



MICHELLE BASS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

Department of Health Care Services California Advancing and Innovating
Medi-Cal (CalAIM)

TITLE: CalAIM Community Supports Spotlight: Asthma Remediation and
Environmental Accessibility Adaptations

DATE: Wednesday, July 20, 2022, 12:00 PM to 1:00 PM

NUMBER OF SPEAKERS: 8

FILE DURATION: 1 hour and 1 minute

SPEAKERS

Jill Donnelly
Neha Shergill
Joel Ervice
Anne Kelsey Lamb
Michelle Wong
Esther Honig
Nancy Wongvipat Kalev
Dipa Patolia

Jill Donnelly:

Welcome, everyone. We're just going to give it another minute or so for folks to join. Okay. Why don't we get started? My name is Jill Donnelly from Aurrera Health Group and welcome to the DHCS CalAIM Community Supports Spotlight Webinar series today on asthma remediation and environmental accessibility adaptations. Before we begin, we do have a few housekeeping notes. All participants will be on mute during the presentation. We'll have some time reserved for questions at the end of the webinar. If you do have a question, please submit to the Q&A feature on Zoom at any point during the presentation. The PowerPoint slides and all materials will be available soon on the DHCS website. We'll share details for where to access that information in the chat and the recording of the webinar will be sent out as well, probably within the next couple of weeks. Additionally, we do have captioning available for this webinar.

Jill Donnelly:

If you'd like to use this feature, please click on the closed captioning at the bottom of your screen and select subtitles. All right, so we will start with some introductions. We'll hear a little bit about Community Supports and then move on to promising practices from presenters in the field. And again, we'll have time for some Q&A at the end, hopefully. And with that, I will hand it off to Neha from DHCS to cover a brief overview of these Community Supports.

Neha Shergill:

Hi, thank you so much. So today we'll begin with the brief overview of CalAIM Community Supports. Community Supports are medically appropriate, cost-effective alternatives to services. Medi-Cal managed care plans may provide in lieu of services traditionally covered by Medicaid. Community support services are designed to potentially decrease utilization of other Medi-Cal benefits, such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use managed care plans are strongly encouraged, but not required to provide the Community Supports. So CalAIM currently includes a robust menu of 14 pre-approved Community Supports to address the health needs of members. The list of pre-approved Community Supports is informed by the work and lessons learned under the whole person care pilot and the health homes program. Managed care plan selected Community Supports to offer when CalAIM went live on January 1st of this year and have the option to add any new Community Supports every six months in January and July. Managed care plans in all counties are encouraged to offer at least one community support by January 1st, 2024.

Neha Shergill:

Next slide, please. The Community Supports are in lieu of services, which are medically appropriate and cost-effective services or settings offered by a managed care plan as a substitute for a Medicaid state plan covered service or setting. Under regulatory requirements in lieu of services must be authorized and identified by plan contracts and offered at plan and enrolling options. This allows for Community Supports to cover a broad range of social and support services for eligible populations. These are financed through capitated rates to plans in the same way as state plan services and does not require 11, 15 waiver savings.

Neha Shergill:

So just getting into what our Community Supports. The slide outlines the 14 pre-approved Community Supports and today's webinar is intended to provide information about the asthma remediation and environmental accessibility and home modification supports and help you inform as you consider offering the support to plan members and patients. Managed care plan community support selections. So many managed care plans have already elected to provide asthma remediation and environmental accessibility adaptations. And by January 2024, 37 counties will be live with asthma remediation and 41 with environmental accessibility adaptations. And a quick guidance summary will now provide a summary of

guidance for asthma remediation and Joel Ervice associate director at Regional Asthma Management and Prevention also known as RAMP will share DHTS guidance and his expertise on asthma remediation. Joel, I'll hand it over to you.

Joel Ervice:

Great. Thank you so much. It's a pleasure to be here today. So environmental asthma trigger remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of an individual or enable the individual to function in the home. Without these services, individuals may experience acute asthma episodes that could result in the need for emergency services and hospitalization. Next slide, please. Poor housing conditions can exacerbate chronic medical conditions and conditions such as asthma can sometimes only be effectively addressed through the removal or reduction of indoor triggers. These triggers can include mold, dust, the presence of rodents and/or pests in the home, pet dander, tobacco and wood smoke, chemical irritants, and fumes from gas stoves and heaters. Next slide, please.

Joel Ervice:

Environmental triggers for asthma can be addressed through environmental remediation in homes. So as this list conveys, asthma remediation can include supplies like mattress and pillow dust covers, HEPA filtered vacuums, dehumidifiers, or air cleaners. It can also include services like minor mold removal and remediation services, ventilation improvements, or integrated pest management. Other supplies and services may also be medically appropriate and cost-effective. It's important to note that this approach creating changes to the home environment is not a new intervention with unknown outcomes. Instead, study after study in various communities across the US has shown consistent improvements in asthma outcomes, reductions in healthcare costs, and reductions in health disparities. What is new and unique is California's leadership and incorporating these services into its healthcare delivery system. Very few states have done so and already California's work is helping to inspire other states to address this important issue.

