Public Health Emergency (PHE) Unwinding

» **The COVID-19 PHE will end soon and millions of Medi-Cal beneficiaries may lose their coverage.**

» **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.

» **How you can help:**
- Become a **DHCS Coverage Ambassador**
- Download the Outreach Toolkit on the [DHCS Coverage Ambassador webpage](#)
- [Join the DHCS Coverage Ambassador mailing list](#) to receive updated toolkits as they become available

DHCS PHE Unwind Communications Strategy

» **Phase One: Encourage Beneficiaries to Update Contact Information**

- Launch immediately
- Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
- Flyers in provider/clinic offices, social media, call scripts, website banners

» **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**

- **Launch 60 days prior to COVID-19 PHE termination.**
- Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.

Today's Session

» **Welcome & Introductions**

» **DHCS Policy Overview: ECM Recap, Outreach, and Engagement**

» **Spotlight: L.A. Care and Illumination Foundation in Los Angeles**

» **Spotlight: La Maestra in San Diego**

» **Q&A**

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated, and person-centered approach to maximizing their health and life trajectory. The goals of CalAIM include:

Implement a whole-person care approach and address social drivers of health.

Improve quality outcomes, reduce health disparities, and drive delivery system transformation.

Create a consistent, efficient, and seamless Medi-Cal system.

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ECM:
Recap, Outreach, and Engagement

What is ECM?

ECM is a new Medi-Cal benefit to support comprehensive care management for enrollees with complex needs that must often engage several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder (SUD), and long-term services and supports (LTSS).

» ECM is designed to address both the clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services, meeting enrollees wherever they are – on the street, in a shelter, in their doctor's office, or at home.

» ECM is part of broader CalAIM Population Health Management system design through which MCPs will offer care management interventions at different levels of intensity based on Member need, with ECM as the highest intensity level.

» **A core component of ECM for all Populations of Focus is Outreach and Engagement.**

For more details, see [ECM Policy Guide](#) (May 2022).

Launch and Expansion of ECM

Counties in pink began begin implementing ECM in July 2022, making ECM **statewide**

| ECM Populations of Focus	Go-Live Timing
1. Individuals and Families Experiencing Homelessness 2. Adult At Risk of Avoidable Hospital/ED Utilization 3. Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD) 4. Transitioning from Incarceration (some WPC counties)	**January 2022** (WPC / HH counties) **July 2022** (all other counties)
5. At Risk for Institutionalization and Eligible for Long Term Care 6. Nursing Facility Residents Transitioning to the Community	**January 2023**
7. Children / Youth Populations of Focus 4. Transitioning from Incarceration (statewide)	**July 2023**

Key Steps In ECM Outreach and Engagement

Identifying Eligible Members
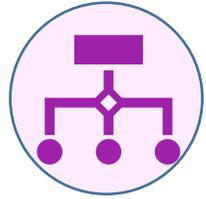
Assigning Eligible Members to an ECM Provider

Outreaching and Engaging Members

Enrolling Members and Completing Care Plans

How Should Eligible MCP Members Be Connected to ECM?

» MCPs are responsible for regularly and proactively identifying Members who may benefit from ECM and who meet the criteria for Populations of Focus. MCPs can utilize available data sources (e.g., enrollment data, encounter data, utilization/claims data, screening or assessment data) to identify Members who meet Population of Focus criteria.
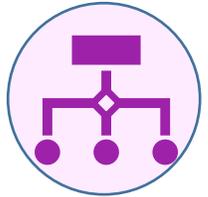
» MCPs may receive referrals for ECM from Providers, community-based entities, and other entities serving Members in any given Population of Focus.

» Members can also self-refer or be referred by family members.

For more details, see [ECM and Community Supports MCP Contract Template](#) & [CalAIM Enhanced Care Management Model of Care Template Addendum I](#) (May 2022) & [ECM Policy Guide](#) (May 2022).

How Should Eligible MCP Members Be Assigned to an ECM Provider?

MCPs assign every Member authorized for ECM to an ECM Provider and provide Member assignment files to ECM Providers.
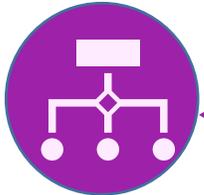
» If a Member prefers a specific ECM Provider, the MCP must assign the Member to that Provider (*to the extent practicable*)

» If a Member's PCP is a contracted ECM Provider, the MCP must assign the Member to the PCP as the ECM Provider, unless the Member indicates otherwise, or a more appropriate ECM Provider is identified

» For the adult Population of Focus with SMI or SUD, MCPs should prioritize county behavioral health staff or behavioral health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus

For more details, see [ECM and Community Supports MCP Contract Template](#) & [ECM Policy Guide](#) (May 2022).

