

CalAIM Enhanced Care Management: Technical Assistance Webinar

A New Vision for Whole Person Care Management

Thursday, June 2, 2022
10:30 AM – 12:00 PM PT



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**
- » **Statewide view: What is ECM and Where are We in Implementation?**
- » **How ECM Looks on the Ground: Community Health Center Network & Alameda Alliance for Health**
- » **Q&A**
- » **Conclusion & Thank You**

Statewide View: What is ECM & Where are We in Implementation?

ECM is a Component of California Advancing and Innovating Medi-Cal (CalAIM)

DHCS launched CalAIM – a multi-year initiative – to improve the quality of life and health outcomes for Californians by implementing broad delivery system, program and payment reform across the Medi-Cal program.

CalAIM Seeks To:

1. Identify and manage member risk and need through whole person care approaches and addressing Social Drivers of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity; and
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Why ECM?

Issues ECM is Designed to Address



Over half of Medi-Cal spending is attributable to the **5% of enrollees with the highest-cost needs**



Medi-Cal enrollees typically have **several complex health conditions**



Enrollees with complex needs must often engage in **several delivery systems to access care**

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

ECM, alongside Community Supports, was informed by Previous Tests

Whole Person Care Pilots (WPC)

- Limited pilot program supported by Section 1115
- Coverage and delivery system agnostic (Medicaid Managed Care, Fee For Service, or uninsured); no requirements for interfacing with managed care plans (MCPs)
- Administered by county based "Local Entities"

Health Homes Program (HHP)

- Benefit (State Plan service) in select counties
- Medi-Cal Managed Care members only
- MCP administered with care management contracted out to providers



Enhanced Care Management

- Care coordination as a MCP contract requirement
- Medi-Cal Managed Care members only
- MCP administered with care management delivered through community providers

Community Supports

- Optional services, but strongly encouraged
- Medi-Cal Managed Care members only
- MCP administered with services delivered through community providers and integrated with ECM

Who is Eligible for ECM & How Does it Work?

ECM is available to Medi-Cal Managed Care Plan enrollees who meet “Population of Focus” criteria.

Eligible Enrollees...

- » Can be identified through their managed care plan (MCP), provider, family/caregiver, community-based organizations (CBOs), or via a self-referral
- » Are assigned an “ECM Provider” who best meets their needs. The ECM Provider makes sure the enrollee has a single “Lead Care Manager” who coordinates their care and services across Medi-Cal delivery systems and beyond.

What is Included in ECM?

DHCS has defined seven “ECM core services,” which must be provided regardless of county/region or ECM Population of Focus.



Outreach and Engagement



Comprehensive Assessment and Care Management Plan



Coordination of and Referral to Community and Social Support Services



Enhanced Coordination of Care



Member and Family Supports



Health Promotion




Comprehensive Transitional Care

Populations of Focus and Go-Live Timing

ECM Populations of Focus

Go-Live Timing

1. Individuals and Families Experiencing Homelessness
2. Adult High Utilizers
3. Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)

January 2022 (WPC/HH counties) 
July 2022 (all other counties)

4. At Risk for Institutionalization and Eligible for Long Term Care
5. Nursing Facility Residents Transitioning to the Community

January 2023 (statewide)

6. Children / Youth Populations of Focus

July 2023 (statewide)

Additionally, the **Incarcerated and Transitioning to the Community** Population of Focus will go live statewide in alignment with pre-release Medi-Cal services. DHCS will announce timing at a later date in alignment with the 1115 demonstration waiver request to provide pre-release services in the 90 days prior to release.

Statewide Scaling from July 1



- » Starting on **July 1, 2022**, ECM will go live statewide for:
 - Individuals and families experiencing homelessness
 - High utilizer adults (such as multiple emergency department visits and/or hospital/short-term skilled nursing facility stays)
 - Adults with SMI and/or SUD

- » Starting on **January 1, 2023**, ECM will extend statewide to:
 - Individuals at risk for institutionalization and eligible for long-term care
 - Nursing facility residents transitioning to the community

What ECM Looks Like on the Ground: *Community Health Center Network (CHCN) & Alameda Alliance for Health*



