CHCF PERSPECTIVES FROM THE FIELD

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by the Camden Coalition

Developing the Enhanced Care Management Workforce

CalAIM (California Advancing and Innovating Medi-Cal), initiated in January 2022, is an ambitious effort to transform Medi-Cal. CalAIM includes a major new benefit — Enhanced Care Management (ECM) — provided through Medi-Cal managed care plans (MCPs) working with a team of community-based providers to address the needs of 10 specific California populations with complex needs, including health-related social needs as well as physical and behavioral health conditions.[1] The ECM benefit builds upon Medi-Cal's Whole Person Care pilots and Health Homes program (PDF) operated in some counties.[2]

The whole-person model of care envisioned for ECM requires providers to develop significant new capabilities to develop the trust and relationships needed to successfully navigate across Medi-Cal's different delivery systems on behalf of their clients. ECM teams must possess skills related to outreach and engagement, care planning, care coordination, health promotion, transitional care support, member and family education, and social services coordination. Specifically, providers must be competent to carry out the following roles:

- Identify, perform outreach to, and engage with eligible members.
- Conduct a comprehensive assessment and create a care plan.
- Provide enhanced coordination of care to enact the care plan.
- Encourage health promotion.
- Provide services to support comprehensive transition care for members leaving the hospital or other institutional settings.
- Educate the individual and their family members about relevant conditions.
- Coordinate and refer the member to community and social support services.

Practitioners also must understand the relevant state and local policies that may impact the populations they serve (e.g., parole, housing, child welfare requirements) and possess unique clinical skills to treat specific populations, such as children or adults with a serious mental illness or substance use disorder.

Training Lags Other Enhanced Care Management Provider Priorities

To better understand what will be required for long-term success, the Camden Coalition conducted research on training needs of ECM providers (see methodology sidebar on page 2). Their major finding was that few organizations have focused on the

About the Perspectives from the Field Series

As California's Department of Health Care Services administers changes to the Medi-Cal program, especially those that are part of the CalAIM initiative, CHCF is intermittently publishing short papers that highlight the perspectives of those in the field who are implementing the changes. These "Perspectives from the Field" seek to inform policymakers and other health care leaders about insights and experiences from people on the ground who work directly with patients.

Methodology

The researchers conducted 2 focus groups and 13 interviews in 2022 with California-based frontline care managers, supervisors, program directors, organization leadership, and managed care plan representatives from organizations participating in Enhanced Care Management (ECM). They focused on the following: (1) the current training being conducted by ECM providers, (2) the challenges that have appeared, and (3) the training resources that organizations would need to do their jobs well.

Interviewees included transitions clinic network providers, county behavioral health providers, Federally Qualified Health Center staff (including those addressing homelessness issues and those in rural settings), and home care agency staff focused on older populations. Several interviews were also conducted with ECM providers who participated in the two precursor programs. All focus group participants and interviewees are referred to as "interviewees" in this paper.

comprehensive training of supervisors and frontline staff despite the extensive skills and knowledge required to perform these functions.

While the interviewees recognized the need for high-quality, ongoing training for ECM staff, they indicated that they are currently prioritizing other challenges over the establishment of training protocols and programs. Among their top challenges were:

1. Hiring sufficient staff

Hiring ECM staff was identified as the biggest challenge because of low pay and the requirement to work in the field when there are higher-paying positions that are remote and less stressful. In addition, workers may be reluctant to enter a workplace that is short-staffed. One ECM provider reported serving 700,000 clients a year with a staff of 275 team members — 100 short of their needs. The problem is especially pronounced in rural areas with an already limited workforce. In a focus group of safety-net providers, 70% of participants said hiring is their biggest challenge in workforce development, while 22% pointed to retention. Only 8% said that training was their biggest challenge.

2. Retention of staff

Interviewees said it is difficult to retain staff due to some of the problems pertinent to hiring, such as low pay and more lucrative jobs elsewhere. Burnout (some of it attributed to the COVID-19 pandemic) also causes staff to leave their jobs. Some respondents noted that staff shortages make it impossible for people to participate in trainings. A clinical services manager for an association of community clinics reported: "One of the major barriers . . . is getting that time from our frontline workers — our nurses, our staff from our health centers — just because there is such a high turnover rate [and] workforce bandwidth issues."

3. Management of acuity and administrative demands

Discussions with interviewees also revealed that ECM providers are overwhelmed by the acuity of the populations served, as well as by the speed, scale, and complexity of the program's administrative requirements. Interviewees reported that the ECM patient population has more intense needs than those enrolled in the Whole Person Care pilots or Health Homes program. The head of provider education for one such organization noted: "The state set out with ECM to make it the most intensive level of care management. These patients are sick — I mean, the level of acuity and intensity is high."

At the same time, interviewees said they are inundated with constantly shifting and complicated ECM instructions and requirements. They reported the need for more trainings about ECM regulations, information on what the plan offers, and community-specific resources.

