WELCOME

HHP CB-CME Webinar Fridays:

Enhanced Care Management 101: Overview for New Providers and Teams

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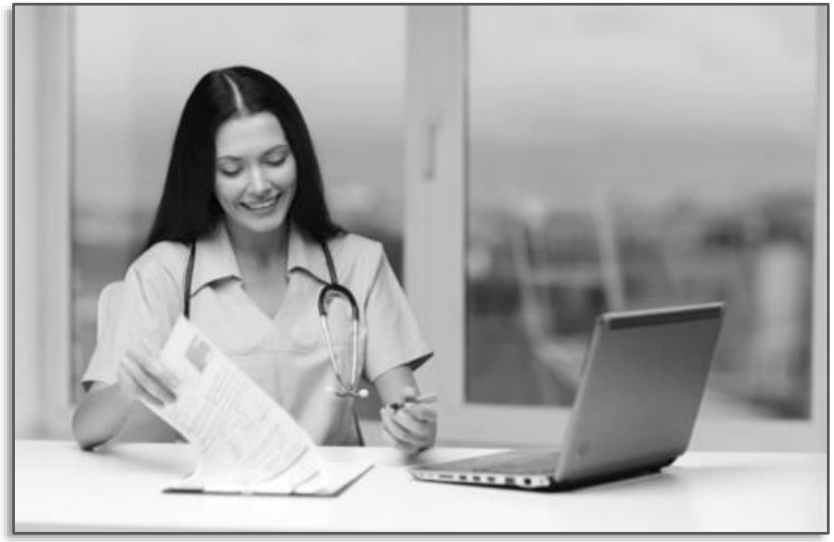

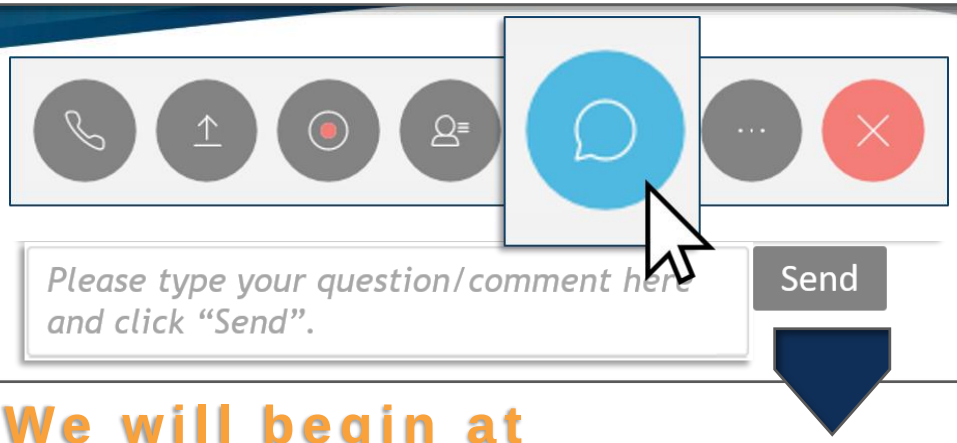

We will begin at 12:03p.m.

Thank you

HHP CB-CME
Webinar Fridays:

Enhanced Care Management 101: Overview for New Providers and Teams

L.A. Care HEALTH PLAN
For All of L.A.

November 5, 2021

Presented by:

L.A. Care Health Plan

Pending Clearance

Housekeeping

- This webinar is being recorded
- Attendance will be tracked via log-in
- Questions will be managed through the Chat. Please submit all questions to Everyone
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Webinar Overview

Topic	Time
Welcome & Introductions	5 minutes
Enhanced Care Management 101: Overview for New Providers and Teams	
• ECM Intro & Core Services	20 minutes
• ECM Population(s) of Focus	10 minutes
• ECM Care Team	15 minutes
• Community Supports	5 minutes
Q&A	5 minutes

Enhanced Care Management 101

Today's Team

Sandra Bolleurs, BSW
Francis Nepomuceno, MPH
Becky Lee, MPA
L.A. Care Health Plan