Dr. Laura Miller

Senior Medical Consultant



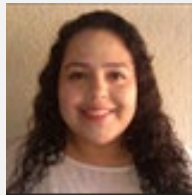
Aleida Kasir, LCSW

CN Program Director



Jacob Deme

CN Ops Supervisor



Melissa Medina, RN

CN Nurse



Jyoti Tripathi

CHCN Senior Data Analyst



Rene Soto

CN Lead CHW



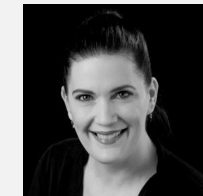
Brenda Bautista

CHW Native American Health Center



Dr. Steve O'Brien

Chief Medical Officer

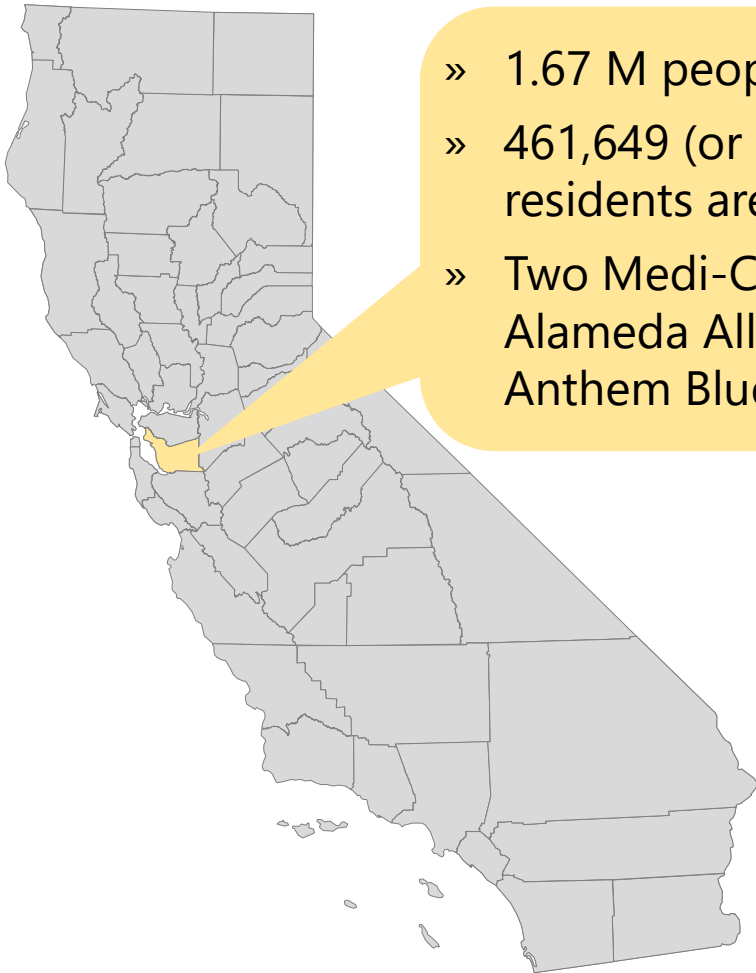


Dr. Amy Stevenson

