CalAIM Population Health Management (PHM) All-Comer Webinar: Emerging Practices on the Implementation of Transitional Care Services

January 19, 2023: 2:30-4 pm PT

DHCS

Agenda

Welcome and DHCS Notice	5 min
Reminder: CalAIM Population Health Management (PHM) Program Requirements on Transitional Care Services	5 min
CDII's Data Sharing Guidance	5 min
Brief Overview of Emerging Practices	20 min
Panel Discussion: Emerging Practices on the Implementation of Transitional Care Services	50 min
Look Ahead	3 min

Continuous Coverage Unwinding

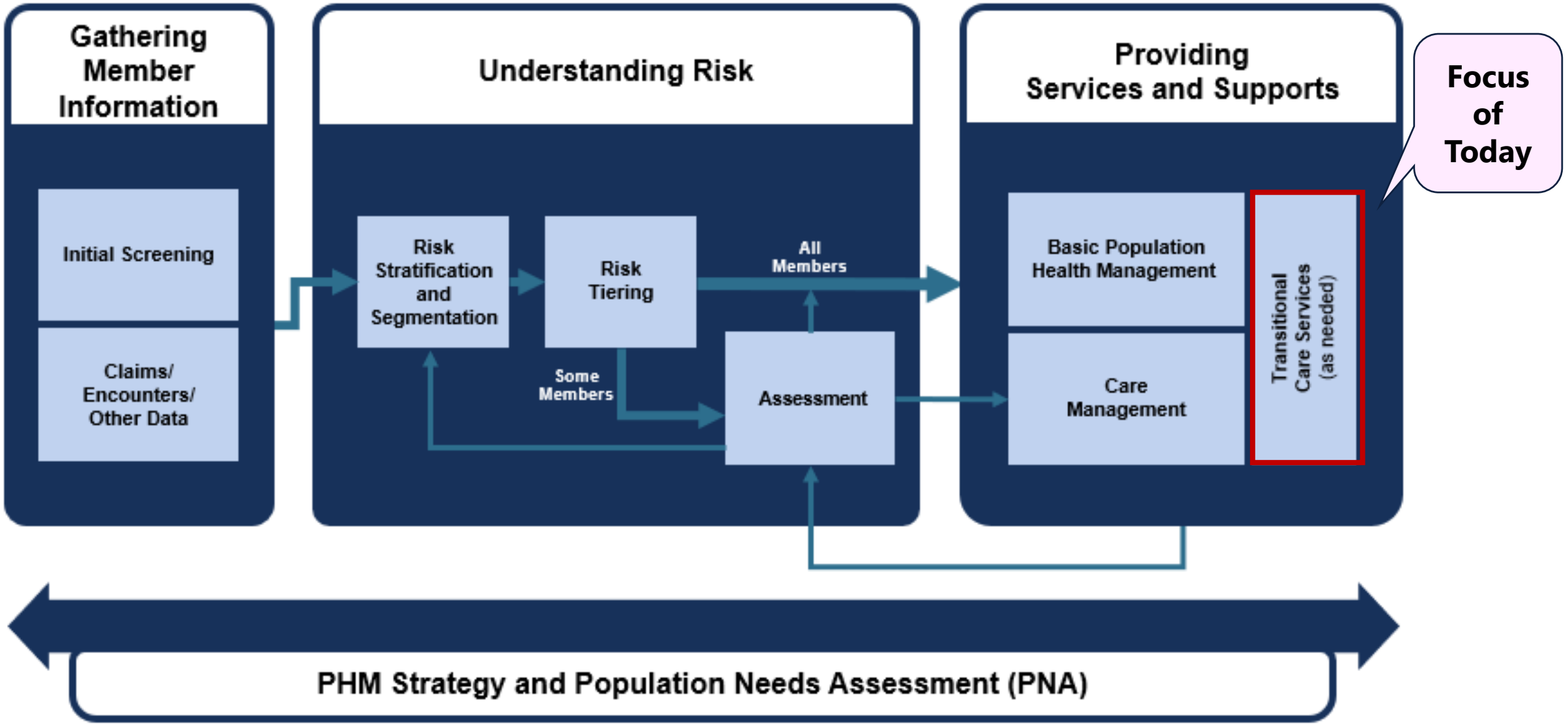
- **The continuous coverage requirement will end on March 31, 2023 and Medi-Cal beneficiaries may lose their coverage.**
- **Medi-Cal redeterminations will begin on April 1, 2023.**
- **Top Goal of DHCS:** Minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
- **How you can help:**
  - Become a **DHCS Coverage Ambassador**
  - Download the Outreach Toolkit on the DHCS Coverage Ambassador webpage
  - Join the DHCS Coverage Ambassador mailing list to receive updated toolkits as they become available
  - Check out the Medi-Cal COVID-19 PHE and Continuous Coverage Unwinding Plan (Updated January 13, 2023)!