"More and more of our case managers' jobs and our contract . . . require significant documentation [and] understanding how to use IT systems, being able to problem solve . . . knowing how to write notes, care plans, SMART goals . . . . When we hire, especially when we focus on hiring people with lived experiences, these are not the things that we have in the past prioritized . . . . We're really looking for people to have an ability to connect with and build trusting relationships with a client."

–Chief of integration services, safety-net ECM provider

Value of Training Workforce with Lived Experience

Interviewees said that training would be helpful for newly hired staff members with more community and lived experience but limited credentials and field experience. One community-based provider noted that recent workforce hires need more onboarding, training, and experience shadowing seasoned team members. Although most ECM providers and frontline staff are knowledgeable about medical problems, many are just beginning to focus on social needs. Relatively few providers and frontline staff are specialists in social needs, and even fewer have been integrating care for both medical and social needs. The majority of ECM providers and staff need training on how to identify and respond to social needs and integrate services.

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Current Training Activities and Tools

For most frontline staff, training is primarily done learning on the job and from formal trainings provided online and/or by internal managers who have previously worked as care practitioners. Provider organizations reported that an in-house trainer with experience both in practice and education would be ideal for many clinics and community-based organizations if it were financially feasible. A few organizations have built infrastructure for themselves and are offering training to other ECM providers (see "Innovative Training Examples" sidebar).

Some network associations and MCPs offer training around ECM program-specific delivery for supervisors and program directors. Such initiatives support common language and standards as well as good partnering practices. Network associations, such as the Community Clinic Association of Los Angeles County and the California Primary Care Association, and payers have structures to convene ECM providers through roundtables, learning collaboratives, and regular webinars and case conferences. In addition, interviews for this paper were completed before the California Department of Health Care Services (DHCS) rolled out an extensive webinar series highlighting promising practices from the field.[3]

Most informational guides on ECM concentrate on the background and structure of the program rather than on providing specific tools to improve the skills of managers and staff. Other broader complex care management trainings are available that are applicable to ECM provision. Many of those trainings are the products of partnerships with educational institutions (e.g., UCSF Complex Care Management Training).[4]

Innovative Training Examples

- **Using robust formal training to boost retention.** An Enhanced Care Management (ECM) provider notes that its robust onboarding and ongoing training program increases retention. Its onboarding includes organization-wide training modules and department-specific trainings that must be completed in the first six months of employment. For the care team, this includes mandated reporter and suicidal intent assessment trainings, as well as health plan- or county-required topics, such as: motivational interviewing, trauma-informed care, harm reduction, cultural humility, and social determinants of health. The frontline staff is also trained in workflow and client intake processes, person-centered care planning, end-of-life planning, and community resources. After three months, frontline staff members have a full caseload and, in six months, are fully trained. Leadership says that the up-front investment pays back in the form of client and staff safety and support as well as in staff retention.
- **Embedding training in weekly 30-minute meetings.** A supervisor at an ECM provider convenes her case managers, patient navigators, and community health worker clinicians every Monday for 30 minutes to conduct a brief training and facilitate a conversation. The topics — based on team member questions — have included client-centered language, nonbinary identity, and training on psychosis and suicide identification. The supervisor reported that she spends a lot of time doing the research and generating talking points, enriching the material with media and articles.
- **Payer enhances a provider's capacity to onboard and train.** One ECM provider contracted with a payer to train their frontline staff on physical health care, mental health care, and community resources. After a period of time, the provider wanted to shorten the onboarding period, but the payer — serving multiple sites — could not be available as quickly as needed. They negotiated a solution by creating a lead position responsible for efficient onboarding. Each new employee is now trained by the provider's lead trainer and also joins the case conferencing and ongoing training provided by the payer.

What Should Trainings Look Like?

Respondents pointed to the need for different types of trainings, including onboarding for new staff, annual refreshers, electives (e.g., addressing hoarding), and training for both managers and frontline staff, as well as trainings based on specific ECM populations. The design of training programs should consider both incentives and challenges for ECM providers, including retention, job satisfaction, efficiency, career development, interdisciplinary training, and time and financial constraints for trainers and trainees. One interviewee emphasized that training on correctly inputting, tracking, and using data to increase reimbursements and improve services is important for appropriate billing and making ECM sustainable. Competencies in this area include identifying patients for proactive engagement, making referrals, documenting case notes, working in the care information exchange and electronic health records and understanding the impact of the program on participants. Network associations, large hospital systems, and payers can build community capacity by supporting workforce training as a collective. Payers receive funding for this purpose and may be better positioned to invest in training than individual provider organizations.

Interviewees identified four types of trainings that work together to create a robust program:

- **Instructor-led synchronous training** is the preferred format because it supports engagement, practice-based learning, and immediate feedback — all of which improve knowledge retention and skill development. Such trainings are usually led by in-house staff but could also be conducted by outside experts.

- **Online asynchronous trainings** are effective as short skill builders or refreshers that team members can take as they are available and needed. They can also be useful as a repository that can be accessed on demand for new staff. Interviewees reported that this format is less effective for longer and more complex topics and that, currently, there are large gaps in the topics covered.
- **Tools for managers to train or engage their team** include case studies, role plays, discussion questions, examples from exemplar communities, and other templates and activities. Such tools can solidify learning and apply it to the participants' context, community, and population. As yet, tools specific to ECM are not widely available.
- **Peer-to-peer connections** within and across teams and organizations through learning collaboratives or roundtables are also helpful to complement formal training and create space for problem solving, solidifying learning, and fostering a sense of community and belonging. Spaces for peer-to-peer connections already exist for many organizations, though staff have been challenged to find time to engage and participate.