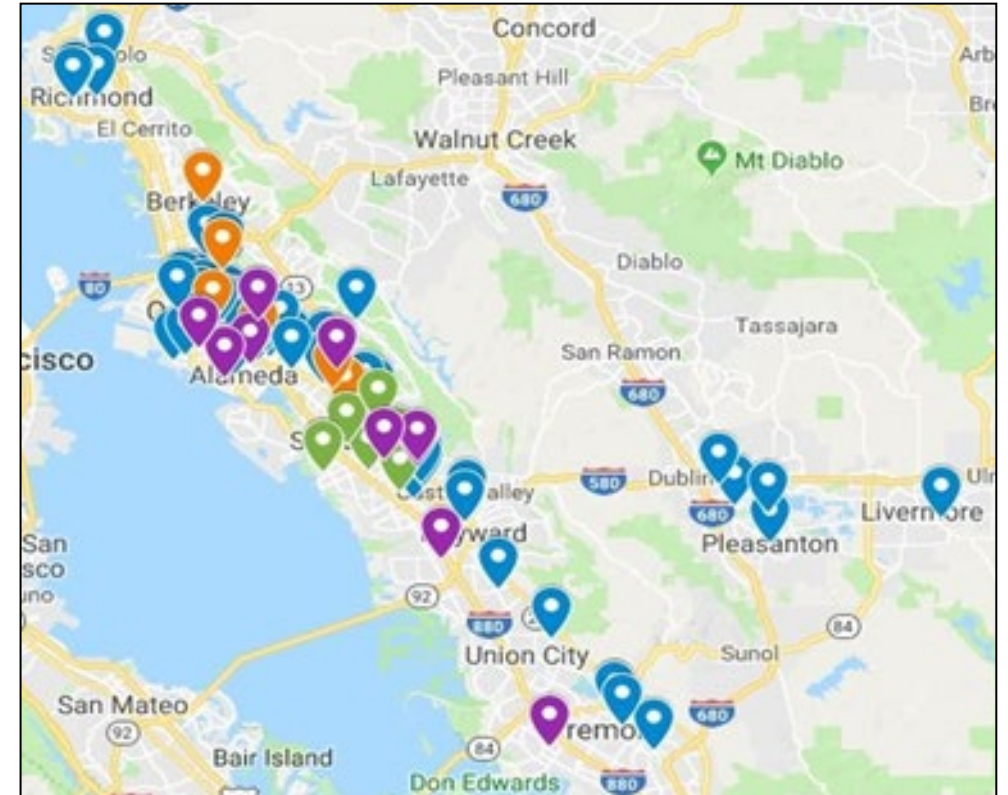
Clinical Manager, ECM

Alameda County

- » 1.67 M people live in Alameda
- » 461,649 (or 28%) of Alameda residents are enrolled in Medi-Cal
- » Two Medi-Cal MCPs in Alameda: Alameda Alliance for Health and Anthem Blue Cross



Alameda County's FQHCs



- CHCN
- Roots Community Health
- Davis Street Clinic
- Alameda Health System

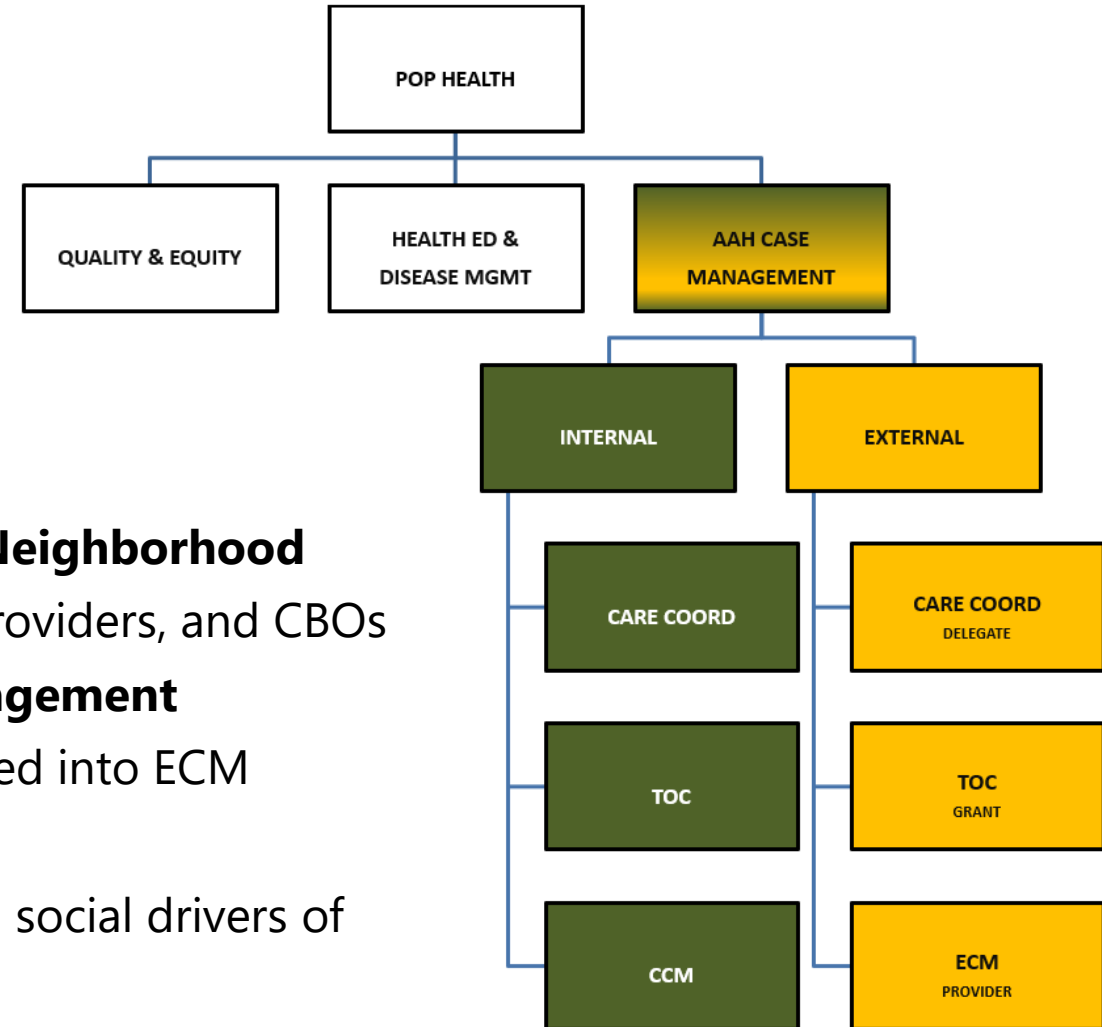
Alameda Alliance for Health (Medi-Cal MCP)

