Connecting the Dots: New Services to Improve Maternal and Infant Health

June 11, 2024

Confidential and Proprietary Information

Health Plans We Support

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- After the webinar you will get a link to the PowerPoint and recording
- Participants are automatically MUTED. Please communicate via the chat
- If we are unable to address your questions in today's webinar, we will address your questions in an upcoming forum

Reminders about Webinars to date and where to find them

- Connecting the Dots: **Children and Youth Involved in Child Welfare** (February 13, 2024)
- Connecting the Dots: **How to Refer your Client to Enhanced Care Management (ECM) and Community Supports (CS)** (March 12, 2024)
- Connecting the Dots: **New Services to Support Children and Youth with Complex Behavioral Health Needs** (April 9, 2024)
- Connecting the Dots: **New Services to Support Families and Youth Experiencing Homelessness** (May 14, 2024)

View recordings here

Scroll down the page to locate "Connecting the Dots – CalAIM Provider Learning Series"

Agenda

- Welcome and Introductions
- Provider Spotlight
- Learning Objectives
- Review ECM Population of Focus: Birth Equity
- Supportive, Respectful, and Culturally Responsive Care
- Provider Perspectives
- Overview of Benefits and Programs
- Connections and Referrals
- Provider Spotlight
- Wrap Up

Welcome and Introductions

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Introductions

Nancy Wongvipat Kalev, MPH

Senior Director, Systems of Care

Health Net

Today's Presenters

Karen Hill, PhD, ANP-C, MSN, RN
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Provider Spotlights

Melissa Hanna, J.D., MBA
Cofounder and CEO
Mahmee

Dr. Melissa Franklin
Director of Maternal, Child and Adolescent Health
Los Angeles County Dept. of Public Health

Learning Objectives

- Explore how to engage members with supportive, respectful, and culturally responsive approaches.
- Describe services available for pregnant and postpartum individuals.
- Describe services available to families with children 0-15 months.
- Name opportunities for early identification/screening.
- Explain how to refer and make connections to the services for members.

Getting to Know You!

Please say hello in the chat with your role and organization!

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Provider Spotlight

Provider Spotlight

ECM Population of Focus: Birth Equity

Birth Equity Population of Focus

ECM Birth Equity Population of Focus Went Live 1/1/24

Adults and Youth who:

1. Are pregnant or are postpartum (through 12 months period); **and**
2. Are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality

Notes on the Definition:

- Clause (1) with "pregnant or are postpartum," with "postpartum" period defined as the 12 month period following the last day of the pregnancy (irrespective of whether live or still birth delivery, or spontaneous or therapeutic abortion).
- Clause (2) is identified based on the California Department of Public Health's (CDPH) most recent State public health data available on the Women/Maternal Dashboard Home Page (including the Pregnancy Related Mortality, Selected Maternal Complications, and Severe Maternal Morbidity Dashboards).

No further criteria are required to be met to qualify for this ECM Population of Focus.

Investing in Better Birth Outcomes

- Health Net, CalViva Health, and Community Health Plan of Imperial Valley are partnering with community-based maternal care providers to address disparities in health and birth outcomes in racial and ethnic groups with high maternal morbidity and mortality rates.
    - We will do this together by:
        - Ensuring **high-quality, patient- and family-centered care and care coordination** for all pregnant or postpartum members, with a special focus on populations experiencing racial and ethnic disparities
        - **Coordinating** maternity care that is **culturally sensitive** and **evidence-based**
        - **Collaborating across delivery systems** to ensure that the pregnant or postpartum member's **health and social needs** are met

For More information, see the DHCS Birth Equity Population of Focus Frequently Asked Questions Document (February 2024): https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-BirthEquity-POF-FAQ%27s-February2024.pdf

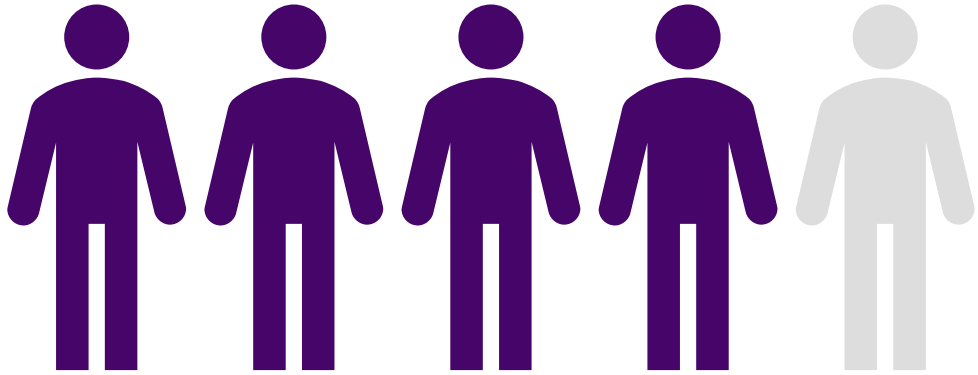
Supportive, Respectful, and Culturally Responsive Care

THE WHY

31%

of maternal deaths occurred among Black individuals who represent only 14% of the US population

50% (approx.) of maternal deaths were among White individuals



More than 4 of 5

Pregnancy-related deaths in the US were preventable.

- 14% of deaths were due to hemorrhage
- 7% were due to hypertensive disorders of pregnancy
- More than 50% of deaths occurred after the first week through 1 year after delivery

THE HOW

Culturally responsive maternal care requires self-awareness, assessment, and honesty.

Every healthcare organization, healthcare provider and staff member has a personal and professional obligation to look at their role in creating culturally acceptable maternal care or exacerbating existing inequities and bias.

- **freedom from abuse and violence,**
- **consent,**
- **privacy,**
- **communication that is understandable, consistent, relevant and free of bias**
- **education and shared decision making,**
- **grounded in dignity and respect, safety**

THE HOW

- A lifelong commitment to self-evaluation, personal and organizational critique for example:
  - How often am I or my team having to change my automatic response or making assumptions?
  - What is my or my team's bias?
  - Why do I or my team have this bias and what can we do about it?
  - Have we ever been surprised?
  - What kind of detrimental things is the bias leading to?
- Rectifying the power imbalances in the provider-patient dynamics,
- Developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and the defined populations

THE HOW
Challenges and obstacles to quality maternal care

- Lack of insurance coverage or money for services
- Unable to schedule an appointment at a convenient time
- Fear of others knowing they were pregnant
- Past experiences with medical services for them or others
- Lack of transportation
- Behavioral health or substance use disorders
- Unplanned or unwanted pregnancies

- Desire for more transparency and communication in prenatal care
- Lack of relationship with providers
- Perceived insignificance of prenatal care due to lengthy wait time and short visit time
- Inflexible work schedule
- Trouble navigating the health system

Empowering Imani

Imani is 29 yr. student and **works part-time as a store clerk**. She had one late **miscarriage and is now 29 weeks pregnant**. Her **partner is a long-haul truck drive**r and is often on the road. **They both want this baby.**

Her family is not happy about this pregnancy as they want her to finish school. She does have a good relationship with her aunt.

