CalAIM Progress For Acute Care Settings: Innovative Models & Early Outcomes

August 5, 2024 and August 7, 2024

Kevin Jarrett-Lee, DNP, RN, CCM, ACM
Associate Director, Utilization Management

Agenda

- **Brief Overview: Goals of CalAIM**

- **Timeline of CalAIM**
  - DHCS Statewide Initiatives
  - Partnership's activities to date

- **ECM Spotlight: High Utilizer Population of Focus**
- **CS Spotlights:**
  - Short-Term Post Hospitalization
  - Recuperative Care (Medical Respite)
  - Medically Tailored Meals

- **New! Community Health Workers**
  - "Bridge-to-Bridge" Pilot

- **Transitional Care Services (TCS)**

What is CalAIM?

CalAIM stands for ***"California Advancing and Innovating Medi-Cal."***

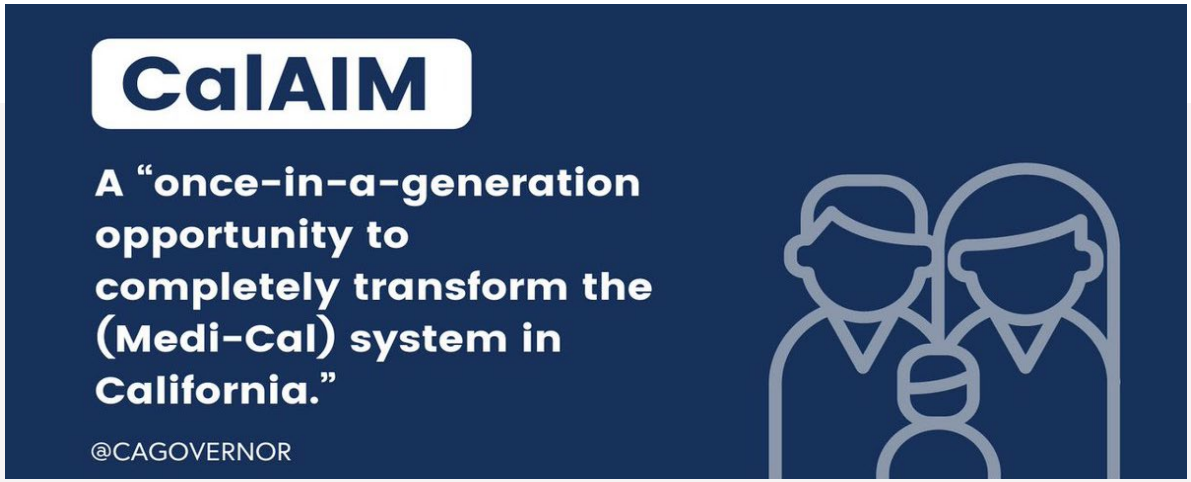
CalAIM is not a singular goal or program; CalAIM is a multi-year, multi-initiative framework being implemented by the Department of Health Care Services (DHCS) over the next 5 years.

All of the initiatives within CalAIM are focused on transforming the delivery of Medi-Cal services, programs and benefits with a goal of integrating services and improving outcomes.

The Centers for Medicare and Medicaid Services (CMS) approved CalAIM and the state's associated waivers on Dec. 29, 2021.

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

[DHCS CalAIM proposal: https://www.dhcs.ca.gov/calaim](https://www.dhcs.ca.gov/calaim)



Goals of CalAIM

1 **Whole-Person Care**

Integrate physical health, behavioral health, and social services to address all aspects of a person's wellbeing.

2 **Population Health Management**

Implement data-driven strategies to improve health outcomes for entire communities.

3 **Health Equity**

Reduce health disparities and ensure equitable access to quality healthcare for all Californians.

4 **Cost Efficiency**

Streamline healthcare delivery to maximize resources and reduce unnecessary spending.