Joel Ervice:

Next slide, please. Eligible populations for asthma remediation include individuals with poorly controlled asthma as determined by different criteria, including an emergency department visit or hospitalization or too sick or urgent care visits in the past 12 months or a score of 19 or lower on the asthma control test. Additionally, a licensed healthcare provider must have documented that the service will likely avoid asthma related hospitalizations, emergency department visits or other high cost services. So I'll turn it now back over to now from DHCS to share the rest of the policy guidance on asthma remediation.

Neha Shergill:

Great, thank you. And just getting into the limitations and restrictions. So limitations and restrictions include the following. If another state plan service is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations that service should be used. Remediations must be conducted in accordance with applicable state and local building codes. Services are payable up to a lifetime maximum of \$7,500. The only exception is if the member's condition has changed so significantly, those additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization. Modifications are limited to those that are of direct medical or medial benefit to the member. Remediations may include finishing to return to the home to habitat condition, but do not include the aesthetic embellishments. Before making any changes to a space, managed care plans must provide the owner and member with written documentation that the modifications are permanent. And that the state is not responsible for maintenance repair, or removal of any modification.

Neha Shergill:

So who can provide asthma remediation? Medi-Cal health managed care plans may manage these services directly coordinate with an existing Medi-Cal provider to manage the services and/or contract with a county agency, community based organization, or other organization as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education. Providers must have the expertise and experience in providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but is not an exhaustive list of providers who may offer their services such as lung health organizations, helping housing organizations, such as those working to address health disparities by improving housing stock, local health departments, community based providers and organizations. And just a note that, as our mediation that is a physical adaptation to residents must be performed by an individual holding a California contractor's license. And now we'll hear from Anne Kelsey Lamb, director of RAMP, associate director at RAMP, who will share some promising practices in our mediation. I'll hand it over to you both.

Anne Kelsey Lamb:

Thank you. Good afternoon. Next slide, please. RAMP's mission is to reduce the burden of asthma with a focus on health equity. We don't provide direct service to people with asthma, but we support those who do. We build capacity through developing tools and providing technical assistance. We create linkages bringing together stakeholders from communities across the state for peer learning and network development. And we advocate for policy and systems change. RAMP along with many other asthma and health equity organizations here in California have been working together on state policy changes to increase access to asthma home visiting services. The asthma remediation option under Community Supports is one result of that work. To be clear, we are not an asthma remediation provider, but we provide technical assistance to organizations who are as well as to manage care plans and other partners. And we're so pleased to talk with you about this important opportunity today.

Anne Kelsey Lamb:

Next slide, please. As you're likely aware, asthma is a significant public health problem and driver of healthcare costs. Asthma is a particular concern for low income Californians enrolled in Medi-Cal. Low income populations like the nearly two million Medi-Cal beneficiaries with asthma. Have higher asthma severity, poorer asthma control, and higher rates of asthma emergency department visits and hospitalizations. We also know that there are significant racial disparities. African Americans in California are five times more likely to go to the emergency department and four times more likely to be hospitalized for asthma than white Californians. And over two million of California's 5.9 million people with asthma are Latino. Fortunately, we know a lot about how to improve asthma outcomes, reduce healthcare costs and reduce disparities. Next slide, please.

Anne Kelsey Lamb:

Asthma remediation is an evidence based intervention that has been proven in study after study to improve asthma outcomes, reduce healthcare costs, and reduce disparities. Here's what it looks like. Over a series of visits, a community health worker, prodromata or other professional meets with a family in their home to provide culturally relevant asthma information and trigger remediation support. After building trust and rapport, they work with a family by providing supplies and services to remediate any identified asthma triggers. The remediation is essential for improving asthma management, even someone with the best clinical care who is following their medication regimen perfectly will continue to have asthma exacerbations if they're regularly exposed to asthma triggers in their homes. Giving a family a HEPA air purifier to help reduce exposure to wildfire smoke or providing pest management services to eliminate cockroach allergens, or helping a family find ways to reduce moisture and get rid of mold.

Anne Kelsey Lamb:

These types of supplies and services truly make a difference in the lives of people with asthma. Next slide, please. The decision to offer asthma remediation as a community support was based on the strong

evidence, including the outcomes listed here. And these are just a handful of the numerous data points demonstrating the impact of asthma remediation. In addition to all the improvements in health outcomes and reductions in costly healthcare utilization, we also want to emphasize how important these services are for the people facing the greatest burden of asthma, low income communities and communities of color. As such, providing these services helps reduce disparities. Next slide, please. There are other benefits as well. We encourage you to review a tool we developed that describes the benefits of asthma remediation for managed care plans. In addition to achieving triple aim goals, these services can help manage care plans, fulfill contractual obligations related to chronic disease management, achieve NCQA accreditation and build positive relationships with the community.