She has **stopped using all substances and experiences anxiety**. She is still very **upset about her last pregnancy**. She says neither the **OB-GYN or hospital staff listened to her when she tried to express her concerns** and she lost her baby, they made **too many assumptions about her lifestyle and partner and made them feel bad**. She believes it is because she is black. ***She felt like nobody cared when she lost Jacob. She never told her family.***

Imani has lots of friends, but most are busy with school and their lives**. She feels alone and would really like to learn more about how to make sure she and her baby survive**. **She is concerned about her insurance lapsing, staying in school, her job, and just handling everything alone**. She **has a new OB-GYN but doesn't really trust her.**

1. **Let's identify her strengths**
2. **How might we help Imani?**

Connecting Hien

34yr old 1st generation Vietnamese woman who lives in **rural central valley** and for whom **English is a second language**. She is **16 weeks pregnant** with her **2nd child**. She did not receive prenatal care with the 1st. Her family is very traditional and does not believe in Western medicine. She is employed in the family restaurant. She has **spotting, pain, her blood pressure is rising, and blood sugars are too high**. Hien is married and wants this child, but it is causing a lot of **stress due to finances**. Her husband was injured at work and is on disability. Her 1st pregnancy was fine, but she got a **post partum infection** and was in the hospital and received antibiotics. She is worried and would like to get regular care, but her family puts a lot of pressure on her not to do so. **She feels like she has no one to talk to about how she feels**.

1. **Let's identify her strengths**
2. **How might we help Hien?**

Provider Perspectives

In Summary

- Valuing Birth Equity PoF Intersectionality
- Holistic and Equitable Maternity Care-assurance of optimal well-being for birthing persons and a willingness of systems to address inequities and racism
  - Black Mamas Matters Alliance (BMMAs) is a trauma and culturally informed organization that provides resources, respects spirituality and health ,and has BIPOC providers that can service as a resource for learning
- Reproductive health and justice that considers race, class, ethnicity, sexuality, citizenship, sex impact, and the right of choice
- Humanity: treating birthing persons with kindness, courtesy, and politeness
- Love and care of self: Respectful care is developing a sense of care as a provider that allows the care for others that are different than themselves

In Summary

- Respectful Culturally Responsive Care starts with organization and healthcare team NOT the patient
- Being humble and willing to see and understand the patient's perspective
- Lifelong commitment to self evaluation, i.e. implicit and unconscious bias
- Supports access, consistent understandable communication across disciplines and with patient and families
- Shared decision making and absence of hierarchy and power dynamics
- Attempting to create more joy, awareness and self-advocacy
- Adopt culturally centered policies and practices and approaches
- Most important listen to patient and family members experience and stories

The Cycle of Respectful Care Framework

Waking Up:
Hospital disparities data
Patient experience survey data
Discrimination, racism, and mistreatment specific to the facility
Quality improvement activities

Getting Ready

Reaching Out: know how provider biases can influence health care and treatment.
Foster dignity and respect by looking patients in eyes and being mindful of body language.
Build empathy by understanding and responding to others' emotions, feelings, and decisions.
Be curious about the impact of social determinants on patients' lives.
Consider patients' knowledge of their bodies and experiences in medical decision making.

Interpersonal:
Change in how we value others and see the world.

Implementing with provider community:

Coalescing with local community:
Ensure patients are discharged with the skills, support, and tools to care for self and family.
Connect with and leverage community assets to ensure patient access to resources for biopsychosocial needs.
Power map local structures with resources to achieve health equity.

Creating Change

Maintaining:
Take care of self and peers to avoid burnout
Become an advocate for institutional, local, state, and federal policy change.
Establish a governance structure, process, and provide resources to support health equity initiatives
Invest in and establishing measures for all quality improvement efforts
Promote values for truth, racial healing and transformation (Kellogg)

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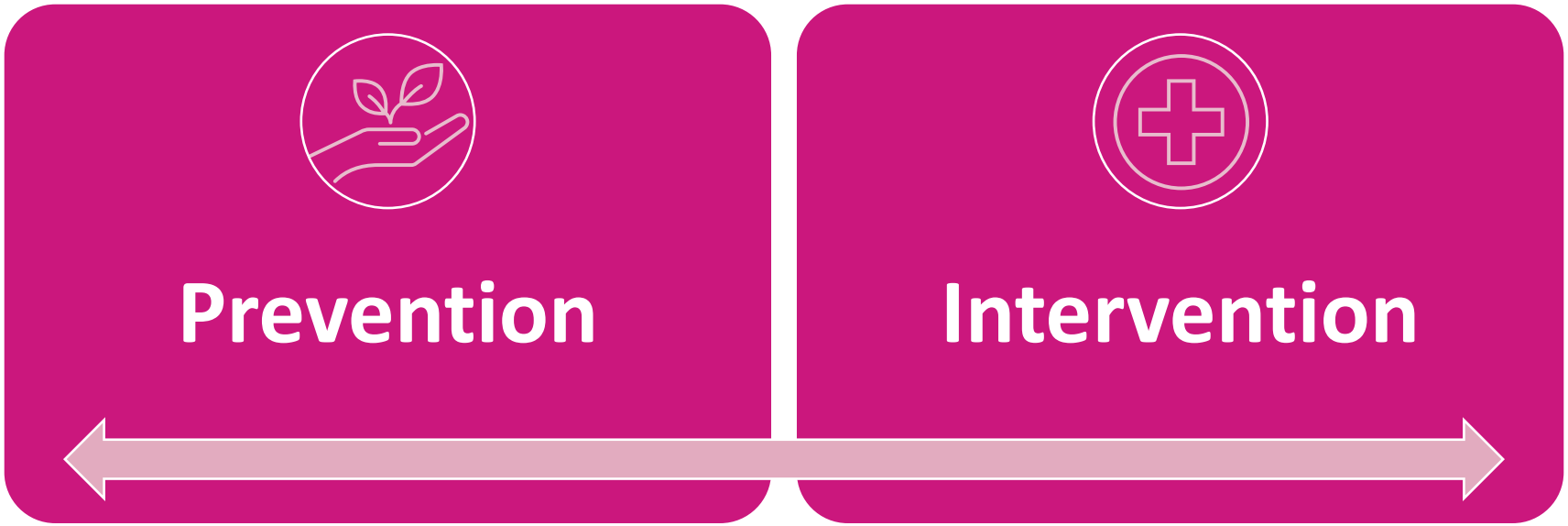
CalViva HEALTH

Community Health Plan OF IMPERIAL VALLEY

Overview of Benefits and Programs

Continuum of Services



ECM's 7 Core Services: A Whole-Person approach with a focus on In-Person Services

1. Outreach and Engagement
2. Comprehensive Assessment & Care Plan
3. Health Promotion
4. Comprehensive Transitional Care
5. Enhanced Care Coordination
6. Individual and Family Social Supports
7. Coordination of & Referral to Community & Social Support Services

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CalViva HEALTH

Community Health Plan OF IMPERIAL VALLEY

Community Supports

Services
Housing Transition/Navigation
Housing Deposits
Housing Tenancy & Sustaining Services
Short-Term Post-Hospitalization Housing
Recuperative Care (Medical Respite)
Day Habilitation Programs
Nursing Facility Transition/ Diversion
Community Transition Services/Nursing Facility Transition to a Home
Personal Care and Homemaker Services
Respite Services for Caregivers
Environmental Accessibility Adaptations
Medically Supportive Food/ Meals/ Medically Tailored Meals
Sobering Centers
Asthma Remediation

