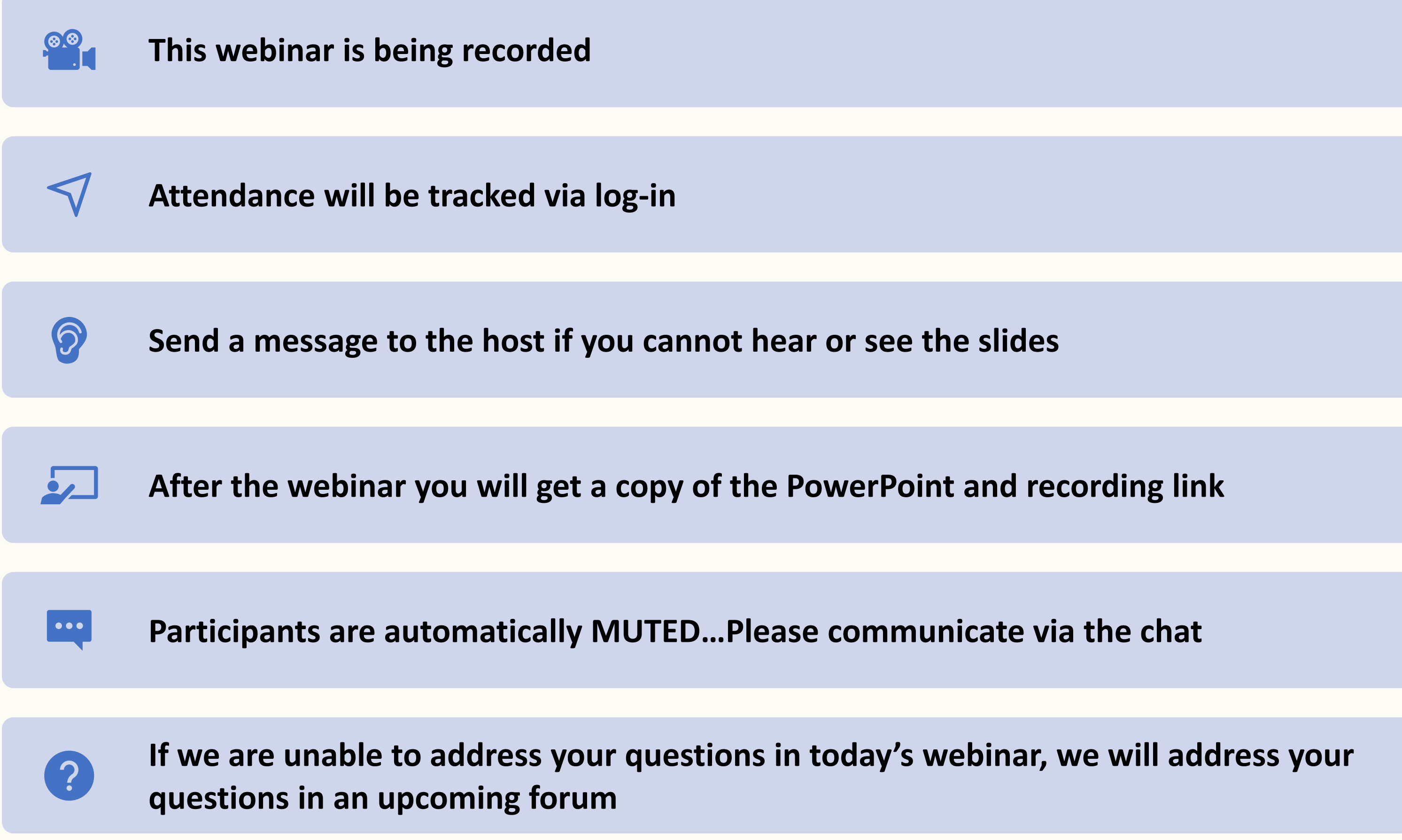
Connecting the Dots: Cross-System Coordination to Maximize Services for the Medi-Cal Member

Wednesday, April 5, 2023

10:00 AM – 11:00 AM

Welcome & Housekeeping



Agenda

Welcome and Introduction from Health Net and L.A. Care

Review Learning Objectives

Understanding the “why” of the Community Supports and desired impact on your clients

Overview of Community Supports in L.A. County

Care coordination best practices, including the warm handoff and closing the loop

Referral processes and strategies to support the Medi-Cal member to access these benefits

Welcome

Nancy Wongvipat Kalev, MPH
Senior Director
Systems of Care

Paola Valdivia
Manager
Community Health

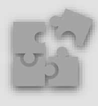
Today's Presenters

Laura Collins, LICSW
Health Management Associates

Flint Michels, RN, MBA, MHSA
Health Management Associates

Learning Objectives

By the end of this webinar, participants will be able to:



Describe your role in the larger picture of services available, to support your clients' health and social needs

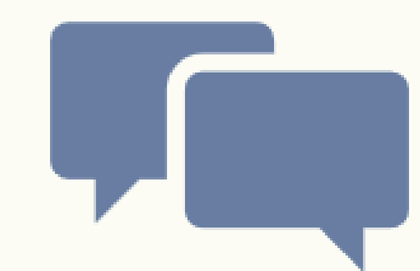
List at least 5 of the CalAIM Community Supports and describe how those services can improve outcomes for your Medi-Cal clients

Describe how to refer your clients to various Community Supports and your role in the process

Integrate referral best practices including *The Warm Handoff* and *Closing the Loop* into your care coordination activities

Chat in your WHY behind this work

A few words



WHY

HOW

WHAT

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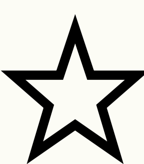
What is CalAIM and why is it important to my organization?

