Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

Contents

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

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February 2, 2024

Transcript

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Alice Keane – 00:00:15	Hello and welcome to today's webinar Launching Enhanced Care Management for the Birth Equity Population of Focus. My name is Alice and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the chat field, which is located on the Zoom panel at the bottom of your screen.
Slide 1	Alice Keane – 00:00:37	We encourage you to submit written questions at any time using the chat. The meeting materials, transcript, and recording from today's webinar will be made available on the DHCS website.
Slide 1	Alice Keane – 00:00:50	Finally, during today's event, live closed captioning will be available in English and Spanish. You can find the link in the chat field.
Slide 1	Alice Keane – 00:00:59	With that, I'd like to introduce Dr. Palav Babaria, Chief Quality and Medical Officer and Deputy Director, Quality and Population Health Management at the Department of Healthcare Services.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 1-3	Palav Babaria – 00:01:12	Thank you so much and welcome everyone on this lovely Friday afternoon to hear more about our newly launched Enhanced Care Management Birth Equity Population of Focus. We can go to the next slide. So just as a reminder, before we dig into today's agenda, as you all are aware, effective April of 2023, CHCS has started its public health emergency unwinding process for continuous coverage, which means that Medi-Cal members do have to do their annual redeterminations, which had been suspended during the public health emergency. Our explicit goal is to make sure that every Medi-Cal member, who is still eligible for Medi-Cal can retain their coverage, and that if they're no longer eligible, they can be connected to a different source of healthcare coverage. We know that many people still have not heard about this process, and so really encourage you all to look at the coverage toolkits that we have, join our mailing list, and for those of you who work directly with Medi-Cal members, please connect them to the Medi-Cal member websites where they can really have more information on how to get through this process most efficiently and effectively. We can go to the next slide. The other thing that I'll call your attention to here is we do have a resources hub and a dashboard that shows county by county what the redetermination process is looking like, how many members are losing coverage, and for what reason. So definitely please check out that resource for any local insights into your region. You can keep going to the next slide.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 4	Palav Babaria – 00:02:57	So today's agenda is really to provide more information about the Enhanced Care Management Birth Equity Population of Focus and how this fits into the larger maternal healthcare context in California and work that is ongoing at Medi-Cal. We'll go into a little bit of the details about the specific Birth Equity Population of Focus and what the requirements are, and then really look to our provider panel discussion to lift up experiences from the field, from people who have been doing this work for a long time and are now ECM providers and how they've worked to transition into the ECM program. And then, we'll also review some commonly asked questions that we've been getting to share with all of you and then open it up to Q and A for everyone on this call.
Slides 4-5	Palav Babaria – 00:03:43	And we will also be posting all of the slides and this recording on our ECM and Community Supports website in the upcoming weeks. So obviously you all have already been introduced to me. Bonnie, I will ask you to introduce yourself as well and we'll be tag teaming this presentation on behalf of DHCS today.
Slide 5	Bonnie Kwok – 00:04:00	Thanks, Paula. Good afternoon everyone. I'm Bonnie Kwok at the Department of Healthcare Services. I am under the Quality and Population Health Management Division and I'm the ECM or Enhanced Care Management Birth Equity Population of Focus Lead. I'm a family physician by training and have prior to joining DHCS, I was a primary care provider in a county FQHC for about eight years, and have cared for prenatal and postpartum individuals and I'm really excited to be here today. I'll hand it back over to Palav.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Palav Babaria – 00:04:41	Thank you, Bonnie. So those of you who joined webinars with us before know that we love having dialogue with you all and don't want to just be speaking into an empty void. So to that effect, the chat is wide open. Please, please use the chat to share your ideas, react to the information that we're presenting, as well as drop questions, and we'll try to get to as many as we can in the Q and A. And we are also going to kick us off with a Zoom poll, really taking advantage of this virtual technology here. So I'm going to read out the questions and for all of you who are joining by Zoom and not by phone, please, please provide your responses.
Slide 6	Palav Babaria – 00:05:17	So the opening audience poll for all 400 some of you who are on the call so far. Number one, how would you describe yourself or the entity you're representing at today's webinar? We really want to know are you providers? Are you plans? Are you members? Are you DHCS staff? What is your relationship to this topic?
Slide 6	Palav Babaria – 00:05:35	And then, question number two, how would you describe your level of familiarity with the Enhanced Care Management Birth Equity Population of Focus from your very well versed in this and have maybe been already providing these ECM services all the way to you just thought this was interesting, you've shown up, but don't have a lot of context.
Slide 6	Palav Babaria – 00:05:58	So we'll give everyone a few minutes to respond to those questions. And once we get sufficient responses, we would close that out.
Slide 6	Palav Babaria – 00:06:28	Great. So we got a lot of responses. Hopefully, you all can see on your end the poll, but really excited that many of you are here today are already contracted ECM providers or you're here because you're interested in becoming an ECM provider or you're serving this population already, or you're from a managed care plan. And it looks like most people are either vaguely, somewhat, or very familiar, but we have some newcomers, too. So when we get to the Q and A phase, literally all questions are great questions. So please don't be shy. Okay, well let's get kicked off and go to the next slide.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Palav Babaria – 00:07:04	So why are we here? We don't want to start on a downward note, but I think we all have probably heard and can acknowledge that we have a maternal health crisis in our country and California is not immune to that. Some of our maternal outcome measures, like maternal morbidity and mortality are better than what the nationwide average is, but we still have a significantly high rate and deep disparities within our maternal morbidity and mortality and other healthcare indicators for pregnant individuals.
Slide 7	Palav Babaria – 00:07:35	A few facts and figures to call out, which most of you are probably already aware of, but in 2021, American Indians and Alaskan Natives and Pacific Islanders reported the lowest access to prenatal care across all of the races and ethnicities in California. And more than a third of those individuals received inadequate prenatal care. From 2018 to 2020, racial and ethnic disparities in terms of pregnancy related deaths or mortality in California continue to persist. And so the mortality for Black individuals is 45.8 deaths per 100,000 live births, and this rate is about 3.6 times greater than the mortality rate for white individuals. Please forgive that typo. It should be mortality.
Slide 7	Palav Babaria – 00:08:20	And then, we also know with increasing data that more than 60% of the maternal deaths in California don't actually occur in the prenatal period or at the time of delivery, but occur in the postpartum period, up to 365 days after childbirth. And you'll see here what some of the common causes are. Really cardiovascular disease, hemorrhage, sepsis, infection, hypertensive disorders. And we also know that when you look at the past, the immediate intrapartum period in the hospital, the rates of suicide, mental health, and substance use issues are the most common causes of mortality in that delayed period. And so this is all to say that we need to do better and we can do better as a state. And so the Birth Equity Population of Focus is not going to solve everything, but is one part of our toolkit to really get us moving in the right direction and addressing these persistent issues. We can go to the next slide.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 8	Palav Babaria – 00:09:19	So a few things to lift up. We recognize that we have a lot of opportunity to improve in the Medi-Cal program. So as a part of our comprehensive quality strategy that we submitted to the federal government in 2022, we explicitly put some targets for ourselves to start closing these disparity gaps by race and ethnicity, specifically for Black and Native American persons. And then we also really called out opportunities to improve depression screening and follow up also for our maternity populations. There's a lot in our quality measures, and you'll see the specific measures here that we are tracking as a state, and have lots of quality improvement initiatives going on. And then some of these quality measures also we require our managed care plans to meet a minimum performance level of the national 50th percentile. We can go to the next slide.
Slide 9	Palav Babaria – 00:10:10	To lift up a few additional things that we are working on in the state. So as all of you know, Medi-Cal covers about half of all the births in the state. And so really, Medi-Cal making a dent in this problem is critical, but also lift up, when you look at our public health data, the morbidity and mortality rates for individuals covered by Medi-Cal are higher, significantly higher, than those covered by commercial insurance. So we also, a disproportionate number of our Medi-Cal members are the ones who are experiencing these poor outcomes. We're taking a lot of multi-pronged steps to address this.
Slide 9	Palav Babaria – 00:10:42	So today we are here to talk specifically about the Enhanced Care Management Birth Equity Population of Focus. But Medi-Cal has also taken great strides to expand coverage of key new benefits such as community health workers, doula services, and dyadic services, which is designed to really support the behavioral health and psychosocial needs for children and their caregivers and families, including parents to improve health outcomes and reduce disparities.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

