WELCOME to today's MCP Learning Community Webinar

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

with funding from California Health Care Foundation

MEDI-CAL PALLIATIVE CARE MCP LEARNING COMMUNITY

Ways to Engage

CCCC is a statewide collaborative community of individuals and organizations promoting high-quality, compassionate care for all Californians who are living their best lives in the face of serious illness.

How can your organization support the movement?

Become a Sustaining Supporter
Become an Organizational Member
Sponsor California's Premier Palliative Care Summit
Hire CCCC to Provide Training for your Staff

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Housekeeping

- This webinar is being **recorded**.
- Links to the recording and slides from this webinar will be emailed to you in the next few days.
- **Post questions in the Q&A or chat box** at any time.

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Social Needs in Palliative Care: Learning from Enhanced Care Management (ECM)

Aulina Bradley, RN
Director of Care Management,
Aetna Better Health of California

Neil A. Solomon, MD
Co-Founder and Chief Medical Officer,
MedZed

Introducing our Speakers

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Enhancing Care for Palliative Populations

Recognizing and Addressing the Interconnected Drivers of Health

Medical Needs

- What are the clinical and social drivers of health and well-being for these individuals?
- How do the clinical and social challenges interact with one another?
- What is the array of services needed to optimize outcomes for palliative patients and support their caregivers?
- How can these services be coordinated to reduce complexity for both members and providers?

Social Challenges

Integrated Health Plan and Direct Care Offerings

Aetna Meeting Members Where They Are

- Access to health assessments in CVS retail stores
- CalAIM Goals and Quality Strategy
- Aetna Medicaid National Experience
- California Health Plan Offerings
- CVS Health Enterprise Strength
- Aetna and CVS Health reimagining Medi-Cal

66K

Medicare Members

1.1M

Commercial Members

40K

Medi-Cal Members

Zeroing in on Complex Populations

ECM Populations of Focus

- Individuals Experiencing Homelessness
- Adult High Utilizers
- Adult with Serious Mental Illness (SMI) / Substance Use Disorder (SUD)
- Adults & Children/Youth Transitioning from Incarceration ** Youth 7/2023
- Adults at Risk for Institutionalization and Eligible for Long-Term Care ** 1/2023
- Nursing Facility Residents Who Want to Transition to the Community **1/2023

SB 1004 Palliative Care

General Patient Criteria:

- In late stage of illness, with continued decline in health status, but not eligible for or participating in hospice
- Individuals for whom death within a year would not be unexpected based on clinical status
- Willingness on part of patient and/or or family/patient designated support person to attempt in-home disease management, also to participate in Advance Care Planning discussions

Additional Disease-Specific Criteria: including Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Advanced Cancer, and Liver Disease

