DHCS | PATH

Providing Access & Transforming Health

BluePath HEALTH

Alameda CalAIM PATH Collaborative

August 16, 2024

Welcome! Please introduce yourself in the chat with your name and organization.

2024 Collaborative Aims and Objectives

BluePath HEALTH

By December 2024, increase eligible members authorized for ECM by 15% & Community Supports by 15%

1. **Build resources and relationships to drive community referrals**
2. **Strengthen ECM and Community Supports provider capacity**
3. **Facilitate relationship building between providers, plans, and referral partners**

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Today's Agenda

Time	Topic
10:00am	Welcome, agenda, and housekeeping
10:05am	Follow-ups from Recent Meetings
10:15am	DHCS Presentation: Statewide Community Referral Strategy
10:45am	Q&A with DHCS
10:55am	ECM and Community Supports Data Update
11:05am	Resources and Upcoming Events
11:15am	Wrap-up
11:20am	Open Office Hours

Housekeeping

Follow-ups from previous meetings

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Community Referrals

- All referral forms are now posted on the collaborative resource center!

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June Poll Top Themes: Community Referrals

What is going well with referring clients to ECM and Community Supports?

- Timely approvals and responsiveness

What are the gaps related to referrals that we can work together as a collaborative to fill?

- Education and awareness
- Streamlined referral systems
- Enhanced communication

July Brainstorm Results

New Ideas
Include an "invite a clinic" blurb in the next newsletter
Ask at a collaborative meeting: “Do you have a best practice to share for other clinics or CBOs to implement, let us know!”
Offer a referrals office hours in the Fall
Plan for a JI-focused collaborative meeting, including detailed overview of pre-release planning
Share workforce resources for recruitment and retention, particularly for CHWs, in meetings and newsletter

Already Underway
DHCS presentation on referrals policy
FindHelp FAQ
Submitted feedback on referrals and presumptive authorization policies to DHCS
Community Wellness Fair

19 completed responses

Most common suggestion was sharing more resources to learn about findhelp.org

New resource in progress: FindHelp FAQ

Alameda CalAIM PATH Collaborative
FindHelp Rollout FAQ

In a meeting of the Alameda CalAIM PATH Collaborative on 7/19/2024, participants raised several questions regarding the upcoming rollout of the FindHelp closed loop referral platform. To address this, this document lays out the key questions and answers from the meeting. This is a living document and will be updated on a regular basis as more information is finalized and becomes available.

Frequently Asked Questions

1. **What is a closed-loop referral?**

In a typical referral, the provider who makes the referral may never learn whether the client actually received the recommended services. Closed-loop referrals include communication between the referring provider and the receiving provider to "close the loop" on whether the client got the services they need or not.
A closed loop referral consists of the following:
Entity 1 sends a referral for a member to Entity 2 to receive services.
Entity 2 receives referral, outreaches to the member, and coordinates to provide services.
Entity 2 'closes' the communication loop and replies back to Entity 1 to communicate if the member was served.

2. **What is FindHelp?**

FindHelp.org is a web-based closed-loop referral platform that providers, community members, and Alameda Alliance for Health can use to help connect members with resources and services.

3. **When will FindHelp become available?**

FindHelp is available now in Alameda County. Alameda Alliance is currently working with providers in their network to onboard them to the platform. FindHelp is expected to be fully up and running for Alameda Alliance providers by January 2025.

4. **Who can use FindHelp?**

FindHelp is available for anyone to use to find services in the community. Health and social services organizations in Alameda County can make accounts to send and receive referrals.

Enhanced Care Management and Community Supports: Community Referrals

Susan Philip, Deputy Director, Health Care Delivery Systems
Laura Miller, MD, Division of Quality and Population Health Management

August 16, 2024

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Agenda

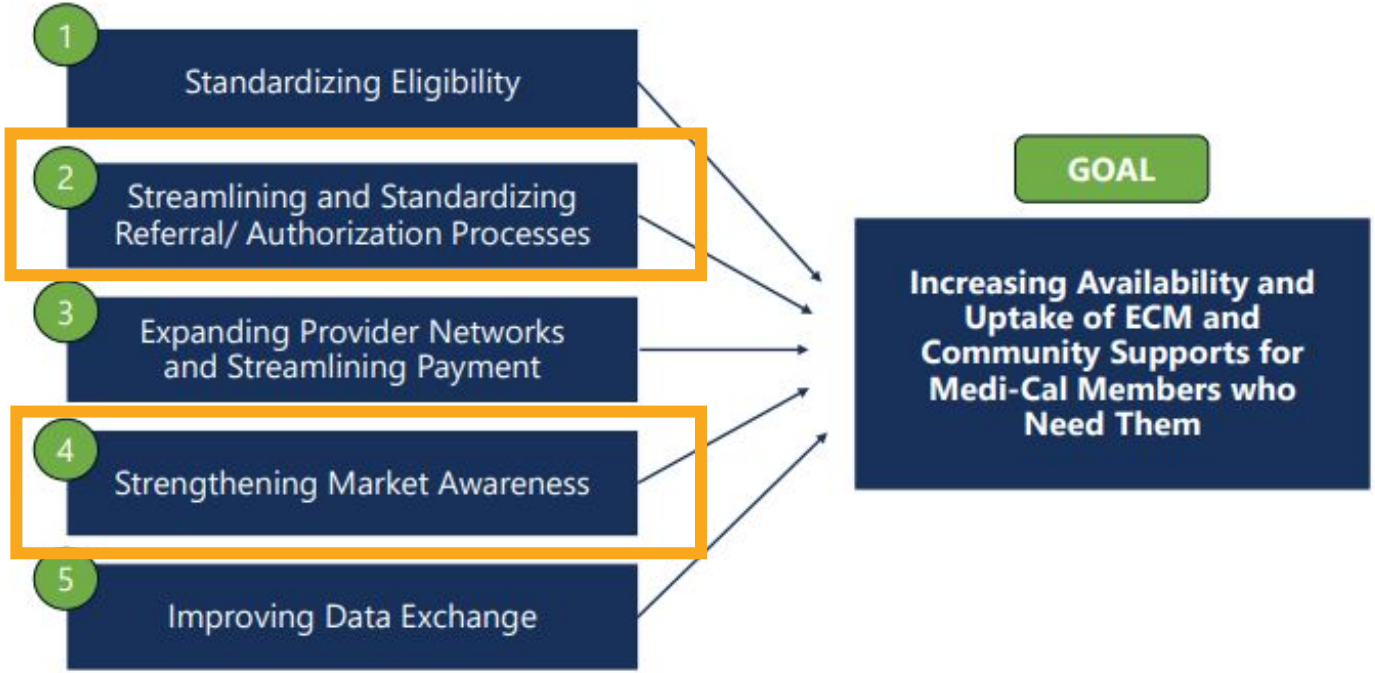
- ECM and Community Supports Action Plan
- Upcoming Guidance: ECM and Closed-Loop Referrals
- Community Awareness and Community Referrals
- Q&A

ECM and Community Supports Action Plan

- DHCS has always envisioned modifying the ECM and Community Supports programs over time and is committed to continuous improvement based on data and stakeholder feedback.
- Since the initial implementation of ECM and Community Supports on 1/1/2022, DHCS has reviewed implementation data and heard feedback from the field that increased standardization of the ECM and Community Supports program design is needed to reduce administrative burden, increase uptake, and ensure consistency of service delivery for Members.
- To address these challenges, in the spring of 2023, DHCS developed an Action Plan that outlines short, medium, and long-term policy and design priorities for ECM and Community Supports.
  - DHCS is currently executing against the medium and long-term priorities, having finished all short-term priorities in 2023.

