PATH – Collaborative Planning & Implementation (CPI)

Welcome! The Northwest Collaborative Planning Meeting will be starting shortly.

November 28, 2023

POPULATION HEALTH
INNOVATION LAB
A Program of the PUBLIC HEALTH INSTITUTE

PATH – Collaborative Planning & Implementation (CPI)

Northwest Regional CPI Meeting

November 28, 2023

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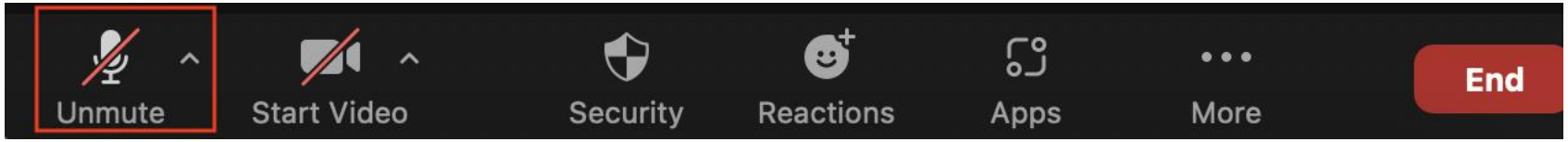
This event is being recorded.

The slides and recording will be available after the event at **pophealthinnovationlab.org/projects/PATH**

Please mute your microphone and video during the presentation.



Staff Intros & Meeting Navigation

CPI Participant Eligibility

The following entities are eligible and strongly encouraged to participate:

- Community Based Organization (CBO)
- County, City, or Local Government Agency
- Federally Qualified Health Center (FQHC)
- Managed Care Plans (MCPs)
- Medi-Cal Tribal and Designee of Indian Health Program
- Providers (including but not limited to hospitals and provider organizations)

We kindly ask vendors and sales people to remove themselves from the convenings and the collaborative. These regional convenings aim to be a safe and intimate place to resolve local implementation challenges.

Land Acknowledgment

The Population Health Innovation Lab team respectfully acknowledges that we live and operate on the unceded land of Indigenous peoples throughout the U.S.

We acknowledge the land and country we are on today as the traditional and treaty territory of the Native American, Alaska Native, and Tribal nations who have lived here and cared for the Land since time immemorial. We further acknowledge the role Native American, Alaska Native, and Tribal nations have today in taking care of these lands, as well as the sacrifices they have endured to survive to this day.

Photo by Ralph (Ravi) Kayden on Unsplash

Commitments to Community Inclusivity

Be Present, Brave, and Curious

- Encourage different opinions and respectful disagreement
- Embrace conflict which can deepen our understanding
- Acknowledge the risk speakers take, and value the privilege to learn from one another
- Make use of opportunities to connect person-to-person

Create An Inclusive Space

- Invite the unheard voices
- Take responsibility for our own voices (make space)
- Resist the temptation to only witness the dialogue (take space)

Invite Anti-Racist Dialogue

- Be aware we all have a bias that may impact action; biases are learned and can be unlearned.
- Address racially biased systems and norms
- Recognize the vast and varied lived experiences participants have with racism.
- Be intentional about power dynamics and how you exercise your privilege
- Avoid defensive responses when people speak from lived experiences with racism

Be Accountable

- Foster awareness of unrepresented community members not "in the room"
- Respect each other's time - participate fully and prepare for each activity
- Commit to actions that move items beyond discussion
- Practice patience and persistence – we cannot solve everything in a single conversation and will revisit topics that require additional discussion

Commitments Courtesy of: Community Health Worker & Promotor Workforce Development Resource Library — Health Leads. (2023, June 29). Health Leads. https://healthleadsusa.org/communications-center/resources/community-health-worker-promotor-workforce-development-resource-library/

Agenda & Objectives

Agenda:

- Welcome & Framing for the Day
- Local Organization Spotlight with Open Door Community Health Centers
- Presentation and Facilitated Q&A with the Department of Health Care Services (DHCS)
- Update from Partnership HealthPlan of California
- Wrap-up and Next Steps

Objectives:

- Build relationships
- Learn about Partnership HealthPlan's improvements and resources
- Increase understanding of the Population Health Management Initiative
- Clarify opportunities for cross-sector data sharing for improved care collaboration

Check-In

Please share any ECM or Community Supports implementation “wins” or "aha moments."

Elevating the Expertise of Local Partners

Local approaches to pain points and solutions in the ECM and CS implementation journey.

Welcome:

Open Door Community Health Centers

Karina Vazquez and Sarah Ross

What to Expect

- Population Health Management Strategy Presentation (30 m)
- Q&A (20 m)
  - Questions PHIL received over the past year
  - Questions from today's curious participants

Northwest & Southwest CPI Collaborative

Randi Arias-Fontenot, RN MS-L Nurse Consultant III (Specialist)
Addie Sherman Chief of Population Health Management Policy at Quality Population Health Management

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Transforming Medi-Cal

Medi-Cal

Medi-Cal offers low-cost or free health insurance to Californians with lower incomes and with disabilities.

Coverage includes:


Doctor Visits


Prescriptions


Dental and Vision Care


Mental Health Services


Substance Use Disorder Treatment


...and more.

There are also unique Medi-Cal programs for low-income Californians who are pregnant, older adults in nursing homes, people with disabilities, or people who have been diagnosed with specific diseases such as breast or cervical cancer, tuberculosis, or HIV/AIDS.

For those who would like to learn more or are interested in applying, go to benefitscal.com or coveredca.com.

Medi-Cal by the Numbers

Medi-Cal provides coverage for:

- **One in three Californians**
- More than half of **school-aged children**
- **Half of California births**
- More than **2/3 of long-term care patient days**

More than **65% of Medi-Cal members** are **people of color.**

More than half of Medi-Cal spending is attributable to the **5 percent of members with the highest-cost needs**.

About 20 percent of Californians are food insecure. California spends approximately $7.2 billion annually on health care associated with food insecurity.

California is transforming Medi-Cal to ensure that Californians get the care they need to live healthy lives.

Medi-Cal members have access to new and improved benefits and services and receive holistic care that goes beyond the doctor's office or hospital and addresses all their physical and mental health needs.

Medi-Cal helps members address their health-related social needs, including:

- Housing supports to provide safe and stable housing while in recovery from illness
- Medically tailored meals to support recovery from illness
- Better integrated and coordinated care for those with long-term needs

Medi-Cal Transformation

Goals include:

A whole-person care approach to address the social drivers of health.

Improved quality outcomes and reduced health disparities through delivery system transformation and payment reform.

A consistent, efficient, and seamless Medi-Cal system.

Medi-Cal Transformation Overview

Med-Cal is…

…**building a more equitable health system** for members with new providers and services **that go beyond the doctor's office or hospital.**

- **Physical Health Care**
- **Mental Health & Substance Use Disorder Treatment**
- **Dental Care**
- **Vision & Hearing Care**

…providing more **comprehensive, personalized, and coordinated care** to all members**, with more focused support for those with complex needs.**

- **Population Health Management**
- **Enhanced Care Management**
- **Community Supports**
- **Justice Involved Initiative**

…**standardizing benefits** across the state **so that Californians have access to the same high-quality services and care no matter where they live.**

- **Behavioral Health Modernization**
- **Managed Care Plan Transformation**
- **Medicare Medi-Cal Plans**
- **Coverage for Long-Term Services and Supports**

