DHCS | PATH

Providing Access & Transforming Health

BluePath HEALTH

Tri-Counties CalAIM PATH Collaborative

August 21, 2024

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Welcome!

BluePath HEALTH

Please introduce yourself in the chat:

- Name
- Organization
- Your role in CalAIM implementation

August 21 Collaborative Meeting

Agenda	
Welcome	**5**
The Role of Hospitals and Health Systems in CalAIM ● *Amelia Grover and Elizabeth Snyder, Dignity Health* ● *Maureen Hodge, Community Memorial Hospital* ● *Deanna Handel, Ventura Health Care Agency*	**30**
DHCS ECM and Community Supports Implementation Data	**10**
Managed Care Plan Updates	**10**
Resources, Upcoming Events, and Closing	**5**
Optional Office Hours	**45**

2024 Aim Statement and Drivers

The Collaborative will increase the number of members referred to ECM and Community Supports, and the number of those successfully enrolled in and utilizing services.

- Build education and awareness of CalAIM among members, providers, and community partners
- Strengthen the provider network to serve all Populations of Focus
- Increase ECM & Community Supports referrals and care coordination among providers

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The Role of Hospitals and Health Systems in CalAIM

Community Referrals: Needs and Opportunities

The Need

- Increase the proportion of ECM and Community Supports referrals that come from the community

Current Challenge

- Current referral pathways rely on the Member Information File (MIF) and outreach to the member from CBOs, yielding low referral rates

What We Know

- Those with existing member relationships are best positioned to identify eligible members and connect them with services
- When members are identified as potentially eligible, current referral processes are not optimized

Shared Goal

- Robust and streamlined community referral pathways to enroll more members who can benefit from ECM and Community Supports

Collaborative Role

- DHCS and the CalAIM PATH Collaboratives can identify promising practices to build community referral pathways

Central Coast Hospitals
MRMC-AG and French

Cal AIM-Enhanced Case Management (ECM)
Transitional Care Center

Elizabeth Snyder, MHA, Sr Director
Amelia Grover, LCSW Manager Social Work
Central Coast Hospitals
August 21, 2024

Dignity Health™
Marian Regional Medical Center

What is CalAim, ECM, & Populations of Focus?

California Advancing and Innovating Medi-Cal (CalAIM)

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.

Enhanced Care Management (ECM)

A new benefit for patients that will provide intensive wrap-around health and social service navigation. ECM is designed to address the *clinical and non-clinical* needs of the CenCal (and State Medi-Cal) patients through true whole person care.

Populations of Focus

CenCal went live with the ECM benefit in July of 2022 and selected 3 Populations of Focus, which are:

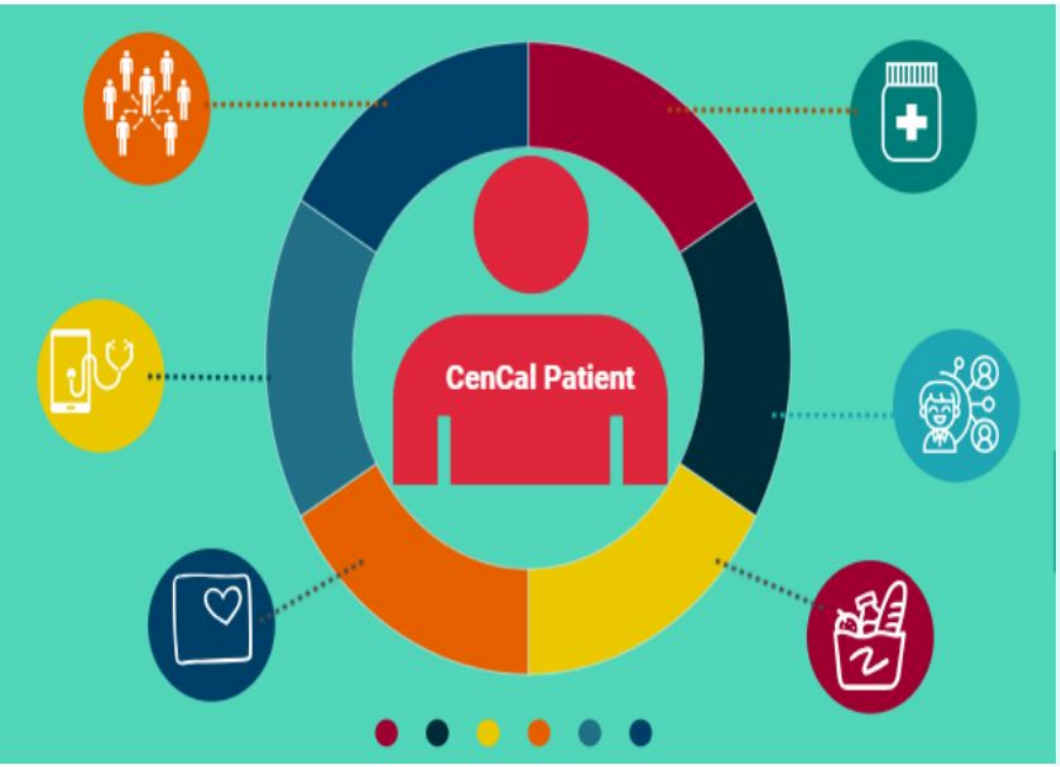
(1) High Utilizers of the ED
(2) Homelessness
(3) Substance Use Disorder (SUD)

Program Design: Transitional Care Center -CalAIM

Key Functions Responsibilities	Nurse Practitioner	RN	Licensed Social Worker	Health Care Worker II	Promotores (Cal Aim-ECM)	Pop Health Data Analyst	Admitting Registrar
Social Determinants of Health				x			
Schedule Transportation for medical appointments				x	x		
Authorizations for Medically Tailored Meals, coordination with Food Pantry, Food Bank and other resources				x			
Schedule PCP Appointments				x	x		
Medicare, Medi-Cal, CenCal, Insurance enrollment/coordination				x			
DME Access & Coordination				x			
Access to medication; pharmacy and APA				x	x		
Patient Assessment	x	x	x				
Disease Management	x	x	x				
Care Planning	x	x	x				
Medication Reconciliation and Management	x	x					
Execute Care Plan within Dignity Network		x	x	x			
Complex Care Coordination	x	x	x				
Behavioral Health Referrals/Resources			x	x	x		
Community Resource Referral			x	x	x		
Financial Assistance and Resources			x	x	x		
Home Visits					x		
Patient Education	x	x	x	x	x		
Rounds in Provider Office	x		x				
Coordination with Medical Respite Programs	x	x	x	x			
Select and Manage Pursuit List	x					x	
Support FY Quality Metrics	x	x	x	x		x	
Referral & Enrollment to DEEP and other Wellness/Education Programs			x	x	x		
Supports Ambulatory efforts in Quality/Gaps in Care	x	x	x			x	
Coordinate ECM admissions with clinicians and HCWs							x
Admit patients in MS4							x
Monitor number of ECM patients and work with providers to drop charges							x
Run monthly reports for TCC programs and goals and identify trends						x	

Enhanced Care Management (ECM) Goals:

Phase I-Population of Focus: Homeless, High Utilizers-ED, SUD

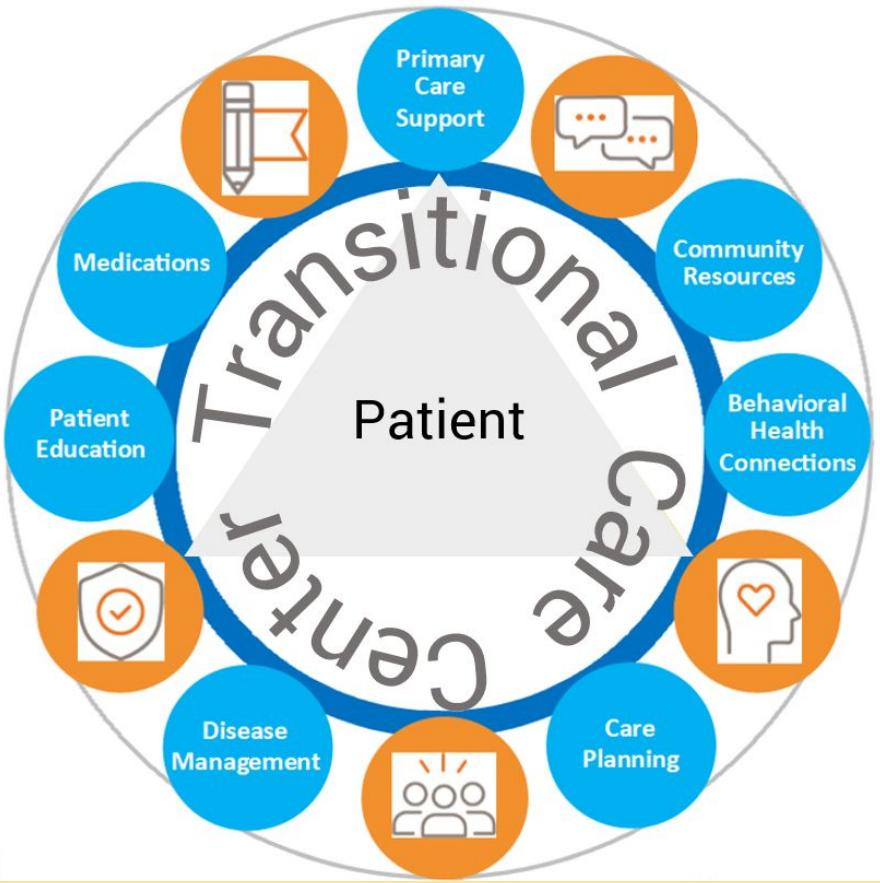


- Addressing Social Determinants of Care (SDOC)
- Improving coordination of care
- Integrating services
- Facilitating community resources
- Improving health outcomes
- Decreasing avoidable utilization and duplication of services

Program Design: Transitional Care Center

The Framework:

- Telephonic outpatient case management
- Address medical and non-medical needs
- Identify populations of risk.Contact all high risk patients who discharge from the 3 Hospitals



ECM Core Service Components

- Outreach to and Engagement with to 1,300 identified patients (Community Health Workers)
- Care Management to 472 enrolled patients (LCSWs and RNs)
- MRMC- Outpatient Admission and documentation in Cerner
- Integration with Hospitals, Clinics, Shelters, Housing, Community Partners and Health Systems