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Slide 9	Palav Babaria – 00:11:08	As you saw in the previous slides, so much of the maternal morbidity and mortality impact comes in that postpartum period. And so Medi-Cal also was among the first states to expand Medi-Cal eligibility from just 60 days postpartum to a full year postpartum and also eliminated premiums for families so we can make sure that the people who need health coverage most have access to it.
Slide 9	Palav Babaria – 00:11:32	We also, through the MCO tax, were able to increase reimbursement rates for all maternity care providers. This is inclusive of OBGYNs, doulas and midwives, effective January 2024, so that those rates are now at least 87.5% of Medicare reimbursement. And there are additional rates planned for January 2025, pending the budget process this year. So this is just an example of some of the investments that have already been made. We can go to the next slide.
Slide 10	Palav Babaria – 00:12:09	So before I hand it off to Bonnie, I will also say for those of you who have not seen it, we'll drop in the chat or Birthing Care Pathway link. There is a larger, more comprehensive assessment of all of Medi-Cal's maternity and postpartum related policies that we are engaging with the stakeholders and about to kick off our member listening tour to really hear directly from Medi- Cal members, especially those experiencing disparities, what is and is not working about the Medi-Cal program when it comes to their care as they're pregnant and in the postpartum period. And we plan on having all of that culminate in a policy strategic plan that will be issued later this summer with implementation thereafter. So again, the Birth Equity Population of Focus is one part of that broader strategy. Bonnie, I think I'm handing it over to you now.
Slide 10	Bonnie Kwok – 00:13:02	Thanks, Palav. I'm going to jump in and talk about Enhanced Care Management, or ECM, and the launch of the Birth Equity Population of Focus. Having my clinical training and working at DHCS, we have quite a few acronyms here, so I'm going to do my best to not use acronyms and just say the whole phrase whenever possible, especially for those folks who are not as familiar to Enhanced Care Management. Next slide, please.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Bonnie Kwok – 00:13:40	So what is Enhanced Care Management? It is a statewide Medi-Cal managed care plan. It's a benefit to support comprehensive care management for members with complex needs. And those needs can include behavioral, physical, dental needs, social needs, and it's across a wide array of delivery systems. One important thing to note about Enhanced Care Management is that it's high touch, it's multidisciplinary, and the goal is to provide in-person interactions with our members, whether that's in their homes, in clinical offices, on the street, we do our best to meet them where they are. I have a bit of a sweet tooth. So this is our Medi-Cal managed care plan care management continuum. There are three tiers, and I have a bit of a sweet tooth and I see this as like a cake. And at the bottom, a tier of this cake, we have our Basic Population Health Management, which is for all Medi-Cal managed care members. This emphasizes preventive care, going to routine screenings, and vaccinations.
Slide 11	Bonnie Kwok – 00:15:03	The second tier up from Basic Population Health Management is Complex Care Management. And CCM is for managed care plan members who have higher risk or medium rising risk. And those are individuals who might be eligible for Complex Care Management includes those with chronic conditions such as diabetes or high blood pressure, where they need additional support to help them manage those conditions. And last but certainly not least, at the very top of this care management continuum cake is Enhanced Care Management, or ECM, where those members have the highest need, whether that's medical, excuse me, social needs, where they can have a lead care manager to help with care coordination.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

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Slides 11-12	Bonnie Kwok – 00:16:11	So this is our care management continuum. I would be remiss if I didn't talk just a little bit about transitional care services because I'm also the Transitional Care Services lead, and that just launched for all members on January 1st of this year. We took a phased approach where Transitional Care Services was available to those who are considered high risk for the purposes of transitional care services on January 1st, 2023. And just a month ago, we launched this for all members. And what this program provides is an additional support with care coordination, additional services for those members who are moving from one level of care or one setting of care to another. For example, if they've just been hospitalized and they're being discharged to home or they were hospitalized and needed to go to a skilled nursing facility. They would get additional support during this transitional period. Next slide, please. What are the Core Enhanced Care Management Services and how do these Core Services support the Enhanced Care Management Birth Equity Population of Focus? On the left, you can see that there are seven Core Services, and we really take into account our members individual preferences and needs. Outreach and engagement, comprehensive assessment care management plan, and enhanced care coordination, coordination and referral to community and social support services, including family members as we build support networks for our members. Health promotion, particularly for basic population health management and comprehensive transitional care as I mentioned earlier, with transitional care services. And I would like to call out specifically, in terms of referral to community and social support services.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

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Slides 12-14	Bonnie Kwok – 00:18:36	Some examples include, connecting the pregnant or postpartum individual, their partner or their family with resources to support their health and the health of their newborn. And connecting to another service called Community Supports. There are a total of 14 available community supports services, and that may be beneficial for some of our birthing individuals, and that includes medically tailored meals, housing supports, and so forth. And lastly, coordination with transition from hospital to home. For example, after delivery at the hospital and transition back to the member's home. Next slide please. So who is eligible for Enhanced Care Management? Enhanced Care Management is available to all members enrolled in a managed Medi-Cal managed care plan, and also meet the Enhanced Care Management Population of Focus definitions. You can see on this slide that there are currently nine Populations of Focus, and the focus for today's presentation is the Birth Equity Population of Focus in row nine at the bottom of the screen. This just went live on January 1st of this year, and the check marks that you see under adults and children and youth indicate which populations can qualify for the specified Population of Focus. Next slide please. So diving a little deeper in sharing some of the background for developing the Birth Equity Population of Focus, one of the Enhanced Care Management or Equity Population of Focus aims is to address underlying risk factors of disparities in health and birth outcomes in populations with high maternal morbidity and mortality rates. And just flagging that if you see this question icon on the screen, that is a commonly asked question. And we are going to address some of those during this presentation. And we'll also save time at the end of the presentation, too, to take your questions as well.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Bonnie Kwok – 00:21:19	So how did DHCS determine eligibility criteria for this Enhanced Care Management for Equity Population of Focus. And disparities were identified through evaluation of research data that was collected from a number of sources, including California's Department of Public Health statewide public health data. It's available in the link. And these slides and the recording of this presentation will be posted on the DHCS website in the coming weeks.
Slide 14	Bonnie Kwok – 00:21:58	So the Women and Maternal Dashboard homepage contains multiple links to the dashboard, as you can see in the asterisk on the bottom right. And we had studied CDPH statewide data on disparities for both the pregnancy related mortality and prenatal care in determining eligibility criteria for this specific Birth Equity Population of Focus. And the data demonstrates along with opinions from subject matter experts who were in agreement that the significant disparities exist with certain racial and ethnic groups.
Slide 14	Bonnie Kwok – 00:22:37	And furthermore, the research data demonstrate that groups experiencing disparities in care for maternal morbidity and mortality are from certain racial ethnic groups, and that includes Black, American Indian, Alaskan Native, and Pacific Islander pregnant and postpartum individuals. We do have other links on this slide, just calling out the-
Slide 14	Bonnie Kwok – 00:23:01	On this slide, I'm just calling out the three links on the bottom left corner. If you would like to do a deeper dive with the Centering Black Mothers Report, the American Indian/Alaskan Native Report, and the MIHA Maternal and Infant Health Assessment briefs. Next slide, please.
Slide 15	Bonnie Kwok – 00:23:26	This slide goes into the definition of Enhanced Care Management, Birth Equity, Population of Focus. And there are two criteria. One is adults and youth who are pregnant or postpartum up to 12 months postpartum and are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