Continuous Coverage Unwinding Communications Strategy

- **Phase One: Encourage Beneficiaries to Update Contact Information**
  - **Already launched**
  - Multi-channel communication campaign to encourage beneficiaries to update contact information with county offices.
    - » Flyers in provider/clinic offices, social media, call scripts, website banners
- **Phase Two: Watch for Renewal Packets in the mail. Remember to update your contact information!**
  - **Launch approximately 60 days prior to termination of the Continuous Coverage requirement.**
  - Remind beneficiaries to watch for renewal packets in the mail and update contact information with county office if they have not done so yet.

Reminder: PHM Program Requirements on Transitional Care Services

PHM Framework



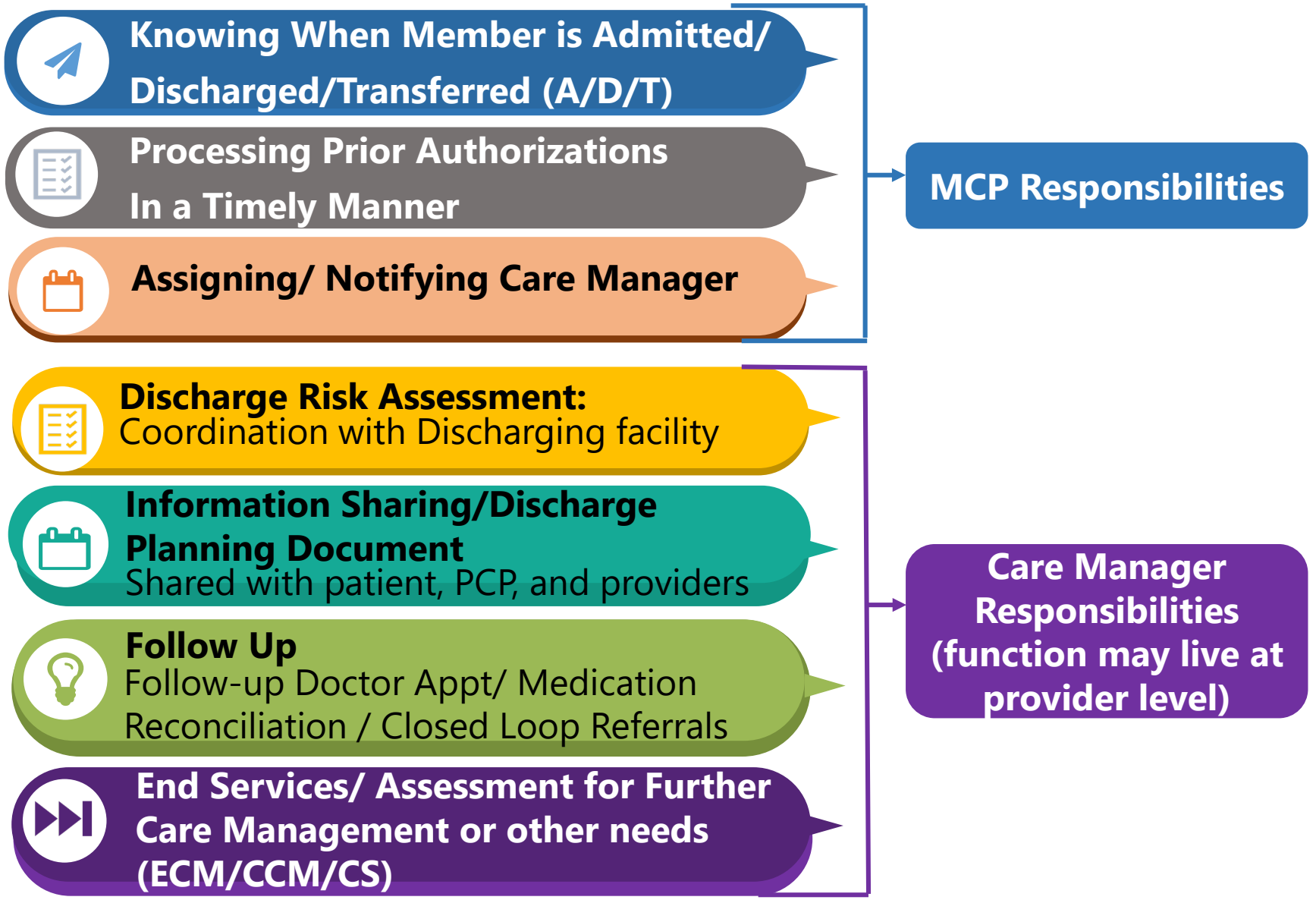
Overview of Transitional Care Services

Care Transitions Definition:
When a member **transfers from one setting or level of care to another**, including but not limited to, discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities to home or community-based settings, Community Supports, post-acute care facilities, or long-term care settings.

