# Enhanced Care Management 101

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# Welcome & Updates

CCAH

## Jessica Hampton, ECM/CS Manager

# ECM 101

## An Overview

## AGENDA:

1. Overview of CalAIM, ECM & Community Supports
2. Eligible Populations of Focus
3. The 7 Core Services
4. Team-based care in ECM
5. Supporting the ECM Provider: CCAH's 4-Pronged Approach

# LEARNING OBJECTIVES

## Upon conclusion of this webinar, participants will be able to:

1. Describe the purpose and timeline for ECM implementation in California
2. Describe the Populations of Focus for ECM
3. Describe the Core Services of ECM
4. Describe how a team approach will be applied
5. Utilize the training supports offered for ECM implementation

# Today's Team

**Laura Collins, MSW, LICSW**
**Senior Consultant, HMA**

**Marc Avery, MD**
**Physician Principal, HMA**

# How familiar are you with the Enhanced Care Management benefit? **Poll**

1. Not familiar at all
2. Somewhat familiar
3. Very Familiar

**What are you most interested in learning about with ECM? Chat in!**

# What is ECM?

- A Quick Overview, starting with CalAIM

# What is CalAIM?

Led by Department of Healthcare Services, CalAIM is: *California Advancing and Innovating MediCal*

A 5-year plan to transform and integrate Medi-Cal's programs more seamlessly with other social services

Overarching goal is to improve medical & social outcomes for Medi-Cal recipients, especially those with the most complex needs

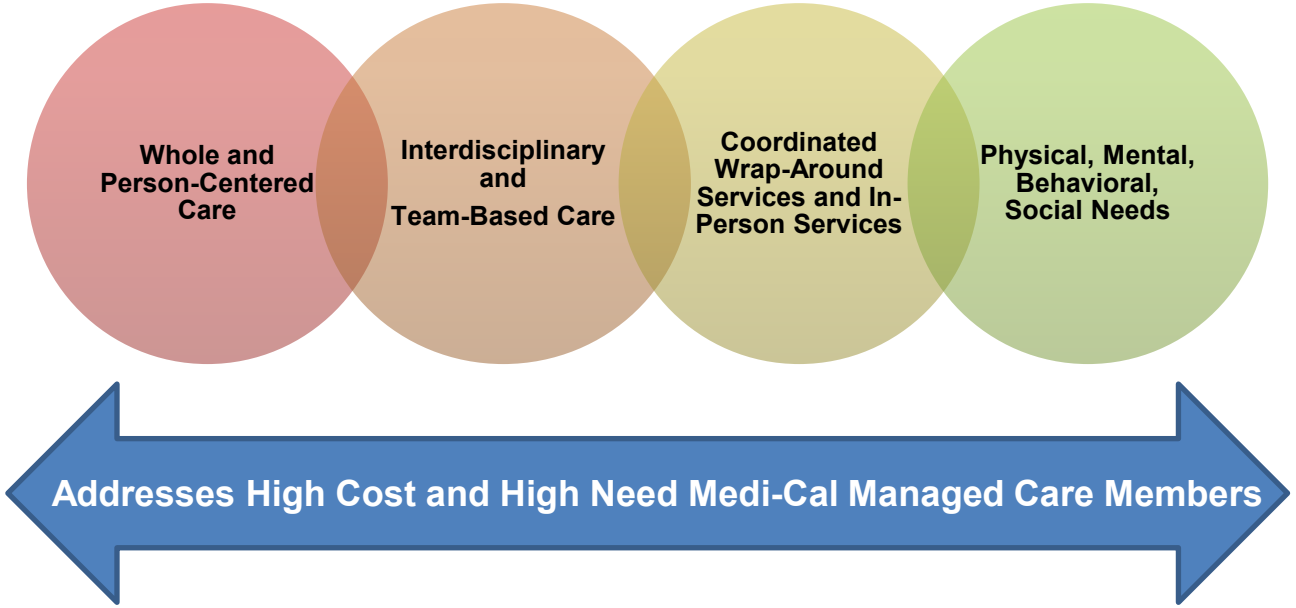
Other goals are service standardization, consistent & equitable care across the state, emphasizing outreach & a "no wrong door" approach

https://www.chcf.org/publication/calaim-explained-five-year-plan-transform-medi-cal/