Medi-Cal Transformation Initiatives

Medi-Cal

Population Health Management

Medi-Cal

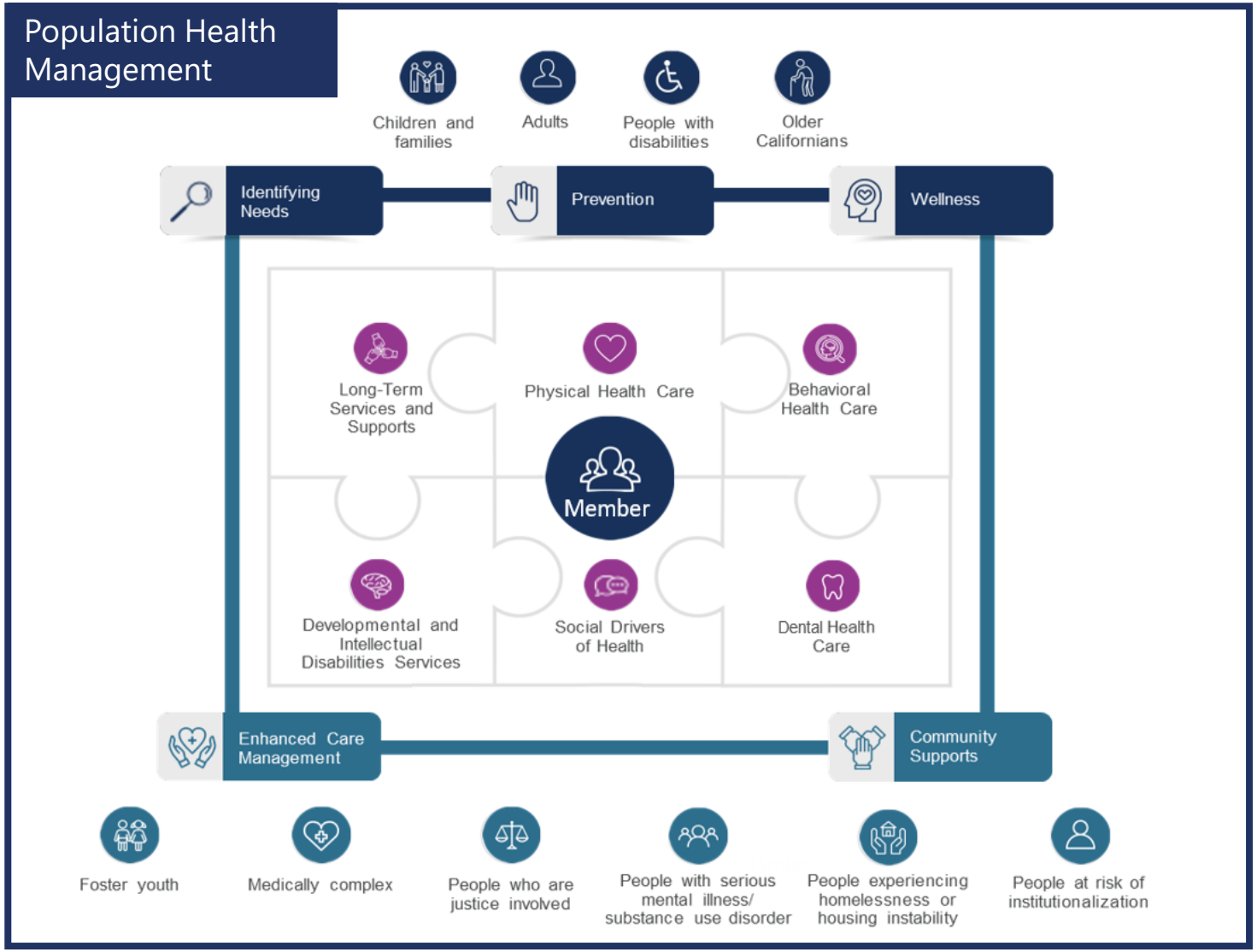
Population Health Management (PHM)

Medi-Cal's Transformation establishes a cohesive, statewide approach to PHM that ensures all members have access to a comprehensive program that leads to longer, healthier lives, improved outcomes, and health equity.

PHM will provide a comprehensive, accountable plan of action that:

- Builds trust and meaningfully engages with members.
- Gathers, shares, and assesses timely and accurate data on member preferences and needs to identify effective benefits and services.
- Connects members to preventive care and other care management and transitional care services.
- Reduces health disparities by linking members to public health and social services that address their health-related social needs.

Medi-Cal Transformation's Person-Centered Approach



ECM and Community Supports

Medi-Cal

Enhanced Care Management & Community Supports

In 2022, DHCS launched two initiatives:

Enhanced Care Management (ECM)

A benefit designed to provide person-centered, community-based care management to the highest need members. Members are assigned a Lead Care Manager who will meet them wherever they are – on the street, in a shelter, in their doctor's office or at home.

Community Supports

Fourteen new services designed to address members' health-related social needs. MCPs are encouraged, but not required, to provide these services to help members live healthier lives.

Early in Our Journey

On January 1, 2022, DHCS launched the first components of Enhanced Care Management (ECM) and Community Supports.

Issues that ECM & Community Supports are Designed to Address in California

Medi-Cal members typically have **several complex health conditions**

Members enrolled in both Medi-Cal and Medicare are **more likely to report being in poor health** than Californians only on Medicare.

Members with complex needs must often engage in **several delivery systems to access care**

People experiencing homelessness have **higher rates of diabetes, hypertension, HIV, and mortality**

Addressing social drivers of health is key to advancing health equity and helping people with high health care and social needs. **More than 65% of Medi-Cal members are from communities of color.**

What Is Enhanced Care Management (ECM)?

ECM is a statewide Medi-Cal Managed Care Plan (MCP) benefit to support comprehensive care management for members with complex needs.

- DHCS' vision for ECM is to **coordinate all care for eligible members**, including **across the physical, behavioral, and dental health delivery systems**.
- ECM is interdisciplinary, high-touch, person-centered, and **provided primarily through in-person interactions** with members where they live, seek care, or prefer to access services.
- ECM is the **highest tier of care management** for Medi-Cal MCP members.

Medi-Cal MCP Care Management Continuum

What Are the ECM Core Services?

ECM is available to members until their care plan needs are met or they opt out of the benefit, which they can do at any time. Members in ECM receive seven core services based on their individual needs.

Outreach and Engagement

Comprehensive Assessment and Care Management Plan

Member and Family Supports

Enhanced Coordination of Care

Coordination of and Referral to Community and Social Support Services

Health Promotion

Comprehensive Transitional Care

This includes scheduling appointments, coordinating transportation and accompanying members to appointments as needed.

ECM Lead Care Managers are strongly encouraged to screen ECM members for Community Supports and refer to those Supports when eligible and available.

Who is Eligible for ECM?

ECM Populations of Focus	Go-Live Timing
1. Individuals and Families Experiencing Homelessness 2. Individuals at Risk for Avoidable Hospital or ED Utilization 3. Adults with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)	**January 2022** (25 counties that participated in Whole Person Care (WPC)/Health Homes Program (HHP)) **July 2022** (all other counties)
4. Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization 5. Adult Nursing Facility Residents Transitioning to the Community	**January 2023** (statewide)
6. Children / Youth Populations of Focus	**July 2023** (statewide)
7. Individuals transitioning from incarceration 8. Birth Equity Population of Focus	**January 2024** (statewide)*

**The Individuals Transitioning from Incarceration Population of Focus has already gone live in several WPC Counties to date.*