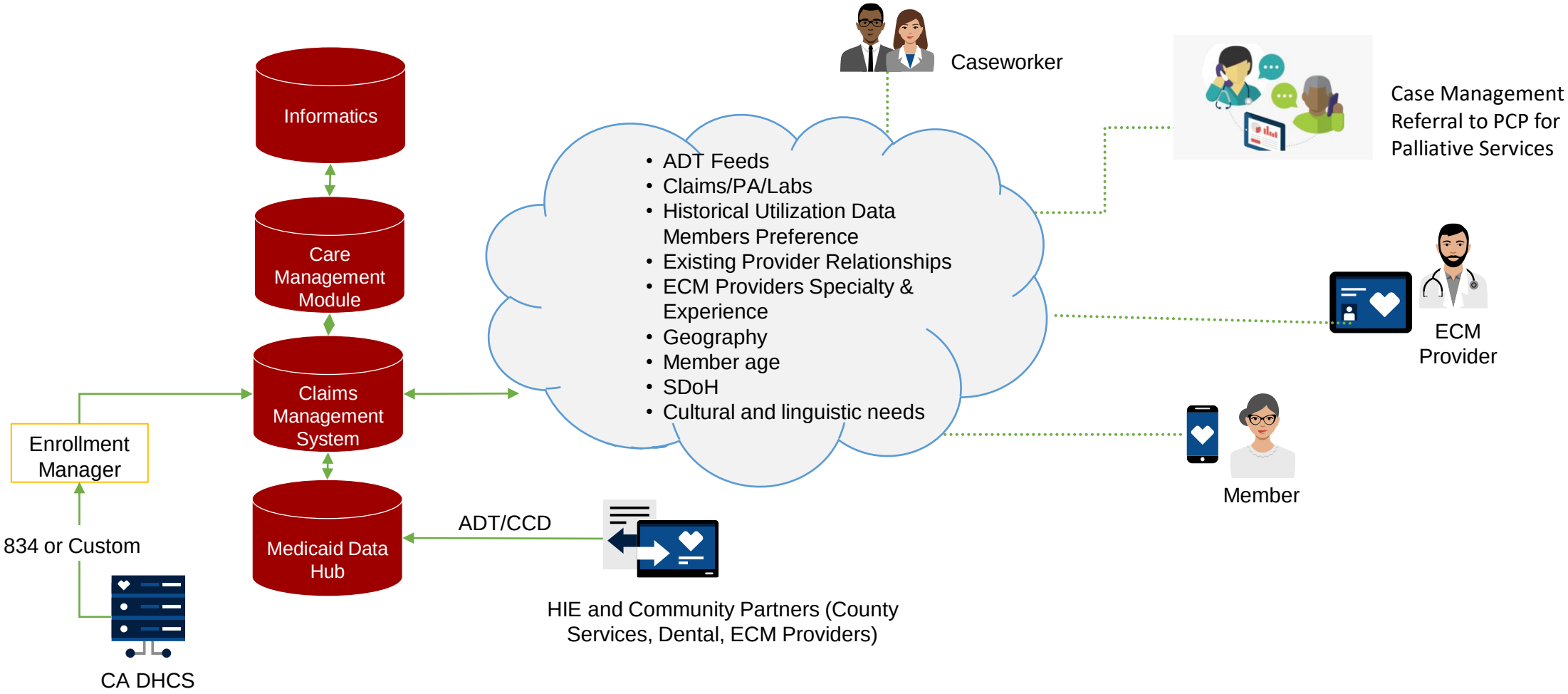
Mapping ECM Overlaps/Non-duplication

1915 c Waivers	Services Carved Out of Managed Care Plans	Services Carved into Managed Care Plans	Duals	Other
Multipurpose Senior Services Program (MSSP)	California Children's Services (CCS)	CCS Whole Child Model	Dual Eligible Special Needs Plans (D-SNPs) [from 2023]	AIDS Healthcare Foundation Plans
Assisted Living Waiver (ALW)	Genetically Handicapped Person's Program (GHPP)	Basic Case Management	D-SNP look-alike plans	California Community Transitions (CCT) Money Follows the Person (MFTP)
Home and Community-Based Alternatives (HCBA) Waiver	County-based Targeted Case Management (TCM)	Complex Case Management	Other Medicare Advantage Plans	Mosaic Family Services
HIV/AIDS Waiver	Specialty Mental Health (SMHS) TCM	Community-Based Adult Services (CBAS)	Medicare FFS	Hospice
HCBS Waiver for Individuals with Developmental Disabilities (DD)	SMHS Intensive Care Coordination for children (ICC)		Cal MediConnect	
Self-Determination Program for Individuals with I/DD	Drug Medi-Cal Organized Delivery Systems (DMC-ODS)		Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)	
			Program for All-Inclusive Care for the Elderly (PACE)	

1. ECM as a "wrap"	MCP Members can be enrolled in both ECM and the other program. ECM enhances and/or coordinates across the case/care management available in the other program. MCP must ensure non-duplication of services between ECM and the other program.
2. Either ECM or the other program	MCP Members can be enrolled in ECM or in the other program, not in both at the same time.
3. Excluded from ECM	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM.