How Should MCP Members Receive Outreach for ECM?
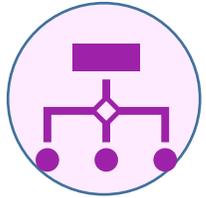
» ECM Providers are responsible for reaching out to, and engaging, assigned MCP Members (or continuing to engage them if they had a pre-existing care relationship)

» MCPs are responsible for defining outreach requirements for ECM Providers in their network, such as the number of required outreach attempts

» MCPs are required to reimburse ECM Providers for outreach as it is considered a core component of ECM

*For more details, see ECM Policy Guide (May 2022) & Model of Care Template (February 2022)*

How Should MCP Members Receive Outreach for ECM?
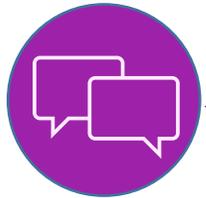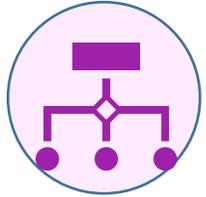
» Strategies for outreach can include (but are not limited to):

  » Using multiple modalities, including:

    » In-person meetings

    » Mail

    » Email

    » Texts

    » Telephone

    » Community/street-level outreach

  » Documenting outreach and engagement attempts and modalities

  » Providing culturally and linguistically appropriate communications and information

  » Prioritizing outreach to Members with the most immediate needs

For more details, see [ECM Policy Guide](#) (May 2022) & [Model of Care Template](#) (February 2022)

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How Should MCP Members Be Engaged in ECM?
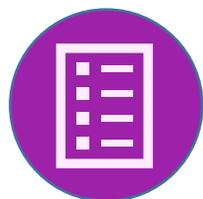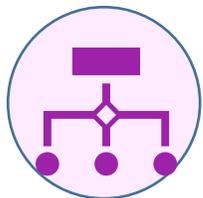
» DHCS does not require documentation of the MCP Member's consent before beginning to provide services

  » An individual may decline to engage in or continue ECM upon initial outreach and engagement, or at any time

  » Providers may opt to have a process for consent

» After a successful outreach and engagement with an ECM Member, the second core service component of ECM involves conducting a comprehensive assessment and developing an individualized care management plan

For more details, see ECM Policy Guide (May 2022).
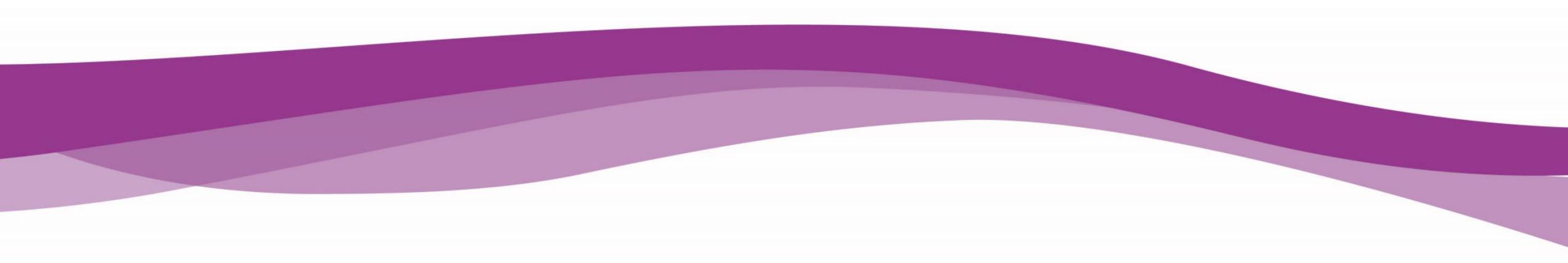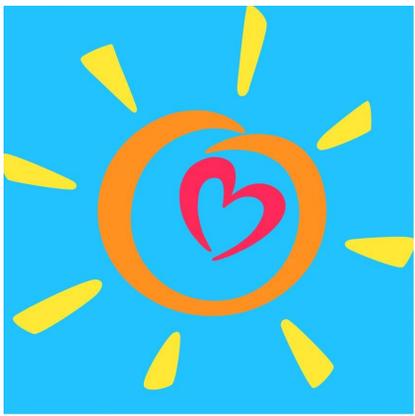
ECM Engagement Spotlight: L.A. Care and Illumination Foundation

