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Tri-Counties CalAIM PATH Collaborative

Ventura In-Person Meeting

September 17, 2024

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Welcome!

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Introductions:

- Name
- Organization
- Your role in CalAIM implementation

Today's Agenda

#	Agenda	Time
1.	**Coffee and Introductions**	**9:00am**
2.	**Welcome and Objectives for the Day**	**9:10am**
3.	**DHCS Update: ECM Referral Standards**	**9:20am**
4.	**Managed Care Plans Referral Presentations** ● *Gold Coast Health Plan* ● *Kaiser Permanente*	**9:30am**
5.	**Referrals 101 Discussion**	**10:00am**
6.	**Closing**	**10:30am**

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

CalAIM ECM and Community Supports

- **Enhanced Care Management (ECM)** is a statewide Medi-Cal benefit available to individuals with complex needs in identified Populations of Focus.
- ECM is the highest level of care management available for Medi-Cal members with the most complex health and social needs.

- **Community Supports** are services Managed Care Plans can offer to address the social determinants of health in non-clinical, cost-effective ways.
- The state has created a list of 14 (soon to be 15) approved Community Supports. Managed Care Plans can select which of the services to offer.

CalAIM ECM and Community Supports

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CalAIM ECM and Community Supports Guide

Types of Community Supports Available in Ventura:

Housing Navigation
Assistance with finding, applying for, and securing permanent housing.

Housing Deposits
Assistance with housing fees, including security deposits and utility setup, such as gas and electricity.

Housing Tenancy & Sustainability
Support to keep your housing, such as help with landlord issues, annual certification, and connections to local resources to prevent eviction.

Personal Care and Homemaker Services
Support for daily activities like bathing, feeding, meal preparation, grocery shopping, and going to medical appointments.

Home Modifications
Home updates that help improve health, safety, and independence, such as ramps, grab-bars, wider doorways, and stair lifts.

Nursing Home Diversion to Assisted Living
Help with transferring to assisted living and receive services like daily living support, medication oversight, and 24-hour onsite direct care staff, instead of going to or staying in a nursing facility.

Day Habilitation Programs
Mentoring to develop skills, such as using public transportation, cooking, cleaning, and managing personal finances

Recuperative Care (Medical Respite)
Short-term residential care if you are discharged from a hospital and without stable housing.

Caregiver Services (Respite Services)
Short-term relief for your caregivers, either where you live or at an approved facility.

Medically Supportive Food/Medically Tailored Meals
Deliveries of nutritious groceries or prepared meals along with vouchers for healthy food and/or nutrition education.

Short-Term Post Hospitalization Housing
Temporary housing after leaving inpatient care settings, including those for SUD treatment, mental health, correctional facilities, and more.

Asthma Remediation
Home updates to help prevent acute asthma episodes through filtered vacuums, dehumidifiers, air filters, and better ventilation.

Nursing Facility Transition to a Home
Assistance returning home from a nursing facility, such as funding for security deposits, utility set-up fees, and health-related appliances like hospital beds.

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 experiencing homelessness with at least 1 complex physical, behavioral, or developmental need.
- 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 with significant mental health or substance use disorders, affected by at least 1 complex social factor **and** 1 or more of the following: at high risk or institutionalization, overdose, or suicide; rely mainly on crisis services, EDs, urgent care, or inpatient stays; or have had 2+ ED visits or hospitalizations for mental health or substance use disorders in the last 12 months.
- Children and youth experiencing significant challenges with mental health conditions or substance use disorders.

Individuals Transitioning from Incarceration:
- Adults recently released from prison, jail, or correctional facilities in the last 12 months **and** experiencing 1 or more of the following: mental illness, substance use disorder (SUD), chronic or significant non-chronic clinical condition, intellectual or developmental disability, traumatic brain injury, HIV/AIDS, or pregnancy/postpartum.
- Children and youth recently released from youth correctional facilities in the past year.

