PATH – Collaborative Planning & Implementation (CPI)

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

April 17, 2024

POPULATION HEALTH
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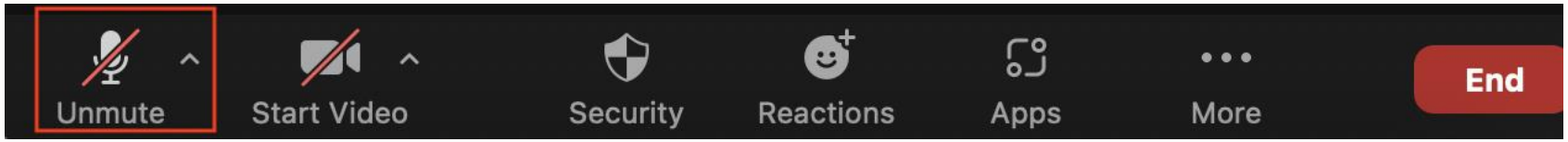
This event is being recorded.

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

Please mute your microphone and video during the presentation.



PATH – Collaborative Planning & Implementation (CPI)

Southwest Collaborative Planning Meeting

April 17, 2024

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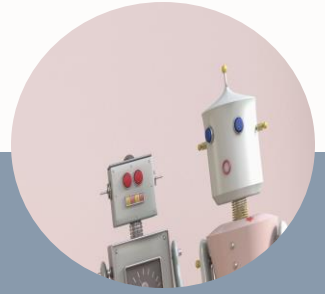
Thank you to our sponsors

Welcome & Housekeeping

Roll Call

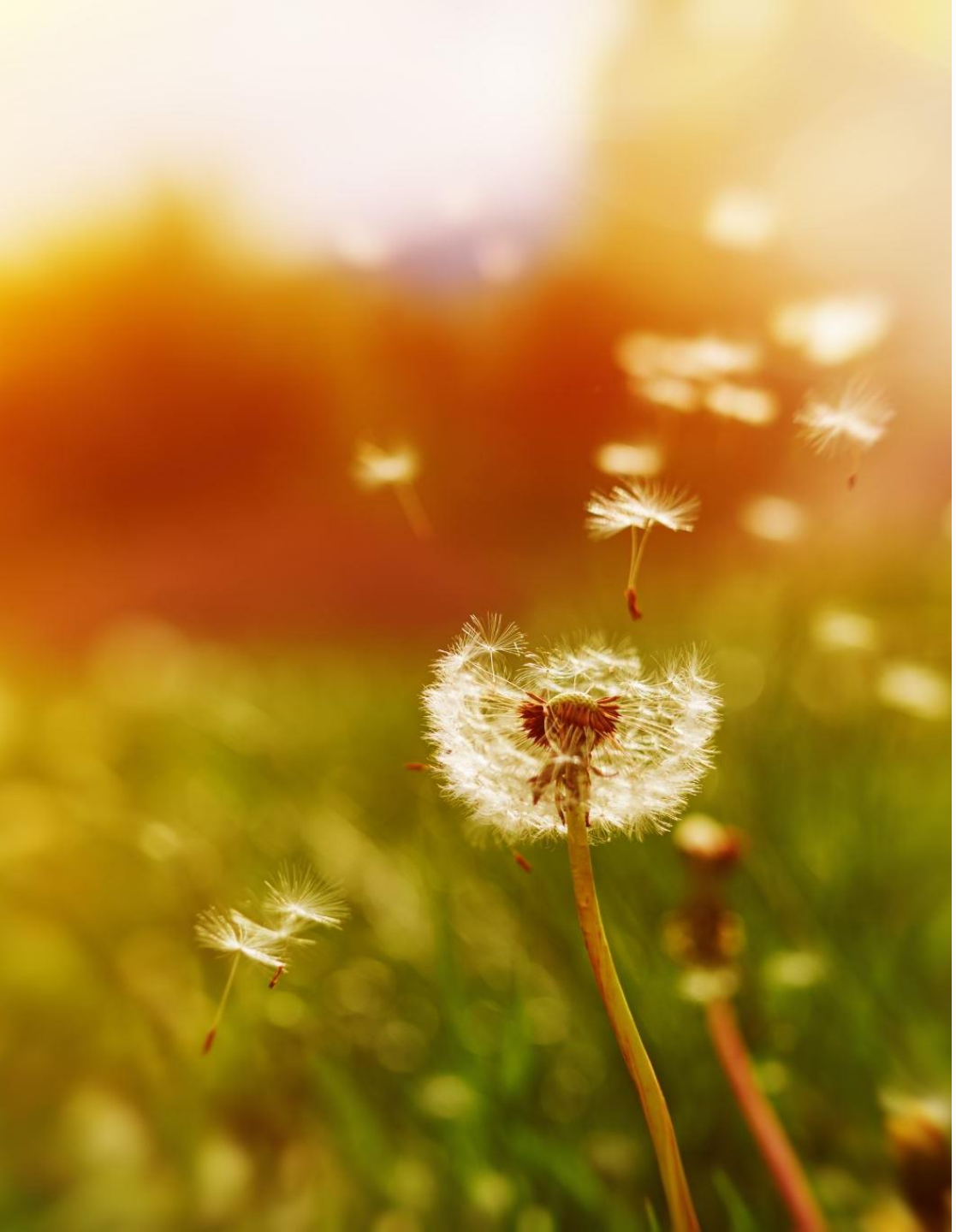
Please rename yourself as
Name, Organization
and share in the chat.



Participation Eligibility

Vendors and salespeople should recuse themselves from soliciting during this collaborative convening.

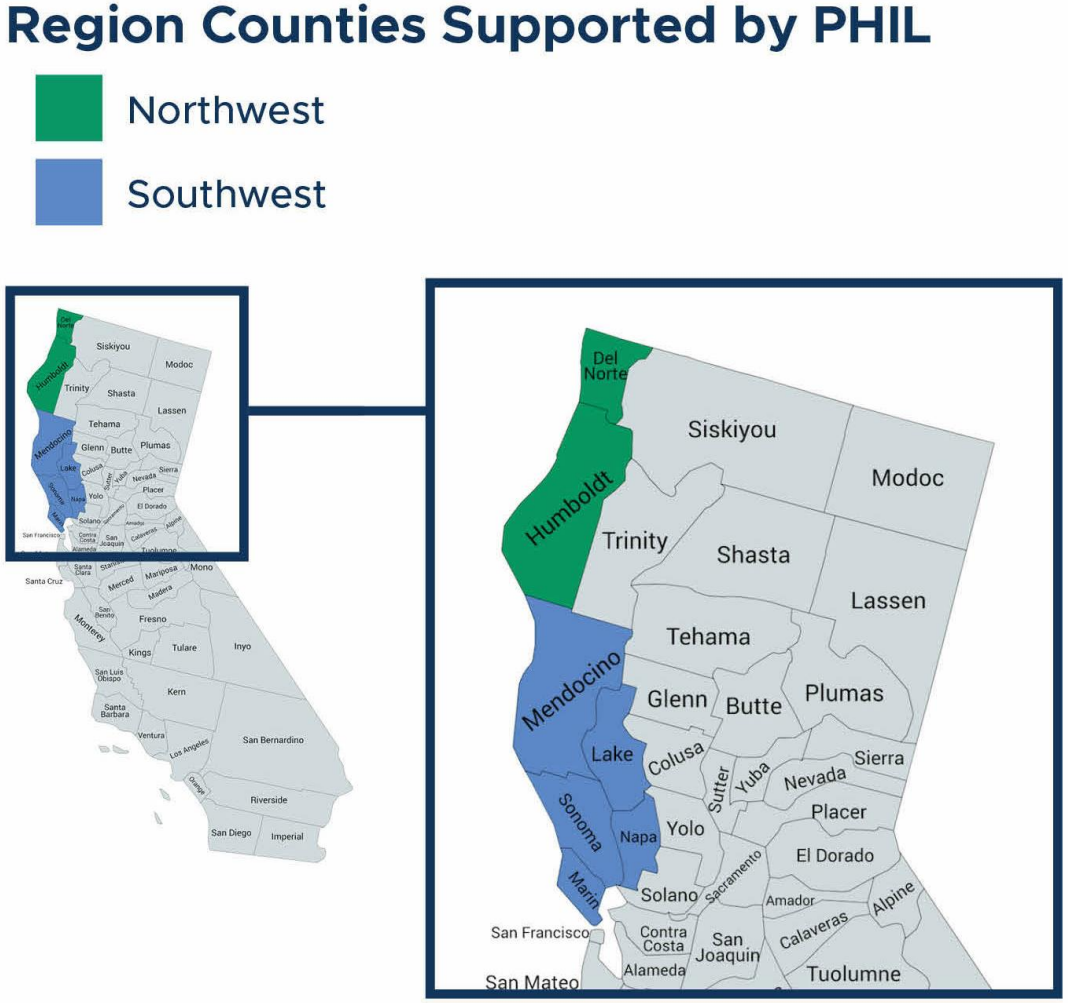
AI meeting tools restricted.