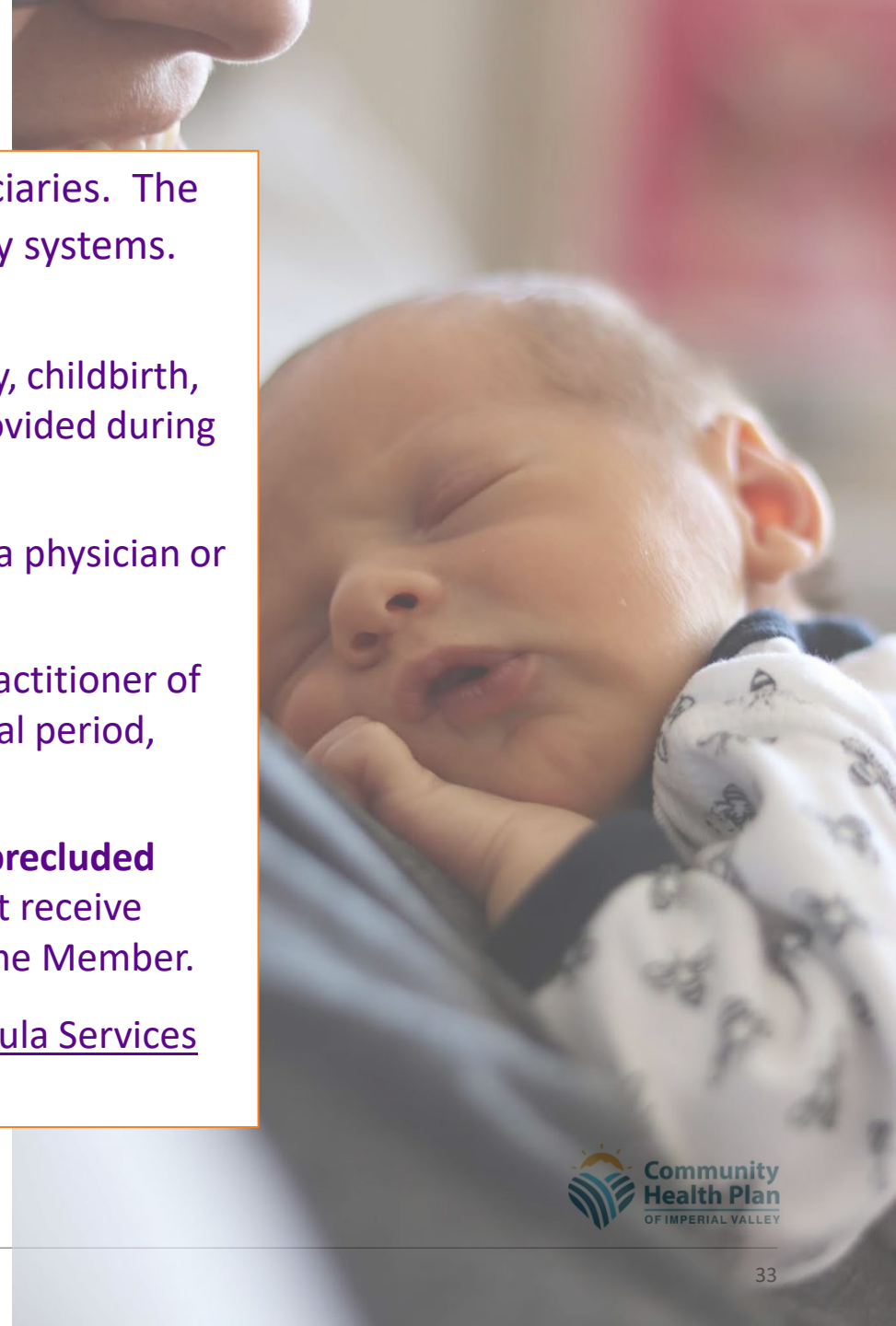
Additional Health Plan Benefits and Services

- Doula
- Mahmee
- Community Health Workers
- Dyadic Services
- Start Smart for Your Baby®

Doula Benefit Overview

Effective January 2023, California added a “doula benefit” all Medi-Cal beneficiaries. The doula service is available in both the fee for service and managed care delivery systems. Doula services include:

- Personal support to women and families throughout a woman's pregnancy, childbirth, and postpartum experience. Includes emotional and physical support, provided during pregnancy, labor, birth, and the postpartum period.
- Pursuant to federal regulations, doula services must be recommended by a physician or other licensed practitioner*
  - An additional recommendation from a physician or other licensed practitioner of the healing arts is required for more than 11 visits during the perinatal period, excluding labor and delivery and miscarriage support.
  - Members receiving doula services who also qualify for ECM are **not precluded from receiving ECM** as long as the MCP ensures that Providers do not receive duplicative reimbursement for the same services provided to the same Member.
- More information is available regarding the doula benefit via the DHCS Doula Services webpage



Additional Health Plan Benefits and Services

Mahmee	Start Smart for Your Baby®	Community Health Workers (CHWs)	Dyadic Services
• Registered Nurses for clinical guidance and remote patient monitoring • Infant feeding education and consults • Doula Care • Mental Health Nutrition • Care Coordination	• Provides members with pregnancy and postpartum education and resources • Assessments and Care Coordination	• CHWs are community members that can provide members with expert guidance through the healthcare system. • Are preventive health services • Can be provided to individuals or in groups	• Helps support child development and mental health by treating children and caregivers together • Who is Eligible? Children/youth and their parent(s)/caregiver(s). The child/youth must be enrolled in Medi-Cal. The parent(s) or caregiver(s) do(es) not need to be enrolled in Medi-Cal or have other coverage

Local Programs

Comprehensive Perinatal Services Program (CPSP)

- Serves low-income pregnant and postpartum individuals enrolled in Medi-Cal from the start of pregnancy to 60 days PP.
- Provides obstetric services, health education, nutrition services, case coordination including strengths-based assessments, individualized care planning (reassessed each trimester), and PP assessment.

https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx

Black Infant Health (BIH) Program

- Serves Black pregnant and postpartum (up to 6 months) living in select California counties and cities, regardless of income, starting at age 16.
- Provides prenatal and postpartum group sessions, case management, skills-based interventions (e.g., stress management, empowerment, healthy behaviors), and individual client-centered life planning.
- Administered by county agencies, with funding and oversight provided by CDPH

https://www.cdph.ca.gov/Programs/CFH/DMCAH/BIH/Pages/Sites.aspx

California Perinatal Equity Initiative (PEI)

- Serves pregnant and parenting Black individuals and their partners, up to the child's first birthday.
- PEI complements the BIH program for whole family care with home visitation programs, group interventions, and fatherhood and partnership initiatives.
- Administered by county agencies, with funding and oversight provided by CDPH

https://www.cdph.ca.gov/Programs/CFH/DMCAH/PEI/Pages/Sites.aspx

American Indian Maternal Support Services (AIMSS)

- Provides perinatal case management and HV services to American Indian pregnant and postpartum individuals through the infant's first year of life.
- Assists program participants with receiving health care, education, emotional support, referrals to services (social and health), and follow-up visits.
- Administered by the Primary, Rural, and Indian Health Department (PRIHD)

https://www.dhcs.ca.gov/services/rural/Pages/AIMSSProgram.aspx

Local Programs

CDPH's California Home Visiting Program (CHVP)

- Voluntary program serving pregnant/parenting families with at least one risk factor (e.g., domestic violence, inadequate income or housing, <12 years of education, SUD or mental health concerns).
- Services generally begin prenatally or right after delivery until about age three and may include parenting skills, information and guidance on newborns and infants, referrals to community resources, screening children for developmental delays, and facilitating interventions.

https://www.cdph.ca.gov/Programs/CFH/DMCAH/CHVP/Pages/Sites.aspx

CDSS' CalWORKs Home Visiting Program (HVP)

- Voluntary program servings individuals who are pregnant/parenting a child <24 months of age and are eligible for CalWORKs aid.
- Services may include prenatal, infant, and toddler care; infant and child nutrition; child developmental screening/assessments; parent education; child development and care; job readiness and barrier removal; and treatment and supports for domestic violence and behavioral health concerns.

https://www.cdss.ca.gov/calworks-home-visiting-program

First 5 California

- First 5 California is dedicated to improving the lives of California's young children and their families through a comprehensive system of education, health services, childcare, and other crucial programs
- Focus Areas:
  - Early Learning and Care
  - Effective Interactions and Teaching
  - Positive Parenting
  - Tobacco Cessation

https://www.ccfc.ca.gov/index.html

- **Does anyone work in these programs? If so, which one?**

AND

- **Are any of you working with these programs today? If so, which ones?**

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CalViva HEALTH

Community Health Plan OF IMPERIAL VALLEY

Integration of QI and CalAIM

Maternity health/perinatal care measures:

- Timely prenatal care in the first trimester
- Postpartum care between 7 and 84 days after delivery

Possible future measures:

- Prenatal Immunization Status
- Prenatal Depression Screening and Follow-Up
- Postpartum Depression Screening and Follow-Up

Quality of Care HEDIS measures that impact children in the first year of life.

