# Connecting the Dots: How to Refer your Client to ECM and CS

March 12, 2024

# Health Plans We Support



# Agenda

- Welcome and Introductions
- Learning Objectives
- Overview of Enhanced Care Management (ECM) and Community Supports (CS) Services
- Understanding the Referral Pathway
- Case Interview – with Provider
- Breakout Rooms
- Wrap Up

# Welcome and Housekeeping

- This webinar is being recorded
- Attendance will be tracked via log-in
- Send a message to the host if you cannot hear or see the slides
- After the webinar you will get a link to the PowerPoint and recording
- Participants are automatically MUTED. Please communicate via the chat
- If we are unable to address your questions in today's webinar, we will address your questions in an upcoming forum

# Welcome and Introductions

# Introductions

**Nancy Wongvipat Kalev, MPH, Health Net**

**Senior Director, Systems of Care**

# Today's Presenter

**Flint Michels, RN, MBA, MHSA**
**Health Management Associates**

# Our Provider Speaker

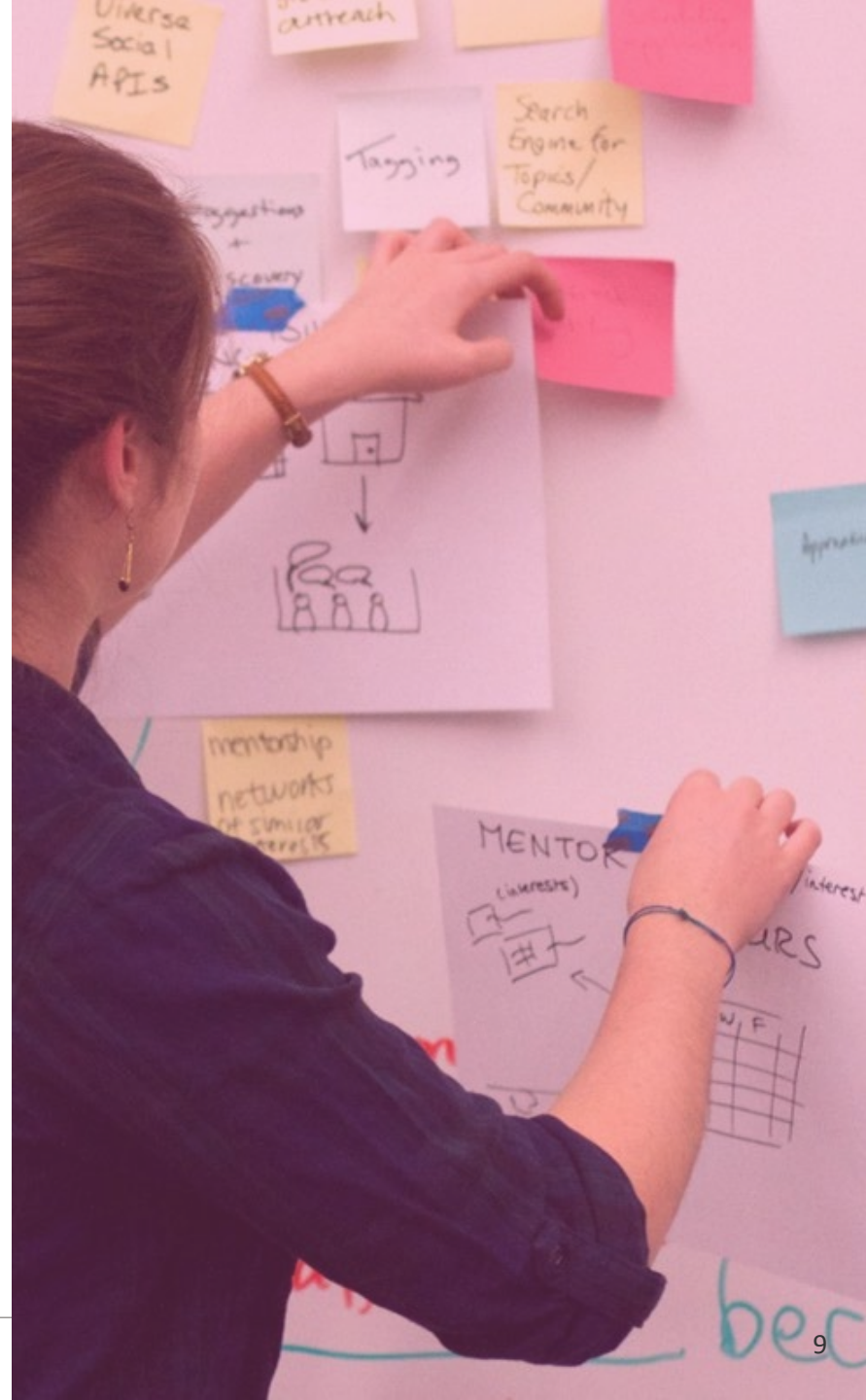
**Eric M. Rosen, PhD, LMFT**
**Director of Program Development**
**Kings View**