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Slide 15	Bonnie Kwok – 00:23:53	Another commonly asked question, when a plan receives a referral, how should it determine if an individual meets the eligibility criteria of experiencing a disparity for the Birth Equity Population of Focus? Plans should first make their best effort in reconciling any discrepancies that exist in the available data sources to determine a member's eligibility. If those discrepancies can't be resolved, then plans must prioritize members' own self-identification of their racial and ethnic group in confirming a member's eligibility for the purposes of the Enhanced Care Management Birth Equity Population of Focus.
Slide 15	Bonnie Kwok – 00:24:41	So under this guidance, plans should provide Birth Equity Population of Focus services to a member who self-identifies with the qualifying eligibility criteria, even in cases where there's missing or different data from plans or even DHCS data... just getting over a cold. So members who identify with multiple racial or ethnic groups are eligible for the Enhanced Care Management Birth Equity Population of Focus as long as one of the groups they identify with aligns with the Birth Equity Population of Focus eligibility criteria, and that includes Black, American Indian, Alaska Native, and Pacific Islander.
Slide 15	Bonnie Kwok – 00:25:45	Moving on to another commonly asked question, can pregnant and postpartum Medi-Cal managed care members be eligible for Enhanced Care Management if they do not meet these Birth Equity Population of Focus criteria? Yes. A pregnant or postpartum member who is enrolled under a Medi-Cal managed care plan can be eligible for Enhanced Care Management if they meet the criteria under other Populations of Focus such as the individuals or families experiencing homelessness. Or another Population of Focus is those with serious mental health conditions or substance use disorder needs. Next slide, please.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Bonnie Kwok – 00:26:44	So how can eligible members access Enhanced Care Management? There are multiple ways for these individuals and their families to access Enhanced Care Management. So community-based service providers, both within the Medi-Cal managed care plan network or outside of their networks may identify and refer eligible members to Enhanced Care Management Services.
Slide 16	Bonnie Kwok – 00:27:14	We strongly encourage that these referrals come from the community. We know that members have improved quality of care when they have trusted providers or members of their healthcare team. And ideally, these referrals are coming from providers who know members the best and are familiar with their needs and preferences. We also strongly encourage non-healthcare agencies to refer members for Enhanced Care Management.
Slide 16	Bonnie Kwok – 00:27:57	Plans also are required to have a process for proactively identifying members who may benefit from Enhanced Care Management and meet the Birth Equity Population of Focus criteria. This is supplemental to and not instead of actively seeking referrals from community providers. And members and families can also self-refer for Enhanced Care Management services, additionally, for community support services as well.
Slide 16	Bonnie Kwok – 00:28:33	And some examples of referral partners for this Birth Equity Population of Focus includes Comprehensive Perinatal Services Program or CPSP, the Black Infant Health Program, Indian Health Programs, clinical providers such as OB/GYNs, family medicine physicians, midwives, Doulas, Promotoras, and community health representatives from tribal communities. Again, we strongly encourage those who are not healthcare agencies to consider referring and applying to become Enhanced Care Management providers. And those non-healthcare agencies include WIC, behavioral health providers, and women's and family shelters. Next slide, please.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Bonnie Kwok – 00:29:38	We are in the process of implementing Memorandum of Understanding or MOUs with key referral partners and organizations to coordinate a whole person care for our members. And we have developed MOU templates for plans and third-party entities to promote access and referral pathways for our Medi-Cal members. This includes organizations such as WIC and other organizations within local health departments or local health jurisdictions, county social services, particularly specialty mental health services, and Medi-Cal mental health plans. As Palav had mentioned in the beginning, and I also saw someone put in the chat that one of the top reasons for pregnancy-related mortality is depression, anxiety, suicide. And this is an opportunity to make sure that these individuals are properly referred and cared for. For additional information, please visit our All Plan Letter, which is linked on this slide. Next slide, please.
Slide 18	Bonnie Kwok – 00:31:22	I want to take a moment here to acknowledge and thank our plan partners in their efforts to operationalize the Enhanced Care Management Birth Equity Population of Focus. Prior to the launch on January 1st, 2024, in the fall, plans had submitted Model of Care submissions indicating their preparedness for this launch. And some of the questions assessed the plan's approach in building Enhanced Care Management provider networks, ensuring that providers have the right level of expertise to care for this population, building referral pathways, and outlining data sources that they're using to proactively identify these members to be referred and receive care under Enhanced Care Management.
Slide 18	Bonnie Kwok – 00:32:23	And the plans reported being well positioned to cultivate Enhanced Care Management referral pathways with a diverse range of community-based organizations and providers. And that includes some of the ones I mentioned earlier, such as Black Infant Health, Indian Health programs, and Doula, Midwifery practices, and Comprehensive Perinatal Support Program.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

