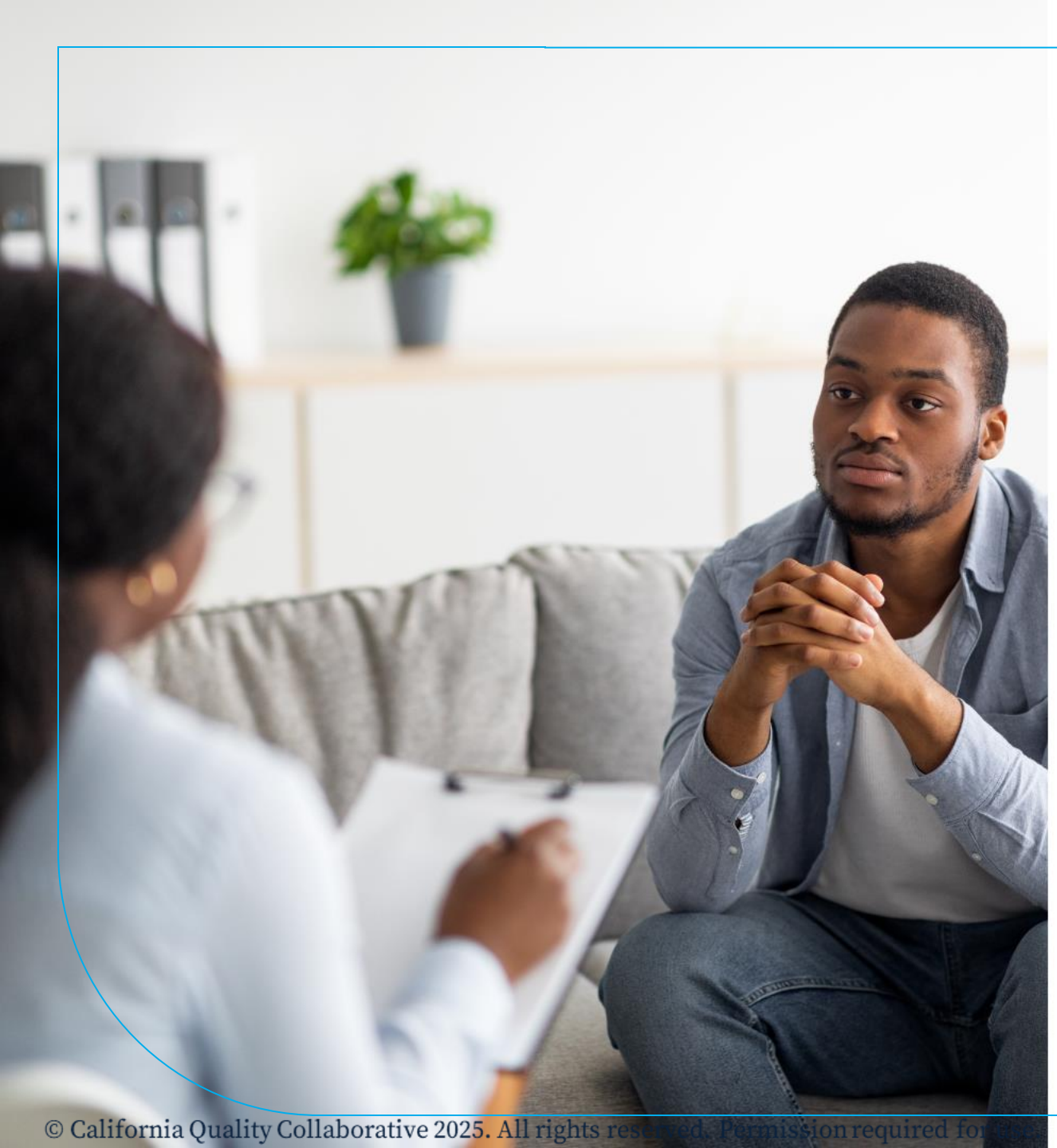


Wednesday, March 19; 12 p.m. – 1 p.m. PT

Cal-IN Peer Group Meeting

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

PBGH California Quality Collaborative

California Quality Collaborative

Advancing the quality and efficiency
of the outpatient health care delivery system by
creating scalable, measurable improvement.