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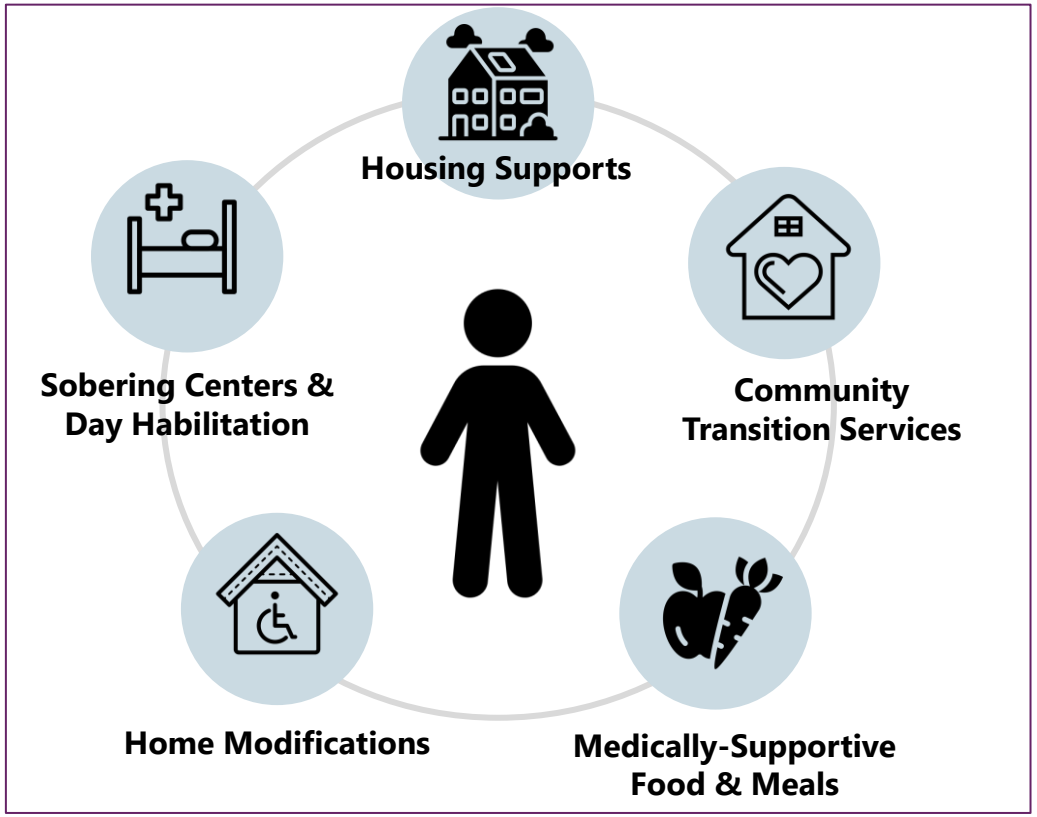
Community Supports

MCPs can offer Community Supports that will help members address health-related social needs, including support to secure and maintain housing and access to medically tailored meals to support short-term recovery.

- Medically appropriate, cost-effective services or settings that can substitute for more costly services or settings, such as hospitalization, skilled nursing facility admissions, or emergency department use
- Optional for the MCP to offer; as such, MCPs offer different combinations of Community Supports.
- MCPs must partner with local community-based organizations to provide culturally-appropriate services in members' communities
- Members do not need to be eligible for ECM to receive Community Supports



Community Supports Services

The below services were approved as Community Supports, including both In Lieu of Services (ILOS) and 1115 waiver services

Managed Care ILOS Authority

- Housing transition navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Caregiver respite services
- Day habilitation programs
- Nursing facility transition/diversion to assisted living facilities
- Community transition/nursing facility transition to a home
- Personal care and homemaker services
- Environmental accessibility adaptations
- Medically-supportive food/meals/medically tailored meals
- Sobering centers
- Asthma remediation

1115 Authority

- Short-term post-hospitalization housing
- Recuperative care (medical respite)

Long-Term Care (LTC)

Medi-Cal

Statewide Access to Managed Long-Term Care

Medi-Cal MCPs are required to cover and coordinate Long-Term Care in all counties.

Starting in 2023, Long-Term Care services and settings coverage include Skilled Nursing Facilities. By 2024, coverage will include Intermediate Care Facilities for persons with Developmental Disabilities, and Subacute facilities, including pediatric facilities.

MCPs will coordinate comprehensive services, ensure seamless care transitions, and provide care in the most appropriate setting based on members' needs.

Ensures access to Enhanced Care Managed and Community Supports for Long-Term Care residents statewide (e.g., Nursing Facility Transition/ Diversion to Assisted Living Facility Community Supports service ensures members can reside in a community facility residence and receive support with daily living activities, medication oversight and 24-hour onsite direct care staff)

Funding & Capacity Building Programs: PATH, IPP, HHIP

Medi-Cal

Building Medi-Cal's Partner Capacity

The Transformation of Medi-Cal includes three initiatives that build the health system capacity and infrastructure to help deliver new programs statewide.

Providing Access & Transforming Health (PATH)

Five-year, $1.85 billion initiative to fund:

- Collaborative planning and implementation
- Capacity and Infrastructure Transition, Expansion, and Development (CITED)
- Technical Assistance Marketplace, including guidance related to topics such as Medi-Cal contracting and building data capacity

Incentive Payment Program (IPP)

$1.5 billion initiative that provides financial incentives to MCPs to invest in:

- ECM & Community Supports providers' health information technology and data exchange infrastructure
- ECM provider capacity building
- Community Supports provider capacity building & MCP take-up
- Promoting the performance and improvement of Medi-Cal programs

Housing and Homeless Incentive Program (HHIP)

Two-year, $1.29 billion initiative that provides financial incentives to MCPs to:

- Develop infrastructure, capacity, and partnerships to connect their members to needed housing services
- Take an active role in reducing and preventing homelessness

Providing Access & Transforming Health (PATH)

PATH is a five-year, $1.85 billion initiative to build up the capacity and infrastructure to implement the transformation of Medi-Cal.

Collaborative Planning and Implementation Initiative	
▪ Support planning to promote readiness for ECM and Community Supports ▪ Launched in January 2023	*Stakeholders may identify and address housing-related issues as part of a collaborative.*
Capacity and Infrastructure Transition, Expansion and Development (CITED) Initiative	
▪ Grants to build ECM and Community Supports provider capacity and infrastructure ▪ Applications for Round 1 & 2 have closed, funding announcements made throughout 2023	*Housing-related Community Supports providers may receive CITED funding to support capacity and infrastructure development.*
Technical Assistance (TA) Marketplace Initiative	
▪ TA for providers, community-based organizations, county agencies, public hospitals, tribal partners, and others ▪ Launched in January 2023	*Medically tailored meals providers may access TA to help them participate in Community Supports.*

Incentive Payment Program (IPP)

Launched in 2022, IPP is a voluntary program to support the expansion of ECM, Community Supports and other Medi-Cal Transformation initiatives by incentivizing MCPs to invest in priority activities:

Delivery System Infrastructure
Support core ECM and Community Supports providers' health information technology and data exchange infrastructure required for ECM and Community Supports

ECM Provider Capacity Building
Support ECM workforce, training, TA, workflow development, operational requirements, and oversight

Community Supports Provider Capacity Building & MCP Take-Up
Support Community Supports workforce, training, TA, workflow development, operational requirements, take-up and oversight

Participating MCPs are required to report on a minimum number of optional measures, such as measured outreach to members experiencing homelessness.
MCP payment is based on the successful completion of and performance against these measures.

Housing and Homeless Incentive Program (HHIP)

MCPs may earn incentives payments for helping members get housing and stay housed.

- HHIP is intended to:
  - Reward MCPs for developing the necessary infrastructure, capacity, and partnerships to connect their members to needed housing services
  - Incentivize MCPs to take an active role in reducing and preventing homelessness.
- To participate, MCPs partnered with their local homeless continuum of care and others and submitted a **Local Homelessness Plan (LHP)** in August 2022 and an **Investment Plan** in September 2022.
- From 2022 to 2024, DHCS will award nearly $1.3 billion in funds to MCPs based on the successful achievement of program measures, LHP components, and the Investment Plan.
  - Priority HHIP measures include establishing a connection between MCPs and street medicine teams.