Action Plan:
Key Domains In Response to Data & Feedback

» DHCS has been focused on revising/reinforcing policies and executing against specific design initiatives across these key areas.



Summary of Progress Against Action Plan Priorities

Short-Term Priorities *(Complete)*

- **July 2023:** DHCS published updated ECM & Community Supports policy guides to reflect all new & reinforced policies (across all Action Plan domains); conducted two public webinars to explain new/reinforced policies.
- **Oct 2023:** DHCS published updated APL 23-020 about requirements of timely payment for claims.
- **Dec 2023:** DHCS published updated HCPCS Coding Guidance; conducted a public webinar to explain updates to the guidance and codes.
- **Dec 2023:** DHCS completes Supplemental Data Request and analysis to understand rates that ECM and Community Supports Providers are being paid for service delivery *(for internal DHCS review only)*

Medium and Long-Term Priorities *(Ongoing)*

- **Summer 2024:** Planning to release universal ECM referral standards and guidance about presumptive authorization for ECM *(see slides 16 - 19)*
- **June & continuing throughout 2024:** Planning to release select updated Community Supports service definitions *(see slide 20)*
- **Q3 - Q4 2024 *(non-exhaustive list below)*:**
  - Begin developing universal referral standards for Community Supports
  - Develop plan-level guidance about contracting with and overseeing HUBs (relevant for both ECM & Community Supports)

Upcoming Guidance: ECM and Closed-Loop Referrals

DHCS Goals for Streamlining ECM Referrals & Authorizations

- **Reduce time** from when a Member is identified for ECM to when they begin ECM services, so Members are connected to the care they need and aren't lost to contact
- **Create a consistent statewide format and process** for ECM referrals submitted by community partners
- **Build awareness of ECM in the community** as an option for referral
- **Improve quality of matching of Members being referred, with ECM Providers**
- **Standardize what information is needed** for MCPs for ECM eligibility, authorization and ECM Provider assignment

What to Expect: ECM Referral Standards

- The ECM Referral Standards have been heavily informed by interviews with MCPs and by reviewing standard forms currently in use in several regions across multiple MCPs.
- **Starting January 1, 2025, all MCPs will collect the same information from referral partners through their ECM referrals.** MCPs may use different tools/forms but the fields will all be the same.
- **MCPs will <u>not</u> be permitted to impose additional documentation requirements for reviewing a Member's eligibility (e.g. ICD-10 codes, proof of homelessness) and authorizing ECM beyond what is included in the ECM Referral Standards.**

Upcoming Guidance on ECM Referrals

In August, DHCS will release new guidance for MCPs in a standalone document on ECM Referral Standards with two solutions. DHCS will also update the ECM Policy Guide with context on ECM Referral Standards.

Purpose of Guidance: Will streamline and standardize the ECM referral process with two solutions:

Guidance

Universal ECM Referral Standards and Form Templates

The **ECM Referral Standards** standardize the information that MCPs are expected to collect for members being referred to an MCP for ECM. Best for Online, EMR, or other electronic referral forms.

The **ECM Referral Form Templates** are an application of the ECM Referral Standards for use by MCPs and referring entities that prefer a PDF or hard copy form. There are two form templates – Adult and Child/Youth.

Draft Presumptive Authorization Guidance

The ECM presumptive authorization guidance will expand MCP use of presumptive authorization, so **specific ECM Providers already contracted in an MCPs' ECM provider network** can start serving Members faster and be reimbursed for their services.

- **Select ECM Providers will be able to directly authorize ECM for Members and be paid for ECM services for a 30-day timeframe** until the MCP authorizes or denies ECM based on a complete assessment of Member eligibility for ECM.
- ECM Providers under presumptive authorization will still submit an ECM referral to the MCP within the 30-day timeframe.
- In cases where the MCP does not authorize ECM, ECM Providers will be paid for services provided up until the MCP communicates the authorization decision within the 30-day timeframe.
- **Example:**

  ECM Providers that are also Community Supports Providers for the Housing Trio ***will have ECM presumptive authorization*** for the Individuals Experiencing Homelessness POF.

Proposed Policy Effective Date for MCPs: January 1, 2025

Draft for Comment: Closed Loop Referrals

Closed Loop Referrals are a key component of DHCS's Population Health Management Program under CalAIM. Closed Loop Referral requirements will first apply to MCPs for ECM and Community Supports referrals.

Draft Definition and Goal

- DHCS defines a Closed-Loop Referral (CLR) as a "referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, and monitored and results in a known closure."
- The goal of CLRs is to increase the share of Medi-Cal Members successfully connected to the services they need by identifying and closing gaps in referral practices and service availability.

Draft CLR Implementation Guidance

- DHCS has released Draft CLR Implementation Guidance for **public comment until September 4, 2024.**
- Draft guidance proposes the CLR requirements will apply to MCPs for two priority services – **Enhanced Care Management** and **Community Supports.** Guidance aims to minimize burden on ECM and Community Supports Providers in implementation of the new policy.
- Draft guidance requires MCPs to track, support and monitor referrals made for ECM and Community Supports that are initiated by community partners, Providers and Members/families.

Summary: Upcoming DHCS Guidance for ECM and Community Supports

DHCS anticipates releasing several areas of guidance for ECM and Community Supports in the coming weeks. CPI Facilitators can support DHCS by reviewing key guidance and providing comments to DHCS in the outlined process for each document.

- **Final guidance** planned for release in August 2024:
  - ✔ Statewide ECM Referral Standards
  - ✔ Updated ECM Policy Guide with presumptive authorization policy for select ECM Providers

- **Guidance planned for public comment** in August and September 2024:
  - Draft Closed-Loop Referral Implementation Guidance (covers ECM and CS referrals)
  - Transitional Rent Concept Paper

- **Guidance planned for targeted comment, including with MCPs,** in August and September 2024:
  - Draft Clarifications for Community Supports Service Definitions:
    - Housing Deposits
    - Medically Tailored Meals
    - Asthma Remediation
    - NF Transition/Diversion to Assisted Living
    - Community Transition Services/NF Transition

CLR Guidance will have a 3-week comment period; Community Supports Service Definitions will have a 2-week comment period; Transitional Rent will have a 3-week comment period

Community Awareness and Community Referrals

Community Referrals: Needs and Opportunities

The Need

DHCS expects MCPs to source most ECM & Community Supports referrals from the community. Use of internal data to identify should be balanced with active community-based outreach and engagement. There is a need to 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 Alameda CalAIM PATH Collaborative can identify promising practices to build community referral pathways.