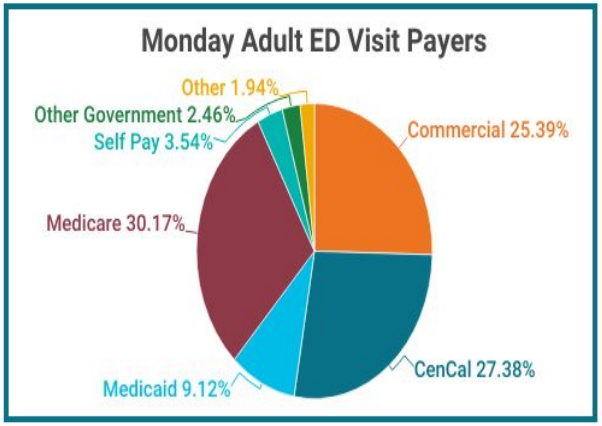
All Hospitals

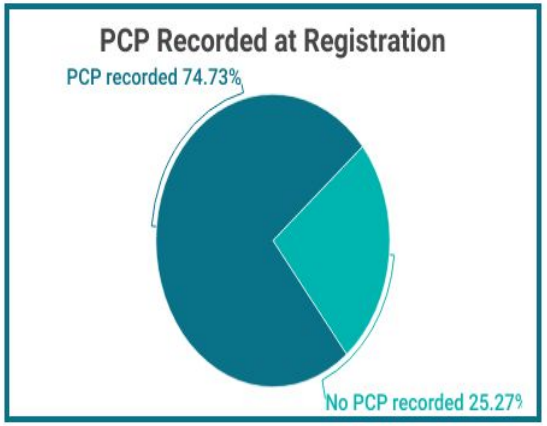
July 2023 - Jan 2024

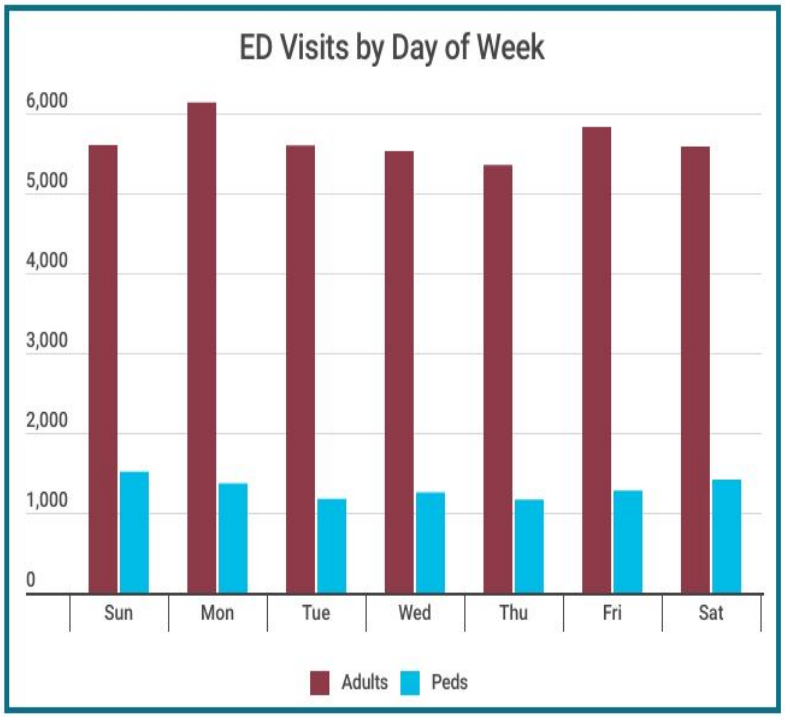
44.7% of Pediatric Visits are After 5pm

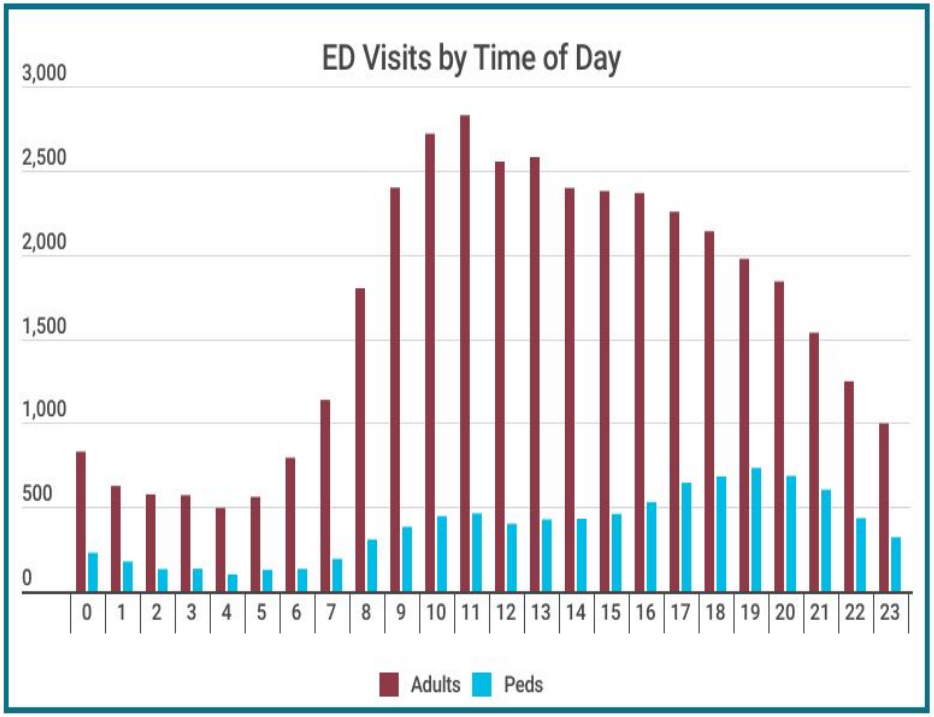
30.3% of Adult Visits are After 5pm

15.5% of Adult Visits are on Monday









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Transitional Care Center

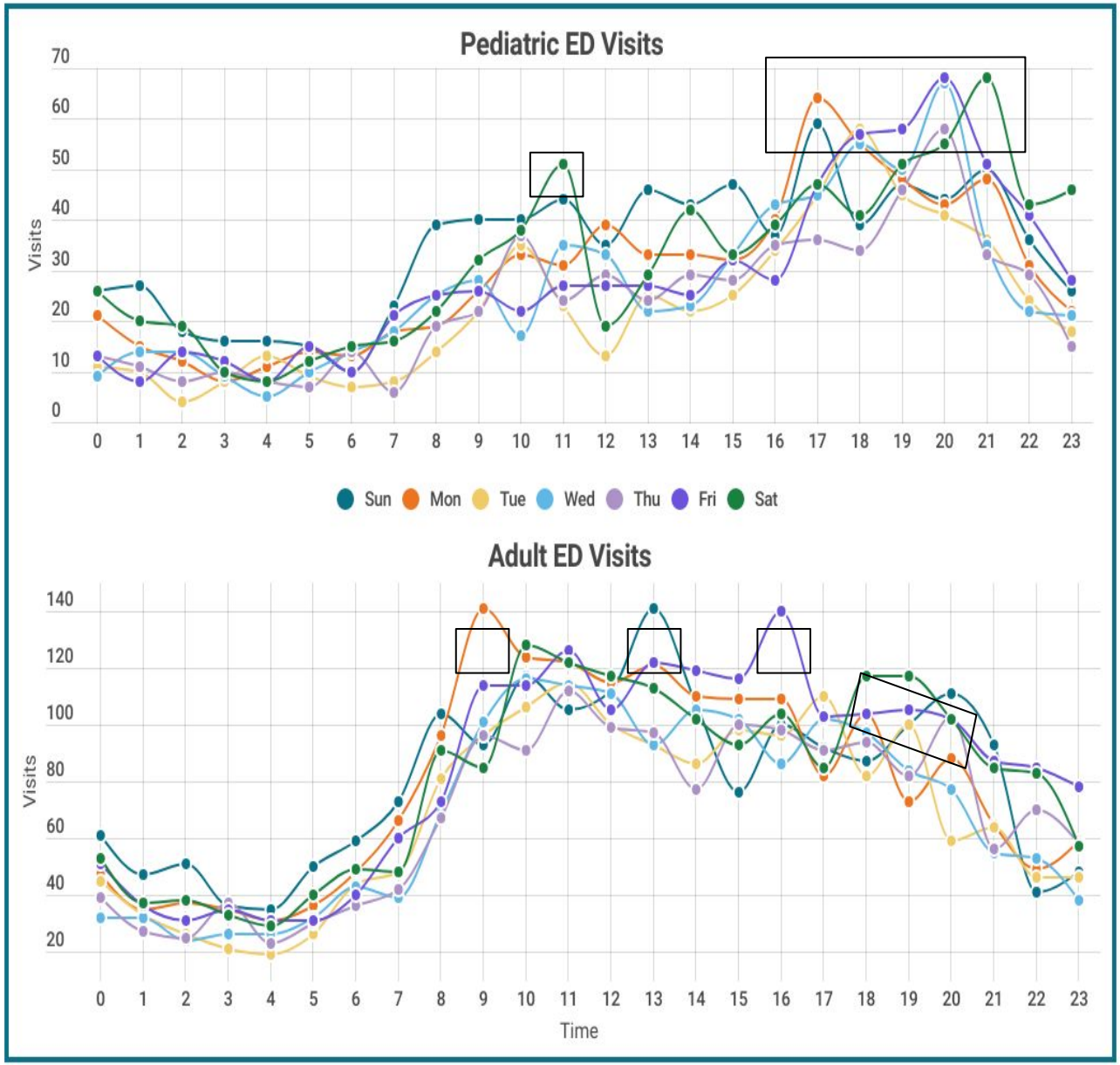
MRMC

July 2023 - Jan 2024

Top Reasons for ED Visits

Issue	Visits
Abdominal Pain	709
Chest Pain	638
Laceration	637
Pregnancy Related Complications	532
Acute Upper Respiratory	480
Nausea, Vomiting	423
Ear Infection	402
Left before seen	382
UTI	380
Headache or Migraine	366
Fracture	364
Contusion	343
Sprain or Strain	337
Viral Infection, Unspecified	330
Back Pain	300

- 44.5% of Pediatric Visits are After 5pm
- 31.2% of Adult Visits are After 5pm
- 14.95% of Adult Visits are on Monday



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Transitional Care Center

AGCH

July 2023 - Jan 2024

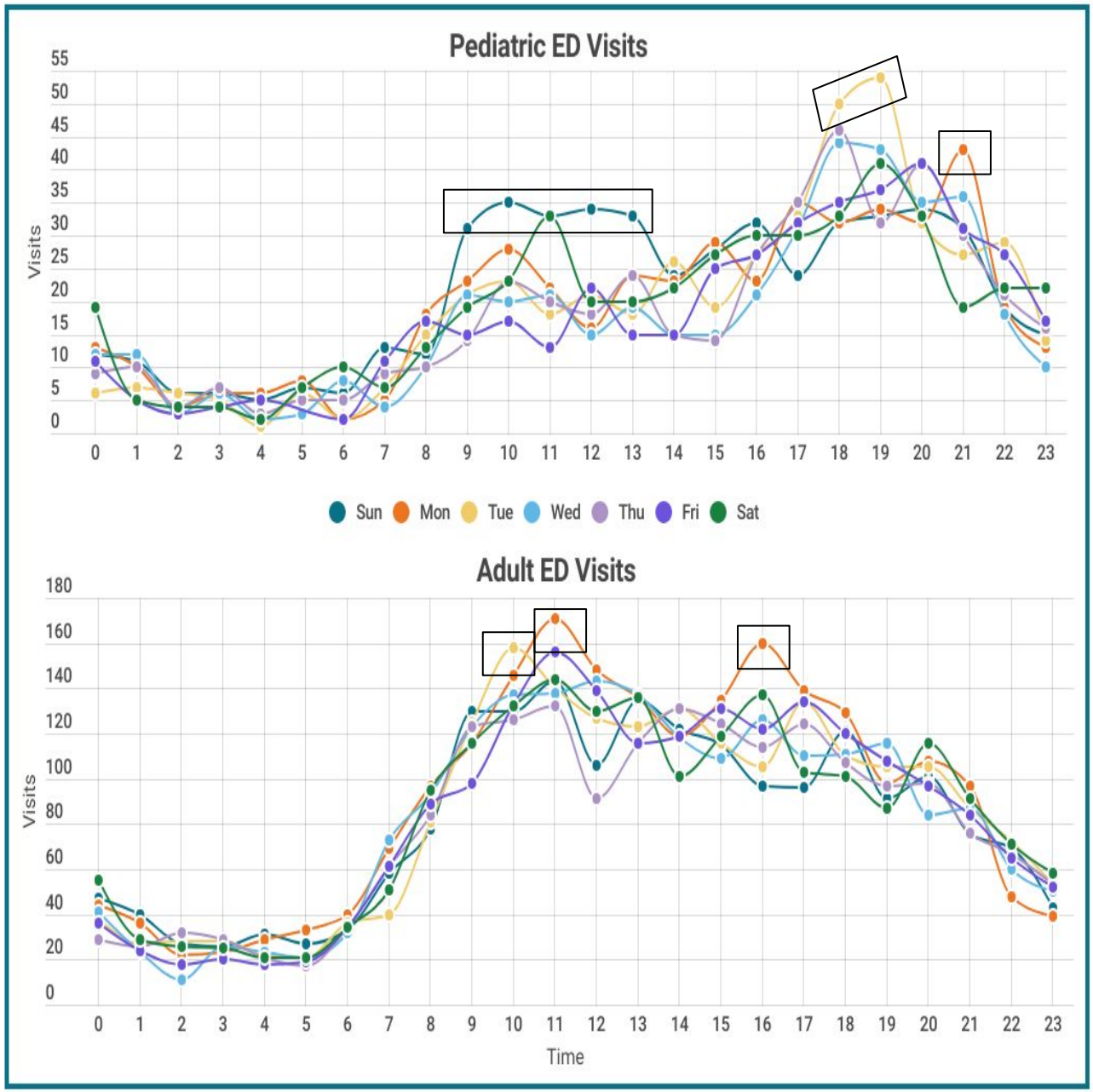
Top Reasons for ED Visits

Issue	Visits
Acute Upper Respiratory	820
Abdominal Pain	740
Chest Pain	638
Laceration	637
Pregnancy Related Complication	417
Fracture	412
Ear Infection	402
Nausea, Vomiting	386
UTI	385
Left Without Being Seen	382
Sprain or Strain	370
Headache or Migraine	366
Contusion	343
Back Pain	342
Sore Throat	259