Adults in the Community at Risk for Long-Term Care Institutionalization:
- Adults living in the community who meet skilled nursing facility criteria or need lower-acuity skilled nursing, are affected by at least 1 complex social factor, **and** can reside 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:

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Recent DHCS Policy Guidance: Referral Standards

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

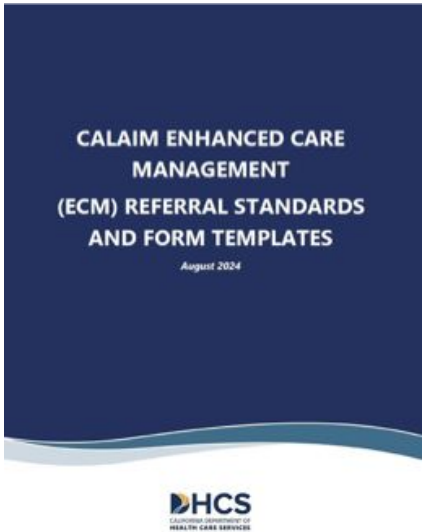
- Robust and streamlined community referral pathways to enroll more members who can benefit from ECM and Community Supports

Collaborative Role

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

DHCS Update: Referral Standards and Form

DHCS developed new ECM Referral Standards and Form Template to streamline and standardize ECM Referrals made to Managed Care Plans (MCPs) from providers, community-based organizations, and other entities.



The new ECM Referral Standards define the information that MCPs are expected to collect for Medi-Cal members being referred to an MCP for ECM.

The new **ECM Referral Form Templates** are forms for use by MCPs and referring organizations that prefer a PDF or hard copy form to make a referral.

DHCS Update: Referral Standards and Form

The ECM Referral Standards and Form Templates define the following:

- Medi-Cal Member Information
- Referral Source Information
- Eligibility Criteria for Adults and Children/Youth
- Enrollment In Other Programs
- Referral Transmission Methods – including guidance encouraging batch referrals

***Note: The ECM Referral Standards will not change the existing processes for the MIF and RTF.**

DHCS Update: Referral Standards and Form

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- **Effective January 1, 2025:**
  - All ECM Referrals **must** follow the guidelines established in the ECM Referral Standards *regardless* of referral modality (electronic, EMR, hard copy, etc.).
  - MCPs choose **which** referral modalities (electronic, EMR, hard copy, etc.) they want to deploy in the community. Electronic referrals are encouraged.
  - MCPs **may not** require additional documentation (e.g., ICD-10 codes, supplemental checklists, Treatment Authorization Request (TAR) forms) from referring partners or ECM Providers beyond the information in the ECM referral.
  - DHCS expects that many MCPs will embed the referral standards into their existing provider portals but may also offer other electronic referral pathways.

DHCS Update: Referral Standards and Form

What role does the Collaborative play?

- Discuss the rollout of new standards and forms, and highlight questions/concerns to the Department of Health Care Services
- Determine how to use the referral form to build greater community awareness and education of CalAIM (e.g. churches, schools, childcare centers, etc)

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Referrals 101:

Gold Coast Health Plan

Kaiser Permanente

Q&A

Determining Priority Use Cases: Referrals

What is a Priority Use Case?

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Personas The WHO	**Use Case Story** The WHAT	**Use Case Scenes** The HOW
Fictional characters who represent a person expected to use a service or product. Also referred to as the human actors within a use case.	**Describes the personas engaging with services, technology, and/or settings over a period of time to accomplish a specific goal. Can be written as a narrative story.**	**Step-by-step interactions between the personas and the systems they use to accomplish the use case.**

Priority Use Case Examples

An older male is discharged from the hospital after a fall at home with new medications and a referral to install new grab bars in his home. His ECM provider is notified of the discharge.

A pregnant 18 year old woman is at risk of homelessness. At a prenatal care appointment, her provider refers her to the Managed Care Plan for ECM and Housing Transition Navigation Services.

Activity: What is your priority use case?