CalAIM is:

1. The ***California Advancing and Innovating Medi-Cal,*** led by the Department of Health Care Services (DHCS)

2. A 5-year plan to transform and **integrate Medi-Cal's programs** more seamlessly with other social services that can improve health outcomes

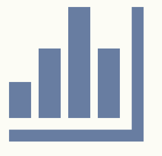


3. Overarching goal is to **improve medical & social outcomes** for Medi-Cal recipients, especially those with the most complex needs

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

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

CalAIM: Community Supports Poll



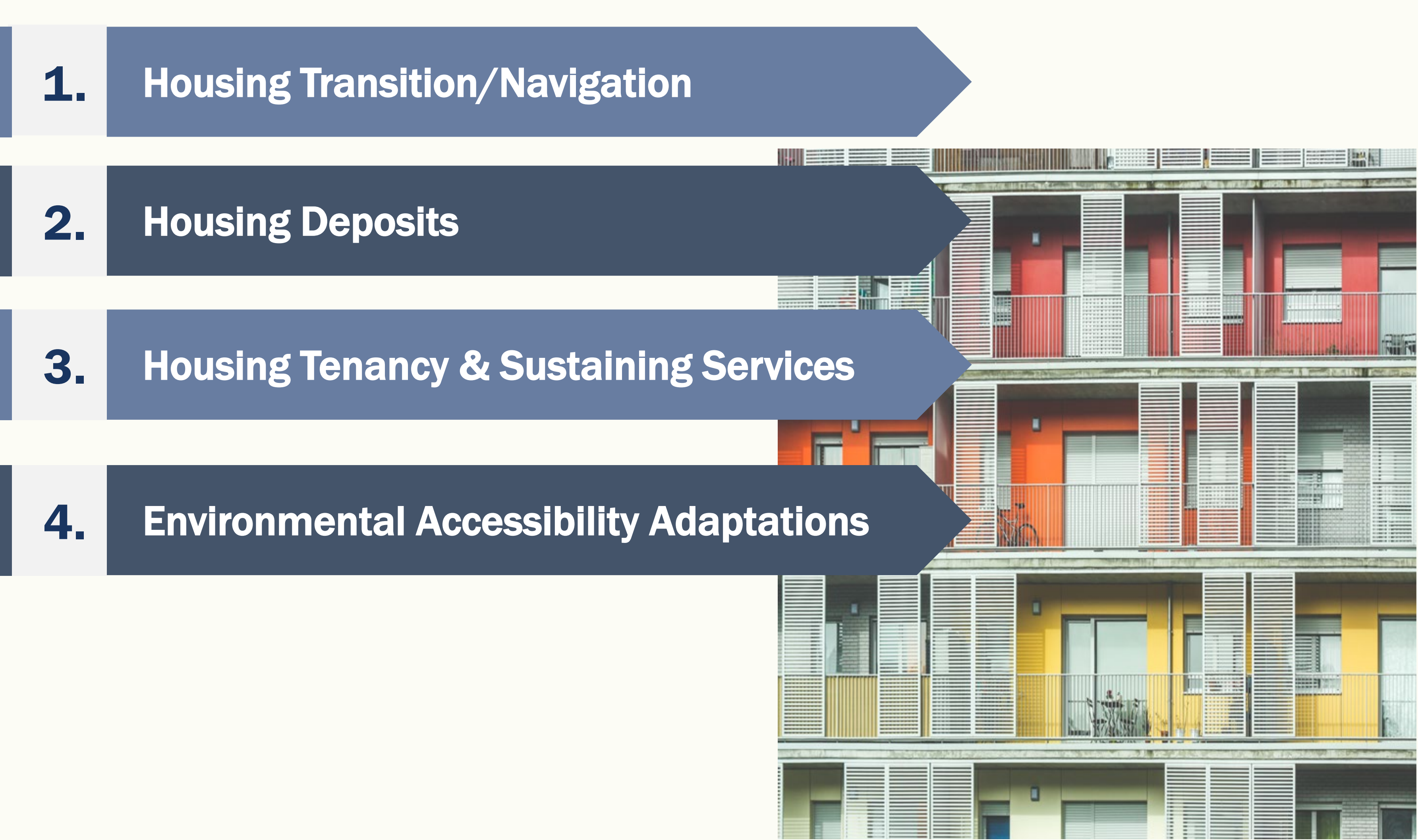
Which community supports program are you providing?

What is Community Supports and Why it Matters

Experience has shown that individuals often need additional supports such as housing, healthy food, respite in order to achieve health-related goals

That's what Community Supports is about - offering the opportunity to obtain those supports because they are medically necessary to improving health outcomes

Community Supports Overview: Housing



https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

Community Supports Overview: Services

1. Recuperative Care (Medical Respite)
2. Day Habilitation Programs
3. Personal Care and Homemaker Services
4. Respite Services for Caregivers

https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

Community Supports Overview: Transition Support

1. Short-Term Post-Hospitalization Housing
2. Nursing Facility Transition/Diversion to Assisted Living
3. Community Transition Services/Nursing Facility Transition to a Home