46.6% -of Pediatric Visits are After 5pm

31.7% of Adult Visits are After 5pm

15.5% of Adult Visits are on Monday



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Transitional Care Center

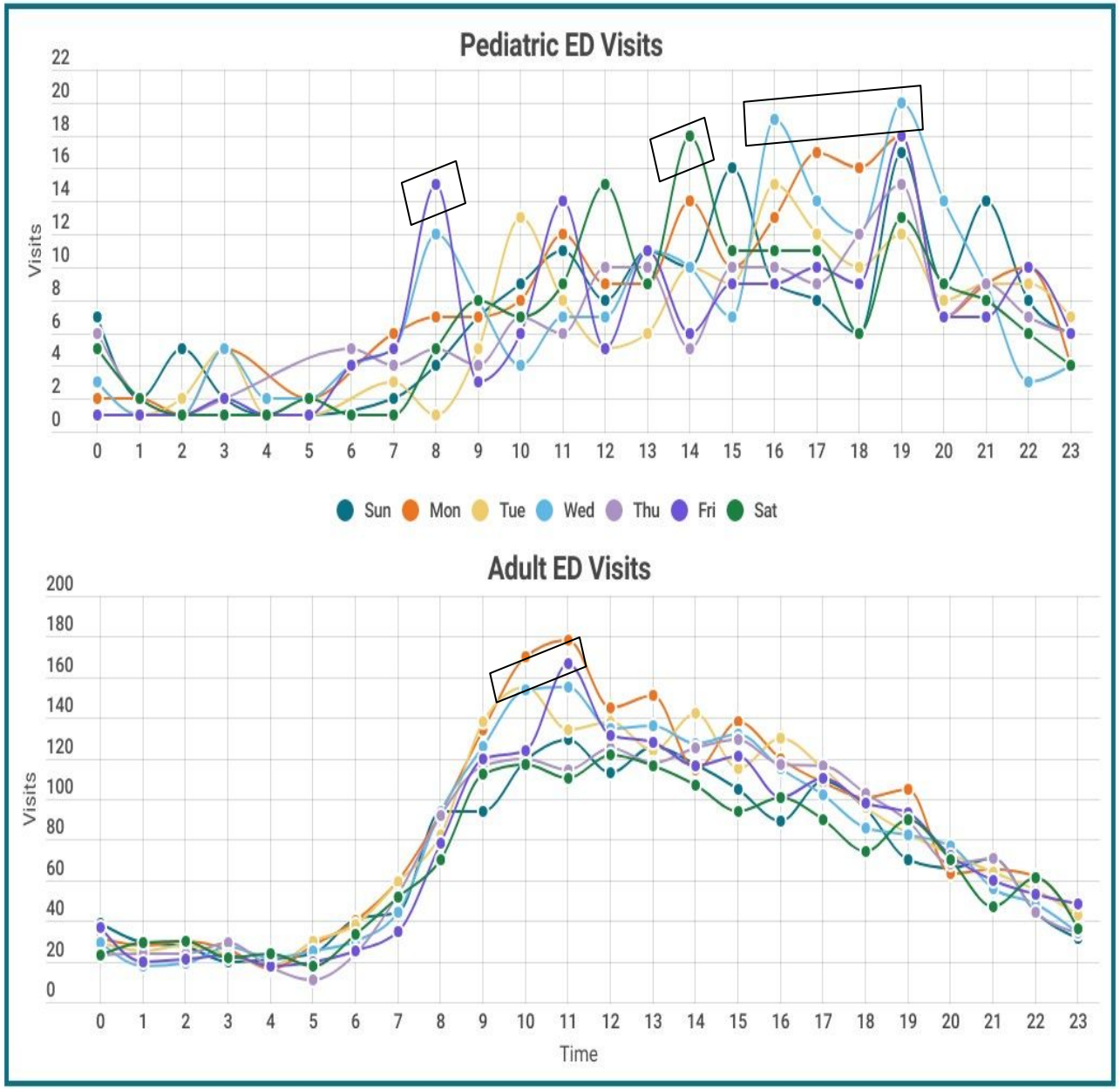
FHMC

July 2023 - Jan 2024

Top Reasons for ED Visits

Issue	Visits
Abdominal Pain	921
Acute Upper Respiratory	615
Laceration	607
Fracture	585
Chest Pain	575
Back Pain	450
Sprain	407
Contusion	396
UTI	362
COVID-19	344
Cellulitis	322
Cough, Unspecified	315
Headache or Migraine	311
Ear Infection	298
Sore Throat	287

- 40.8% of Pediatric Visits are After 5pm
- 27.8% of Adult Visits are After 5pm
- 15.95% of Adult Visits are on Monday



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Transitional Care Center

ECM and the Dignity Health Hospitals

CARE COORDINATION EFFORTS:

- The Social Workers have access to the CenCal Provider Portal
- **Current state**: checking ECM care provider on referrals to SW and engaging the ECM provider (focusing on high risk ER cases)
- **Future State**: Engage ECM in care planning as appropriate and/or handing off care plan to ECM provider
- The **Social Worker** team making referrals to ECM on patients who would benefit from this service
- **Integration/Partnership** with Transitional Care Center team

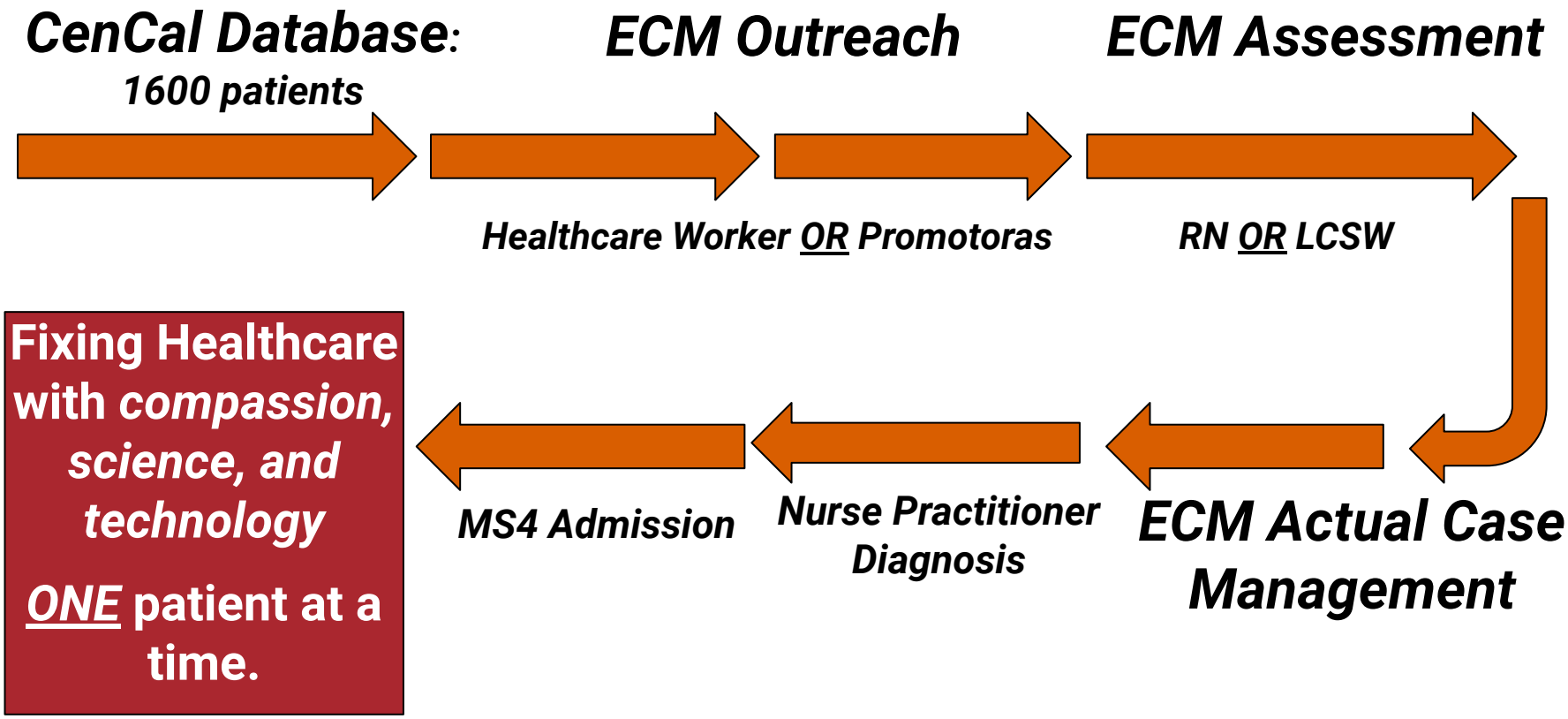
Collaboration Success # 1

- **Patient A**
  - **SLO PH assigned ECM provider**
  - **Collateral**
  - **Trust building interventions**
  - **Care planning collaboration**
  - **Multi-agency meeting**
  - **Outcome: Patient d/c to right level of care with cohesive community plan**

Collaboration Success # 2

- **Patient B**
  - **History of multi-agency collaboration due to complex, high risk needs**
  - **SLO PH assigned for outreach, but unsuccessful outreach**
  - **Patient well known to hospital due to age and health condition(s)**
  - **Prado initiated urgent multi-agency meeting prior to patient coming to hospital**
  - **Collaboration for ECM Lead**

CalAim Enhanced Case Management Pathway*



Enhanced Care Management Program

Maureen Hodge, LCSW
Director of Ambulatory Behavioral Health and Grants

The CMH Behavioral Health Team is committed to supporting the mental, physical and social health of CMH patients by *providing* integrated behavioral health resources including individualized mental health resources, psych-social education, supportive referrals offered throughout the county.

What are CMH BEHAVIORAL HEALTH PROGRAMS

Behavioral Health Integration (BHI)

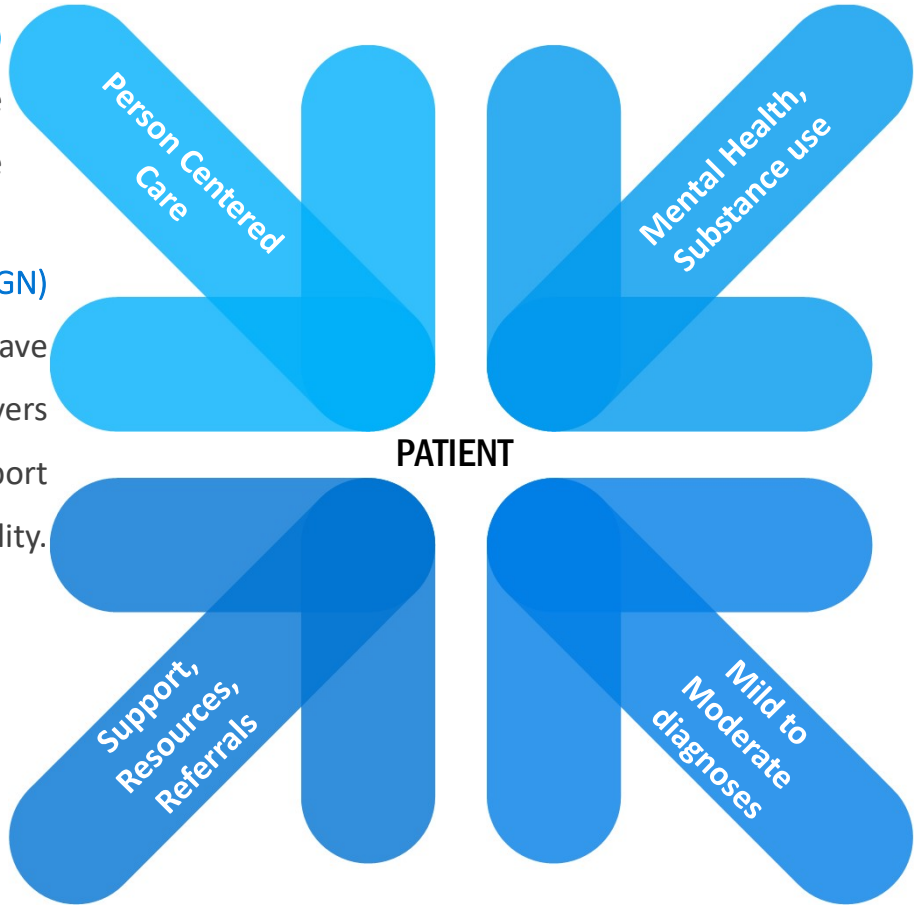
Patients with mild to moderate Depression, Anxiety, Substance Use

Caregiver Navigator (CGN)

Caregivers of patients who are in crises, have chronic conditions, dementia, or caregivers need direction and support to support patient stability.

Substance Use Navigation

Patients in the ED with mental health or Substance Use issues or those leaving the Justice System will work with LCSW and Addiction Specialist (MD or PA.)



Enhanced Care Management Program (ECM)

Patients with mental health or substance use issues, multiple ED or hospital visits, or are at risk of Long Term Placement. Gold Coast Only

Psychotherapy 1:1

Patients see LCSW or Clinical Psychologist for traditional or telehealth mental health support.

High Risk Case Management

Patients with 2 or more chronic conditions, ED/Hospital visits, poly pharm can be referred to RN Case Manager.

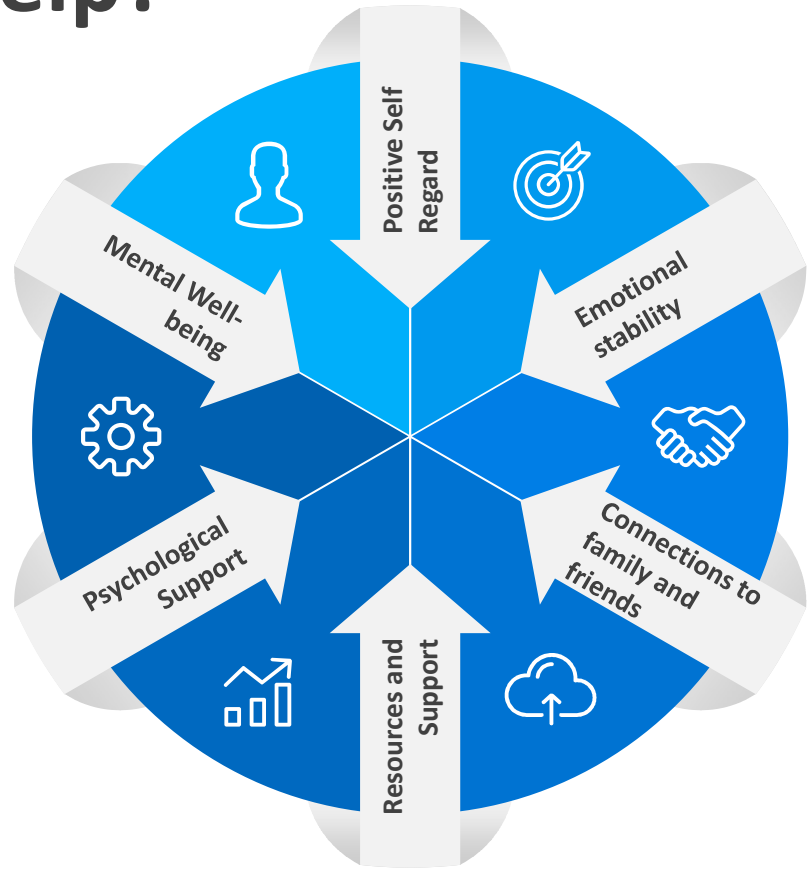
What does Behavioral Health Team provide and how can we help?