Increasing Community Awareness

DHCS Action Plan Lever #5: Strengthening Market Awareness

DHCS Actions Taken

ECM & Community Supports
Added additional requirements for MCPs' public Provider Directories.

Effective no later than July 1, 2023, MCPs are to list all ECM and Community Support Providers in the Provider Directory.

- MCPs should specify if a Provider is an ECM, Community Supports Provider, or both.
- By January 1, 2024, MCPs' network directories should indicate which Population(s) of Focus each ECM Provider is equipped to serve.
- MCPs will need to add a disclaimer in the Directory stating that both ECM and Community Supports require prior authorization and are limited to Members who meet specific eligibility criteria.

Review of **MCP websites** and handbooks to ensure they include the most up-to-date information about ECM and Community Supports.

Release simple **"stock" marketing materials** to be shared with and disseminated by MCPs to their contracted networks of Providers promoting awareness of ECM and Community Supports.

Opportunities for PATH Collaboratives

CPIs can help advance this priority by:

- Partnering with local stakeholders on **regional efforts to increase member and provider awareness** of ECM and Community Supports.
- Supporting and promoting local **roadshows/trainings for referring providers**.
- Sharing **communications best practices** in their region and promoting peer-to-peer learning forums.

Strategies to Boost Community Referrals

Strengthen partnerships to foster referral pathways and provide community education on how to make referrals to ECM and Community Supports

Increase community awareness of CalAIM and offer CalAIM 101 presentations to community organizations, including both contracted and non-contracted providers.

Identify and support organizations with existing relationships and touchpoints with eligible members that are well-positioned to become high-volume referral partners.

Support providers and community partners to develop systems to better identify eligible members and refer them to services.

Adopt practices and strategies to remove barriers in referring members to services.

CA PATH CPI Collaborative Efforts to Enhance Community Referrals

- Asset mapping is a tool used broadly across CPI facilitators to enhance awareness of provider services and provider networking.

- Ongoing CalAIM education is key to strengthening market awareness of ECM and Community Supports.

- Workgroups offer ideal opportunities for providers to network, discuss best practices, and elevate more complex regional concerns.

- In-person CPI collaborative convenings & public facing resource fairs aim to increase regional awareness of ECM and Community Supports services.

- CPI Facilitators continue to explore hub model designs as a potential opportunity to enhance referrals and connections to services.

- CPI Facilitators are working collaboratively with CPI participants and MCPs to develop and enhance provider directories.

- CPI Facilitators regularly spotlight regional providers at monthly collaborative convenings to enhance market awareness & provider connection.

- Regional MCPs present referral processes at regional CPI convenings and engage with participants regarding questions or concerns.

DHCS Resources Available to Build Capacity and Increase Community Referrals

Technical Assistance (TA) Marketplace

- TAM helps ECM and Community Supports providers access support needed to implement ECM and Community Supports, with over $820K awarded in Alameda County so far.
- Domains include: Building Data Capacity, ECM, Community Supports, Managed Care, Health Equity, **Cross Sector Partnerships,** and Workforce.

CITED Funding

- Over $380M CITED funds for ECM and Community Supports awarded to date.*
- Round 3 CITED awards will be announced in Fall 2024.
- **Round 4 will take place in 2025.**

IPP Funding

MCPs are encouraged to use IPP funds to support four priority areas:

- Delivery System Infrastructure
- ECM Provider Capacity Building
- Community Supports Provider Capacity Building
- Quality and Emerging CalAIM Priorities

*Additional information on entities awarded CITED funding can be found on the PATH CITED webpage. Additional information on award funding by county can be found on the CalAIM Dashboard.

Modalities for Accessing PATH TA Resources

- **"Off-the-Shelf" TA Projects** Ready to go, TA offerings packaged for convenient, efficient delivery

- "Off-the-Shelf" projects are **more standardized resources** like trainings, well-defined program models or data tools, or best practices guides that are relevant in a variety of settings with little to no customization

- **"Hands-On" TA Projects** – Customized TA projects tailored to the unique needs of the TA recipient

- "Hands-On" projects require the TA Vendor to work together with the TA recipient to develop a **unique Scope of Work (SOW) and Budgets** to describe the project and corresponding deliverables

- **"On-Demand" TA Resources** – Static TA resources made available directly through CA-PATH website

- "On-Demand" TA resources **do not require any direct contact** between the Recipient and Vendor and will eventually be available as part of a TA resource library


Q
A

Additional Questions

Questions on CPI: Collaborative @ca-path.com

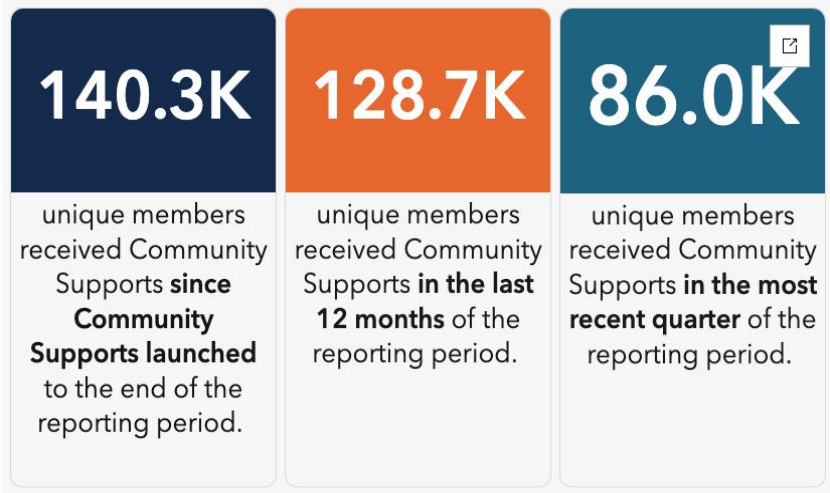
Questions on ECM and Community Supports: CalAIMECMILOS@dhcs.ca.gov