Mary Zavala, LCSW, MPP, MA

LA Care

Director, Enhanced Care Management
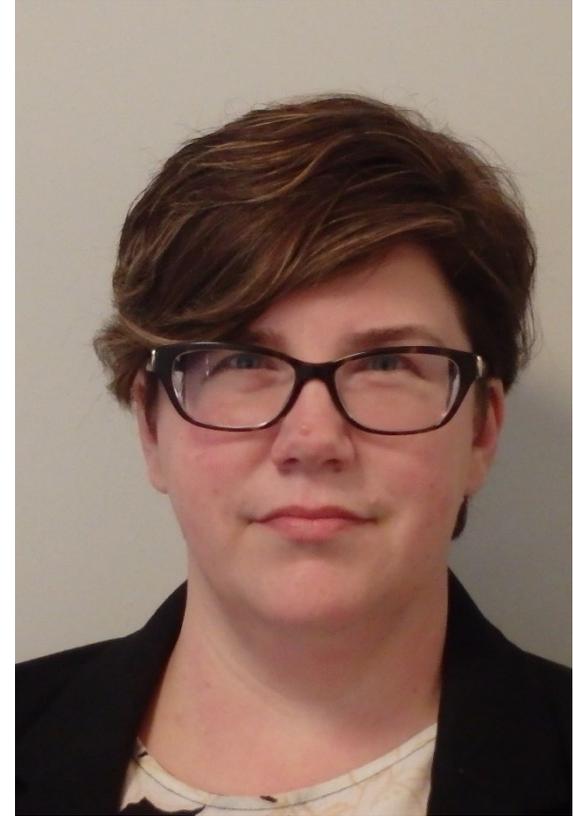
Melissa Wanyo

LA Care

Manager, Enhanced Care Management

About L.A. Care Health Plan

» L.A. Care is the nation's largest publicly operated health plan, serving more than 2.7 million Members.

» Our mission is to provide access to quality health care for Los Angeles County's vulnerable and low-income residents and to support the safety net required to achieve that purpose.

» We have 3 Plan Partners: Anthem Blue Cross, Blue Shield Promise Health Plan, and Kaiser Permanente
  » Data and processes discussed in this presentation are reflective of the ECM program run out of L.A. Care and does not represent our Plan Partners.

At A Glance: L.A. Care's ECM Benefit

Our ECM Benefit

» Grandfather HHP and WPC Members

» More than **16,000** Members currently enrolled

» **49** Contracted Provider Organizations

Our ECM Team & Operations

» Internal staffing supports Member care, clinical oversight & provider relationship management

» Robust training & technical assistance offerings on ECM-related topics

County Collaboration

» Strong partnerships with other LA County MCPs

ECM Member Identification:
L.A. Care's Strategies

Data Mining

- Use ECM inclusionary and exclusionary criteria

Referrals from ECM Providers

- Providers are strongly encouraged to refer ECM-eligible Members identified in the course of their day-to-day work
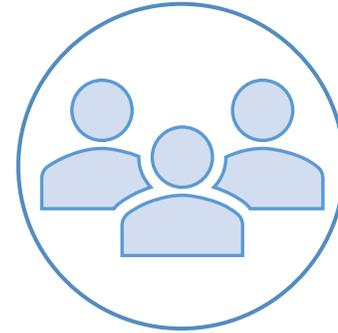
Referrals from the Community

- Including referrals from non-contracted organizations and Members

Identifying Members for ECM
Data Mining

» Data Sources:
  » Internal MCP data
  » Data matches/exchanges from external sources, as available

» Eligible Members are shared via the Member Information File with ECM Providers to begin outreach

» We match prospective Members to ECM Providers based on characteristics and available knowledge of pre-existing relationships
  » We learned in HHP that maximizing the pre-existing relationship maximizes likelihood of Member opt-in

Identifying Members for ECM
Referrals from ECM Providers Already Serving Members

» Contracted ECM Providers include:
  » Community Clinics & FQHCs
  » Community-Based Behavioral Health Agencies
  » County Hospital & Clinics System
  » County Mental Health
  » Homeless Services Agencies
  » Recuperative Care Providers
  » Other Community-Based Orgs

» Many of our ECM Providers are also contracted with other MCPs

» We have a single L.A. county-wide ECM referral form that all MCPs accept
  » The form includes submission instructions for each MCP
  » The form makes it easy for Providers to send referrals to the right plan

Identifying Members for ECM
Community Referrals

» Building awareness through relationships
  » Internal Care Management and other departments
  » Community Supports teams
  » Primary care providers, IPAs
  » Other community partners, including hospitals, CBOs

» What are the best Provider-facing materials?
  » Succinct and focused to the audience
  » Easy to share
  » Websites!

