
# Welcome to the Spring CBO Convening

ACEs LA

screen. treat. heal.

**APRIL 24, 2024**

Health Services
LOS ANGELES COUNTY

# AGENDA

- Introduction: Teresa Ward
  Antelope Valley Partners for Health
- Speaker: Charmaine Dorsey, LCSW
  BHI
- Breakout Rooms:
  NoC Partner Meet & Greet
- Closing Remarks: Lisa Gantz, MD
  High Dessert Regional Center

# CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM): WHAT DOES IT MEAN FOR DHS AND BEYOND?


- Charmaine Dorsey, MSW, LCSW
- Director, Patient and Social Support Services
- Health services, Los Angeles County

# OBJECTIVES

1) Provide an overview of DHS Population Health Management

2) Provide an overview of CalAim

3) Current DHS initiatives related to CalAim

# OVERVIEW OF DHS POPULATION HEALTH MANAGEMENT

# DEFINITION

- Process of improving clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models.

  – American Hospital Association

- Proactively helping people stay well by identifying illnesses before they worsen and anticipating member needs before they increase.

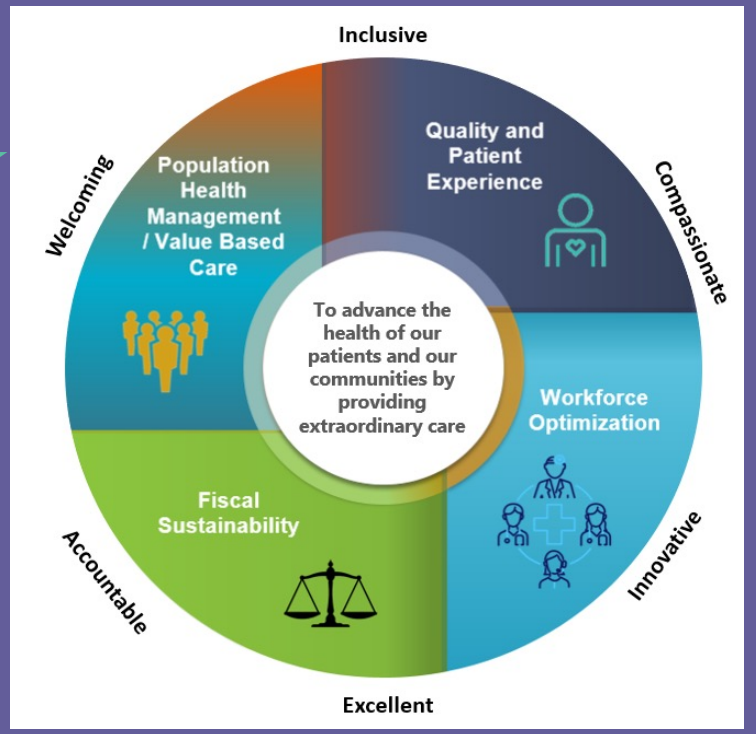
  – CA Dept of Health Care Services

# Population Health Management/ Value Based Care

**Goal:** Transform our system and services to provide cost-effective care of the whole patient across the continuum.

**Objectives:**

1. Increase the amount of time a patient is cared for in the right setting.
2. Increase the breadth of services available across the continuum.
3. Improve access to data and information to guide and monitor health outcomes and cost.
4. Increase the provision of tailored interactions for specific needs.



# POPULATION HEALTH MANAGEMENT PROGRAMS

- Comprehensive Primary Care and Preventive Services
- Care Management/Disease Management Services
- Health Education Services
- Social Support Services
- Non-specialty Mental Health Services

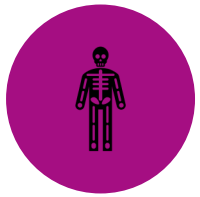
# DEPARTMENT OF HEALTH SERVICES PRIMARY CARE SERVICES

Serves over 550,000 empaneled patients in primary care clinics

Over 400,000 outpatient primary care visits

Around 75% of patients covered by Medi-Cal

# CURRENT PATIENT POPULATION



14% patients are stratified as high-risk, complex/high utilizers

16% patients have hypertension

14% patients have diabetes

5.5% patients have substance use disorder diagnoses

2.9% patients have depression

Majority of patients have one or more social determinants of health needs

# CARE MANAGEMENT

## Basic Population Health Management

- PCMH engagement and care coordination
- Behavioral Health Integration
- Social Services
- Chronic Disease Risk Reduction Programs
- Health Education and Promotion