Anne Kelsey Lamb:

So if you're a managed care plan and haven't already selected asthma remediation, we encourage you to take a look at this document and consider selecting it in the next round. Next slide, please. To support the expansion of these proven services, selecting asthma remediation as a community support is a great place to start. As another step, plans will want to identify the beneficiaries who most need asthma remediation. The evidence demonstrates that asthma remediation services are most impactful when they're provided to beneficiaries with poorly controlled asthma. As such, the eligibility criteria included in the asthma remediation policy guidance. We're selected to ensure that plans are providing services to those who need them most. Managed care plans will also want to identify asthma remediation providers. The asthma remediation option provides an important opportunity to increase access to asthma home visiting services for people with poorly controlled asthma and in doing so.

Anne Kelsey Lamb:

It can also help sustain and scale the network of asthma home visiting programs to reach additional parts of California. We're privileged to have existing asthma home visiting programs in many communities across the state. Some of these programs have been in existence for upwards of 20 years. Others are newer, some are community based organizations, others are based at clinics and public health departments. They provide critical services to clients and families with poorly controlled asthma doing so for a wide range of different populations. Once plans have a good understanding of which beneficiaries will benefit from asthma remediation most, you can select partners who will be the best match for those beneficiaries. Plans may even consider contracting with multiple organizations for asthma remediation. In one county, for example, there is an asthma home visiting program with longstanding connections to the Southeast Asian immigrant community. Another with vast experience working more specifically with the Filipino community and yet another based in the Latino community, each of these organizations brings linguistic and cultural expertise to their work.

Anne Kelsey Lamb:

Collectively, they can help you meet the needs of your beneficiaries. Next slide, please. To find a potential partner or multiple partners, we encourage plans to first look at our directory of asthma home visiting programs. The directory provides basic information about asthma home visiting programs across the state, including service areas, services provided client eligibility and contact information. Two versions are currently available. One organized by county and another by organization. We developed this directory precisely for plans and other organizations to find and connect with local programs. Next slide, please. And I will turn it back to my colleague, Joel.

Joel Ervice:

Thanks Anne. So prior to launching as a remediation under Community Supports, DHCS invested 15 million towards supporting asthma home visiting programs, that investment is being implemented as a grant program through the Sierra health foundation, and it's called the asthma mitigation project. There are 28 grantees and ramp is providing TA and infrastructure support. The grant program ends next spring. So the rollout of asthma remediation is well timed. First, if managed care plans contract with the asthma home disease programs that have already been providing these services, it'll make for a smooth

transition without interrupting services to beneficiaries. Second, asthma mitigation project is being evaluated by external evaluators so we're learning a lot about best practices that can be incorporated into the asthma remediation option. Pictured here is the report created by the external evaluators that outlines some of these best practices. Whether you're a managed care plan looking for an asthma remediation provider to partner with or an organization considering becoming an asthma remediation provider, we encourage you to keep these best practices in mind as you develop your approach to asthma remediation services.

Joel Ervice:

One such best practice is the community health worker or health educator model. Not only do asthma home visitors go through extensive training, but many of the home visitors share the same social, cultural, and economic characteristics as the clients. These home visitors can be the bridge between their communities and the healthcare system. One colleague called them agents of change who are well trusted in the community and meet participants where they are at intentionally building rapport, trust, comfort, and connection. Home visitors also excel at using participant centered service delivery models, including culturally responsive curriculum. These approaches are tailored to participants' unique needs and preferences. This can include bilingual staff flexibility and scheduling, including meeting clients at night or on the weekends and shifting educational approaches to meet the needs of children or adults. Using these approaches. Participants are more engaged and likely to adopt home visitor suggestions, which lead to better outcomes.

Joel Ervice:

Next slide, please. If you're a plan pursuing as a remediation where asthma homes Zoom and programs exist in your service area, we hope you'll look to them first as potential partners. And we are happy to help facilitate connections and support new partnerships. RAMP is here to provide you in local asthma programs with support and technical assistance. Think of us as informal asthma remediation infrastructure to help ensure successful partnerships between plans and local providers and to help ensure your beneficiaries get the services they need. We're confident that many of the existing asthma home programs will be enthusiastic about partnering with you and the delivery of asthma mediation services and are very capable collaborators. Some asthma home programs have experienced working with managed care plans and will transition into this role smoothly. For other asthma home programs, relationships with managed care plans are new so much like plans might need help to understand the ins and outs of HEPA vacuums, air filters and integrated test management.