Check-In

Happy Spring! What are you looking forward to doing with your extra daylight hours?

Collaborative Planning & Implementation Overview



CPI collaboratives will work together to identify, discuss, and resolve CalAIM implementation issues.

- Learn more about the PATH CPI initiative here.
- Catch up with us! Find meeting minutes, Readiness Roadmap Resources, and registration links on the PHIL website.

Agenda for Today

- Welcome, Framing, & Check-In
- Data Informed Goals for 2024
- Update from Managed Care Plans
- Local Organization Spotlight
- CalAIM Revenue and Program Enhancement Strategies
  - Spotlight: Partnership HealthPlan of California's ECM Quality Improvement Program (QIP)
- PATH CPI Updates and Upcoming Events
- Evaluation and Close

Objectives

1. Facilitate an open forum to enhance transparency surrounding challenges, successes, and innovations in CalAIM Enhanced Care Management (ECM) and Community Supports services.
2. Review local CalAIM utilization data to understand trends and inform current and future work.
3. Identify and uplift revenue enhancing opportunities to complement CalAIM payments.
4. Encourage shared learning and provide a platform for open dialogue with CalAIM providers, local Managed Care Plans, and other local stakeholders to strengthen a culture of collaboration.

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/

CalAIM's Data Dashboard: A Closer Look at Utilization Data

Terminology

- Population: Eligible Medi-Cal Managed Care Plan (MCP) members
- Enhanced Care Management (ECM) Penetration rate: Percentage of overall MCP members who received ECM in that county.
  - While DHCS expects that 3-5% of Medi-Cal membership will be eligible for ECM, [ECM penetration rates] will vary…*There are no explicit targets for ECM penetration rates at this time, just baseline trends that will evolve as more data is collected.*
  - PHIL is modeling 5% as an ECM goal based on historical data and research.
- Capacity: Number of members that could potentially be given services, based on provider estimates

Network - Enhanced Care Management

ECM Network | CS Network

Applied Filters

Reset

County = Napa, Marin, Lake, Mendocino, Sonoma, Humboldt, Del Norte ¦ Plan Parent = Partnership ¦ Time Frame: 2023 Q4

Plan Parent

Multiple selections

County Size

All

Total ECM Providers

89

ECM Providers Delivering Community Supports

34

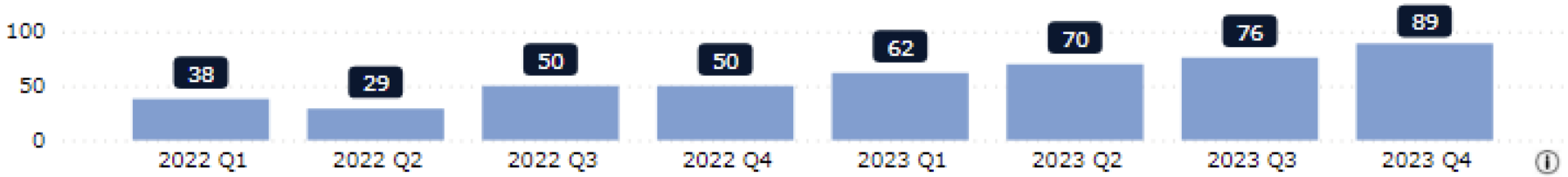
Total Provider Capacity

21K

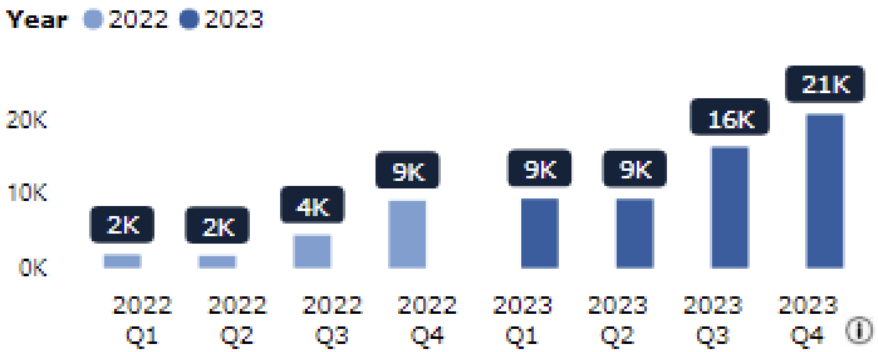
Total Capacity Filled

6,874

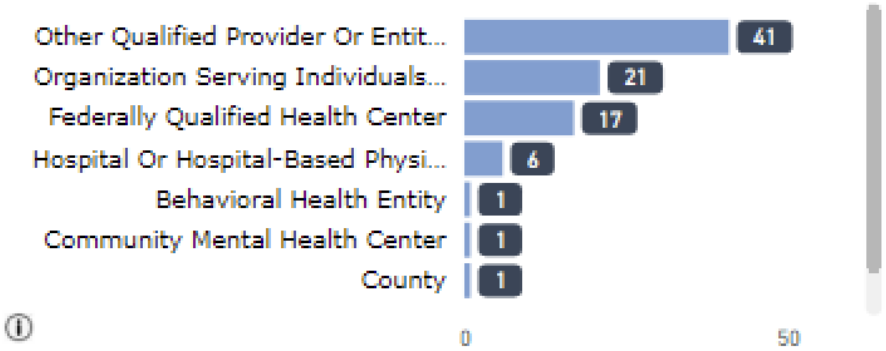
Total ECM Providers



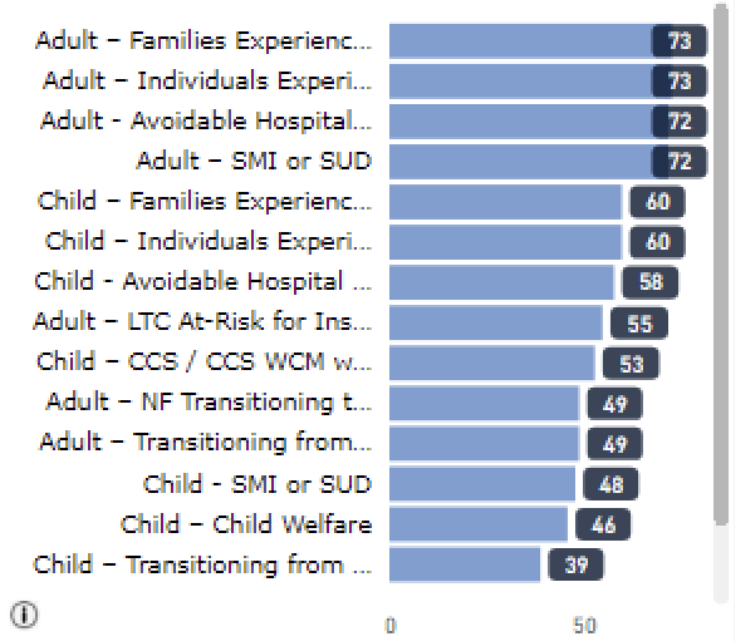
Capacity Over Time



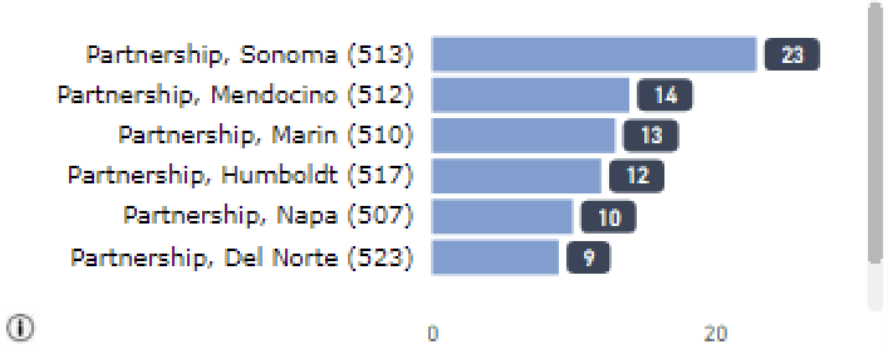
by Provider Type



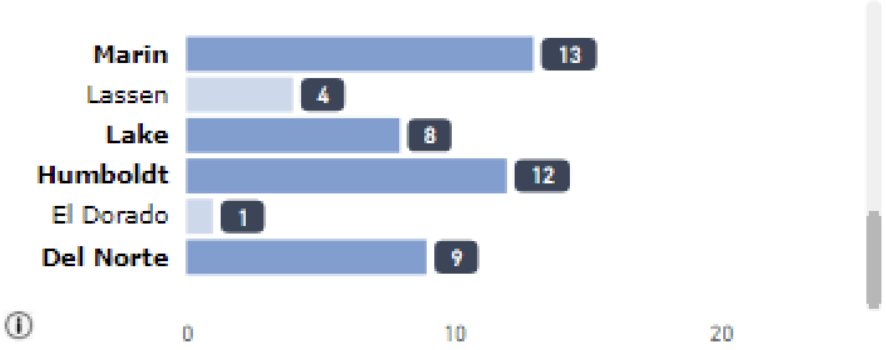
by Population of Focus Served



by Plan



by County



Network - Community Supports

ECM Network | CS Network

Applied Filters Reset

County = Marin, Sonoma, Lake, Mendocino, Humboldt, Napa, Del Norte ¦ Plan Parent = Partnership ¦ Time Frame: 2023 Q4

