CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties Webinar

November 17, 2022

Transcript

Contents

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Julian – 00:00:19	Hello and welcome. My name is Julian and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please tap your question into the Q&A field, which is located at the Zoom panel at the bottom of your screen. We encourage you to submit written questions at any time using the Q&A. Finally, during today's event, live closed caption will be available in English and Spanish. You can find a link in the chat field. With that, I'd like to introduce Juliette Mullin, senior manager at Manatt. Juliette, you now have the floor.
Slides 1-2	Juliette Mullin – 00:00:53	Thank you, Julian, and welcome everyone to today's CalAIM Enhanced Care Management and Community Supports Office Hours. Today, we are going to be having a great discussion with some organizations implementing CalAIM in YOLO County, Santa Barbara County, and San Luis Obispo. We'll also be joined by the DHCS team and we're going to have a really great conversation about implementation in new counties. You might be wondering what I mean by new counties. We are referring here to counties that did not have Whole-Person Care or Health Homes Programs in place when we launched CalAIM in January of 2022, or prior to launching CalAIM in January of 2022. We're going to have a conversation about what it was like to implement CalAIM in those counties and we'll explain all of that for you shortly. Before we dive in, I'm going to introduce Aita Romain to provide a couple DHCS updates about the Public Health Emergency. Aita.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 2-4	Aita Romain – 00:01:51	Hi. Thanks, Juliette. We have spoken about this in the past so I will be very quick. First of all, the Public Health Emergency has officially been extended until mid-January 2023. Health and Human Services has said that it would provide 60-day notice before terminating Public Health Emergency. Since no notice of the end of the PHE has provided at this time, we do want to remind you about how you can become a DHCS Coverage Ambassador. You can access the links here. Next slide, please. Also, look towards our two-phase rollout, which we start with encouraging beneficiary to update the contact information and then also to watch out for renewal packets in the mail. Next slide, please. Back to you, Juliette.
Slide 4	Juliette Mullin – 00:02:54	Great. Thank you, Aita. As I noted, we are today in a CalAIM Office Hours about new counties. I explained a little bit earlier what we mean by new counties here, but you may also be wondering what we mean by Office Hours. If you're joining in Office Hours for the first time, Office Hours are a Q&A conversation with DHCS leaders and stakeholders who are implementing CalAIM focused on a specific topic. Today's topic is CalAIM implementation in "new counties." When we say new counties, again, I'll repeat it here for folks who've just joined us, new counties refers to counties who did not have the Whole-Person Care or Health Homes Programs in their counties. Today. What we'll do is I'm going to start with a round of introductions in just a moment and then I'm going to explain to everyone joining today how you can participate.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 4-5	Juliette Mullin – 00:03:46	How can you, as a participant of today's Office Hours, ask questions of our panel? Then we're going to have the DHCS team give us a broad overview of CalAIM just so that everyone has a clear understanding of what it is, what is ECM, what is Community Supports. They'll also explain how the Whole-Person Care program and the Health Homes Program really informs both the design and the implementation of CalAIM in 2022. Once we get through all of that, we will open it up for our Q&A conversation and we're going to have a conversation with the people that I'm about to introduce here. If we go to the next slide, let's introduce the team. From DHCS, we are joined by Aita Romain, who just provided an update on the Public Health Emergency, as well as Dr. Shaw Natsui from the Quality and Population Health Management Division, which oversees the ECM program.
Slide 5	Juliette Mullin – 00:04:36	We are also joined by some leaders from the Managed Care Quality and Monitoring Division. Today. We have Neha Shergill, Shel Wong, and Tyler Brennan joining us, and they're going to share some broad overview and answer any questions about community support. We have two organizations that have joined us today to share about their implementation experience in counties that did not have Whole-Person Care or Health Homes. From CommuniCare in Yolo County, we have Dr. Suzanne Eidson-Ton, the chief medical officer of CommuniCare, and we have Maira Fernandez, the manager over the ECM program. From Good Samaritan Shelter in Santa Barbara County and San Luisa Obispo County, we have Sylvia Barnard, the executive director of that organization. They're going to tell us a little bit about their organizations in a moment, but just wanted to thank all of these great panelists for joining today and looking forward to the conversation. Next slide, please.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Juliette Mullin – 00:05:34	How can you, as a participant, participate? Today, we are going to start with a broad list of questions that I'm going to go through. I'm going to essentially interview our two organizations here to understand and learn from their experience implementing CalAIM in their organization. We have created these questions based on many previous questions we've received from stakeholders in the past, questions we've received in previous webinars, and any questions that get submitted via email prior to an Office Hour session. As we move throughout, we invite anyone participating in today's session to please post any questions you have in the chat as we go.