Questions on PATH: 1115@dhcs.ca.gov

DHCS

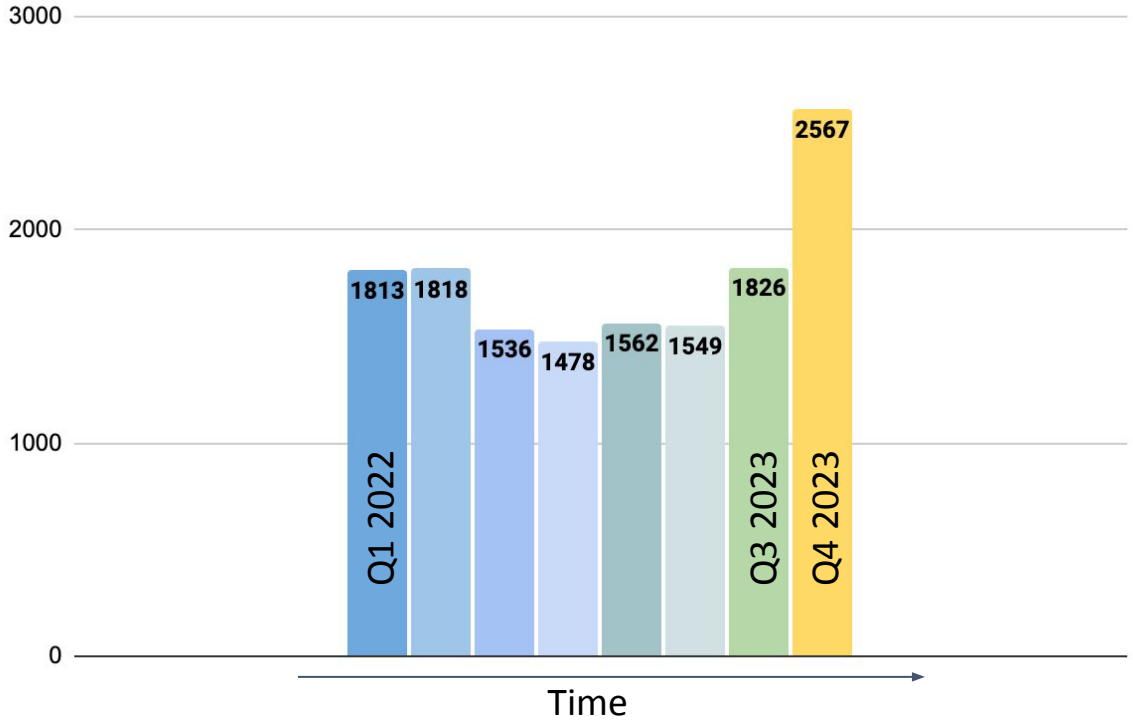
DHCS ECM and Community Supports Data

- **ECM and Community Supports Quarterly Implementation Report updated by DHCS, with data through December 2023**



View the full report here

Alameda County, ECM Enrollment by Quarter



Source:
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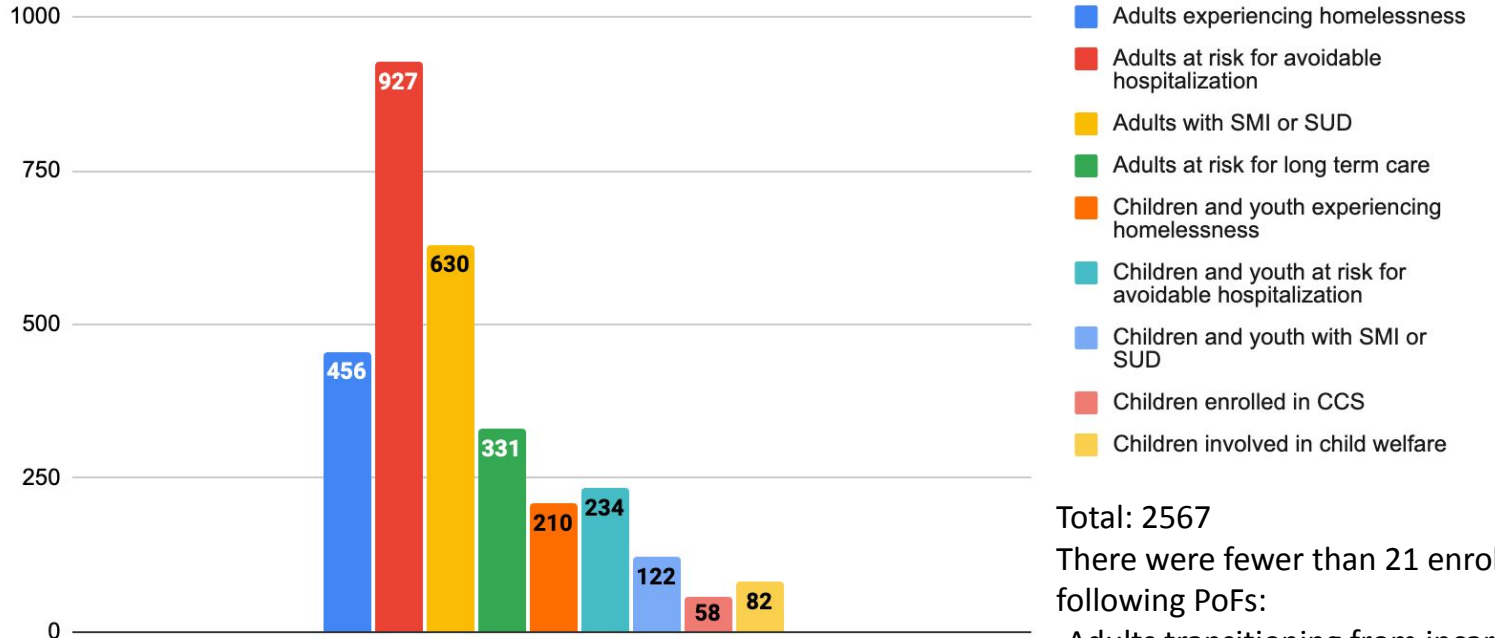
Alameda County, ECM Enrollment by PoF

Q4 2023



Total: 2567

There were fewer than 21 enrollees in the following PoFs:

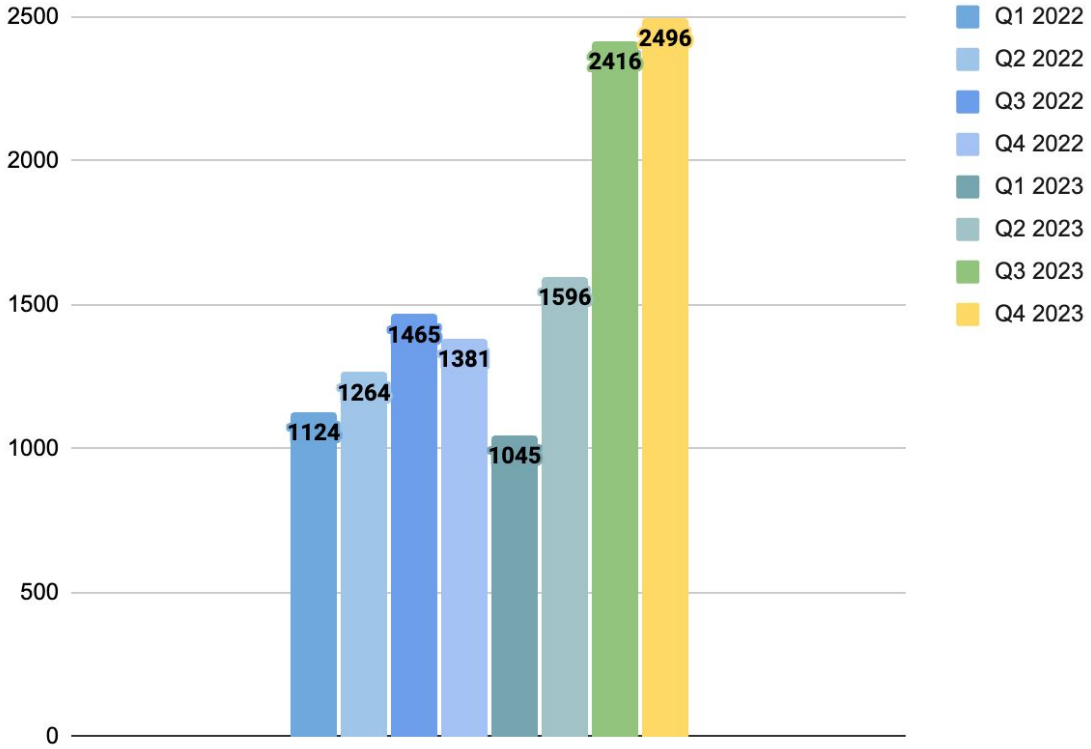
-Adults transitioning from incarceration

-Adult nursing facility residents transitioning to the community

Unique members may be included in multiple PoFs

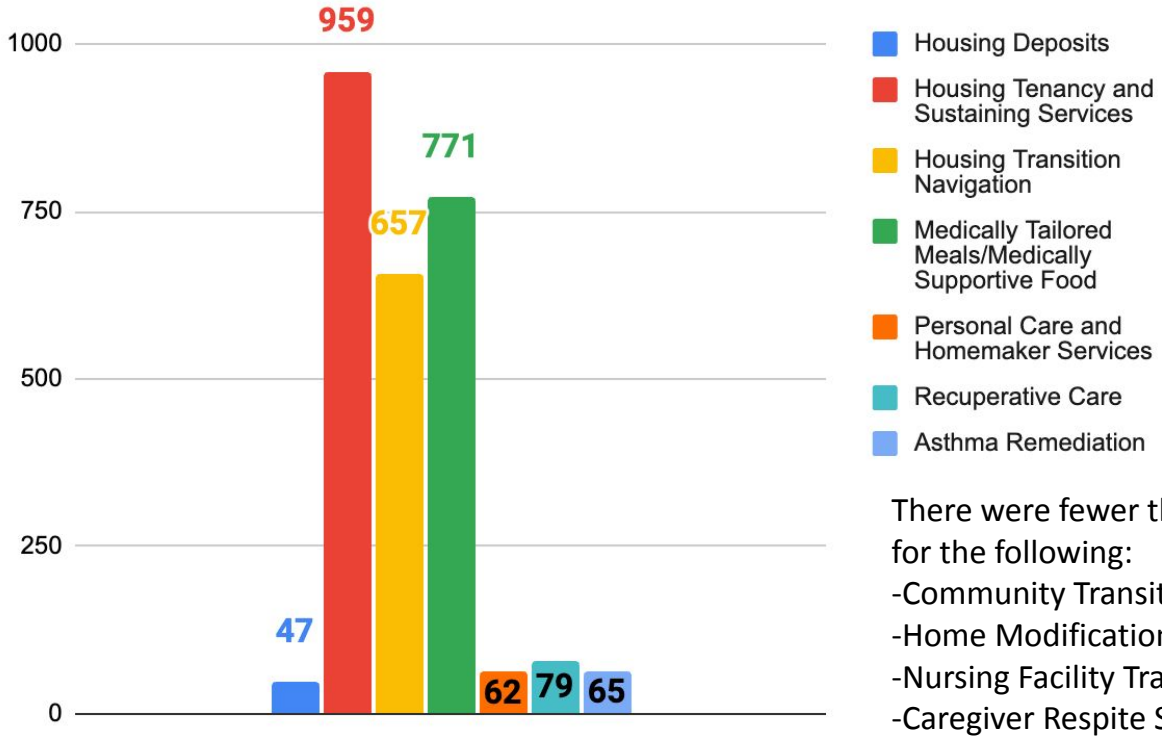
Source: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117

Alameda County, Community Supports Utilization by Quarter



Source: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117

Alameda County, Community Support Enrollment by Service, 2023

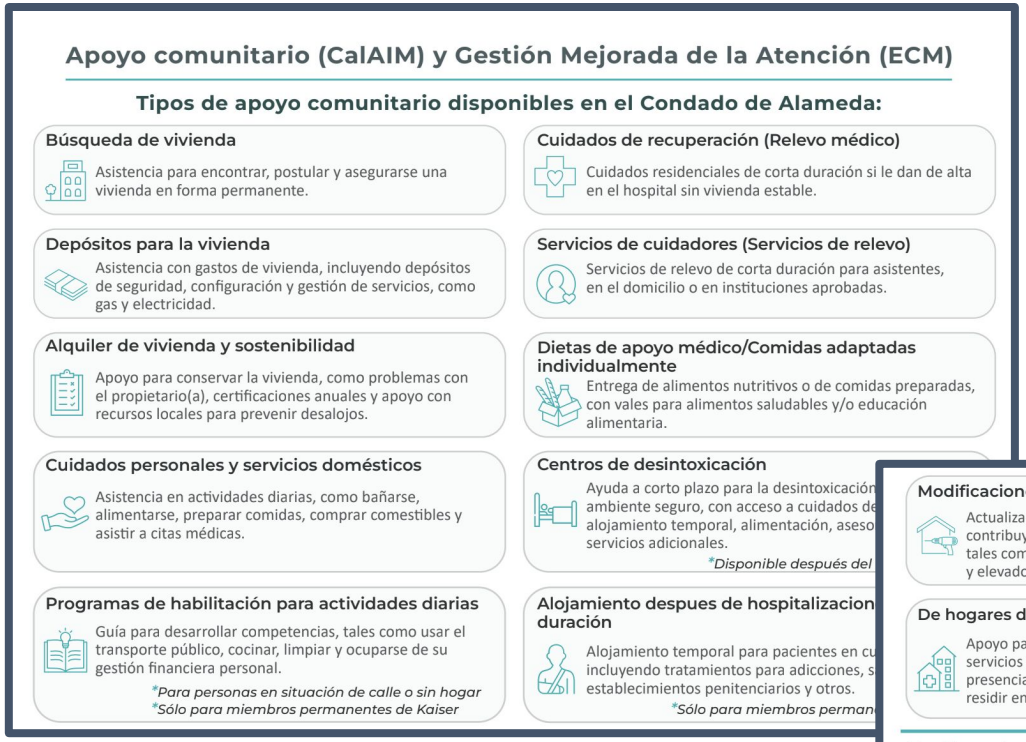


Source: https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117

There were fewer than 21 authorizations for the following:
-Community Transition Services
-Home Modifications
-Nursing Facility Transition/Diversion
-Caregiver Respite Services

Resource Updates

- ECM and Community Supports Provider Job Aid
- PATHways to Success
- Wellness Fair



Apoyo comunitario (CalAIM) y Gestión Mejorada de la Atención (ECM)

Tipos de apoyo comunitario disponibles en el Condado de Alameda:

Búsqueda de vivienda
Asistencia para encontrar, postular y asegurarse una vivienda en forma permanente.