Targeted Engagement

Algorithm for Identification of Eligible Members



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Aetna Contracted Community Supports

- Housing Deposit Services
- Housing Tenancy and Sustaining Services
- Housing Transition Navigation Service
- Medically Supportive Food/Meal/Medically Tailored Meals
- Asthma Remediation Services, also known as Asthma Trigger Remediations
- Community Transition Services/Nursing Facility Transition to a Home or Assisted Living Facility
- Day Habilitation
- Environmental Accessibility Adaptations (EAA), also known as Home Modifications
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- Personal Care and Homemaker Services
- Recuperative care or medical respite care
- Respite Services
- Short-term Post Hospitalization Housing
- Sobering Centers

Building on Experience with High-Risk, High-Need Patients

End-to-end integrated care provider focused on serving high-risk, home-based patients with chronic conditions and complex social needs

Partner with Medicaid and Medicare Advantage health plans.

Customized solutions, including:

- Delivering in-home tech-enabled primary care and behavioral health support
- Providing Palliative Care, including emotional and spiritual support and advance care planning
- Coordinating and providing wraparound social services
- Closing specific care gaps

ECM services build on our work with Whole Person Care and Home Health Pilots. They are grounded in our Longitudinal Social Care solution, a technology-driven Community Health Navigator (CHN) program that executes a SDoH plan for patients in conjunction with a plan's clinical personnel.

Current ECM Programs

8

Contracts

8

Counties

3,700+

Members Enrolled

Introducing Our Community Health Navigators

“What it really comes down to is, can a CHN walk in the shoes of their members? Are they connected to the community and truly passionate about giving back?”

Recruiting CHNs

- In touch with local culture, environment, challenges, as well as resources and organizations
- Member-focused, committed, and compassionate
- Persistent and creative at “detective work” of finding members
- Constructive problem solvers
- Collaborative and team-oriented

Training New CHNs

- Locating and engaging members
- “Meeting Members Where They Are”
- Motivational interviewing/overcoming objections
- Safety in the field
- Proper documentation
- Teamwork
- Communication skills
- COVID-19 safety and information

Systematically Supporting and Empowering CHNs

Team-based Approach Promotes Shared Knowledge and Best Practices

Daily All-California Team Huddle

Daily Local Market Meeting

Weekly 1:1 and Ride Along

Bi-Weekly Content Training

- Content knowledge and training
- Best practice and success sharing
- Load balancing
- Team collaboration
- Goals and performance

- **Housing Navigation**
- **Diabetes, Hypertension, other chronic diseases**
- **Mental Health and Substance Use**
- **Domestic Violence and Mandatory Reporting**
- **LGBTQ+ Community Access to Healthcare**
- **Cultural Humility/Cultural Competence/Bias**
- **Budgeting for Members**
- **Accessing and Researching Resources**
- **Applying for State/Federal Programs**

Finding and Engaging Hard-to-Reach Members

CHNs Employ a Method and a Determination to Go the Extra Mile

Telephonic Outreach

- Use proven relationship scripting in outbound calls
- Attempt minimum of 5 calls
- Rotate call time-of-day and day-of-week
- Conduct calls in member's preferred language

Community Outreach and Fieldwork

- Visit known addresses
- Attempt minimum of 5 "door knocks"
- Network with local social and other organizations to find transient members
- Visit member bedside when admitted

Lead Tracing

- Utilize available technology platforms to find alternative contact information
- Collaborate with health plan for previous addresses
- Conduct background checks