https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

Community Supports Overview: Other Services

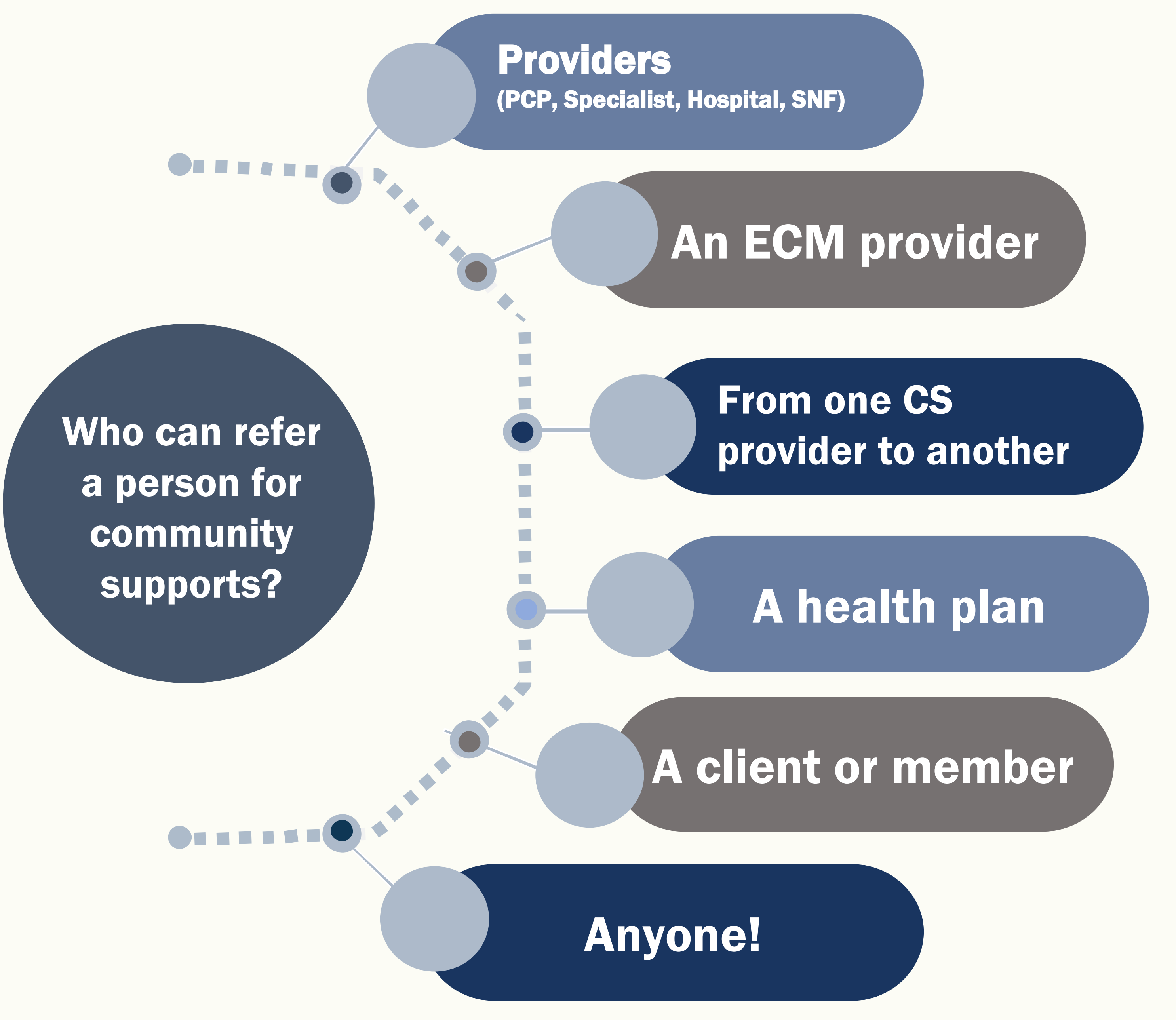
1. Medically Supportive/Medically Tailored Meals
2. Sobering Centers
3. Asthma Remediation

https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf

Community Supports available in L.A. by Health Plan

Community Support Service	L.A. Care	HealthNet
Housing Transition/Navigation*	✓	✓
Housing Deposits	✓	✓
Housing Tenancy & Sustaining Services*	✓	✓
Short-Term Post-Hospitalization Housing	**Launch TBD**	✓
Recuperative Care (Medical Respite)	✓	✓
Day Habilitation Programs	**N/A**	✓
Nursing Facility Transition/ Diversion	***Available in 2024***	✓
Community Transition Services/Nursing Facility Transition to a Home	***Available in 2024***	✓
Personal Care and Homemaker Services	✓	✓
Respite Services for Caregivers	✓	✓
Environmental Accessibility Adaptations	✓	✓
Medically Supportive Food/ Meals/ Medically Tailored Meals	✓	✓
Sobering Centers	✓	✓
Asthma Remediation	***Available in 2024***	✓

*Note: Housing Transition Navigation Services and Housing Tenancy and Sustaining Services are referred to as Homeless and Housing Support Services (HHSS) at L.A. Care


Who can refer a person for community supports?
Providers
(PCP, Specialist, Hospital, SNF)
An ECM provider
From one CS provider to another
A health plan
A client or member
Anyone!