Goals for Transitional Care

- ✓ Members can transition to the **least restrictive level of care that meets their needs and is aligned with their preferences** in a timely manner without interruptions in care.
- ✓ Members receive the **needed support and coordination to have a safe and secure transition** with the least burden on the Member as possible.
- ✓ Members continue to have the **needed support and connections to services that make them successful in their new environment**.

Reminder: MCP PHM Requirements on Transitional Care Services



New Policy Guidance on Phased Transitional Care Implementation

Starting on 1/1/23, MCPs will be required to provide transitional care services to all high-risk members.

Formal Guidance on Phased Implementation of Transitional Care Services	
By 1/1/23	• MCPs must ensure **all transitional care services are complete (including having a care manager/single point of contact) for all high-risk members**[1] as defined in the PHM Policy Guide. • MCPs must implement **timely prior authorizations** and **know when members are admitted, discharged or transferred for all members** *(see more info on Data Exchange Framework (DxF) guidance on the next two slides)*. • MCPs must develop and **execute a plan to ramp up** transitional care services. The plan must address how the MCPs will meet the timeline and requirements.
By 1/1/24	• MCPs are required to ensure **all transitional care services are complete for all members**. As noted in the PHM Policy Guide, MCPs are strongly encouraged to contract with hospitals, Accountable Care Organizations, PCP groups, or other entities to provide transitional care services, particularly for lower- and medium-rising- risk members.

New Policy Guidance on Phased Transitional Care Implementation, ctd.

1. High risk members are defined as any population listed under Section D. Understanding Risk, 2) Assessment to Understand Member Needs Section of the PHM Policy Guide, including but not limited to: any "high risk" members as identified through the MCPs' Risk Stratification and Segmentation (RSS) mechanisms or through the PHM Service once the statewide RSS and risk tiers are available; any other populations who require assessments, such as those in ECM or CCM, those who received LTSS, Children with Special Health Care Needs (CSHCN), Pregnant Individuals, Seniors and Persons with disabilities who meet the definition of "high risk" as established in existing APL requirements, etc.

CDII Guidance

California's Health and Human Services (CalHHS)
Data Exchange Framework (DxF)

In July 2022, CalHHS released the Data Exchange Framework (DxF), which includes a single data sharing agreement and associated policies and procedures that will govern health information exchange statewide.

AB 133 required that:

- CalHHS (in consultation with stakeholders and local partners) establish a **Data Exchange Framework** by July 1, 2022
- A broad spectrum of health care organizations – including health plans - **execute the Framework's data sharing agreement (DSA) by January 31, 2023**, and **exchange or provide access to health information with other mandated organizations by January 31, 2024**.*

* For more information, please see the DxF FAQs and the DSA Signing Portal

Health plans required to sign the DxF's data sharing agreement include:

a) Health Care Service Plans and Disability Insurers providing hospital, medical, or surgical coverage that are regulated by the California DMHC or the California Department of Insurance

(b) Medi-Cal MCPs that have signed a comprehensive risk contract with the DHCS pursuant to the Medi-Cal Act or the Waxman-Duffy Prepaid Health Plan Act, and that are not regulated by the California DMHC or the California Department of Insurance.

Source: DxF FAQs

California's Health and Human Services (CalHHS)
Data Exchange Framework (DxF)

A set of draft DxF policies and procedures (P&Ps) was released by CalHHS in January 2023 for public comment and includes provisions relevant to transitional care, particularly as it pertains to event notifications.

- *In July 2022*, CalHHS released the **DxF data sharing agreement (DSA) and initial set of P&Ps**.
- *In January 2023*, CalHHS released a **new set of P&Ps for public comment** which address the following topics:
  - [***New***] California Information Blocking Prohibitions
  - [***New***] Technical Requirements for Exchange
  - [***New***] Real-Time Exchange
  - [***New***] Early Exchange
  - [***Amended***] Privacy Standards and Security Safeguards

*The draft **Technical Requirements for Exchange P&P** includes provisions that:*

1. *Require Participant Hospitals to send electronic Notifications of admission, discharge, and transfer (ADT) events to at least one qualified health information organization (QHIO)*
2. *Require QHIOs to share Notifications of ADT events with all other QHIOs*
3. *Require QHIOs to accept requests for electronic Notification of ADT Events from their participants and communicate them as requested in an acceptable format.*

CalHHS is soliciting public comment through February 14, 2024 on drafts of the new set of DxF P&Ps. The draft documents can be found on the CalHHS Data Exchange Framework website.

