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

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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.

DEPARTMENT OF HEALTH SERVICES PRIMARY CARE SERVICES
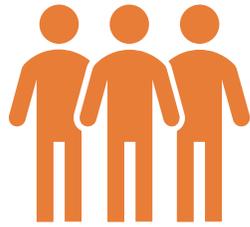
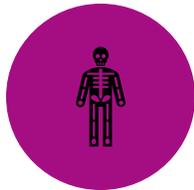Serves over 550,000 empaneled patients in primary care clinics

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

Health Services
LOS ANGELES COUNTY

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

CARE MANAGEMENT

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

ECM: Whole-Person, Interdisciplinary approach

Community Supports:

- 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

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

ENHANCED CARE MANAGEMENT AND COMMUNITY SUPPORTS

(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

- 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

HOW ARE CBO'S INTEGRATED INTO CALAIM?

TIME FOR CURIOSITY & REFLECTION

THANK YOU!

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