Social Determinants of Health

Review Health, Education, Transportation, Housing, Finances, Social & Community Connections.

Mild to Moderate Mental Health

Referrals to mental health providers both internal or external, psychiatry, substance use groups, and more.



Resources and Support

Referrals, Supports, or Programs that can support patient's mental health.

Patients with Chronic Conditions

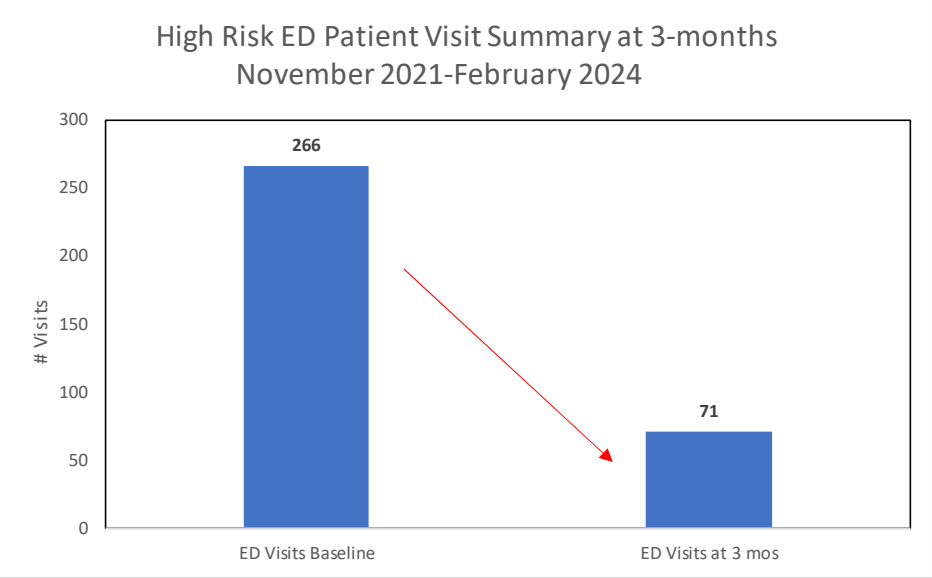
Multiple health conditions often means significant supports for specialty appointments, guidance, and direction.

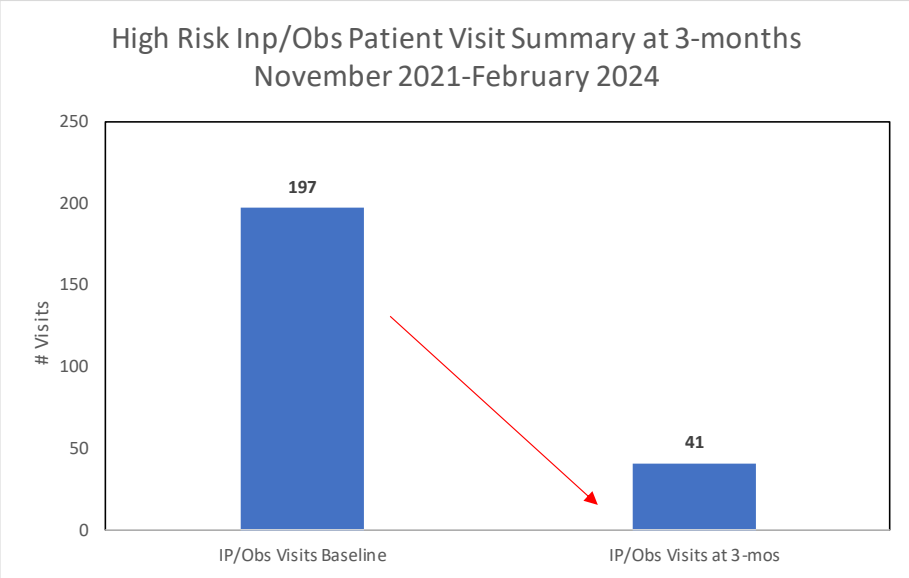
ED Patient Visit Summary 3 Months with High Risk RN

High Risk ED Patient Visit Summary at 3 Months

# patients with 3-month follow-up =	88	**ED visits reduced by:**
ED baseline visit count =	266	**73%**
ED visits at 3 months =	71	

# patients with 3-month follow-up =	88	**Inp/Obs visits reduced by:**
Inp/Obs baseline visit count =	197	**79%**
Inp/Obs visits at 3 months =	41	





ED Patient Visit Summary 6 Months

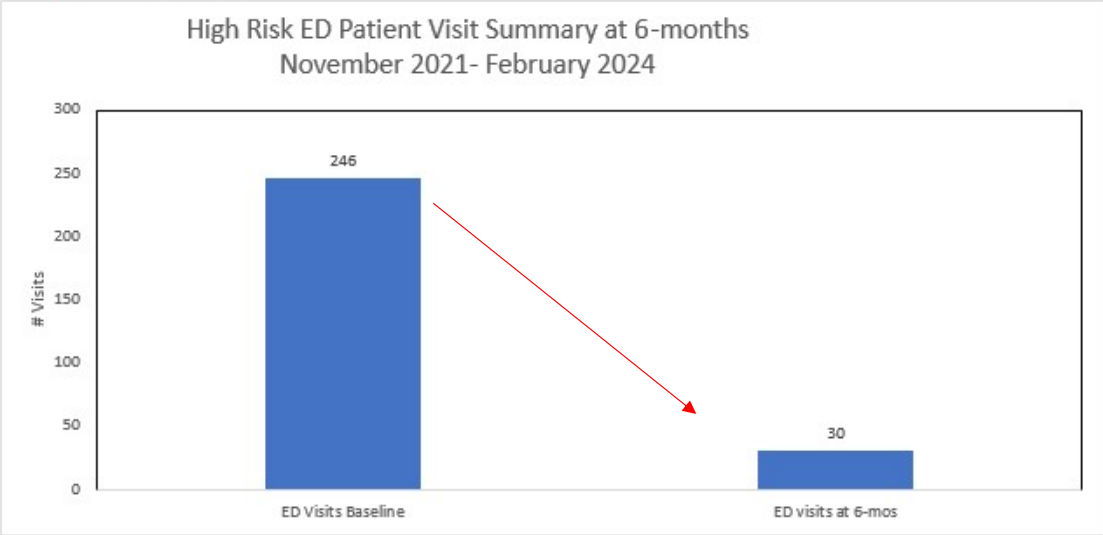
High Risk ED Patient Visit Summary at 6 Months

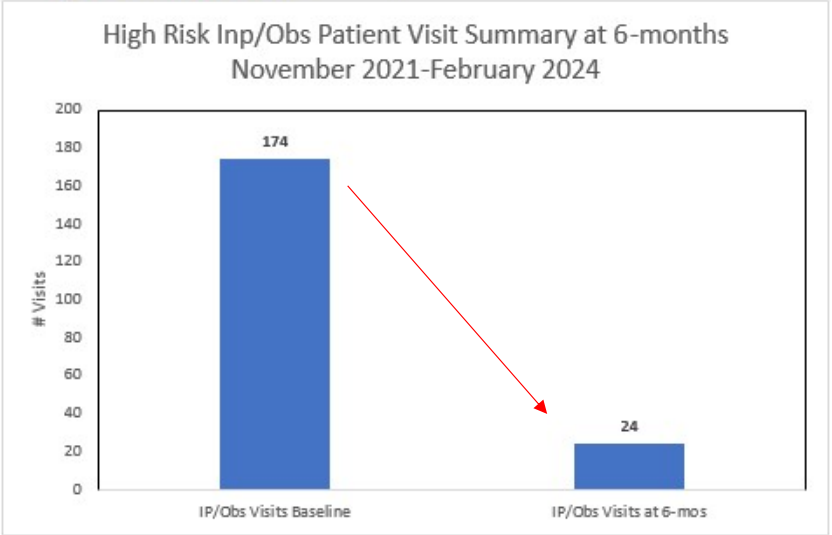
# patients with 6-month follow-up	78
ED baseline visit count =	246
ED visits at 6 months =	30

ED visits reduced by: 88%

# patients with 6-month follow-up	78
Inp/Obs baseline visit count =	174
Inp/Obs visits at 6 months =	24

Inp/Obs visits reduced by: 86%





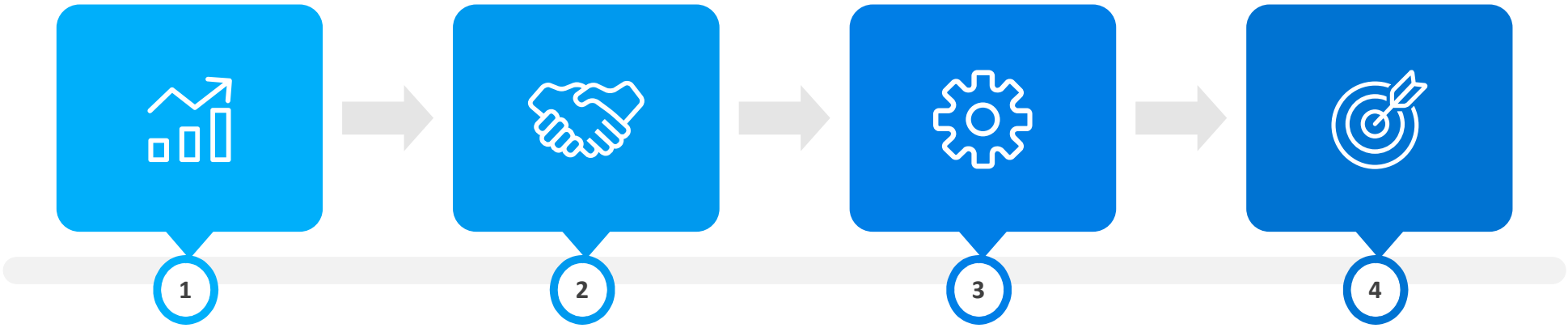
Highlights of ECM to date

- Integration of all Inpatient and Outpatient programs for ECM Referrals (28 outpatient clinics, two hospitals)
- Active Continuity between inpatient and outpatient social service/case management staff to engage & identify high risk patients eligible for ECM
- Providers engaging at a higher level
- Importance of the CHW role – new to our system and going well
- Existing licensed and master level staff critical to program
- Justice Involved patients enrolling in ECM in conjunction with our COSSUP Grant

Opportunities for Warm Handoffs

- Within the CMH Health system, referrals come from:
  - Substance Use Navigator from the ED
  - Case Management and Social Services Department within the system
  - Providers from any one of our 28 Ambulatory Health Clinics (MD's, APP's, Nurses)
  - Chronic Case Management Ambulatory Team (RN's, LVN's)
  - Justice Involved COSSUP Program from Ventura County Jail
  - Gold Coast Health Plan Referrals (Receive from partners through CS program)
  - Ambulatory High Risk Case Management

What Is the Referral Process?



1

Referrals come from Email, Task, or phone call inquiry

2

Staff Follows up with Patient via phone

Patient will receive a minimum of 3 calls for Outreach & sometimes more depending on each situation

3

Staff Schedules Appointment and does Initial Intake

Staff go anywhere that meets the patient's needs

4

Patient Receives Ongoing Support in person, Telehealth, and regular check in calls.

Staff communicate regularly with providers for updates as needed.

AMBULATORY BEHAVIORAL HEALTH TEAM

BEHAVIORAL HEALTH INTEGRATION (BHI)/ PSYCHOLOGICAL SERVICES

- Mayra Medina, BHI Coordinator
- Chris Lee, LCSW
- Jennifer Elson, LCSW
- Jacquelyn Valles, LCSW

CAREGIVER NAVIGATOR (CGN)

- Janice Aharon-Ezer, LMFT

HIGH RISK CASE MANAGEMENT (HRCM)

- RN – Onboarding now

MSW INTERNSHIP PROGRAM

2 Students for Behavioral Health Team starting September, 2024

ENHANCED CARE MANAGEMENT (ECM)

- Tatiana Salinas, ECM Coordinator
- Dailey Whitehouse, LCSW
- Armida Marquez, MSW
- MSW (onboarding now)
- Angel Sanchez, RN
- Maricela Sanchez, Community Health Worker
- Maricela Morales, Community Health Worker
- Silvia Espinosa Magana, Community Health Worker
- Dr. Lara, Clinical Champion

COSSUP/SUBSTANCE USE NAVIGATION (SUN)

- Chris Lee, LCSW
- Ian Anderson, CADC
- Alexa Genesi, CADC

Community Memorial HEALTHCARE

Thank you!