Depósitos para la vivienda
Asistencia con gastos de vivienda, incluyendo depósitos de seguridad, configuración y gestión de servicios, como gas y electricidad.

Alquiler de vivienda y sostenibilidad
Apoyo para conservar la vivienda, como problemas con el propietario(a), certificaciones anuales y apoyo con recursos locales para prevenir desalojos.

Cuidados personales y servicios domésticos
Asistencia en actividades diarias, como bañarse, alimentarse, preparar comidas, comprar comestibles y asistir a citas médicas.

Programas de habilitación para actividades diarias
Guía para desarrollar competencias, tales como usar el transporte público, cocinar, limpiar y ocuparse de su gestión financiera personal.

**Para personas en situación de calle o sin hogar*
**Sólo para miembros permanentes de Kaiser*

Cuidados de recuperación (Relevo médico)
Cuidados residenciales de corta duración si le dan de alta en el hospital sin vivienda estable.

Servicios de cuidadores (Servicios de relevo)
Servicios de relevo de corta duración para asistentes, en el domicilio o en instituciones aprobadas.

Dietas de apoyo médico/Comidas adaptadas individualmente
Entrega de alimentos nutritivos o de comidas preparadas, con vales para alimentos saludables y/o educación alimentaria.

Centros de desintoxicación
Ayuda a corto plazo para la desintoxicación
ambiente seguro, con acceso a cuidados de
alojamiento temporal, alimentación, asesor
servicios adicionales.
**Disponible después del*

Alojamiento despues de hospitalizacion
duración
Alojamiento temporal para pacientes en cu
incluyendo tratamientos para adicciones, s
establecimientos penitenciarios y otros.
**Sólo para miembros perman*

ECM and CS Provider Job Aid- Redesign now available in Spanish!

Modificaciones en el domicilio
Actualizaciones y mejoramientos de domicilio que contribuyen a la buena salud, seguridad e independencia, tales como rampas, barras de apoyo, entradas más amplias y elevadores.

Remediación del asma
Actualizaciones en el domicilio para prevenir episodios asmáticos agudos, gracias a filtros al vacío, deshumidificadores, filtros de aire y ventilación mejorada.

De hogares de ancianos a asistencia en la vida diaria
Apoyo para hacer la transición a una vida asistida y recibir servicios diarios de asistencia, vigilancia médica y presencia de personal durante las 24 horas, en lugar de residir en un hogar de ancianos.

Transición de hogar de ancianos a la casa
Asistencia para retornar a casa desde un hogar de ancianos, tales como financiamiento de depósitos de seguridad, gastos en infraestructura de salud, como camas de hospital.

Explicando los servicios de Administración de la Atención Mejorada (ECM) a los miembros:

Su gerente de atención principal especializado coordinará los servicios de salud y atención médica, por teléfono, presencialmente o donde usted vive.

Su gerente de atención principal puede:

- Encontrar el médico y hacer una cita
- Gestionar el transporte gratuitamente hacia y desde las citas
- Verificar las prescripciones y ayudar a renovarlas
- Conectarlo con recursos locales y ayuda alimentaria en la comunidad, alojamiento y otros servicios sociales

Los servicios de ECM no reemplazan:

Sus beneficios: Es un beneficio adicional para miembros de Medi-Cal.
Sus médicos: Mantiene sus actuales médicos y otros proveedores.
Sus opciones: Usted puede cancelar ECM en cualquier momento.

ECM es gratis! Sin costos adicionales para usted.

**Ver reverso para detalles sobre los criterios de elegibilidad*

bluepathhealth.com/bluepath-health-calaim

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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

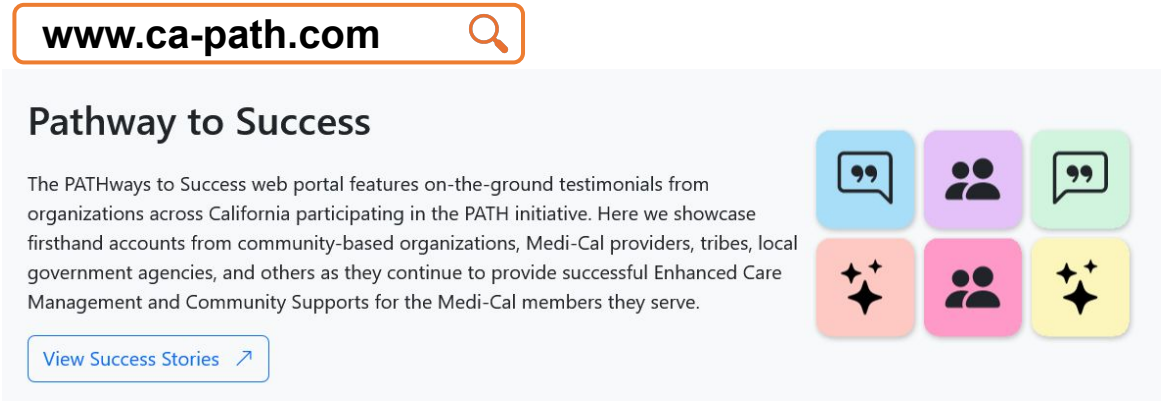
View All Success Stories

DHCS is featuring PATH success stories from organizations across California

As community-based organizations, Medi-Cal providers, tribes, local government agencies, and others continue to participate in the PATH initiative, DHCS will share their firsthand accounts of providing Enhanced Care Management (ECM) and Community Supports for the members they serve.

"PATHways to Success" showcases how PATH is helping organizations build relationships and make the investments needed to transform Medi-Cal and better serve California's highest need members.

Visit ca-path.com and scroll to "Pathway to Success" to view success stories from organizations participating across PATH.



Does your organization have a PATH success story to share?

Please send an email to communications@ca-path.com to get started.

Senior Wellness Fair

Location: San Lorenzo Library - Greenhouse Community Room

Date: August 24th, 2024

Time: 11 am - 1 pm

Share widely and invite your clients!