Launched in 2007, CQC is a **multi-stakeholder quality improvement program** of the Purchaser Business Group on Health. Core funding comes from health plans sharing a delivery system.

Identifies and spreads best practices across outpatient delivery system in California

Trains 2,000 individuals from 250 organizations each year

CQC's track record includes **20% relative improvement** in clinical outcomes and **10:1 ROI**

Sponsors

Anthem Blue Cross
blue california
blue california Promise Health Plan
California Health Care Foundation
CalOptima Public Agency Better. Together.
CVS Health
aetna
health net
KAISER PERMANENTE
L.A. Care Health Plan
MOLINA HEALTHCARE
United Healthcare
VHP Valley Health Plan

Collaborative Family Healthcare Association

3 Pillars of CFHA

Where the Modern Healthcare Team Gathers

Content

- Learning Opportunities
- In-Person & Virtual Conference
- Listserv

Community

- Special Interest Groups
- Workgroups
- Large BHI Community

Consultation

- Technical Assistance
- Tools & Resources for Organizations & Providers

https://www.cfha.net/#:~:text=Where%20the%20Modern%20Healthcare%20Team%20Gathers

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

PBGH California Quality Collaborative

Our Objectives

Today, we'll:

Review lessons learned from the BHI and Enhanced Care Management Program at Share Ourselves

Connect with behavioral health integrated leaders in California

Poll

- Is your organization doing Enhanced Care Management?
  - Yes
  - No, but we want to!
  - No
  - What is Enhanced Care Management?

California Quality Collaborative

Behavioral Health Integration and Community Support

What is Enhanced Care Management (ECM)?

- **Enhanced Care Management (ECM)** is a component of **California Advancing and Innovating Medi-Cal (CalAIM)** initiative. ECM is a statewide **Medi-Cal** managed care benefit that addresses clinical and non-clinical needs of individuals with complex health conditions through the coordination of services and comprehensive care management.

ECM Provider Toolkit:
https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx

What is Enhanced Care Management (ECM)?

What Is ECM?

- ECM gives qualified members extra services from a dedicated ECM provider, which is an entity that contracts with a Medi-Cal managed care health plan.
- A **lead care manager**, who works for the ECM provider, coordinates the member's health care services and links them to community and social services.
- The member's ECM provider works with all of their providers to give an **added layer of support**.
- Members get these **extra services at no cost** as part of their Medi-Cal benefits.
- ECM will **not take away** any of the member's current Medi-Cal benefits.

ECM Provider Toolkit:
https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Home.aspx

Who can receive ECM?

- **ECM** is intended for the highest risk, highest cost Medi-Cal patients with the most complex and social needs. To be eligible, patients must be enrolled in a Medi-Cal managed care health plan and meet criteria for at least one the **Populations of Focus**:

ECM Populations of Focus		Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	✓	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

DHCS Policy Guide:
https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx

How is ECM delivered?

- **ECM** offers seven types of **Core Services** intended to be interdisciplinary, high touch, and person-centered:

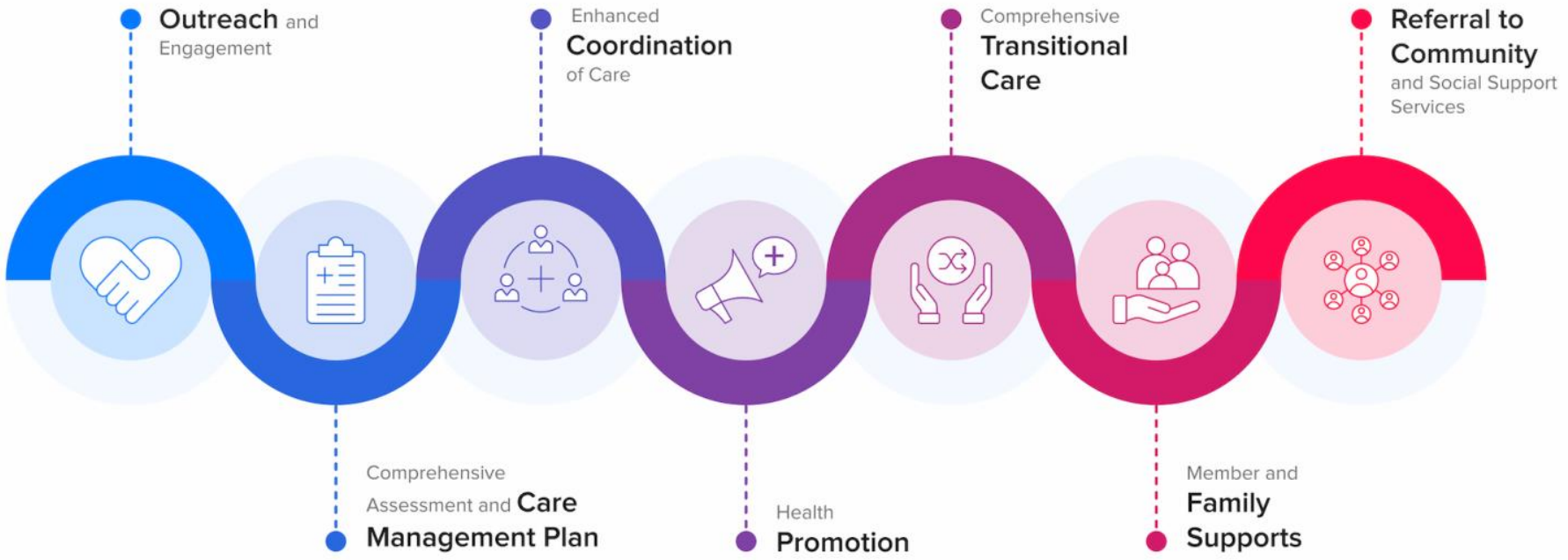


Image:
https://spritehealth.com/2023/05/03/7-calaim-ecm-services-you-need-to-know-about/

California Quality Collaborative

Enhanced Care Management

Share Ourselves

ABOUT SHARE OURSELVES

- **Our Mission:**

We are servants who provide care and assistance to those in need and act as advocates for system change.

- **Our Values:**

Lead with Dignity

Champion Justice

Strive for Excellence

Serve with Heart

ABOUT SHARE OURSELVES

- **Our Locations:**

  Seven locations across OC

  - Primary Care Clinics
  - Mobile Unit
  - School-based Clinic
  - Shelter Clinic

ABOUT SHARE OURSELVES

- **Our Patients:**

2024 Uniform Data System (UDS) Report

- **15,300** Patients
- 630 Patients Experiencing Homelessness
- 85% Insured
- 15% Uninsured

ABOUT SHARE OURSELVES

- **Our Services:**

Five primary service lines aimed at modeling whole person care.

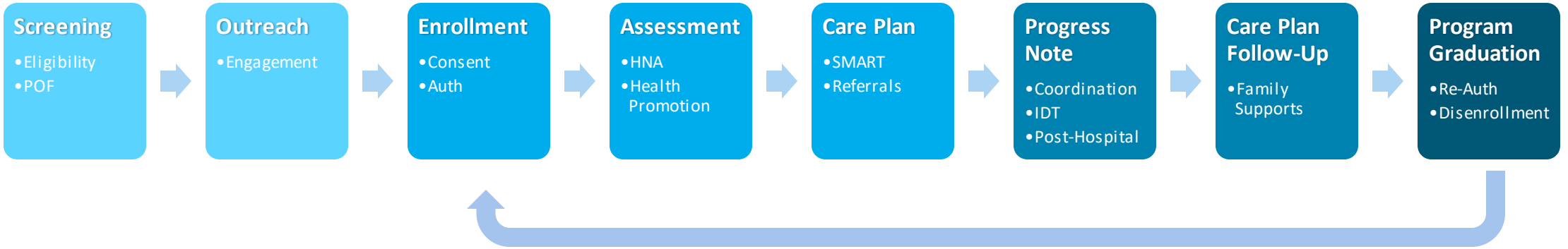
ECM AT SHARE OURSELVES

- **Adoption Planning:**
  - ❑ Partnerships
  - ❑ Finances
  - ❑ Staffing Structure
  - ❑ Facility and Locations
  - ❑ Communications
  - ❑ Technology
  - ❑ Training
  - ❑ Reporting