Maureen Hodge, LCSW
Director of Ambulatory Behavioral Health and Grants
mhodge@cmhshealth.org
Office 805-948-2816

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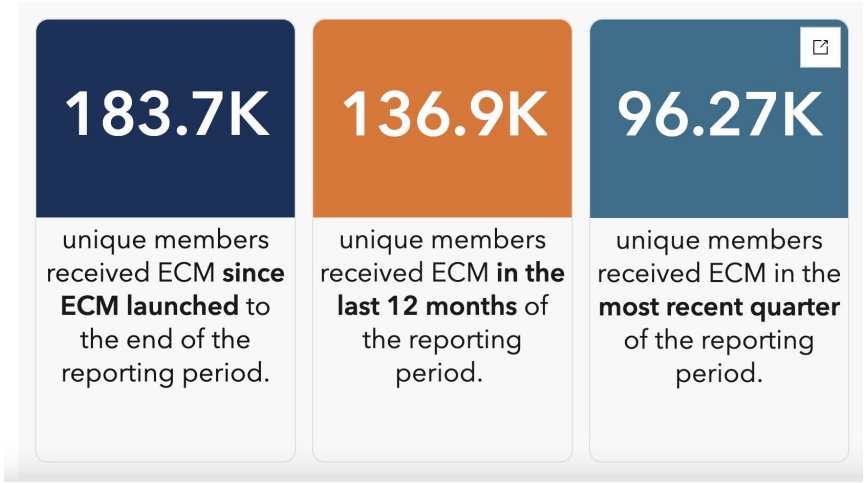
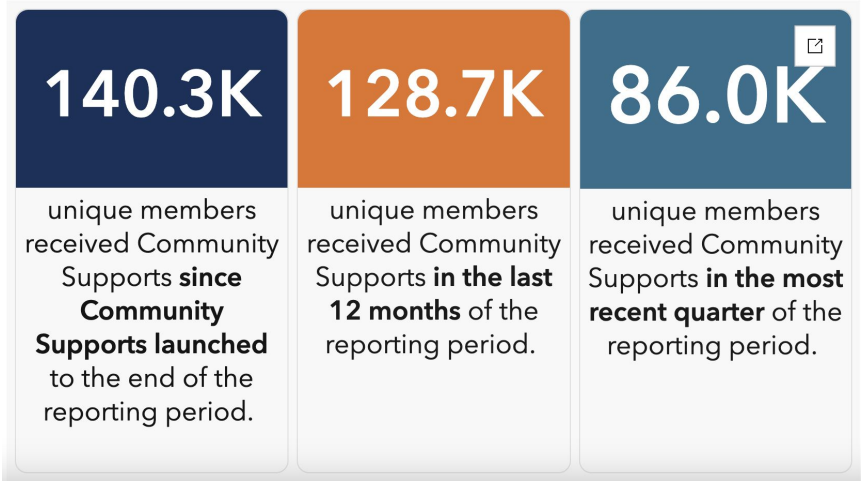
The Role of Hospitals and Health Systems in CalAIM

DHCS ECM and Community Supports Implementation Data - August 2024 Update

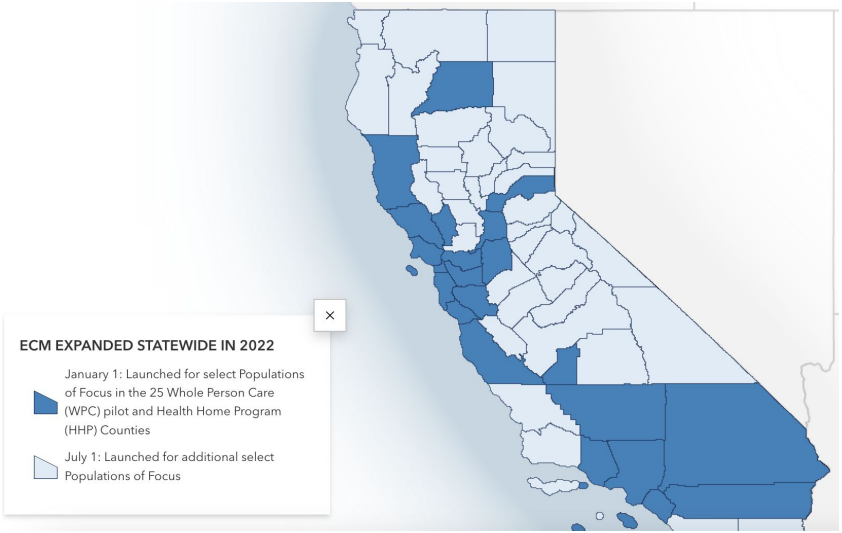
DHCS Implementation Report

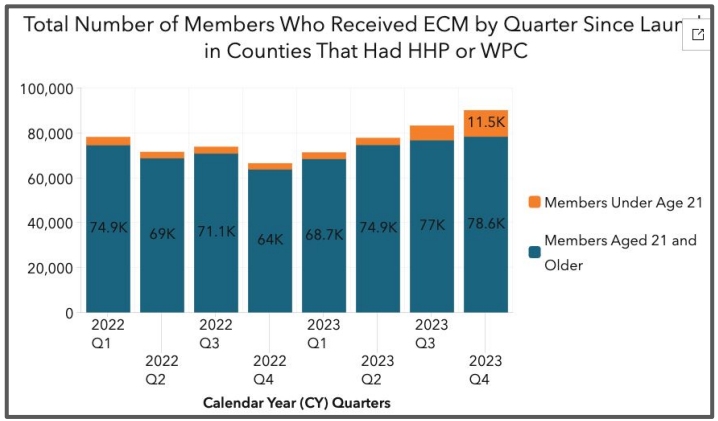


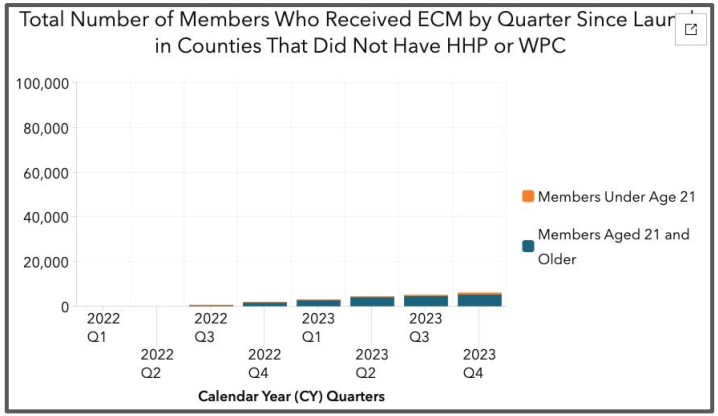


DHCS Implementation Report

Whole Person Care/Health Homes Pilot Counties vs. Non-WPC/HHP Counties

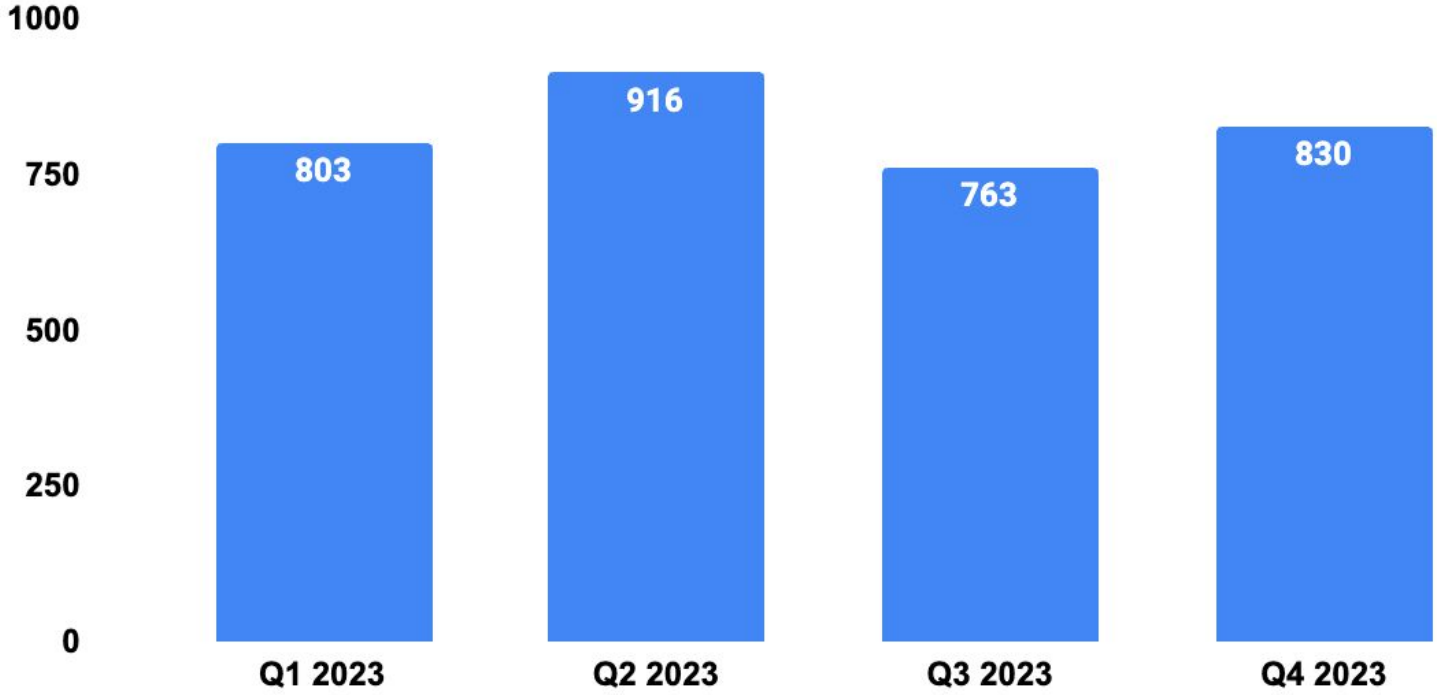






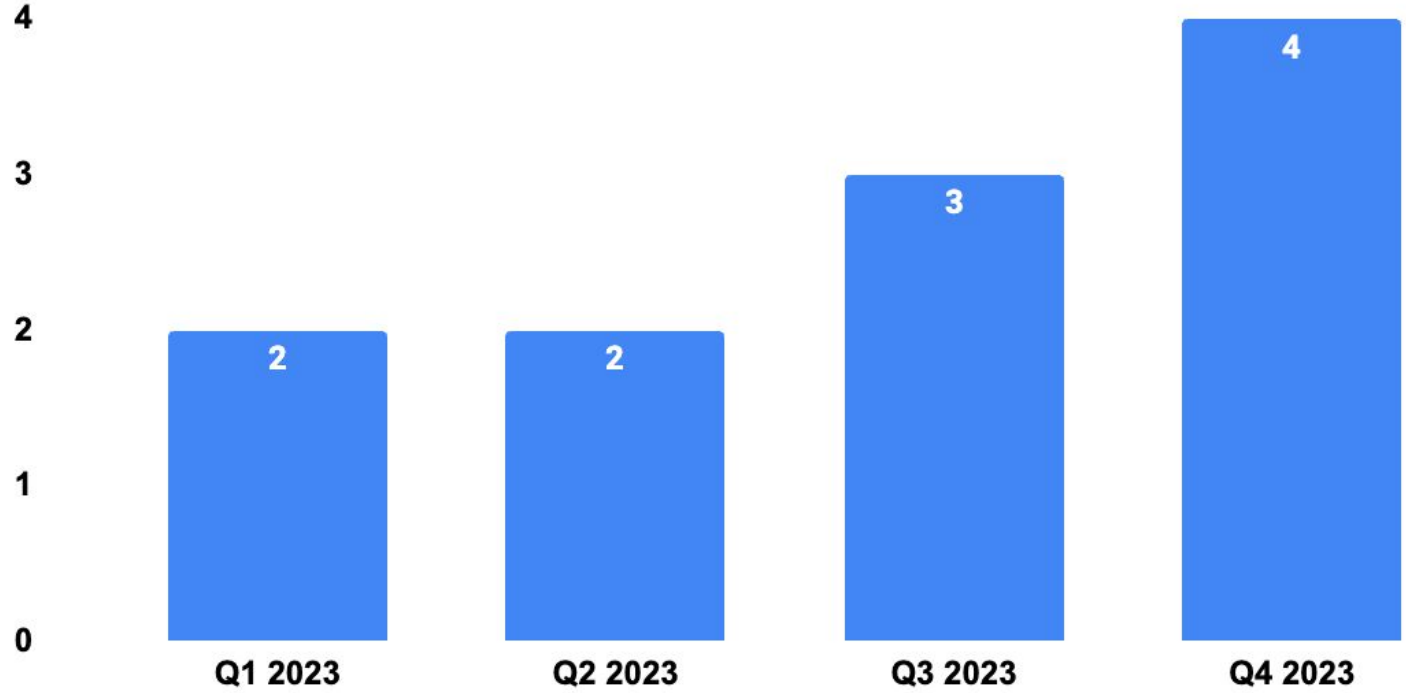
Ventura

Total Members Who Received ECM in Ventura County, by Quarter



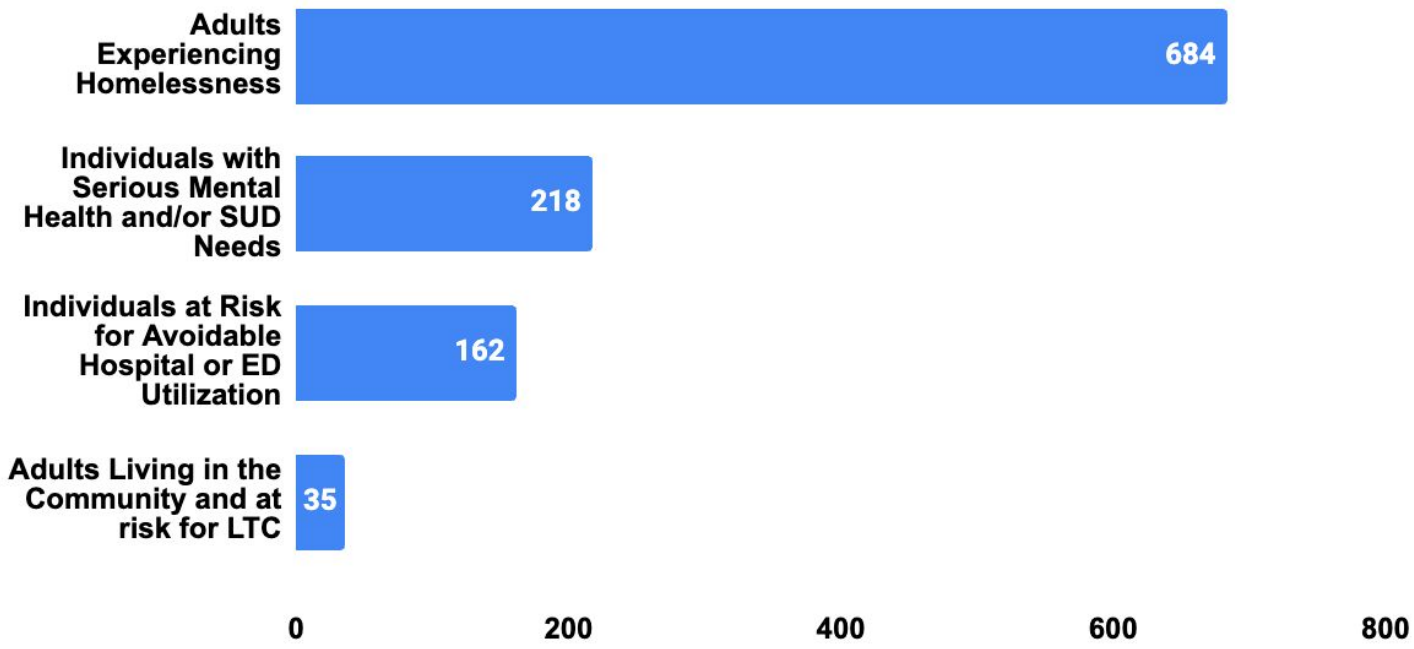
Total Members Who Received ECM in Ventura County, by Quarter