Next meeting:

September 20th, 10am - 12pm

On Zoom, Register here:

https://us02web.zoom.us/meeting/register/tZwuf-6trzgpHtxCQ1uxMMiv2xZiTS8yuLmA#/registration

See you for the 3rd Friday mornings each month in 2024!

Thank you for attending!

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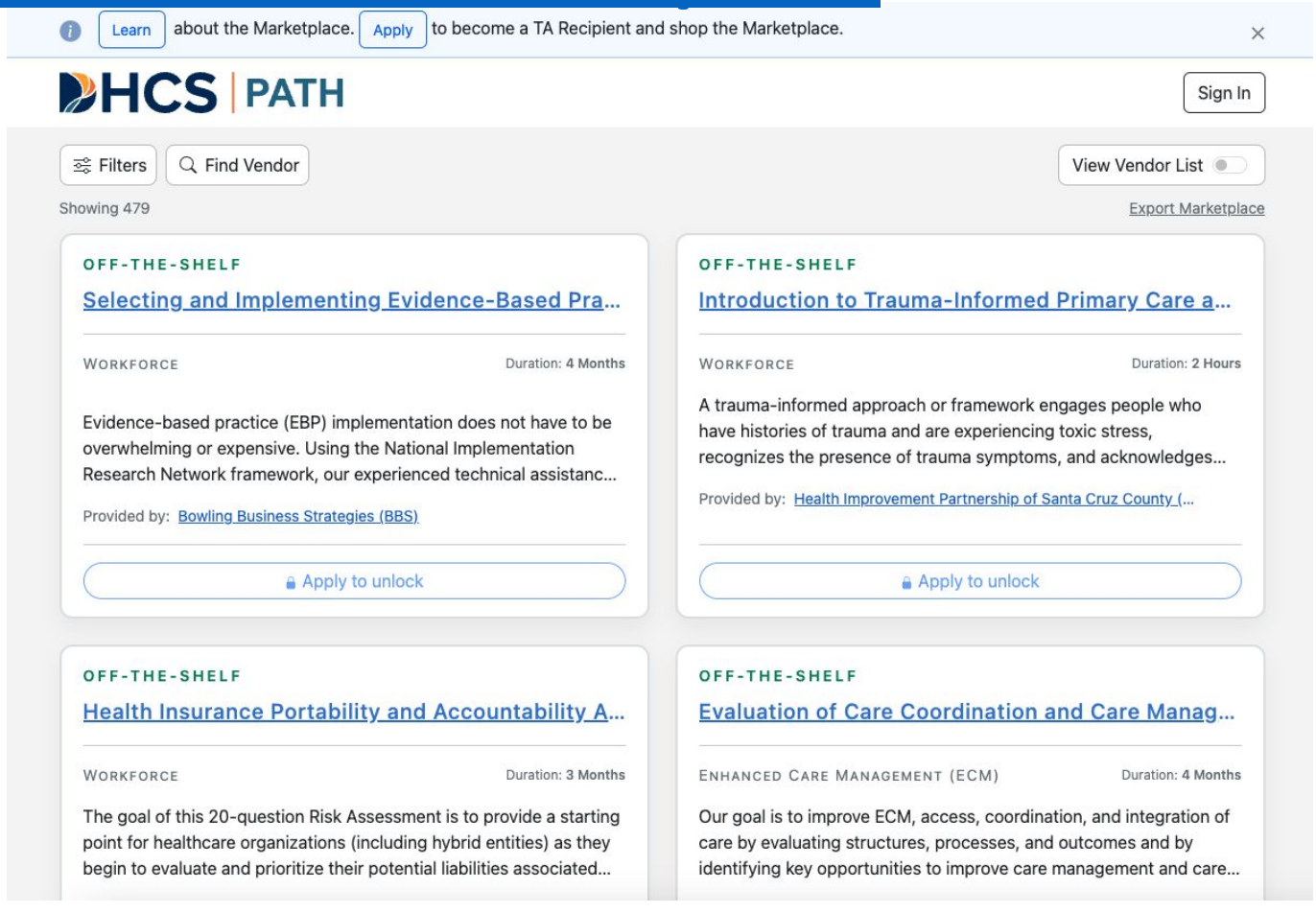
Providing Access & Transforming Health

BluePath HEALTH

Appendix

Check out the TA Marketplace!



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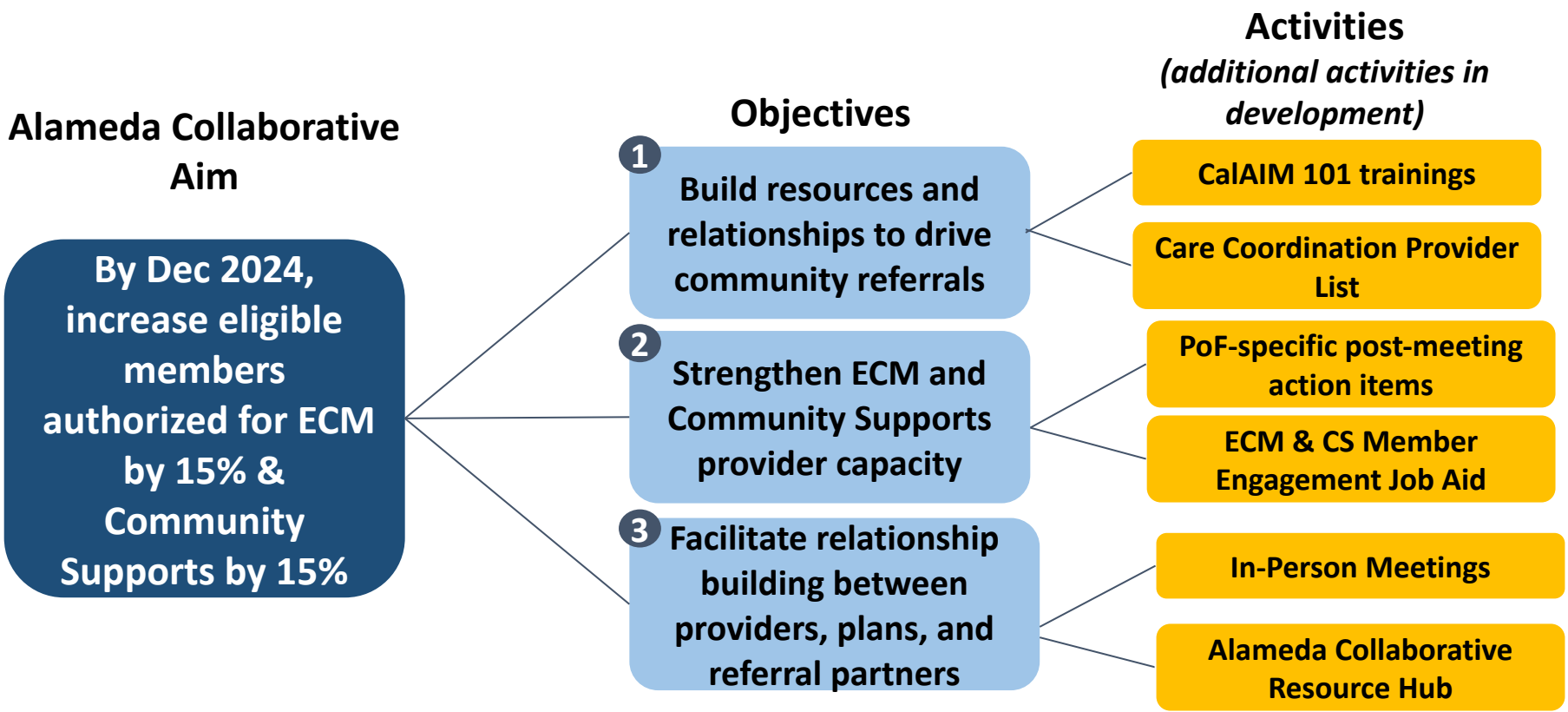