Plan Parent

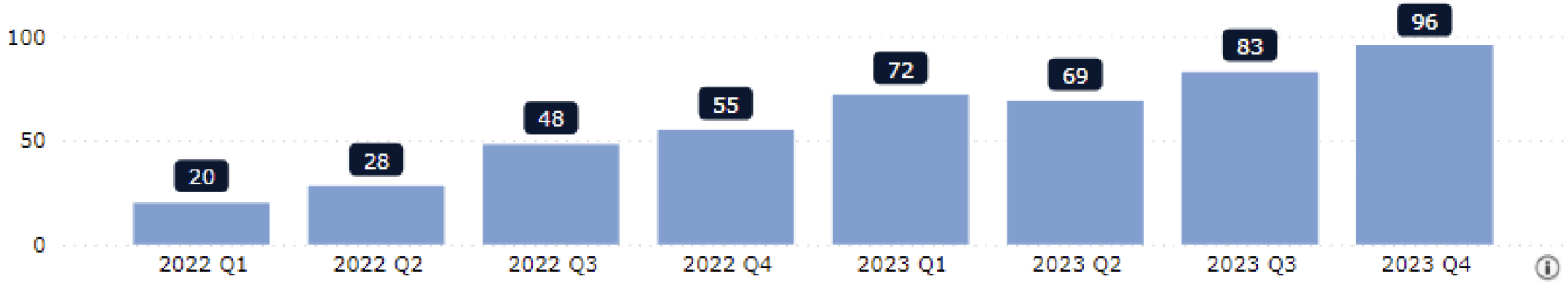
Multiple selections

County Size

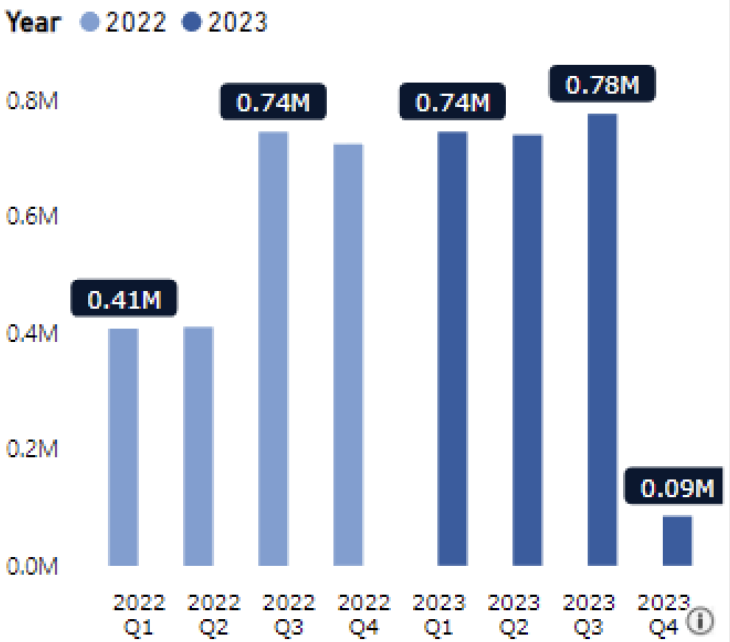
All

Total CS Providers	CS Providers Delivering ECM	Providers Delivering 2+ Community Supports	Total Provider Capacity
96	34	76	85K

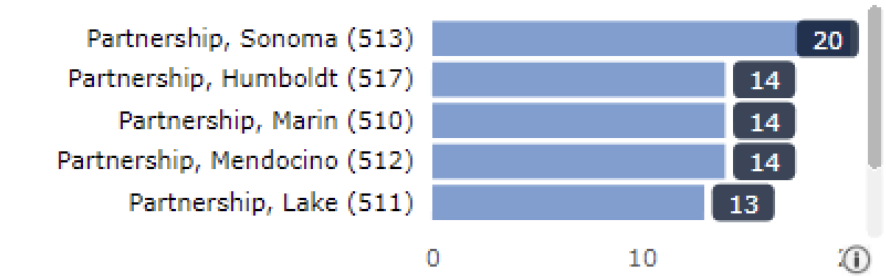
Total Community Supports Providers



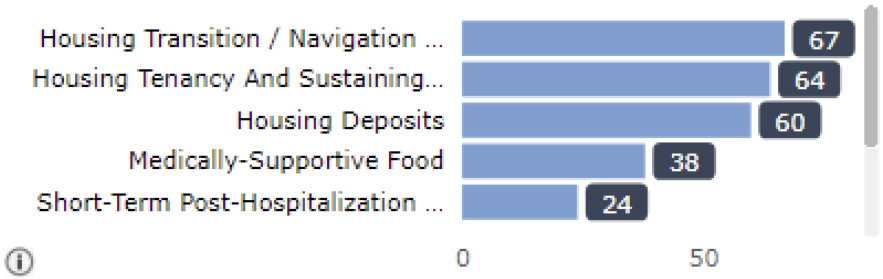
Capacity Over Time



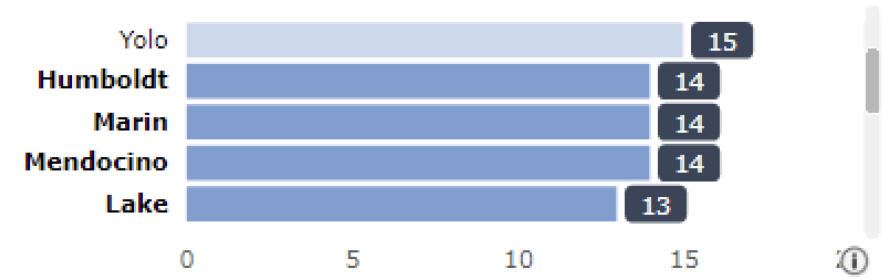
by Plan



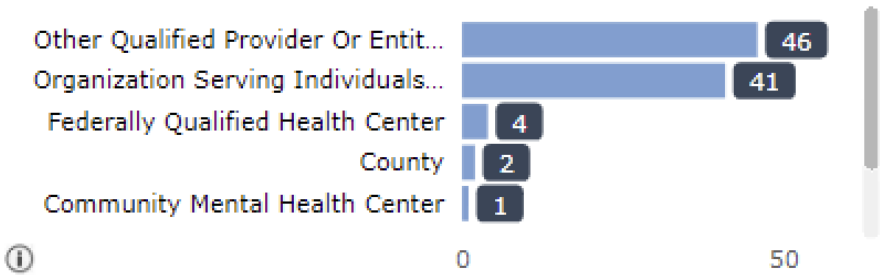
by Community Support Type



by County



by Provider Type



ECM Enrollment

Enrollment | Disenrollment

Applied Filters

Reset

County = Sonoma, Napa, Lake, Mendocino, Marin, Humboldt, Del Norte | Plan Parent = Partnership | Time Frame: 2023 Q4

Plan Parent: Partnership

Dual Status: All

Age Group: All

Aid Code Group: All

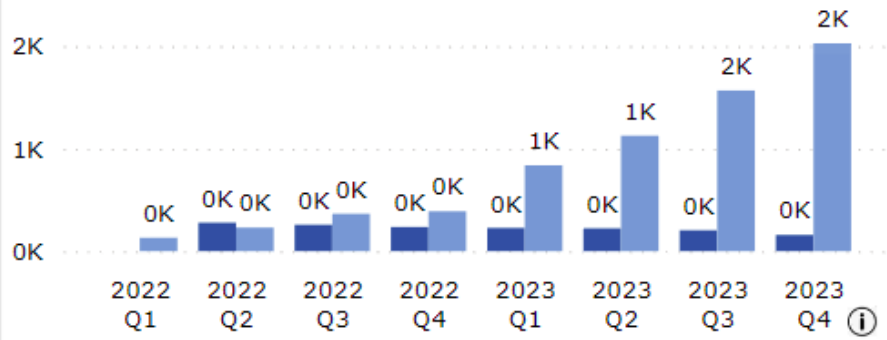
Primary Language: All

County Size: All

Total Enrolled

Program of Origin: WPC, New

Quarter: 2023 Q4



Received ECM (in Quarter)