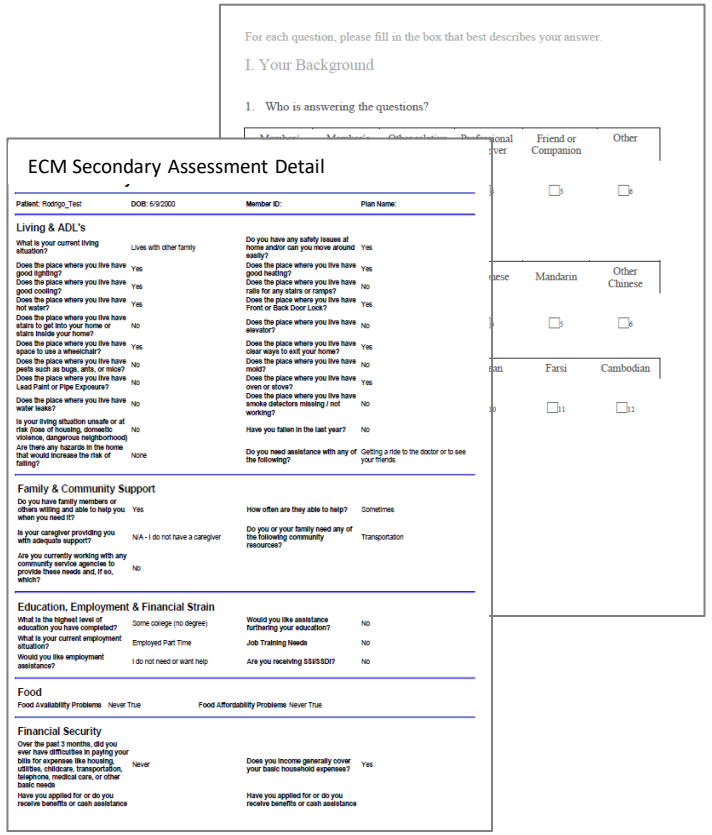
Creating the Roadmap for Integrated Care

Weaving Together Clinical and Social Care

CHN

Clinical Consultant

Program Manager



For each question, please fill in the box that best describes your answer.

I. Your Background

1. Who is answering the questions?

Friend or Companion	Other
☐5	☐6

Mandarin	Other Chinese
☐5	☐6

Farsi	Cambodian
☐11	☐12

ECM Secondary Assessment Detail

Patient: Rodrigo_Test | DOB: 6/9/2000 | Member ID: | Plan Name:

Living & ADL's

What is your current living situation?	Lives with other family	Do you have any safety issues at home and/or can you move around easily?	Yes
Does the place where you live have good lighting?	Yes	Does the place where you live have good heating?	Yes
Does the place where you live have good cooling?	Yes	Does the place where you live have rails for any stairs or ramps?	No
Does the place where you live have hot water?	Yes	Does the place where you live have Front or Back Door Lock?	Yes
Does the place where you live have stairs to get into your home or stairs inside your home?	No	Does the place where you live have elevator?	No
Does the place where you live have space to use a wheelchair?	Yes	Does the place where you live have clear ways to exit your home?	Yes
Does the place where you live have pests such as bugs, ants, or mice?	No	Does the place where you live have mold?	No
Does the place where you live have Lead Paint or Pipe Exposure?	No	Does the place where you live have oven or stove?	Yes
Does the place where you live have water leaks?	No	Does the place where you live have smoke detectors missing / not working?	No
Is your living situation unsafe or at risk (loss of housing, domestic violence, dangerous neighborhood)	No	Have you fallen in the last year?	No
Are there any hazards in the home that would increase the risk of falling?	None	Do you need assistance with any of the following?	Getting a ride to the doctor or to see your friends

Family & Community Support

Do you have family members or others willing and able to help you when you need it?	Yes	How often are they able to help?	Sometimes
Is your caregiver providing you with adequate support?	N/A - I do not have a caregiver	Do you or your family need any of the following community resources?	Transportation
Are you currently working with any community service agencies to provide these needs and, if so, which?	No		

Education, Employment & Financial Strain

What is the highest level of education you have completed?	Some college (no degree)	Would you like assistance furthering your education?	No
What is your current employment situation?	Employed Part Time	Job Training Needs	No
Would you like employment assistance?	I do not need or want help	Are you receiving SSI/SSDI?	No

Food

Food Availability Problems: Never True | Food Affordability Problems: Never True

Financial Security

Over the past 3 months, did you ever have difficulties in paying your bills for expenses like housing, utilities, childcare, transportation, telephone, medical care, or other basic needs	Never	Does you income generally cover your basic household expenses?	Yes
Have you applied for or do you receive benefits or cash assistance		Have you applied for or do you receive benefits or cash assistance	

Comprehensive Care Plan

- Enhanced coordination of care
- Individual and family support
- Coordination and referral to community and social services