Joel Ervice:

As asthma Zoom programs may need some additional support around things like billing and reporting in order to maximize their success in partnering with plans and others. Regardless, we are here to support them in the process and we encourage you not to shy away from contracting the such organizations. For example, sometimes the small community based organizations that may be less familiar with things like medical billing will be the most effective at meeting the needs of diverse community members. Next slide, please.

Joel Ervice:

While asthma home programs exist in many parts of the state, there are some gaps in coverage. So if you're a plan or a clinic or a community based organization, and you're interested in providing these asthma services in places or for populations where there aren't already programs, we can help. Specifically, we can provide technical assistance to you or other organizations in your community about getting an asthma home program started. For example, we can share best practices for asthma remediation services, including common program designs, services, and supplies, and training resources. We can connect staff with training programs and opportunities to shadow more experienced asthma educators.

Joel Ervice:

We can share sample implementation manuals with nuts and bolts information for getting your program off the ground. We can also provide you with strategic guidance that responds to the specific needs of your organization, whether you work in one neighborhood, county, or in many different counties. Next slide, please. And if there's one thing that you take away from this webinar, it's that we're happy to help you as you work to support people with asthma. So whether you're already moving forward with asthma remediation or you're just considering it, please feel free to reach out. Like that, I'll turn it back over to DHCS. Thank you.

Michelle Wong:

Thank you. Now to provide a summary of guidance on environmental accessibility, adaptations and modifications. So environmental accessibility adaptations also known as EAs or home modifications are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of an individual or enable the individual to function with greater independence in the home. These are services without which the member would require long term care in a nursing home or other institutions. These services are available in a home that is owned, rented, leased, or occupied by the member. For a home that is not owned by the member, the member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home such as grab bars and chairlifts. Next slide, please.

Michelle Wong:

Examples of environmental accessibility adaptations include ramps and grab bars to assist members in accessing the home, doorway widening for members who require a wheelchair, chairlift, making a bathroom and shower wheelchair accessible, like constructing a roll and shower. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the member, and installation and testing of personal emergency response systems for members who are alone for significant parcel the day without a caregiver or otherwise require routine supervision, including monthly service costs as needed. So this community support is targeted towards individuals at risk for institutionalization in a nursing facility.

Michelle Wong:

When authorizing environmental accessibility adaptation patients as they need support, the managed care plan or MCPs must receive and document an order from the members, current primary care physician or other health professional, thus assigning the requested equipment or service as well as documentation from the provider of the equipment or service describing how it meets the medical needs of the member. This includes any supporting documentation describing the efficacy of the equipment where appropriate for sure, to suffice in showing the purpose and efficacy of the equipment. However, a brief written evaluation specific to the member describing how and why the equipment or service meets the needs of the member will still be necessary.

Michelle Wong:

Authorization requirements. MCPs must receive and document a physical or occupational therapy, evaluation and report to evaluate the medical necessity of the requested equipment or service, unless the MCP determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following, an evaluation of the member and current equipment needs specific to the member describing how and why the current equipment does not meet the needs of the member. An evaluation of the requested equipment or service that includes a description of how and why it is necessary for the member and reduces the risk of institutionalization.

Michelle Wong:

This should also include information on the ability of the member and/or primary caregiver to learn about and appropriately use any requested item and a description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the member and a description of the inadequacy. If possible, a minimum of two bids from an appropriate provider of the requested service with itemized services, cost, labor, and applicable warranties and verification that a home visit has been conducted to determine the suitability of any requested equipment or service.

Michelle Wong:

So service limitations and restrictions. If another state plan service such as durable medical equipment is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used. Environmental accessibility adaptations must be conducted in accordance with applicable state and local built-in codes. As mentioned earlier, environmental adaptations are payable up to a total lifetime maximum of \$7,500. The only exception to the 7,500 total maximum is if the member's place of residence changes or if the member's condition has changed so significantly that those additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization. Home modifications may include finishing such as drywall painting to return the home to habitable condition, but do not include aesthetic embellishments. Modifications are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household.

Michelle Wong:

Adaptations that add to the total square footage of the home are excluded, except when necessary to complete an adaptation, such as configuring a bathroom to accommodate a wheelchair. Before commencement of a physical adaptation to the home or equipment that is physically installed in the home, like grab bars, MCPs must provide the owner and member with written documentation that the modifications are permanent and that the state is not responsible for maintenance or repair of any modifications nor for the removal of any modifications if the member ceases to reside at the residence. Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other state local or federally funded programs in accordance with the Cal STCs and federal DHCS guidance. Next slide please. So who can provide environmental accessibility adaptation? Some allowable providers include area agencies on aging, local health departments and community based providers and organizations.