2.186

Cumulative Received ECM

3.688

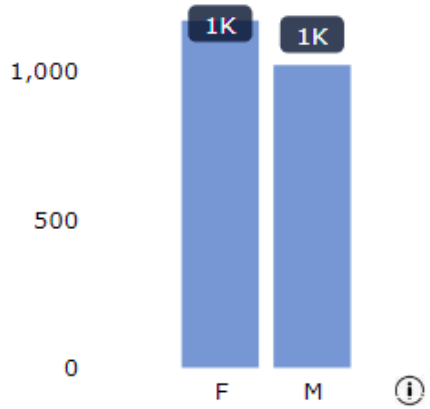
Enrolled (End of Quarter)

2.457

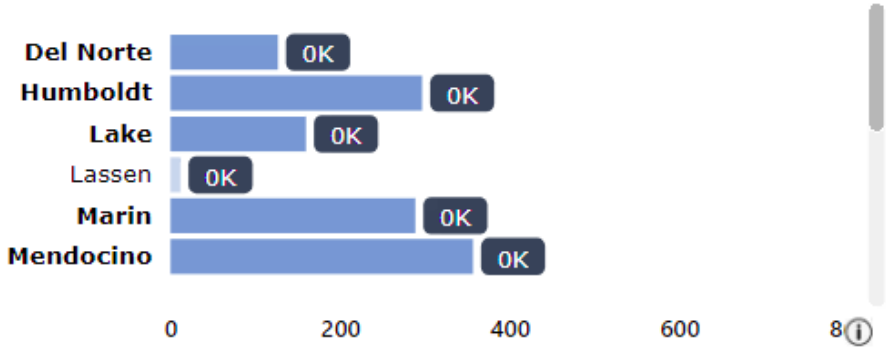
Disenrolled (in Quarter)

271

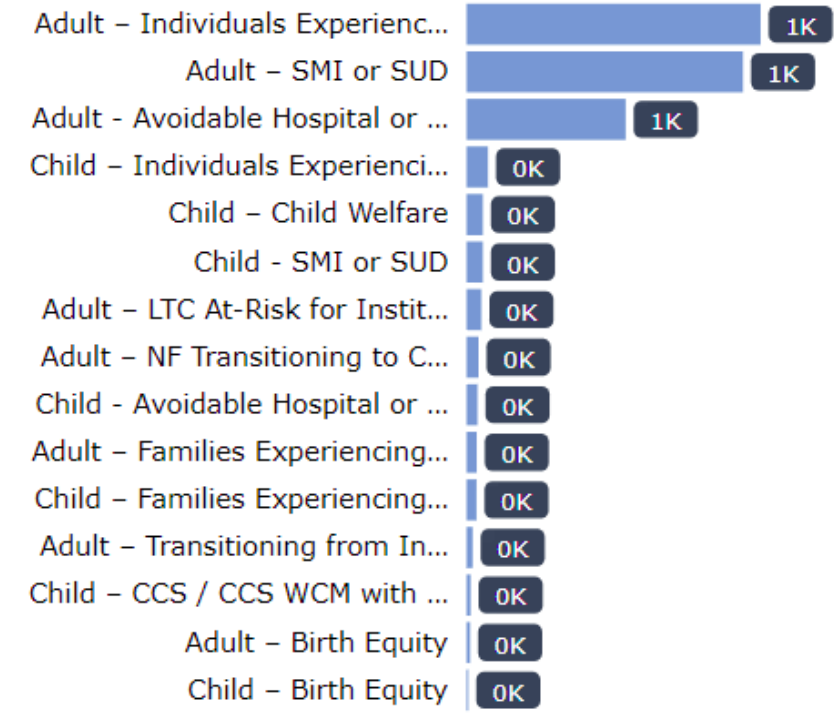
by Sex



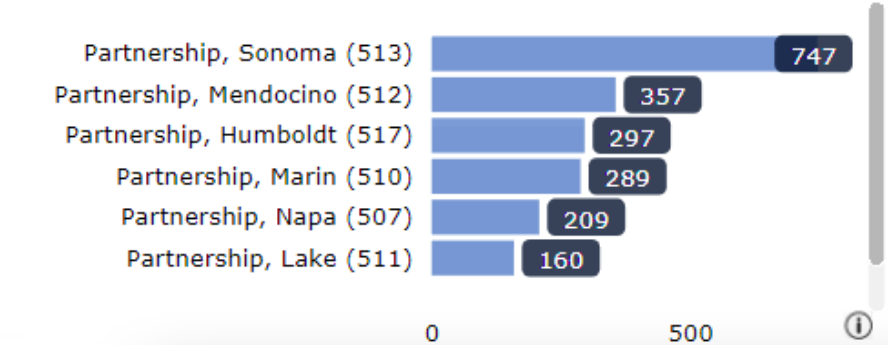
by County



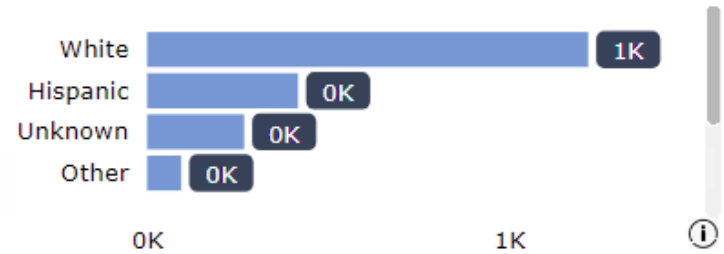
by ECM Population of Focus



by Plan



by Race / Ethnicity



Community Supports

Applied Filters Reset

County = Marin, Sonoma, Napa, Lake, Humboldt, Mendocino, Del Norte

Plan Parent
Partnership

Dual Status
All

Age Group
All

Aid Code Group
All

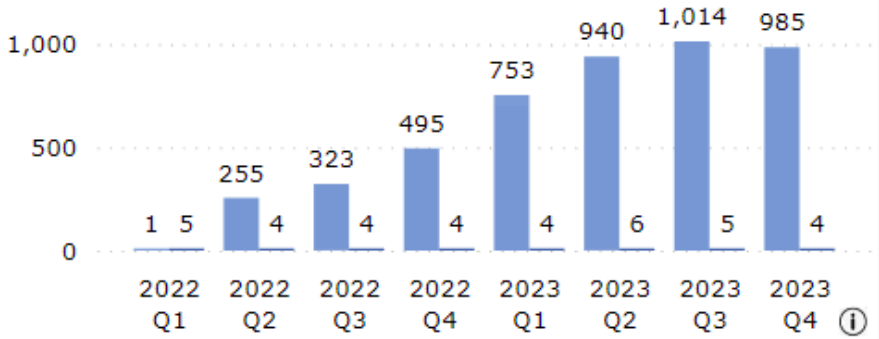
Primary Language
All

County Size
All

Receiving Community Supports

Program of Origin: New, WPC

Quarter: 2023 Q4



Received Community Supports (in Quarter)

989

Approved for Community Supports (in Quarter)

1,983

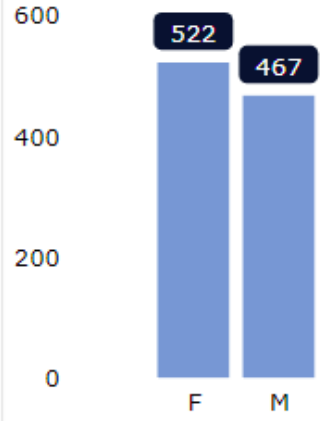
Received Both ECM & Community Supports (in Quarter)