Slides 6-7	Juliette Mullin – 00:06:15	I'm going to have an eye on the chat as I'm asking questions and I may ask some of those questions out loud to our panelists. We'll also be looking at the chat and responding to those as we're able throughout the session today. You can also participate verbally. If you would like to ask any of the panelists the question out loud, you can do so by raising your hand in Zoom and we'll be taking people off of mute to ask some questions when we get to that point in the session. If we go to the next slide, I will hand it over to my colleague Alice with Manatt Events to explain how you can get in line, especially if you've joined us via phone only today.
Slide 7	Alice Hayes – 00:06:52	Thanks, Juliette. Participants may raise their hand for Zoom facilitators to unmute them to share comments. The facilitator will notify participants when we all take questions from the line. If you logged on via phone-only, press *9 on your phone to raise your hand and listen for your phone number to be called. If selected to share your comment, please ensure you are unmuted on your phone by pressing *6. If you logged on via Zoom interface, press Raise Hand in the reactions button on the screen. If selected to share your comment, you'll receive a request to unmute. Please ensure you accept before speaking.
Slide 8	Juliette Mullin – 00:07:31	Thank you, Alice. With that, I will hand it back to Aita to give us an overview of CalAIM, ECM, and Community Supports. Aita.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 9-10	Aita Romain – 00:07:39	Thanks. CalAIM is a long-term commitment to transform and strengthen Medi-Cal. It includes implementing a Whole-Person Care approach in addressing social drivers of health, improving quality outcomes, reducing health disparities, and driving delivery system transformation, and creating a consistent, efficient, and seamless Medi-Cal system. Next slide, please. Two key components of CalAIM that went live this year were Enhanced Care Management and Community Supports. ECM is a Medi-Cal benefit that addresses the clinical and nonclinical needs of the highest-need individuals through a coordination of services and comprehensive care management. Community Supports is our services that Medi-Cal managed care plans are strongly encouraged, but not required, to provide as medically appropriate and cost effective alternatives to utilization of other services. This was, in the past, called In Lieu of Services. Our email address as well as our website still has that ILOS in place of that Community Supports language. Next slide, please.
Slide 11	Aita Romain – 00:08:59	What exactly is Enhanced Care Management? As I mentioned before, it is meant to address both the clinical and non-clinical needs of the highest-need enrollees through the intensive coordination of health and non-health-related services. Essentially, it also means meeting enrollees where they are, so in their communities, whether that's on the street or in a shelter or in their doctor's office. It is an essential part of the population health management system where managed care plans offer care management at different levels of intensity based off of their member needs. It includes the seven Enhanced Care Management Core Services, which are outreach and engagement, comprehensive assessment and care management plan, enhanced coordination of care, member and family supports, health promotion, comprehensive transitional care, as well as coordination of and referral to community and social services. Next slide, please.

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Aita Romain – 00:10:01	The populations of focus that have gone live for Enhanced Care Management so far include individuals and families experiencing homelessness, adults at risk for avoidable hospital or emergency department utilization, adults with serious mental health and/or substance use disorder needs, and individuals with intellectual or developmental disabilities. As long as they were a part of those prior populations of focus that I mentioned, as well as adults, pregnant, and postpartum individuals at risk for adverse prenatal outcomes. Those two starred populations there are considered a subpopulation of the key populations that have gone live, however, those populations do overlap. And then essentially, in some Whole-Person Care counties, there are individuals transitioning from incarceration, has also gone live. Now, what we expect in January 2023 is for the long-term care populations of focus, which includes adults living in community and at risk for institutionalization and eligible for long-term care, and adults who are nursing facility residents, as well as those transitioning to the community.