Overview of Emerging Practices

Speakers

Name	Title	Organization
Katherine Barresi	Senior Director, Health Services	Partnership HealthPlan
Nicole Gore	Care Coordination Program Manager	Santa Rosa Community Health
Alaina Zertuche **Sarah Behr** **Jonjie Bernado**	Manager of Care Management Supervisor of Social Work Director of Care Management	Providence Santa Rosa Memorial Hospital
Dr. Khush Grewal	Medical Director	Community Health Center Network

Transitional Care Services

PHC uses a multi-modality approach to meet the needs of our members, providers and hospitals to ensure safe transitions and quality outcomes.

Primary Actions

We place emphasis on interventions that are designed to prevent the onset of future incidents or problems around transitions of care

- Contracts
- Primary Care Quality Incentive Program
- Hospital Quality Incentive Program

Secondary Actions

Emphasis on early interventions that help decrease prevalence of readmissions or inappropriate utilization of resources

- Hospital/ED Navigator Programs
- Community Health Workers/Promatoras
- Data Sharing (HIE) investments

Tertiary Actions

Targeted activities that improve transitional care outcomes while offering short/long-term support to hospitals, providers, SNFs and/or communities

- Embed health plan clinical staff as Transitional care manager
- Extended length of stay meetings

Transitional Care Services Best Practices: A health plan perspective

- **Partnerships with hospitals and providers**
  - Utilization Management and hospital / long term care staff as joint partners
    - Joint case management meetings for PHC members with extended length of stays
    - Timely authorizations for members leaving an acute setting
    - Long term care luncheon
  - Local meetings involving care management staff from the health plan, hospital, provider/clinics, community partners to discuss patients, programs/services, referral pathways, updates, best practices, etc.
  - Where necessary, embedded health plan staff in hospital settings for transitional care work
- **Data Sharing / Integration**
  - Health Information Exchange
  - Electronic Medical Record access for plan staff; concurrent review and sharing of records
  - Access to PHC systems for delegated review functions
- **Alignment of priorities to address quality and readmission**
  - NCQA
    - Complex Case Management / Transitional Care Management requirements
  - Accreditation requirements (ex: Medicare, JCAHO, etc.)
  - Quality Incentive Programs
    - Hospital, Primary care, Long term care

Providence SRMH Care Management

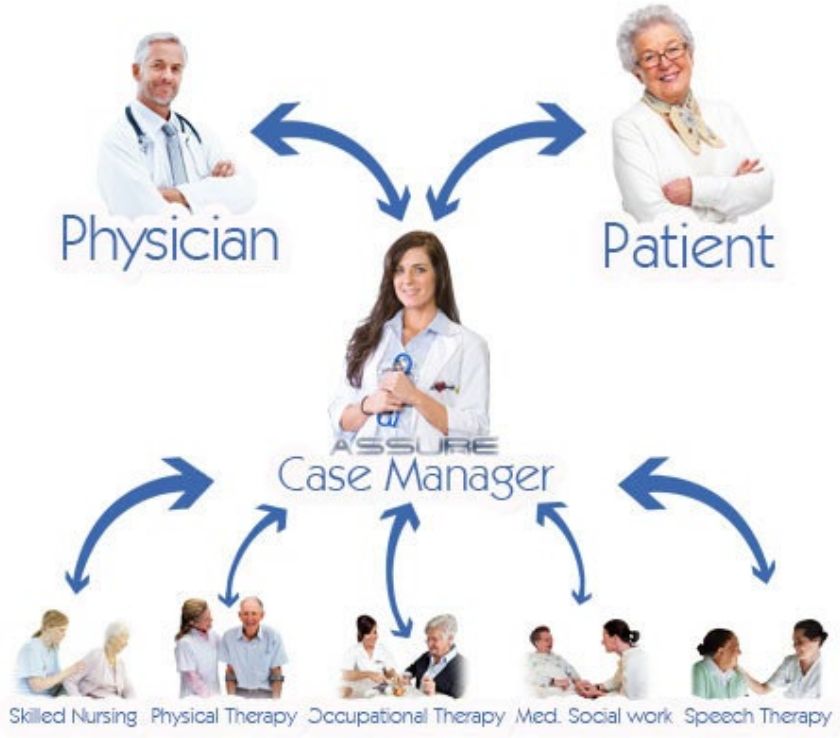
What is Care Management?

- Our department aims to improve the quality and efficiency of healthcare delivery in a hospital setting.
- Key components are transition management, disease management and prevention, and patient education and self-management support.