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Slide 18	Bonnie Kwok – 00:32:50	They also utilize perinatal screenings and assessments to identify eligible members. And the majority of plans have implemented a mission discharge or transfer feeds, also known as ADT feeds, to notify when a member transitions between levels or settings of care.
Slide 18	Bonnie Kwok – 00:33:13	We recognize that this is a huge effort and there are opportunities for improved access. And some of those opportunities for improvement includes referral pathways, especially for members who need access to behavioral health agencies, and also leveraging that behavioral health data and substance use disorder screenings and reports for member identification.
Slide 18	Bonnie Kwok – 00:33:47	And next, our goal here, especially for this coming year, is to continue improving and enhancing quality data exchange. And that includes timely, thorough, and accurate data information or health information and doing so at the local and regional levels specifically for pregnant and postpartum individuals.
Slide 18	Bonnie Kwok – 00:34:23	And last but not least, another opportunity is to continue to build network capacity for providers who have the expertise in serving pregnant and postpartum individuals who are eligible for the Birth Equity Population of Focus. And particularly members who identify as Black, American Indian, Alaska native, and Pacific Islander. Next slide, please.
Slide 19	Bonnie Kwok – 00:34:59	One of the key tenants for Enhanced Care Management for equity population of focus is having that lead care manager or single point of contact. These lead care managers are responsible for sharing information and maintaining that regular contact or touch points with the member and the members' care team. That includes the clinical team as well as teams in social services organizations.
Slide 19	Bonnie Kwok – 00:35:29	So Enhanced Care Management provides whole-person care management and offers the single point of contact who is accountable to ensure that care coordination occurs across multiple systems and programs. And we aim to have this lead care manager who comes from the member's community, who knows this member the best and is able to provide support during pregnancy from the time of conception and postpartum as well.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Bonnie Kwok – 00:36:09	So as Palav mentioned earlier, that Enhanced Care Management doesn't take away from funding from existing care management programs, but other programs care managers can choose to contract as an ECM provider and receive additional reimbursement for Enhanced Care Management from Medi-Cal managed care plans. Excuse me. So programs where an ECM lead care manager can coordinate with the broader team includes the Comprehensive Perinatal Services Program, Black Infant Health Program, Indian Health Programs, Home Visiting Programs such as the Nurse Family Partnership, and Dyadic services as well. Next slide, please.
Slide 20	Bonnie Kwok – 00:37:07	You're going to hear from John from the California Health Collaborative later on during the panel discussion, but his organization did receive PATH CITED funding. And PATH CITED stands for Providing Access and Transforming Health Capacity and Infrastructure Transition Expansion and Development. I think for this slide, I'm just going to say PATH CITED.
Slide 20	Bonnie Kwok – 00:37:37	On January 15th, 2024, we opened the Round 3 application period and strongly encourage you to take advantage of this opportunity. And what the PATH CITED initiative provides is funding to build capacity and infrastructure for our provider partners. And that includes increasing the provider workforce, building the infrastructure to support and monitor Enhanced Care Management and community supports services, and also to conduct further outreach to under-resourced or underserved populations, and to assist with enrollment into these care management programs.
Slide 20	Bonnie Kwok – 00:38:27	And partners who have the expertise and the experience in serving pregnant and postpartum individuals are strongly encouraged to apply. The deadline to apply for Round 3 PATH CITED funding is February 15. 13 days from now. If you want more information, please check out the PATH CITED website, which is down below. Next slide, please. I'm going to hand it back to poll to lead our provider panel discussion.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 21-22	Palav Babaria – 00:39:14	Thank you so much Bonnie, and I see a lot of questions in the chat. We will get to all of them shortly, but I am beyond honored and delighted to be joined by our panelists, Team Lily from Zuckerberg, San Francisco General Hospital, and the California Healthcare Collaborative. I'm going to ask them each, and I think if we go to the next slide, it has their names to introduce themselves in the order that they appear on this slide. And then we'll kick it off for a panel discussion and we'll take the slides down so we can see each other.
Slide 22	Palav Babaria – 00:39:45	And I will just say, I think we at DHCS obviously have set the vision and the policy for this program, but at the end of the day, it is truly the ECM providers that are working with our members and moving the needle on quality and health equity. So thank you all so much for joining us. Randi, I'll pass it off to you.
Slide 22	Randi Tanksley – 00:40:07	Good afternoon, everyone. My name is Randi Tanksley. I am the Director of Family Navigation Services at San Francisco General. I am part of an initiative called Solid Start. Solid Start's goal is to improve patient experiences here in the hospital while connecting them to community resources.
Slide 22	John Bodtker – 00:40:31	Hi, I am John Bodtker. I'm the CalAIM Director at California Health Collaborative. We're a statewide nonprofit that has roots in lots of grant-funded programs, including Perinatal Black Infant Health, MSSP, and a bunch of other related programs.
Slide 22	Rebecca Schwartz – 00:40:58	Hi, everybody. My name is Becca Schwartz. I'm a clinical social worker at San Francisco General Hospital. I'm the social worker and I'm one of the founding partners in Team Lily. We are a pregnancy care clinic providing pregnancy services to folks who are experiencing barriers to care, primarily homelessness or unstable housing, substance use disorder, significant mental health issues. I'm happy to be here.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Leslie Shelton – 00:41:28	Hello, everyone. My name is Leslie Shelton with California Health Collaborative. I am the CalAIM MCP liaison and also the project director for our First 5 Home Visitation program that serves Black and Hispanic pregnant moms and perinatal families with ages of zero to five. So we provide home visiting services, support, and health education for our families and moms.
No Slide	Palav Babaria – 00:41:54	Fantastic. Okay, let's take down the slide so we can all see each other. Perfect. And we will kick it off with a few questions. So first off, really just want to understand how you all made this decision to become an ECM provider. What were the key factors that influenced you in deciding to contract with the managed care plans? And then if you could also tell us a little bit about your team's experience serving birthing individuals who are eligible for the ECM Birth Equity Population of Focus? What are some of those lessons learned and must-haves for serving individuals that identify as Black, American Indian, Alaska native, or Pacific Islander. And whichever group wants to go first.
No Slide	John Bodtker – 00:42:44	Well, so at the California Health Collaborative, we really saw with CalAIM an opportunity to add new sustainable types of services to a lot of the types of programs that we already run. So traditionally, we do a lot of grant-funded and other types of programs that are reaching very similar populations. And a lot of these have care management aspects also. So that kind of gave us that institutional past performance and the internal subject matter expertise.
No Slide	John Bodtker – 00:43:24	Really, our two main specialty populations are pregnancies and moms, and then long-term care seniors and frail seniors like that kind of modeled by our MSSP type of programs. And so at the organization, we just saw that it was a great fit for services that aligned with our mission. It's focused on the communities we already work with, and it's largely based on a lot of the types of programs and pilot models that we already were operating, right

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	John Bodtker – 00:44:01	So CHCI has experienced with black infant health, and really just a whole gamut of very similar pilot models that really turned out to be, I think, where ECM is going. So there's sort of that organizational expertise, plus being able to diversify our funding streams. Makes it more sustainable for the organization. So that's a major shift too, but it includes a lot of new responsibilities and new ways of thinking on how we work with managed care plans and be sustainable in that aspect.
No Slide	Palav Babaria – 00:44:46	Team Lily, if you want to go next.
No Slide	Rebecca Schwartz – 00:44:49	Sure. Yeah. I think Team Lily had a model of care already that we feel like is working well at really putting patients at the center of their healthcare and working very collaboratively and individually with patients to set the priorities of each visit of each encounter. And many of those priorities were sort of non-medical. It had to do with their social situation and really prioritizing that and integrating that.
No Slide	Rebecca Schwartz – 00:45:21	And what ECM did for us was provide an opportunity to become more sustainable in our funding. We were also a grant-funded program. And really pursue reimbursement for a lot of those services that are essentially like the glue that we see being so necessary for people to be able to engage in medical care and be retained in medical care. Yeah.
No Slide	Palav Babaria – 00:45:43	Fantastic. Go ahead, Randi.
No Slide	Randi Tanksley – 00:45:48	Yeah. Two of the things I think that are kind of important and key in doing this work is having folks from the community, having folks that can provide care that is racially congruent with the population that we serve...