Hitting the Road:
Spreading the Word about ECM

» Invitations to speak / share information:

    » Conferences

    » Association meetings

    » Team or staff meetings

    » Word of mouth – 1:1 conversations

» Preparation & presentation are key

    » Hit what they want and need to know

    » Make it relatable to the work they're doing

Presentation Example:
ECM & Community Supports Overview in a Provider Staff Meeting

» Through word of mouth, we were invited to present to Case Managers and Social Workers at one of the large local health systems (not contracted as an ECM Provider)

» Presentation Plan:
  » Forum: Staff Meeting
  » Audience: Hospital and clinic case managers and social workers (over 100 attendees)
  » Topic: ECM & Community Supports
  » Presenter: Mary

» Materials: Create a high-level slide deck that is targeted to the audience
  » Who is eligible?
  » What do enrollees get / what is the benefit to them?
  » How do I refer them?
  » Where can I learn more?
  » Who can I contact for help?

Strategies for Additional Roadshows

» We haven't developed a "formal" process for spreading the word but know this is needed

   » We had planned hospital engagement strategy in HHP, but pandemic hit
   » Need to revisit now for ECM

» Considerations

   » What providers do we engage?
      » Hospitals & Health Systems
      » Community Orgs
      » Patient Advocacy Groups
   » Do we go to the providers (i.e., 1:1 presentations like in the example) or do we host large town halls? Or both?
   » What are new opportunities to specifically educate our Members about ECM?

ILLUMINATION FOUNDATION
DISRUPTING THE CYCLE OF HOMELESSNESS

Pooja Bhalla, DNP, RN
Co-CEO

Ryan Uhl
Program Director

About Illumination Foundation
Street2Home System of Care

SUPPORTIVE SERVICES • CASE MANAGEMENT • BEHAVIORAL HEALTH SERVICES • HOUSING NAVIGATION AND RETENTION

Care Model

Street/Homeless	Navigation Center/ Family Emergency Center	Medical Respite Recuperative Care & Short Term Post Hospitalization	Micro-Community (Permanent Supportive Housing)	Permanent Housing

Funding Source

Funded by the city or county	Funded by CalAIM and hospitals	Funded by HUD (Housing Urban Development), Private Funding, Self-Pay

About Illumination Foundation
Number of Clients Served

Total People Served by Illumination Foundation
- **4,362** people were served by Illumination Foundation in 2021
- **421** people served in Los Angeles County by Illumination Foundation in 2021

L.A. Care ECM Members Served by Illumination Foundation
- Assigned ~885 members for ECM
- Enrolled 195 members in ECM to date (22%)

About Illumination Foundation
Onboarding Process for Staff

Program preparation (pre-field work): Program education and training includes how to navigate Member Information File documentation, trauma-informed care, de-escalation, motivational interviewing, and cultural and linguistic competency education

Assisted outreach and engagement fundamentals: New staff shadow established outreach personnel and then will be assigned their own target outreach list, which will be overseen by lead outreach entities

Assisted care planning fundamentals: New staff shadow established care planners on how to administer the health risk assessment and build care plans

How Illumination Foundation Identifies Eligible Members for ECM

Weekly, cross-program case conferencing: Care team members from housing, healthcare and ECM discuss client care details, including member status, progress, and programmatic needs

Cross-program education: Education for all staff on how to identify ECM populations of focus and program eligibility, equipped with eligibility forms

Building on our in-person opportunities: Spreading the word through flyers and staff training when visiting members residing in assisted living, FSP, board and care, transitional housing

How Illumination Foundation Identifies Eligible Members for ECM
Building on in-person opportunities

Spreading the word through flyers and staff training when visiting members residing in settings such as assisted living, FSP, board and care, transitional housing

1. **In-Person Introduction**: Lead case manager goes into field to meet with mutual member. ECM program is explained and service relationship is carved out.