Membership: 301,000 + 6,000 IHSS

| | |
|--|-----|
| Latino/a | 35% |
| Black | 20% |
| White | 13% |
| Asian American & Pacific Islander | 12% |

Preparation for ECM

- » **2017. Self-funded Health Homes pilot with CHCN's Care Neighborhood**
 - Created partnerships & linkages with Alameda County, providers, and CBOs
- » **2019. Health Homes pilot integrated with WPC case management**
 - Created one care management program which transitioned into ECM
- » **TODAY: ECM**
 - Community-based, intense care management focused on social drivers of health and staffed primarily by CHWs
 - All CB-CMEs became ECM providers



CHCN/Care Neighborhood

- » Founded in 1994, **Community Health Center Network (CHCN) is a managed service organization** working to improve access to healthcare and the quality of that healthcare to its members in **medically-underserved communities throughout Alameda County, CA** and surrounding counties.
- » In May 2022, CHCN has over 180K members
- » CHCN contracts on behalf of **eight health center organizations** for professional risk, giving all members access to primary care at our health centers and specialty care services
- » **Services** provided include:
 - Utilization Management
 - Claims
 - Provider Relations
 - Inpatient/Concurrent Review
 - Eligibility
 - Special Projects

Health Service Organizations



NATIVE AMERICAN HEALTH CENTER
Serving the community since 1972



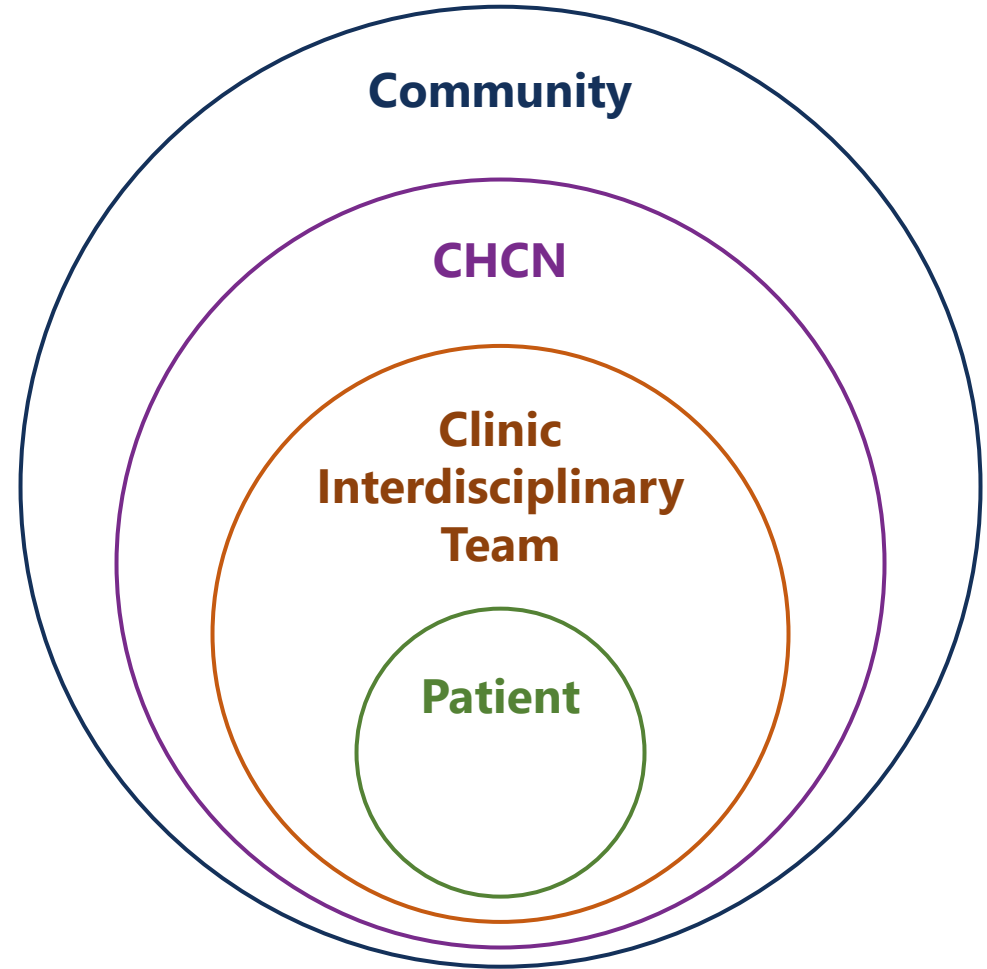
History of Care Neighborhood

- » **2013.** Pacific Business Group on Health (PBGH) funded Intensive Outpatient Care Program (IOCP) with CHCN focused on social drivers of health for high-risk members
- » **2014.** Licensed clinical social worker (LCSW) staffing pilot launched
- » **2016.** First community health worker (CHW) hired and MCP support via grant for CHW positions fiscal year 2016 – 2017
- » **2017.** 12 CHWs in all 8 health centers, mentored by CHCN LCSWs and supported by clinic-based teams, eventually expanding to 18 CHWs in **2018**
- » **2019.** Care Neighborhood is a community-based care management entity (CB-CME) under HHP/WPC with Alameda Alliance for Health (AAH) and Anthem Blue Cross (ABC)
- » **2022.** Care Neighborhood is now an ECM Provider under CalAIM
 - **Today.** 28 CHWs and 755 patients

Care Neighborhood's Case Management

Clinic-Based Case Management for High-Risk Members

- » **Innovative case management program for high-risk members**, where high-risk members are connected to community resources around social drivers of health
- » **CHWs are integrated into the medical home** and serve as the primary care coordinator
- » **CHWs employ a person-centered approach** and use techniques such as motivational interviewing, harm reduction, and trauma informed care to build meaningful relationships
- » **CHCN** provides technical training and support and tools, as well as contracting and billing



Best Practice Tools / Analytics / Workflows

Care Neighborhood's CHWs

The heart of Care Neighborhood's case management model is community health workers (CHWs) who build trusting relationships with patients