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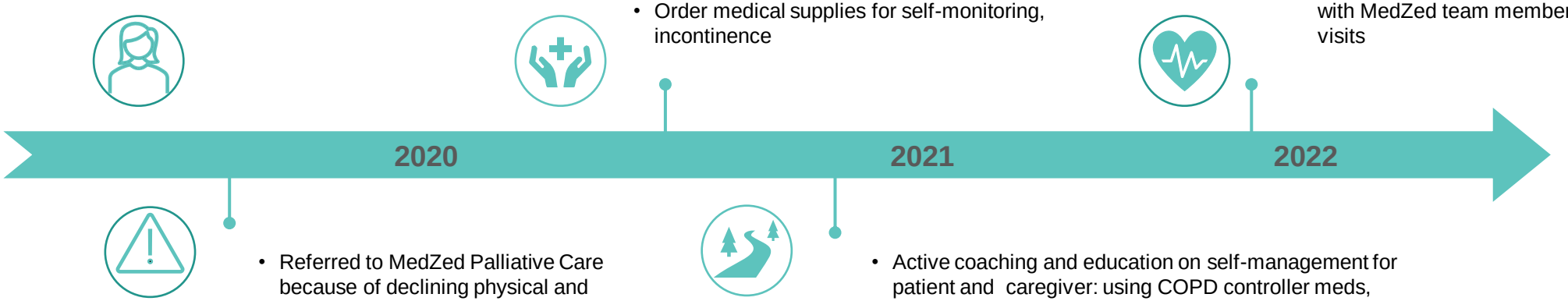
Enabling a Return to Independence and Well-Being

Supporting and Motivating Patient and Caregiver

- **Marta, a 59-year-old female in Los Angeles**
- **Numerous severe chronic conditions: CHF, COPD, diabetes, hypertension, chronic kidney disease, obesity, bipolar disorder**
- **Lives in room and board facility, supported by IHSS caregiver**



- Referred to MedZed Palliative Care because of declining physical and mental health, inability to self-manage conditions, high risk of mortality
- On continuous oxygen, bed-bound
- 9 ED visits in 6 months for COPD exacerbation

- Team of CCP, LVN and MSW develop integrated care plan
- Help connect to new PCP and secure referrals to specialists (cardiology, pulmonology, nephrology, and psychiatry)
- Apply for DME (portable oxygen), increased IHSS support
- Order medical supplies for self-monitoring, incontinence

- Active coaching and education on self-management for patient and caregiver: using COPD controller meds, healthy eating, self-monitoring, exercise
- Intensive focus on understanding and improving patient's quality-of-life, goals, self-esteem, and motivation
- Ongoing commitment to developing relationship of trust: open-ended questions, empathetic listening, consistency and continuity

- Marta takes active role in self-managing health: blood pressure under control, reduced BMI, improved nutrition
- Fully ambulatory, no longer uses oxygen
- Travels on own via bus to PCP and specialist appointments
- Across 2 years, 32 visits (mostly virtual) with MedZed team members, only 2 ED visits