Slides 12-13	Aita Romain – 00:11:12	Those will go live in January 2023. We anticipate our children and youth populations of focus to go live in July 2023, quickly followed by the pregnant and postpartum individuals at risk for adverse perinatal outcomes who are subject to racial and ethnic disparities, to go live as a subpopulation of our children and youth populations of focus that will go live in January 2024. We are also anticipating that individuals transitioning from incarceration will go live, at some point, in 2024 as well. Next slide, please. What are Community supports? Community Supports are services that Medi-Cal managed care plans are strongly encouraged to, as I mentioned before, but not required to address, which includes medical and social drivers of health needs. Community Supports are medically appropriate, however, they are cost effective alternative services or settings that are provided as a substitute for more costly services or settings such as hospitalization, SNF admissions, or ED use.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Aita Romain – 00:12:17	Managed care plans must follow the DHCS standard Community Supports service definitions in the policy guide, which you can find on our website, but they also may make their own decisions about when it is cost effective and medically appropriate. Community Supports are not restricted to the Enhanced Care Management populations of focus that I just listed on the prior slide and should be made available to all members who meet eligibility criteria for specific Community Supports. A managed care plan can offer both Community Supports and Enhanced Care Management to the same individual, and a provider can also be a Community Support and Enhanced Care Management provider. Next slide, please.
Slides 14-15	Aita Romain – 00:12:58	The 14 Community Supports that are currently set out as optional, identified by DHCS, are housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing, recuperative care, respite services, day rehabilitation programs. I really put myself throughout reading all these. Nursing facility transition/diversion to assisted living facilities, community transition services/nursing facility transition to a home, personal care and homemaker services, environmental accessibility adaptations, meals and medically tailored meals or medically-supportive foods, and then sobering centers, as well as asthma remediation. Next slide, please. Now, I'll hand it back over to Juliette.
Slide 15	Juliette Mullin – 00:13:58	I will hand it to Shel Wong to give us an overview of the Whole-Person Care program and the Health Homes Program. Shel.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Shel Wong – 00:14:06	Thanks, Juliette. The design and implementation of CalAIM was informed by two key DHCS programs. DHCS launched the Whole-Person Care Pilots or WPC in 2015 as part of its Medi-Cal 2020 Section 1115 Demonstration. Whole-Person Care Pilots have tested patient-centered interventions to coordinate physical, behavioral, and social services such as housing services. 23 counties were reported to have participated in the Whole-Person Care program. DHCS also launched the Health Homes Program in 2018. HHP serves eligible Medi-Cal managed care plan members with complex medical needs and chronic conditions who may intensive care management and coordination. Health Homes was administered by 17 health plans across 12 counties. Next slide, please.
Slides 17-18	Shel Wong – 00:15:04	More than 50% of the state population resides in counties that had Whole-Person Care or Health Homes. As shown on this map, the dark blue represents counties that implemented the Health Homes Program, Purple represents Whole-Person Care, and the light blue represents both Health Homes and Whole-Person Care. Next slide. As I mentioned at first, Whole-Person Care Pilots and Health Homes Program preceded Enhanced Care Management and Community Supports. Whole-Person Care was administered by lead entities, primarily through counties, but also cities and local health authorities. Enrolling in Whole-Person Care could be free for service, managed care, or at the point where they were eligible for Medi-Cal but not yet insured. There was no requirement to interface with managed care plans. Health Homes Program, however, was a benefit offered in select counties and was only available to manage care plan members.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Shel Wong – 00:16:04	MCPs administered Health Homes and providers were contracted to provide the care management. These two programs were smaller in the sense that they weren't offered statewide, but DHCS was able to gather a lot of lessons learned that helped inform CalAIM program and design. The value of coordinating care across the spectrum for those who really needed additional support and who really were medically vulnerable, as well as had social concerns, that portion went into what we call Enhanced Care Management. These programs help to identify successes, and there are also programs that help to identify the successes of nontraditional services that address the combined medical and social drivers of health needs. Those are also known as Community Supports. As Aita mentioned earlier, Community Supports are strongly encouraged, but not required, for managed care plans to provide.
Slides 18-19	Shel Wong – 00:17:02	The managed care plans administer these services to eligible members through community providers, as well as coordinating with the enhanced care managers when someone is receiving both ECM and Community Supports. Next slide. ECM went live for some populations of focus on January 1st of 2022 in the 25 counties that previously participated in Health Homes and/or Whole-Person Care. Approximately 95,000 Medi-Cal members were eligible and automatically transitioned into ECM on January 1st from these prior programs. ECM also went live statewide for active populations of focus for the remaining 33 counties on July 1st of this year. Now, I'll pass this back to Juliette.