Laura Collins, LICSW
Senior Consultant, Health Management Associates

Learning Objectives

Obtain a high-level understanding of the Enhanced Care Management (ECM) benefit, the ECM Populations of Focus, and the ECM Core Services

Discuss the roles and responsibilities of the ECM Care Team members, including the responsibilities of the Managed Care Plans (MCPs)

Review the additional new resources available to ECM members, under Community Supports

Today's Agenda

1. **ECM Benefit Summary**
    - 7 ECM Core Services
    - Populations of Focus
2. **Role of the ECM Provider**
    - ECM Care Team Roles
3. **Role of the Health Plan/Managed Care Plan**
4. **ILOS/Community Supports Summary**
5. **Q&A**

What is ECM?

Enhanced Care Management (ECM) will be a new statewide Medi-Cal benefit replacing Whole Person Care & Health Homes Program

Very similar to Health Homes Program but will include additional populations & additional Core Services

ECM is a whole-person, interdisciplinary and wrap-around approach to comprehensive care management

ECM addresses the physical, behavioral health and social needs of high-cost, high-need MediCal managed care members

ECM provides and coordinates services that are community-based, person-centered and prioritize on-the ground/in-person services

ECM's Seven Core Services

A Whole-Person Approach with a Focus on In-person Services

Outreach and Engagement

ID, Locate, Contact and Engage → Prioritize those most in need → Various Strategies/Modes → Multiple Attempts → Culturally & Linguistically Appropriate

Comprehensive Assessment and Care Plan

Engage Primarily In-Person & use Innovative Alternatives → Develop a Comprehensive, Individualized, Person-Centered Assessment & Care Plan → Timely Reassessment & Updates to Plan

ECM's Seven Core Services

Enhanced Coordination of Care

Organize & implement activities in the Care Plan → Promote Integration of all Care → Engage in Care & Reduce Barriers → Communicate with the Team

Comprehensive Transitional Care

Provide Support During Transitions of Care (TOC) → Coordinate with Providers → Educate the Member → Review Medications → Overall Goal to Reduce Avoidable Readmissions

ECM's Seven Core Services

Health Promotion

Identify Member's Strengths, Resiliencies & Supports → Coaching to healthy lifestyle choices → Promote Skill-building and Self-Management

Individual and Family/Social Supports

Identify, Document & Educate Chosen Caregiver/Support → Integrate Supports in Member's Care → Connect with Additional Resources

Coordination of & Referral to Community & Social Support Services

Identify Needed Resources → Coordinate and Refer → Follow up (Close the Loop)

ECM Populations of Focus

Jan 1, 2022

1. Individuals experiencing homelessness
2. High utilizers with frequent hospital or ER visits/admissions
3. Individuals with Serious Mental Illness or SUD and other health needs
4. Individuals transitioning from incarceration

Jan 1, 2023

5. Individuals at risk for institutionalization, eligible for long-term care
6. Nursing facility residents who want to transition to the community

July 1, 2023

7. Children or youth with complex needs including SED

The 4 Populations of Focus Going Live January 1, 2022

1. Homelessness

Individuals **Experiencing Homelessness** AND

- has a **complex condition** with **inability to successfully self-manage**
- for whom **coordination of services** would likely result in improved health outcomes
- AND/OR **decreased utilization** of high-cost services