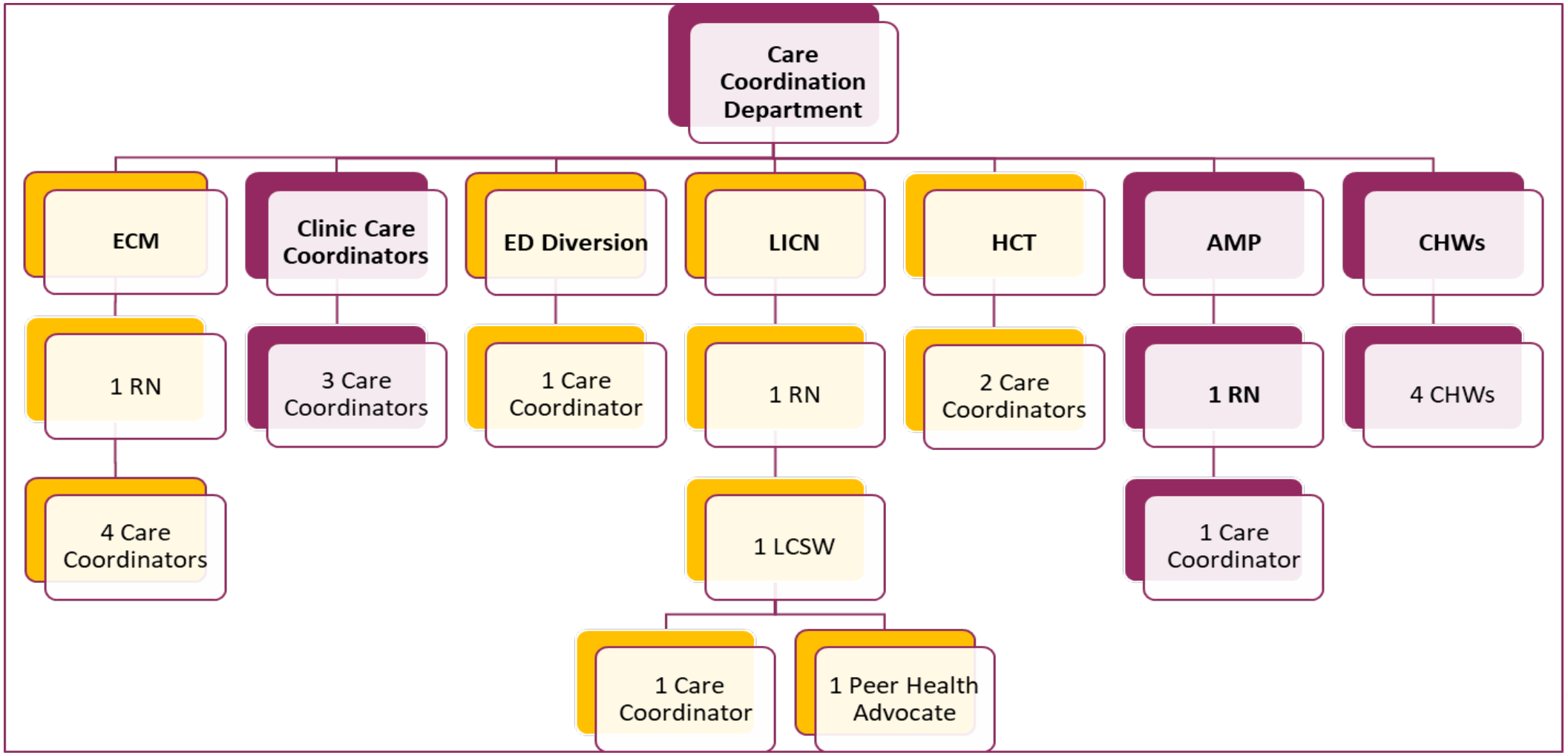
Providence SRMH Care Management

Benefits of a Hospital Care Management Program

- Improved patient outcomes
- Enhanced communication and coordination between healthcare providers
- Increased efficiency and cost savings



Care Coordination Department Overview



How SRCH Measures Success

- Re-Hospitalization Admission Rates
- Successful PCP Linkages
  - Referred and Attended
  - Timeframe
- Successfully Housed/Sheltered
- Patient Health Outcomes
  - BP and PHQ9
  - Medication Adherence
- Patient Outreach and Engagement
  - Follow Up Appointments
  - Patient Resource Navigation
  - Closing the Loop

SRMH & SRCH Partnership

Background

- Addressing Community Need
- Quality Improvement Initiatives
- Providence Funded Projects
  - ED Diversion & Homeless Care Transitions
- Other Collaborative Projects
  - Enhanced Care Management & Local Indigent Care Needs

SRMH & SRCH Partnership Cont.