- **Implementation:**
  - ✓ Contracting with CalOptima
  - ✓ CM Break-Even Analysis
  - ✓ Restructuring of Social Services
  - ✓ Embedding CM at each site
  - ✓ Presentations & Standing Meetings
  - ✓ EMR (EPIC) build
  - ✓ Internal/External trainings
  - ✓ Dashboard & KPIs

ECM AT SHARE OURSELVES

- **ECM** build is about road-mapping and establishing the care management process:



1. Script
2. Collaborator
3. Workflow
4. Template
5. Target
6. Dashboard

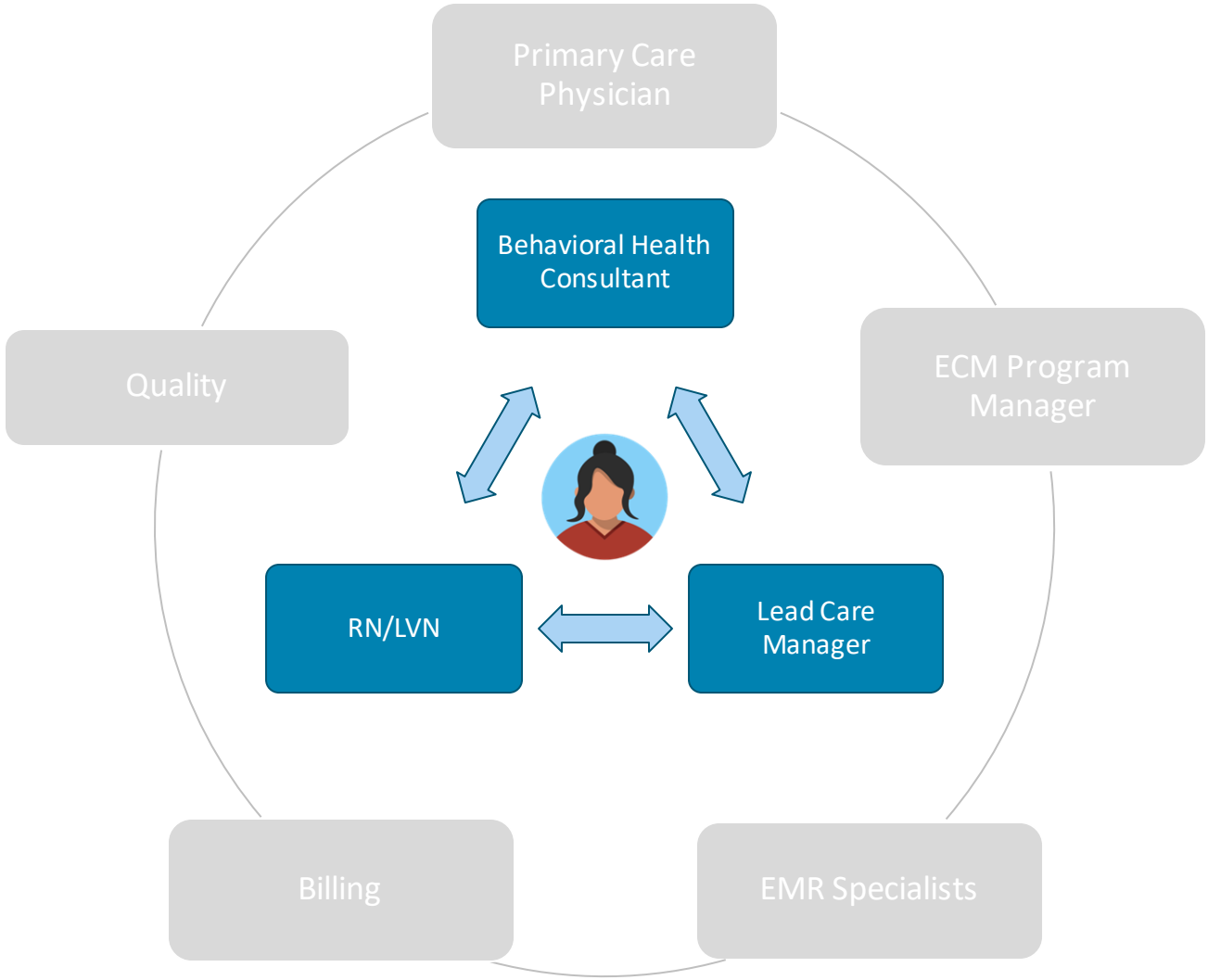
ECM AT SHARE OURSELVES

- **Challenges:**
  - ❑ Partnerships
  - ❑ Finances
  - ❑ Staffing Structure
  - ❑ Facility and Locations
  - ❑ Communications
  - ❑ Technology
  - ❑ Training
  - ❑ Reporting

- **Opportunities:**
  - ❖ Rushed and Pressured Program
  - ❖ Billing & Resource Demands
  - ❖ Competitive Hiring Market
  - ❖ Private Space Constraints
  - ❖ Paradigm Shift
  - ❖ Restrained EMR Autonomy
  - ❖ Significant Learning Curve
  - ❖ Vague KPIs

ECM AT SHARE OURSELVES

- **How we (try to) make it work:**
  - ❖ People
    - ○ Support Team
    - ○ Care Team
    - ○ Patients



BH SERVICES AT SHARE OURSELVES

Current Level of Integration:

Coordinated Care		Co-Located Care		Integrated Care	
1	2	3	4	5	6
Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration Onsite	Close Collaboration with Some System Integration	Close Collaboration Approaching an Integrated Practice	Full Collaboration in a Transformed /Merged Practice