Slide 20	Juliette Mullin – 00:17:58	Fantastic. Thank you, Shel. Now we're going to spend the rest of our conversation today really talking about those counties that implemented ECM in July and didn't have the Whole-Person Care and Health Homes Programs established in their counties prior to CalAIM. I'm going to start our conversation with Sylvia. Sylvia, I'm hoping you could actually just pick us off by sharing a little bit about Good Samaritan Shelter, about the organization generally who you serve, what types of services you provide.

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Sylvia Barnard – 00:18:29	Yeah. Good Samaritan Shelter is located in Santa Barbara and San Luis Obispo counties. We're the largest homeless shelter and homeless services provider in Santa Barbara County. We provide everything from warming centers to emergency shelter, transitional permanent housing. We provide drug and alcohol treatment services. We provide mental health services. We provide housing retention, housing placement, rapid rehousing. We kind of have created our own continuum of care. Specifically we started in North County of Santa Barbara County and then we've expanded greatly in the pandemic down to Santa Barbara. In the process of us growing to where we are, we have 600 beds under roof in 40 different locations, is that we have just cobbled together different funding sources to be able to create a system that is as effective as it can be based on the restrictions of our funding.
Slide [none]	Sylvia Barnard – 00:19:29	In order to get people to housing, we make sure that we're participating in coordinated entry, but we need resources. Every resource that comes down, we've been able to pull together and be able to create a comprehensive system, but it's all driven by funding availability and resources availability. At times, we may have less rapid rehousing spots, or less resources, or our shelters are always running in the red because we don't have enough case management funding. That's kind of where Good Samaritan has gotten to today and looking forward to... We currently are a provider, but looking forward to the expansion of the support services.
Slide [none]	Juliette Mullin – 00:20:13	Great. Thank you, Sylvia. Kind of piggybacking off of that and looking at where you're going now, can you tell us a little bit about how you learned about CalAIM, and ECM, and Community Supports and became engaged with that? And then why Good Samaritan decided to pursue being an ECM provider and a Community Supports provider?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Sylvia Barnard – 00:20:32	Our managed care system is called CenCal. We work closely with them. We have, over the years, we actually are a mental health provider through them for those that have mild to moderate diagnosis, and so we're able to provide services through them. We also have been doing our respite services through a contract from them through a hospital to us. We've worked with them over the years, but more from a distance. When ECM happened and Enhanced Care Management was an opportunity, we met with them. We sought them out first because we saw the whole list of supportive services, including sobering centers, which we already do. We wanted to make sure that we were able to work with them for funding sustainability. We were concerned that we were going to lose funding for some of the services that we were already providing, but realized that we needed to enhance those services.
Slide [none]	Sylvia Barnard – 00:21:30	We did become an enhanced case management program, an ECM provider back in July. It's been a little bit of a slow ramp up. We served 3000 people a year, and probably all of them would qualify for ECM services, but our ramp up was slow until we came up with a plan, which we have in place now, that we're anticipating with some IPP funding that will make a difference. But what we first did was we just incorporated it within the systems that we had and the staffing that we had in fear of creating positions that would not be able to be reimbursed. We realized that we have a transient population, people are moving around, but most of them are actually within our system. That's how we became an ECM provider. The support services, it was easy for us to transition our respite beds into RCP beds, recuperative care. That was an easy transition for us that happened October 1st with an expansion of additional beds in a different location. But there's still transition that needs to happen and more support services.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Sylvia Barnard – 00:22:42	The biggest piece I think that we did not have on the upfront was capacity. It's interesting, in our county, we're actually the only ECM provider to date, and we are an agency that's familiar with medical billing. We already provide Medi-Cal services for both mental health and drug Medi-Cal. We are already familiar with that process. The process through the managed care system through CalAIM is much simpler than that, but we were the only agency that really even knew what an NPI number was, and to how to be able to apply for those and make that happen.
Slide [none]	Sylvia Barnard – 00:23:20	The biggest thing that I would suggest is for agencies that are from this counties like ours that don't have Whole-Person Care is to really focus on capacity building on the front end and go after funding to be able to make that happen through PATH or IPP. We just submitted our IPP application this week. It was the first round. Once we figured out what the possibilities are and how it can provide better services for the clients we serve plus, it was much easier to come up with a plan, but we went to a conference to figure that out and didn't know that on the front end.