MCP Transition

Medi-Cal

DHCS is Transforming Medi-Cal Managed Care Through Multiple Channels

Starting in 2024, New Mix of High-Quality MCPs Available to Members

New Commercial MCP Mix

- Contracts with commercial MCPs announced in Dec. 2022, operational readiness process has been underway since Jan. 2023

Model Change in Select Counties

- Conditional approval for 17 counties to change their managed care model
- Includes a new Single Plan Model and expansion of County Organized Health System (COHS) model

Direct Contract with Kaiser

- In 32 counties in which Kaiser operates
- Based on provider / plan linkage or population-specific criteria for active choice / assignment such as Dual-eligible, foster children

Restructured and More Robust Contract Implemented Across All Plans in All Model Types in All Counties

Improved Health Equity, Quality, Access, Accountability and Transparency

New Requirements of MCP Partners

More robust MCP contract includes provisions strengthening:

1. Transparency
2. High-Quality Care
3. Access to Care
4. Continuum of Care
5. CalAIM Initiatives
6. Coordinated / Integrated Care
7. Increasing Health Equity and Reducing Health Disparities
8. Culturally Appropriate Care
9. Language Services
10. Addressing Social Drivers of Health
11. Local Presence and Engagement
12. Children's Services
13. Behavioral Health Services
14. Accountability and Commitment to Compliance
15. Administrative Efficiency
16. Emergency Preparedness and Essential Services
17. Value-Based Payment

New Requirements of Managed Care Plan (MCP) Partners

REQUIREMENTS	CONTRACT PROVISIONS
Transparency	Publicly post additional information about their own and subcontractors' activities, e.g., Community Investment Plan and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results
High-Quality Care	Meet stronger quality expectations aligned with the DHCS Comprehensive Quality Strategy (CQS)
Access to Care & Continuum of Care	Provide access to high-quality, culturally-competent, and community-based care across a comprehensive array of person-centered health care and social services, e.g., wellness and prevention programs that meet National Committee for Quality Assurance (NCQA) requirements, long-term care.
CalAIM Initiatives	Implement and support initiatives to improve the quality of life and health outcomes of member populations by establishing broad delivery system, program, and payment reform across Medi-Cal.
Coordinated/Integrated Care	Provide appropriate care management services to all members based on population risk stratification. Leverage broad data sets and data exchange capabilities to systematically coordinate members' care across all health and social services.
Increasing Health Equity & Reducing Health Disparities	Partner with DHCS to advance health equity and reduce health disparities, including by implementing equity-focused interventions, meeting health disparity reduction targets, and obtaining NCQA Health Equity accreditation by 2026.

New Requirements of Managed Care Plan (MCP) Partners

REQUIREMENTS	CONTRACT PROVISIONS
Addressing Social Drivers of Health	Implement new strategies to identify and address unmet health-related social needs, such as food security and housing, through comprehensive screening and population needs assessments and new services like Community Supports.
Local Presence and Engagement	Ensure MCPs and their network providers understand and meet community needs
Enhanced Children's Services	Provide additional support for children, such as care management
Behavioral Health Services Expansion	Expand screening for behavioral health needs and access to comprehensive evidence-based behavioral health services for all members consistent with DHCS' No Wrong Door policy.
Accountability, Compliance, and Administrative Efficiency	Have robust accountability, compliance, monitoring and oversight programs to meet stronger DHCS expectations related to accountability for and oversight of delegated entities.
Emergency Preparedness and Essential Services	Have an Emergency Preparedness and Response Plan that will ensure delivery of essential care and services, including telehealth, and continuity of business operations during and after an emergency
Value-Based Payment	Apply high-priority quality and health equity outcome measures in value-based payment arrangements, among other requirements.

Impact on Medi-Cal Managed Care Members

- Members will have **easy access to information** that can guide them in choosing the best plan for their families and/or individual needs.
- Members will have access to **comprehensive person-centered health and social services**.
- Members will benefit from care and services that **take into account their culture, sexual orientation, gender and gender identity, and preferred language**.
- Members' **physical health care will be better integrated with their behavioral health care**, narrowing the divide between the two and improving access to mental health support and substance use disorder treatment.
- Members who need extra help will have **access to care management** based on their health care needs.
- Members will have better access to **expanded preventive and early intervention services for children** and services that support physical, social, and emotional development and address adverse childhood experiences.

MCP Transition

DHCS' Principles for MCP Transition
✓ Plan for and ensure a smooth and effective transition
✓ Ensure minimal service interruptions for all members, especially for vulnerable groups most at risk for harm from interruptions in care
✓ Provide outreach, education, and clear communication to members, providers, managed care plans (MCPs), and other stakeholders
✓ Proactively monitor MCPs implementation of transition responsibilities

- DHCS is currently involved in transition planning and stakeholder engagement efforts.
- In June 2023, DHCS released an MCP Transition Program Guide containing DHCS Policy and MCP requirements on continuity of care, member enrollment policies, and other topics.

Dual Eligible Members

Medi-Cal

Integrated Care for Dual Eligible Medi-Cal and Medicare Members

In January 2023, two initiatives went live to support the statewide goals of improved care coordination and person-centered care for dually eligible members, those individuals who are enrolled in both Medicare and Medi-Cal.

All dually eligible members statewide have been enrolled in Medi-Cal managed care.

Cal MediConnect plans transitioned to Medicare Medi-Cal Plans (MMPs), a Medicare Advantage plan, and enrollment for these plans opened in seven counties. Under MMPs, a single managed care organization:

- Operates a member's Medicare and Medi-Cal plans
- Coordinates all benefits and services across both Medicare and Medi-Cal
- Provides members with integrated materials and care coordination
- Ensures continuity of care during the transition

Behavioral Health

Medi-Cal

Behavioral Health Initiatives Schedule

Policy	Go-Live Date
Specialty Mental Health Services (SMHS) - Criteria for Services	January 2022
Behavioral Health No Wrong Door	July 2022
Behavioral Health Standard Screening and Transition Tools	January 2023
Recovery Incentives: California's Contingency Management Program	March 2023
Behavioral Health Payment Reform	July 2023
Behavioral Health Current Procedural Technology (CPT) Code Transition	July 2023
Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration	2023 (Earliest to CMS) 2024 (Starts)
Administrative Integration of SMHS and Substance Use Disorder (SUD)	January 2022 2023 (Phase I) 2025 (Phase II) January 2027 (Fully Integrated)
Drug Medi-Cal Organized Delivery System (DMC-ODS) Traditional Healers and Natural Helpers	TBD

Behavioral Health Transformation: Administrative Integration

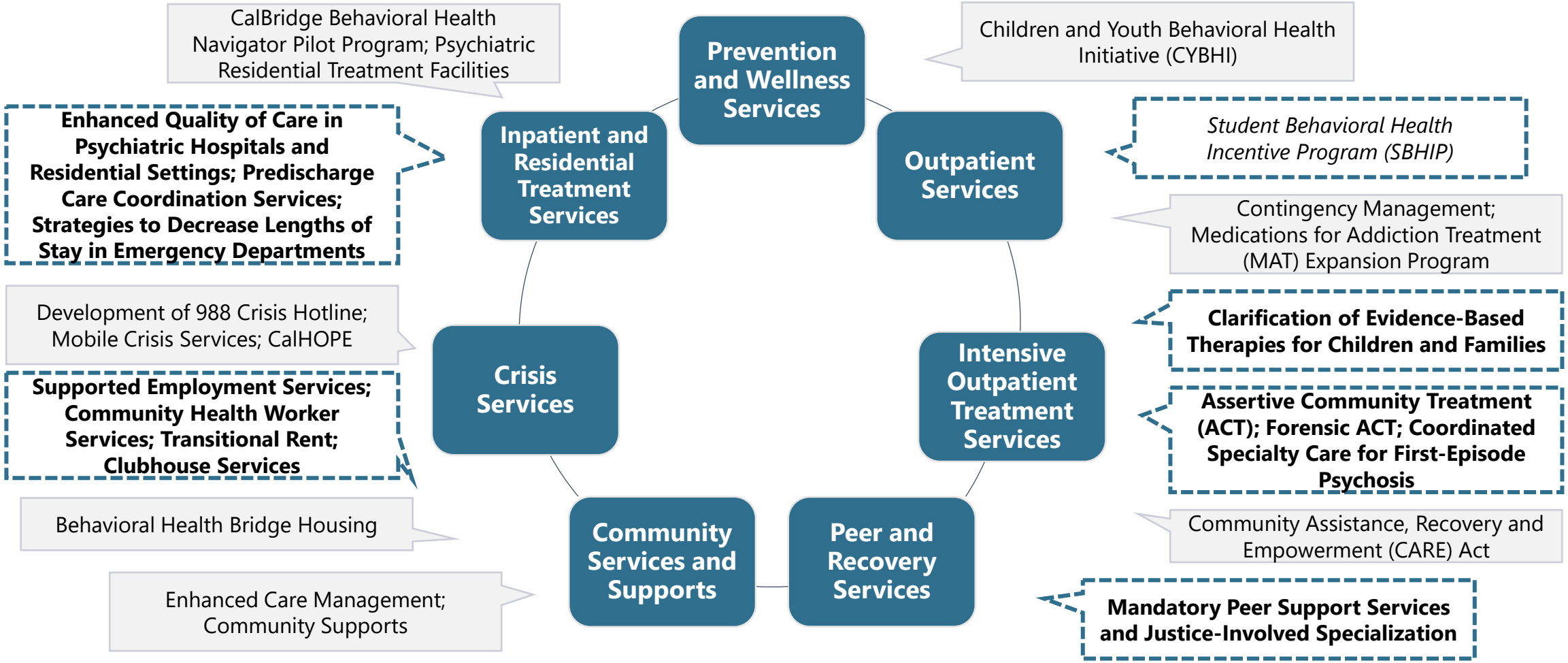
Medi-Cal Transformation will streamline policies to improve access to behavioral health services, simplify how these services are funded, and support administrative integration of mental illness and substance use disorders treatment.