Image:

https://www.ntst.com/-/media/care-coordination-checklist-final/dsc_5100-resize/rich-g-hs/coordinated-care.jpg?h=228&w=677&hash=7DEFEFC1506D111B88F9F79F7E05DC46

SAMHSA Framework for Integrated Care:

https://archive.thepcc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf

CURRENT STATE OF BH @ SHARE OURSELVES

THE MODEL

PCBH

Specialty BH

THE TEAM

3 PCBH Providers (BHCs)

2 Specialty BH Providers

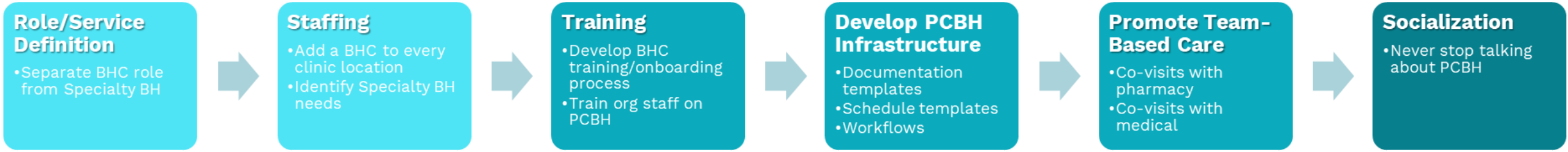
3 open BHC positions

1,258 unique patients in 2024

THE WORK

- PCBH Implementation/Training
- Healthy Steps
- Wellness and Recovery
- Pathway Identification:
  - Testing for Autism and ADHD (peds)
  - Diabetes
  - Healthy Habits for Nutrition (peds)
- Clinic quality projects
- ECM

OUR JOURNEY FROM CO-LOCATION TO PRACTICE TRANSFORMATION (PCBH)



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BHC's – Extending the Work of the PCP/Medical Team

BHC (Primary Care Behavioral Health Provider)

Primary care referral reasons

- Smoking cessation
- Healthy living
- Diabetes
- Stress/anxiety
- Depression
- Somatic concerns
- Substance use
- sleeping/insomnia
- High blood pressure
- Relationship problems
- Domestic violence
- Attention difficulties
- Treatment adherence
- Parenting strategies
- Behavioral problems
- Chronic/persistent pain
- Coping with medical conditions
- Grief/loss
- ...ANY concern related to human behavior!