Definition of *Homelessness*

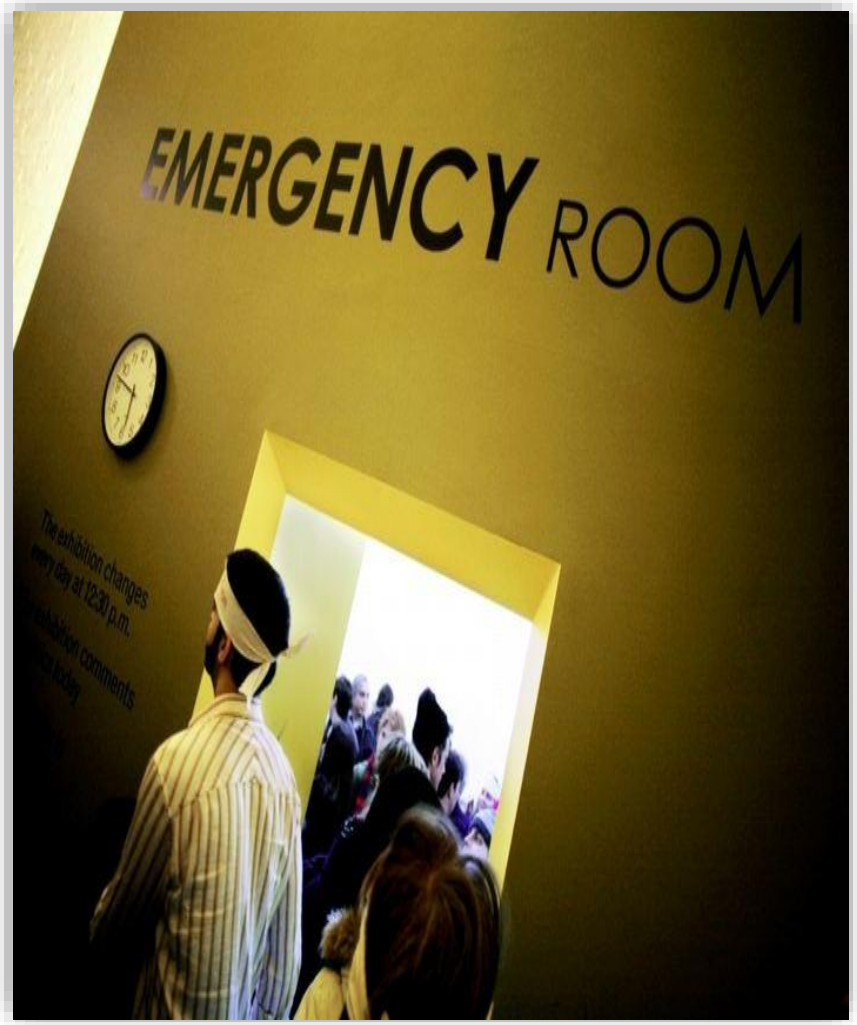
DHCS defines homelessness as one of the following. An Individual or family:

- who lacks adequate nighttime residence
- with a primary residence that is a public or private place not designed for or ordinarily used for habitation
- living in a shelter
- exiting an institution to homelessness
- who will imminently lose housing in next 30 days
- Unaccompanied youth and homeless families and children and youth defined as homeless under other Federal statutes
- Victims fleeing domestic violence

2nd Population of Focus as of January 1, 2022
Individuals who are *High Utilizers* of Services

High Utilizers with frequent hospital or ER Admissions in a 6-month period

- **5 or more emergency** room visits **AND/OR**
- **3 or more unplanned hospital** admissions AND/OR
- **multiple short-term skilled nursing** facility stays
- **AND** any of the above could have been **avoided with appropriate outpatient** care or improved treatment adherence



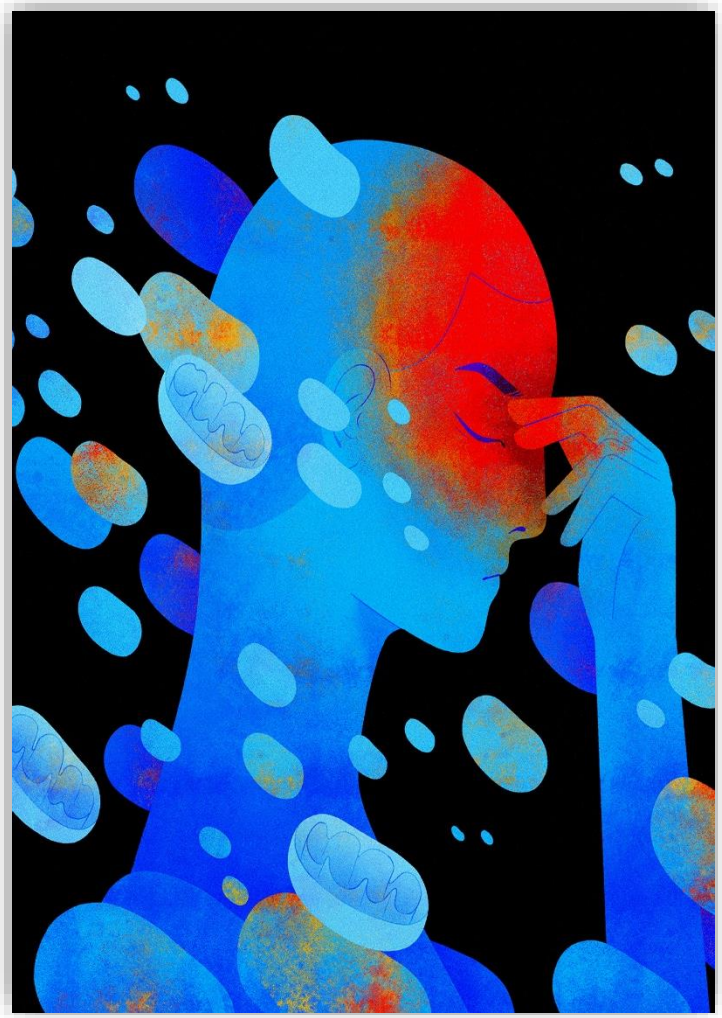
3rd Population of Focus as of January 1, 2022
Serious Mental Illness (SMI)/ Substance Use Disorder (SUD)