Please say hello in the chat with your role and organization!

# Learning Objectives

- Discuss the importance of referrals and understand the referral pathway.
- Describe the referral processes for a client going from ECM to CS services, and vice versa.
- Understand how to assess a client for referrals.
- Understand how to use FindHelp for referrals.

**Please answer the poll questions so we can get to know you!**



# *ALL Community Supports are Available Statewide*

| Community Support Service | Health Net |
|---|---|
| Housing Transition/Navigation | ✓ |
| Housing Deposits | ✓ |
| Housing Tenancy & Sustaining Services | ✓ |
| Short-Term Post-Hospitalization Housing | ✓ |
| Recuperative Care (Medical Respite) | ✓ |
| Day Habilitation Programs | ✓ |
| Nursing Facility Transition/ Diversion | ✓ |
| Community Transition Services/Nursing Facility Transition to a Home | ✓ |
| Personal Care and Homemaker Services | ✓ |
| Respite Services for Caregivers | ✓ |
| Environmental Accessibility Adaptations | ✓ |
| Medically Supportive Food/ Meals/ Medically Tailored Meals | ✓ |
| Sobering Centers | ✓ |
| Asthma Remediation | ✓ |

# *Why are referrals important for CalAIM?*

Ensuring clients receive the services they need to improve health outcomes and reduce costs

Prove the vital linkage between medical and social risks

Increase the collaboration between services to maximize the benefits to all

Reduce provider confusion about service models that overlap at times

MCPs are required to **partner with** primary care and other delivery systems to guarantee that members' needs are addressed.

**Define: "Closed Loop Referrals"**

# Closed Loop Referrals

**Beginning in 2025,** Medi-Cal Managed Care Plans (MCPs) will be required to close referral loops for their members made to/from health and community resources including:

- Enhanced Care Management and Community Supports providers;
- Community Health Workers (CHWs)
- California Children's Services (CCS)
- WIC providers
- County social service agencies
- Specialty mental health and substance use disorder services.

**Closed Loop Referrals** are defined as coordinating and referring the Plan member to available community resources and following up to ensure services were rendered.

# WHEN should a referral be made for an ECM or CS client

# What “flags” might indicate someone needs to be referred to ECM? (or at least assessed more)

| Indicators that demonstrate a person may be needing a referral to ECM: |
| --- |
| They are within one or more of the Populations of Focus (PoF) – see next slide |
| They are at-risk for needing a higher level of services (hospital, SNF, etc.) |
| Homeless individuals |
| They have significant Mental Health Disorders |
| They have significant Substance Use Disorders |
| |

**As a Community Supports Provider, how do you know if one of your clients has an assigned ECM provider?**

# *ECM Eligible Populations*

**Individuals Experiencing Homelessness**

- Adults Without Dependent Children/Youth Living With Them
- Unaccompanied Children/Youth Experiencing Homelessness

**Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly "High Utilizers")**

**Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs**

***Individuals Transitioning from Incarceration****

**Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization**

**Adult Nursing Facility Residents Transitioning to the Community**

**Children and Youth Enrolled in California Children's Services (CCS) with Additional Needs Beyond the CCS Condition**

**Children and Youth Involved in Child Welfare**

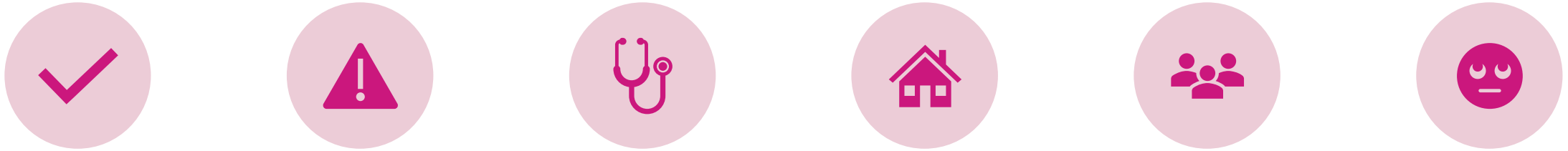
***Birth Equity Population of Focus****

***New POF as of January, 2024**

# What “flags” might indicate someone needs to be referred to a Community Support? (or at least assessed further)

| Indicators that demonstrate a person may be needing certain Community Supports services: (examples only) | POTENTIAL Community Support Referral(s) |
|---|---|
| Housing Instability or Homelessness; housing needs adaptations to meet members needs or based on their medical condition (Asthma). | **Housing Navigation**<br>**Asthma Remediation** |
| Needing to transition from one setting (hospital) to another (home) and may need assistance or diversion to another setting temporarily to ensure stability. | **NFTD or CTS** |
| Struggling to maintain independence in current housing – putting them at risk for ED visits or hospitalizations. | **Recuperative Care** |
| Lack of education or support for food/meals appropriate for their high-risk condition. Perhaps newly diagnosed with a new condition or struggling to manage the food related requirements for their meal planning. | **MTM** |
| Struggling with Activities of Daily Living, putting them at risk for hospitalization or ED visits. | **Respite or PCHS** |
| Caregiver burnout is evident or highly likely. | **Caregiver Respite** |

# WHEN is it a good time to evaluate someone's need for ECM and/or Community Supports?



ANY TRANSITION EVENT

ANY CHANGE IN CONDITION

ANY NEWLY DIAGNOSED CONDITION

ANY CHANGE IN HOUSING

ANY CHANGE IN SUPPORT STRUCTURE

ANY KNOWN HIGH-STRESS EVENTS

# ECM Assessment – Indicators for Coordination/Collaboration

**When completing the C/Y ECM Assessment:**

- Note if the Member is involved in other programs.
- If so, care team members (case manager, care coordinators, case workers, etc) should be noted in the Care Plan.
- Proactive and frequent communication should occur with these programs/members of the C/Y's care team.
- Also note if anyone else in the family is receiving ECM services, as collaboration may be indicated.

**Section 1. Indicate the C/Y member's Population of Focus and other Los Angeles County Programs the C/Y member is involved in.**

*The purpose of this section is to identify other programs the C/Y member is involved in; and support you to coordinate the C/Y member's care and health-related social needs.*

**Population of Focus for C/Y Member:** ☐Experiencing Homelessness ☐At-Risk for Avoidable Hospital/ED Utilization ☐SMI/SUD ☐Transitioning from Youth Correctional Facility ☐CCS/CCS WCM ☐Child Welfare ☐I/DD ☐Pregnant/Postpartum
*(As identified on the referral/authorization form)*

**Programs the C/Y Member is Involved in:** ☐SMHS ☐DMC ☐DMC-ODS ☐Juvenile Justice ☐CCS ☐CCS WCM ☐Child Welfare ☐Regional Center Services
☐Local program serving pregnant/postpartum individuals (e.g., Comprehensive Perinatal Services Program [CPSP], California Home Visiting Program [HVP], etc.) (List):
☐Other(s), List:
☐N/A

**Date of Consent for Opt-in to ECM services:** _____ ☐Verbal ☐Written
☐C/Y Member ☐Parent/Guardian/Caregiver ☐DCFS ☐Court ☐Foster parent(s)

**Is anyone else in the family enrolled in ECM?** ☐Yes ☐No
If yes, list family member name(s), relationship(s) to C/Y member, and ECM Provider(s):

# ECM Assessment – Indicators for Coordination with Others

**When completing the C/Y ECM Assessment:**

- If applicable, leverage available assessments.
- This is another opportunity to identify potential partners/entities for collaboration and communication.