Betty Sanchez Tiburcio Vasquez
– Hayward
Jan 2017



Cecelia Schonholtz
Tri-City, Liberty
April 2017



Diana Escamilla
LifeLong West
Berkeley
July 2017



Thu-An Tran
Asian Health Services
Oct 2017



Brenda Bautista
Native American Health Center
Nov 2017



David Hoang
Asian Health Services, RKLMC
May 2018



Blanca Ramirez
LifeLong, Ashby
June 2018



Rosa Vargas
Tri-City, Liberty
June 2018



Rene Soto
La Clinica, San Antonio
June 2018



Sangeeta Chibber
Tri-City, Mowry II
July 2018



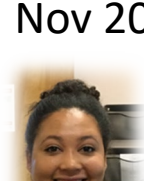
Johanna Gonzalez
West Oakland Health Council
July 2018



Camilo Turbay
La Clinica, Transit Village
Aug 2018



Jacob Deme
LifeLong, Downtown Oakland
Aug 2018



Adrienne Carter
LifeLong East Oakland
July 2017



Faustine Luo
Asian Health Services
Sept 2018



Eileen Esparza
Axis Community Health
Oct 2018



Nicole Del Castillo
LifeLong West Berkeley
Nov 2018



Heather Cowart
LifeLong Howard Daniel
Feb 2019

Components of ECM

What do DHCS’s seven ECM “Core Services” look like in CHCN’s model?



Outreach and Engagement



Comprehensive Assessment and Care Management Plan



Coordination of and Referral to Community and Social Support Services



Enhanced Coordination of Care



Member and Family Supports



Health Promotion



Comprehensive Transitional Care

Identification of MCP Members Eligible for ECM

Initial Identification Processes

What DHCS Requires

- » MCPs must identify eligible members for ECM through analysis of multiple forms of data to identify those who meet the “Populations of Focus” criteria
- » MCPs must receive and respond to referrals from providers or requests from Members and families themselves

What it Looks Like

- » Claims, encounters, and supplemental data used for AAH to generate eligibility list
- » Providers and CHWs may refer into the program – CHCN has centralized referrals
- » CHCN receives eligibility files from the health plans (AAH and ABC)
- » ECM eligible members are identified in EPIC
- » CHCN has a system to track members referred to the plans; so far, smooth with both plans

Outreach and Engagement



Outreach & Engagement

| What DHCS Requires in ECM | What it Looks Like |
|---|--|
| <ul style="list-style-type: none"> » ECM Providers are responsible for reaching out to and engaging assigned ECM eligible MCP members » Outreach and Engagement is considered one of the ECM "Core Services" and is factored into payment to MCPs » MCPs are expected to include compensation for outreach in their contracts with ECM Providers | <ul style="list-style-type: none"> » A clinic-based CHW: <ul style="list-style-type: none"> ▪ Completes a pre-outreach review of utilization and the medical record <u>and</u> ▪ Outreaches to member at a clinic appointment, via phone call, or at hospital » On average, it takes at least 3-4 interactions with a member to engage » CHW has support from clinic RN and social worker, as well as from CHCN staff » AAH pays for outreach <ul style="list-style-type: none"> ▪ Tiered payments based on outreach modality |