CalAIM Overview

Key CalAIM Areas of Focus

Population Health Management

Enhanced Care Management & Community Supports

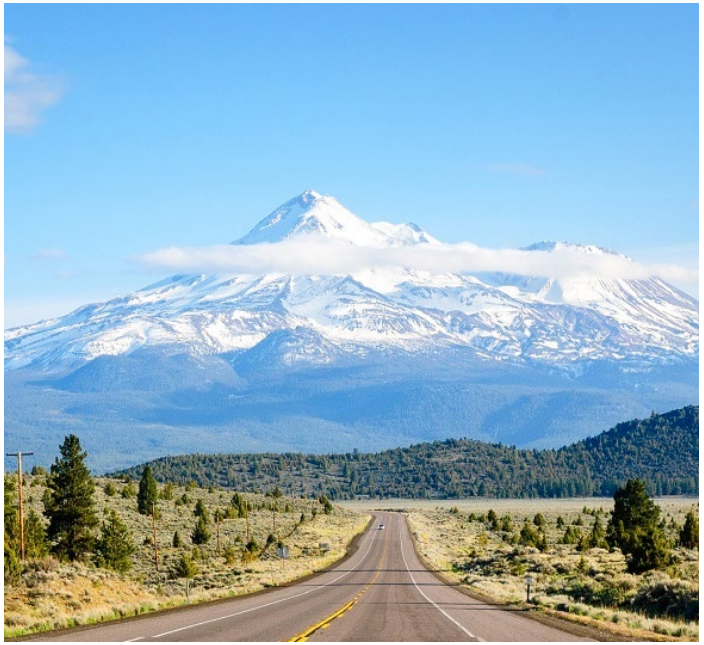
Dual Eligible Special Needs Plans (D-SNP) & Integration of Long-Term Support Services

Services & Supports for Justice Involved Adults & Youth

Behavioral Health Delivery System Transformation

Standardization with Medi-Cal Enrollment

Partnership's CalAIM Activities



1. **January 2022**

   Partnership HealthCare launches Enhanced Care Management (ECM) and Community Supports services.

2. **July 2022**

   Expansion of ECM to include additional populations of focus.

3. **January 2023**

   Introduction of new Community Supports offerings and Community Health Workers program.

4. **July 2023**

   New Community Supports offerings, new Populations of Focus For ECM.

5. **Ongoing**

   Continuous evaluation and expansion of services to meet community needs.

Partnership's Strategy for CalAIM Services

1

Needs Assessment

Conduct comprehensive community health assessments to identify service gaps and priorities.

2

Partnerships

Collaborate with local healthcare providers, community organizations, and social service agencies.

3

Service Integration

Develop seamless pathways between medical care, behavioral health, and social services.

4

Continuous Improvement

Regularly evaluate outcomes and adjust strategies to maximize impact and efficiency.

What Works & How Can We Do Better?

Spotlight Enhanced Care Management: High Utilizers

Target Population

Individuals with frequent emergency department visits or inpatient stays. Often have complex medical and social needs.

Interventions

Intensive care coordination, health coaching, and connection to community resources. Personalized care plans address medical and social determinants of health.

Outcomes

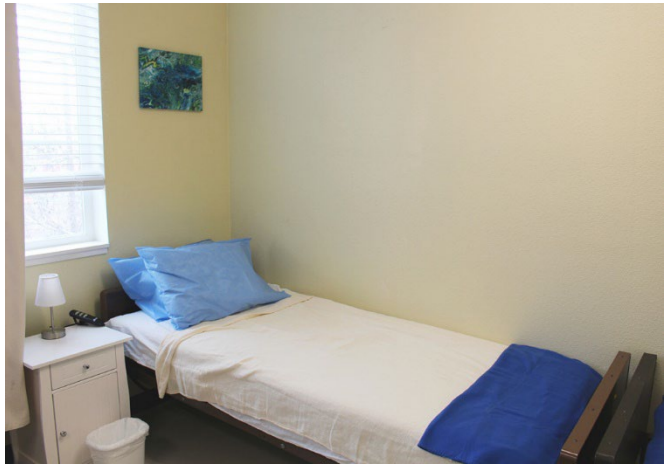
Reduced hospital readmissions, improved chronic disease management, and enhanced quality of life. Cost savings through prevention of avoidable acute care utilization.