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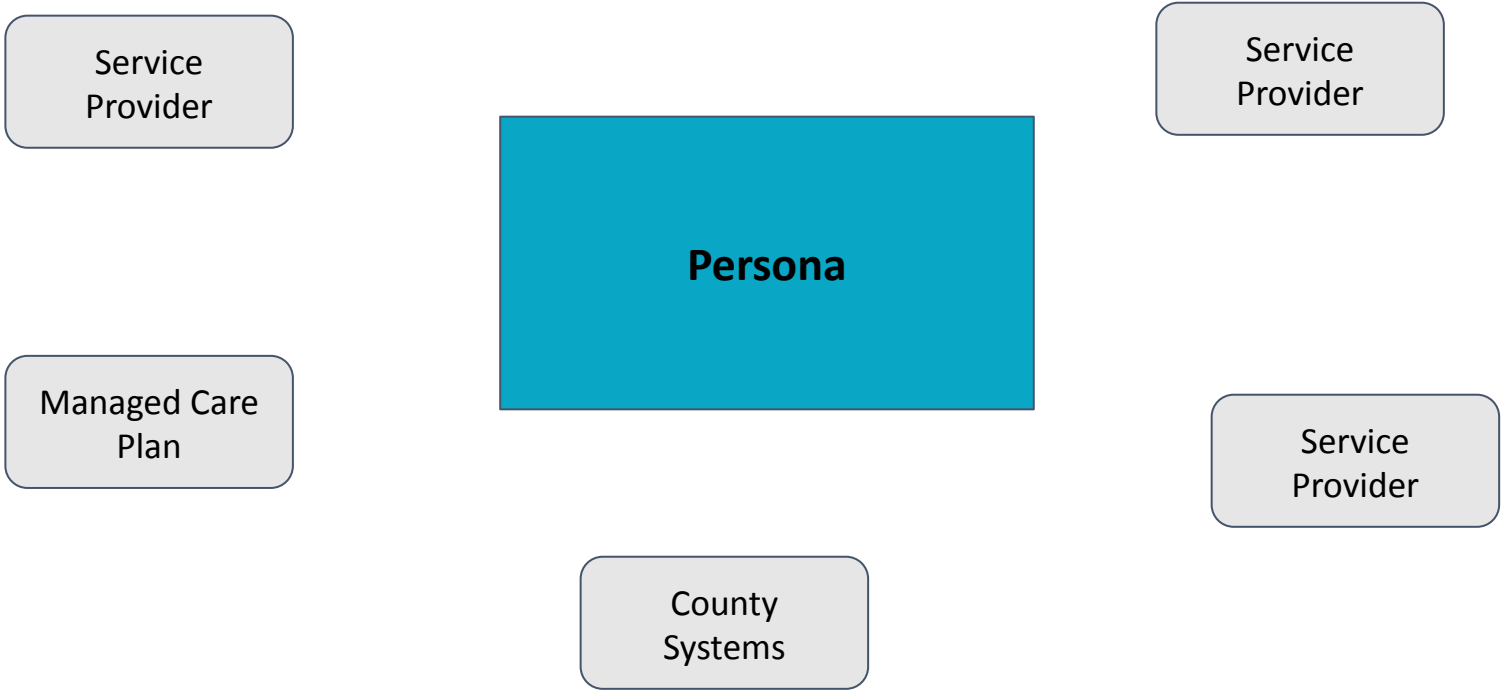
Step 1: Where can referrals be improved in your work?
Identify 2-3 areas within current operations that can be improved by enhanced data sharing between entities.

Step 2: What problem are you trying to solve? What are your ideal dynamics of the future state of referrals? What outcomes do you aspire to see?
For each area you identified in Step 1, note down 2-3 sentences describing what you'd like to see change.

Step 3: Define your persona
Looking at the examples on the prior slide, who is a fictional Medi-Cal member you would like to solve this problem for? What challenges are they experiencing and who is serving them?

Activity: What is your priority use case?



Discussion

Additional DHCS Updates

- **Presumptive Authorization Policy Update** (page 107)
  - DHCS to host webinar on October 9, 11am - 12pm to share details on Referral Standards and Presumptive Authorization

- **Transitional Rent Concept Paper**
  - Public comment period open through September 20. Submit your comments to: CalAIMECMILOS@dhcs.ca.gov

- **PATH TA Marketplace Recipient Webinar**
  - September 26, 10am - 11am

Next Steps

October Meeting:
Wednesday, October 16
11:00am - 12:30pm
On Zoom

“How to Refer” Resource:
1-page infographic or explainer detailing how to make an ECM or Community Supports referral to GCHP and KP.

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Thank you for turning in your evaluation!
Questions or suggestions?
pathinfo@bluepathhealth.com

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Appendix

CalAIM TA Marketplace