263

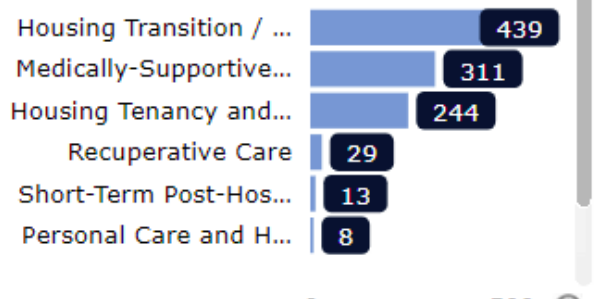
Cumulative Received Community Supports

2,319

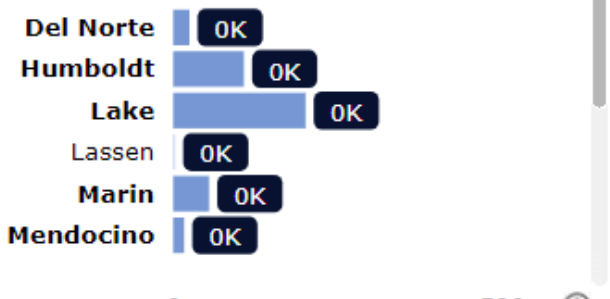
by Sex



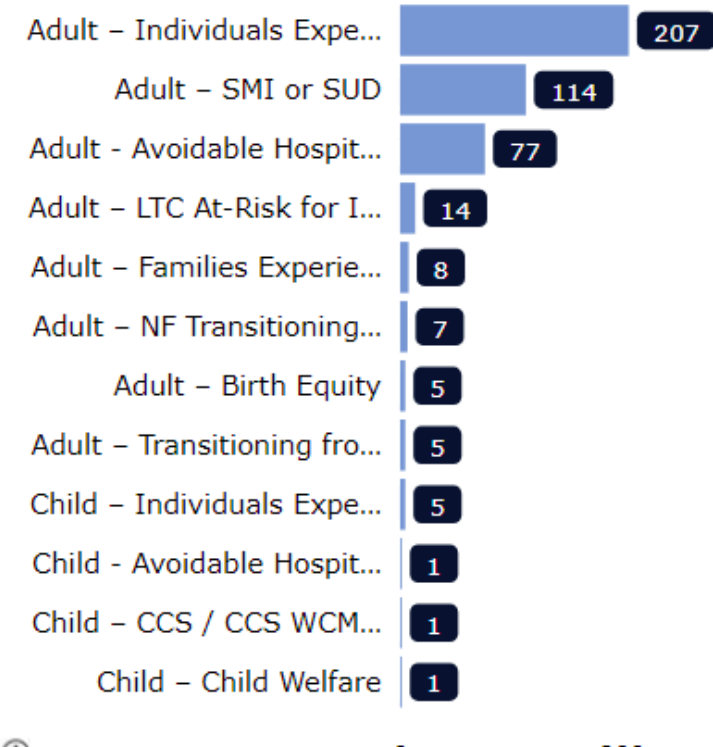
by Community Support Type (ILOS)



by County

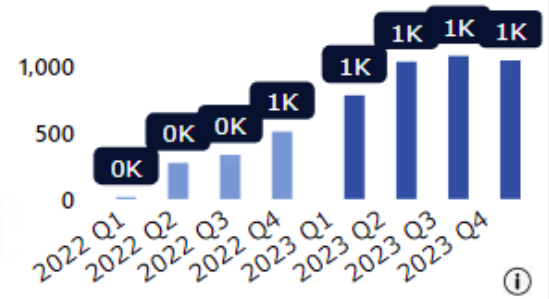


by ECM Population of Focus

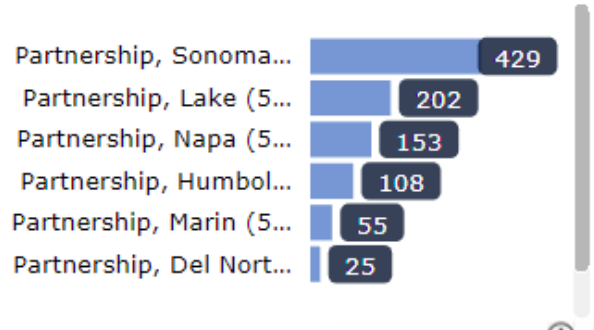


Number of Services Delivered

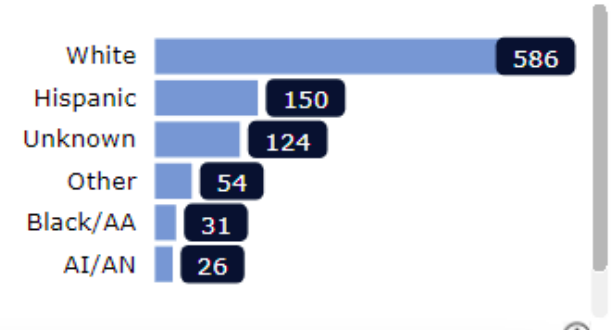
Year: 2022, 2023



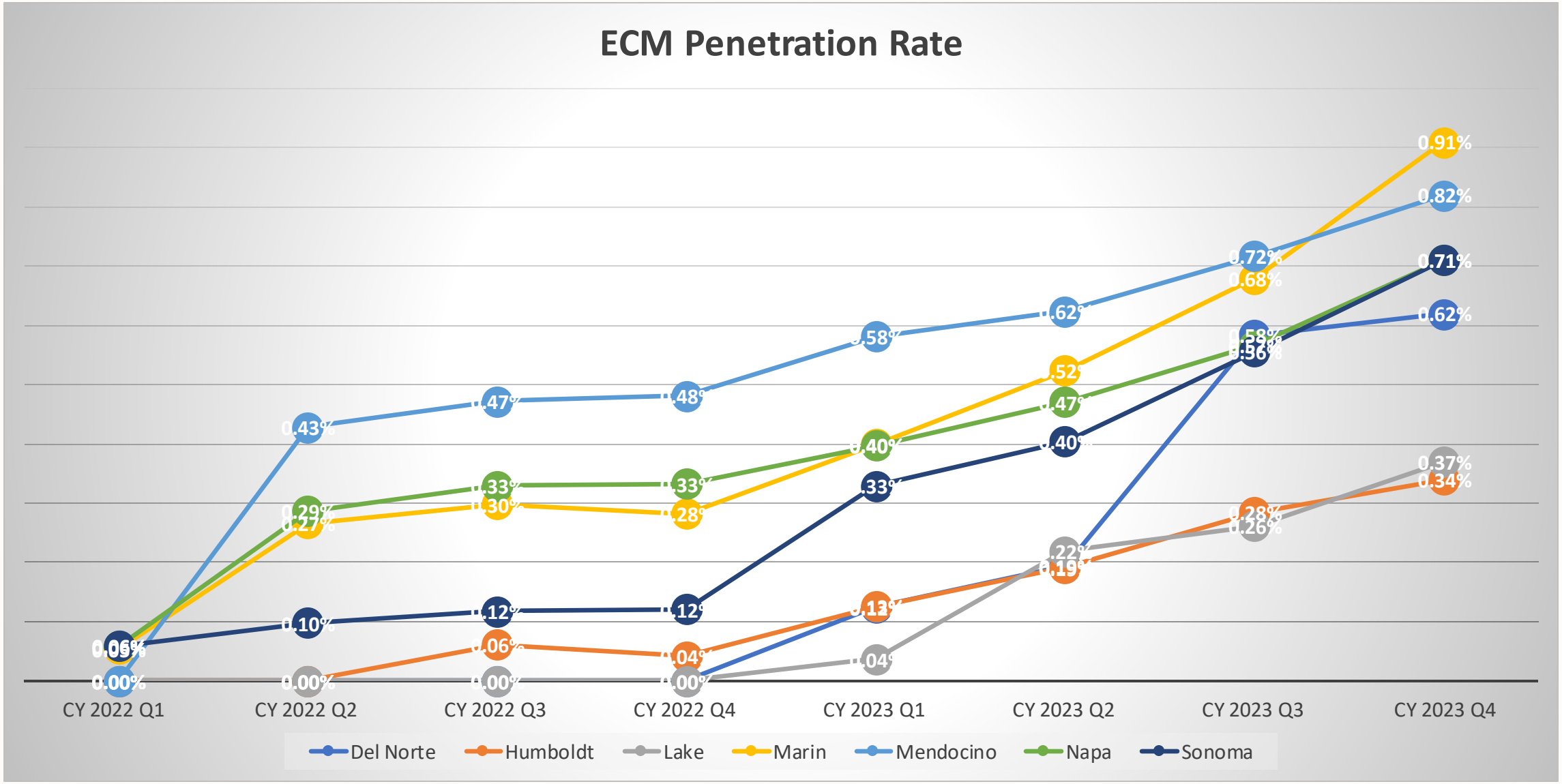
by Plan



by Race / Ethnicity



Trends in ECM Penetration Rate



ECM Penetration Rate Goals

				Percent increase needed to reach each level of penetration				
County	Average MCP Members in the Last 12 Months of the Reporting Period	Number of Unique Members Who Received ECM in the Last 12 Months of the Reporting Period	Percentage of MCP Members Who Were Enrolled in ECM in the Last 12 Months of the Reporting Period (Penetration Rate)	5% Penetration Rate	4% Penetration Rate	3% Penetration Rate	2% Penetration Rate	1% Penetration Rate
Del Norte	12,857	80	0.62%	704%	543%	382%	221%	61%
Humboldt	61,850	208	0.34%	1387%	1089%	792%	495%	197%
Lake	35,541	130	0.37%	1267%	994%	720%	447%	173%
Marin	51,368	470	0.91%	446%	337%	228%	119%	9%
Mendocino	41,959	345	0.82%	508%	386%	265%	143%	22%
Napa	35,499	251	0.71%	607%	466%	324%	183%	41%
Sonoma	132,867	945	0.71%	603%	462%	322%	181%	41%

Southwest CPI Aim Statement

The Southwest PATH Collaborative Planning and Implementation (CPI) initiative aims to help improve the *quality of services* for members who are eligible for Enhanced Care Management and Community Supports, as well as increase the number of *local* providers by 29% and expand the number of Medi-Cal members receiving CalAIM services by 100% by December 31, 2024.