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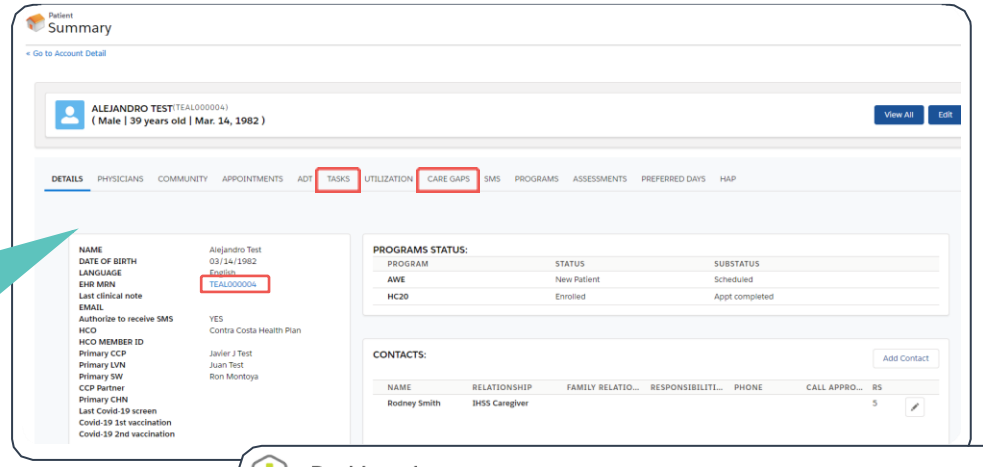
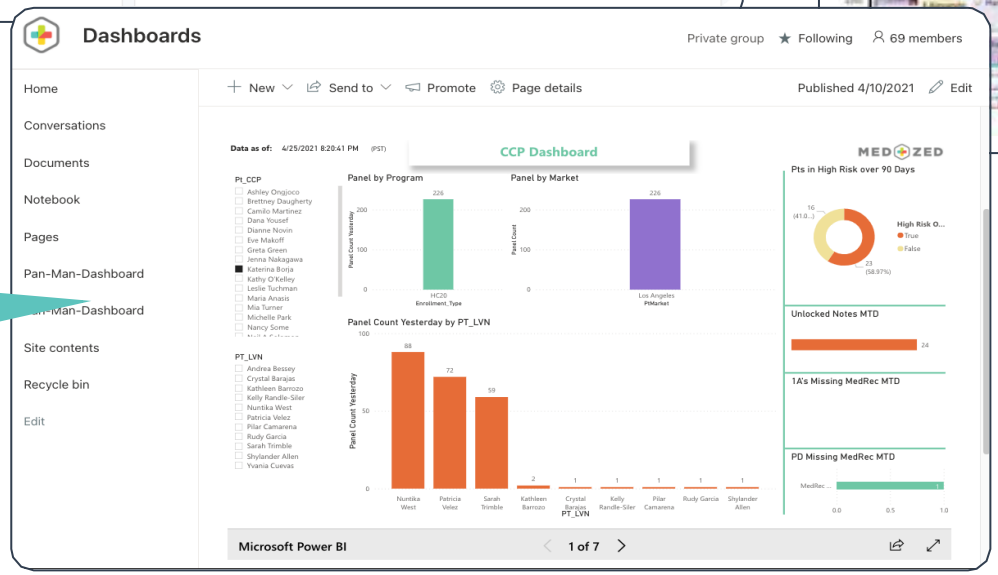
Leveraging Technology to Optimize Care