Slide [none]	Juliette Mullin – 00:24:02	That's great. Thank you for sharing that. Maybe we'll just actually take a moment to pause here. I know we did not give an overview of what IPP and PATH was at the beginning of our session today. I'm wondering, Shel, if you could, just in a couple sentences, share what IPP is and what PATH is for participants today who might not be familiar with it.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Shel Wong – 00:24:28	Yes. IPP and PATH are both incentive funding programs that are offered through DHCS. There is a little bit of a difference between the two funding programs. IPP or the Incentive Payment Program is tailored towards the managed care plans, so where the Managed Care Plans report on their achievements towards a set of measures and can earn payments that way. Whereas PATH, there's a bunch of different initiatives under the PATH program that those are mostly tailored towards providers and local entities. Information on both IPP and PATH can be found on the DHCS ECM and Community Supports website. If someone doesn't mind dropping a link to that website in the chat, that's the best way to find the information currently for both programs.
Slide [none]	Juliette Mullin – 00:25:28	Great. Thank you, Shel, I didn't want to keep going with acronyms that we hadn't explained to the participants today. Appreciate that. I think that's a really, really helpful overview, Sylvia, of your organization and how you got started with CalAIM and how you engaged with CenCal to really get the systems up and running that you needed, and also really a really helpful explanation for why you all decided to pursue CalAIM. I'm wondering if we can maybe just shift over to CommuniCare for a moment and ask essentially the same questions. Would love, maybe Suzanne, we can start with you. If you could tell us a little bit about CommuniCare. Who do you serve, what types of services do you provide, what should people know about your organization?
Slide [none]	Suzanne Eidson-Ton – 00:26:12	Definitely. Thank you. CommuniCare is a federally qualified health center, a network of community health centers within Yolo County. We provide medical care, primary care, perinatal care, dental care, as well as many, many behavioral health services as well, and including medication assisted treatment and things like that. We serve one in nine Yolo County residents. We also have a mobile medicine team as well. We serve a lot of residents who are experiencing housing instability as well in our county. Most of our patients have Medi-Cal that we also serve patients that don't have any insurance.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Juliette Mullin – 00:27:03	Great, thank you. Can you walk us through your process of working with Partnership to become an ECM provider? I think my two core questions for you are why did you decide to go down that path and become an ECM provider? And then what did that process look like with Partnership?
Slide [none]	Suzanne Eidson-Ton – 00:27:20	Great. Yes. I might ask Maira to join me in answering the second part of the question. But the first part around why, I mean, in providing medical care to our patients, we definitely need to have some kind of case management. I think that, especially for those very complex higher risk individuals, ECM is a really great way to provide that. There had been a previous program through Partnership HealthPlan that we had participated in called IOPCM that had some overlap as far as populations of patients that were covered under that. We had participated in that. That really helped smooth the way to being able to shift to participating in the ECM program. I don't know if you want to add some details, Maira, around how we do that with Partnership.
Slide [none]	Maira Fernandez – 00:28:20	Yeah. Thank you. We participated in IOPCM. During that transition, we had many conversations as to our patients that were enrolled in IOPCM could transition to ECM services. We, as CommuniCare and case management, we saw the benefit that IOPCM had on our patient population and just the difference it made in just in their general medical, dental, and behavioral health. During that transition, we continued the conversation with Partnership and decided that it was a, for sure, ECM would not only encompass making sure that patients had adequate medical, dental, behavioral SUD care, but it also focused on addressing the social determinants of health. In the start of all this, we had 45 patients that actually grandfathered in to ECM. We already had just that little leeway and us having some sort of caseload that we can just transition into ECM. The conversation with Partnership was pretty smooth because we already had a relationship with them just with IOPCM and just the whole case management care coordination aspect of IOPCM and ECM.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Juliette Mullin – 00:29:51	Just a point. Oh, sorry. Go ahead, Suzanne. I cut you off.
Slide [none]	Suzanne Eidson-Ton – 00:29:58	No. I was just saying thank you.
Slide [none]	Juliette Mullin – 00:30:02	Well, I was just going to ask if you could clarify. IOPCM, was this just a Partnership specific program that was a case management program?
Slide [none]	Suzanne Eidson-Ton – 00:30:11	Yes. Right. It was a Partnership specific program and there's some of the same populations that are covered in ECM, but ECM is actually a little bit broader as far as the populations that it covers, but it was sort of a support for case management of those individuals.