Enhanced Care Management:
What and Why

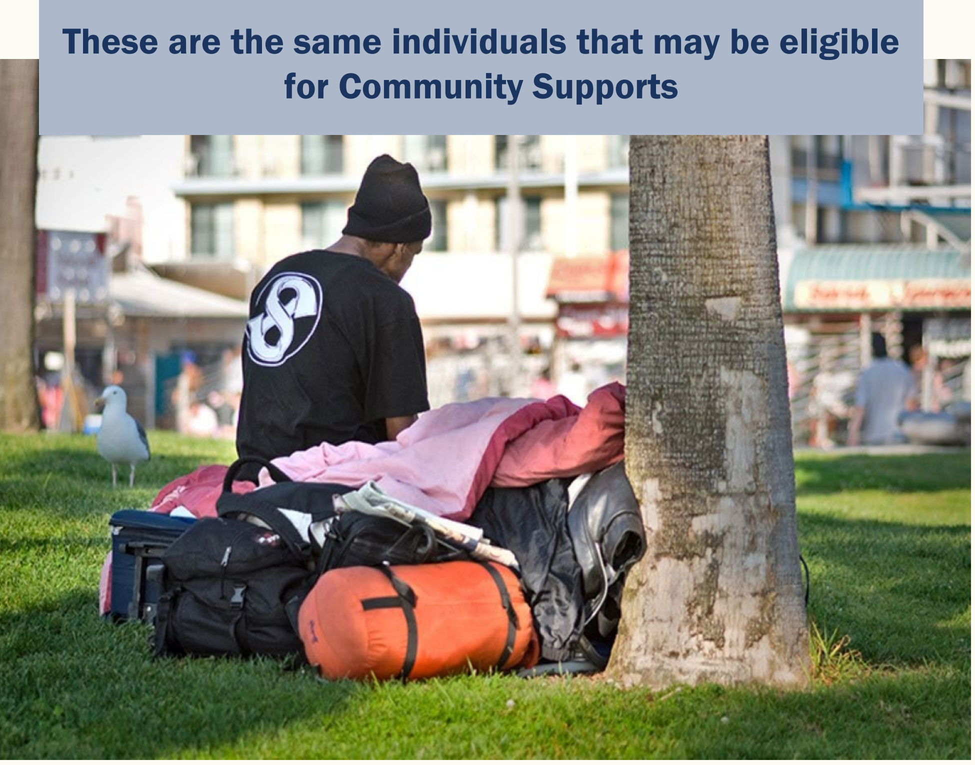
Enhanced Care Management

A higher level of care management and support for the "highest need" Medi-Cal members

Snapshot of the ECM Populations of Focus

1. Individuals and families experiencing **homelessness**
2. Individuals at risk for **avoidable hospital or emergency department utilization**
3. Individuals with **serious mental health and/or substance use disorder** needs
4. Adults living in the community and at risk for **long-term care institutionalization**
5. Individuals **transitioning from incarceration**
6. Children and youth enrolled in **California Children's Services (CCS)** with additional needs beyond the CCS condition
7. Children and youth involved in **child welfare**
8. Individuals with **intellectual or developmental disabilities (I/DD)**
9. **Pregnant and postpartum** individuals at risk for adverse perinatal outcomes

These are the same individuals that may be eligible for Community Supports



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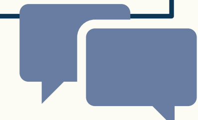
Overview of the 7 Core Services

1. Outreach and Engagement
2. Comprehensive Assessment and Care Management Plan
3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

Introducing Felix:

- 76-year-old Latino with diabetic complications (retinopathy, sensory neuropathy), depression
- Former kitchen worker who used to eat at work; now has food insecurity
- Losing his room in a house that he has lived in for several years
- Hospitalized related to his medical condition
- Ready to discharge from the hospital but still in need of medical support and likely ongoing support related to his conditions

What is the first thing that comes to mind in terms of a CS service for Felix?



Care Coordination & Referrals

Care Coordination Activities & Continuity of Care in CalAIM

Revisiting its importance

Continuity of Care

1. Client care is **coherent and linked**
2. There is **good information flow** between providers
3. There is **consistent coordination** of care

The Result

1. A **stronger relationship** [engagement] with the client
2. Contributes to client **safety**
3. Overall **better care** & outcomes

(https://www.rcgp.org.uk/clinical-and-research/our-programmes/innovation/continuity-of-care.aspx)
(https://www.healio.com/news/psychiatry/20191106/continuity-of-care-vital-for-patients-with-serious-mental-illness)

Coordinating & Referring to Other Services

Educate client on resources available

Identify when a client might need to be referred for other services

Knowing how to refer a client for services

Update

If applicable to your CS service, ensure the Client's Plan is **updated** to reflect the involvement of other providers/support services

Follow up to ensure and document the coordination of services with other providers/ support services

With the client, determine what services are missing – think about the services that **address specialty medical/BH & other SDOH** needs