# What is ECM?

- Enhanced Care Management (ECM) is a new statewide CalAIM benefit replacing  Whole Person Care & Health Homes Programs
- Very similar to Health Homes Program but will include additional populations & additional Core Services
- ECM is a whole-person, interdisciplinary & wrap-around approach to comprehensive care management
- ECM addresses the physical, behavioral health & social needs of high-cost, high-need MediCal managed care members
- ECM provides and coordinates services that are community-based, person-centered & prioritize on-the-ground and in-person services

# Enhanced Care Management Framework Review



# Community Supports (Formerly In Lieu of Services)

## CS/ILOS

CS is adjunct to ECM as another component of CalAIM that focuses on addressing the social determinants of health of MediCal beneficiaries, including those who had received services via Whole Person Care & Health Homes

Similar to ECM, Community Supports focuses on serving those individuals with complex physical, behavioral, developmental and social needs

There are a menu of services that DHCS has approved, including housing support, recuperative care, meals, sobering centers, asthma remediation and other community transition services

# Community Supports (CS)

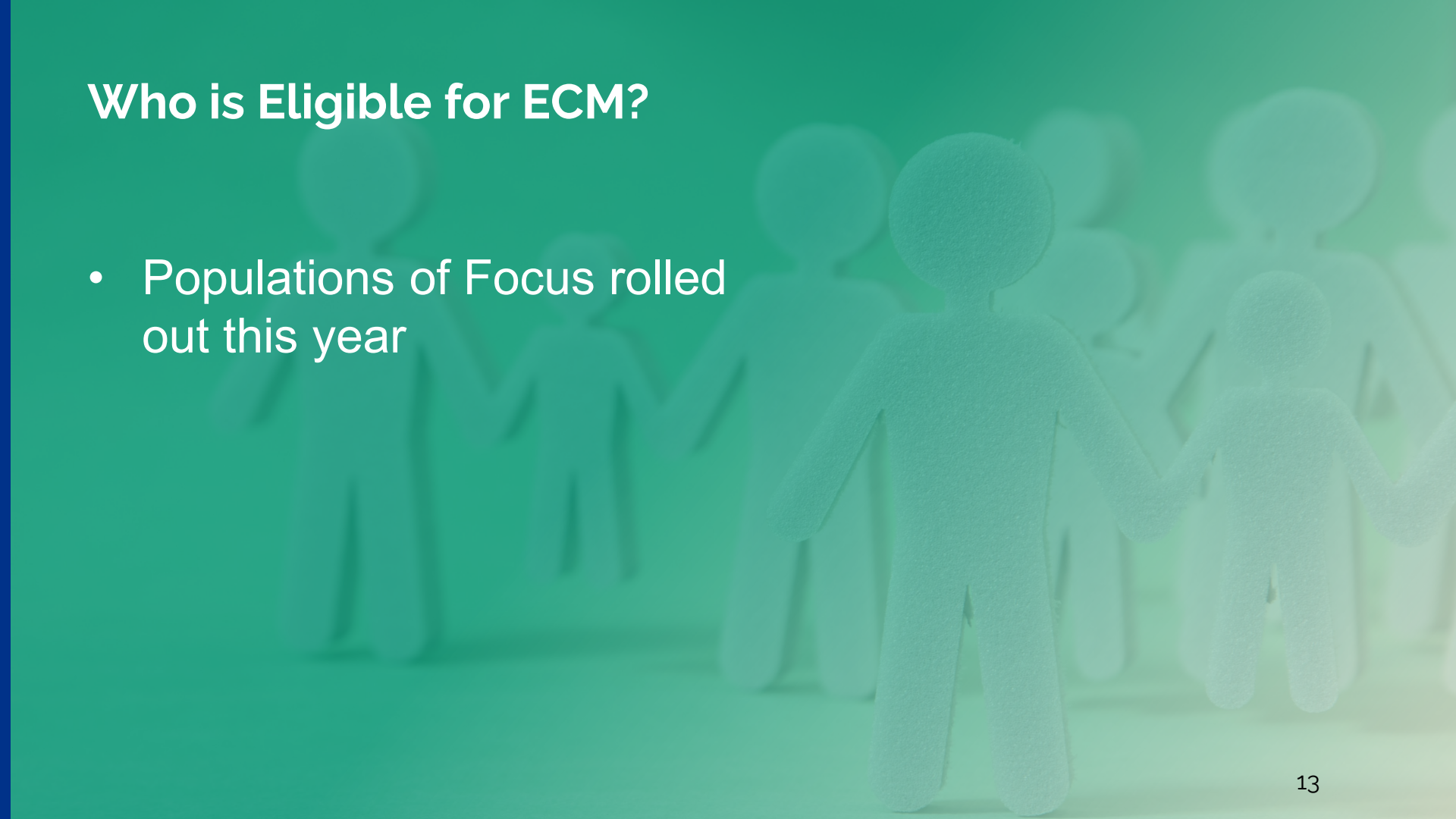
- **Under CalAIM there are 14 possible Community Supports programs**