Appendix

Background: Existing Alameda County efforts to expand community awareness and referrals for ECM and Community Supports

- Compiled referral forms on Collaborative Resource Center
- KP accepts all ECM and Community Supports referral forms
- AAH is simplifying and consolidating their ECM and Community Supports referral forms
- KP has developed ECM and Community Supports flyers that are member-facing
- ECM and Community Supports Provider Job Aids in English and Spanish are being used
- ECM and Community Supports Provider List comprises providers for both MCPs and is updated on a bimonthly basis

Background: Alameda PATH activities and tools available to increase awareness

Provider Guide (English and Spanish)

*See bottom of other side for details on ECM services.

Individuals who meet the criteria for one or more of these 9 populations of focus are eligible for Enhanced Care Management (ECM):

Individuals Experiencing Homelessness:
- Adults with complex physical, behavioral, or developmental needs.
- Children, youth, and families with members under 21 years old experiencing homelessness.

Individuals At Risk for Avoidable Hospital or Emergency Department Utilization:
- Adults with 5 or more avoidable ED visits or 3 or more avoidable unplanned hospital or nursing facility stays in the past year.
- Children and youth with 3 or more avoidable ED visits or 2 or more avoidable unplanned hospital or nursing facility stays in the past year.

Individuals with Serious Mental Health and/or Substance Use Disorder Needs:
- Adults facing significant challenges with mental health or substance use disorders, who also experience at least one complex social factor impacting their health and one or more of the following: a high risk for institutionalization, overdose, or suicide; primarily seeking care from crisis services, EDs, urgent care, or inpatient stays; or 2 or more ED visits or hospitalizations due to mental health or substance use disorder in the past year.
- Children and youth experiencing significant challenges with mental health conditions or substance use disorders.

Individuals Transitioning from Incarceration:
- Adults rec... the follow... condition,
- Children a...

Adults in the Community at Risk for Long-Term Care Institutionalization:
- Adults in the community who meet skilled nursing facility criteria or need lower-acuity skilled nursing, face at least one complex social or environmental health factor that affects health, and can remain in the community with comprehensive support.

Adult Nursing Facility Residents Transitioning to the Community:
- Nursing facility residents who are interested in moving out, likely candidates to do so successfully, and able to reside continuously in the community.

Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs:
- Children and youth in CCS or CCS WCM facing at least one complex social factor affecting their health.

Children and Youth Involved in Child Welfare:
- Children and youth meeting any of the following: currently in foster care, received foster care in the last year, aged out of foster care up to age 26, eligible for or in California's Adoption Assistance Program, or receiving or have received California's Family Maintenance program in the last year.

Birth Equity Population of Focus:
- Black, American Indian, Alaska Native, or Pacific Islander adults or youth who are pregnant or have been pregnant in the last 12 months.

For more details on these eligibility criteria, please visit the ECM Policy Guide

bluepathhealth.com/tricountiespathresources

Member-facing Flyer (KP)

Are you a Medi-Cal member?

Do you have complex medical needs? Do you need help with things like housing, staying safe at home, and getting personalized support?

We can help. Medi-Cal Enhanced Care Management and Community Supports programs provide extra support for Medi-Cal members who qualify.[1]

A lead care manager can support you by:
- Meeting with you and your family in person or by phone
- Learning your needs and coordinating care for them
- Helping you apply for assistance programs that can help with things like groceries, utilities, and in-home services

Get additional help with:[2]
- Finding or keeping housing
- Getting meals to your home after you leave the hospital or a nursing facility
- Managing money, learning social skills, and learning how to use public transportation
- Doing daily tasks like bathing, dressing, and grocery shopping for a short time

To request these services or see if you qualify, call:
Northern California: **1-833-721-6012** (TTY **711**)
Southern California: **1-866-551-9619** (TTY **711**)

1. Dual-Special Needs Plan (D-SNP) members may receive similar services under their D-SNP plan instead. If you have a D-SNP plan, call 1-800-443-0815 (TTY 711) to learn what services are available. 2. Many other services are available.

Learn more at **kp.org/medi-cal-programs**

KAISER PERMANENTE

Community Wellness Fair

Omatochi

2024 Wellness Fair

Promoting Senior Well-being

Stop by any of the booths at the **free wellness fair** to learn about your medical benefits, brush up on new computer skills, or do a craft. Bring your friends and enjoy an afternoon of socializing and learning!

WHEN AND WHERE

August 24, 2024 | 11 AM - 1 PM
San Lorenzo Library
395 Paseo Grande
San Lorenzo, CA

SIGN UP TO ATTEND HERE!

Scan the QR code with your camera or visit https://shorturl.at/r7RiL

MORE DETAILS

- RECEIVE HEALTH SCREENINGS
- PARTICIPATE IN FITNESS DEMONSTRATIONS
- ATTEND INFORMATIVE WORKSHOPS
- GAIN ACCESS TO VALUABLE RESOURCES

DHCS | PATH

BluePath HEALTH

Background: ECM Referrals and Authorization Landscape in Alameda County

- **Referral Documentation:** Providers have noted that the amount of documentation required by Alameda Alliance for Health (AAH) can take time for the referring provider to collect, thereby delaying referrals
- **Authorization Timelines:** Providers say that AAH regularly meets 5-day or 72-hour (expedited) authorization timeline for ECM; however, some members are still lost to contact during that time
- **Presumptive Authorization:** AAH regularly uses retroactive authorizations to ensure that there are not gaps in care. Providers in the county are interested in a statewide presumptive authorization policy
- **ECM Provider Assignment:** Providers have indicated that there are not particular concerns with which providers members are being assigned for ECM or Community Supports

Background: Alameda Alliance CLR: Find Help FAQ

» Facilitators are developing a FindHelp FAQ in partnership with Alameda Alliance for Health.