Michelle Wong:

All environmental accessibility adaptations are physical adaptations to a resident that must be performed by an individual holding a California contractor's license, except for perk installations, which may be performed in accordance with assistance installation requirements. Next slide, please. So we'll share some examples of the program benefits. Community aging in place advancing better living for elders, a center for Medicare and Medicaid services innovation program. Provided home repairs and adaptive modifications to dual eligible Medicare, Medicaid participants, and resulted in a Medicare savings of \$922 per member per month for up to two years, an additional savings of \$867 per member per month in Medicaid for up to a year. A study that focused on the reduction of disability and promotion of aging in place through home based care programs found that 75% of participants improve their performance and activities of daily living after five months, the same study found that a number of activities of daily living that participants reported difficulty with dropped 49% from 3.9 out of eight to two out of eight.

Michelle Wong:

Another study of home modifications found a 20% decrease in falls in the home per year among participants who received home modification. Next slide, please. The non-binding Community Supports pricing guide guidance outlines a high level pricing approach for both asthma remediation and environmental accessibility adaptation. The caps release services are aligned with the current sending

caps in place within California's home and community based services labor program to remote consistency between programs and services and in preparation for offering successful Community Supports as a statewide benefit in future years. And now I'll pass things to Jill to introduce our next speaker.

Jill Donnelly:

Thanks, Michelle. All right. Well, we are very excited to have Esther from Libertana Home Health to talk a bit about some of the promising practices. I'll hand it over to you, Esther.

Esther Honig:

Great. I thank you so much. I appreciate you having me on here and it's exciting to be able to talk about this great opportunity for individuals throughout the DHCS program. Again, my name is Esther Honig. I am the director of external affairs here at Libertana, and I'm excited to speak with you today. Next slide, please. To begin with, I wanted to give you a brief overhead of what we here at Libertana are able to provide as services that we provide throughout the state. So at its core, we are a home health agency, but we also provide a myriad of waiver services to individuals such as assisted living waiver services, California community transitions, home and community based alternative waivers, and that really focuses a lot on transitioning individuals from a skilled nursing facility into the community or into a home based setting, as well as providing palliative care, respite personal care and homemaker services. And here in Los Angeles County, there is a program that is called Intensive Case Management Services or ICMS, which transitions individuals going from homeless to house.

Esther Honig:

Goes through the whole process of helping individuals obtain housing deposits all the way into sustaining long term tendency in a home, which brings us into the last service last, but certainly, not least, which is enhanced care management and Community Supports. Next slide, please. So I know we went through a little bit of an overview. We went through much more detailed overview previously of what home mods are, but repetition is key. So what is home modifications is physical adaptations to a home necessary to allow for greater independence for the individual and reduce the risk of institutionalization. Some of the services that we provide is widening doorways. We provide a wheelchair shower, bathroom and shower wheelchair accessibility, ramps, and various services to ensure that the individual can create and stair lifts for the individual. Next slide, please.

Esther Honig:

Some of the requirements that we require for the individuals is to have a physical or occupational therapist evaluation and report requesting of services. So this is very key to ensure that the individual is going to have a home modification that really suits the needs of the individual as well as will be approved by the managed care plan or by the state, through the community and support. So they need to show some sort of need that the individual requires this service to be conducted, and that it really will increase their activities of daily living in some sort or that the equipment that they have is insufficient in some sense. Next slide, please.

Esther Honig:

The process. So once we receive an evaluation and report, we are able to send our care team out to assess the needs of the client to make sure that the evaluation report really does tailor to the needs of the individual, as well as assess the location that they're living. If they're living in their own home, it is a lot easier to get the process started right away as we do not need additional layer of approval for the individual. If the individual is living in an apartment or a unit, we do need to have approval from the landlord or the tenant, those who are overseeing the unit to make sure that they're okay with any home modifications that is made. Once that is done, we request a minimum of two bids from separate contractors who are insured and licensed under the contractor state licensed board for the requested services.

Esther Honig:

Oftentimes we will request more than two bids, and we ensure that the whatever is being requested will fall in line with the requirements of the funding sources, as well as the needs of the individual. After that is done, we submit this request to the proper channels, depending on which funding source we're using, it might go directly to the state, or if it's through DHCS, it would go through the managed care plan to go through the approval process. Once it is authorized by the various entity, then we work with the client and the awarded bid, the contractor, to ensure that there's a contract in place to work with the client. At this stage, we put down half of the money up front, allow the contractor to start the work, we assess the work once it is completed and ensure that it's done in a timely matter, and once it is done to the point where it will help the individual or help the clients, then we give them the final check and move forward. Next slide, please.

Esther Honig:

Now I'm going to walk you through a case study of an individual who we helped with a home modification for their service. This client that we had, he lives in a studio apartment, has an IHSS caregiver, but only during the daytime, which left him with no care at night. He has a disability and is wheelchair bound and was unable to use the restroom or go into the shower without the assistance of somebody with him. Because of that, we were able to obtain the proper authorization for this. And as you can tell, we installed grab bars and created a walk-in shower and created a situation where the bathtub turned into a walk-in shower so he was able to get into the shower safely and securely on his own at night. So this really did help improve the client's independence, his safety, and increased his confidence for himself to be able to conduct the needs that he needed in order to move from the wheelchair over to the bath bathroom, anything along the lines in that bathroom and reduce the client's risk of fall during the hours that the client was alone.