- Immunizations up to age 2 years.
- Well care visits for children 0 to 30 months of age.
- Developmental Screenings by 1 year, 2 years and 3 years of age
- Lead screening by 2 years of age. First lead screening is recommended when babies start crawling.
- Topical fluoride varnish application at least twice from 1 – 20 years of age.

Integration of QI and CalAIM

CLINICAL PERFORMANCE IMPROVEMENT PROJECT (PIP)

- A 3 year project to improve infant well care visits in the **Black or African American** population
- Barrier Analysis indicates the following drivers for engagement with the health care system:
  - **Trust in the system**
  - Their provider and their infant's provider
  - Their experience with prenatal care, in the hospital during delivery and postpartum care
- Opportunity to establish the ECM Provider as a **trusted messenger** and source of information from pregnancy through postpartum / the first year of life of the infant
- ECM/CHW/Doulas can empower members to select the PCP for their infant prior to delivery, so that the member gets the baby established with a PCP to start building that relationship

DOULA COLLABORATIVE – STARTED BY THE INLAND EMPIRE HEALTH PLAN (IEHP)

- Doulas are a trusted source of information and can impact infant well care in addition to prenatal and postpartum care
- Any MCP/health plan is welcome to join the meetings
- A separate workgroup that includes community organizations, such as WIC, BIH (Black Infant Health) and other CBOs that work with the pregnant population
- Working on non-branded materials for Medi-Cal members and doulas

Connections and Referrals

Identifying Members for ECM

Identification for ECM
•Encounter data •Provider records or reports •Race and ethnicity data at multiple interventions (e.g., eligibility, enrollment, Provider recorded) •Comprehensive Perinatal Services Program (CPSP) •Black Infant Health (BIH) Program •California Perinatal Equity Initiative (PEI) •American Indian Maternal Support Services (AIMSS) •CDPH's California Home Visiting Program (CHVP) •CDSS' CalWORKs Home Visiting Program (HVP) •Maternity care providers, including midwives, doulas, and hospitals •ADT feed data, when available •Members and their families (self-refer)

Early Identification/Screening

Program Assessments	Other	Comprehensive ECM Assessment
• PEI (California Perinatal Equity Initiative) • CPSP (Comprehensive Perinatal Services Program) • BIH (Black Infant Health Program) • AIMSS (American Indian Maternal Support Services) • CHVP (CDPH's California Home Visiting Program) • CalWORKs HVP (CDSS' CalWORKs Home Visiting Program)	• Health Risk Assessments • ACEs • Maternal Depression Screening • SBIRT/SABIRT • Developmental Screening (child)	• Physical Health Care • Mental Health Care • SUD Care • Community-based LTSS needs • Oral Health Care • Palliative Care • Social Supports • SDOH Care

ECM Providers – Connecting Members to Care

7 **Coordination of & Referral to Community & Social Support Services**

Examples include:

- Connecting the pregnant/postpartum member, their partner, and their family to resources to support the member's health, and the child's health
  - Including prenatal and postpartum appointments
  - Well-child visits
  - Coordinating transportation
  - Ensuring connections to benefits such as WIC
- Connecting to Community Supports
- Coordinating the transition to home after labor and delivery

- **As a Provider, how do you know if one of your clients has an assigned ECM provider or is receiving Community Supports?**
- **And if needed, how do you make a referral/connection to either ECM or CS?**

Connecting Members to Local Programs and ECM

CPSP | BIH | PEI | AIMSS | CHVP | CalWORKS HVP | First 5

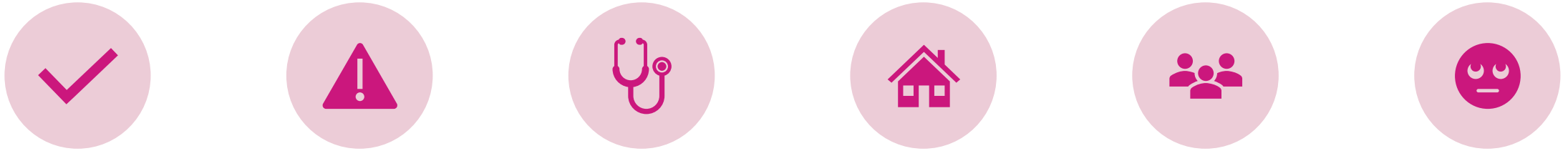
If you **are** one of these programs

- Consider:
  - If ECM would be a good fit for your program
  - How you might work with your local ECM providers

If you **are not** one of these programs

- Consider:
  - Getting to know your local programs
  - Establishing working relationships to help connect members as needed

WHEN is it a good time to evaluate someone's need for ECM and/or Community Supports?



ANY TRANSITION EVENT

ANY CHANGE IN CONDITION

ANY NEWLY DIAGNOSED CONDITION

ANY CHANGE IN HOUSING

ANY CHANGE IN SUPPORT STRUCTURE

ANY KNOWN HIGH-STRESS EVENTS

WHEN is it a good time to consider connections to a doula?

WHEN THE MEMBER BECOMES PREGNANT

ANY CHANGE IN CONDITION, DIAGNOSIS, SOCIAL SUPPORT, ETC

DURING LABOR AND BIRTH

POSTPARTUM

Connecting Imani to Care

- What services or programs do you think you may want to offer connections to?
- What about as she moves along the continuum of care?

Pre-Conception → **Pregnancy** → **Postpartum/Infancy** → **Early Childhood**

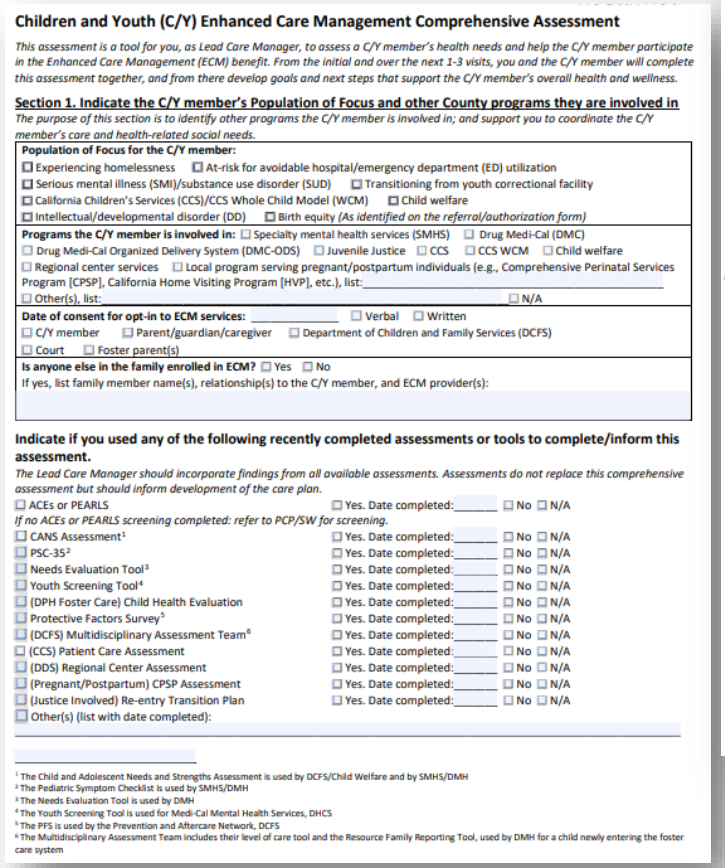
Connecting Hien to Care

- What services or programs do you think you may want to offer connections to?
- What about as she moves along the continuum of care?