Spotlight: Enhanced Care Management High Utilizers

- Of the Adult members (meeting High Utilizer criteria) enrolled in ECM since 2022, 75 have experienced:
  - ZERO ED visits in the last 6 months
  - ZERO Inpatient stays in the last 6 months

- Of the Children/Youth (meeting High Utilizer criteria) enrolled in ECM since 2023, 38 have experienced:
  - ZERO ED visits in the last 12 months
  - ZERO Inpatient stays in the last 12 months

Spotlight: Community Supports



COTS - Committee on the Shelterless: Recuperative Care Bed – Sonoma Co.

Service	Description	Key Outcomes
Short-Term Post-Hospitalization Housing	Temporary housing for patients discharged from hospitals	Reduced readmissions, improved recovery
Recuperative Care (Medical Respite)	Short-term residential care for recuperating patients	Faster healing, reduced healthcare costs
Medically Tailored Meals	Nutritious meals aligned with medical needs	Better nutrition, improved chronic disease management

Spotlight: Community Supports

- Member who was at Skilled Nursing Facility, 3+ Chronic conditions, Mental Health needs, was approved for **Short-Term Post Hospitalization Housing** and **Housing Transition & Navigation** services.

- The member transitioned out of the skilled facility, was to the Short-Term Post Hospitalization setting, was connected with a Community Supports provider to assist in locating housing.

New! Community Health Workers Pilot “Bridge to the Bridge”

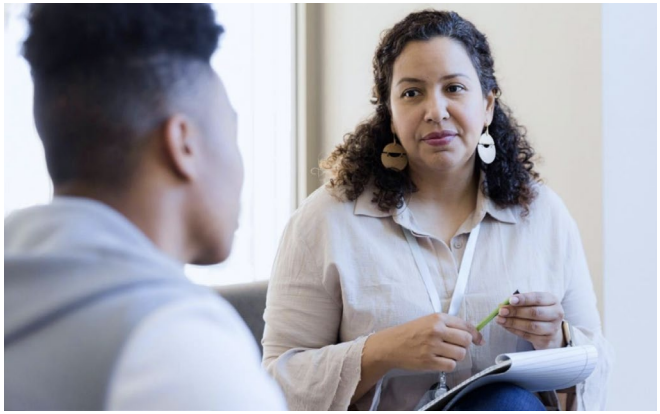
- **Background:** The Bridge Program funded by DHCS allocated $3.97M to work/fund Substance Use Navigators (SUNs) at 32 hospitals using CHWs. 17 of these sites were in Partnership’s network. The funding for this program sun set state wide.

- **Pilot:** Partnership has elected to continue to fund this program to allow the current SUN navigators at hospitals to transition to Community Health Workers (CHWs) for one (1) year. The program will be managed by Partnership's Behavioral Health department and the goals of the pilot are to:

  - **Develop SUNs into CHWs and provide CHW curriculum with options for SUD and MH services.**

  - **Hold quarterly learning collaboration meetings to include best practices for all of the hospitals**

  - **Develop a sustainable model for end of one year funding cycle so CHWs can continue their work**