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	Randi Tanksley – 00:46:03	... if I care that is racially congruent with the population that we serve. And also, having partnerships with community-based organizations. We have a partnership with Homeless Prenatal Program that is just a few blocks from here, and a lot of our patients are familiar with their services, and they can actually be seen here by HPP. So we have some community health workers from HPP and case managers that can see patients as they come in for their visits.
No Slide	Palav Babaria – 00:46:28	That's fantastic, and thank you for lifting up that integrated model. So let's get a little bit deeper now into the weeds about the care model itself and who serves as the lead care manager and how you've been able to scale as you've entered the ECM program. So starting with Team Lily, we'd love to hear a little bit more in depth about the model and how it works, who's the lead care manager, and then how are you thinking... Obviously, Team Lily was serving this population before, but if you want to lift up, what are some of those must haves to really serve a birthing population as opposed to individuals that may qualify through other ECM populations of focus by virtue of being homeless or having a substance use disorder but are pregnant and what some of those nuances are?
No Slide	Rebecca Schwartz – 00:47:14	Yeah, so for Team Lily, the lead care managers can be anybody. When we're a small team, I'll just say that right off the top. We're one OB-GYN, two part-time psychiatrists. We are two social workers and a navigator, a patient navigator and the people and a newly hired therapist. So we have a small team of providers and our lead care managers can be any of the social worker or navigator. So there are three of us on our team who serve as lead care managers. And similar to all of the care at Team Lily, we've really tried to let it be patient-driven so the primary relationship, the primary touch point for a particular patient will become the lead care manager in that case.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	Rebecca Schwartz – 00:47:58	And yeah, I think our primary strategy has been for providing all the care for pregnant folks who are experiencing barriers, has been this model of building the relationship, investing in the relationship, and then also building our partnerships with community. So with the other community organizations serving our clients, with the shelter system serving our clients, with the substance use treatment services. So really investing in those relationships so that we can advocate, we can help navigate. And so again, ECM has allowed us to have a point person on our team for each client who we're enrolling and to invest our time even further in building those relationships for each patient.
No Slide	Rebecca Schwartz – 00:48:51	And I would say that as we're scaling it slowly in part because it's really the biggest challenge for us, and I don't know if this may resonate with other programs, but we are very... In this model in which we're very client centered, we don't have a lot of structures or protocols that are providers are also balancing. We're kind of doing what is asked of us by our clients on any given day and helping them as best we can move through their priorities. And so, integrating the additional kind of documentation needs and assessments that are required for ECM has been really a training process for our staff. And so, that is where we are right now is trying to integrate some of that work, carve out time, get back out of the field a little bit in order to dedicate time to that. And that's the scaling process for us.
No Slide	Palav Babaria – 00:49:56	And just to follow up on some of what Rebecca and Randi, you both have said, I think we can acknowledge, and I see a lot of chatter about this too, that there is intersectionality and individuals qualify from multiple populations of focus and are often experiencing multiple things. And so, how have you sort of thought about community supports and other wraparound services, especially for those Team Lily, ECM members who are homeless or have an SUD or SMI diagnosis?

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	Rebecca Schwartz – 00:50:30	I mean, that was our work from before, before we had ECM and the funding was, so we really think about it, coming from a place of understanding the stigma and the prejudice and the barriers to care that our clients face who are experiencing pregnancy while having a substance use disorder or a mental illness and also unstable housing and the trauma that they bring to care. I think this is an audience that is aware of this, but so many prior negative experiences with healthcare for this population specifically. And so, understanding that we need an approach that really understands that deeply and is patient and allows folks to set their own priorities and works with them on those priorities. That's always been the vision and the core of Team Lily services. And I think where it is, it's the scaling up, it's the capacity to do that while meeting kind of programming requirements. That's where we're working now. Yeah, that's it ECM.
No Slide	Palav Babaria – 00:51:37	And then last question for you all, as we touched upon earlier in our slides, so many of the needs and issues change postpartum, especially where now there's often that little human going home with the postpartum individual. And so, what have you seen as the biggest needs and roles that the lead care managers are playing during that transition period from hospital to home and their early days postpartum, and any advice for other providers on the call on that period?
No Slide	Rebecca Schwartz – 00:52:12	Is that for me? Yeah. Hey, Randi, I want to make sure you answer well.
No Slide	Palav Babaria – 00:52:16	Any Team Lily representative can answer.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	Rebecca Schwartz – 00:52:21	Yeah. I would just echo that is such an urgently important time. The postpartum transition is everything. It is a place where we see some people really reaching out and asking for help and some people not reaching out, but very much still in need of that help. So one of the things that ECM has allowed us to do is, again, to have a point person on the team who's going to hold that client whether... And that dyad, that mom and parent and baby who may be reaching out with a lot of needs and may quietly be kind of struggling and holding that case to being able to do the really proactive outreach, going to the home, making calls and texts even daily sometimes helping ensure that the insurance barriers are over, that everybody has insurance, that everybody is making it to their visits, all that glue. Yeah.
No Slide	Palav Babaria – 00:53:17	Perfect. Randi, any final reflections on those questions from you?
No Slide	Randi Tanksley – 00:53:26	No. No, I don't have any. Sorry.
No Slide	Palav Babaria – 00:53:30	Okay, no worries. Just want to make space. So we'll turn over to the California Health Collaborative who in our prep calls, I think you all have done a really amazing job, not just sort of being ECM providers, but also providing community supports and leveraging the CHW benefit to build out this true continuum of care. You're operating in multiple counties, and I think you've accessed most, if not all, of the various technical assistance resources that the department offers through CITED, PATH, the learning collaboratives.
No Slide	Palav Babaria – 00:54:02	So would love to hear a little bit more about what your strategy was in offering all those services and then specifically, how you use the technical assistance and grants that you received to sort of launch and build out infrastructure for your organization? Where were the areas that you felt were most critical billing or data exchange? And especially for the providers on this call who haven't yet become ECM providers, what's your advice for them for what resources they should be looking to leverage and what things they should focus most on?