Mental Health and Substance Use Disorder (SUD) Delivery System Functions for Integration:

Clinical	Administrative	Oversight
24-7 Access Line	State-County Contracts	Quality Improvement
Intake/Screening/Referral	Data Sharing/Privacy	EQRO
Assessment	EHR Integration & Redesign	Compliance Reviews
Treatment Planning	Cultural Competence Plans	Network Adequacy
Beneficiary Informing Materials		Licensing & Certification

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration

The demonstration is designed to complement and amplify the state's existing initiatives to build out the continuum of care for members living with Serious Mental Illness (SMI)/ Serious Emotional Disturbance (SED).



Recovery Incentives: California's Contingency Management (CM) Program

DHCS is piloting Medi-Cal coverage of CM services in Drug Medi-Cal Organized Delivery System (DMC-ODS) counties that elect and are selected to participate through March 2024. Eligible Medi-Cal members will:

Participate in a structured **24-week CM Program -**12 weeks with twice weekly testing/incentives and a 12-week continuation with once weekly testing/incentives

Receive incentives for testing **negative for stimulants only,** even if they test positive for other drugs

Earn a **maximum of $599** over the 24-week period in the form of gift cards

Generate incentives and track progress using **Incentive Manager** software

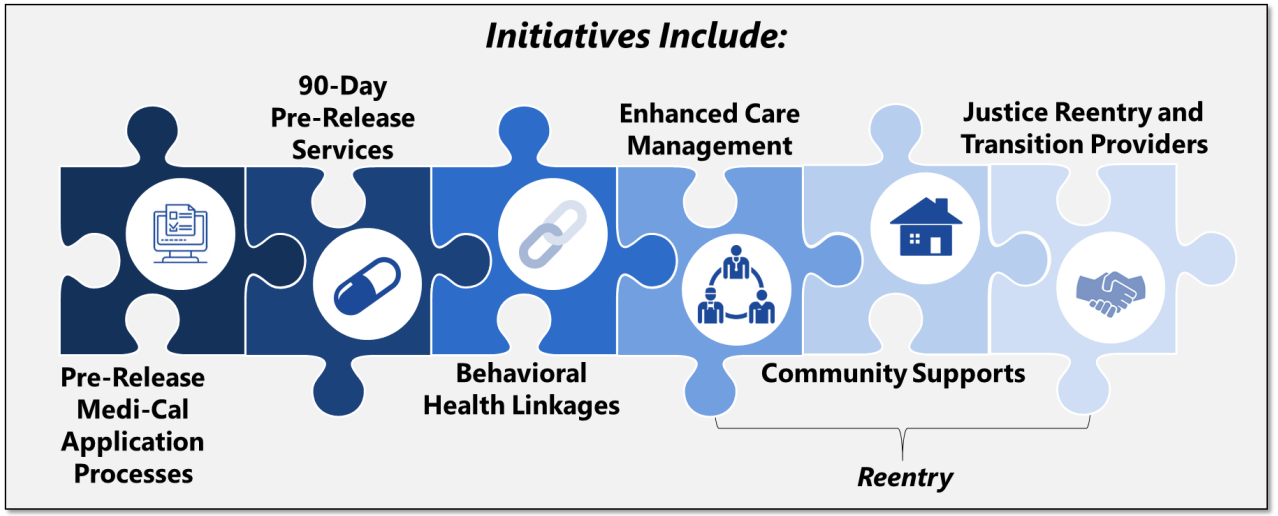
Justice-Involved

Medi-Cal

Services and Supports for Justice-Involved Adults and Youths

Medi-Cal Transformation addresses poor health outcomes among justice-involved adults and youths through Medi-Cal enrollment, targeted services to incarcerated individuals, and continuity of care during re-entry.

- Incarcerated individuals will be screened for Medi-Cal eligibility and enrolled if eligible
- Individuals will receive targeted services and links to mental health and substance use disorder services in the 90 days prior to release
- Funding will be available for services that support re-entry, such as care management, full scope medication services, and medication assisted treatment



Addressing the Needs of the Justice-Involved Population Is Key to Advancing Health Equity

Addressing the unique and considerable health care needs of justice-involved populations — who are disproportionately people of color — will help to improve health outcomes, deliver care more efficiently, and advance health equity.

In California, and across the US, justice-involved populations are disproportionately people of color.

<u>In California:</u>

- **28.5% of incarcerated males are Black,** while Black men make up only 5.6% of the state's total population
- **Incarceration rate by race and ethnicity:**
  - **Black men:** 4,236 per 100,000
  - **Latino men:** 1,016 per 100,000
  - **Men of all other races/ethnicities:** 314 per 100,000

Questions?

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

@MediCal_DHCS

@MediCalDHCS

Facilitated Q&A Session (1)

What is the DHCS vision for how MCPs can best support successful implementation of Care Coordination, Navigation, and Referrals across all health and social services providers, including Community Supports providers?

Facilitated Q&A Session (2)

How is DHCS aiming to support systems interoperability for CBO's, tribal entities, and organizations that serve historically underserved populations with traditional healthcare providers without them having to compromise culturally appropriate services or unreasonable cost burden?

Facilitated Q&A Session (3)

How is DHCS encouraging contracts with community and social service organizations for some of the other Basic Population Health Management services (e.g. wellness and prevention, Addressing Chronic Disease, Maternal Health outcomes, etc.)?

Facilitated Q&A Session (4)

How are local provider organizations in each region participating in the Population Needs Assessment and what are the plans to ensure that there is not duplicative burden on organizations, or the people served with other required needs assessments?