Assessment and Care Planning



Comprehensive Assessment & Care Management Plan

| What DHCS Requires in ECM | What it Looks Like |
|---|--|
| <ul style="list-style-type: none"> » ECM Lead Care Managers lead development of a comprehensive assessment with the ECM member, their family/support person, and providers » Care plan must incorporate physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports, and social drivers of health » Care plan must be: <ul style="list-style-type: none"> ▪ Reviewed, maintained, and updated appropriately ▪ Reassessed at an appropriate frequency | <ul style="list-style-type: none"> » Assessments <ul style="list-style-type: none"> ▪ All engaged members receive health and social drivers of health assessments embedded in the EHR (SUD, PHQ9, Mobility, Social Supports – this is called the Super Visit) ▪ CHW and patient create goals and CHW facilitates linkage to resources (e.g., patient requests medically tailored meals) » Care Plan <ul style="list-style-type: none"> ▪ Developed with patient, reflective of their goals and documented in the EHR ▪ Reviewed periodically in team meetings at the health center |

Enhanced Coordination of Care



Enhanced Coordination of Care

What DHCS Requires in ECM

- » Organize patient care activities and sharing the information with the multi-disciplinary care team
- » Maintain regular contact across providers serving the Member
- » Provide support and coordination for care and identifying and mitigating barriers to care
- » Communicate the member's needs in a timely manner
- » Ensure regular contact with the member and their support team

What it Looks Like

- » CHWs
 - Care is given by an embedded team that includes a CHW, who is the primary care coordinator
 - CHCN and experienced CHWs train new CHWs
 - CHCN LCSW and RN provide consultative support for CHWs
- » Care Coordination
 - Navigation, home visits, care coordination
 - Accompaniment to medical or other community appointments (as needed)

Health Promotion



Health Promotion

What DHCS Requires in ECM

- » Include services to encourage and support ECM members to make lifestyle choices based on healthy behavior
- » Work with members to identify and build on successes and support networks
- » Provide services (e.g., coaching) on healthy behaviors and skills strengthening to manage conditions and prevent chronic conditions
- » Link members to resources (e.g., smoking cessation courses, self-help recovery courses)
- » Leverage motivational interviewing to engage the member

What it Looks Like

- » Education around chronic conditions and self-management (e.g., impactive diet, asthma triggers, calendars/reminders for taking insulin)
 - CN Nurse conducts home visits for additional health education for patients (i.e., diabetes management)
- » Supports patient engagement with primary care, mental health providers, and specialists to facilitate long term health maintenance
- » Connect enrollees with MCPs for health education resources and home visits

Transitional Care



Comprehensive Transitional Care

What DHCS Requires in ECM

- » Facilitate ECM members' transitions from and among treatment facilities (including admissions and discharges)
- » Provide information to hospital discharge planners about ECM
- » Develop transition plan for members experiencing a transition, including evaluating for medical care needs and referring to appropriate services
- » Track ECM members' admission/discharge status
- » Coordinate medication review and reconciliation

What it Looks Like

- » CHWs are notified in real-time of an inpatient admission
- » CN RN supports CHWs if they visit patient in hospital
- » CN RN tracks patients who are in hospital and may participate in discharge planning
- » CN MD reviews discharge summary, distills the key points and identifies areas for CHW follow up post discharge
- » Discharged patients are discussed in team meeting
- » Coordinate with other transition of care programs

Member and Family Supports



Member & Family Supports

What DHCS Requires

- » Document a member’s authorized family and representatives to ensure all required authorizations are in place for communication with ECM providers
- » Ensure ECM Lead Care Manager serves as the primary point of contact
- » Identify supports needed for the member and/or family and assist in accessing the services
- » Provide education about care
- » Ensure the member has a copy of their care plan and understands how to request updates

What it Looks Like

- » CHWs employ a person-centered approach and use techniques such as motivational interviewing, harm reduction, and trauma informed care to build meaningful relationships with patient
- » CHWs include family members, friends, and/or faith leaders in planning and care, to the extent desired by the patient
- » CHWs ensure that the identified support people sign a release of information and are documented in the EHR

Coordination/Referral



Coordination of & Referral to Community & Social Support Services

What DHCS Requires

- » Determine appropriate services to meet the member’s needs, including social drivers of health, housing services, and Community Supports
- » Coordinate and refer member to available community resources and follow up after referral

What it Looks Like

- » CHWs utilize a centralized resource directory created and updated by CN central staff
- » Linkages to community and social supports
- » Connection to housing resources
- » CHWs participate in phone calls/meetings with members and social services to provide support, follow through, and encouragement

Connecting ECM to Local Community Supports

Community Supports are services that **MCPs are strongly encouraged but not required to provide** as substitutes for utilization of other healthcare services or settings.