Coordination of & Referral to Services

Determining what is Missing

1

Know what is available – specialty medical, BH, other community resources

2

Confirm with your client that they need and want this service

- *Make the warm handoff*

3

Follow up to ensure services were rendered, or not

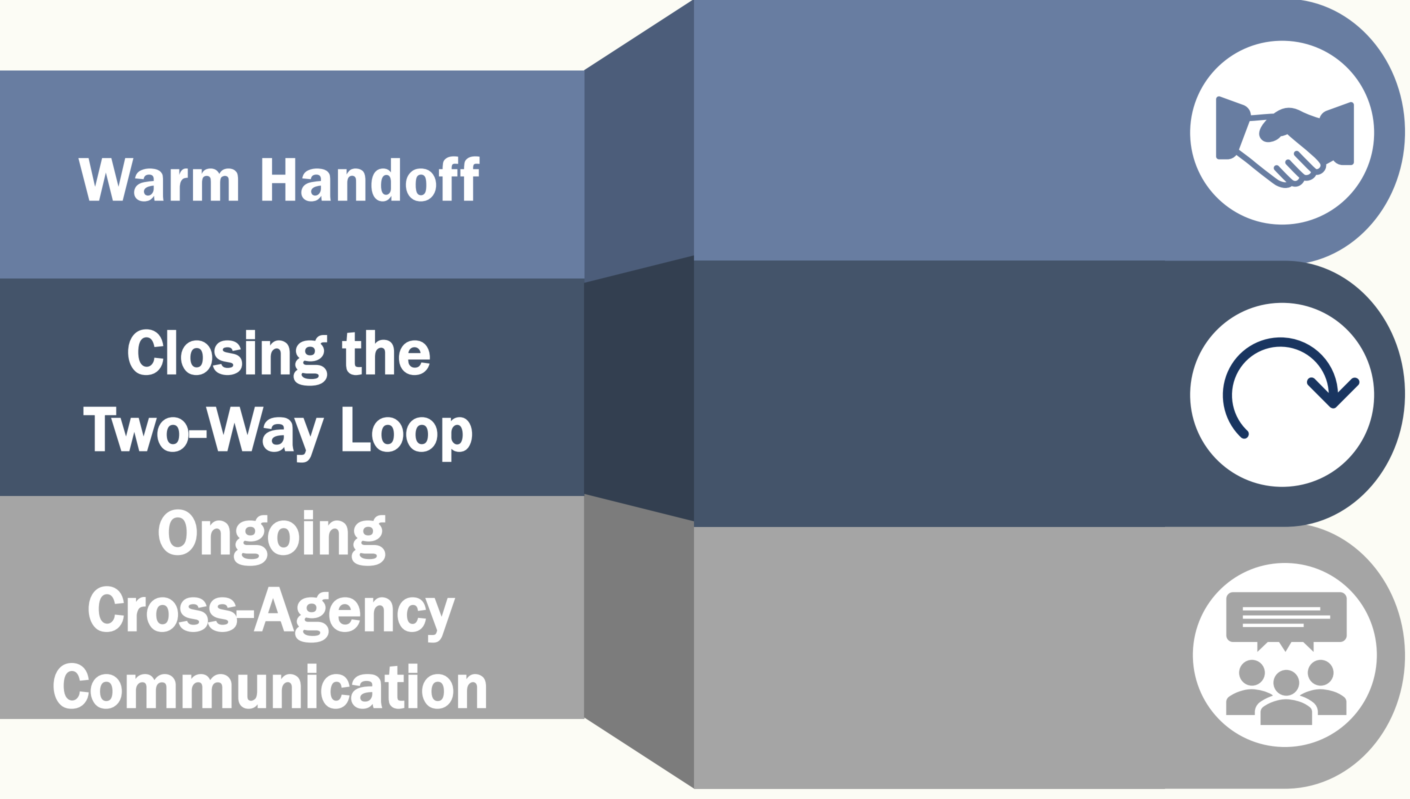
- *Close the loop*

Key component of this work – building & strengthening relationships with local programs