This CPI will facilitate this by supporting the progression of CPI participants along the Readiness Roadmap to effectively integrate Enhanced Care Management (ECM) and Community Supports services within the Medi-Cal system.

Questions?

Partnership HealthPlan of California Presentation

Updates on CalAIM

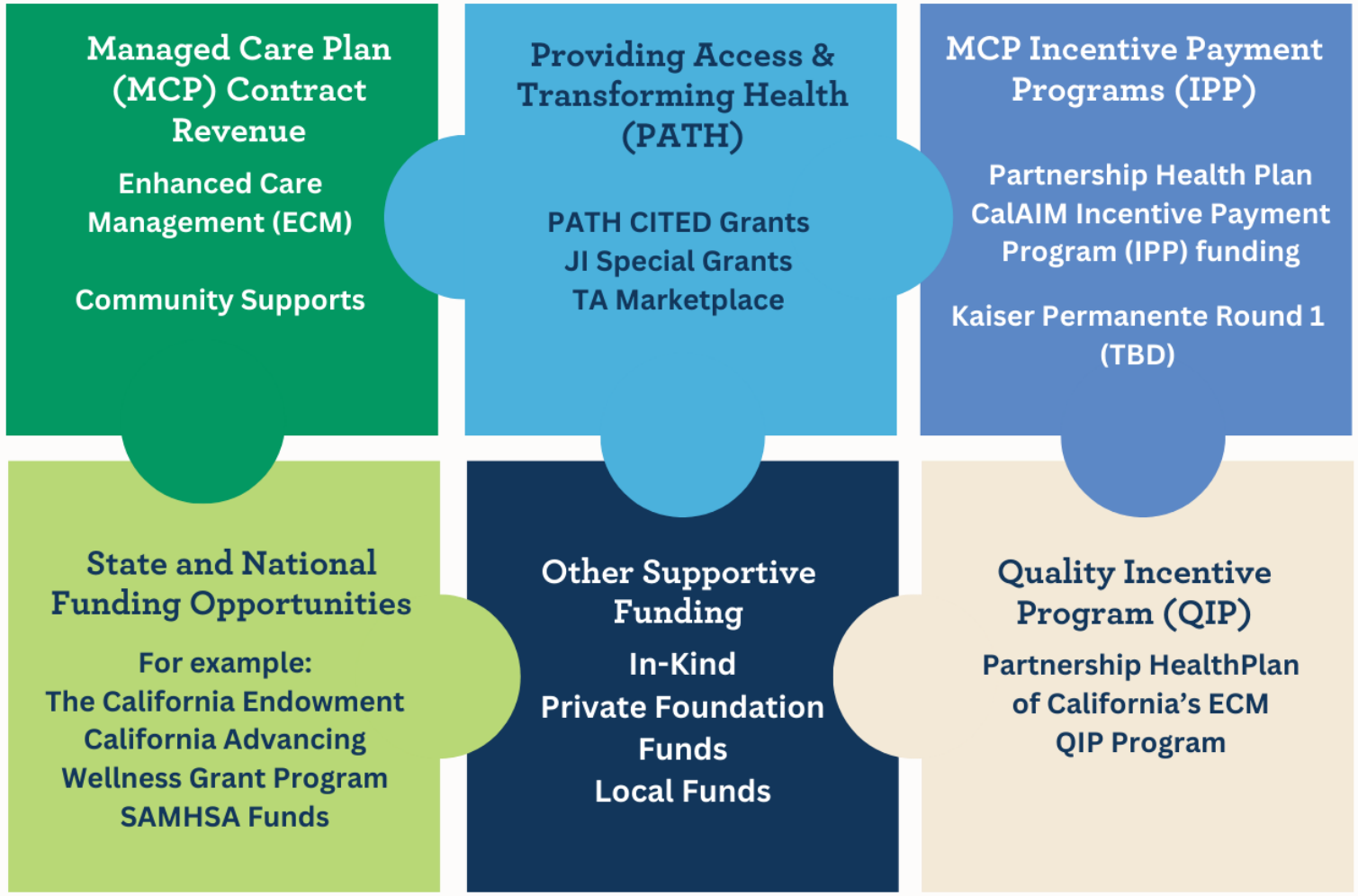
Ashley Peel (ECM Program Manager)
Paula De La Cruz (CS Project Coordinator)

Kaiser Permanente

Updates on CalAIM implementation

Vanessa W. Davis, MPH
Director, Medicaid

CalAIM Revenue Enhancement Strategies



Elevating the Expertise of Local Peers

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

Welcome:

Committee on the Shelterless (COTS)

Shannon Garay

COTS
Est. 1988

A little about COTS

COTS' mission is to "assist those experiencing homelessness to ***find and keep housing****,* ***increase self sufficiency*** *and* ***improve well-being****.*

COTS
Est. 1988

ECM Populations of Focus we serve

- Adults and children **experiencing homelessness**
- Adults at risk for **avoidable hospital or emergency stays**
- Adults with **Substance Use Disorder** (SUD) or **Serious Mental Illness** (SMI)

COTS
Est. 1988

Programs We Offer

Onsite meals for clients and the community

Recuperative Care

ECM

Emergency Shelter for Individuals

Non-Congregate Shelter for Individuals

Family Shelter

Permanent Supportive Housing

Community Housing

Rapid Rehousing

COTS

Est. 1988

2023 ECM Stats

Individuals served: 156

Avg per Quarter: 112

ECM Care Managers: 6-8

QIP Incentive earned: 100%

COTS
Est. 1988

Key things we learned

- Have a **reliable tool** for keeping track of the data
- Monitoring QIP measures **throughout the quarter** rather than near the end makes a huge difference
- Early and often **communication** between CalAIM Admin and Care Managers keeps things running smoothly

COTS
Est. 1988

Data Collection and Monitoring Tools

- We updated our electronic case management system to **capture Blood Pressure and PHQ-9 data** and add Excel export function

- **Monitor PointClickCare** to ensure client records are available and that Care Plans and ROIs have been uploaded

- Modified the ECM QIP Submission Template for **internal analysis**

Track everything in one place

COTS
Est. 1988

2024 ECM QIP PHQ-9 Depression Screening and Blood Pressure Screening Submission Template

(Revised 3/25/2024

Measurement Period: **January 1, 2024 - December 31, 2024**

Submission Frequency: **Quarterly** Submission Deadline: **2nd Friday of month following end of quarterly reporting period**

Submission Method: **sFTP Folder** Submission Naming Convention: **Facility Name_Dep-BP_Month-Year**

All information must be entered for each member. Incentive dollars will not be awarded for incomplete entries.

** Enter PHQ-2, PHQ-9(OV), or GDS tool in "Score" column*

Provider Site Name	NPI Number	Patient Name	CIN	DOB	PHQ-9 Depression Screening		Blood Pressure Screening	
					Screening Date	* Score	Screening Date	Reading

Submission Naming Convention: **Facility Name_Dep-BP_Month-Year**

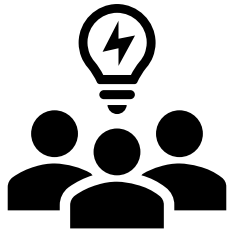
r. Incentive dollars will not be awarded for incomplete

** Enter PHQ-2, PHQ-9(OV), or GDS tool in "Score" column*

Patient Name	CIN	DOB	PHQ-9 Depression Screening		Blood Pressure Screening		TAR Submission Date	Date ICP Uploaded in PCC	Date ROI Uploaded in PCC
			Screening Date	* Score	Screening Date	Reading			

COTS
Est. 1988

Managing Teams

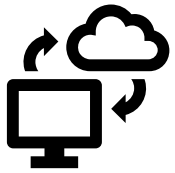


- Established Workflows and Processes for Care Managers
- Closely monitor PointClickCare
- ECM Agenda Items at Team Meetings

COTS
Est. 1988

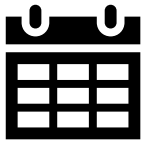
Established Workflow and Processes for Care Managers

Submit TAR and Notify Program Manager and CalAIM Admin that TAR has been submitted



PCC: Upload the ICP and ROI to PointClickCare right away, if the option is available, if not, email CalAIM Admin.