Community Supports offered by AAH:

1. **Housing Transition Navigation Services**
2. **Housing Deposits**
3. **Housing Tenancy and Sustaining Services**
4. Short-Term Post-Hospitalization Housing
5. **Recuperative Care (Medical Respite)**
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications)
12. **Meals/Medically-Tailored Meals or Medically-Supportive Foods**
13. Sobering Centers
14. **Asthma Remediation**

ECM Payment Model

Payment for ECM

What DHCS Requires

- » MCPs must pay contracted ECM Providers for the provision of ECM in accordance with contracts established between MCPs and each ECM Provider
- » MCPs are encouraged to tie ECM Provider payments to value
- » DHCS does **not** set rates paid to ECM Providers. MCPs negotiate with ECM Providers

What it Can Look Like (Alameda Health Alliance example)

- » Eligibility list generated from data + referrals
- » Payment Per-Enrollee-Per-Month (PEPM) continued from HHP/WPC
 - High risk tier (higher payment):
4 encounters/month, ≥ 1 face-to-face
 - Low risk tier (lower payment):
 ≥ 1 encounter/month

Data Sharing: Bird's Eye View

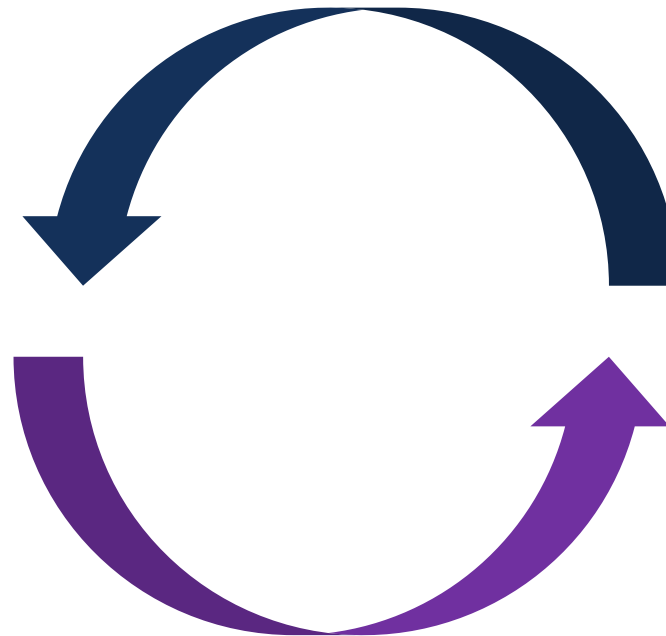
Monthly "Member Information File"