Participant Questions

Partnership HealthPlan of California

Update on Process Improvements

Ashley Peel and Bianca Veneracion

PHC Updates

November 2023

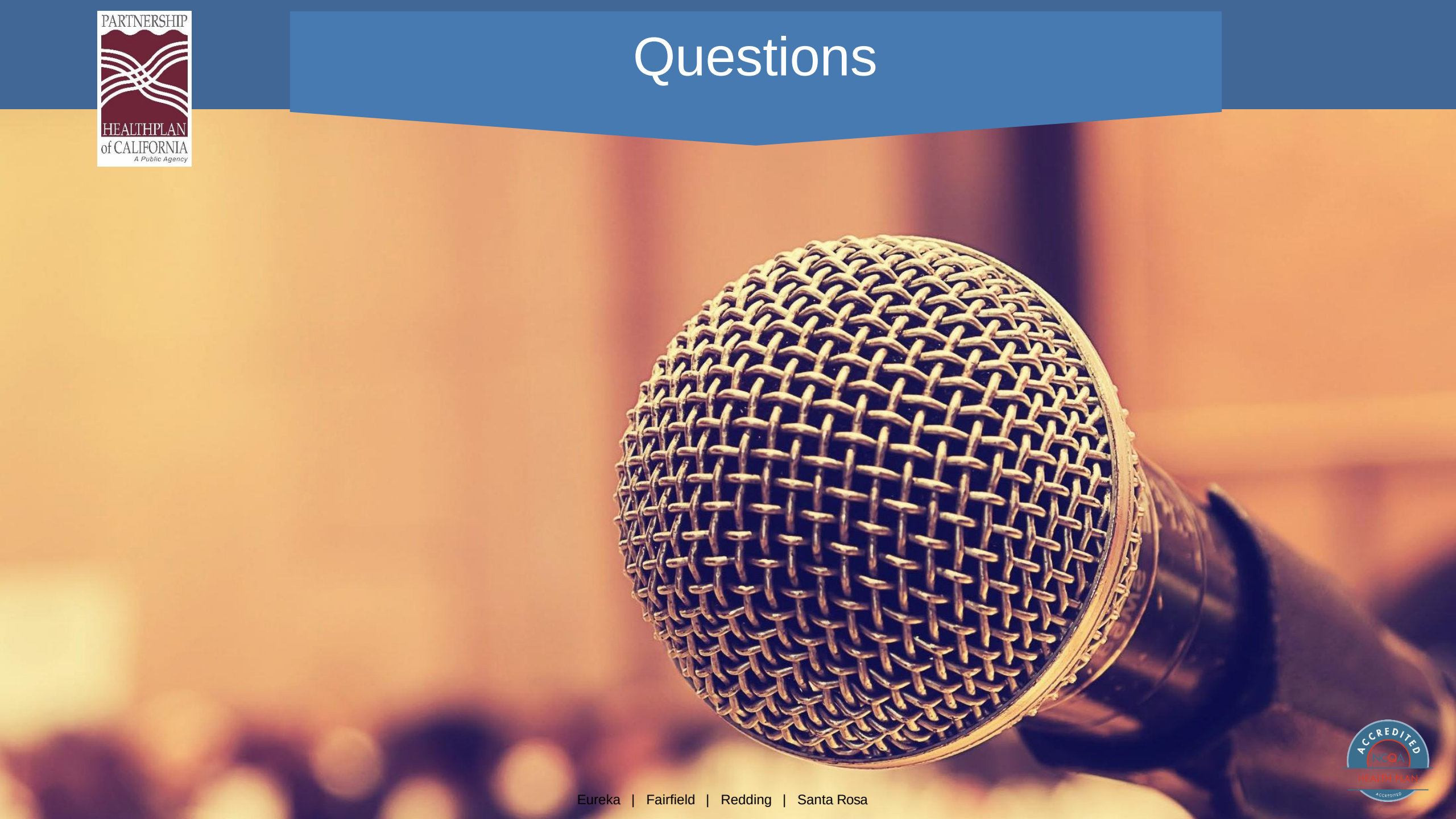
Updates

- **ATTENTION!! CalAIM ECM & CS Referral Source Webinar on 11/30 has been postponed. New date and flyer to follow**
- **Transportation Benefit Overview – December or January**
- **Excel Basics for ECM Providers – registration will be sent soon**
- **December Population of Focus Spotlight on Birth Equity and Justice**

Resources

- **PHC ECM Webpage**
- **PHC Community Supports Webpage**
- **Care Coordination Department: 800-809-1350**
- **Transportation Services Department: 866-828-2303**
- **Provider Relations Department: 707-863-4100**
- **Claims Customer Service:855-798-8757**

Questions



Post-Event Evaluation

To continue improving our work as your CPI Facilitator, PHIL kindly asks that you complete this brief survey. Your feedback ensures quality improvement and will inform planning and activities through the evolution of the collaborative.

https://bit.ly/3Rj1yGf

Upcoming Events

Our next CPI regional meeting is virtual

- NW: Wednesday, December 20 | 1:00 – 2:30 pm PT
- SW: Thursday, December 21 | 1:00 – 2:30 pm PT

ECM roundtable with PHC

- If you were unable to attend the last **ECM RoundTable** and would like the **Chat Q&A**: Please let Vicki, Lynn, or the PHIL team know and one of us will get those out to you. (See slide Appendix for more details)
- Register for the monthly ECM roundtable.

Office Hours

- Thursday, December 7 | 12:00 – 1:00 pm PT
- Monday, December 11 | 2:00 – 3:00 pm PT

Pop-up Event

Info Session with Kaiser Permanente

Tuesday, December 5, 2023

10:00 – 11:00 am

For counties that will be transitioning to Kaiser Permanente in January, learn about what to expect and have the opportunity to be and dialogue and ask questions with a local Kaiser representative.

This event will be recorded. If you are unable to attend, please submit any questions to our PATH CPI team to path@pophealthinnovationlab.org.

Pop-up Event

DHCS to Host Statewide PATH CPI Best Practices Webinar on Relationship Building with Organizations in the CalAIM Environment

Thursday, December 7, 2023

12:30 – 1:30 pm

The webinar is part of a biannual series of PATH CPI webinars designed to highlight best practices for implementing Enhanced Care Management (ECM) and Community Supports, increasing providers' successful participation in CalAIM.

All webinar recordings and best practices resources will be made available at ca-path.com/collaborative.

Thank You!

Feel free to contact our PATH CPI team

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Thank you!