**Indicate if you used any of the following, recently completed assessments or tools to complete/inform this assessment.**

*The Lead Care Manager should incorporate findings from all available assessments. Assessments do not replace this comprehensive assessment but should inform development of the care plan.*

☐ ACEs or PEARLS ☐ Yes. Date Completed:_____ ☐ No ☐ N/A

*If no ACEs or PEARLS screening completed: refer to PCP/SW for screening.*

☐ CANS Assessment[1] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ PSC-35[2] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ Needs Evaluation Tool[3] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ Youth Screening Tool[4] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (DPH Foster Care) Child Health Evaluation ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ Protective Factors Survey[5] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (DCFS) Multidisciplinary Assessment Team[6] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (CCS) Patient Care Assessment ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (DDS) Regional Center Assessment ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (Pregnant/Postpartum) CPSP Assessment ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (Justice Involved) Re-entry Transition Plan ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ Other(s) (list with date completed):

_____

[1] The Child and Adolescent Needs and Strengths Assessment is used by DCFS/Child Welfare and by SMHS/DMH
[2] The Pediatric Symptom Checklist is used by SMHS/DMH
[3] The Needs Evaluation Tool is used by DMH
[4] The Youth Screening Tool is used for Medi-Cal Mental Health Services, DHCS
[5] The PFS is used by the Prevention and Aftercare Network, DCFS
[6] The Multidisciplinary Assessment Team includes their level of care tool and the Resource Family Reporting Tool, used by DMH for a child newly entering the foster care system

# ECM Assessment – Possible Indicators for CS Referrals and/or Coordination needs

When completing the C/Y ECM Assessment:

- **Be on the look out for opportunities to connect to Community Supports Services.**

Asthma Remediation needed?

Day Habilitation needed?

Housing Supports needed?

## Section 4. Physical Health

Has the C/Y member (or their parent/guardian/caregiver, if applicable) been told by a doctor or medical provider that they have any medical conditions? ☐Yes ☐No
If yes, please check all that apply:
☐Asthma/Chronic Lung Disease ☐Cancer ☐Cerebral Palsy ☐Cleft Lip/Palate ☐Congenital heart defect
☐Cystic Fibrosis ☐Pre-Diabetes ☐Diabetes Type 1 ☐Diabetes Type 2
☐HIV/AIDS ☐Hypertension *(high blood pressure)* ☐Kidney disease ☐Muscular Dystrophy
☐Physical disability/para/quadriplegic/amputation ☐Seizures/Epilepsy ☐Sickle Cell Disease
☐Spina Bifida ☐Organ Transplant (list): _____ ☐Genetic condition(s) (list):_____
☐Other conditions not listed above (list):

Has the C/Y member been to the hospital, emergency room, or a skilled nursing facility in the past 12 months?
☐Yes ☐No ☐N/A ☐Declined to Answer
If yes, how many times and what for? (list all):

## Section 10. Social Determinants of Health (SDoH)

**Housing**

Where does the C/Y member live? (check all that apply)
☐ House ☐ Apartment complex ☐ Board and care facility ☐ Residential treatment center ☐ Group Home
☐ Skilled Nursing Facility ☐ Permanent Supported Housing ☐ Protective housing ☐ Shared housing (i.e. couch surfing if loss of housing) ☐ Motel/Hotel ☐ Trailor Park ☐ Campground ☐ Emergency or Transitional Shelter ☐ Hospitalized with no safe discharge plan ☐ Homeless ☐ Other:
☐ Decline to Answer

# ECM Assessment – Possible Indicators for CS Referrals/Coordination

When completing the C/Y ECM Assessment:

- Example: Asthma remediation perhaps?

1. Member has asthma

2. You discover they have been to the emergency room twice this month.

3. You find that they have some potential environmental triggers.

**Section 4. Physical Health**

Has the C/Y member (or their parent/guardian/caregiver, if applicable) been told by a doctor or medical provider that they have any medical conditions? ☐Yes ☐No
If yes, please check all that apply:
☐Asthma/Chronic Lung Disease ☐Cancer ☐Cerebral Palsy ☐Cleft Lip/Palate ☐Congenital heart defect
☐Cystic Fibrosis ☐Pre-Diabetes ☐Diabetes Type 1 ☐Diabetes Type 2
☐HIV/AIDS ☐Hypertension *(high blood pressure)* ☐Kidney disease ☐Muscular Dystrophy
☐Physical disability/para/quadriplegic/amputation ☐Seizures/Epilepsy ☐Sickle Cell Disease
☐Spina Bifida ☐Organ Transplant (list): _____ ☐Genetic condition(s) (list):_____
☐Other conditions not listed above (list):