- **The Alliance (CCAH) is offering 7:**
  - Housing Transition Navigation Services
    - Assistance with obtaining stable housing
  - Housing Tenancy & Sustaining Services
    - Assistance with maintaining safe & stable tenancy
  - Housing Deposits
  - Medically Tailored Meals
  - Sobering Center
  - Recuperative Care (July)
  - Short-term Post-Hospitalization Housing (July)

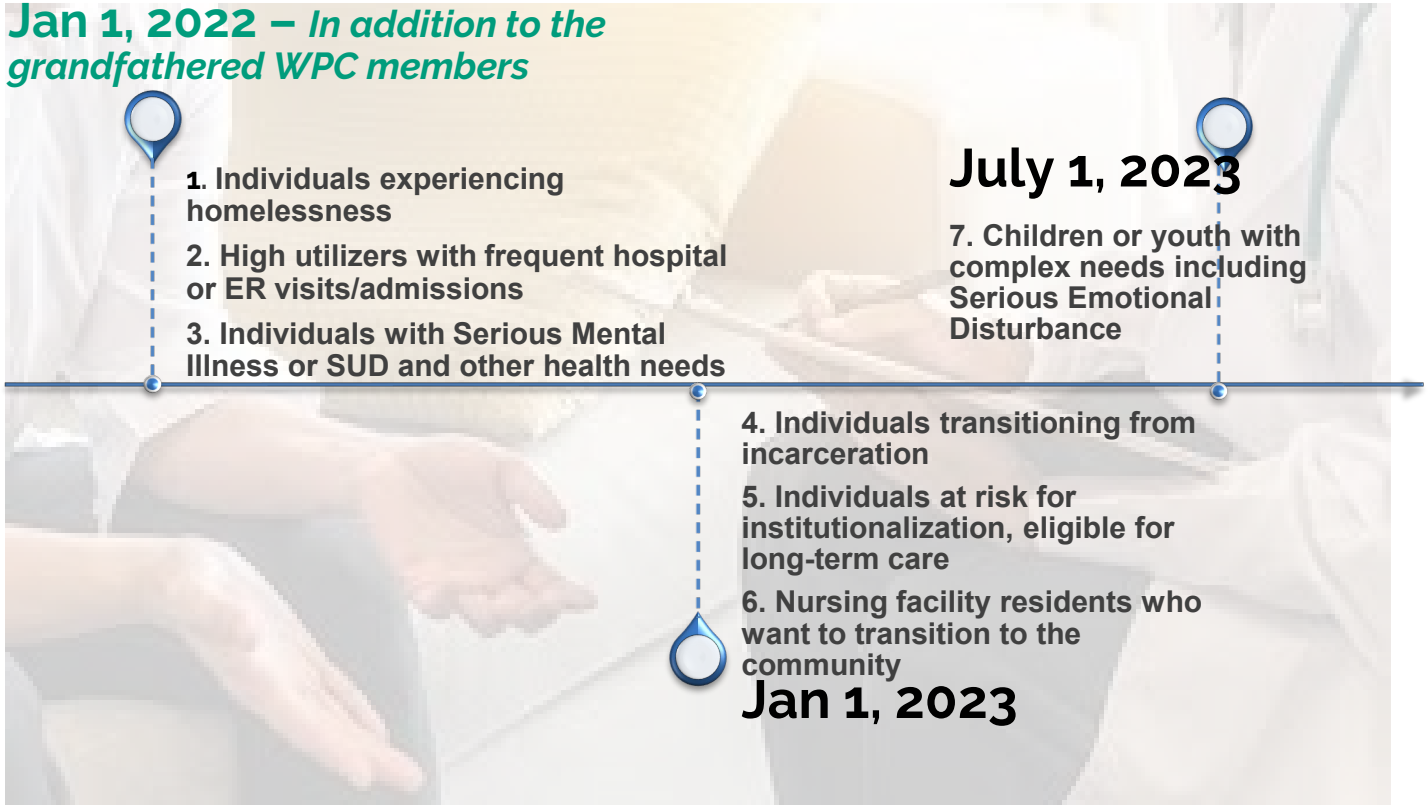
- **There are criteria for accessing each of the Community Supports**
- **ECM providers can refer their members to CS services & are expected to collaborate**