2. **Coordinated Seminar:** Identity population of focus and refer member. Schedule follow-up to revisit site and give presentation

3. **Dissemination:** Informational flyers and handouts to circulate at site

4. **Ongoing Correspondence:** Meet, educate, and train program staff on ECM and how to link members

How Illumination Foundation Outreaches ECM Members Once Referred

Direct engagement with referring care team agents: Establish care team roles, help the member acclimate to new care team environment, provide platform for member to complete their ECM health risk assessment

Primary Care Physician Contact: Retrieve updated contact and client care information from recent PCP contact

Community Resources HMIS, CHAMP, and Collective Medical are used to locate members, in addition to community-based, closed-loop platforms such as FindHelp and Unite Us

How Illumination Foundation Enrolls Members Once Reached

Enrollment: Educate on purpose, goals, and expectations of program, then discuss enrollment

Assessment: Complete Health Risk Assessment, preferably in presence of other care coordinators

Building the Care Plan: Collaborate with member to encompass their goals and aspirations

Completing the Care Plan: Ongoing, living document that is updated and expanded upon when member identifies new goals in service needs

ECM Engagement Spotlight:
La Maestra in San Diego County
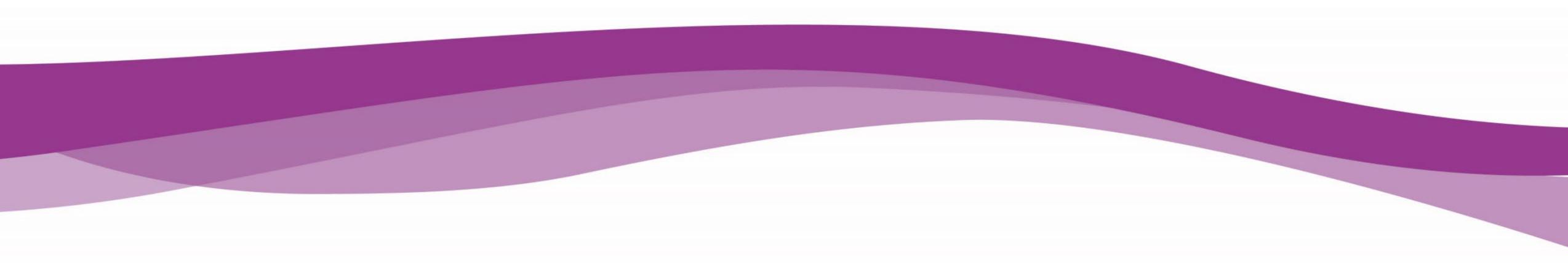
La Maestra Community Health Centers
City Heights · El Cajon · National City · Lemon Grove

Dr. Uchey Dijeh DrPh
Director

Norma Van Drunen
Manager

About La Maestra

La Maestra's Mission: To provide quality healthcare and education, improve the overall well-being of the family, bringing the underserved, ethnically diverse communities into the mainstream of our society, through a caring, effective, culturally and linguistically competent manner, respecting the dignity of all patients.

» La Maestra was formed in 1990

- » One of the most culturally diverse health centers in California
- » Staff come from the cultures served, ensuring cultural and linguistic competency in all programs and services, through cultural alignment
- » More than 30 languages and dialects spoken by 500+ employees

» La Maestra Circle of Care® - All health care services and Social Determinants of Health (SDoH) programs have elements focusing on education, case management, social services in an integrated approach

About La Maestra

» Currently contracted with six Medi-Cal Health Plans to offer ECM and Community Supports services in San Diego County

» Recognized as HUB
  » Providing ECM and Community Supports services to La Maestra and Non-La Maestra patients

» La Maestra ECM and Community Supports Care Coordination standardization through Continuous Improvement and Evaluation (CI&E) Best Practice:
  » Developed a centralized care coordination tool supporting integration meeting ECM and Community Supports requirements for all MCPs
  » Team Performance Measures and Goals
  » Establishing Metrics for Structure of Care
  » Process of Care
  » Outcomes Metrics

La Maestra Has Created an ECM Standardized Care Coordination Tool

Through a standardized tool, La Maestra ensures that care coordination is consistent regardless of site, care manager, referral source, MCP

» Tool is currently in Access database; planning to move this into their EHR

» Team adds key information from referral and MCP into the tool

» Team tracks care coordination – including all outreach steps – in the tool

How La Maestra Identifies Eligible Patients

» Lists from 6 partner MCPs

» Referrals from within La Maestra
  » Strategies for promoting these referrals include:
    » Increasing ECM and Community Supports services awareness and education
    » Ongoing collaborative partnerships with various practices/providers and SDOH programs
    » Adding ECM and Community Supports as referral options in EHR
    » Dedicated staff assigned to follow up on referral within 24-48 hrs