Has the C/Y member been to the hospital, emergency room, or a skilled nursing facility in the past 12 months?
☐Yes ☐No ☐N/A ☐Declined to Answer
If yes, how many times and what for? (list all):

**Section 10. Social Determinants of Health (SDoH)**

| Does the place where the C/Y member live have: | | |
|---|---|---|
| Good lighting: ☐ Yes ☐ No | Good heating: ☐ Yes ☐ No | Good cooling: ☐ Yes ☐ No |
| Rails for any stairs/ramps: ☐ Yes ☐ No | Hot water: ☐ Yes ☐ No | Indoor toilet: ☐ Yes ☐No |
| A door to the outside that locks: ☐ Yes ☐ No | Stairs to get into their home or stairs inside their home: ☐Yes ☐No | Elevator: ☐ Yes ☐ No |
| Space to use a wheelchair: ☐ Yes ☐ No | Clear ways to exit their home: ☐ Yes ☐ No | Lead paint: ☐ Yes ☐ No |
| Mold/mildew/dampness: ☐ Yes ☐ No | Overcrowding: ☐ Yes ☐ No | Unreliable utilities: ☐ Yes ☐ No |
| Mice, cockroaches, or other pests: ☐ Yes ☐ No | Additional housing and/or home environment safety concerns? ☐ Yes ☐ No ☐ Decline to Answer If yes, please explain: | |

# What does the Referral Pathway look like?

**Member**

Informs member of POTENTIAL CS support eligibility

Member consent

**CS Provider**

findhelp

Referral

CS provider reconfirms eligibility via health plans provider portal (HN or CVH)

Provider Order, if needed

**ECM Provider**

ECM Assessment or during course of ECM services, CS Service connection indicated

Reviews auth guide to determine possible eligibility

ECM provider supports member to acquire provider order

ECM provider submits provider order and referral via find help to CS Provider

findhelp

- findhelp – Health Net
- findhelp – CalViva Health

health net

CalViva HEALTH

Community Health Plan OF IMPERIAL VALLEY

# Recuperative Care Expedited Referral Process

*Members who are in need of recuperative care are granted presumptive eligibility and can be admitted directly to a recuperative care facility from the hospital.*

| Step 1 | Step 2 | Step 3 |
|---|---|---|
| Confirm member eligibility for the Plan in the provider portal. | Contact the recuperative care provider directly. Use the Provider Directory if needed | Transfer the member to recuperative care facility. **No authorization is required prior to transfer**. Notify the concurrent review nurse of the transfer to approve the authorization. |

# How do you find an entity to refer to?

# Time for polls – What do you use to find local providers?

**How do you refer for ECM and/or CS now?**

- **Provider Portal**
- **Fax**
- **Call in**
- **FindHelp**

**Have you used FindHelp? Yes or no?**

***Comment on: What would be helpful to reduce barriers to referrals?***

*More information*

*More access*

*Or do poll with open narrative comments*

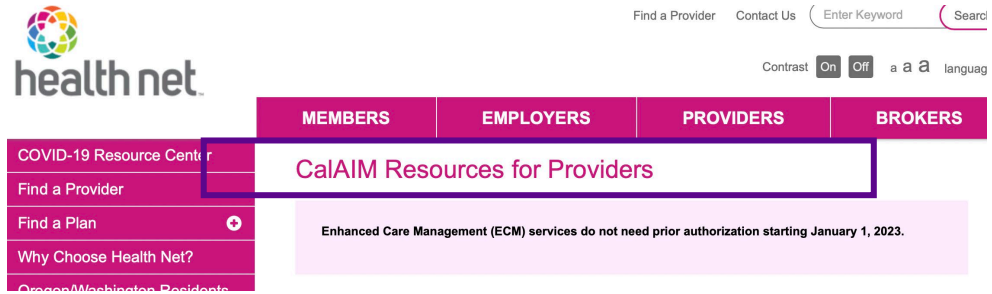
# Provider Directories

**Provider directories can be found at these links:**

1. **Health Net: Provider Directories for Medi-Cal Members | Health Net**
2. **CalViva Health: Provider Directory (calvivahealth.org)**
3. **Community Health Plan of Imperial Valley: Find a Provider - Community Health Plan of Imperial County (chpiv.org)**