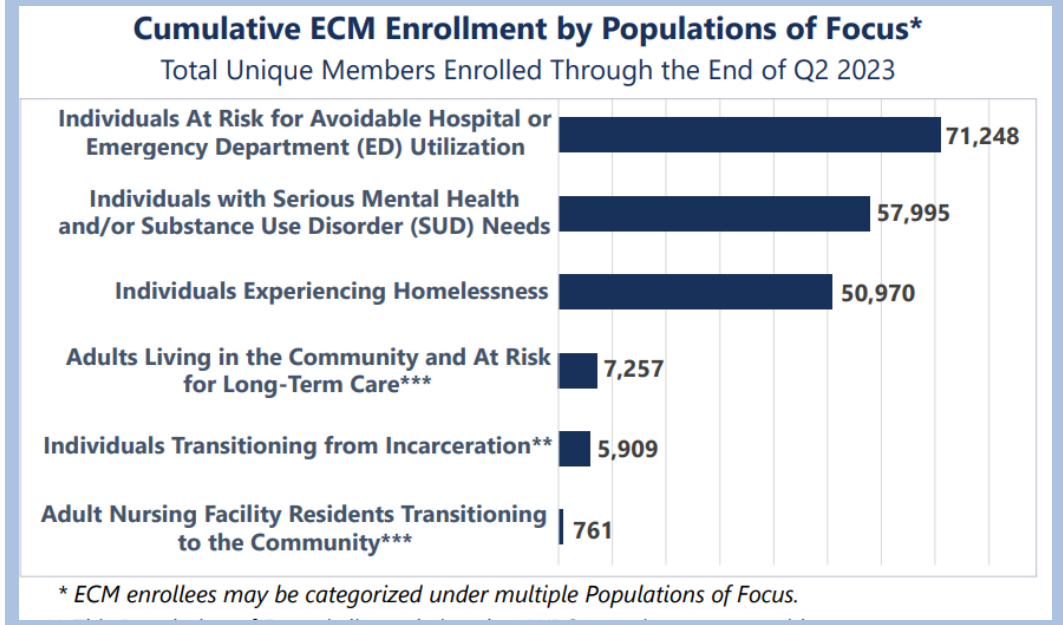

Appendix

Policy Landscape Updates

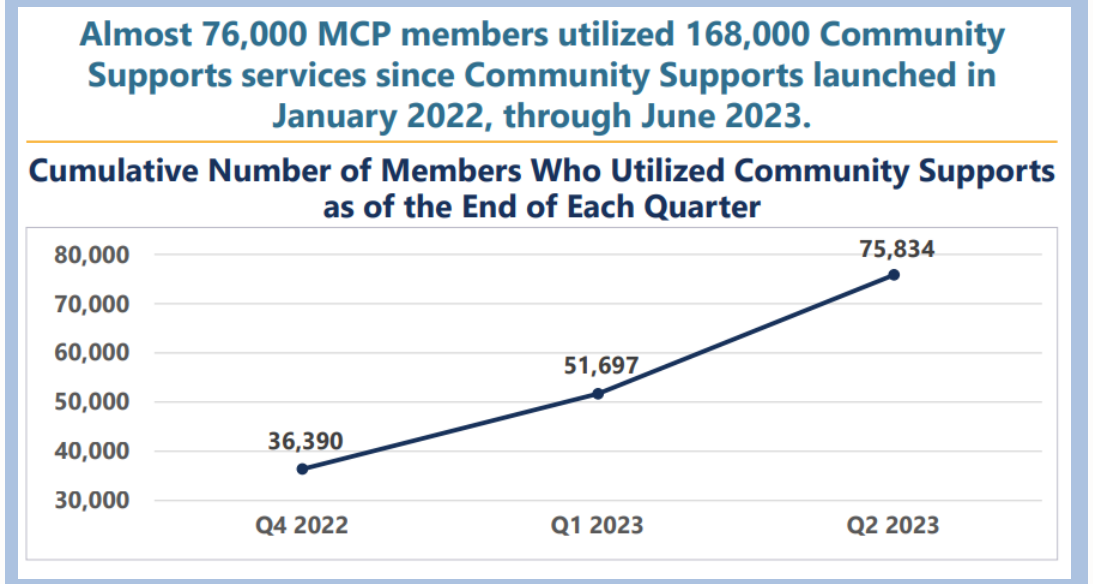
DHCS and CalAIM Strategy

Data Updates: ECM and Community Supports

ECM Enrollment Since Launch



Community Supports Utilization Since Launch



Full DHCS Q2 Data Implementation Update: November 2023 Available Now

Upcoming Webinars by DHCS

- **Relationship Building with Organizations in the CalAIM Environment**
  PATH CPI Best Practices Webinar: Dec. 7, 2023 | 12:30 – 1:30 p.m. PT.
  Advance registration required
- **The CalAIM Behavioral Health Workgroup meeting on 12/1 is open to the public.**
  This meeting will provide updates on and discussion of the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) and CalAIM behavioral health documentation redesign initiatives. email questions to BHCalAIM@dhcs.ca.gov.
- **A Webinar on the adult expansion of Medi-Cal** (advance registration required) for community-based organizations, MCPs, providers, and other interested stakeholders, including those representing consumers, immigration, health care, legal aid, and immigrant adults. Is being held on December 4, from 11 a.m. to 12 p.m. The webinar, which will be live interpreted in Spanish, will provide background information about the expansion, implementation planning, noticing, outreach, and more. Individuals may also submit questions or request to register for the webinar by sending an email to AdultExpansion@dhcs.ca.gov.

Community Health Worker Certification

- On Nov. 13th,CalHHS and the Dept. of Healthcare Access and Information (HCAI), announced a pause in CHW Certificate finalization process to get additional feedback from stakeholders on CHW training standards towards the certification process.

- CalHHS identified 3 state goals of the CHW Initiative:
    1. CW/P/Rs are an essential workforce and their voices matter.
    2. Build out the CHW Workforce infrastructure across California
    3. Increase the uptake of CHW services supported by the CHW Medi-Cal benefit.

- Note: CHW benefits are still active while the state makes a final determination.

2024 Medi-Cal MCP Transition Policy Guide

- DHCS released frequently asked questions (FAQs) as a companion resource to the most recent version of the 2024 Medi-Cal MCP Transition Policy Guide .

- The latest version includes a summary of communications resources, a transition policy for assessment and screening tools, and updates to the data sharing section and Appendix.

- Please email questions about the policy guide to MCPTransitionPolicyGuide@dhcs.ca.gov. The policy guide and FAQs will be updated throughout the remainder of this calendar year to keep MCPs informed of new and developing guidance.

Children and Youth ECM Spotlight

Now Available: Enhanced Care Management for Children and Youth Populations of Focus Spotlight

- DHCS recently published the Enhanced Care Management (ECM) for Children and Youth Populations of Focus (POFs) Spotlight, which is designed to help contracted and prospective ECM providers serving children and youth develop and enhance their ECM models.

- It is also intended to support provider organizations that are considering if ECM for children and youth is right for them.

ECM Is Available for Children and Youth in the Following Populations of Focus (POFs):	
	Children and Youth Experiencing Homelessness
	Children and Youth at Risk for Avoidable Hospital or Emergency Department (ED) Utilization
	Children and Youth With Serious Mental Health and/or Substance Use Disorder (SUD) Needs
	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) With Additional Needs Beyond the CCS Condition
	Children and Youth Involved in Child Welfare
Note: In January 2024, ECM will also launch for Individuals Transitioning from Incarceration and Birth Equity POFs, which are inclusive of children and youth.	

Partnership ECM Roundtable Highlights

1. 2023 ECM QIP Program Specifications available at ECM QIP webpage here

2. ECM QIP Helpdesk:
   - Deanna Watson, Program Manager, ECMQIP@partnershiphp.org

3. Updated answers on authorizations, referrals and re-authorization.

4. Excel Class training from ECM, information coming soon.

5. Email Vicky, Lynn or PHIL for a full copy of the ECM roundtable Q&A document.

Resources

- Many thanks to the CPI Facilitators and Participants in other counties for sharing their shared ideas journey maps. Special shout out to Health Begins and the Stanislaus / San Joaquin Region for the base maps used today.

- Please check out this amazing guide put together by the HealthBegins team: A CONTRACTING BEST PRACTICES GUIDE FOR BECOMING A MEDICAID COMMUNITY SUPPORTS PROVIDER

Resources for Networking Community Organizations

1. Model Contracts for Community Based Integrated Care Networks
2. Connecting Those at Risk to Care: The Quick Start Guide to Developing Community Care Coordination Pathways
3. Improving Health And Well-Being Through Community Care Hubs
4. Working with Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies

Data Exchange Framework Resources

1. Information is Power – Slides
2. DSA Signatory Grants Guidance Document
3. Data Exchange Framework (DxF) Glossary of Defined Terms

Data Exchange Framework

- View the CalHHS Data Exchange Framework, Data Sharing Agreement, and initial set of Policies and Procedures released to aid collaboration.
  - View the Executive Summary.
  - Frequently Asked Questions (FAQ)
- What is the Data Exchange Framework?

  The data exchange framework is an agreement across health and human services systems and providers to share information safely. That means every health care provider can access the information they need to treat you quickly and safely; health care, behavioral health and social services agencies can connect to each other to deliver what Californians need to be healthy; and our public health system can better assess how to address the needs of all communities.
- Why is it needed?

  Every Californian, no matter where we live, should be able to walk into a doctor's office, a county social service agency, or an emergency room and be assured health and human services providers can access the information they need to provide safe, effective, whole person care—while keeping our data private and secure.

Accountable Communities for Health

ACHs are Multisector Collaboratives

Multisector collaboratives (MSCs) are formed when multiple organizations in various sectors, such as hospitals, schools, local government, and community-based organizations develop partnerships that "take a systems approach to their work and are driven by a common goal and accountability to the communities they serve."

Source: *Powering Change Curriculum*, Population Health Innovation Lab

ACH Essential Elements

ACHs are health-focused multisector collaboratives (MSCs) that create shared responsibility and accountability for the health of a community

Figure 1: Essential Elements of ACHs

Source: Funders Forum on Accountable Health.

Aligning Systems for Health with ACHs

Research exploring how collaboration & alignment among public health, health care, & social service sectors—in partnership with community residents & tribal nations—leads to outcomes in 22 Accountable Communities of/for Health (ACHs) in Washington & California.