Pre-Conception → Pregnancy → Postpartum/Infancy → Early Childhood

ECM Assessment – Indicators for Coordination/Collaboration

- Updated Adult ECM Comprehensive Assessment Tool
- Both the Adult tool and the C/Y tool have pregnancy and postpartum related components
- Throughout each document, lead care managers have opportunities to identify and make connections to needed services and supports



Children and Youth (C/Y) Enhanced Care Management Comprehensive Assessment

This assessment is a tool for you, as Lead Care Manager, to assess a C/Y member's health needs and help the C/Y member participate in the Enhanced Care Management (ECM) benefit. From the initial and over the next 1-3 visits, you and the C/Y member will complete this assessment together, and from there develop goals and next steps that support the C/Y member's overall health and wellness.

Section 1. Indicate the C/Y member's Population of Focus and other County programs they are involved in

The purpose of this section is to identify other programs the C/Y member is involved in; and support you to coordinate the C/Y member's care and health-related social needs.

Population of Focus for the C/Y member:

☐ Experiencing homelessness ☐ At-risk for avoidable hospital/emergency department (ED) utilization
☐ Serious mental illness (SMI)/substance use disorder (SUD) ☐ Transitioning from youth correctional facility
☐ California Children's Services (CCS)/CCS Whole Child Model (WCM) ☐ Child welfare
☐ Intellectual/developmental disorder (DD) ☐ Birth equity *(As identified on the referral/authorization form)*

Programs the C/Y member is involved in: ☐ Specialty mental health services (SMHS) ☐ Drug Medi-Cal (DMC)
☐ Drug Medi-Cal Organized Delivery System (DMC-ODS) ☐ Juvenile Justice ☐ CCS ☐ CCS WCM ☐ Child welfare
☐ Regional center services ☐ Local program serving pregnant/postpartum individuals (e.g., Comprehensive Perinatal Services Program [CPSP], California Home Visiting Program [HVP], etc.), list:_____
☐ Other(s), list:_____ ☐ N/A

Date of consent for opt-in to ECM services: _____ ☐ Verbal ☐ Written
☐ C/Y member ☐ Parent/guardian/caregiver ☐ Department of Children and Family Services (DCFS)
☐ Court ☐ Foster parent(s)

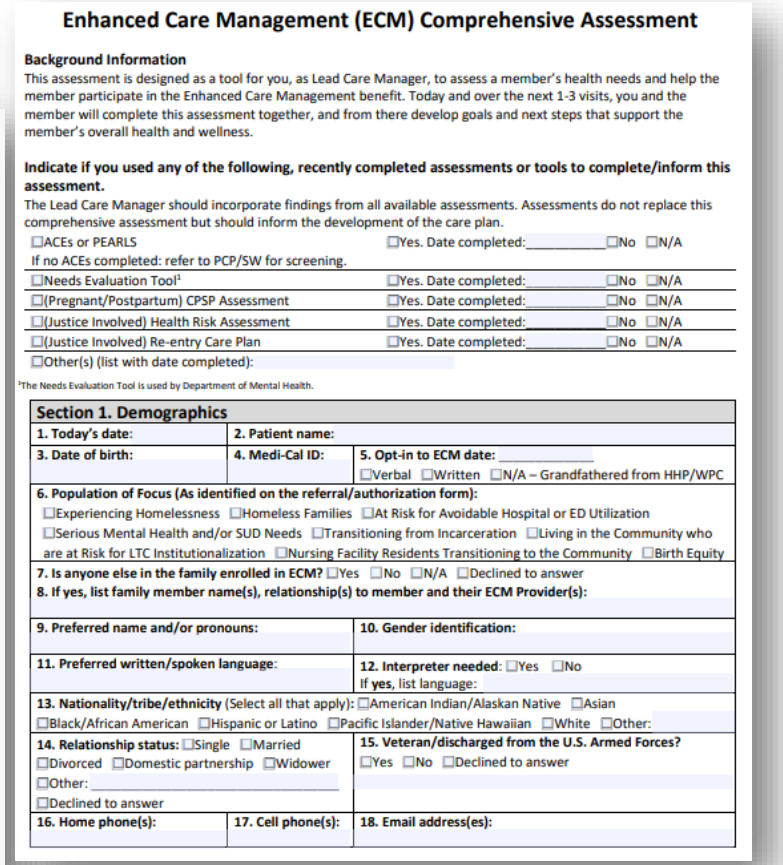
Is anyone else in the family enrolled in ECM? ☐ Yes ☐ No
If yes, list family member name(s), relationship(s) to the C/Y member, and ECM provider(s):

Indicate if you used any of the following recently completed assessments or tools to complete/inform this assessment.

The Lead Care Manager should incorporate findings from all available assessments. Assessments do not replace this comprehensive assessment but should inform development of the care plan.

☐ ACEs or PEARLS	☐ Yes. Date completed:_____	☐ No	☐ N/A
If no ACEs or PEARLS screening completed: refer to PCP/SW for screening.			
☐ CANS Assessment[1]	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ PSC-35[2]	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ Needs Evaluation Tool[3]	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ Youth Screening Tool[4]	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ (DPH Foster Care) Child Health Evaluation	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ Protective Factors Survey[5]	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ (DCFS) Multidisciplinary Assessment Team[6]	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ (CCS) Patient Care Assessment	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ (DDS) Regional Center Assessment	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ (Pregnant/Postpartum) CPSP Assessment	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ (Justice Involved) Re-entry Transition Plan	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ Other(s) (list with date completed):			

[1] The Child and Adolescent Needs and Strengths Assessment is used by DCFS/Child Welfare and by SMHS/DMH
[2] The Pediatric Symptom Checklist is used by SMHS/DMH
[3] The Needs Evaluation Tool is used by DMH
[4] The Youth Screening Tool is used for Medi-Cal Mental Health Services, DHCS
[5] The PFS is used by the Prevention and Aftercare Network, DCFS
[6] The Multidisciplinary Assessment Team includes their level of care tool and the Resource Family Reporting Tool, used by DMH for a child newly entering the foster care system



Enhanced Care Management (ECM) Comprehensive Assessment

Background Information

This assessment is designed as a tool for you, as Lead Care Manager, to assess a member's health needs and help the member participate in the Enhanced Care Management benefit. Today and over the next 1-3 visits, you and the member will complete this assessment together, and from there develop goals and next steps that support the member's overall health and wellness.

Indicate if you used any of the following, recently completed assessments or tools to complete/inform this assessment.

The Lead Care Manager should incorporate findings from all available assessments. Assessments do not replace this comprehensive assessment but should inform the development of the care plan.

☐ ACEs or PEARLS	☐ Yes. Date completed:_____	☐ No	☐ N/A
If no ACEs completed: refer to PCP/SW for screening.			
☐ Needs Evaluation Tool[1]	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ (Pregnant/Postpartum) CPSP Assessment	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ (Justice Involved) Health Risk Assessment	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ (Justice Involved) Re-entry Care Plan	☐ Yes. Date completed:_____	☐ No	☐ N/A
☐ Other(s) (list with date completed):			

[1] The Needs Evaluation Tool is used by Department of Mental Health.