Individuals with SMI/SUD and other Health Needs

1. Who **meet eligibility criteria** for participation in, or obtaining services through

- County Specialty Mental Health (SMH) System AND/OR
- Drug Medi-Cal Org Delivery System (DMC-ODS) OR
- Drug Medi-Cal (DMC) program **AND**

2. Actively experiencing **one complex social factor** influencing their health **AND**



3rd Population of Focus as of January 1, 2022
Serious Mental Illness (SMI)/ Substance Use Disorder (SUD)

3. AND meet one of the following:

- High risk for institutionalism, overdose and/or suicide
- Use crisis services, ERs, urgent care or inpatient stays as sole source of care
- 2+ ED visits or 2+ hospitalizations due to SMI or SUD in the past 12 months
- Pregnant and post-partum (12 months from delivery)

4th Population of Focus as of January 1, 2022
Transitioning from Incarceration

Individuals Transitioning from Incarceration AND

- **Have at least one of the following conditions**

1. **Chronic mental illness (SMI)**
2. **Substance Use Disorder (SUD)**
3. **Chronic disease (e.g., hepatitis C, diabetes)**
4. **Intellectual or developmental disability**
5. **Traumatic brain injury**
6. **HIV/AIDS**
7. **Pregnancy**

Lead Care Manager

Primary Responsibilities

- Responsible for care coordination activities
- Engage eligible Members
- Oversee provision of ECM services and implementation of the Assessment and Care Plan
- Offer services where the Member lives, seeks care, or finds most easily accessible
- Connect Member to other social services and supports
- Advocates on behalf of Members with health care professionals
- Uses motivational interviewing, trauma-informed care, and harm-reduction approaches
- Coordinate with hospital staff on discharge plan
- Accompany Member to office visits, as needed
- Monitor treatment adherence
- Provide health promotion and self-management training

Community Health Worker

Primary Responsibilities

- Engage eligible ECM Members
- Accompany ECM Member to office visits, as needed, and in the most easily accessible setting
- Health promotion and self-management training
- Arrange transportation
- Assist with linkage to social supports
- Distribute health promotion materials
- Calls Member to facilitate visits with care manager
- Connect ECM Member to other social services and supports the Member may need
- Advocate on behalf of Members with health care professionals
- Use motivational interviewing, trauma-informed care, and harm-reduction approaches
- Monitor treatment adherence

ECM Clinical Consultant and ECM Director

Clinical Consultant

Review cases and advise the care team

Clinical resource for care team

Facilitate access to primary care, behavioral health, other relevant providers

ECM Director

Overall responsibility for management of the team & administration of ECM

Responsible for overall quality of ECM service delivery & team performance to ensure quality of ECM service delivery and operations

The ECM Care Team

- ***What ECM Care Team role to you identify with?***

1. Lead Care Manager

2. Community Health Worker

3. Clinical Consultant

4. ECM Director

What is the Health Plan's Responsibility in ECM?