Total Number of ECM Provider Contracts In Ventura, by Quarter



Total Number of ECM Provider Contracts In Ventura, by Quarter

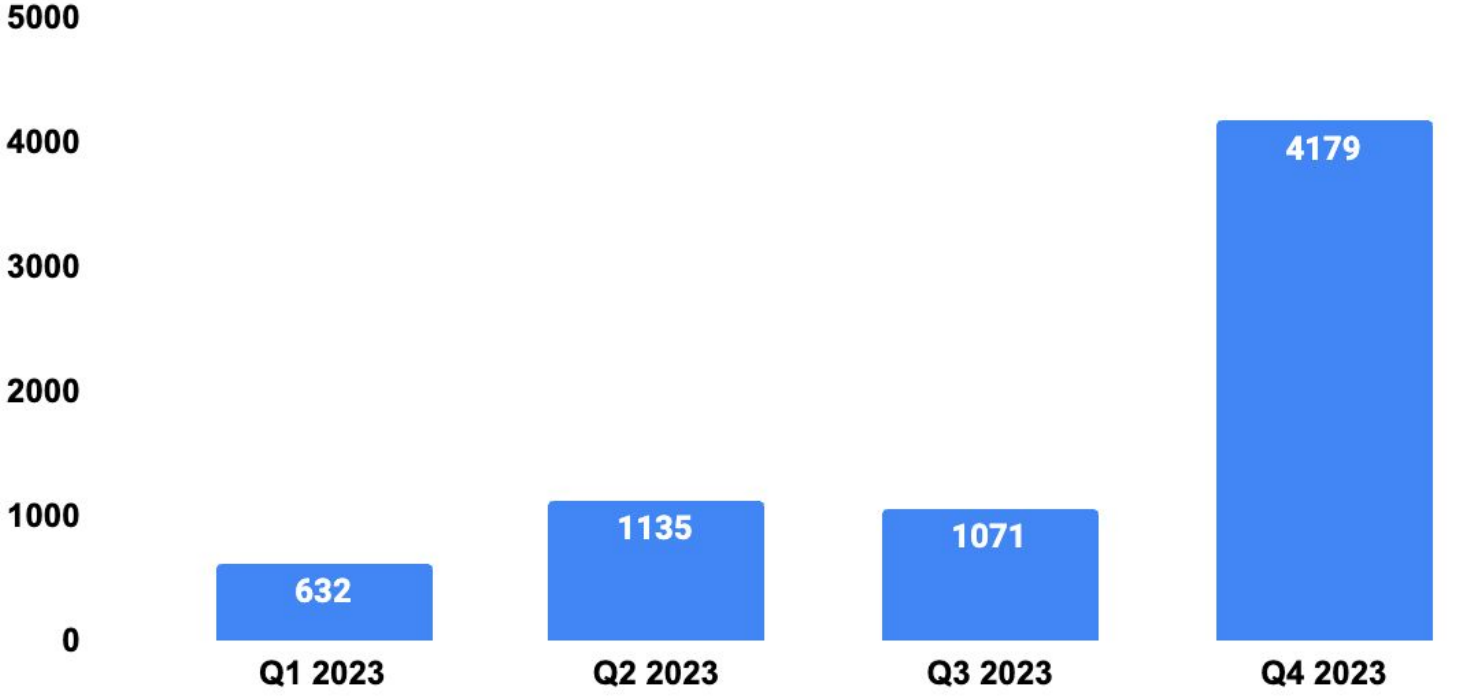
Total Members who Received ECM in Ventura County by POF, Q4 2023 (October - December)



ECM POF <11 members:

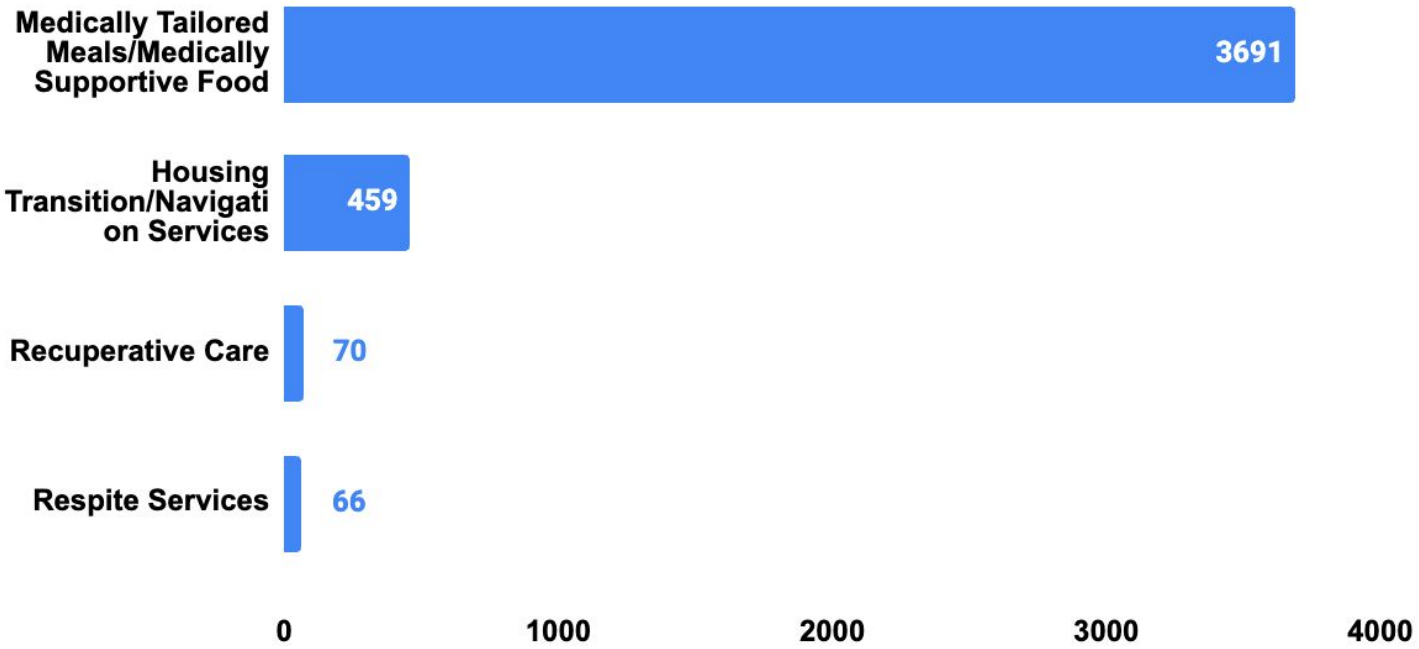
- Children and Youth Experiencing Homelessness
- Children and Youth with Serious Mental Health and/or SUD Needs

Total Members who Received Community Supports in Ventura County, by Quarter



Total Members who Received Community Supports in Ventura County, by Quarter

Total Members who Received Community Supports in Ventura County by Service, Quarter 4 2023 (October - De…

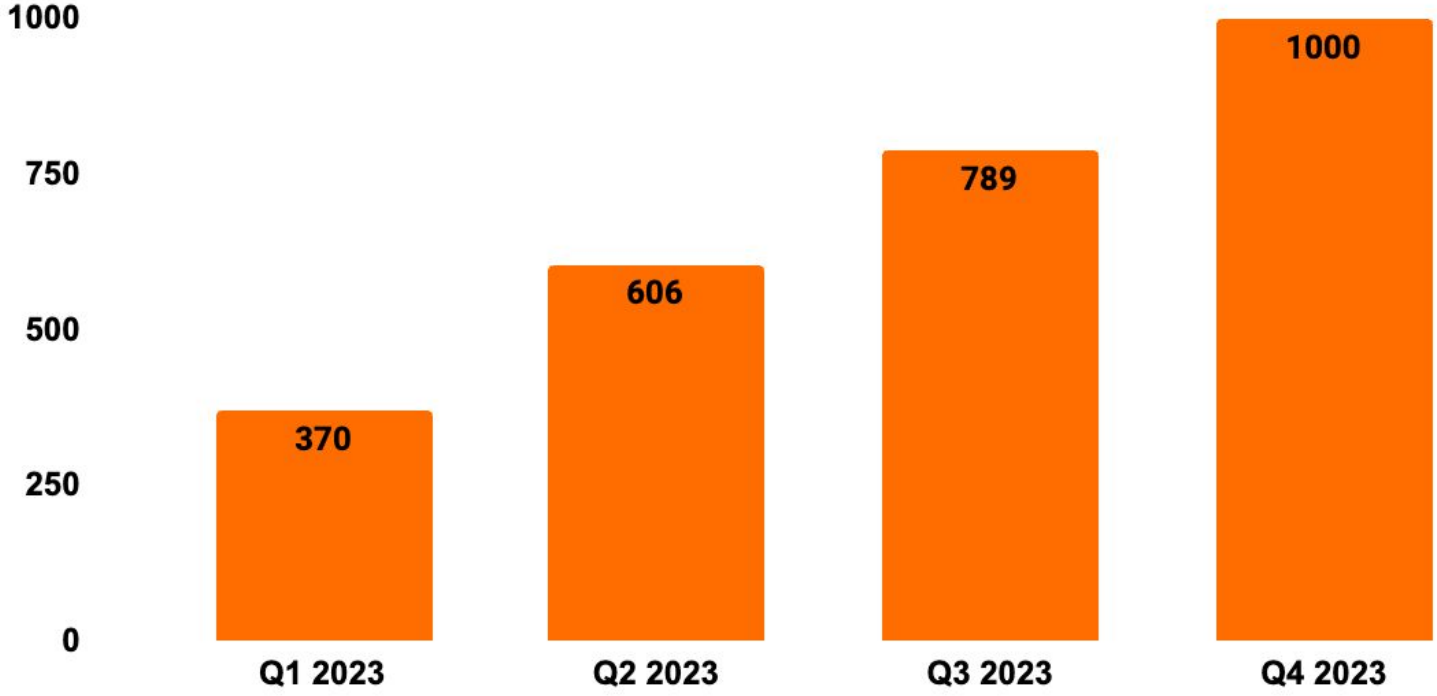


Services with <11 members:

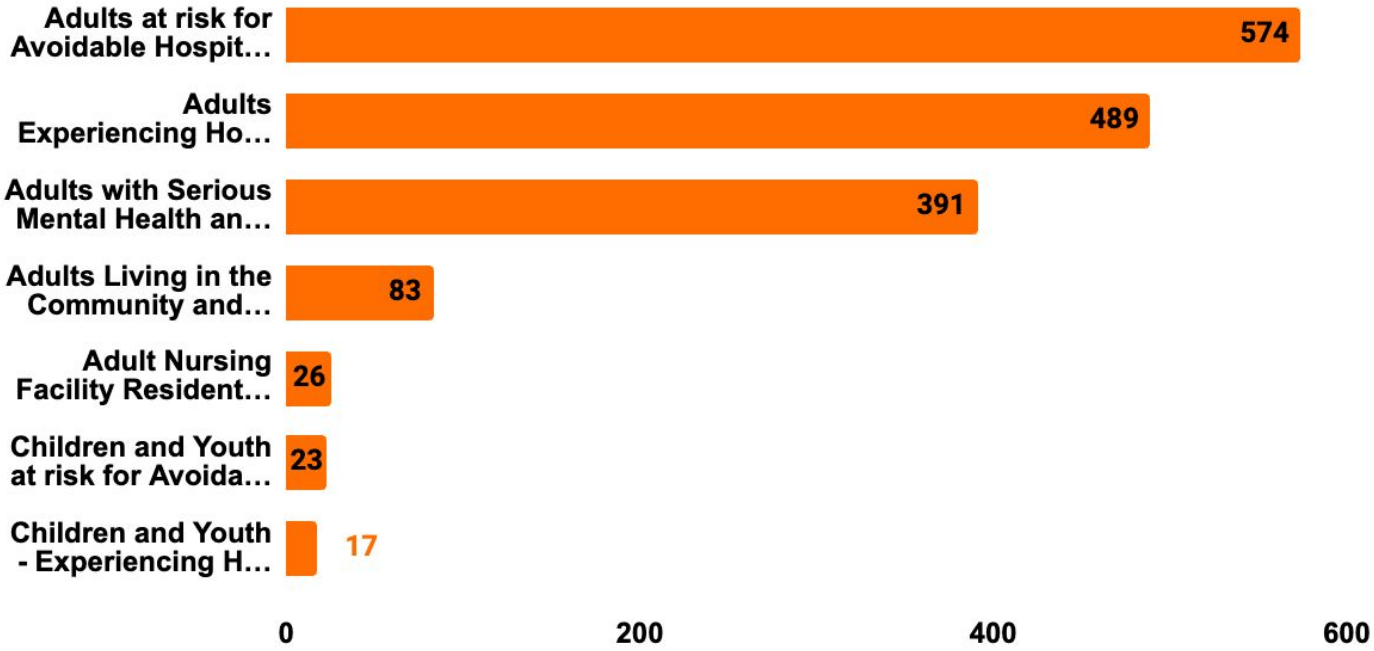
- Personal Care and Homemaker Services
- Short-Term Post-Hospitalization Housing