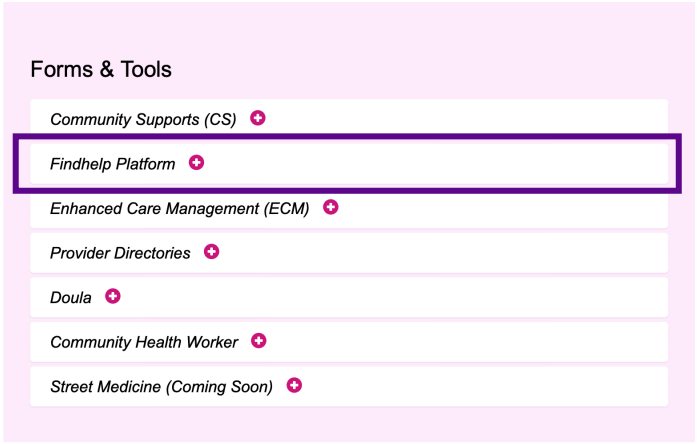
# Using Findhelp

1.

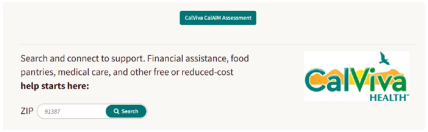



Start from the **CalAIM Resources for Providers landing page**.

2.

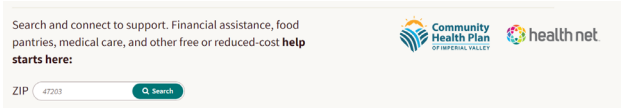



Then, scroll down to the Forms & Tools box and click on **"Findhelp Platform"**




CalViva Community Supports by findhelp - Search and Connect to Social Care

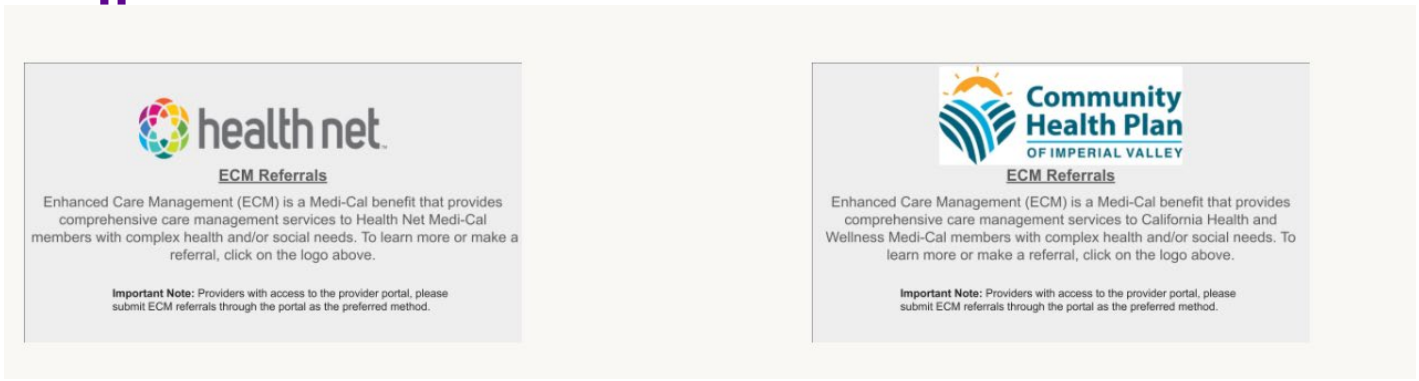
3. You should now be at the **Findhelp landing page**




Community Supports by findhelp - Search and Connect to Social Care

# Using Findhelp (cont.)

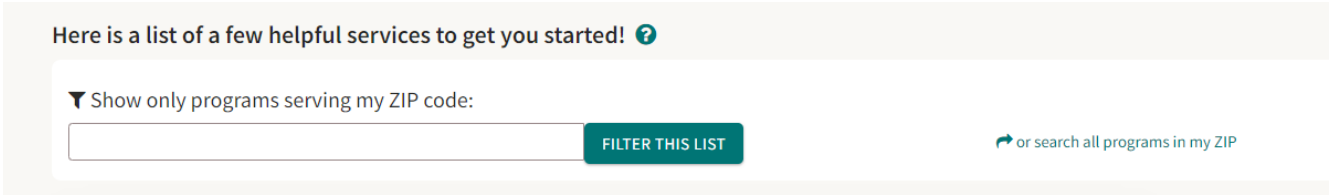
4. Then, scroll down to these boxes and click on either, **based on who you are contracted with.**




- [CalViva Community Supports by findhelp - Search and Connect to Social Care]


[Community Supports by findhelp - Search and Connect to Social Care]

5.