Keep a running list of clients not in PCC, and check again at the end of the month



EOM- Notify CalAIM Admin if client is still not in PCC

COTS
Est. 1988

Blood Pressure Readings and PHQ-9 Scores Workflow

Administer BP and PHQ-9 at initial Care Management Meeting

Document in Electronic Case Management system

Repeat monthly for any scores higher than recommended by Partnership

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Monitoring Measure Performance

Designated staff as central point person for ECM data management and communication:

Monitor PointClickCare to ensure that CMs can access their clients in the system, and that documents have been uploaded

Act as the **Point of Contact** to communicate with PHC and PCC when technical issues arise in the portal (missing clients, upload issues, etc.)

Track updates and communicate with Care Managers when:

- Their client was added to PCC
- BP and PHQ-9 scores are missing or out of date
- Documents are missing, incorrectly labeled, etc.

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Communication

- ☑ Make ECM QIP Measures a team meeting agenda item
- ☑ Email reminders ahead of deadlines
- ☑ Make time to discuss strategies for clients who are resistant to getting their blood pressure taken
- ☑ Express appreciation for efforts
- ☑ Celebrate successes big and small

Even partial credit for ECM QIP is worth the effort.

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Enhanced Care Management (ECM) QIP Overview

April 17, 2024

Amy McCune

Quality Incentive Programs Manager

ECM QIP Overview

ECM QIP FACTS

- ECM QIP launched in 2022
- ECM contracted providers are invited to the program any quarter throughout the year.
- Calendar year program
- Quarterly measure periods
- Quarterly incentive payments

ECM QIP Incentive Payouts

2022

- Payout: $810,500
- Q1-Q3: one measure only
- 67 participating providers

2023:

- Payout $ 1.9 million
- 168 participating providers

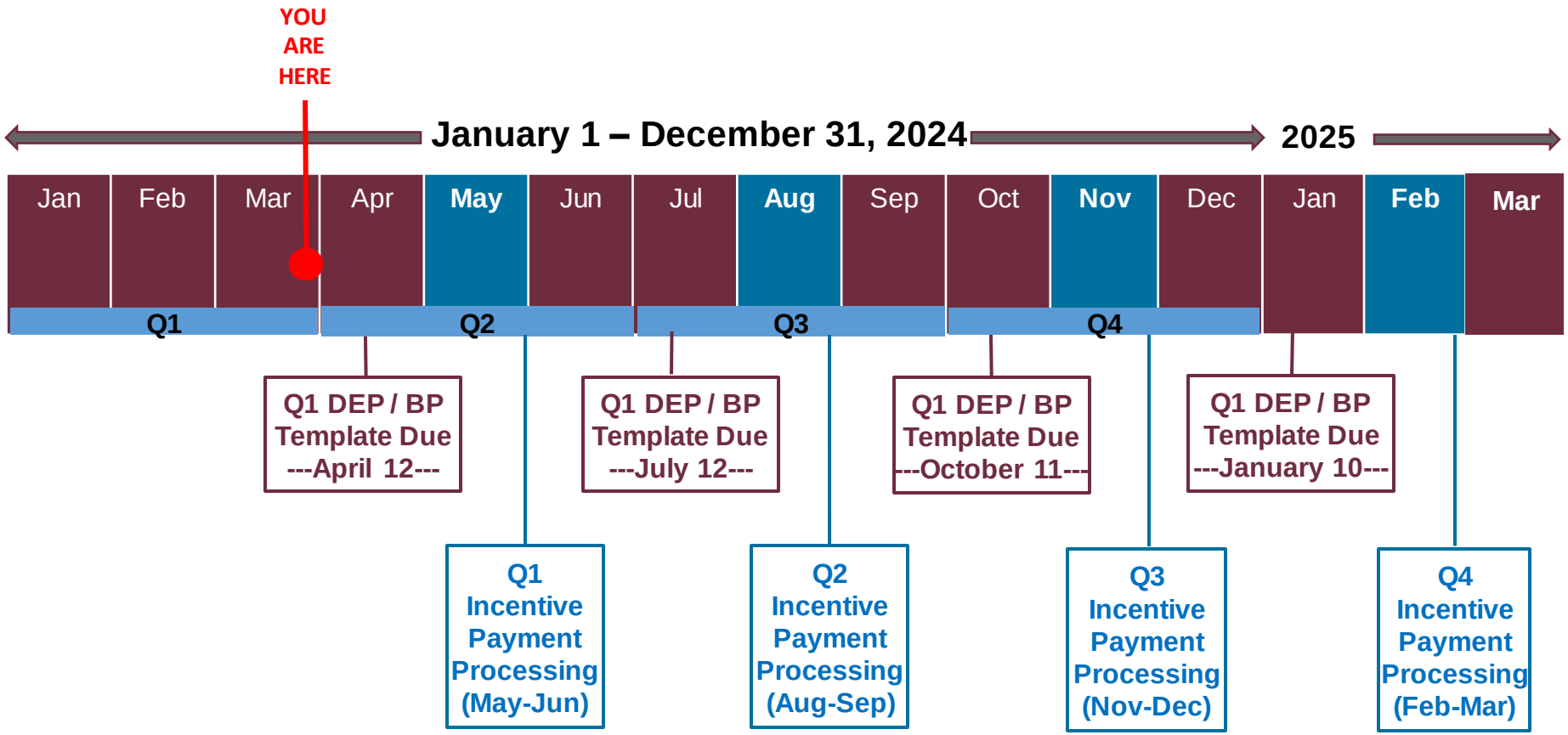
Guiding Principles

The ECM QIP adheres to the 3 guiding principles of California's DHCS CalAIM program:

- Identify and manage member risk and need through whole-person care approaches and addressing Social Determinants of Health.
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

ECM QIP - Timeline

2024 Measurement Year Timeline



ECM QIP - Measure Summary

2024 Measure Summary

Measure	Submission Deadline	Reporting Requirement
Gateway Measure: Timely Reporting		
ECM Provider Return Transmission File (RTF)	DUE MONTHLY to ECM Team	Provider submits RTF to CalAIM/ECM team via sFTP folder
ECM Provider Initial Outreach Tracker File (IOT)	DUE MONTHLY to ECM Team	Provider submits IOT to CalAIM/ECM team via sFTP folder
Provider Capacity Survey	DUE MONTHLY to ECM Team	Provider submits Capacity Survey the CalAIM/ECM team via Google Docs (or another form of communication agreed upon by PHC and ECM provider)
Measure 1		
Care Plan and ROI upload into PointClickCare	Upload within 60 DAYS of TAR auth request date	Provider uploads documents into PointClickCare
Measure 2		
PHQ-9 Depression Screening	DUE QUARTERLY 2nd Friday after qtrly period	Provider submits template via sFTP folders
Measure 3		
Blood Pressure Screening	DUE QUARTERLY 2nd Friday after qtrly period	Provider submits template via sFTP folders

ECM QIP - Gateway Measure

Timely Reporting Gateway Measure

- Determines the number of incentive dollars (placed in an incentive pool) available for earning through 3 reporting measures in the program.
- Opportunity to earn an allotted percentage of incentive pool dollars based on full or partial credit by meeting the 3 measures, with potential to earn 100% of the incentive dollars available in the pool.
- The incentive rate is $100 per member per month (PMPM). This means for every enrolled ECM member, $100 will be placed in the incentive pool.

  Example: In April, a provider submits timely reports for 50 enrolled ECM members. A total of $5,000 will be held in the incentive pool.

Incentive Pool Accrual: ECM providers are required to submit **3 timely reports** to accrue incentive pool dollars

- 100% of incentive dollars accrued if all 3 reports received on or before due date
- 50% of incentive dollars accrued if any submissions received up to 1 week or 5 business days past due
- No incentive dollars accrued for any submissions not received within 5 business days
- Submissions more than 30 days overdue may initiate a corrective action, including separation from participation in the ECM program.

Incentive Pool Allotment: Providers can earn a percentage of the allotted incentive pool by meeting any or all of the 3 reporting measures.

ECM QIP - Reporting Measure 1

Care Plan/ROI Submission into PointClickCare

Description: Providers will upload a Care Plan and ROI into PointClickCare within 60 days of TAR authorized request date or TAR renewal authorized request date.

NOTE: *PHC or DHCS ROI forms have a 5-year expiration. Providers need only to upload the ROI at original TAR date if using these forms. Providers using their own ROI form need to upload every quarter*

Measurement Period: Quarterly

Eligible Incentive: 30% of total incentive pool allotment

Targets: Full credit: ≥ 80%
Partial credit: 70 - 79%

Reporting Guidelines: Provider must upload both documents into PointClickCare. No submission to PHC is required. PHC audits PointClickCare for evidence of documents.

ECM QIP - Reporting Measure 2

PHQ-9 Depression Screening

Description: Depression screening is completed using Patient Health Questionnaire-9 (PHQ-9) for all ECM enrolled members as part of initial assessment and development of the Care Plan.