# Who is Eligible for ECM?

- Populations of Focus rolled out this year



# ECM Populations of Focus



## 1st Population of Focus as of January 1, 2022

## *Homelessness with a Condition*

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

3. AND meet one of the following:
   - High risk for institutionalization, 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)

# Which Population of Focus would you like to learn more about? Check your top 2 **Poll**

1. **Individuals experiencing homelessness**
2. **High utilizers with frequent hospital or ER visits/admissions**
3. **Individuals with Serious Mental Illness**
4. **Individuals with Substance Use Disorders**
5. **Individuals transitioning from incarceration**
6. **Individuals at risk for institutionalization, eligible for long-term care**
7. **Nursing facility residents who want to transition to the community**

# What do they Get?

- The ECM Core Services

# ECM's Seven Core Services

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

## Outreach & Engagement

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

## Comprehensive Assessment & 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 & 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)

# What is your comfort level with providing the 7 Core Services? **Poll**

1. **Not comfortable at all**
2. **Somewhat comfortable**
3. **Very comfortable**

# Which Core Service(s) would you like to learn more about?

*Check your top 2* **Poll**

1. **Outreach & Engagement**
2. **Comprehensive Assessment & Care Planning**
3. **Enhanced Coordination of Care**
4. **Comprehensive Transitional Care**
5. **Health Promotion**
6. **Individual & Family Social Supports**
7. **Coordination of & Referral to Community & Social Support Services**

# How will you Deliver this?

- Team-based Care

# Lead Care Manager

## Primary Responsibilities

- Responsible for care coordination activities
- Engage eligible Members
- Oversee provision of ECM services & implementation of Assessment & Care Plan
- Offer services where 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 & harm-reduction approaches
- Coordinate with hospital staff on discharge plan
- Accompany Member to office visits, as needed
- Monitor treatment adherence
- Provide health promotion & self-management training

# ECM Clinical Consultant and ECM Director

## Clinical Consultant

~Review cases & 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 & operations

