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CalAIM ECM Health Center Workflows and Processes

Aliados Health
Promising Practice

PROMISING PRACTICE OVERVIEW

CommuniCare Health Centers (CCHC) was enrolled in the Partnership Health Plan Intensive Outpatient Care Management (IOPCM) program, a model of care for patients with complex care needs and transitioned into the Enhanced Care Management (ECM) program in January 2022, grandfathering those complex care members into ECM care coordination. Each member is followed by a Lead Care Manager (LCM) assisting the member with health and health-related social needs. The focus population includes the unhoused, high hospital utilizers, and those diagnosed with a severe mental illness (SMI), or substance use disorder (SUD). CCHC's ECM program currently serves 127 patients with complex needs and challenges that make it difficult to improve their health.

AIM

CCHC aims to serve their current and future populations of focus through ECM by ensuring a solid foundation of case managers, with a goal of successfully "graduating" their enrollees from the ECM program once the social drivers of health (SDOH) that previously qualified the patient for ECM, are no longer present.

PROCESS

Medical Case Management services are currently embedded within the Primary Care Team and work directly with primary care providers and nurses participating in their huddles and team meetings. In the future, ECM work may be housed with behavioral health. There is one full-time case manager at each site. In year 2: Two full-time case managers, in conjunction with behavioral health case managers, are slated for this program which will also be accessible through mobile medical.

- Case Managers have access to ER visits and hospitalizations, medical records (Sutter Link, Dignity Access, and UC Davis Provider), and can access any appropriate discharge reports.
- Relevant Care Gap Reports
- Eligibility Verification, TAR Submission, and Care Planning are submitted through the PHC portal and once approved, uploaded to Collective Medical.
- Training in TAR submission, billing, care planning, ROI submission, monthly member tracking, and coding.
- Care Team: Nurse, Case Manager, Medical Assistant, and Provider.
- Case Managers track their work with templates through eCW, telephone encounters, and Relevant reports.
- Five appointment types were created specifically for ECM members.
- Referrals: Internal referrals are assigned to a provider and the provider's case manager. For Partnership HealthPlan referrals, the member is attached to a clinic/provider.
- Implement workflows into training, merge assessments and templates.

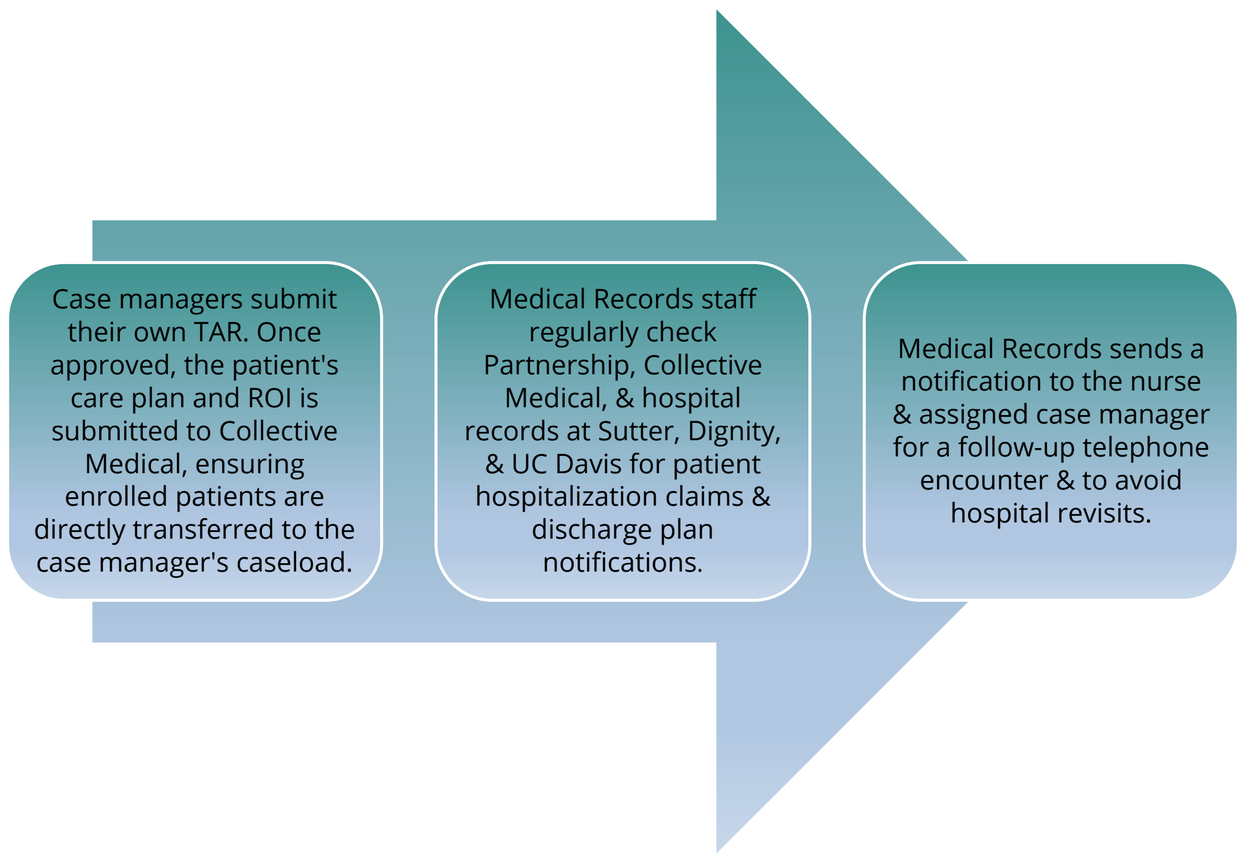
REFERENCES

Partnership ECM Care Plan Guide

ACTIONS TAKEN

Case managers track their work and patient contact through various templates within eCW, as well as through phone encounters and Relevant reports. Case Managers maintain rosters of 35-40 patients each. This creates ease with IOT reporting (tracking successful/unsuccessful engagement). There are five different appointment types and templates for ECM services within eCW. While reporting is a team effort, each case manager is responsible for their own patients and ensuring that each enrolled patient has all required documentation uploaded. At the end of each month, each ECM enrollee has a claim submitted to billing on their behalf by their case manager. Billing codes are dependent on appointment type. Case managers are notified through eCW if any errors are detected in their claims.

CURRENT WORKFLOW



RESULTS TO DATE

CCHC is currently serving 127 ECM enrollees, with an average of 35-40 patients assigned to each medical case manager. The case management department is continuously growing, preparing to serve additional populations of focus in the future.

LESSONS LEARNED

ECM is currently housed under primary care transitioning into Behavioral Health on March 1st, 2023. ECM case managers will be embedded in primary care, Mobile Med and Behavioral Health. ECM case managers were trained in TARs, care planning, and collective medical.
Challenges: Patient information is being tracked in multiple places, making some administrative work duplicative. There is a high volume of patients in need, and case managers are still in need of training to provide ECM services.
CCHC highlights the value that case management has for its patients and is excited about case management to now be recognized as a billable service.