NOTE: Scores from previous quarters can be used if screening was done within 12 months of reporting period AND The previous score was normal (14 points or lower). If abnormal, screening must be done every quarter until normal.

The Patient Health Questionnaire-2 (PHQ-2) can be used instead of PHQ-9. If PHQ-2 score is 3 points or higher, screening must be done again using the PHQ-9.

NEW! **Members with Intellectual/Developmental Disabilities:** The following additional depression screening tool options are now approved to use for members with intellectual and/or development disabilities.

Tool	Positive Finding
Geriatric Depression Scale Short Form (GDS)	Total Score ≥5
Patient Health Questionnaire (PHQ-9) (OV) (Observational Version)®	Total Score ≥10

Reporting Periods: Quarterly

Eligible Incentive: 35% of total incentive pool

Targets: Full credit: ≥ 90%
Partial credit: 80 - 89%

Exclusions: Members 11 years and younger

Reporting Guidelines: Providers submit required information on a PHQ-9 Depression & Blood Pressure Screening Template. Submissions due quarterly, via sFTP folder, by 2nd Friday following reporting period.

ECM QIP - Reporting Measure 3

Measure 3: Blood Pressure Monitoring

Description: Blood pressure (BP) screening needs is completed for ECM enrolled members, 18 years and older, regardless of prior diagnosis of hypertension. Screening must be by in-person visit by ECM staff, clinic visit, or patient use of PHC approved home BP kit.

Screening results from previous quarters can be used if captured within 12 months of the reporting period ***AND*** the previous result was normal. Normal blood pressure is either SBP < (less than) 140 or DBP < (less than) 90. If either the SBP was ≥ 140 or DBP was ≥ 90, screening must be done every quarter until result is normal.

Reporting Periods: Quarterly

Eligible Incentive: 35% of total incentive pool

Targets: Full credit: ≥ 80%
Partial credit: 70 - 79%

Exclusions: Members 17 years and younger

Reporting Guidelines: Provider submit required information noted on a PHQ-9 Depression & Blood Pressure Screening Template.

Reporting Guidelines: Providers submit required information on a PHQ-9 Depression & Blood Pressure Screening Template. Submissions due quarterly, via sFTP folder, by 2nd Friday following reporting period.

ECM QIP Provider Spotlight:

The following providers scored 85% - 100% and earned 100% of their incentive pool:

CPI Northwest (Humboldt/Del Norte Counties):

- Arcata House Partnership

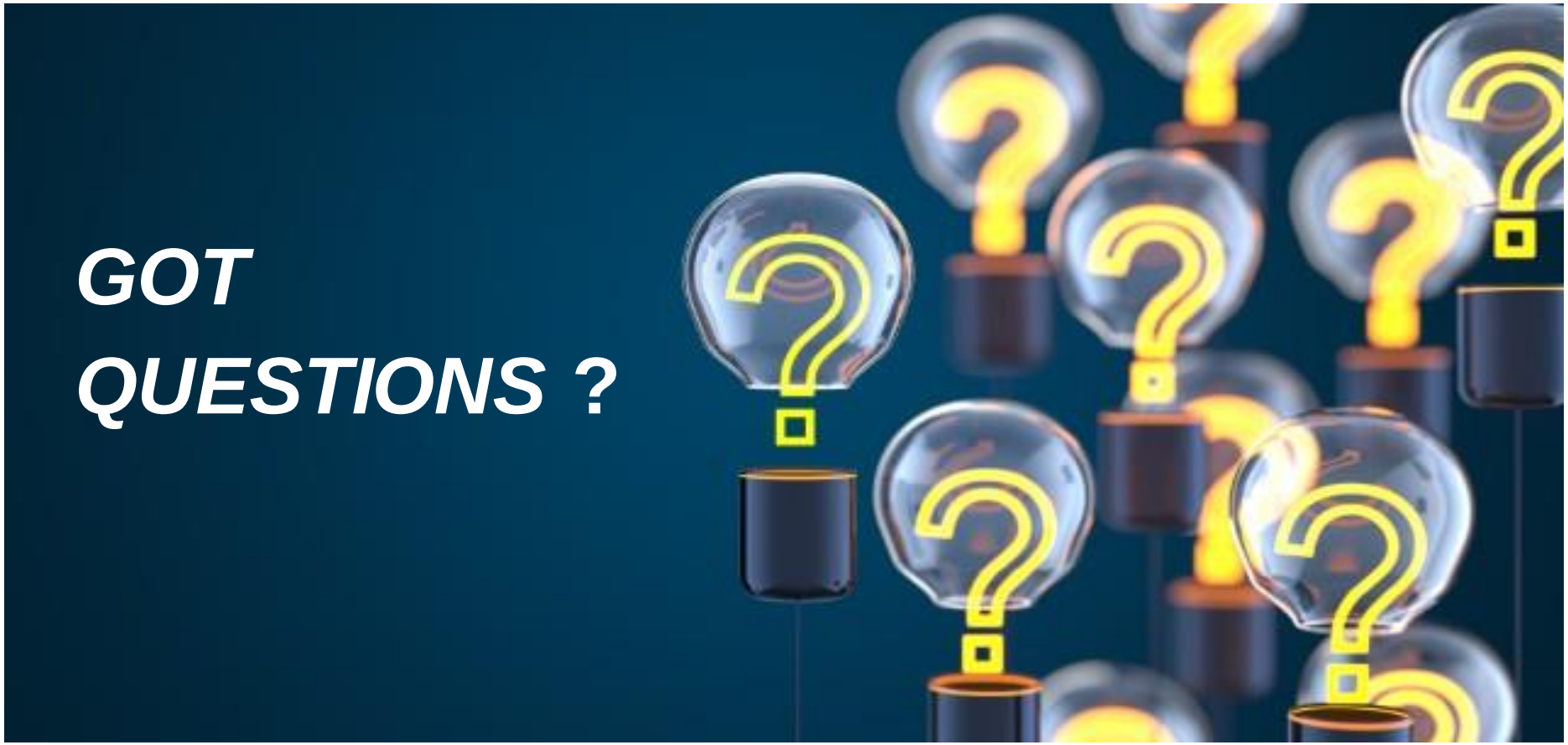
CPI Southwest (Lake, Mendocino, Sonoma, Marin Counties):

- Community Support Network
- Homeward Bound of Marin
- Marin Community Clinics
- Mendonoma Health Alliance
- Redwood Quality Management Company
- Ritter Center
- Sonoma Valley Community Health Center
- Commission on the Shelterless (COTS)

ECM QIP Tools & Resources

- Blood Pressure Monitoring Best Practices for Enhanced Care Management Providers
- Patient Health Questionnaire (PHQ)
- ECM QIP Email: ECMQIP@partnershiphp.org
- ECM QIP Webpage: https://www.partnershiphp.org/Providers/Quality/Pages/ECM-QIP-Enhanced-Care-Management.aspx

ECM QIP



ECM QIP Next Steps

- In-person Training Opportunities
  - Self-Administered Blood Pressure Monitors (order and distribute)
  - Depression Screening Tools and Best Practices
- Zoom Poll: Tell Us What You Think
- Evaluation and Survey:
  - Share your ideas to strengthen Complex Care Case Management
  - Incorporate program improvements into data and Multi-Disciplinary Team Case Conferencing

Updated CalAIM Budget Estimator

- Thank you for piloting this tool in its early phases!
- Camden Coalition incorporated CalAIM feedback and updated it.
- And the new tool is now publicly available here.
- Provides an excel-based program development tool that can be used with other organizational budget tools.
- Allows for organizational specific caseloads and funding sources.
- Incorporates CalAIM costs and revenue estimates alongside other program funding.

Office Hours

PATH CPI Office Hours:

- Monday, April 22 from 12:00 – 1:00 pm (Register here)
- Wednesday, May 8 from 1:00 – 2:00 pm (Register here)
- Monday, May 27 from 12:00 – 1:00 pm (Register here)

Southwest CPI Updates and Upcoming Events

Updates and Upcoming PATH CPI Events

Our next CPI regional meeting is virtual. We hope to see you online!

- SW: Wednesday, May 15 from 1:00 – 2:30 pm (Register here)
- NW: Tuesday, May 21 from 1:00 – 2:00 pm (Register here)

Post Convening Email:

- Will include details about the potential June QIP Pop-Up Event!

NEW PHIL Policy Brief:

- Look for it in Early May!

Post-Event Evaluation

To continue improving our work as your CPI Facilitator, PHIL kindly asks that you complete the brief survey that pops up in a new tab at the close of the meeting. Your feedback ensures quality improvement and will inform planning and activities through the evolution of the collaborative.

Thank You!

Feel free to contact our PATH CPI team

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Thank you!