Current Collaborative Strategies

- Weekly Leadership Meetings
  - Address Challenges and Barriers
  - Review and Improve Workflows
- Case Conferencing
- Data Sharing
  - Monthly Reports
- Consistent Communication
  - Needs and Expectations
  - Internal Updates

ALAMEDA HEALTH CONSORTIUM

COMMUNITY HEALTH CENTER NETWORK

Community Health Center Network (CHCN) Care Transition Nursing (CTRN) Program

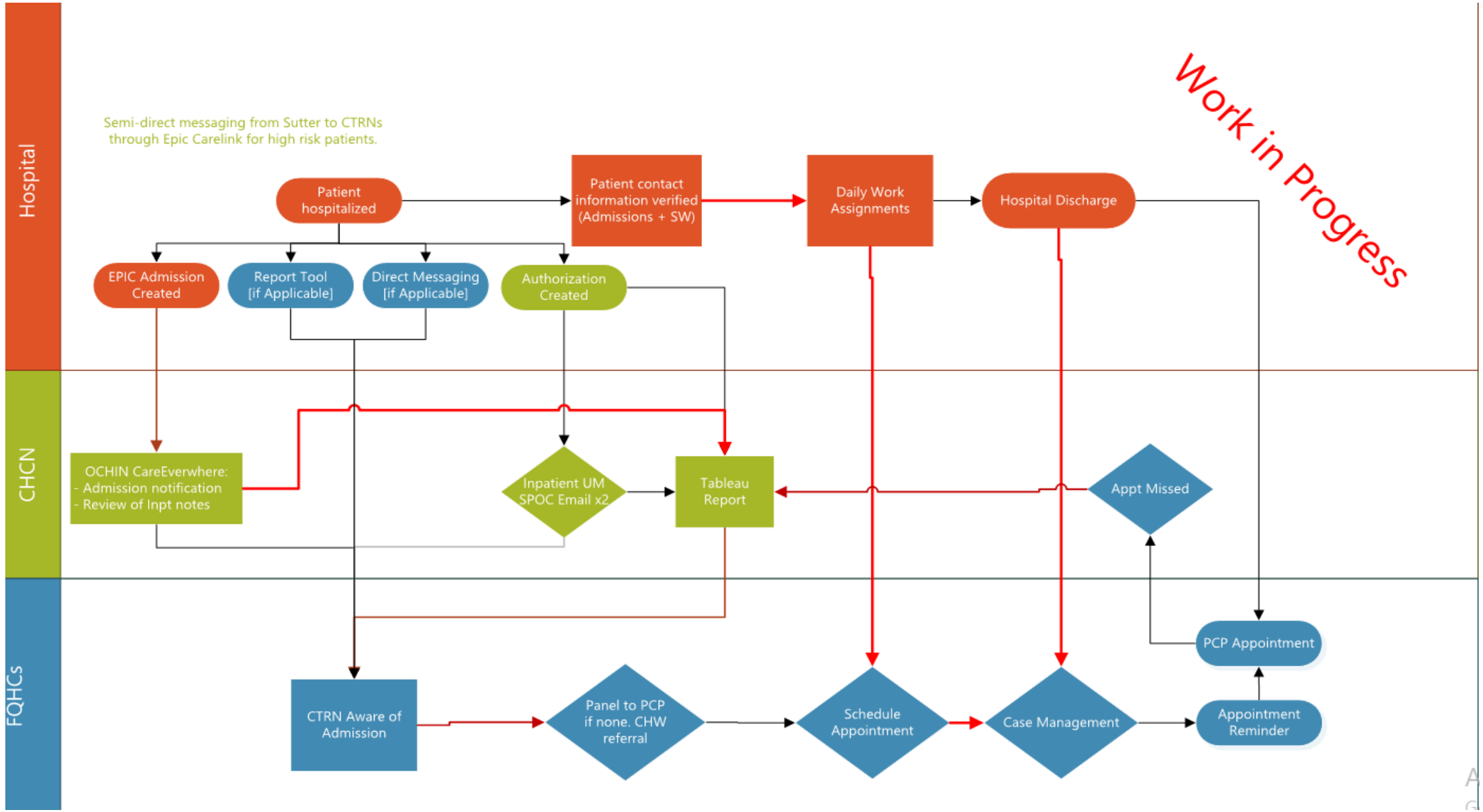
January 2023

CHCN Care Transition Nursing (CTRN) Program

- ***Nurse-led teams*** at all 8 CHCN safety net health centers with funding from Alameda Alliance (and previously by Sutter Health).
- ***Medical case management***, medication reconciliation, and PCP/specialist engagement
- ***Support*** with SDOH including referrals to ECM, Behavioral Health, Housing Resources and other case management programs.
- ***Engagement*** and ***collaboration*** with hospitals and health plans to improve the quality of care transitions.