CPI Foundational Slides

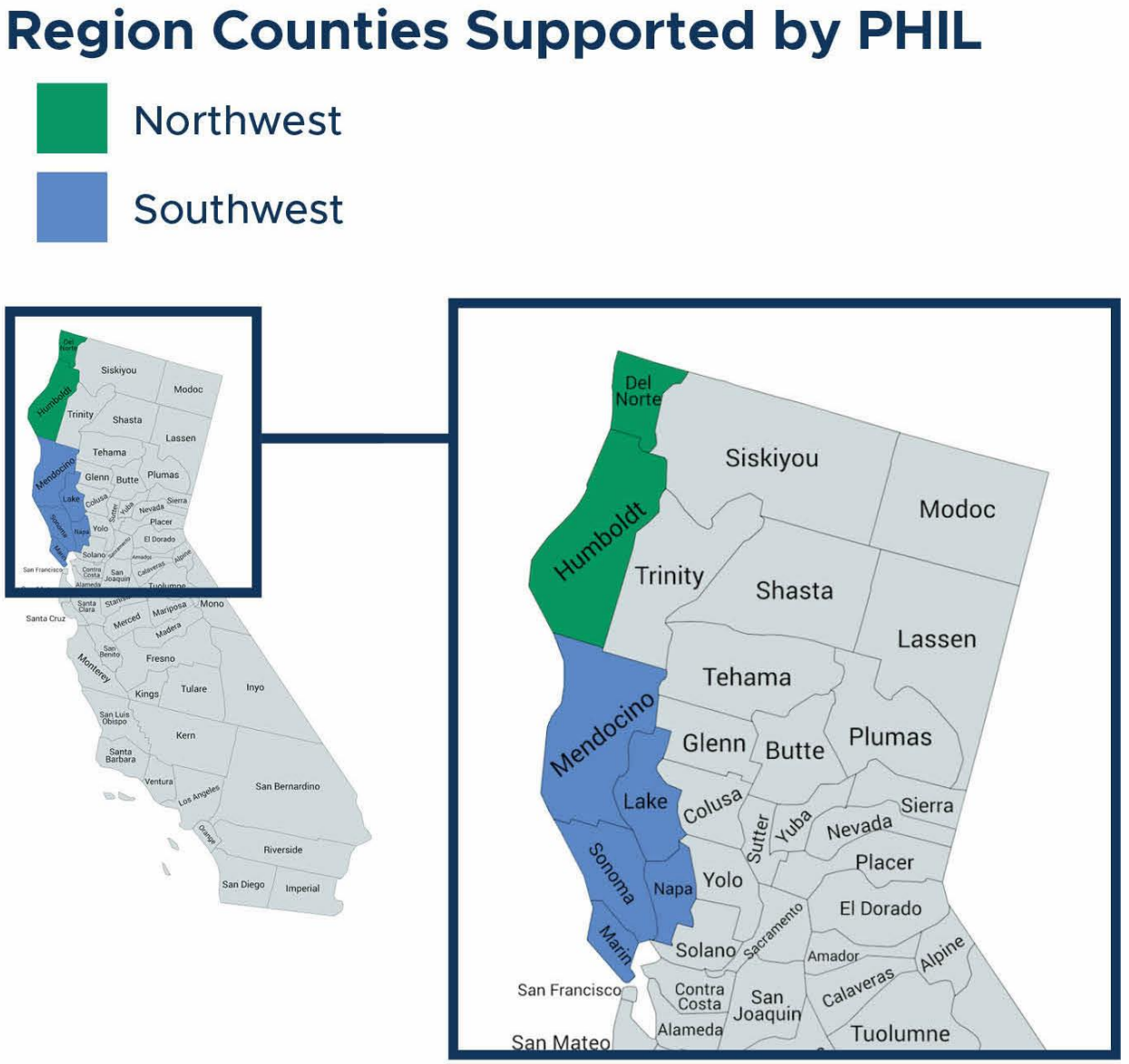
CPI Regions

Northwest Region

- Del Norte County
- Humboldt County

Southwest Region

- Mendocino County
- Sonoma County
- Marin County
- Lake County
- Napa County

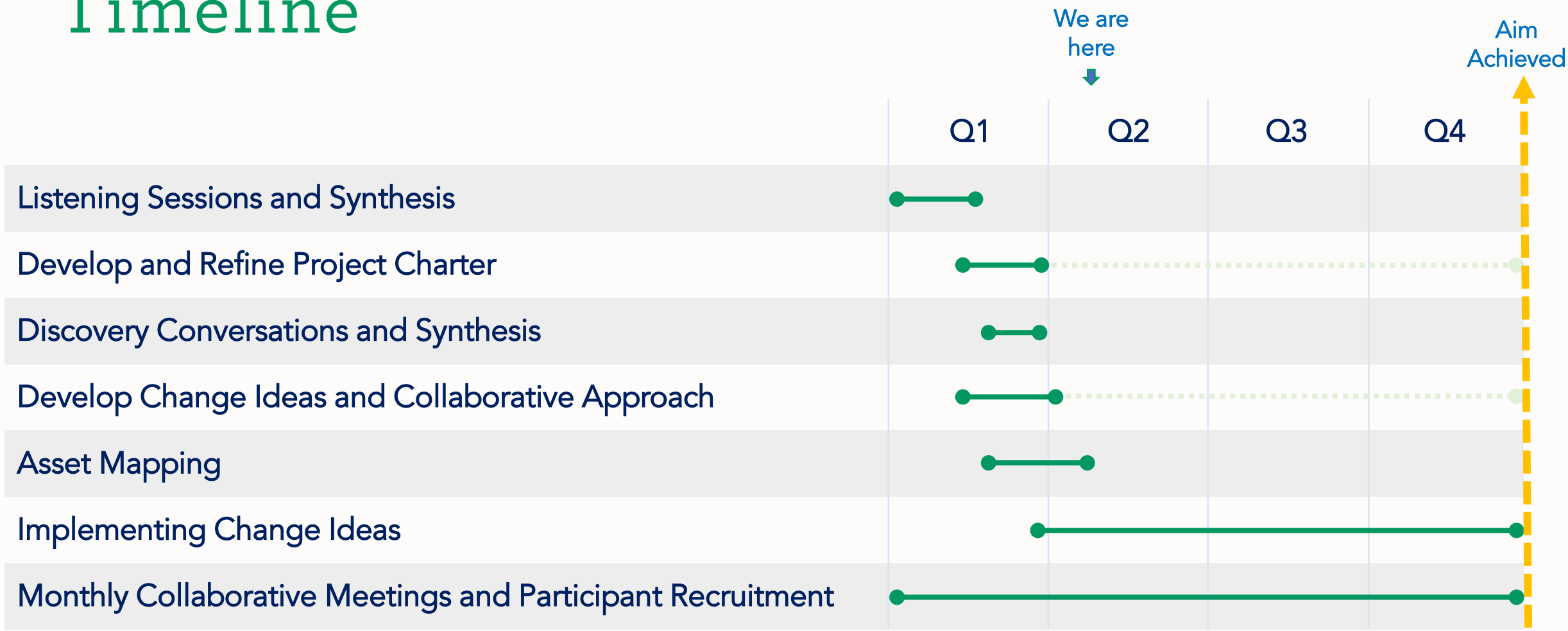


Goal / Aim Statement

The PATH Collaborative Planning and Implementation (CPI) initiative will support the advancement of CPI participants at least one step along the Readiness Roadmap towards successfully implementing Enhanced Care Management (ECM) and Community Supports services within the Medi-Cal delivery system through collaborative solutions that expand CPI participants' capacity and infrastructure needed to move towards an equitable, coordinated, and accessible Medi-Cal system by Dec 31, 2023.

(updated 4/15/23)

Timeline


We are here
Aim Achieved
Q1
Q2
Q3
Q4
Listening Sessions and Synthesis
Develop and Refine Project Charter
Discovery Conversations and Synthesis
Develop Change Ideas and Collaborative Approach
Asset Mapping
Implementing Change Ideas
Monthly Collaborative Meetings and Participant Recruitment

Support Strategies to Achieve Our Aim

We propose a multi-pronged approach:

Capacity Building

Technical Assistance offered to CPI organizations

Training opportunities to address challenges

Collaborative Systems Improvement

Foster cross-county systems solutions across all regional stakeholders, including the Managed Care Plan

Relationship and Network Building

Networking opportunities (including monthly CPI meetings) will address siloes and support the establishment of regional collaboration.