Esther Honig:

In addition, it did help the individual while the caregiver was there, as the client was able to use the grab bars as leverage to help the caregiver assist with whatever needs the individual needed. Next slide, please. As you can tell, and as we've spoken before, the data truly does speak for itself. You can see that many studies have been conducted to show that there is strong evidence that finds that home modification interventions improve the functions for people with variety of health conditions in multiple settings. This in turn reduces the rate and risk of fall among older adults and allows for individuals to really safely and securely be able to age at home. As this is really the ultimate goal of this program to allow individuals to age at home, reduce the risk of institutionalization and ensure the longevity of the individual.

Esther Honig:

Next slide, please. And with that, I wanted to thank you again for having us here. Here we have left our forms of communication if you have any questions or want any assistance in getting through the home modification process. Please feel free to reach out to myself, or any of the others over here, including the director of CalAIM services here at Libertana and our EAA manager, Yanine Arias. Thank you again.

Jill Donnelly:

Thank you so much, Esther. All right. We have another wonderful speaker. I'm going to hand things over to Nancy Wongvipat Kalev and Dipa Patolia, both from California Health and Wellness and Health Net to talk about both of these programs, both asthma remediation and environmental accessibility. So thank you both for joining us.

Nancy Wongvipat Kalev:

Thank you, Jill, and thank you for having us. So Dipa and I are going to tag team on this. She will provide a brief overview of our organization, so Health Net and California Health and Wellness, and also a brief

overview of our population health management model that includes asthma management, which our account aim, enhanced care management and supports program, particularly the asthma remediation component and home mods are a part of. And then I will discuss our implementation for the two community support services and then turn it back to her for a member case study. So with that, I will turn it to Dipa. Thank you.

Dipa Patolia:

Great. Thank you, Nancy. So if we can move on to the next slide, and thanks again for the opportunity to present here. So Health Net and California Health and Wellness are California's longest serving medical partners with over three million members in 58 counties across the state. So we really do a good job of regionalization and identifying the uniqueness of each of the regions and counties that we serve, as well as the population that we serve. We have a steadfast commitment to the program and we're committed to equity, quality, continuous improvement, really building on the lessons learned and best practices along the way to improve access and support our communities ultimately. So our legacy demonstrates that long-term commitment and willingness to adjust based on any new programs, any new strategies to better partner with our states and our community partners out there to be innovative to address the evolving needs of the communities.

Dipa Patolia:

And so asthma remediation is one of the many programs that we're really excited to partner on and really build on to better serve members in need of these services. So if we can move on to the next slide. We'll talk a little bit about our program as it relates to asthma mediation. And so CalAIM and ECM and community support services are a part of our comprehensive population health management service continuum. We have a very robust process internally, and so adoption of asthma remediation has been seamless. And so we really want to make sure that we continue to do a good job of sharing our best practices. So far what we have is a strong process of coordinated closed loop care that allows for assessing best practices and lessons learned along the way and incorporating these strategies in a cohesive way across our organization to promote that systematic program development, ensure timely and appropriate referrals into asthma remediation and ultimately, reviewing the outcomes of these services to better inform and widen our reach.

Dipa Patolia:

So it starts with identification of our asthma members, which we have a comprehensive process for. We not only look at those with a diagnosis of asthma, but we know oftentimes, medications can be leading indicators. So evaluating members who are on an inhaler had short term use of an inhaler as a proxy to see if they might have a diagnosis for asthma. And we also look further into their adherence to therapy. So Health Net population's health asthma program has clinical and non-clinical expertise. So for clinical assistance or help with medications, we have incorporated text messaging, telephonic outreach campaigns, as well as the boots on the ground team that I'll speak about in just a minute. We also have a clinical pharmacy team, especially a cohort of that team that's dedicated to asthma management. So really incorporating best practices, guideline directed medication therapy, strong partnerships with providers to promote optimal therapy regimens and making sure members are on their controller inhalers and taking their rescue inhalers as appropriate as well.

Dipa Patolia:

So this also looks into prescription delivery, member education, so on, and so forth. The member connections team is the staff with lived experience. These are the staff who are out there supporting our members in the communities, identifying triggers within the home while they're doing home visits and then making those quick and efficient seamless referrals for in-home modifications and for asthma remediation. And finally we have our ECM and CS service. So really that's identification and referral of asthmatic members for Enhanced Care Management, Community Supports, asthma remediation, so on, and so forth. And a team that's integrated throughout this process is also our quality improvement team.

So they're helping us measure adherence regimens. They're helping us track our provider prescribing patterns, as well as all the different areas where we can more cohesively measure success for these programs. So with that, I will turn it over back to Nancy.