➢ *Ultimate goal: Prevent readmissions through primary care engagement*

CTRN Workflow



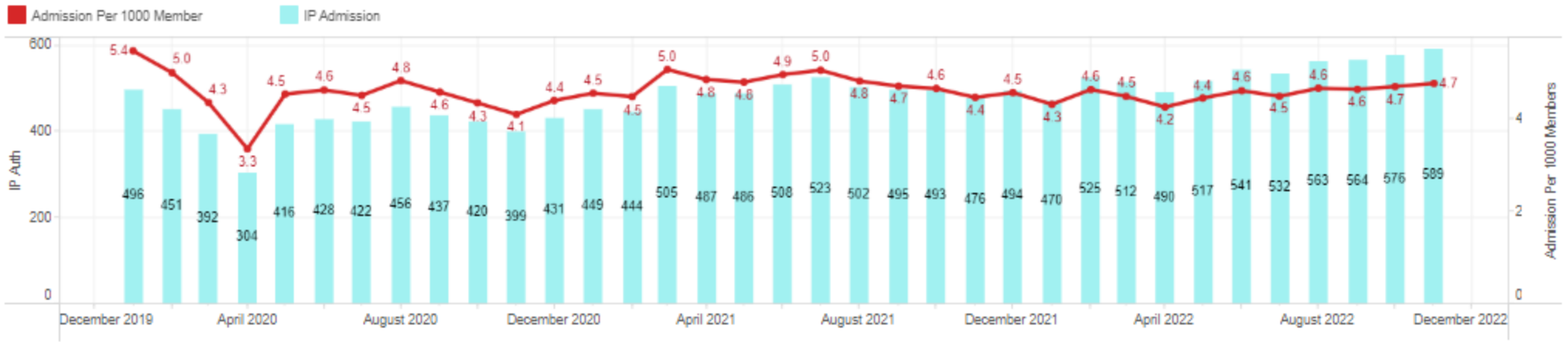
AHC CHCN

2020-2022 Outcomes

Clinic: (All) | HP: AA | LOB: (All) | Age: 0 – 117 | Date Range: January 2020 – November 2022 | Hospital: ALL

IP Admission Per 1,000 Member Trend

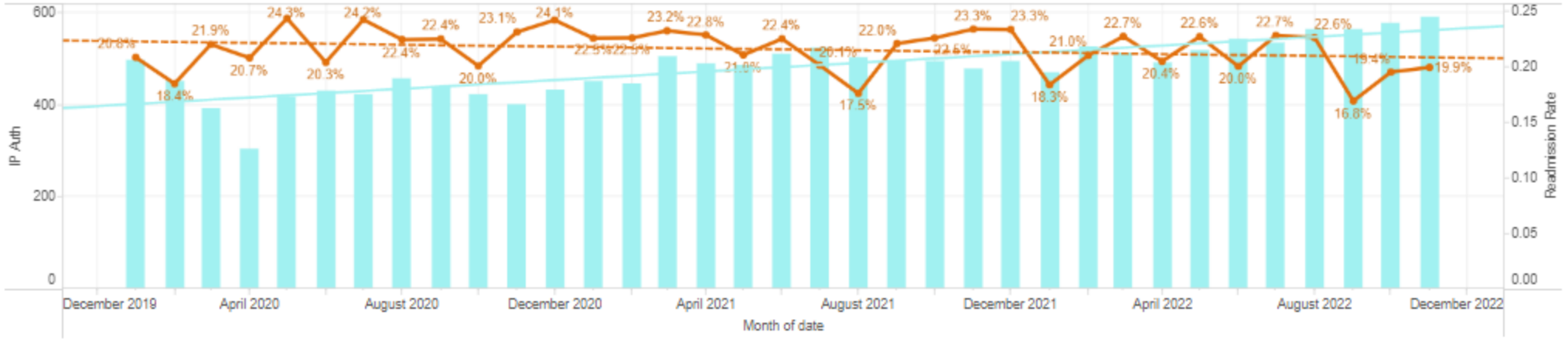
Date Updated: 1/3/2023 9:06:47 AM



Inpatient Readmission Rate Trend

Readmission happend in the hospital for previous admission happended anywhere

Readmission: readmission 30 days | Measure Names: Readmission Rate, IP Admission



Panel Discussion: Emerging Practices on the Implementation of Transitional Care Services