» Referrals from the community
  » Strategies for promoting these referrals include:
    » Enrolled Member sharing ECM/Community Supports experience
    » Non-La Maestra Provider referrals
    » La Maestra ECM and Community Supports information shared through flyers and website

Referrals from the Community: How La Maestra Spreads the Word on ECM

» Establishing good communication and fostering collaborative relationships with non-La Maestra organizations

» Providing clear definition of what our services are and where La Maestra ECM comes in to support both non-La Maestra patients and Non-La Maestra Providers

» Providing training support and information on ECM and Community Supports to non-ECM providers

» Streamlining ECM and Community Supports referral process

» Sharing additional ECM materials (e.g., flyers and La Maestra ECM Community Supports contact information)

How La Maestra Assigns Members to a Care Manager

» La Maestra has a care manager team for each MCP partner, ensuring that care managers understand the workflows of that MCPs and can navigate those workflows on behalf of the member

» Within the MCP team, LM assigns care managers to members based on their needs and to ensure culturally appropriate care for each individual members

  » La Maestra ECM maintains culturally diverse multi-disciplinary care teams and provides diverse, culturally component and interdisciplinary, high-touch, person-centered care services to all ECM members regardless of language.

  » La Maestra ECM enrolled member languages: 20% Arabic; 37% English; 41% Spanish; 2% other languages including Somali, Tagalog and Vietnamese

  » La Maestra ECM staff languages: 100% English; 35% Arabic; 60% Spanish: 5% other languages

    » Additional language support from La Maestra Language Services is available

How La Maestra Outreaches Eligible Members for ECM

» A round of **6 outreach attempts** (telephonic/in-person/mail) completed within 2 months and additional attempts as needed

» Best practices for outreach include:

  » Leverage centralized care coordination tool to track all needed outreach
    » Use existing appointments with care team for outreach
    » Coordinate in-person outreach attempts by geography
  » Complete outreach within 60 days to ensure that members don't fall through the cracks
  » Consistent and clear documentation of outreach, following required processes from MCPs
    » Staff uses this documentation for billing at the end of the month

La Maestra's Best Practices to Guide Enrollment of Newly Enrolled ECM Members

1. Highlight ECM Population of Focus
2. Confirm ECM eligibility and active status with assigned MCP
3. Summarize the current care needs and status with conditions verified and SDOH barriers
4. Verify if care is established with PCP or not
5. Confirm non-duplication of services
6. Confirm that Member provided consent and was enrolled in ECM
7. Assess using motivational interviewing: Identify problems and challenges faced by Member, note care coordination recommendation for supportive interventions
8. Create care coordination progress plan to support member and ensure that applicable health screenings are initiated and completed
9. Summarize action steps and inform Member that care plan will be shared with PCP/care team
10. Member verbalizes understanding of care plan

Upcoming Webinars

ECM and Community Supports TA Series: Member Engagement Office Hours
Thursday, September 1st
2:00 – 3:00 PM PT
Registration link

ECM and Community Supports TA Series: ECM Long Term Care Populations of Focus Webinar
Thursday, September 8th
1:30 – 3:00 PM PT
Registration link

ECM and Community Supports TA Series: ECM Long Term Care Populations of Focus Office Hours
Thursday, September 22nd
2:00 – 3:00 PM PT
Registration link

ECM and Community Supports TA Series: ECM and Community Supports in Rural CA Office Hours
Thursday, September 29th
2:00 – 3:00 PM PT
Registration link

ECM and Community Supports TA Series: Housing Supports via ECM & Community Supports Webinar
October 13th
1:30 – 3:00 PM PT
Registration link

ECM and Community Supports TA Series: Housing Supports via ECM & Community Supports Office Hours
October 27th
2:00 – 3:00 PM PT
Registration link

Review DHCS Resources & Materials for Providers

» Learn more about ECM & Community Supports:
- Policy Guides: ECM & Community Supports
- FAQs
- Fact Sheets: ECM & Community Supports
- ECM Key Design Implementation Decisions

» Review ECM & Community Supports guidance documents:
- Billing & Invoicing Guide
- Coding Options
- Community Supports Pricing Guide (Non-Binding)
- Data Guidance for Member-Level Information Sharing
- Contract Template Provisions
- Standard Provider Terms & Conditions

Thank You!

For more information about CalAIM, visit:
https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx

For more information about ECM and Community Supports, visit:
https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices

Send questions or comments to
CalAIMECMILOS@dhcs.ca.gov