligence driven, symptom-checker feature that includes a Chatbot interface to assess health care concerns, provide health information and directions to appropriate care.
- **myStrength:** Mobile and web-based self-help resources, empowering members to be active participants in becoming healthy, both mentally and physically
- **Aunt Bertha:** Find free and reduced cost social services, access via Health Net website
- **ConferMed:** provider-facing service, specialty electronic consultations

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Managed Care Plan - Contact Information

Health Net

Member Service and Provider Service:

Phone: (800) 675-6110

Public Programs/LTSS:

Phone: (800) 526-1898
Fax: (866) 922-0783
Email: help_referral@healthnet.com

Website: www.healthnet.com.

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Thank you!

Overview:
Health Plan of San Joaquin

Lakshmi Dhanvanthari, MD

Chief Medical Officer

Health Plan of San Joaquin

Health Plan of San Joaquin

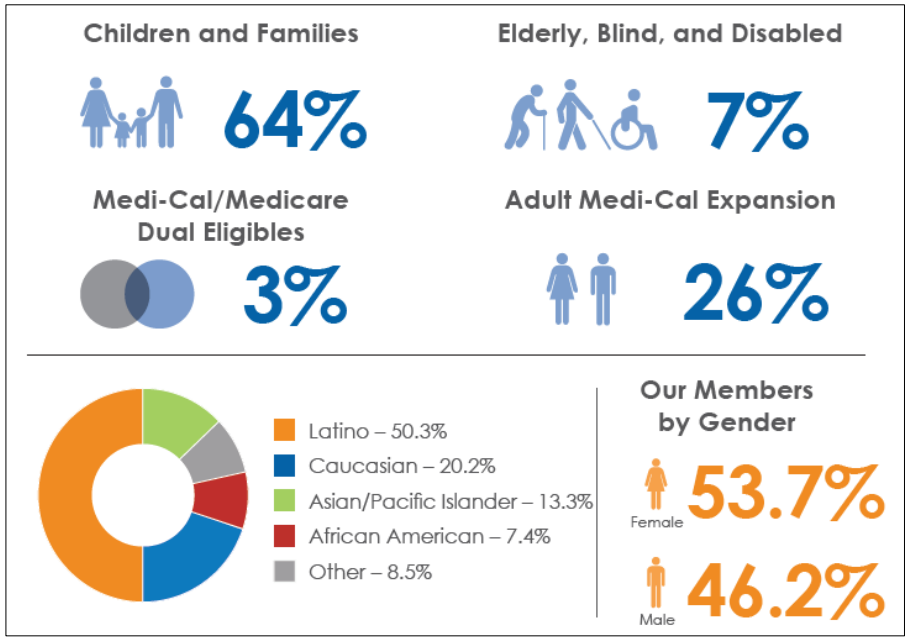
Road to Home:
Home and Community Transitions

September 10, 2020

The Communities We Serve – Our Membership by Population

Health Plan of San Joaquin serves almost 347,000 members.

- 212,736 in San Joaquin County
- 134,058 in Stanislaus County



For more than 20 years, Health Plan of San Joaquin has continued to work on behalf of low-income children, their families, and the most vulnerable citizens of our community.
Many of them have families from the communities being affected by today's events and pandemic.

At HPSJ, we live by our values that drive each of us every day: ***Accountability***; ***Dedication***; ***Integrity***; ***Stewardship***; ***Teamwork***; *and* ***Diversity***, "*Respect(ing) the uniqueness of individuals, their ideas, thoughts, and needs*."

Our values make up the spirit that sustains our mission to "*provide healthcare value and advance wellness through community partnerships*."

Care Transitions from Acute Care and other Inpatient Facilities

HPSJ's Medical Management team collaborates proactively with the case management teams of the facilities.

- HPSJ's concurrent review nurses and the transition of care team of health navigators and nurses work with the hospital case managers from the time of admission.
- The hospital CM's begin discharge planning upon admission and they work collaboratively with the health navigators and the concurrent review nurses to obtain all the required services, medications and DME upon discharge.
- Dedicated CCRNs, TOC nurses and health navigators are assigned to network hospitals, long-term acute care facilities and skilled facilities.
- Members are followed from acute care to home and back to the PCP.
- Members with complex health care needs are identified and followed by the transition of care, case management or social work teams.
- Members that need long term care are followed by HPSJ's team during the month of the admission and the month following and then disenrolled from HPSJ since LTC is not a benefit through HPSJ per the DHCS contract.