Barriers to Developing Training Programs over the Long Term

Respondents described a number of specific barriers to workforce training over the long term:

- **Lack of statewide standards.** Research participants noted that the ECM program is being implemented differently across the state, without a standard model of care. As a result, each county, payer, or ECM provider must create workforce hiring and training standards individually.[5] Most interviewees said such standards should come from the state, as they have for community health workers (CHWs),[6] although some noted that flexibility (especially regarding the hiring of nonlicensed staff) enables providers to tailor their program and workforce to their community's shifting needs.

> *"One of the major concerns is that there's not consistency in training or even consistency in the model of care for ECM."*
>
> — Executive of a community-based provider that implemented the Whole Person Care Pilot program

- **Funding is limited and short term.** Training is a financial burden because of its direct costs and lost staff time. It is even more expensive for those providers, such as physicians, who can bill at higher rates, to attend. Interviewees said that CalAIM Incentive Payment Program (IPP) funding is helpful but is short term. It is less expensive for internal managers to train staff, but ECM providers often do not have the in-house expertise or the time and funding to develop it. Therefore, training efforts are largely focused on care managers (e.g., CHWs, medical assistants, or case managers) and supervisors. Several payers stated that they might fund training going forward if they see enough value in it (e.g., in the form of staff retention, efficiency, and quality of care).
- **Perceived limited market value in training.** Although high-quality training improves patient outcomes, individual frontline staff members are not currently rewarded financially or otherwise as a result. However, some interviewees pointed to the benefits of continuing education units, accredited certificates, and promotions as incentives for frontline staff training. One organization with a robust training program noted that their training and culture of support resulted in very little staff turnover during and in the wake of the COVID-19 pandemic.

Recommendations

The responsibility to purchase, organize, and deliver staff training is a tremendous amount of work for providers already struggling with hiring, retention, and delivery of a complex benefit, such as the ECM model of care. The research pointed to several recommendations for addressing near-term workforce gaps and laying the foundation for robust ECM training in the future:

Recommendation #1. Identify a standard model of care and workforce standards for ECM providers.

DHCS can provide needed guidance and structure for the ECM model of care, and for hiring and training by outlining standards for the ECM workforce. Interviewees said this would be useful but noted that they appreciate flexibility and do not want overly prescriptive standards that rely on formal credentials that could inadvertently exclude CHWs and other providers with lived experience.

Recommendation #2. Encourage investments in supervisor workforce development and supports.

Focusing on supervisors can help to stabilize teams and support retention. Through either IPP funding or value-based payment, MCPs can create additional incentives to increase provider organizations' ability to hire, retain, and train staff. In addition, CalAIM's Providing Access and Transforming Health (PATH) Capacity and Infrastructure Transition, Expansion and Development initiative, and the PATH Technical Assistance Marketplace are funding vehicles to enable ECM providers to access training programs.[7]

Recommendation #3. Foster peer-to-peer learning opportunities and support for frontline staff and supervisors.

Interviewees reported that peer-to-peer learning is a valuable way to work through challenges and share best practices. Conveners should create spaces (both physical and virtual) for frontline providers and supervisors to learn together and from each other. Regional associations are well equipped to create such programming, and the PATH Collaborative Planning and Implementation initiative may be another venue for organizations to come together around workforce development.[8]

Endnotes

1. *Enhanced Care Management (ECM) Implementation Timeline and Updated Populations of Focus* (PDF), California Department of Health Care Services (DHCS), updated December 2022.
2. "California Advancing and Innovating Medi-Cal (CalAIM): Transition from the Health Homes Program (HHP) and Whole Person Care (WPC) Pilots to Enhanced Care Management (ECM) and Community Supports (ILOS) public webinar (PDF)," DHCS, September 21, 2021.
3. "CalAIM Enhanced Care Management, Community Supports, and Incentive Payment Program Initiatives," DHCS, accessed March 13, 2023.
4. "Complex Care Management Training," UCSF Center for Excellence in Primary Care, accessed January 25, 2023.
5. "Enhanced Care Management (ECM) Model of Care," Partners in Care Foundation, accessed January 25, 2023.
6. *California State Plan Amendment (SPA) No. 22-0001* (PDF), DHCS, July 26, 2022.
7. "Capacity and Infrastructure Transition, Expansion and Development (CITED)," DHCS, accessed March 13, 2023; "Technical Assistance Marketplace," DHCS, accessed March 13, 2023.
8. "Collaborative Planning and Implementation," DHCS, accessed March 13, 2023.

About the Authors

The Camden Coalition is a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, New Jersey, and across the country. The nonprofit works to advance the field of complex care by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and well-being.

About the Foundation

The California Health Care Foundation (CHCF) is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.