Slide [none]	Juliette Mullin – 00:30:31	Got it. Great. Sylvia shared a little bit her words of wisdom for an organization that's starting doing ECM and her focus on capacity building and starting there. What would you say to an organization... We hear all the time from organizations, "We want to be part of ECM. We want to be part of Community Supports. What do you recommend we do?" What would you recommend that an organization do first if they want to participate in ECM?
Slide [none]	Suzanne Eidson-Ton – 00:31:01	Well, I will answer that first maybe, and then Maira can chime in too. I actually think that it's really important to have relationships with the healthcare organizations in the community as well as the other organizations that are serving these individuals that we're talking about. I feel like those partnerships are really important in understanding what the needs are and how your organization can fill those needs. I think finding the case managers, I mean, having the people who have that ability to connect with the individuals and provide the services. Do you want to say more about that, Maira?

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Maira Fernandez – 00:31:41	Yeah. I think it's also important for any organization that's starting is just to take a step back and look within the organization. We're already doing the case management, the care coordination somehow. Just focusing on that and what are we already doing within our agency to enhance that and be able to be a billable service, be able to provide that and be sustainable, and make case management and care coordination grow in an agency.
Slide [none]	Juliette Mullin – 00:32:17	Great, thank you. I'll keep with the CommuniCare team for another question here. I'm wondering if you could give us just an overview of what your ECM program looks like. Who's on the team, how have you structured that, and how have you operationalized the core ECM services?
Slide [none]	Suzanne Eidson-Ton – 00:32:37	Do you want to take that one, Maira?
Slide [none]	Maira Fernandez – 00:32:39	Yeah. Yeah. Currently we have four full-time case managers. Our biggest or our largest clinic has two embedded case managers, but we structured it for them to be available to providers, nurses, MAs within the clinic. We're under the director of nursing and then it's the supervisor. It's a very unique structure because each case manager is part of a team. We always say they're the hub. They're part of team meetings, part of mobile med, and making sure that they're available for the clinic as a whole. Each case manager right now has about between 30 to 35 enrolled patients in ECM. It's just they're embedded and part of the team.
Slide [none]	Suzanne Eidson-Ton – 00:33:39	Yeah. I'll just add that when she's saying embedded, embedded in the primary care team particularly, and so they do ECM but they're also available to assist the primary care team to figure out is someone eligible for ECM, or if they're not eligible for ECM, what other services could maybe help support this patient in the things that they need.
Slide [none]	Juliette Mullin – 00:34:12	Great.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Suzanne Eidson-Ton – 00:34:12	Can I say one more thing about workforce too? Which is I think in thinking about who are great ECM providers as far as the individuals doing the work, I think really we do try to look at lived experience as part of the qualification for that. I think that's really helpful when we're thinking about workforce for this particular program. They are of in the same office with our nurses and it is a program that's under the director of nursing, so they have that sort of clinical support as well.
Slide [none]	Juliette Mullin – 00:34:50	That's great. I think you almost anticipated my next question. I was going to ask you how you gather your team and who you look for. That's perfect. Sylvia, we could ask you the same questions. Could you tell us a little bit about your ECM team, and who's on that team, and how you've structured that? Because we know, I think, everyone on this call knows, and folks that are learning about ECM for the first time, will be discovering that ECM teams can have different compositions and can look different from organization to organization.
Slide [none]	Sylvia Barnard – 00:35:18	Our mental health director took the lead on ECM and her staff supported her in being able to start up the system with CenCal. We've proposed in our capacity-building grant that we would have a specific ECM manager, care coordinator, and a CalAIM coordinator for the support services, because we anticipate that we'll be maybe even providing more support services than even ECM at that point, at the point that we're up and running. We have case managers within our system, especially our shelter systems, that are already doing the work, much like what Maira said. We're incorporating it into that. But I think the key for us is really getting someone who is an ECM care coordinator specifically, that's their job, and they can track the referrals, the approvals, and those that are supposed to be getting services, especially with the transient population that are homeless because they come in and out of our one shelter or out into outreach, or they may show up at the sobering center.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Sylvia Barnard – 00:36:27	Being able to track them through our system is really important to make sure that they can have that continued ECM services and not just at the shelter, for example. We eventually will probably do the same thing as hire specific ECM case managers, but we're trying to figure out how it works within the system of the population that we serve, if that makes sense.