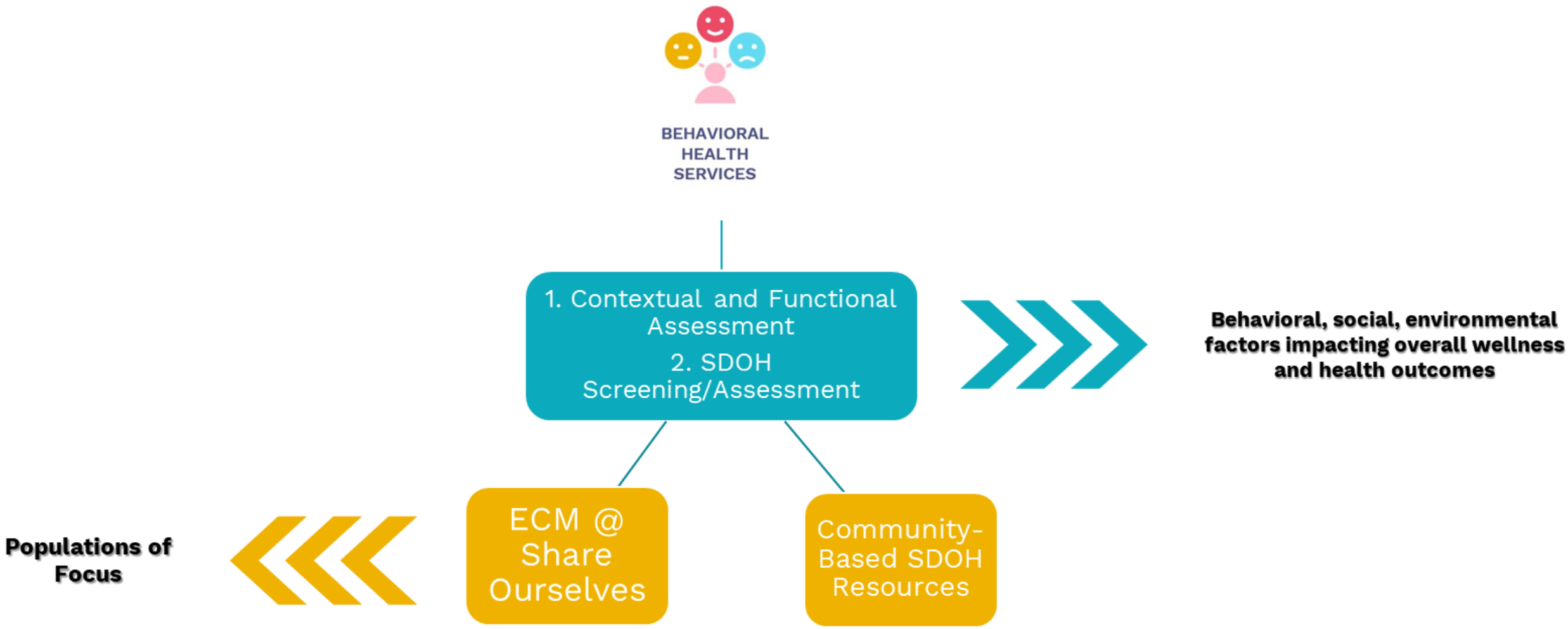
Higher level of care for sub-set of clinic population

Specialty BH @ Share Ourselves

Community-Based BH Supports

California Quality Collaborative

ECM – Extending the Work of the BHC



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ECM - Crucial Partnerships with BH and Nursing

- Case consultation
- Interdisciplinary Team Meetings
- Site Specific Support
- Day to Day Support

Discussion Questions

1. Where are your organizations at around Enhanced Care Management / social needs support?
2. How does behavioral health integration align with that work?
3. What are challenges you have faced/are facing about addressing patients' social needs?
   - What areas need the most support: screening, medical team engagement, resources, too many hats, funding?
4. What tools/resources would be helpful to you at this point in your work?

Open Discussion

- Burning questions?
- Needs?
- Resources?
- Meeting topic suggestions?