Nancy Wongvipat Kalev:

Thank you, Dipa. And Dipa mentioned, and if we can, just back to the previous slide, our internal structure for managing our members with asthma. But of course, we have a similar structure with our enhanced care management programs in our community and provided partners that we've contracted with to serve our asthmatic members, right, for ECM, for the non-clinical and clinical programs, those with boots on the grounds, through community health workers and those with lived experiences. So really acknowledging that we have the internal structure and external structure through our provider network, through our ECM and community support provider network as well. Next slide, please. So in our planning for the CalAIM implementation and determining which community support services that we should stand live first, right? We have five years to implement this. We knew that asthma remediation was really a critical priority area.

Nancy Wongvipat Kalev:

And so upfront, we knew that this was a day one implementation. And as a health plan, it's really a direct opportunity in that we know who our numbers are, who are accessing ER, emergency room use, and those who are accessing our pharmacy for various asthma medications and devices. And so we have that opportunity right away to impact those living with asthma who can benefit from asthma remediation. And so in terms of implementation, we are in 31 Medi-Cal counties. And so the implementation also accounted for some of the seamless coordination and continuity of services for whole person care and health homes, programs members, some of whom are also asthma, right? And so in of our counties where we had whole person care here in health home programs, you can see the counties listed here. We went live with asthma remediation on January 1st and then with whole modifications just 20 days ago and 19 days ago.

Nancy Wongvipat Kalev:

And then in the 20 counties that Health Net and California Health and Wellness are in, which did not have a whole person here or health homes programs. We went live with both on January 1st. And another factor now that played into that in addition to asthma really as a major disparities' area with our communities of color and populations that really are most effective by health disparities is our network availability. So in looking at who of our community providers was ready to provide asthma remediation and home modifications also impacted our timeline for implementation. Next slide, please. And thank you Elizabeth, for the time check. We'll speed through this. So I wanted to share our contracted providers as of this month for asthma and home modifications. And to note really that we are not done contracting and that we are seeking local providers who are trusting in the communities who have been doing this work effectively with various cultural groups, different communities, where they may not have experience with managed care.

Nancy Wongvipat Kalev:

We want to be able to provide more technical assistance and engagement in order to be able to successfully contract. And we know that you are the ones who have that member engagement. And this is the issue that we're seeing now is we have lots of services that are ready to go, and the challenge has been in reaching the member and in engaging with our heart to reach members. Next slide, please. So our referral process is pretty straightforward, but we've discovered that it really is not in that there are lots of nuances in needing to provide ongoing technical systems and training and ongoing support for our providers, for our community partners, for internal staff in order to seamlessly move through this process. So essentially our Community Supports for process, and this is relevant, not just for asthma mediation, but for all CS services is we identify potential members for the CS services. And we've created an authorization guide, which I'll share a snapshot in the next slide.

Nancy Wongvipat Kalev:

And our last slide, we'll have a link to all of our authorization guides that has the eligibility criteria, know the billing codes, any restrictions, and so forth to really help providers, the able to identify members who are eligible. And of course, self referrals by member can also happen. So CS referrals can come from any source. And then we refer members through CS through either for the Community Supports refined help, which we've added as a close loop referral platform for all of our providers or any of our providers can also go through direct referrals to Health Net and California Health and Wellness. The Community Supports' provider then assess the members for eligibility and obtain consent from the member and then submit authorization. And this is key in that it's really the Community Supports providers who will need to submit the authorization in order to render the services and be paid for the services. Next slide, please.

Nancy Wongvipat Kalev:

So we've created an authorization guide for all 14 of our community support services. What you see here is the asthma remediation one, and we'll be looking to update it as DHCS also updates the DHCS policy guides, but essentially, this is a tool that helps providers identify those who are eligible and you can see also the lifetime maximum billing codes and so forth, and any other resources. Next slide, please. So I think this gets into the heart of what we wanted to discuss here. We've had several lessons learned throughout our CS Community Supports implementation process, and this is not specific to just asthma remediation and home modifications. So the first is we have discovered that the extensive collaboration between our plans and our providers of providers have been key in the beginning, we've partnered with ramp and Sierra health foundation, for example, to help identify cohort of the asthma mitigation providers who are funded through Sierra health foundation to look at interest in contracting, right?

Nancy Wongvipat Kalev:

And so some of those whom actually have become contracted with us, we've worked with the central California Asthma Collaborative since 2021 to pilot their in-home visiting program before contracting officially as an asthma remediation provider, once January became live. And so really that extensive partnership learning from our community providers have been key to our success of our implementation. The second lessons learned is the foundational need for ongoing operational support and funding for our local providers, ongoing technical assistance and training and warm handoffs between providers and health plans and the members, and really having this monthly check-ins with all of our providers to share best practices, to brainstorm and troubleshoot on barriers that are being encountered.