Section 1. Demographics

1. Today's date:	**2. Patient name:**	
3. Date of birth:	**4. Medi-Cal ID:**	**5. Opt-in to ECM date:** _____ ☐ Verbal ☐ Written ☐ N/A – Grandfathered from HHP/WPC
6. Population of Focus (As identified on the referral/authorization form): ☐ Experiencing Homelessness ☐ Homeless Families ☐ At Risk for Avoidable Hospital or ED Utilization ☐ Serious Mental Health and/or SUD Needs ☐ Transitioning from Incarceration ☐ Living in the Community who are at Risk for LTC Institutionalization ☐ Nursing Facility Residents Transitioning to the Community ☐ Birth Equity		
7. Is anyone else in the family enrolled in ECM? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer **8. If yes, list family member name(s), relationship(s) to member and their ECM Provider(s):**		
9. Preferred name and/or pronouns:		**10. Gender identification:**
11. Preferred written/spoken language:		**12. Interpreter needed:** ☐ Yes ☐ No **If yes**, list language:
13. Nationality/tribe/ethnicity (Select all that apply): ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic or Latino ☐ Pacific Islander/Native Hawaiian ☐ White ☐ Other:		
14. Relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic partnership ☐ Widower ☐ Other: _____ ☐ Declined to answer		**15. Veteran/discharged from the U.S. Armed Forces?** ☐ Yes ☐ No ☐ Declined to answer
16. Home phone(s):	**17. Cell phone(s):**	**18. Email address(es):**

ECM Assessment – Indicators for Coordination/Collaboration

- **Note if the Member is involved in other programs**
- **Proactive and frequent communication should occur with these programs/members of the person's care team**
- **Also note if anyone else in the family is receiving ECM services, as collaboration may be indicated**

Programs the C/Y Member is Involved in: ☐SMHS ☐DMC ☐DMC-ODS ☐Juvenile Justice ☐CCS
☐CCS WCM ☐Child Welfare ☐Regional Center Services
☐Local program serving pregnant/postpartum individuals (e.g., Comprehensive Perinatal Services Program [CPSP], California Home Visiting Program [HVP], etc.) (List):
☐Other(s), List:
☐N/A

Date of Consent for Opt-in to ECM services: _____ ☐Verbal ☐Written
☐C/Y Member ☐Parent/Guardian/Caregiver ☐DCFS ☐Court ☐Foster parent(s)

Is anyone else in the family enrolled in ECM? ☐Yes ☐No
If yes, list family member name(s), relationship(s) to C/Y member, and ECM Provider(s):

This could be an opportunity to connect someone to needed services and to uncover any barriers to accessing care

Section 3. Physical Health

6. **Do you know who your regularly assigned healthcare providers are?** ☐Yes ☐No
   Provider name(s)/clinic(s)/phone #(s):

   If yes, when was the last time you saw your regular doctor? ☐Less than 3 months ago
   ☐Less than 6 months ago ☐6-12 months ago ☐More than 1 year ago ☐Not sure

7. **Do you have a provider for women's health**? ☐Yes ☐No ☐N/A
   Provider name/clinic/phone #:

8. **Have you had a dental visit in the past 12 months?** ☐Yes ☐No ☐Not Sure ☐Declined to Answer
   Dentist's name/phone #:

ECM Assessment – Indicators for Coordination with Others

Opportunities to identify where you can link someone to additional care/services

Section 7. Pregnancy/Postpartum

7. Do you have the following plans for pregnancy and labor and delivery?

A. Birth plan: ☐Have ☐Don't have, but want ☐Don't have and don't want

B. Delivery wishes: ☐Vaginal ☐Natural (unmedicated/no epidural) ☐C-Section
☐Vaginal birth after C-Section (VBAC)

C. Delivery location: _____

D. Birthing classes: ☐Have ☐Don't have, but want ☐Don't have and don't want

E. Labor support person(s) (including doulas): ☐Have ☐Don't have, but want ☐Don't have and don't want
If have, list:_____

F. Going into labor: When to call someone and/or go to your birthing location:
☐I know what to do ☐I need help with this

G. Goals/plan for transportation to the hospital: ☐Have ☐Don't have, but want ☐Don't have and don't want

H. Childcare goal/plans for other kids: ☐Have ☐Don't have, but want ☐Don't have and don't want ☐ N/A

I. Breastfeeding plans: ☐Have ☐Don't have, but want ☐Don't have and don't want

Comments:

22. Do you need any of the following during your pregnancy or postpartum care: (check all that apply)

☐Education/resources on pregnancy/post-pregnancy (body changes, baby growth, postpartum discomforts, self-care after pregnancy, etc.)
☐Education/resources on family planning/birth control
☐Education/resources on infant health (nutrition, developmental milestones, safe sleeping)
☐Education/resources on immunizations for self and baby
☐Education/resources on parenting skills/parenting classes
☐Essential baby supplies (crib, diapers, formula, bottles, breast pump, clothing, blankets, and other supplies)
☐Car seat
☐Finding childcare or assistance paying for childcare
☐Other:
☐Declined to Answer

ECM Assessment – Indicators for Coordination with Others

Connections for baby

Mental health screening opportunities

Section 7. Pregnancy/Postpartum

23. Do you have a doctor for your baby? ☐Yes ☐No ☐N/A ☐Declined to Answer
If **yes**, provider name/phone #:

24. When (day and or month) did you most recently take your baby to the doctor? _____
☐Not Sure ☐N/A ☐Declined to Answer

25. Has the doctor told you that there are health issues with your baby that needs follow up?
☐Yes ☐No ☐Not Sure
If **yes**, do you need support in following up with any of those issues? ☐Yes ☐No ☐Not Sure

26. Do you have a dentist for your baby? ☐Yes ☐No ☐ N/A *(no teeth present and less than 1 year of age)*
☐Declined to Answer
If **yes**, provider name/phone #:
Date of Last Visit (if known, or an approximate date):

27. Edinburgh Postnatal Depression Scale (EPDS) Screener
☐ Declined to Complete (and reason, if provided):

- **Have Member self-complete** the screener here: https://www.mcpapformoms.org/Docs/EdinbPostDepScale%20english%20no%20numbers.pdf. The Member should complete the scale themself, unless they have limited English or has difficulty with reading.

Scoring:

- Score of 9 and above: consult with clinical consultant and supervisor.
- Score of 13 and above: consult with clinical consultant and supervisor *and* initiate referral for behavioral health
- Positive score (1, 2, or 3) on question 10: immediate discussion required: consult with clinical consultant and supervisor *and* initiate referral for behavioral health

Depression – Patient Health Questionnaire (PHQ-9) – For youth aged 11 and older

- ***If a recent (within past month) PHQ-9 has been completed by another provider and is in chart, enter score here: _____ and date: _____***
- ***If no PHQ-9 in chart, complete the PHQ-2+Q.9 below***
- ***Follow scoring guidelines below.***

☐ N/A ☐ Declined to Complete (and reason, if provided):

PHQ-2 plus Question 9
Over the last two weeks, how often have you been bothered by any of the following?