Cal-MAP
California's Child & Adolescent Mental Health Access Portal

Cal-MAP is a mental health care access program designed to increase timely access to mental health care for youth throughout California's communities, especially in the state's most underserved and rural areas. California Primary Care Providers (PCPs) can connect with a team of psychiatrists, psychologists and social workers provide **no-cost consultation, education, and resource navigation** for mental and behavioral health concerns in youth 0-25.

- **Providers** - register for Cal-MAP to receive
  - Consultation: Real-time, direct-connect PCP-to-child and adolescent psychiatrist consultation for California-based primary care providers regarding screening, diagnosis, and treatment for youth ages 0-25 M-F 8:30-4:30, as well as specialized psychologist consultation in Early Childhood, Eating Disorder, Substance Use, Autism, ADHD and Mood/Anxiety Disorders.
  - Education: PCPs, school-based clinicians and staff can access no-cost trainings that offer accredited continuing medical education (CME) and continuing education units (CEUs).
  - Resource Navigation: An LCSW social worker can provide guidance on resources and referrals to PCPs, and direct support for families facing significant linkage barriers to connect with services.
- **Families and patients** can access handouts and resources.

Find all details on the Cal-MAP website

IHA – Symphony Provider Directory
BH Focus Groups

About Symphony Provider Directory

Symphony's advanced, cloud-based platform serves as a single source of accurate provider information, helping health plans and providers streamline complex data exchange processes.

As California's statewide data source, Symphony improves the efficiency, quality, and ease of provider directory data . This ensures compliance with regulatory requirements while helping consumers get the information they need.

Dental and Behavioral Health expansion

- Symphony already facilitates data exchange for all provider types; however, we recognize that Dental and Behavioral Health markets face unique challenges in validating provider directory information. For example, directory errors for behavioral health providers are the highest of all specialties by some estimates – which is alarming given the current mental healthcare access crisis in the US.
- Symphony is well poised to expand our solution to tackle these challenges in 2025. IHA is currently holding focus groups, exploring new reference sources for validation, and participating in relevant industry conferences.
- **Interested in joining a focus group? Reach out to symphonyinfo@iha.org.**

BHI Events

- University of Washington Integrated Care Conference (June 5 and 6, Seattle).
- CFHA: Spring Masterclass: Pediatric Primary Care Skill Development is a half-day virtual training designed to equip participants with practical, evidence-based skills to enhance pediatric care in integrated setting (April 11).
- CFHA: Integrated Care Conference in Raleigh, North Carolina (October 16th – 18th) the premier conference for healthcare professionals and allies interested in bringing medicine and behavioral health together.

Wrapping Up

- 2025 Cal-IN Meetings (12 p.m. – 1 p.m.)
  - Wednesday, June 18 | Topic: BHI Training and Development
  - Wednesday, September 24 | Topic: TBD
  - Wednesday, December 3 | Topic: TBD
- Cal-IN Collaboration Space
  - Basecamp
- Peer Group Roster [link]
  - Opt-in document; link will be posted on Basecamp
  - Members can add: name, org, email, how long integrated, your strengths, what you want to talk about

Resource: Aligning ECM with BHI

	Collaborative Care Model (CoCM)	Primary Care Behavioral Health (PCBH)
Care Team Structure	Psychiatric consultant, BHCM, and PCP work together to manage behavioral health conditions.	BHC embedded in primary care; team-based approach.
Care Coordination Role	ECM supports transitions to specialty behavioral health, provides follow-up after crisis events.	ECM bridges gaps between primary care, behavioral health, and community resources.
Role in Stepped-Care	ECM ensures smooth transitions to higher levels of care when needed.	ECM facilitates access to specialty care for patients needing more intensive support.
Social Determinants of Health (SDoH)	ECM care managers supplement CoCM by addressing social needs, connecting patients to housing, food, and transportation services.	ECM care managers connect patients to housing, food support, and transportation services to support behavioral health.
Hospital & ED Utilization	Reduces avoidable ED visits and readmissions through proactive care management.	Prevents crisis escalations by ensuring continuity of care and follow-up after crises.
Integration with Primary Care	Works closely with PCPs and BHCMs to ensure patient follow-through.	Strengthens PCBH by ensuring warm handoffs and long-term patient engagement.