Share patient information in real-time



Gain insight into population health



Schedule and visit patients efficiently

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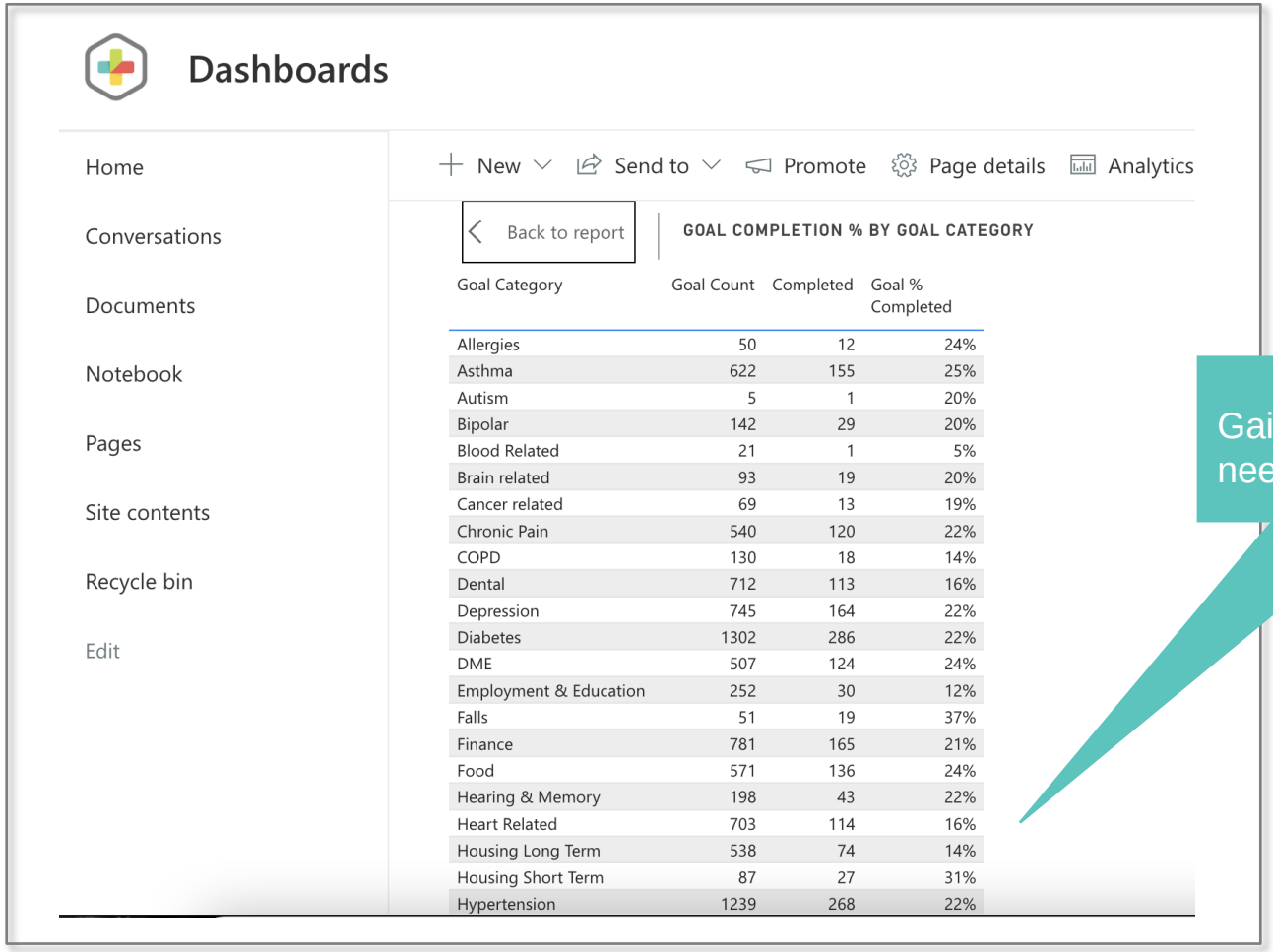
Zeroing in on Key Problem Areas



Goal Category	Goal Count	Completed	Goal % Completed
Allergies	50	12	24%
Asthma	622	155	25%
Autism	5	1	20%
Bipolar	142	29	20%
Blood Related	21	1	5%
Brain related	93	19	20%
Cancer related	69	13	19%
Chronic Pain	540	120	22%
COPD	130	18	14%
Dental	712	113	16%
Depression	745	164	22%
Diabetes	1302	286	22%
DME	507	124	24%
Employment & Education	252	30	12%
Falls	51	19	37%
Finance	781	165	21%
Food	571	136	24%
Hearing & Memory	198	43	22%
Heart Related	703	114	16%
Housing Long Term	538	74	14%
Housing Short Term	87	27	31%
Hypertension	1239	268	22%

Gain insight into areas in need of better solutions

Early Health Plan Perspectives on Executing ECM

Command Center Monitors Process and Progress

Health Plan Command Center Participants

- Executive Leadership (CEO, COO, CMO)
- Network Director
- Provider Relations
- Care Management
- Utilization Management
- Systems Configuration Team
- Appeals and Grievances
- Delegation Oversight
- Member Services
- Project Management

ECM Risks, Issues, and Concerns Post Go-Live

- Tracking of provider trainings
- Accuracy of Targeted Engagement Lists (TEL)
- Data sharing inbound & outbound files
- Resource sharing
- Referral process
- Documentation requirements
- Claims/encounters processing
- Invoice submissions
- Contracting status
- Billing modifiers

Commitment to Communication and Collaboration

Aetna and MedZed ECM Partnership and Learning

- Ongoing Dialogue between Aetna and MedZed
- Bi-Monthly Case Conferences
- Monthly Medical Directors Meeting
- Ongoing Denial Monitoring
- Delegation Oversight/ECM Scorecard
- Member Referral Advance Planning

Possibilities for Meeting Social Needs in Palliative Care

Open Questions for Discussion

Do you currently find that your palliative care members have complex social needs? If so, how are you managing these members today?