- ***Build & maintain a Community Resource Directory for your team's work***

Continuity of Care Workflows

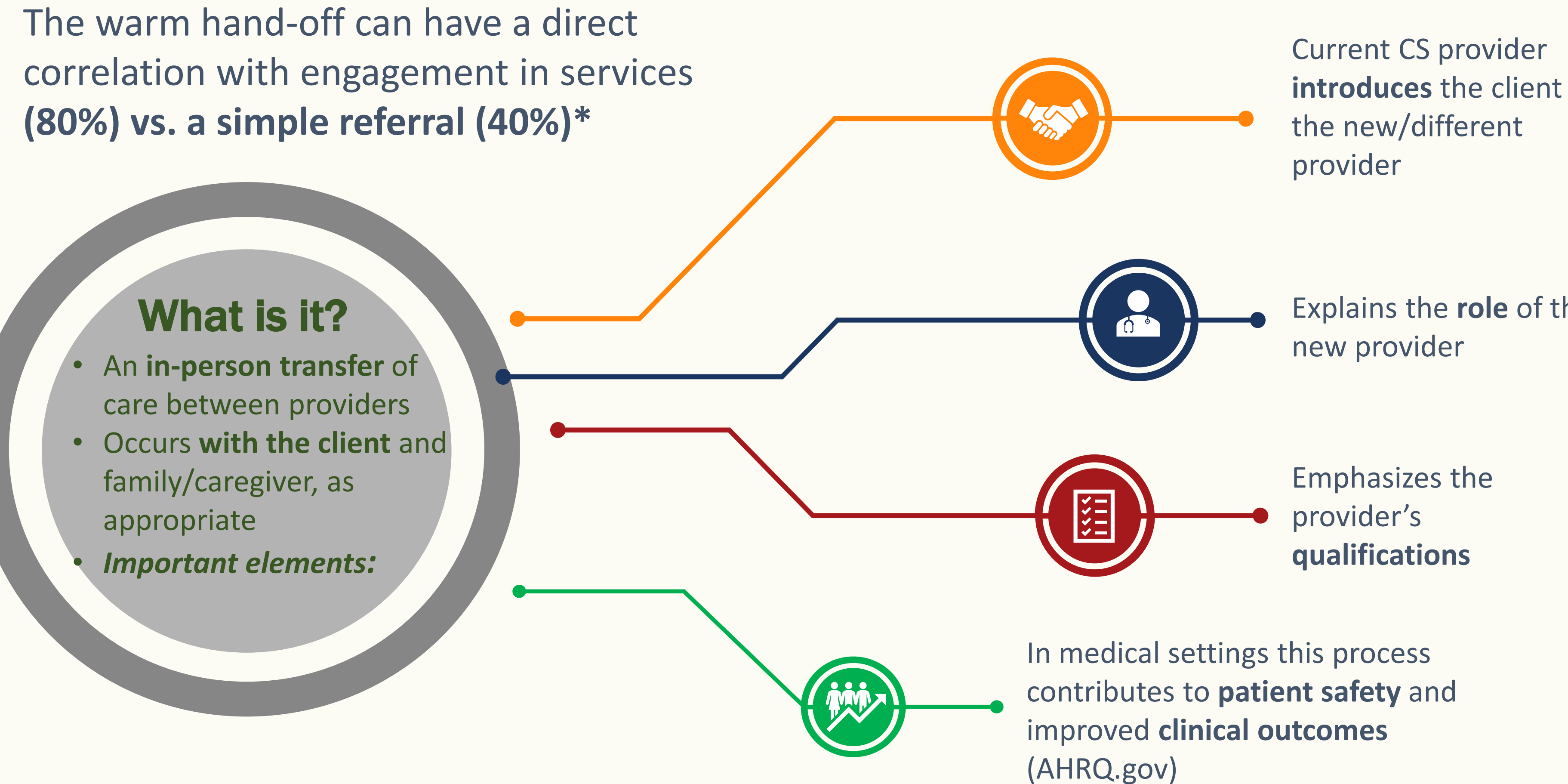
Referral Process



The Warm Hand-off

A key tool for engagement & continuity

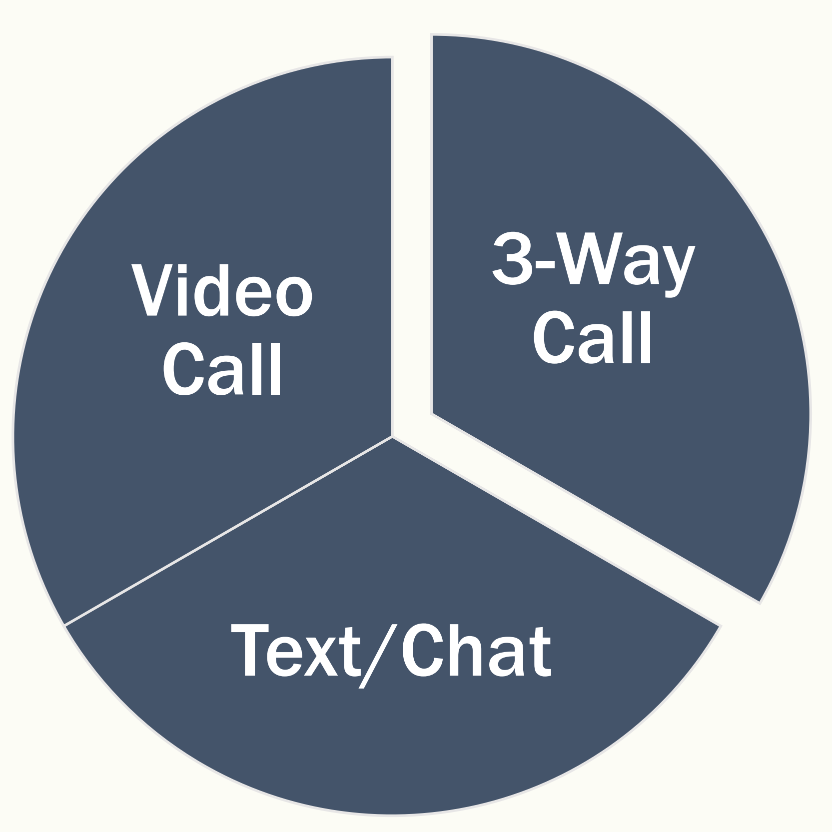
The warm hand-off can have a direct correlation with engagement in services **(80%) vs. a simple referral (40%)***



*Sierra Family Medical Clinic training; https://www.youtube.com/watch?v=umif1TDdKrM
https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/warm-handoff-qsg-brochure.pdf

The Virtual Warm Hand-Off

What does this look like?



What virtual approaches have worked best for you for the warm hand-off?

The Warm Hand-Off Checklist

Promoting Continuity of Care

Warm Handoff Check List	
Both providers and client are present (in the room or virtually)	✓
If previous provider recommends & if client consents, include the Family/Caregiver	✓
Current provider makes the introduction, and	✓
Summarizes the reason for meeting together	✓
Both providers talk about the CS, ECM or other program and answer the client's questions (having a flyer/brochure is helpful)	✓
Current provider talks about the work-to-date, highlighting successes & issues/concerns	✓
Ask the client for their input, preferences and goals	✓
Discuss with the client about the need for ongoing coordination (if continuing to work with both) and agree on coordination plan	✓
Gain Release of Information (ROI) for records and ongoing coordination	✓

Pending Clearance

What | Why

- **The easy flow of information from both parties:** the "two-way" loop
- **Closing the Referral Loop** involves:
  - **Documentation** of
    - the completed referral
    - confirmation of the appointment/visit/contact
    - notes of the contact & recommendations are accessible to involved parties
  - Be sure to document if the referral **is unsuccessful** (and address the barriers)

- Quicker **access to care, speedier assessment** which improves overall client **safety and outcomes**

[Sources: Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era](https://www.rmf.harvard.edu/About-CRICO/Media/Press-Releases/News/2017/November/IHInpsfReferralGrantPublication); *https://www.rmf.harvard.edu/About-CRICO/Media/Press-Releases/News/2017/November/IHInpsfReferralGrantPublication*

Supporting Communication when Coordinating Care

Gaining the Client's Consent

1 When to talk with your client about consenting to share information

- Prior to, or during the warm hand-off

2 How to talk with your client about consent to release information

- Explain the "why"
- Allows for a team of advocates to coordinate
- Less intrusive and duplicative – a more client-centered approach