ECM Oversight and Support

The Managed Care Plans (MCPs) will monitor the performance of ECM providers and will support the delivery of ECM by:

- Ensuring providers uphold all applicable requirements related to ECM including
  - ECM Care Team Capacity to provide the 7 Core Services to the Populations of Focus
  - Ensure ECM services are
    - Community-based
    - Interdisciplinary
    - High-touch
    - Person-Centered
- All ECM data capturing activity/monitoring will include:
  - Eligibility, outreach, enrollment, assessment completion, volume of service utilization, timeliness of deliverable submission, and/or other relevant TBD metrics (pending DHCS final guidance)

Community Supports (Formerly Lieu of Services – ILOS)

Its Purpose and Administration

It is part of CalAIM – one in a series of Medi-Cal reforms led by the State focused on improving the quality of life and health outcomes of Medi-Cal beneficiaries

Medi-Cal managed care plans will integrate in Community Supports (CS) into their population health management plans – often in combination with the new Enhanced Care Management (ECM) benefit

CS would be focused on addressing combined medical and social determinants of health needs and avoiding higher levels of care or other future health care costs

For example, CS might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays and emergency department use

L.A. Care Community Supports (CS)

Four Programs Going Live in Jan 2022

- **Housing Transition Navigation Services and Tenancy and Sustaining Services**
  - Combined and named Homeless and Housing Support (HHSS)
  - Provides assistance with obtaining and maintain stable housing & tenancy
  - Interventions include:
    - Assistance with housing search/application completion
    - Development of a housing support plan
    - Behavioral interventions to support stable housing including
      - Financial literacy and timely rental payment
- **Meals/Medically Tailored Meals**
  - Delivered to the home, tailored to meet dietary needs
  - Up to 3xday and/or food and nutrition services for or to 12 wks or longer
- **Recuperative Care (Medical Respite)**
  - Post-hospitalization, short term residential care
  - Supportive environment and daily care to promote medical stability
  - Case management and care coordination services

ECM Members Accessing Community Supports

Eligibility, Referrals and Collaboration

- Each Community Support Service will have its own eligibility criteria
- ECM providers can refer their own members to CS
- ECM providers are expected/required to collaborate with CS providers

Transition to HHSS

- Homeless Health Homes Program members will be grandfathered into HHSS
- If current HHP CB-CME becomes a HHSS provider, these members will continue to receive housing navigation and tenancy services from the same provider
- If not, these members will be reassigned to a new HHSS provider

WPC Members' Transition to Community Supports

- Enrolled in HFH ICMS and ODR ICMS or currently receiving Recuperative Care
  - Will continue to receive these services from existing ICMS/Recup provider
  - Assigned to new ECM provider if their ICMS/Recup provider is not with ECM
- WPC member notices regarding transition to CS
  - Late 2021/early 2022
  - Notice guidance is pending DHCS at this time

Summary – ECM 101

The Basics of ECM

The 4 Populations of Focus and 7 Core Services going live 1/1/22

Role of the ECM Provider

With a focus on the individual Care Team
Roles and Responsibilities

Responsibilities of the Managed Care Plan in ECM

An initial review of ILOS/Community Support programs

Q&A
Chat in!

More Resources on the DHCS Website

DHCS ECM Policy Guide:

https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide-September-2021.pdf

DHCS ECM and Community Supports Website:

https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx

DHCS ILOS/Community Supports Policy Guide:

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

Coming Up Next

ECM Populations of Focus Going Live
January 1, 2022 Webinar

When: Friday, November 19, 2021

Time: 12:00 p.m. – 1:00 p.m.

https://www.lacare.org/healthhomes

ECM Bootcamp:
A Practical Approach to ECM Benefit

A three-day virtual series detailing reviewing the vital components of the ECM Benefit

Participation is mandatory for ECM care team members with organizations starting ECM 1/1/2021

When:

Tuesday, December 7, 2021

Wednesday, December 8, 2021

Thursday, December 9, 2021

Time: 12:00 p.m. – 2:00 p.m. every day

From all of us…