Slide [none]	Juliette Mullin – 00:36:53	It does. I'm curious, especially on your note of the population that we serve, I'm going to ask you the same question that Suzanne just spoke to, which is as you're recruiting people to serve as case managers, to serve as people on your Community Supports teams, what are you looking for? What are some of the core qualifications you're looking for as you're hiring?
Slide [none]	Sylvia Barnard – 00:37:14	We have always had a history of hiring individuals with lived experience and also having a passion for this work. I can't tell you how many people we've hired that have lasted less than an hour. You really have to have a big heart for this population and be able to understand who we're serving. Based on the different positions, we're in a position where we have hired nurses, we have... EMTs make great employees, by the way, because they are used to dealing with individuals in crises. But we have an array, we try to have a balance in all of our programs. We have drug and alcohol counselors, we have mental health practitioners. We have created multidisciplinary teams in that way, especially for housing retention and housing navigation.
Slide [none]	Sylvia Barnard – 00:38:05	We have some great successful models and now we have funding opportunities to be able to sustain that, which is great. I think having a lot of the different expertise. It's hard because with this population, it's not like it's just a medical issue. It could be a mental health issue, it could be drug and alcohol. Being able to have individuals that really understand the Whole-Person Care, as you will, really the big picture of it, is helpful to be able to really connect them to services that they need as well.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Juliette Mullin – 00:38:38	Yeah. No, that makes great sense. You've talked a little bit about your ECM team, but you've also been speaking to your Community Supports. I'm wondering if you could tell us a little bit about your Recuperative Care Program, how you stood that up, how you worked with CenCal to get that structured in the way that was going to work for CenCal as a Community Supports provider.
Slide [none]	Sylvia Barnard – 00:38:59	Yeah. We have been a medical respite provider. I don't understand all the funding of how it worked, but there was some pass-through funding that went from CenCal and it was allocated to the hospital through Dignity Health. It's called Marian Medical Center. That's when we started our program. We actually started our respite program before there was funding attached to it. We've been operating that for about five years. We were very excited about recuperative care and being able to transition straight to CenCal because that would allow actually more individuals to get services. Oftentimes, because the referrals were controlled by the hospitals, we would have an individual that had outpatient foot surgery, or had a cast on, or had some kind of medical need that didn't meet the hospital criteria that actually could never get into a bed. Now, recuperative care will allow for our other partners, and even our agency, to make a referral for someone.
Slide [none]	Sylvia Barnard – 00:39:56	We have a lot of individuals that have very complex medical issues and some that have terminal illnesses that really need a respite or a recuperative care bed. We're able to do that. In Lompoc, we did not have a program there. We transitioned the one in Santa Maria, and then in Lompoc, we didn't have one there, but we have a place to set it up at our Bridge House Program. We set it up there and worked with the hospital. We barely opened that, I think, two weeks ago, and I heard that we have our fourth client coming in this week. That's been incredible for them. They've never had that opportunity. They also have self-funded a bed when they could fill it. But the nice thing about recuperative care is it also allows for up to 90 days.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Sylvia Barnard – 00:40:43	Oftentimes, we would get referrals for, "Okay, seven days and this person doesn't need recuperative care," but we'd be putting them in the general population. Our shelter was already full. But now they can really have that time to be able to recuperate and not feel so rushed for the next bed to be filled. It's more controlled by the organization, our agency, than it is by a hospital system. The hospital, we're looking to expand beds with them. That's exciting too, but it's really a great opportunity for more individuals to get the services that they desperately need that they haven't had access to in the past.
Slide [none]	Juliette Mullin – 00:41:21	That's really helpful. I'm wondering, you've talked about the benefits of the transition and being able to work directly with CenCal. Could you tell us a little bit about how you built the infrastructure that you needed from a billing and invoicing perspective to be able to do that? Or did you already have that in place based on your previous work with CenCal?
Slide [none]	Sylvia Barnard – 00:41:40	Yeah. We had a consultant biller who does billing for our CenCal mental health, mild to moderate contract. It was very minimal, to be honest with you. It wasn't a lot of billing. She has definitely taken on the new billing. The CenCal has made it pretty simple for us to be able to pull the data out of our own internal system, upload it into reports, and then be able to bill accordingly. But we have proposed in our capacity-building grant that we would hire our own full-time biller, at least for the first year, to figure out the systems because we actually think that we're going to probably hit every support services just because our agency already does that now. We follow individuals all the way into housing up to a couple years.