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	John Bodtker – 00:54:34	So it's really interesting to hear the Team Lily modeled because at California Health Collaborative we're a little bit different. So we're geographically distributed. Now we're contracted in 15 counties with five health plans, several different populations of focus including community support. And we're also trying to stitch together the community health worker service benefit to tie in some of these other services and resources and really make a network model across this large geography. So we're kind of approaching it from a remote-based team with in-person services being kind of the ideal thing. But we hit the ground really with no infrastructure other than a vast patchwork of different grant-funded programs ranging from perinatal mental health and substance use, all kinds of things like that. But sort of a patchwork, a lot of resources, a lot of relationships, lots of connections, lots of expertise, but really trying to build a model of like, all right, how can we make this congruent across our catchment area and really understand the services that we need?
No Slide	John Bodtker – 00:55:54	Really, one of the biggest barriers we had, well, there's several, and that one is contracting to get the contracts with the care plans. Other is the technology for documentation and billing and claims. And particularly when you start talking about managing multiple managed care plans and their contracts, and unfortunately, each of the managed care plans has disparate requirements in terms of workflows and claims. So there's a lot of complexity that we're trying to address using the technology to make a seamless experience for our care team. So there's that stitching this together, getting our platforms together, managing the workflows of hundreds of patients and trying to stay on top of that. So that's been a big effort and we learned that a traditional EHR wasn't really what we needed. There was a lot of technology needs to assess and a lot of planning and strategy on how to build the scaffolding and skeleton of what we need for this program and then start flushing it out with staff and capacity. And we've been really fortunate to have a lot of success with all the different resources that DHCS has been providing.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	John Bodtker – 00:57:19	So the PATH CITED funds, IPP awards from by county and health plan, the TA Marketplace, consultant support. We're really being the administrative team. So having that extra consultant support coming in from the TA Marketplace has been instrumental. And I really can't compliment enough the CPI and planning initiatives for really giving us a forum to understand the market, to understand different counties, lots of different counties, to understand the pulse of what other providers are experiencing. The CPI have really helped us avoid some pitfalls that we wouldn't have known otherwise. And so, that's been instrumental in the strategy side, and it's really just a lot of time making sure that we know what resources are out there, taking advantage of them, and trying to keep our eye on that vision of how do we bring more and better services to the people on the ground, and then how do we stitch these funding streams and plans together to really meet the community need?
No Slide	John Bodtker – 00:58:32	And I just can't say enough that the resources out there and the support from DHCS and applying for them and managing them and the follow through has been absolutely critical to getting to where we're at right now.
No Slide	Palav Babaria – 00:58:50	Follow-up question on that is, and you hinted at this, but I think your team has deep experience really serving Medi-Cal members who live in rural and remote service areas, which we know for ECM generally has been a challenge across the state and in building some of the county-based coalitions to support maternal health. So I would love to hear what are some of the success stories or how you were able to do that, especially when we know that workforce challenges in these rural and remote areas can be a major barrier.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	John Bodtker – 00:59:21	Yeah. So one of the really nice things, I think about our model being in a lot of counties is in the way that the CPI funds have come out is that we can hire locally and then manage kind of from a central area. So we have the ability to flexibly staff and scale the different remote areas and get people there to actually meet and engage, not only with the enrollees obviously, and Rebecca touched on this, but it's building those relationships with the providers and the community and the other supports that are available outside of ECM, because that's really what we're trying to do is use this model to link people to what they need, help them assess and plug them in with those resources.
No Slide	John Bodtker – 01:00:10	So I think the geography and the staffing model has been critical, and that's also a big part of why our technology has been such a critical need too, because you can't run it out of an office on paper and binders. We're out there in the field meeting with folks and providers, and we have to be able to manage that remotely and scale it.
No Slide	Palav Babaria – 01:00:39	Thank you. And then a question for all of you, and I've seen comments in the chat about sort of the rates for ECM, and we also talked a little bit about building this continuum of how do you leverage other benefits like doulas or dyadic services or community health workers for individuals either who are on ECM, who can receive doula and dyadic services, but not CHW services or as sort of a step down once they've graduated from ECM. So what tips and advice do you all have for providers about how to braid together funding depending on what your model is or how to leverage some of those other benefits?
No Slide	John Bodtker – 01:01:19	So yeah, a big part of that is well, being aware of the resources and learning how they work and aligning that with your project goals and incentives. So it's really understanding those tools and utilizing them. Could you repeat the question?
No Slide	Palav Babaria – 01:01:44	What you described, and I think both of you, is that you had pre-existing programs that were grant or otherwise funded. And so, have you had to braid together ECM funding or strategies on how to do that?

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	John Bodtker – 01:01:55	Oh yeah, yeah. So yeah, we've braided through multiple IPP awards, multiple grants, also like the QHIO Onboarding, which is helping inform our technology platform so we can participate in QHIO with the SEOH codes and all of that.
No Slide	John Bodtker – 01:02:22	So those are some of the big tools that we're using, but we're also looking at how... So we have other existing programs expanding tobacco, other family care programs that employ CHWs. And then, so we're spending a lot of effort trying to develop our CHW service benefit internally so that we can leverage existing CHW staff and relationships with providers. And it's sort of like a stand aside from these calculating benefits specifically, right? Because the CHW kind of lays outside of that, but it's really part of that same model of building a network to tie those providers together across a big geography and really know those resources. And I think the CHWs gives a way to stitch the ECM and community sports benefits across with other programs and services that we're providing and really have the tools.
No Slide	John Bodtker – 01:03:25	The other neat thing about the CHW service benefits is there's a lot of flexibility in how you can operationalize it, and we've really found that the managed care plans have been very open and receptive to some creative planning. We've got some ideas on the works on how we want to use this benefit in some new ways to reach people. And there's a lot of planning on that, but we still have a lot of work to go to see how to operationalize these new things. But with the dyad benefit and some of the other services out there, including asthma remediation, kind of a CHW type of thing, we're looking at trying to unify that with the CHW workforce across multiple counties.
No Slide	Palav Babaria – 01:04:14	Great. Team Lily, any advice on how you are braiding funding or using other benefits to really help support this member group?

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	Rebecca Schwartz – 01:04:26	I'm not sure I'm the best on our team to speak to our braiding funding, but I would just say we're always leveraging community partnerships. It is never our goal to be the only provider team involved in a family's life. We are always looking for ways to make a successful linkage to community organizations, to Homeless Prenatal Program to black infant health, to the nurse family partner, the public health nurses, and their tremendous work that they do. And I think we've just really invested the time on our team into building and maintaining those relationships so we can make successful linkages and not just referrals that aren't going to go anywhere, but actually connect people, make sure there's a human that's able to receive help when someone doesn't have a steady phone number or a way to be contacted back, walk it all through to make sure that those connections are made.
No Slide	Palav Babaria – 01:05:23	And that is really the elbow grease that makes the difference. So thank you Rebecca, and Randi, and John, and Leslie for all of that hard work. Last long question, and I know our audience is eager, and before actually we move on to that, I will remind everyone on this call that DHCS does not set the ECM rates. And so, providers can absolutely negotiate rates with their managed care plans for those that are thinking about sustainability. And we also recognize that depending on what population of focus you're serving, a highly medically complex population that needs many more licensed individuals in the care team is going to be more expensive and needs a higher reimbursement rate than if you're serving a population that has fewer medical needs, but maybe more social needs. And you have a larger proportion of non-licensed members in the care team. And so, we encourage you all to have those conversations with your managed care plans and negotiate away.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	Palav Babaria – 01:06:19	So in terms of the last piece, as all of you hopefully know, as a part of our ECM And Community Supports Action Plan, we absolutely at DHCS have a vision that ideally, all referrals for ECM are coming from the community, from someone who knows the member knows what their needs are, and can help advise on what type of ECM provider would be best positioned to serve them. This could be from their medical providers, this could be from a family member. This could be self-referrals. We also know that the uptake of ECM is much better when those referrals come in than when there is data mining and cold outreach that is being done to members. But that also needs people to really be aware of ECM and have referral pathways and have those local linkages so that everyone who is touching these patients and members knows how to get them into ECM.
No Slide	Palav Babaria – 01:07:07	So we'd love to hear from you all, what efforts have you seen locally in your communities to promote awareness of the ECM benefit? What types of referral strategies have worked, and any other ideas you have to fix those problems?
No Slide	Leslie Shelton – 01:07:25	I can kind of answer to the referral strategies and then John can jump in. Part of the reason why I got bring into CalAIM is because we are already serving birth equity populations of focus already. So part of our goal is to work together where we are actually also bringing in first five families and seeing what their needs are and referring them to ECM services and providing services as well. So I feel like our collaboration comes from in-house because we have multiple programs, perinatal programs within CHC that have similar populations where First 5 program participants may end their program but still need services. And so from that step, after they end the program, we can then see if they qualify for ECM or refer them over. And so, the goal is to work together in-house as well as out in the community referring clients. So I know that is one of our current goals and our future goal.
No Slide	Palav Babaria – 01:08:48	Team Lily, anything to add to that in terms of provider referrals or awareness?