3 Health Insurance Portability and Accountability Act (HIPAA)

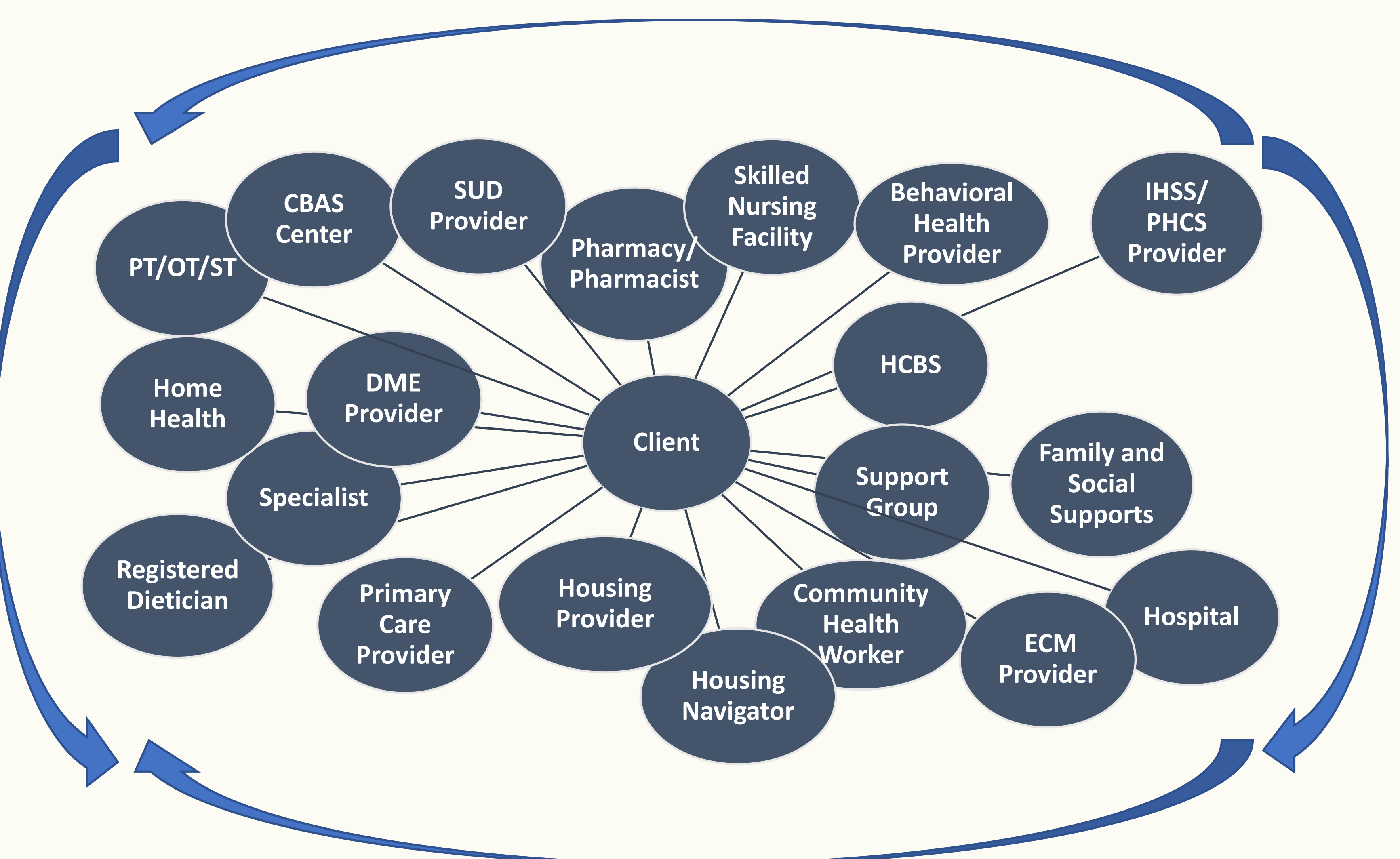
- Calling out the TPO clause (Treatment, Payment and Operations)
- Written authorization, consent or other form of release is not required for most TPO disclosures*

*https://www.hhs.gov/hipaa;

J.Moore; UNC School of Gov't 5/2018

Person-Centered Coordination of Care:

think about the broader support team
when connecting the dots for your clients



Poll + Chat

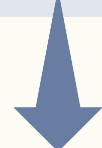
Connecting the Dots for Felix:

- 76-year-old Latino with diabetic complications (retinopathy, sensory neuropathy), untreated depression
- Former kitchen worker who used to eat at work; now has food insecurity
- Losing his room in a house that he has lived in for several years
- Hospitalized related to his medical condition
- Ready to discharge from the hospital but still in need of medical support and likely ongoing support related to his conditions

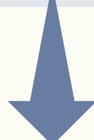
What are the CS & other services you might think of for Felix?

Connecting the Dots for Felix

Hospital Discharge

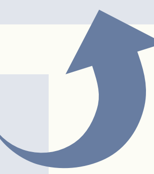


Short-Term Post-Hospitalization Housing (STPH)

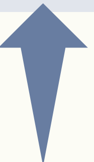


Recuperative Care

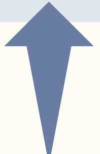
ECM



Medically-Tailored Meals



Personal Care and Homemaker Services (PCHS)



Day Habilitation

Connecting the Dots: Other Scenarios

Referral from an ECM Provider (Nursing facility transition to community)

- Community Transition Services/Nursing Facility Transition to a Home (CTS/NFT)
- Environmental Accessibility Adaptations (Home Modifications)

Referral from an FQHC/Medical Provider

- Asthma Remediation
- Respite Services

Referral from the Housing Navigation and Transition CS Provider

- **Housing Tenancy and Sustaining Services***

At At L.A. Care, Housing Transition Navigation Services and Housing Tenancy and Sustaining Services fall under one service known as Homeless and Housing Support Services (HHSS)

Connecting the Dots in L.A. County Coordination of Care -

Making & Managing Referrals

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Poll Question:

Who sends you most of your referrals?

1. Other CS providers
2. ECM Providers
3. Specialty Providers
4. Primary Care Providers/Clinics
5. Clients Self-Refer
6. Other sources – *chat in!*

*https://www.hhs.gov/hipaa;

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Poll Question:

What is your overall experience with receiving referrals?

1. **Positive -** the referral has all the info I need, and the referring provider is responsive to questions

2. **Mixed -** Some providers are responsive, and some are difficult to reach after receiving the referral

3. **Negative -** not enough information in the referral and/or the referring provider is difficult to reach/not responsive to follow-up questions

*https://www.hhs.gov/hipaa;

Poll Question:

What is your overall experience with making referrals?