# Other Possible Roles Supporting the ECM Team

## Community Health Worker

- Supports the work of the Lead Care Manager with a focus on outreach and other in-person activities, such as
  - Accompaniment to appointments
  - Transportation support
  - Linkage to supports
  - Check-ins

## Housing Navigator

- Housing support & advocacy

**What other roles are not represented here?**

**Chat in!**

# Supporting your ECM work

- CCAH's Approach

# Supporting your ECM work: CCAH's 4-pronged approach

Activate Care Training

Practice Coaching

Webinars

Quarterly Learning Sessions

# Your ECM Support Team

## Your Practice Coaches

**Laura Collins, LICSW**
**Santa Cruz County**

**Karen Hill, PhD, ANP-C**
**Monterey County**

**Deb Peartree, RN, MS**
**Merced County**

**Marc Avery, MD**
**Curriculum Design Lead**

**Liz Arjun, MPH, MSW**
**Project Manager**

# More ECM & CS Resources from DHCS

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

**DHCS ECM Provider Toolkit:** https://www.aurrerahealth.com/wp-content/uploads/2021/12/Provider-Toolkit_FINAL.pdf

**DHCS ECM Member Toolkit:** https://www.aurrerahealth.com/wp-content/uploads/2022/01/ECM-Member-Toolkit_FINAL.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/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

# Q&A

Chat in!

# Coming Up Next

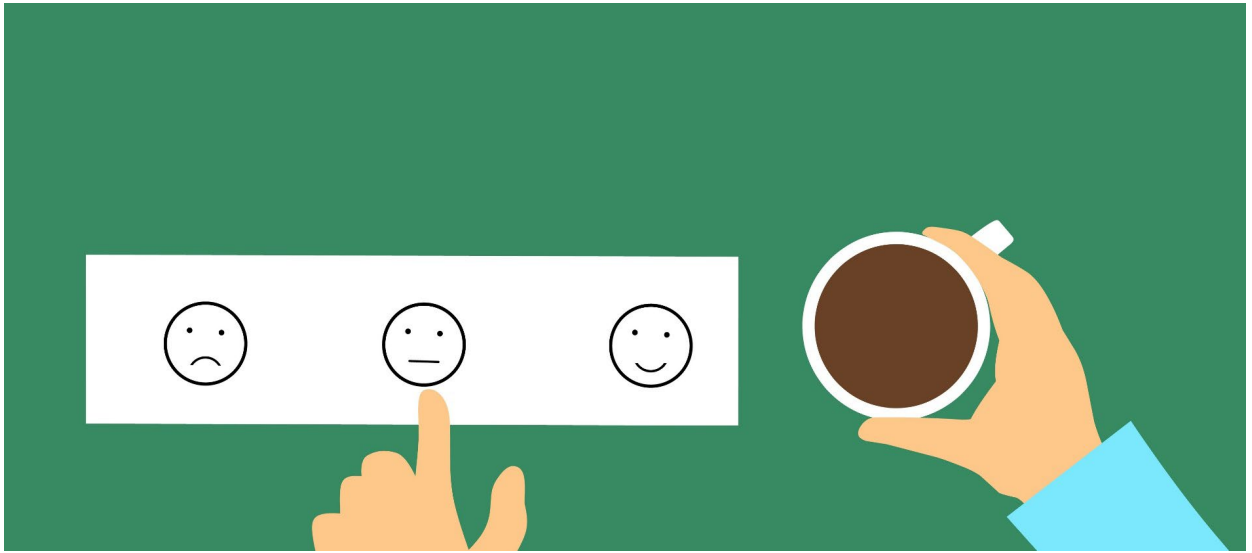
## The ECM Assessment: Practical Strategies

**When: Thursday April 28, 2022**

**Time: 10:00 a.m.**

**Before You Go…**
**Please Complete the Evaluation of Today's Session**

*Please Click on the Link in the Chat Box*



# ECM 101: AN OVERVIEW

**From all of us…**