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	Randi Tanksley – 01:08:53	Yeah, so similarly to CHC, we refer to the health plan. So a lot of times we know before the health plan, if the patient is pregnant, if the patient is homeless-
No Slide	Randi Tanksley – 01:09:03	We know before the health plan, if the patient is pregnant, if the patient is homeless, if they're having any of those things come up that makes them eligible for ECM. So we're already working with the patient and we refer into the health plan.
No Slide	Palav Babaria – 01:09:22	Great. Well, I know our audience is eager to ask questions, so final lightning round. If each of you wants to just in 15 seconds give your one pearl of wisdom to individuals who are considering serving the Birth Equity Population of Focus. And all of you in the chat, if you also want to add your pearl of wisdom, we'll happily take all of that wisdom back and share it.
No Slide	John Bodtker – 01:09:47	I would just say I think there's an incredible potential here. We are seeing our care team make an incredible difference in people's lives through this program. So we were fortunate to have ECM with some of the long-term care and senior Population before rolling into this in January. So it's like we've seen how these community supports come together and really truly make a difference in keeping people at home and out of long-term care in that Population. And we're just barely getting a glimpse of the potential over here on the Birth Equity side. There's so many aspects of this program that we want to enhance and build out to really make a member journey that caters to their needs and meets their needs across it. So the ability to be creative and inspired in what you do, I think, is really important here. And also just knowing that there are tools out there and resources to get started if that's what you want to do.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	Rebecca Schwartz – 01:11:06	I think our experience has taught us that our team members have an enormous amount of creativity and resourcefulness and meeting the needs of our clients. And that these are a different set of skills. And I don't know, just being able to attend to ECM, bring this infrastructure around documentation and billing in takes time and investment and training and technical support. And Randi's been so tremendously helpful to our team in providing expertise and technical support and we really need it. And so just planning for that, that it's going to take time for people to feel confident navigating these new systems as we're bringing them on board and it's important to plan for that.
No Slide	Palav Babaria – 01:12:02	Randi and Leslie, any pearls of wisdom you want to share?
No Slide	Leslie Shelton – 01:12:11	I think I lost connection for a minute. Can you repeat the question?
No Slide	Palav Babaria – 01:12:16	Your 15 seconds of a pearl of wisdom that you want to share with the group of any advice or lessons learned about being an ECM provider for the Birth Equity Population of Focus?
No Slide	Leslie Shelton – 01:12:27	I would say a pearl of wisdom is to utilize what you have in-house already within your agency. Utilize your experts, utilize anyone who may have worked in the Population of Focus, which is what I think John is doing a great job. He's really bringing in all of the experts, those who have been working with this Population Focus for many years. So I would start within your agency, focus on that, focus on building a team around that and then moving forward with, of course, all the ECM services.
No Slide	Randi Tanksley – 01:13:09	I agree with everybody else. I think one of the things that I have told our partners and other folks thinking about becoming ECM providers when they're already working with this Population of Focus, it can be a little confusing learning what ECM is, but you're already doing the work. The documentation piece is a little different and I feel like that's what we've been asked to do a little differently, but we're already doing the work.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
No Slide	Palav Babaria – 01:13:41	Fantastic. Well, thank you so much to our panel. And I want to open it up. Sarah, are there any specific questions for the panel that we should lift up? Or we can move into our next few slides and then have general Q&A?
No Slide	Sarah Allin – 01:13:54	I think it would be great... There are a few questions for the panel, but let's go through a few of the frequently asked questions that we've prepared and then we'll come back around to the panel, but that sounds great.
No Slide	Palav Babaria – 01:14:07	Great.
No Slide	Sarah Allin – 01:14:09	So I think we will pull up the slides and do a couple more and hand it to Bonnie.
Slide 24	Palav Babaria – 01:14:22	Sorry, go ahead Bonnie.
Slide 24	Bonnie Kwok – 01:14:26	Okay, well thank you again to our esteemed panelists for sharing your important perspectives. For those of you who are just launching Enhanced Care Management for the Birth Equity Population of Focus or are considering to become an ECM provider, and we hope you are, we hope these insights shared here today will be helpful as you navigate through the next steps of this work. And for those of you considering if ECM Birth Equity is right for your organization, I just want to provide a very quick reminder of the basic requirements of becoming an Enhanced Care Management provider. And again, this has been emphasized during this presentation that really we're looking for community-based entities or organizations or providers, those who have experience and expertise. And Palav had already covered the fourth bullet from the top about DHCS not setting ECM provider rates, but those discussions should be had with the managed care plans.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Bonnie Kwok – 01:15:35	Next slide please. I'm going to go through these slides a little more quickly so that we can save some time for questions. If you see me present or work with me long enough, you know that I love analogies. And as I'm hearing our panelists speak and what I'm seeing in the chat, some of you all are already sharing some emerging or best practices. And I'm seeing this Enhanced Care Management web that's building. And we really need to continue to find more weavers or providers to build this web with us. At the risk of sounding cliched, it really does take a village to raise a child. And really takes many organizations and providers to build this network to serve this Birthing Population.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 25-26	Bonnie Kwok – 01:16:34	So our panelists had covered these items already, but please refer individuals for Enhanced Care Management. Please consider becoming an Enhanced Care Management provider and build these referral pathways with Enhanced Care Management providers, so that we can continue to build this robust provider network. John had mentioned the TA marketplace, so that's technical assistance marketplace, to help you get started. There was a question in the chat about what other resources is available, so please look at our Enhanced Care Management Provider Toolkit. And there's also CalAIM collaborative Planning and Implementation groups at the regional level. Next slide please. These are some additional frequently asked questions. The first one, "If the plan is looking at its own data to proactively identify the population eligible for the Birth Equity Population of Focus, how should it navigate using race and ethnicity data for multiple sources?" And we've shared this earlier, but we are expecting plans to source most of the Enhanced Care Management referrals from the community to determine whether there are members who may be eligible to receive Enhanced Care Management. However, to the extent that plans use their own data to look at eligibility, they shouldn't limit themselves only to the plan data feed, which is shared from DHCS to the plans. If there are instances where the data on the racial or ethnic group of a member varies by source, again, we encourage plans to prioritize members self-identification of the racial and ethnic group in confirming their eligibility for the Birth Equity Population Focus. And again, those racial ethnic groups are Black, American Indian, Alaskan Native and Pacific Islander.
Slide 26	Bonnie Kwok – 01:18:47	The next question is, "What's the relationship between the Birthing Care Pathway and Enhanced Care Management Birth Equity Population of Focus?" And Palav had touched on this briefly at the beginning. And there's also a slide next which I will address. And I can also address members receiving doula, dyadic or community health worker services as well. So if you can go to the next slide please.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 27	Bonnie Kwok – 01:19:23	For the Birthing Care Pathway, this is still in its early stages of development, but we're developing a comprehensive pathway for all Medi-Cal members at the time of conception up to 12 months postpartum. And through this pathway, we want to address care delivery policies and program initiatives that encompasses medical, behavioral, health related social needs, and share further recommendations and guidelines. We are expecting to publish a report in the summer of this year for our initial policy recommendations or learnings that we have had in our work groups, which encompasses our clinical care work groups, social drivers of health work group, and really lifting up the members' voices work groups, so that we can continue to be as member centered as possible and putting members in the forefront of this work. Next slide please.
Slide 28	Bonnie Kwok – 01:20:38	I want to emphasize these additional supports for our Medi-Cal birthing individuals. And there has been some discussion already about the doula, community health worker and Dyadic Services benefit. So I'll start with the Doula Services. The doulas can provide a member centered, culturally sensitive, culturally concordant care to any birthing individual in Medi-Cal. And this can support individuals and families up to one year postpartum. For the community health worker benefit, we really emphasize preventive health services. And we know that there's increased rates of intimate partner violence during pregnancy and encourage CHWs to have that training and background to provide care for those who need it.
Slide 28	Bonnie Kwok – 01:21:42	Next for Dyadic Services, Palav also mentioned this in the beginning of where this model can serve not just the child at let's say a Well-Child visit, but also the caregiver or parent or guardian of this child or children as well. And this is a service where the caregiver can also be cared for. And we know that there are times where the caregiver may prioritize the health of the child, but the caregiver's health is also a priority. And this is a great benefit for improving screening for behavioral and psychosocial needs.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