1. **Positive -** I hear back quickly from both the Health Plan with their decision and once a provider is identified they reach out promptly

2. **Mixed -** Response time varies from the Health Plans depending on the type of referral and some providers do not reach out to confirm the loop is closed

3. **Negative -** Consistently delayed response as to confirmation of eligibility from the Plans and consistent lack of communication from the receiving providers

*https://www.hhs.gov/hipaa;

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The Referral Process in L.A. County

To Community Supports (CS):

Through the Health Plans:

- LA Care: www.lacare.org/providers/provider-resources/community-supports
- Health Net: Via Find Help portal https://healthnet.findhelp.com/
- *CS Providers may also assist with referrals*

To ECM:

Standardized Referral Form:

- Health Net: Via Find Help portal https://healthnet.findhelp.com/
- L.A. Care: Paper/E-Form process https://www.lacare.org/sites/default/files/pl1196-1198_la_mcp_ecm_referral_form_202112.pdf
- *The potential ECM Provider may assist with the referral*

The Referral Process in L.A. County

What are your challenges in referring your client to CS and ECM services in LA County?

Share some strategies in making successful referrals

What other sites do you go to for local resources?

- 211 - https://211la.org/
- One Degree – www.1degree.org

Q&A

What's Next

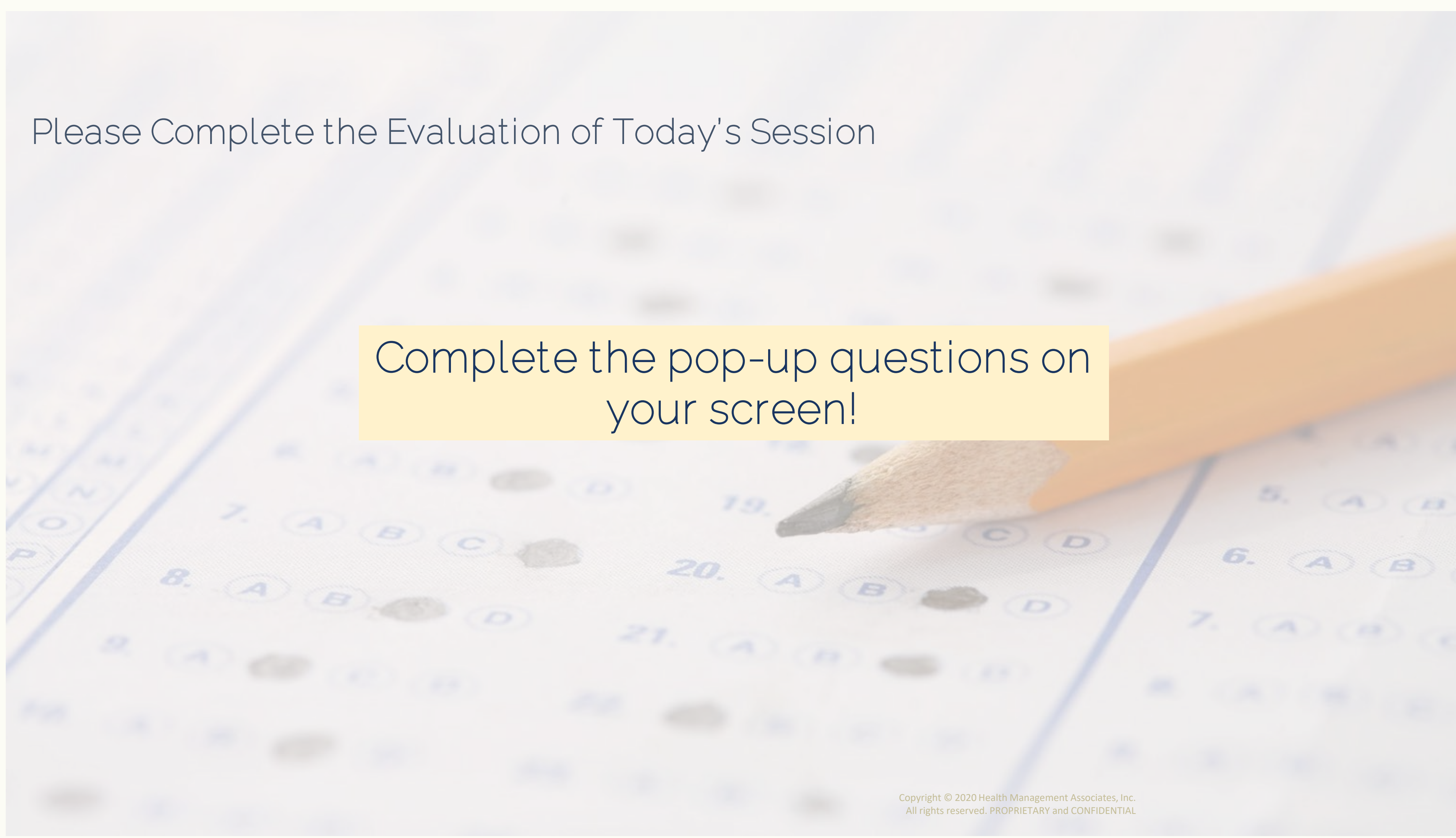
Monthly webinars to support you in your work to support clients to access the services they need including topics such as:

- Understanding Clients with Serious Mental Illness and Substance Use Disorders and how best to meet their needs.
- De-escalation strategies
- Providing culturally responsive care
- Strategies to work across systems
- Resource sharing

Please hold the **first Wednesday** of the month from **10 am–11 am**

Wednesday, May 3rd 10 AM – 11 AM

Before You Go...



Resources/Links

- CS Policy Guide: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf
- CalAIM for Providers: https://www.healthnet.com/content/healthnet/en_us/providers/support/calaim-resources.html
- CalAIM for Members: https://www.healthnet.com/content/healthnet/en_us/members/medi-cal/calaim-resources.html