1. Have you experienced a reduction in interest or pleasure in doing things?
Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐

2. Have you felt down, depressed or hopeless?
Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐

3. (Q.9) Thoughts that you would be better off dead or of hurting yourself in some way
Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐

ECM Connects Member to CS

Member

Informs member of POTENTIAL CS support eligibility

Member consent

CS Provider

findhelp

Referral

CS provider reconfirms eligibility via health plans provider portal (HN or CVH)

Provider Order, if needed

ECM Provider

ECM Assessment or during course of ECM services, CS Service connection indicated

Reviews auth guide to determine possible eligibility

ECM provider supports member to acquire provider order

ECM provider submits provider order and referral via find help to CS Provider

findhelp

- findhelp – Health Net
- findhelp – CalViva Health

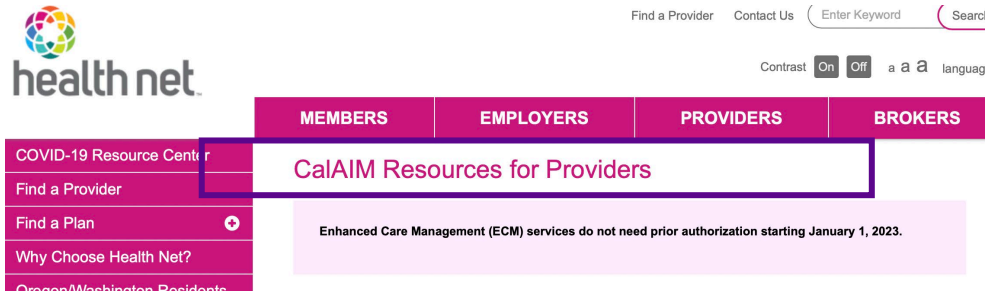
health net

CalViva HEALTH

Community Health Plan OF IMPERIAL VALLEY

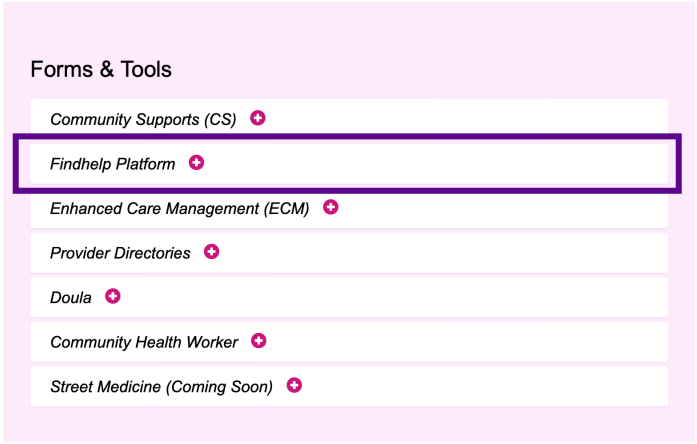
Using Findhelp

1.

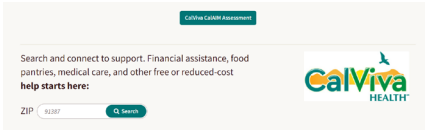


Start from the [CalAIM Resources for Providers landing page](#).

2.

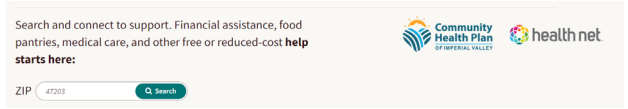


Then, scroll down to the Forms & Tools box and click on **"Findhelp Platform"**



CalViva Community Supports by findhelp - Search and Connect to Social Care

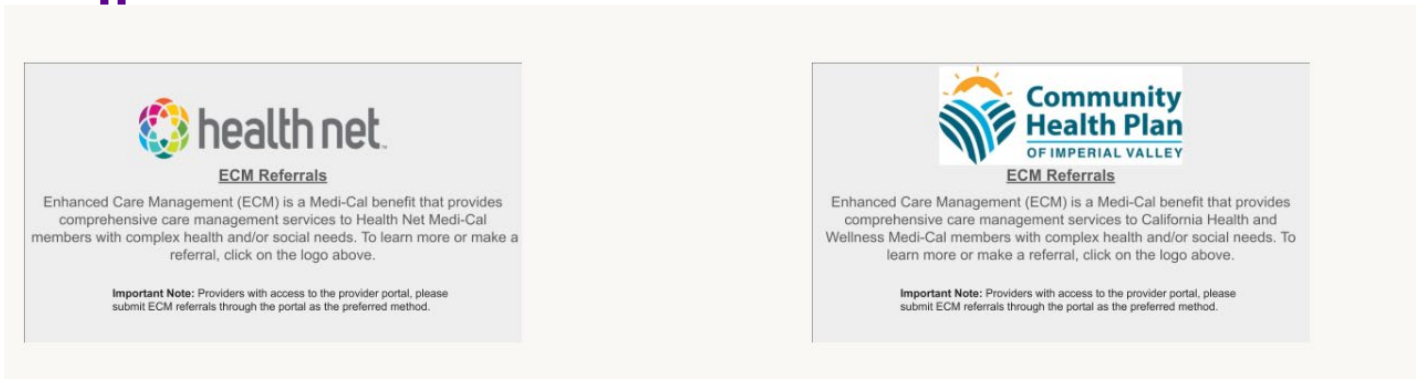
3. You should now be at the [Findhelp landing page](#)



Community Supports by findhelp - Search and Connect to Social Care

Using Findhelp (cont.)

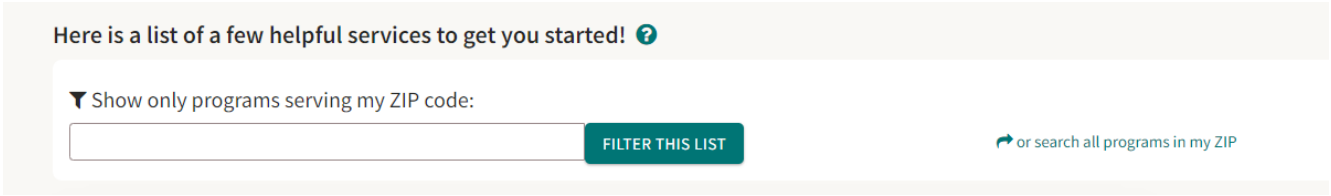
4. Then, scroll down to these boxes and click on either, **based on who you are contracted with.**



- [CalViva Community Supports by findhelp - Search and Connect to Social Care]

[Community Supports by findhelp - Search and Connect to Social Care]

5.



You should now be at this page, where you can **enter your zip code to look for services near you.**

Health Plan Contact and Resource Information

	Health Net	CalViva	Community Health Plan of Imperial Valley
Member Services	1-800-675-6110	1-888-893-1569	1-833-236-4141
Provider Directory 	https://www.healthnet.com/content/healthnet/en_us/members/medi-cal/provider-directory.html	https://www.calvivahealth.org/wp-content/uploads/2024/01/CalVivaHealth.Fresno.Kings_.Madera.01.16.2024_V01.2024-Provider-Directory.pdf	https://chpiv.org/wp-content/uploads/2023/11/DIR063648EP00_SHP_CA_MCL_MCL_IMP_V1_2024_20231023_2.pdf
Online Provider Directory (Find a Provider Tools)	https://www.healthnet.com/portal/providerSearch.action	https://providers.mhn.com/member/practSearchStartStep2.do?memberType=OPT&memSelectorRadio=OPT&memberTypeSelect=HNAZ&method=startSearch&submit.x=15&submit.y=6&calViva=calViva	https://chpiv.org/find-a-provider/#directory

Ideas for Action: Organizational Level

Attitude and Assumptions

- Commit to building a culture that is focused on providing supportive, respectful, and culturally responsive care
- Host **trainings** to build the skills of your teams

Building Trust

- Encourage **simulations or exemplars** in training environments where team members can practice skills in building trust and rapport
- Encourage mentor / mentee relationships that can help colleagues grow

Engagement

- Create **policies and procedures** that guide teams to use effective engagement strategies
- Provide **feedback** to team members after you observe interactions

Ideas for Action: Individual Level

Attitude and Assumptions

- **Reflect** on your current attitude and assumptions towards members / clients. How might you consider a different perspective?
- Complete an **implicit bias training**. What did you learn? And how might you use that in your role?

Building Trust

- When working with a member / client, identify areas that you will want to **re-visit**, once you have time to build trust and rapport.
- Do what you say you are going to do. (This takes organization and time management skills).