Are you cross referring members into ECM and or Palliative Care programs?

programs? How do you coordinate their services?

What decision points prompt a change in services (level of intensity) for members in your current environment?

Appendix

Community Supports: Definitions

- **Housing Deposit Services**
  - Identification, coordinating, securing, or funding one-time services and modifications necessary to enable the member to establish a basic household. Funding to support security deposits, set-up fees/ deposits for utilities, first months and deposit, services necessary for member's health and safety, and goods/medically necessary adaptive aides to preserve the member's health and safety in the home. Does not include provisions beyond first and last month's rent. Lifetime maximum of $5000.
- **Housing Tenancy and Sustaining Services**
  - Services to maintain a safe and stable tenancy once housing secured. Services can include the identification and intervention of behaviors that jeopardize housing, education on role/rights/ responsibilities of tenant and landlord, coaching on maintaining and developing landlord/property managers, assistance with landlord/neighbor disputes, advocacy/linkage to community resources, benefits advocacy, assistance with annual housing recertification
- **Housing Transition Navigation Services**
  - Does not include room and board. Includes tenant screening and housing assessment, housing support plan, searching for housing, assistance with securing housing (applications/documentation), benefit advocacy, identifying/securing resources for rent subsidy and expenses, assisting with reasonable accommodations, landlord education/engagement, ensuring living environment safety/ move-in readiness, advocacy with landlords, move-in support, housing support crisis plan, transportation resources, and environmental modifications as necessary.
- **Medically Supportive Food/Meal/Medically Tailored Meals**
  - This service provides up to three meals per day and/or medically supportive food (for example, a voucher) and nutrition services for up to 12 weeks or longer if medically necessary.

Community Supports: Definitions

- **Asthma Remediation Services, also known as Asthma Trigger Remediations**
  - Physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the member or enable the member to function in the home while reducing acute asthma episodes that could result in the need for emergency services and hospitalization. Lifetime cap is $7500.

- **Community Transition Services/Nursing Facility Transition to a Home or Assisted Living Facility**
  - Non-recurring set up expenses for members who are transitioning from a licensed facility to a living arrangement in a private residence or assisted living facility where the member is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable the member to establish a basic household that does not include room and board.

- **Day Habilitation**
  - Provided in home or out-of-home, non-facility setting. Programs designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills to remain in their natural environment.

- **Environmental Accessibility Adaptations (EAA), also known as Home Modifications**
  - Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of a member, or enable the member to function with greater independence in the home, without which the member would require institutionalization. Lifetime cap is $7500.

Community Supports: Definitions

- **Nursing Facility Diversion Services to an Assisted Living Facility**
  - This service is for members residing in the community, who are at risk of imminent need for nursing facility level of care and are willing to reside in an assisted living facility as an alternative to long term placement in a nursing facility. Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board.

- **Personal Care and Homemaker Services**
  - Assistance with activities of daily living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Can include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Homemaker or chore services include help with tasks such as cleaning, shopping, and laundry. Services aid members who could not remain in their homes. May request urgent/expedited review

- **Recuperative care or medical respite care**
  - Short-term residential care for members who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. At a minimum, includes interim housing with bed and meals and ongoing monitoring of the members medical or behavioral health condition. Limited to continuous 90 day stay.
- **Respite Services**
  - Respite services for non-paid caregivers of members only. Provided on a short-term basis due to the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. Services can be provided in the home or a facility. May request urgent/expedited review

Community Supports: Definitions

- **Short-term Post Hospitalization Housing**
  - This service provides housing for members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical, psychiatric, or substance use disorder recovery immediately after exiting one of the following:
    - Inpatient hospital
    - Residential alcohol or drug abuse recovery or treatment facility
    - Residential mental health treatment facility
    - Correctional facility
    - Nursing facility
    - Recuperative care

    The member must also be receiving housing navigation services. May request urgent/expedited review. Lifetime benefit one-time and not to exceed duration of six months.

- **Sobering Centers**
  - Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.