You should now be at this page, where you can **enter your zip code to look for services near you.**

# Warm Handoffs

# What is a **warm handoff?**

*Definition*: a **transfer and acceptance** of patient care responsibility achieved through **effective communication**. It is a real-time process of passing patient-specific information **from one caregiver to another** or **from one team of caregivers to another** for the purpose of ensuring the continuity and safety of the patient's care.

sea_8_steps_hand_off_infographic_2018pdf.pdf (jointcommission.org)
Warm Handoff: Intervention | Agency for Healthcare Research and Quality (ahrq.gov)
The impact of warm handoffs on patient engagement with behavioral health services in primary care. (apa.org)

# Steps to Ensure a Warm Handoff

1. Standardize forms and communication model to share information
2. Do not rely on verbal communication only
3. Determine the breadth and depth of information to be shared
4. Combine multiple data sources as appropriate
5. Make sure critical information is highlighted
6. Conduct hand-off in person, verbally, via teleconference – and ensure time is sufficient for questions
7. Include as many care team members as possible, as well as the patient and family
8. Use portals and other platforms to augment and support communication but do not rely on these platforms as sole communication pathway

sea_8_steps_hand_off_infographic_2018pdf.pdf (jointcommission.org)
Warm Handoff: Intervention | Agency for Healthcare Research and Quality (ahrq.gov)
The impact of warm handoffs on patient engagement with behavioral health services in primary care. (apa.org)

# Provider Spotlight

**Eric M. Rosen, PhD, LMFT**
**Director of Program Development**
**Kings View**
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www.kingsview.org

# Interview with a Provider – Questions

1. Tell us briefly a bit about Kings View – do you provide ECM and some CS's? If so, when did you start and what geographic area(s) do you support?
2. Are you seeing many "**organic referrals**"? How are you connecting with CalAIM and non-CalAIM providers?
3. How do you **identify** when it is appropriate to refer your clients to other entities?
4. What **tool(s)** do you use to find providers to refer to when needed?
5. What is an **example** of a "supportive warm handoff" / referral from an entity to Kings View for ECM and/or CS services?
6. What are some of the **barriers** to effective referrals to and from different entities?
7. What **advice** do you have for others regarding cross collaboration and communication?

# Breakout Rooms

# Placeholder- Questions for Breakout

**Notes only:**
**Each person chooses a room "live" - they pick a room.**

**3 rooms plus main room moderator – Regional model: 1) SoCal; 2) NorCal; and 3) CentralCA**

**Elvia, Aashna, Flint, MaryEllen, Liz, Serene available to support – two mods per room plus main room.**

**Regional reps plan to be in each room – need to align breakout rooms with their breakouts.**

**Each participant: (10 min for introduction)**

1. **Introduce yourself: Name, title, Name of organization you represent (put in chat – people can then copy for themselves and we can collect and distribute collectively) but still encourage use of findhelp and/or provider directory!!!**

**(put in chat and HMA will collect and collate for all)**

1. **Are you CS, ECM provider, or other (describe) and if CS, which CS(s)**
2. **What city/region do you primarily provide services – "community of focus"**
3. **Any specific populations you focus on, if applicable.**

**After all have discussed the above, pick one or more of the following to discuss as a group: (script and timing to be developed)**

1. **What is best way for you to receive a referral and why?**
2. **What works well or doesn't work well for referrals in your organization?**
3. **Where do you look to find a CS or ECM provider when needed and why?**

**All go back to main room for close out / next steps**

# Medi-Cal – 2024 Footprint

## Health Net

- Amador
- Calaveras
- Inyo
- Los Angeles*
- Mono
- Sacramento
- San Joaquin
- Stanislaus
- Tulare
- Tuolumne