Nancy Wongvipat Kalev:

And then finally, the essential role of timely, complete data sharing. So now it's really critical that we have data to help identify members, for example, who qualify for Community Supports, right? So our Community Supports providers can help conduct outreach, but also at the same time, it's critical that we receive data on, for example, capacity of our providers. So we know if we need to conduct additional contracting or help with capacity building or infrastructure support. Next slide, please. And from here, I will turn it to Dipa for a member case example. Thank you.

Dipa Patolia:

Sure. Thank you so much, Nancy. And I know we're running a little bit short of time, so I'll keep this short and sweet, but we had a really good encounter with a member. It was a 41 year old female member with asthma and hypertension with several ER visits in the past year. And when we reached out to the member, she let us know that her asthma was not under control. We have been working with this member on adherence to the inhalers. We saw that there were opportunities to get refills in and timely pick ups of those medications as well as timely visits with her provider. So through the conversation we identified that this member was a good fit for asthma remediation. We counseled the members on, on the importance of avoiding allergens and triggers in the home and around the work that the asthma remediation team would be able to do.

Dipa Patolia:

The member was agreeable to asthma remediation. We let her know that there would be appropriate handoffs and follow through, and that we would be following up with the member as soon as the asthma remediation was complete to understand her experience and see if any further interventions are needed at that point. And so this just showcases the opportunity for us to utilize asthma remediation and really follow it through the process to make sure it's ultimately a positive experience for our members. One thing we picked up on is asthma remediation may not be the easiest term to remember as well as the most, I guess, easy way to understand the program. So we are working on the terminology a little bit to make sure that it's in a format that's easy to understand for our members, but also follow that process through to our asthma mediation providers. So that's just one lesson learned along the way that we wanted to share. And this will ultimately be followed through on to completion. So thanks for the chance to share a positive member experience.

Nancy Wongvipat Kalev:

Thanks, Dipa. And actually, just to wrap it up, we do have a last slide on some of the resources that we referenced. The authorization guides are here for Health Net versus California Health and Wellness, as well as resources that we provide through our provider portal. And then we've published a lessons learned publication on Community Supports lessons learned that I've shared the three major lessons learned that was part of this larger publication of bridging the divide California. And that wraps up our presentation. Thank you.

Jill Donnelly:

Great. Thank you both so much. I know we're running low on time, but certainly, time well spent with those great presentations. Maybe we can go to the next slide. So we do have a few FAQs in here that we probably won't spend a whole lot of time on. There were some questions in the Q&A that came in around pricing, and I would recommend circling back to the non-binding pricing guidance that Michelle offered the link to earlier. The link is also on the ECM Community Supports' website for DHCS. Again, it's non-binding, all health plans are making their own determinations, but that would be a place to look for more information. We recommend if you've listened to this webinar and you think your organization might be a good fit for becoming a provider for either of these Community Supports or any of the others, we really recommend reaching out to your local health plans to determine the application process.

Jill Donnelly:

And then there were a couple of questions as well around referrals and the overlap of ECM and CS. And I think we may have a moment to get to that before we run out of time though, why don't we go to the next slide? So I think we're getting a little feedback there. I wanted to point you towards some provider resources. Again, we will share these slides in the coming days, there is a Community Supports explainer. There's also quite a bit of prior information prior webinars and policy guides on the DHCS website. And again, I wouldn't hesitate to reach out to MCPs in your county if you're interested in participating. And then, next slide. Just also pointing out, we will include citations for all of the research that was referenced in this presentation. All right. I think we are out of time on questions. There was one that I will throw to Michelle. Michelle, the question that came in was around documentation for asthma remediation referrals, what would be needed for an individual referral? What's your thoughts on that?

Michelle Wong:

Yeah, so the community support policy guide does outline the overall requirements, kind of what I mentioned earlier. But we do recommend that providers and members, if they're self-referring, reach out to their managed care plans to see what specific documentation is required for that plan.

Jill Donnelly:

Great. Thank you so much. And we've also had a few questions about the lifetime limit. Maybe can you

speak briefly, maybe this is a good question for Neha. Can you speak briefly about why there is a 7,500 lifetime maximum? We may have lost her.

Michelle Wong:

I Think I can take this one.

Jill Donnelly:

Sure. Great.

Michelle Wong:

Yeah, we might have lost her. I can take it too. So the limit was not decided by CMS, it was actually modeled on limits for similar services in the state DHCS. I can never say that waiver program.

Jill Donnelly:

Yep. Great. Thank you so much. And if we could go to the next slide. We just wanted to highlight that there is another Community Supports webinar coming up on August 18th at 1:00. We're so grateful for everyone who was able to attend today and a special thank you to all of our presenters. The next webinar will be on short-term post-hospitalization and recuperative care medical respite. So we look forward to seeing you then. Thank you so much for joining us today. Have a good one.