## Care Management

- Complex Care Management (non-ECM eligible)
- CalAIM Enhanced Care Management
- MCP managed Complex Case Management

## Transitions of Care

- Discharge planning prior to discharge
- PCMH follow-up after discharge
- DHS CCM/ECM care manager follow-up
- MCP managed services

# ENHANCED CARE MANAGEMENT

- Commenced in January 2022 (transition of Health Homes)
- Part of the State CalAIM Initiative
- Core Services:
  - Outreach and Engagement, Comprehensive Assessment & Care Management, Enhanced Coordination of Care, Health Promotion, Comprehensive Transitional Care, Patient and Family Supports, Coordination and Referrals to Community and Social Support Services

# OVERVIEW OF CALAIM

# ENHANCED CARE MANAGEMENT AND COMMUNITY SUPPORTS

ECM: Whole-Person, Interdisciplinary approach

- Addresses clinical and non-clinical needs with most complex and medical and social needs
- Systematic coordination of services
- Comprehensive Care Management
- Community Based
- High Touch and PersonCentered

Community Supports:

- Housing Support
- Medically Tailored Meals
- Asthma Remediation
- Nursing Facility Transition
- Respite Care

(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; and

(7) Coordination of and Referral to Community and Social Support Services. Notably, the nuances of supports and services provided through ECM will vary based on the needs of the Member.

1) DHCS’ vision for ECM is to coordinate all care for Members who receive it, including across the physical and behavioral health delivery systems.

2) Replaces/incorporates concepts Whole Person care and health homes

3) Populations of Focus: Individuals and families experiencing homelessness, Adult high utilizers, Adult smi/sud, individuals transitioning from incarceration, Individuals at Risk for Institutionalization and Eligible for Long-Term Care Services, Nursing Facility Residents Who Want to Transition to the Community, Pediatrics, Birth Equity

# CURRENT DHS INITIATIVES RELATED TO CALAIM

# ENHANCED CARE MANAGEMENT AND COMMUNITY SUPPORTS

**Led and Facilitated by Managed Care Plans (DHS 3-Plan model)**

LA Care

Healthnet

Molina

**ECM within Primary Care Clinics**

**Community Supports via Health Plan and Housing For Health**

# HOW ARE CBO'S INTEGRATED INTO CALAIM?

- The Role of Community-Based Organization Networks in CalAIM: Seven Key Considerations (milbank.org)
- CBO's provide a unique opportunity to partner and leverage connection, expertise and needs of the community
- CBO can negotiate contracts with MCP's (medical plans)
- Non-Clinical Services
- Adhere to privacy and reporting requirements

# TIME FOR CURIOSITY & REFLECTION

# THANK YOU!


- Charmaine Dorsey, MSW, LCSW
- 213-288-9142
- cdorsey@dhs.lacounty.gov
- www.dhs.Lacounty.gov

ACEs LA

screen. treat. heal.

# BREAKOUT SESSION 30 Minutes

# Closing Thoughts

**CalAIM and its importance:**

- Addresses clinical and non-clinical needs with most complex and medical and social needs, through systematic coordination of services in the following categories:
  - Housing Support
  - Medically Tailored Meals
  - Asthma Remediation
  - Nursing Facility Transition
  - Respite Care
- CBO’s provide a unique opportunity to partner and leverage connection, expertise and needs of the community

# Closing Thoughts

**The importance of sharing space between community providers and clinical providers:**

- Building partnerships and understanding our medical neighborhood enhances our role as patient advocates, leading to healthier communities. By collaborating across service sectors, we provide more holistic care and address non-medical issues impacting health.
- The CLR has been instrumental in connecting our clinic with local CBOs, encouraging staff to use One Degree, and improving our referral processes.

# Thank you for attending

# Thank you for attending

Harbor-UCLA Medical Center

Ambulatory Care Network
HEALTH SERVICES • LOS ANGELES COUNTY
*Quality • Compassion • Responsibility*

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER

Los Angeles General Medical Center

Olive View-UCLA MEDICAL CENTER

MEDICAL FINANCIAL PARTNERSHIP

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

one degree

Health Services
LOS ANGELES COUNTY