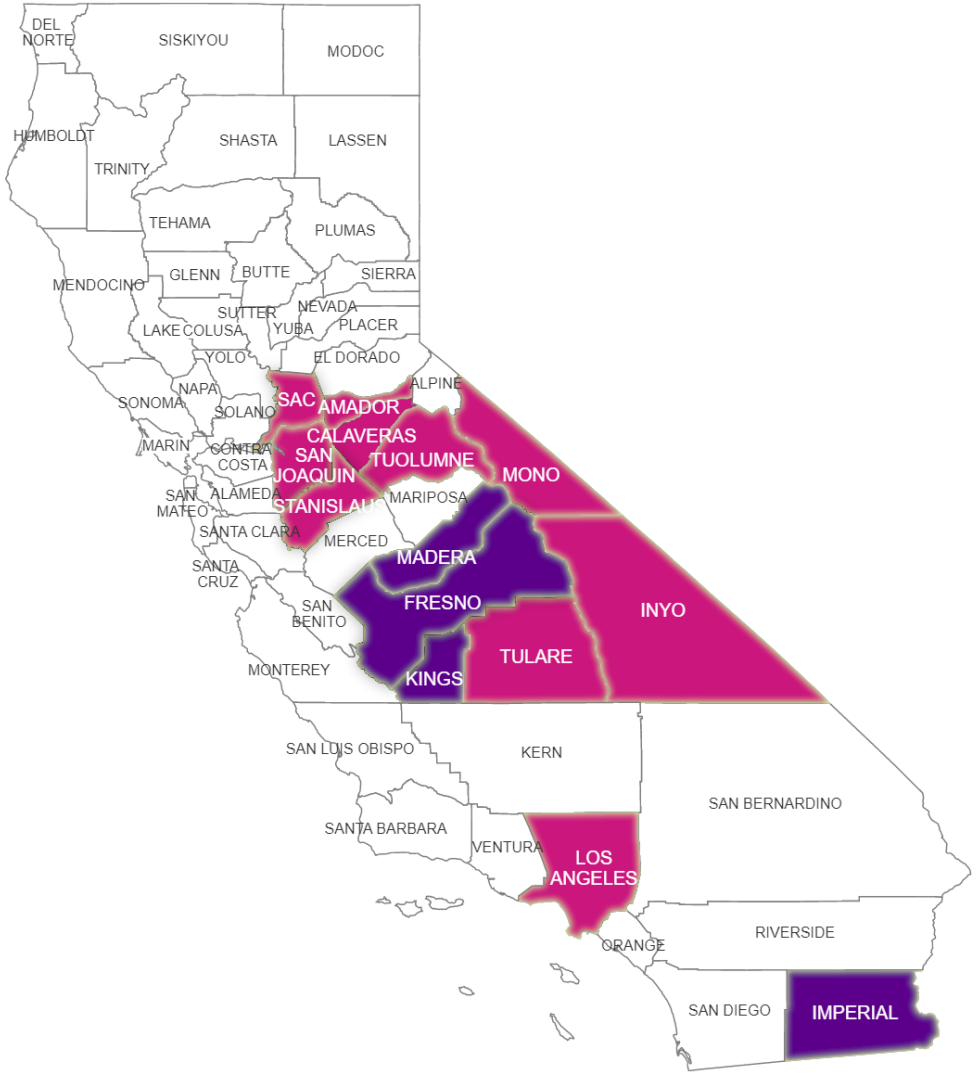
## CalViva Health

- Fresno
- Kings
- Madera

## Community Health Plan of Imperial Valley (CHPIV)

- Imperial

# Medi-Cal – 2024 Footprint




Health Net Community Solutions
*Direct Contract with DHCS*

Local County Partners
*Subcontractor to local plan*

# Welcome back!

**Quick Chatterfall feedback – What did you think about the breakout room concept?**

**1 = not helpful**

**5 = Somewhat helpful**

**10 = very helpful!**

# Questions?

*if time allows*

# *THANK YOU!!!!*
# *Before You Go…*

**Please Complete the Evaluation of Today's Session**

**Once the webinar has concluded, the survey will pop-up in a separate browser.**

# Glossary of Terms

- CS – Community Supports
- DC - Discharge
- EAA – Environmental Accessibility Adaptions
- ECM – Enhanced Care Management
- HHSS – Housing Support Services
- MCP – Managed Care Plan (Health Plan)
- PCP – Primary Care Provider
- STPHH – Short Term Post-Hospitalization Housing