navigation

support

education

connection

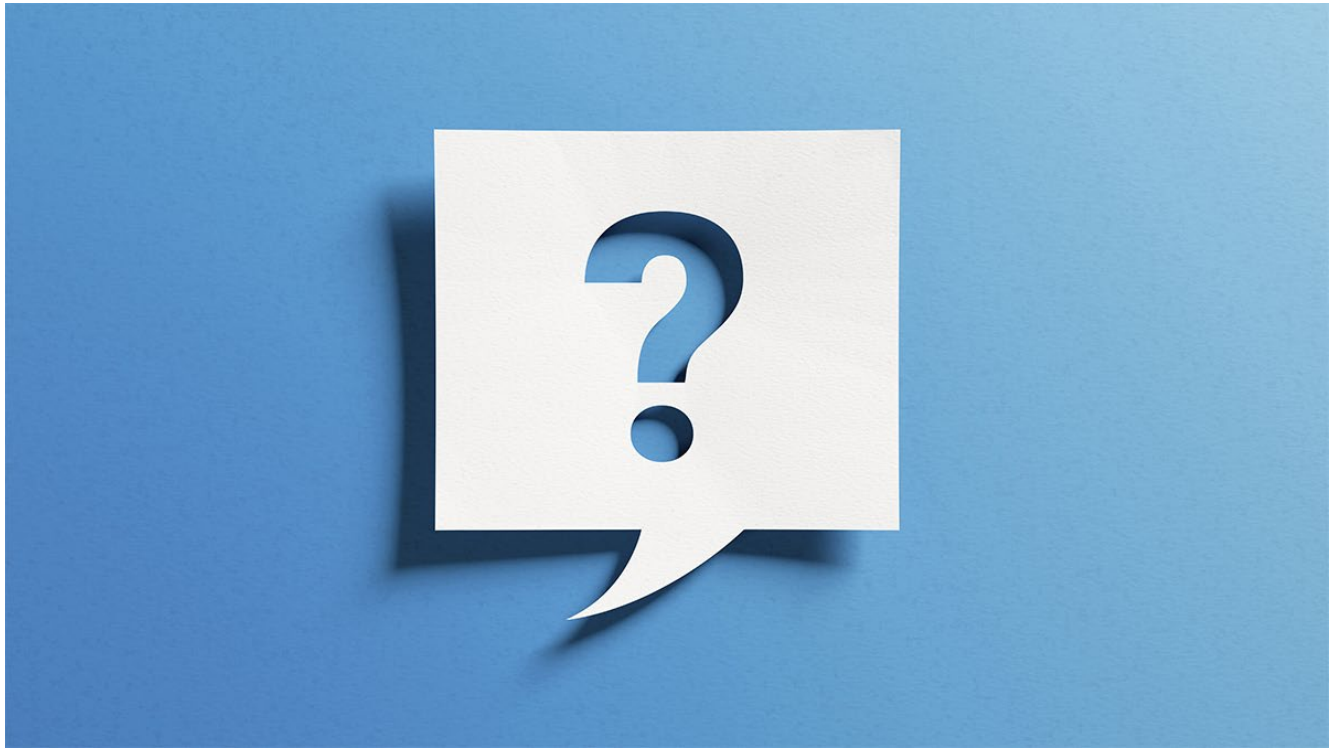
New! Transitional Care Services

- Partnership provides Transitional Care Services (TCS) for all high-risk members.
- Utilization Management teams: assist with difficult placements and discharge planning through concurrent review process
- Case Managers in the Care Coordination Dept. can assist members with needs pre/post discharge, such as:
  - Support with discharge planning
  - Outpatient appointments/follow-up
  - Medication reconciliation
  - DME, supplies, Home Health
  - Referrals to specialty care
  - Disease Management / Education
  - Community Resources
  - Transportation

PHC Care Coordination:
1-800-809-1350
CareCoordination@partnershiphp.org

PHC Transportation Services:
1-866-828-2303
Mon-Fri 7am-7pm

Questions



Resources

PHC CalAIM Webpage:

http://www.partnershiphp.org/Community/Pages/CalAIM.aspx

ECM Populations of Focus:

https://acrobat.adobe.com/link/track?uri=urn%3Aaaid%3Ascds%3AUS%3Aea3bb6fe-76a7-3456-ab74-05e19da9c64d&viewer%21megaVerb=group-discover

PHC ECM Referral Form:

www.partnershiphp.org/Community/Documents/CalAIM%20Webpage/ECM%20Documents/ECM%20Referral%20Form.pdf

PHC CS Referral Form:

http://www.partnershiphp.org/Community/Documents/CalAIM%20Webpage/Community%20Supports%20Documents/CS%20Referral%20Form.pdf