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Slide 28	Bonnie Kwok – 01:22:35	Last but not least, Transitional Care Services. I mentioned earlier that the Transitional Care Services has launched for all members starting January 1st, 2024. And for the purposes of Transitional Care Services, all birthing individuals pregnant up to 12 months postpartum considered high risk for Transitional Care Services, and they will have access to a Transitional Care Services lead care manager. And for those members who are enrolled in Enhanced Care Management, that Enhanced Care Management lead care manager will also be their Transitional Care Services manager, as we're emphasizing this continuity of care. Next slide please. I'm going to hand this back to Palav and open it up for questions and discussion.
Slide 29	Palav Babaria – 01:23:38	Thanks Bonnie. Sarah, I'll have you guide us through our Q&A. I know time is sharp, but we'll try to get through as much as we can.
Slide 29	Sarah Allin – 01:23:44	Yeah, maybe Palav, there have been a number of questions about how the agency set the eligibility criteria for the Population of Focus. Some of what we talked about in this deck is also the idea that members can self-identify that they meet the criteria. I want to just clarify that a little bit for the group and talk through how the agency hopes this is operationalized in the field for determining eligibility for the Population.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

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Slide 29	Palav Babaria – 01:24:13	Absolutely. So I think as we kicked off, ECM Birth Equity Population of Focus is one specific tool to explicitly address the disparities that we are seeing in our data as a state and provide extra support to over time close those disparities. It is by no means the only Medi-Cal required service or care management support or wraparound services that the Medi-Cal program covers or that the state offers through other departments and agencies or individuals who are pregnant. It is just one of many options. And so we encourage all of you who are taking care of pregnant or postpartum individuals in any way to really be looking at your entire population, identifying what member needs are and connecting them to specific services that they qualify for or would benefit from. One of which would be the Enhanced Care Management Birth Equity Population of Focus.
Slide 29	Palav Babaria – 01:25:06	I will also lift up that in our Population Health Management Policy Guide. We actually have a requirement that managed care plans have to do an assessment of all pregnant individuals in the Medi-Cal program. So that is one venue by which some of those needs and referrals and linkages are made and identified. Specifically around self-identification this policy is consistent with Medi-Cal eligibility and enrollment. So in current state Medi-Cal members, when they're signing up for their Medi-Cal or doing redetermination self-identify and fill out race and ethnicity information on their Medi-Cal application. We as a state have never asked for additional documentation evidence or anything. And so that this follows that same philosophy and principle that has been a part of the Medi-Cal program for many, many years.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

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Slide 29	Sarah Allin – 01:25:54	Great. Thank you, Palav. I think we have time to sneak in another question or two. One of the things that often comes up across lots of our ECM Populations of Focus is how does that ECM lead care manager and ECM provider work with other models that are serving the family? I love what Becca said. She said something like, "We never want to be the only provider working with a family and being in a family's life." We've gotten a number of questions about how does a home visiting program or model collaborate with ECM? How as a comprehensive perinatal services program should we interact with ECM? Do you want to talk a little bit about the vision for how these models intersect and work together?
Slide 29	Palav Babaria – 01:26:36	Absolutely. I think some of you have heard me say this in other venues, but fragmentation is the enemy of healthcare. And so really, the vision is that collectively at the local level in communities, we are really connecting all the different services, right? No one provider is going to be able to do everything for the member and their family. But we do need to be coordinated and talking to each other and breaking down silos, because when we don't do that as the providers, it is really members and their families that bear the brunt of navigating all of that fragmentation. And so we do envision that local programs are figuring out, yes, there's an ECM lead care manager, but that they're working with other care managers who exist, that they're identifying other services, community supports, aesthetically tailored meals, other home visiting programs that may be beneficial to that individual and family.

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

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Slide 29	Palav Babaria – 01:27:26	We recognize that's hard because all of the referral and eligibility criteria for those different programs varies and are fragmented and aren't the same county to county. And I think that is where those local connections and local relationships where you really can pick up the phone and make a call and not send an email into the ether are really critical and important. There are some hard stops, so we'll refer you all to our ECM policy guide and the billing guidance. I think the biggest thing is there is federal and state restrictions on double billing. And so if someone provides a single service, you can't both get paid from your home visiting program and from the Medi-Cal program for that single same service. But we do allow, other than the CHW exclusion, someone can be in a home visiting program and enrolled through that and then also be receiving ECM Care Management services through that program. We just want those entities to coordinate and work together so that they're maximizing the services that they have to offer to that member.
Slide 29	Sarah Allin – 01:28:26	Great. Okay. Last one, lightning round. One of the things I've heard you talk about, Palav, is how important community-based referrals are for this population, making sure we're really lifting up birthing individuals and making sure that they're referred in. You also as a provider make referrals to ECM. We've gotten a lot of questions in the chat about, "How do I get connected to making a referral? How do I do that? How does that work?" Do you want to just talk a little bit about the logistics of the different pathways and what advice you might give to someone who's newer to this ECM environment and is trying to figure out, "Where do I go to make a referral?"

Launching Enhanced Care Management (ECM) for the Birth Equity Population of Focus

February 2, 2024

Transcript

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Slide 29	Palav Babaria – 01:29:03	Great question. And because I do this in my own clinical practice, I made a referral today. All of our managed care plans are required to have a website that is dedicated to ECM and community support that has information about how referrals can be made. They're also required to have a list of all their ECM and community support providers. So for anyone on this call, you can go to the Managed Care Plan website for the managed care plan or plans that operate in your county and find that information.
Slide 29	Palav Babaria – 01:29:32	We know each plan does it a little bit differently, so some plans have, some plans have call centers, some plans have email addresses. Some have a faster different pathway for providers referring versus self-referrals from a member or a family member. We have gotten the feedback from many of you that we need to streamline that process. So the state is working on updating our policy around referrals throughout calendar year 2024 to really try to simplify and streamline the referrals process statewide, and make it easier for the bulk of our referrals to come from community support sources. But in the meantime, really figuring out on the Managed Care Plan website or meeting with your managed care plan directly to establish those referral pathways is the best way to go.
Slide 29	Sarah Allin – 01:30:21	Thank you, Palav. A big thank you again to our panelists. Such a wonderful set of perspectives and important perspectives. Palav, have any closing remarks before we close today?
Slide 29	Palav Babaria – 01:30:35	I would just say, I recognize we did not get to everyone's questions, and so you will get our email address. It's also on the ECM Community Supports website. Please do feel free to email us for burning questions that weren't answered today. And there'll be lots of other conversations. But I am super excited about this Population of Focus because we have a crisis and we have disparities that I know all of us are collectively committed to closing. And I hope that if we can really leverage the potential of this benefit, we will really make a dent in those disparities. Thank you all.