Panel Discussion: Transition Care Services Implementation

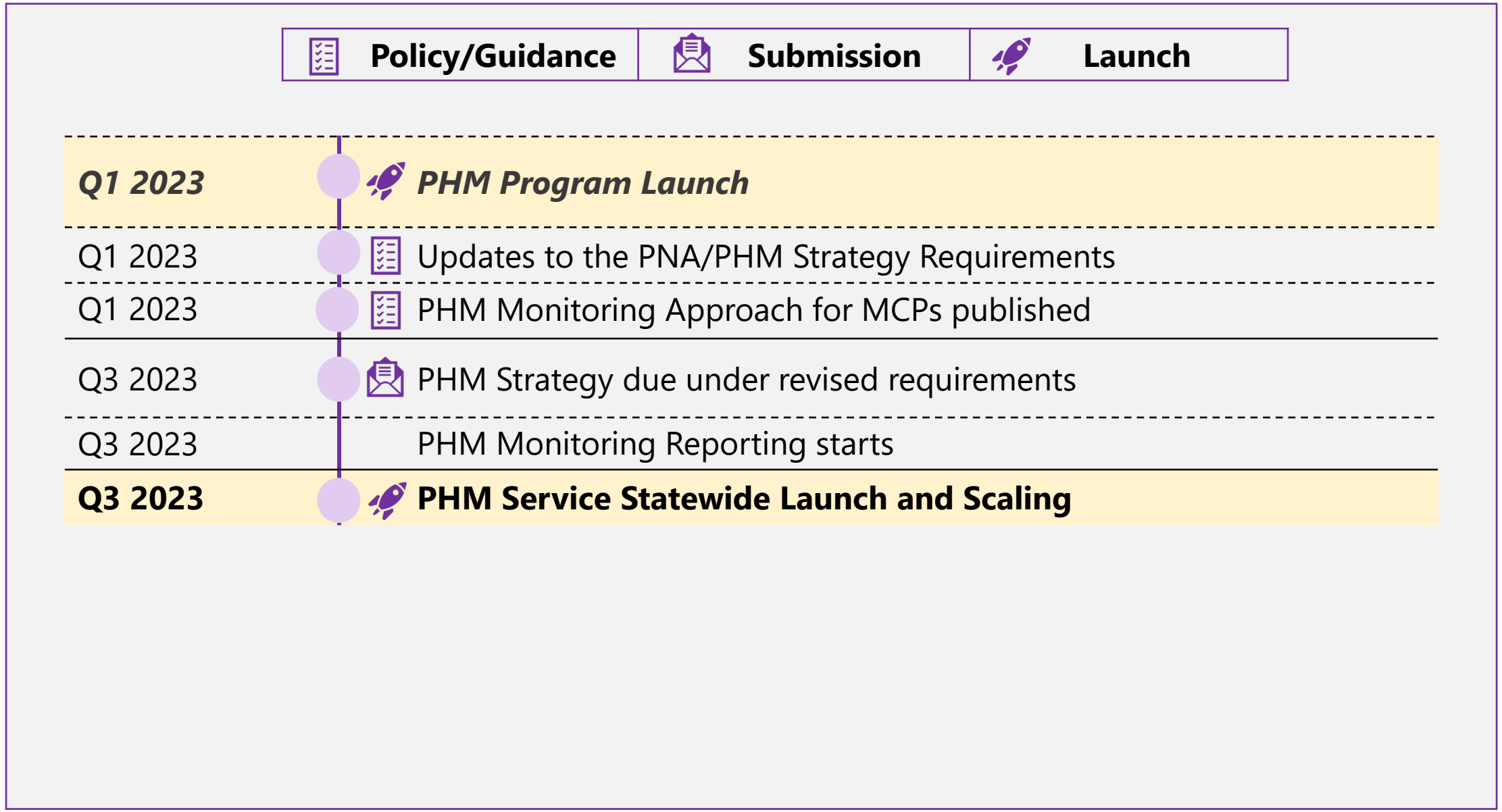
Today, we are joined by guest speakers for a panel discussion on Transitional Care Services implementation, emerging practices, potential challenges, and opportunities.

Discussion Topics

1. Identifying Individuals to Receive Transitional Care Services (10 min)
2. Assigning a Care Manager and Building the Relationship Between Care Manager and the Member (15 min)
3. Coordinating Between Health Plans, Hospitals/SNFs, PCPs, and Care Managers (20 min)
4. Evaluation and Improvement (5 min)

Look Ahead

Overview: *PHM Initiative High-Level Timeline*



Questions?

Upcoming Meeting of Interest

PHM Advisory Group Meeting

Topic: PHM Monitoring Approach for MCPs

Wednesday, February 8
1:30 AM – 3:00 PM PT

Registration Forthcoming

Thank You

Key Resources:

» DHCS CalAIM Website: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx
» DHCS Population Health Management Website: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx
» For questions, please email: PHMSection@dhcs.ca.gov