COMMUNITY HEALTH CENTER NETWORK

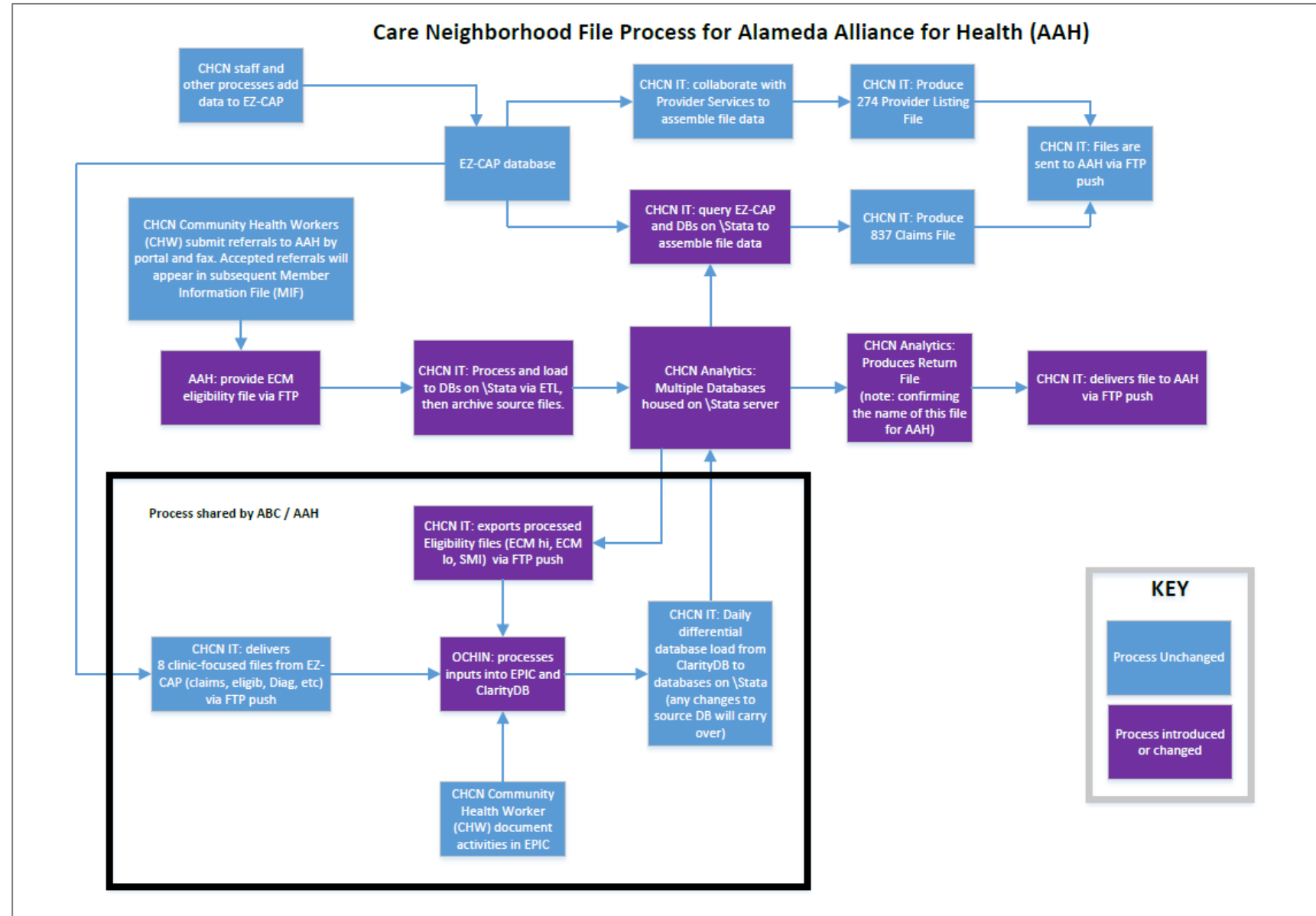
EPIC EHR

System of record for all CHWs, PCPs, and all clinic staff



Monthly "Return Transmission File"

Up Closer: "It's Complicated"



Training for ECM Lead Care Managers

- » **At CHCN, lead care managers are Community Health Workers**
- » AAH hosts ongoing monthly learning collaboratives and is establishing a standard onboarding training for all ECM Providers and staff
- » CHCN leverages experienced CHWs to train and provides consultative support from CHCN RN and LCSW for CHWs serving as lead care managers
- » CHCN provides initial onboarding and training and manages a bi-weekly meeting for CHWs and training
- » Trainings for new CHWs takes roughly two weeks, including elbow support, crisis protocols, EHR documentation, mandated reporter training, etc.
 - CHWs are usually up to speed (managing 30+ patients) within 8 months
- » CHCN supports the community health centers in their hiring of CHWs and how to identify successful CHWs, focus on lived experience rather than a full resume, etc.

ECM Excitement & Challenges

Excitement

- » So many people getting coordinated care to better navigate our fractured systems
- » Social drivers of health recognized and now we can intervene
- » CHWs get hands on medical experience and can use this for furthering their health care careers
- » The Populations of Focus are expanded
- » Highlights for Care Neighborhood enrolled patients (3 months post enrollment)
 - 37% decrease in inpatient admissions
 - 32% decrease in emergency department visits
 - 71% drop in total health care costs (on average)

Challenges

- » Transitioning data sharing processes from HHP/WPC to ECM
- » Supporting CHWs as they navigate the hierarchy of working with licensed professionals
- » CHW salaries in the very expensive Bay Area
- » CHW advancement – need career ladders
- » Housing crisis in Alameda County remains a major barrier for patients and exacerbates mental health issues



Upcoming Webinars

ECM TA Webinar #2: ECM in Rural California

Tuesday, June 14th
11:30 AM – 1:00 PM PT

Register [here](#)

ECM TA Webinar #3: ECM & Community Supports

Tuesday, June 21st
10:00 – 11:30 AM PT

Register [here](#)

CalAIM PHM Advisory Group July Meeting

Wednesday, July 27th
10:30 AM – 12:00 PM PT

Register [here](#)

Community Supports Webinar: Sobering Centers

Wednesday, June 15th
1:00 – 2:00 PM PT

Register [here](#)

Medi-Cal Children's Health Advisory Panel Meeting

Thursday, July 14th
TIME TBD

Register [here](#)

Community Supports Webinar: Asthma Remediation

Wednesday, July 20th
12:00 – 1:00 PM PT

Register [here](#)

Review DHCS Resources & Materials for Providers

- » Learn more about ECM & Community Supports:
 - [Policy Guide](#)
 - [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/provgovpart/Pages/CalAIM.aspx>

For more information about ECM and Community Supports, visit:

<https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices>

Send questions or comments to

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