Santa Barbara

Total Members Who Received ECM in Santa Barbara, by Quarter



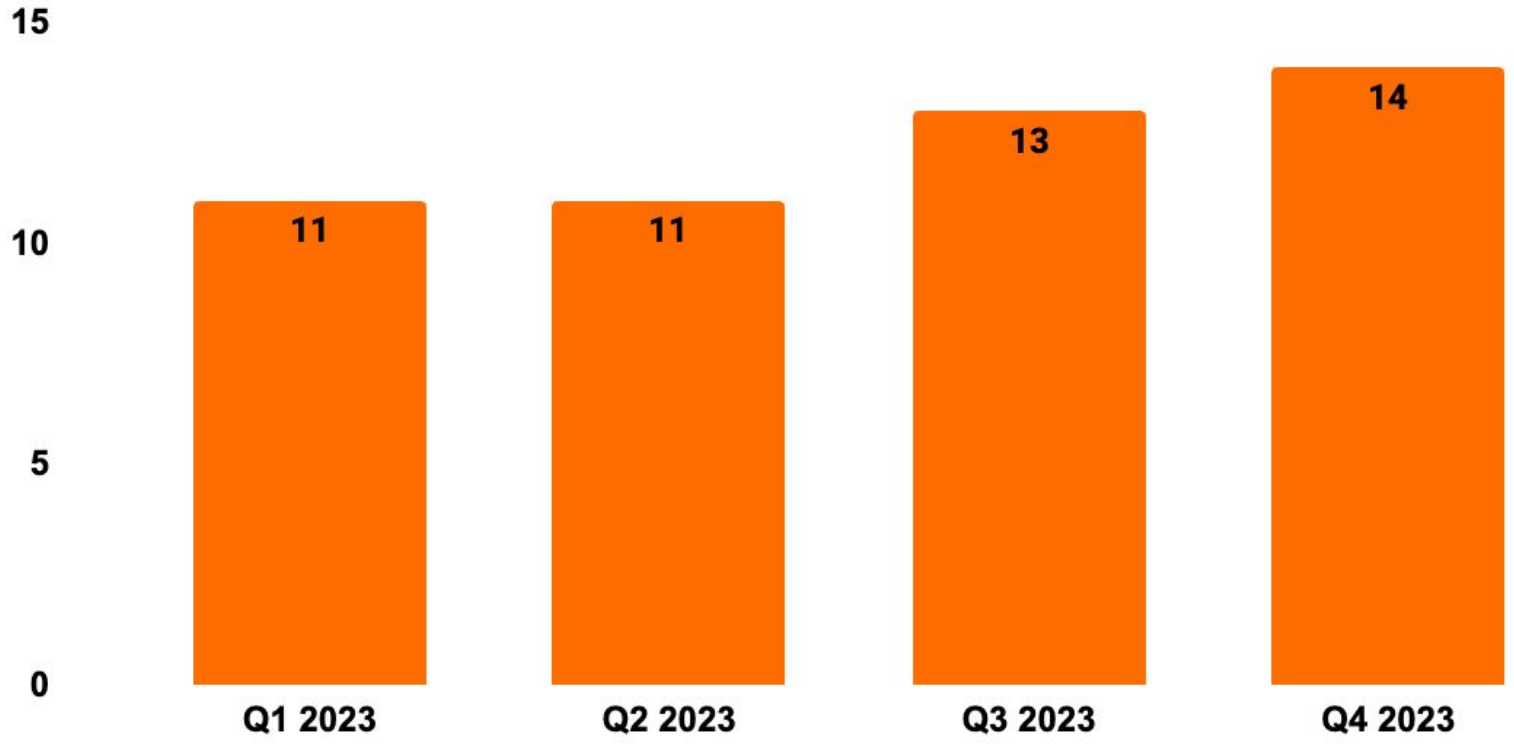
Total Members who Received ECM in Santa Barbara by POF, Q4 2023 (October - December 2023)



ECM POF with <11 members:

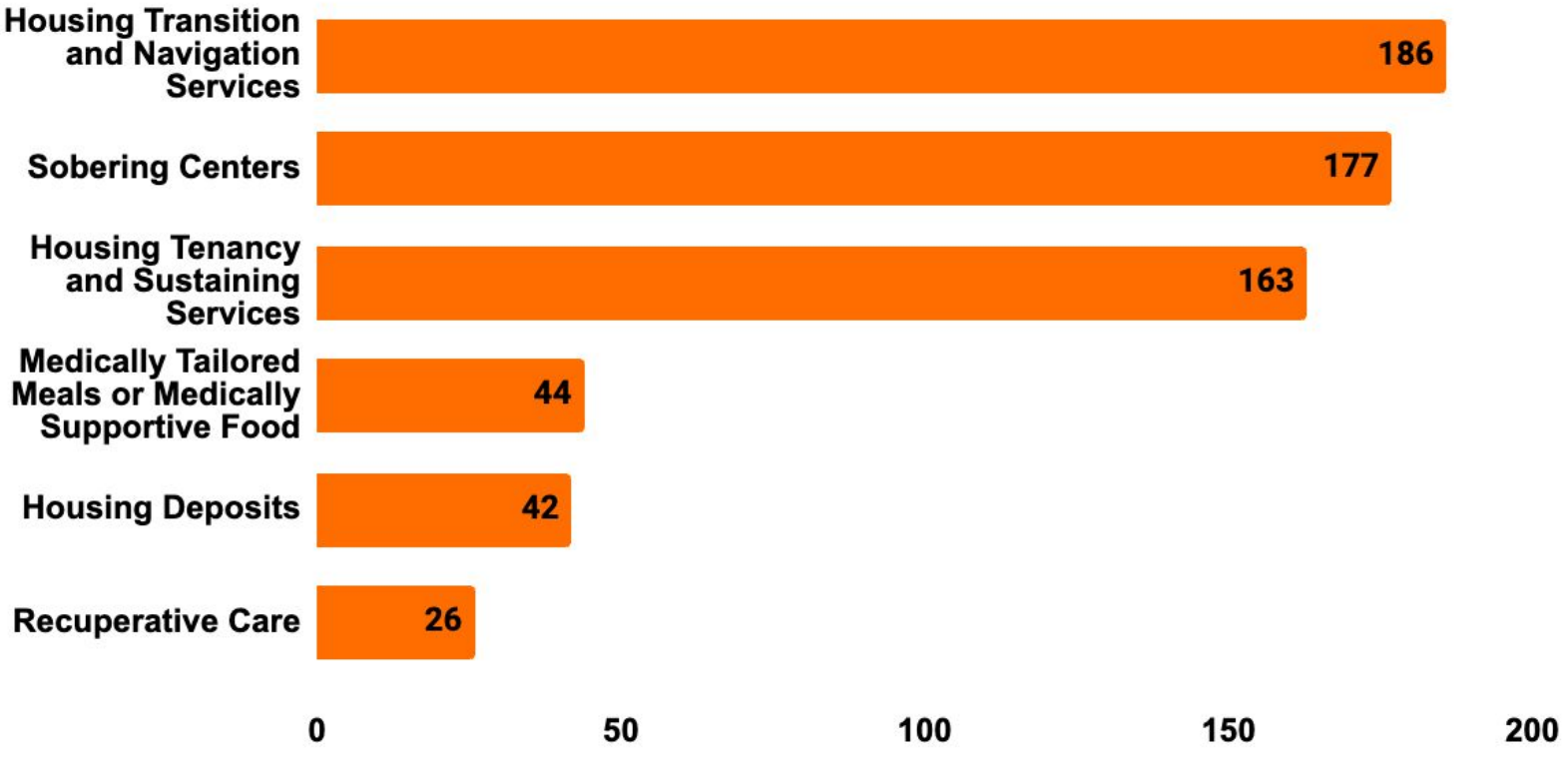
- Children and Youth with Serious Mental Health and/or SUD needs
- Children and Youth Enrolled in CCS with Additional Needs
- Children and Youth Involved in Child Welfare

Total Number of ECM Provider Contracts in Santa Barbara, by Quarter



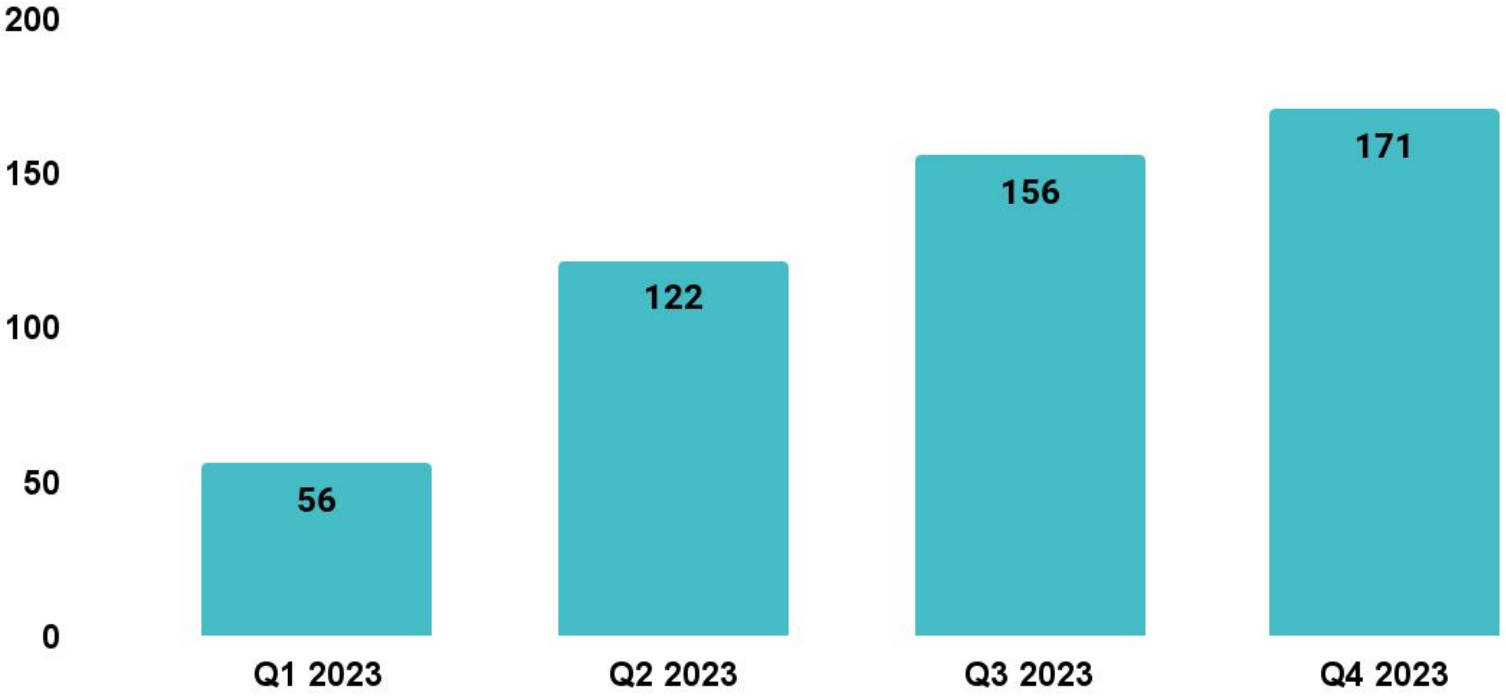
Total Number of Community Supports Provider Contracts in Santa Barbara, by Quarter

Total Members who Received Community Supports in Santa Barbara by Service, Q4 2023 (October - December)