HPSJ's Clinical Programs

Current Clinical Programs at HPSJ:

- Case Management
- Complex Case Management and Condition Management
- Disease Management
- Pre-Natal Program
- Transitions of Care (TOC) Program
- Population Health Management
- Behavioral Health including Autism
- Social Work (including social determinants of health)

Transitions of Care Program (TOC)

Overview of the Program:

- The concurrent review team & the TOC team coordinate with the hospital and skilled nursing facility nurses and case managers to ensure safe and timely patient discharges from the hospital
- Registered Nurses, with assistance from health navigators, contact patients, assess needs, and work with hospital staff and physicians.
- The program components include:
  - Patient Education
  - Medication Reconciliation
  - Short Term case management (14 days post hospital discharge)
  - When indicated, referrals to longer term Case Management, Social Work or Behavioral Health Interventions

Program Goals:

- Safe Discharge
- Medication Education/Reconciliation
- Reduction in Acute hospital bed days
- Collaborating with hospital to identify skilled beds, home health or community resources
- Addressing social determinants of health needs
- Ensuring timely follow up care with the PCP
- Improving Health Outcomes

HPSJ **Medical Directors** are involved as needed

Case Management Programs

Case Management Programs:

Complex Case Management

- Members with the highest Risk score are managed through a case management vendor with the ability to provide feet on the street access.

Disease Management

- COPD
- CHF
- Asthma
- Diabetes
- CKD (a new program)

Program Enrollment

- Proactive Identification through advanced analytics
- Referrals
  - PCPs and other network physicians
  - Members self -referral
  - Inpatient Review Nurses
  - Other Departments

Care Coordination

- HPSJ's members may have complex needs which require services from multiple providers systems
- HPSJ's CM and social work teams collaborate to provide education and interventions for members and caregivers
- Identify and refer to various community resources including IHSS,CBAS, PACE , MSSP and other programs

Pre-Natal Program

- A tailored education program focusing on each trimester of pregnancy
- In coordination with the Health Education Team

Social Work Programs

Overview

- Social work team is an integral part of Case Management
- Referrals are assessed per member's risk and social needs.
- Contacts are made via telephone, face-to-face hospital visits or at HPSJ Offices.
- Social Workers work closely with other teams, PCPs and community partners.

Social Work Interventions

- Transportation - facilitating Non-Emergency Medical Transportation (NEMT).
- Identifying other social needs such as shelter, food, education and connecting the member to community resources.
- Identifying the member's behavioral health needs and connecting them to resources.
- Screening for depression through PHQ4 and collaborating with the Behavioral Health vendor for mild-to-moderate needs, along with County Behavioral Health for severe behavioral health needs and referrals to the County Drug Medi-Cal program for Substance Abuse Disorders.

Community Resources

HPSJ's teams work with various resources in the community and refer members based on their specific need.

Programs that HPSJ and its network providers connect members with includes:

- Home Health
- CBAS
- Respite Care
- Palliative Care
- Hospice
- PACE program
- MSSP program
- Food Bank
- Homeless Shelters
- Operation Room Key
- Public Health Department
- County Behavioral Health
- Long-Term Support Services
- Support Groups i.e.:
  - Veterans Support /Resources
  - Grand Parent Support Services
  - LGBTQ
  - Caregiver Support Services
- Substance and Tobacco Adult/Adolescent
- Children and Family Services
- Utilities services
- Housing Services
- Financial Resources
- Transportation Services

Today, we have representatives from the various organizations that can give us a deeper insight into the specific programs so the transitions from acute care facilities and skilled facilities to the community are improved.

Thank You!

Introduction: Community Resources

Lizeth Granados, Chief Operations Officer

Health Plan of San Joaquin

PACE

Programs of All-Inclusive Care for the Elderly

Jason West,

Central Valley PACE

ALW

Assistant Living Wavier Program

Jenna Silva,

Star Nursing Inc.

CCT

California Community Transitions

Yanine Arias,

Libertana

HCBA

Home and Community Based Alternatives Waiver

Sima Semmel,
Libertana

IHSS

In Home Support Services

Renee Smith,

San Joaquin County Health Care Services

MSSP

Multipurpose Senior Services Program

Stephanie Navarette,

Stanislaus County Aging & Veterans Services

CBAS

Community-Based Adult Services

Lenore Gotelli,

Active Live Adult Day Health Care Center

Respite (Homeless)

Sandra Maple,
Gospel Center Rescue Mission

San Joaquin County Health Care Services

Greg Diederich,
Agency Director

Stanislaus County
Health Services Agency and
Behavioral Health and Recovery Services

Alisa Bettis,
Assistant Director of Quality and Planning
Kevin Panyanouvong,
Chief of Adult Services

Questions and Remarks

Lizeth Granados, Chief Operations Officer

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Follow Up, Recognitions, and Final Comments

Michael Schrader, Chief Executive Officer

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END

Thank you for your attendance.

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