Engagement

- Practice **active listening** to understand how you will **co-develop a plan of care** that is focused on the member /client's self-identified goals.
- **Meet the member / client "where they are"** and use their **preferred method of communication**.

Ideas for Action: Referrals

Organizational Level

- Create **workflows and desk guides** that help team members know how, where, and when to refer to additional services / supports
- **Establish relationships** via standing meetings with local providers to identify ways to work together and improve referral pathways / steps
- Start with **Provider Directories** – who do you know? Who should you be reaching out to, to start building relationships?
- Stay **up-to-date** on providers, contact information, service offerings, etc. to support teams in getting people connected

Individual Level

- As you complete your assessment, **triage items** that need immediate referral and those that may be done at a different time (but give yourself and your member / client a date to get it done by)
- Remember to consider all information to determine if action may be needed and take opportunities for open-ended questions to **identify root barriers to care**
- Consider ways to ensure **loop closure** in your day-to-day activities
- Stay **in the know** with any materials about providers, contact information, service offerings, etc. to support your members with accurate information

Provider Spotlight

Provider Spotlight

Chat in with questions you have for our spotlighted Providers

Questions?

if time allows

THANK YOU!!!!
Before You Go…

Please Complete the Evaluation of Today's Session

Once the webinar has concluded, the survey will pop-up in a separate browser.

Appendix

ECM Assessment – Indicators for Coordination with Others

When completing the ECM Assessment:

- If applicable, leverage available assessments.
- This is another opportunity to identify potential partners/entities for collaboration and communication.

Indicate if you used any of the following, recently completed assessments or tools to complete/inform this assessment.

The Lead Care Manager should incorporate findings from all available assessments. Assessments do not replace this comprehensive assessment but should inform development of the care plan.

☐ ACEs or PEARLS ☐ Yes. Date Completed:_____ ☐ No ☐ N/A

If no ACEs or PEARLS screening completed: refer to PCP/SW for screening.

☐ CANS Assessment[1] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ PSC-35[2] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ Needs Evaluation Tool[3] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ Youth Screening Tool[4] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (DPH Foster Care) Child Health Evaluation ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ Protective Factors Survey[5] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (DCFS) Multidisciplinary Assessment Team[6] ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (CCS) Patient Care Assessment ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (DDS) Regional Center Assessment ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (Pregnant/Postpartum) CPSP Assessment ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ (Justice Involved) Re-entry Transition Plan ☐ Yes. Date Completed:_____ ☐ No ☐ N/A
☐ Other(s) (list with date completed):

_____

[1] The Child and Adolescent Needs and Strengths Assessment is used by DCFS/Child Welfare and by SMHS/DMH
[2] The Pediatric Symptom Checklist is used by SMHS/DMH
[3] The Needs Evaluation Tool is used by DMH
[4] The Youth Screening Tool is used for Medi-Cal Mental Health Services, DHCS
[5] The PFS is used by the Prevention and Aftercare Network, DCFS
[6] The Multidisciplinary Assessment Team includes their level of care tool and the Resource Family Reporting Tool, used by DMH for a child newly entering the foster care system

ECM Assessment – Possible Indicators for CS Referrals and/or Coordination needs

When completing the ECM Assessment:

- **Be on the look out for opportunities to connect to Community Supports Services.**

Asthma Remediation needed?

Day Habilitation needed?

Housing Supports needed?

Section 4. Physical Health

Has the C/Y member (or their parent/guardian/caregiver, if applicable) been told by a doctor or medical provider that they have any medical conditions? ☐Yes ☐No
If yes, please check all that apply:
☐Asthma/Chronic Lung Disease ☐Cancer ☐Cerebral Palsy ☐Cleft Lip/Palate ☐Congenital heart defect
☐Cystic Fibrosis ☐Pre-Diabetes ☐Diabetes Type 1 ☐Diabetes Type 2
☐HIV/AIDS ☐Hypertension *(high blood pressure)* ☐Kidney disease ☐Muscular Dystrophy
☐Physical disability/para/quadriplegic/amputation ☐Seizures/Epilepsy ☐Sickle Cell Disease
☐Spina Bifida ☐Organ Transplant (list): _____ ☐Genetic condition(s) (list):_____
☐Other conditions not listed above (list):

Has the C/Y member been to the hospital, emergency room, or a skilled nursing facility in the past 12 months?
☐Yes ☐No ☐N/A ☐Declined to Answer
If yes, how many times and what for? (list all):

Section 10. Social Determinants of Health (SDoH)

Housing

Where does the C/Y member live? (check all that apply)
☐ House ☐ Apartment complex ☐ Board and care facility ☐ Residential treatment center ☐ Group Home
☐ Skilled Nursing Facility ☐ Permanent Supported Housing ☐ Protective housing ☐ Shared housing (i.e. couch surfing if loss of housing) ☐ Motel/Hotel ☐ Trailor Park ☐ Campground ☐ Emergency or Transitional Shelter ☐ Hospitalized with no safe discharge plan ☐ Homeless ☐ Other:
☐ Decline to Answer

ECM Assessment – Possible Indicators for CS Referrals/Coordination

When completing the ECM Assessment:

- Example: Asthma remediation perhaps?

1. Member has asthma

2. You discover they have been to the emergency room twice this month.

3. You find that they have some potential environmental triggers.

Section 4. Physical Health

Has the C/Y member (or their parent/guardian/caregiver, if applicable) been told by a doctor or medical provider that they have any medical conditions? ☐Yes ☐No
If yes, please check all that apply:
☐Asthma/Chronic Lung Disease ☐Cancer ☐Cerebral Palsy ☐Cleft Lip/Palate ☐Congenital heart defect
☐Cystic Fibrosis ☐Pre-Diabetes ☐Diabetes Type 1 ☐Diabetes Type 2
☐HIV/AIDS ☐Hypertension *(high blood pressure)* ☐Kidney disease ☐Muscular Dystrophy
☐Physical disability/para/quadriplegic/amputation ☐Seizures/Epilepsy ☐Sickle Cell Disease
☐Spina Bifida ☐Organ Transplant (list): _____ ☐Genetic condition(s) (list):_____
☐Other conditions not listed above (list):

Has the C/Y member been to the hospital, emergency room, or a skilled nursing facility in the past 12 months?
☐Yes ☐No ☐N/A ☐Declined to Answer
If yes, how many times and what for? (list all):

Section 10. Social Determinants of Health (SDoH)

Does the place where the C/Y member live have:		
Good lighting: ☐ Yes ☐ No	Good heating: ☐ Yes ☐ No	Good cooling: ☐ Yes ☐ No
Rails for any stairs/ramps: ☐ Yes ☐ No	Hot water: ☐ Yes ☐ No	Indoor toilet: ☐ Yes ☐No
A door to the outside that locks: ☐ Yes ☐ No	Stairs to get into their home or stairs inside their home: ☐Yes ☐No	Elevator: ☐ Yes ☐ No
Space to use a wheelchair: ☐ Yes ☐ No	Clear ways to exit their home: ☐ Yes ☐ No	Lead paint: ☐ Yes ☐ No
Mold/mildew/dampness: ☐ Yes ☐ No	Overcrowding: ☐ Yes ☐ No	Unreliable utilities: ☐ Yes ☐ No
Mice, cockroaches, or other pests: ☐ Yes ☐ No	Additional housing and/or home environment safety concerns? ☐ Yes ☐ No ☐ Decline to Answer If yes, please explain:	

Additional Resources

- DHCS Webinars
- DHCS Comprehensive Quality Strategy (2022)
- DHCS Birthing Care Pathway
- CPSP Program – FAQs
- ECM Policy Guide (February 2024)
- ECM Birth Equity PoF FAQs (February 2024)
- Community Supports Policy Guide (July 2023)