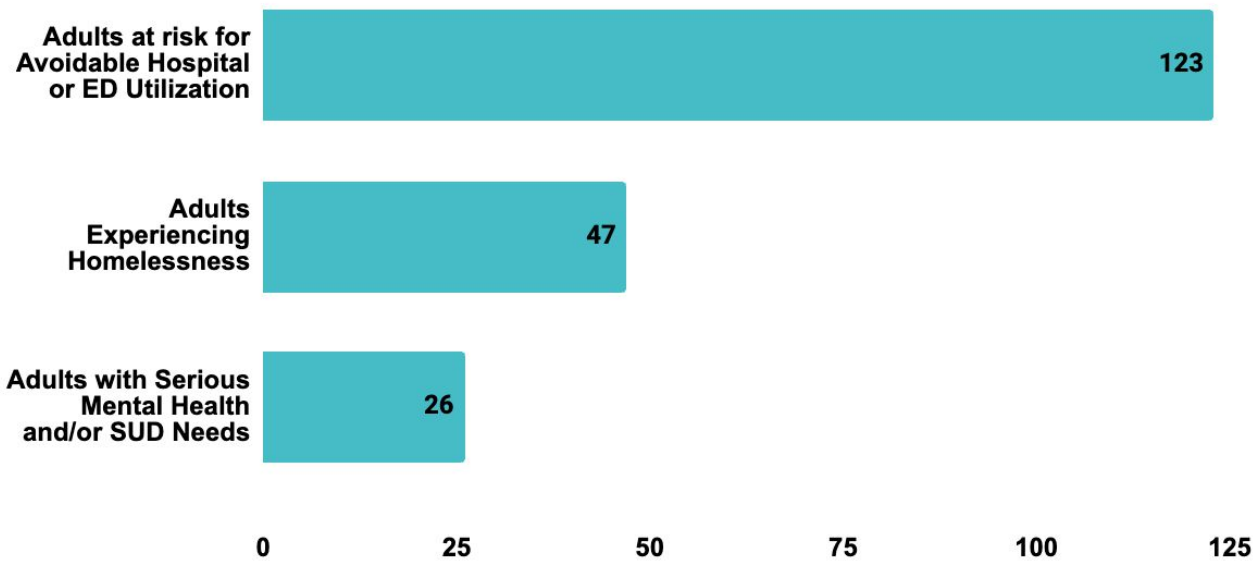


San Luis Obispo

Total Members Who Received ECM in San Luis Obispo, by Quarter



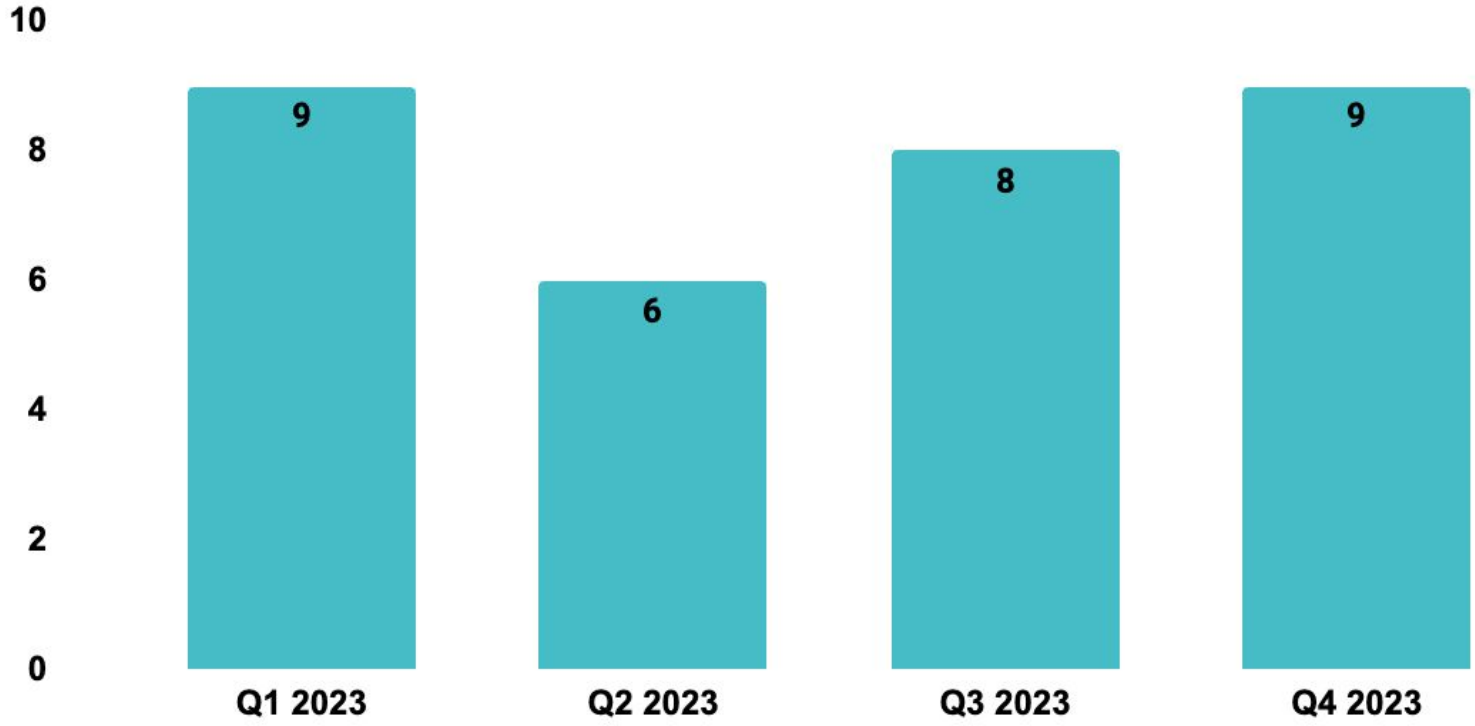
Total Members who Received ECM in San Luis Obispo by POF, Q4 2023 (October - December 2023)



ECM POF with <11 members:

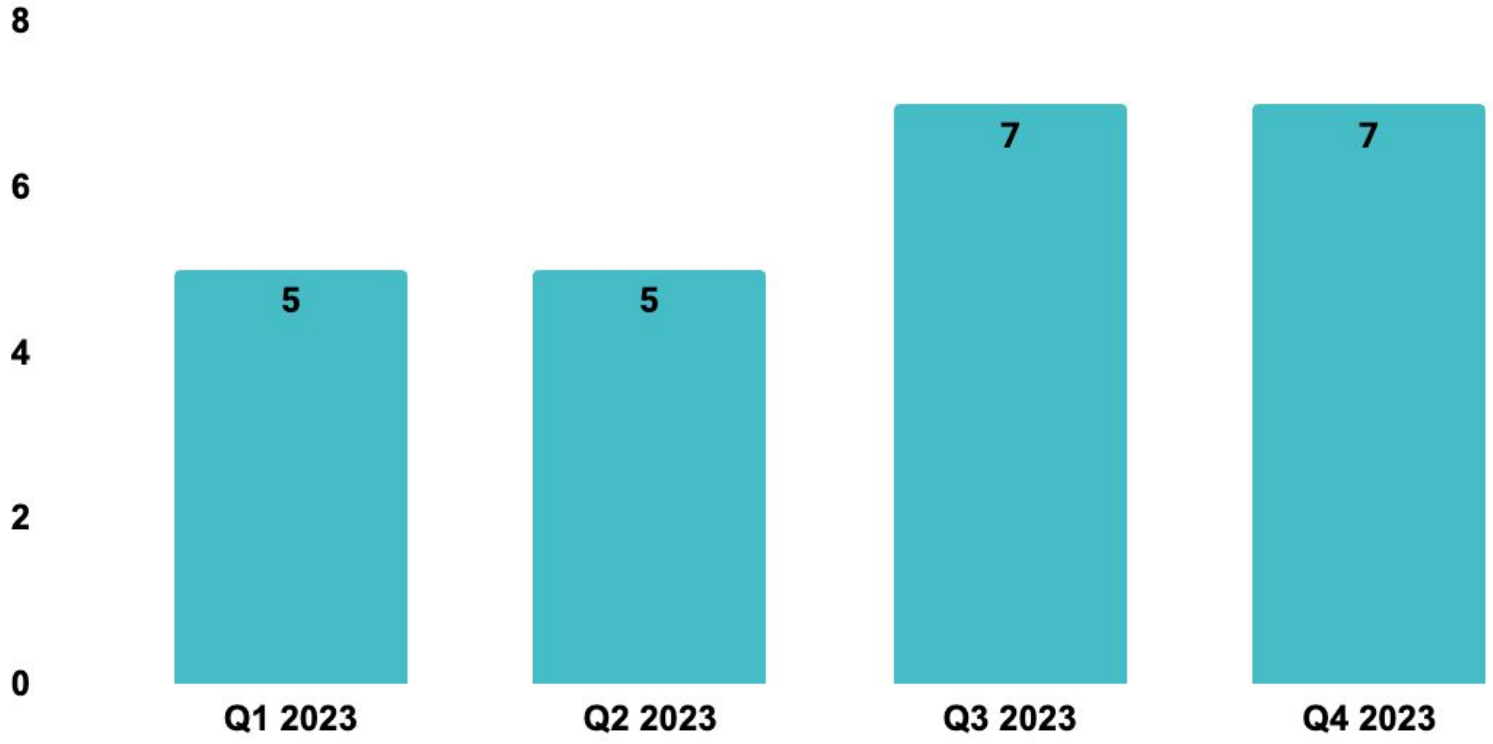
- Adults Living in the Community and at Risk of LTC
- Adult Nursing Facility Residents Transitioning to Community
- Children and Youth at risk for Avoidable Hospital or ED Utilization
- Children and Youth Experiencing Homelessness

Total Number of ECM Provider Contracts in San Luis Obispo, by Quarter



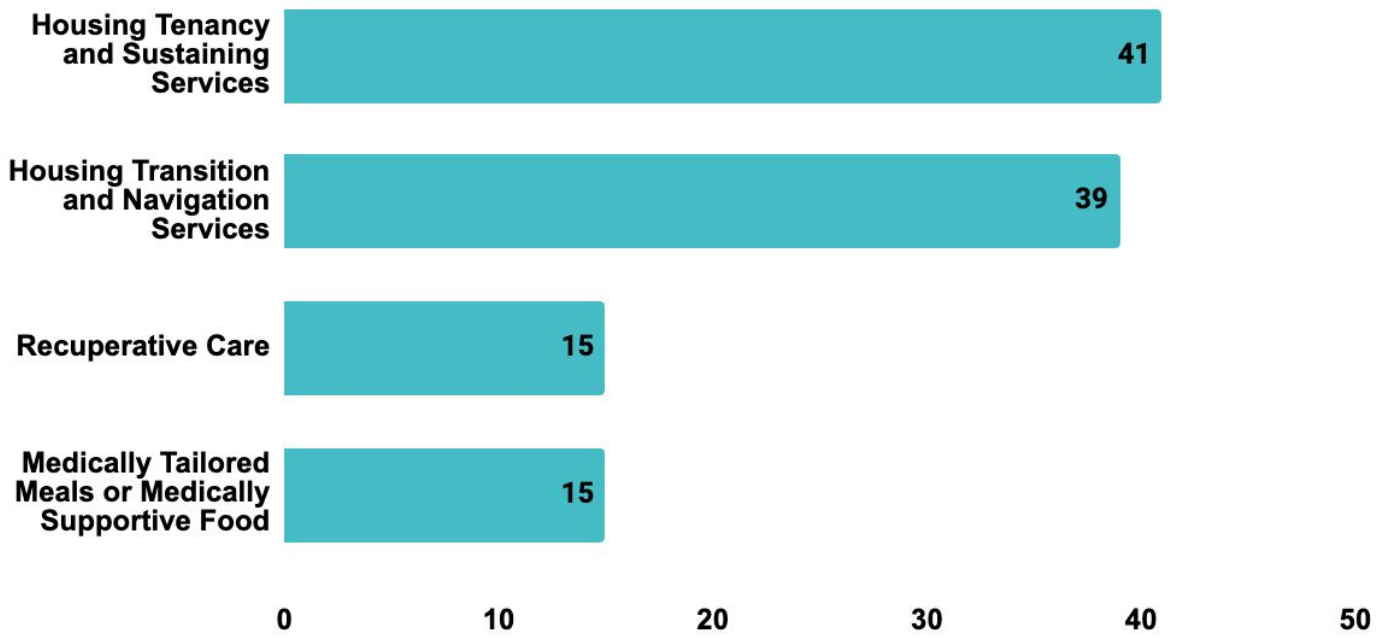
Total Number of ECM Provider Contracts in San Luis Obispo by Quarter

Total Number of Community Supports Provider Contracts in San Luis Obispo, by Quarter



Total Number of Community Supports Provider Contracts in San Luis Obispo by Quarter

Total Members who Received Community Supports in San Luis Obispo by Service, Q4 2023 (October - December)



Services with <11 members:

- Housing Deposits
- Sobering Centers

Managed Care Plan Updates

Resources and Updates

DHCS | SUCCESS

CA Path Home

NOW LIVE: “PATHways to Success”

Learn about the difference PATH is making for organizations and the Medi-Cal members they serve across California.

PATH is Growing Local Partnerships and Strengthening Services for Members

June 14, 2024

For more than 20 years, Lifespring Home Nutrition has provided Southern Californians with special dietary needs access to nutritious, medically tailored meals (MTM) to heal their bodies and manage their...

Read More

View All Success Stories

September Meetings: In-Person!

BluePath HEALTH

DHCS | PATH

Ventura
Tuesday, September 17
Ventura County Community Foundation
9:00am - 11:00am

San Luis Obispo & Santa Barbara
Wednesday, September 18
Santa Maria Library
10:00am - 12:00pm

BluePath HEALTH

Thank you for responding to our brief survey.
Questions or suggestions?
pathinfo@bluepathhealth.com

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Office Hours

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Appendix

CalAIM TA Marketplace