Slide [none]	Juliette Mullin – 00:42:28	Your goal to do all core team services in primary care?
Slide [none]	Sylvia Barnard – 00:42:31	Almost. We're not going to do the ones that transition out of skilled nursing, that's too much for us, but we'll probably hit maybe nine or 10 of them. We already do it now.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Juliette Mullin – 00:42:42	Yeah. Yeah. I do want to ask you about your sobering centers and I know you're going to start a partnership on Community Supports, a Community Supports partnership with CenCal on that in January. Before we transition to that, I do want to ask the CommuniCare team the same question about having to set up systems. Could you tell us a little bit about what it was like or if you had to make any core changes in the way you worked with Partnership and the systems you had to set up to be able to do the member data exchange then the billing component of it?
Slide [none]	Maira Fernandez – 00:43:13	We already have our billing department. It was just more of creating workflows. They know the billing side, we know the case management. We created templates within our own medical records charting, making sure that the case managers were trained in new billing codes and stuff like that. That was really new to us. IOPCM did not involve any of the billing side of it. It was just more of exchanging Excel spreadsheets and stuff like that with Partnership. That was a change for us. But having the billing department, they took on the billing part of it and just trained case managers and myself just to make sure that we're coding and submitting correct claims within our own appointments. They have their own resource schedule that they create appointments and we take the billing off of that. It's pretty structured. It was really bumpy at the beginning and it's just new for the case management department, but we have that billing department to back us up.
Slide [none]	Suzanne Eidson-Ton – 00:44:26	Yeah. I think related to that is the way that you exchange information with Partnership though. Do you want to just briefly mention that?
Slide [none]	Maira Fernandez – 00:44:37	Yeah. It's more of the billing department doing the claims. They submit directly the claims electronically. It's just more of us, on this side, creating monthly claims along with TARs, a new thing for management as well.
Slide [none]	Suzanne Eidson-Ton – 00:44:58	But there's that information management system and I'm forgetting the name of it, Maira, that you all-

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Maira Fernandez – 00:45:05	Collective Medical?
Slide [none]	Suzanne Eidson-ton – 00:45:06	Yes.
Slide [none]	Maira Fernandez – 00:45:07	The Collective Medical is another component. That has more to do with just exchanging care plans and ROIs, making sure that everything is updated in that system. We have more of the side of exchanging RTF files and IOT files within Partnership and ourselves that everything matched the RTF to the billing side. We just needed to make sure that those components matched up. That was the bumpy... Right at the beginning, just creating those and making sure that whatever we were submitting reflected what was in the TAR reflected what was in the billing component of it.
Slide [none]	Suzanne Eidson-Ton – 00:45:53	Exactly. That was new. That was completely new, the Collective Medical and how the information exchange was. Luckily, Partnership put on quite a few webinars for everyone who was starting up around how to do Collective Medical and how to get the information about the individuals they were referring to us and then how we could also submit treatment authorization requests for individuals that we identified that we thought would meet the ECM criteria.
Slide [none]	Juliette Mullin – 00:46:24	That's great. Thank you for that overview. It's really helpful. I'm seeing a question in the chat that I want to ask of either team. It's about ECM and it's from an ECM provider that doesn't operate within an FQHC or a primary care clinic. They're asking, "What advice can you offer to help new programs like us find referrals and enroll new members so that they can build a caseload of ECM members?"

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Suzanne Eidson-Ton – 00:46:54	I mean, I would suggest, I think, if there are FQHCs in the area or other community health centers, building relationships with them and finding out... Because they're seeing a lot of patients. I would say also emergency departments as well, building relationships with them to see if they have identified people that might meet criteria for ECM. Also, I think the insurance companies, at least I know Partnership identifies patients as well, and then refers to the providers of ECM.
Slide [none]	Sylvia Barnard – 00:47:31	I would suggest getting a list of all the community-based organizations that are already signed up and then identifying the ones that aren't signed up because many of them, like my agency and like the partner agency on here, have built in potential participants that aren't getting services. In my county, the only people that are getting services are connected to Good Samaritan because we're the only ones that have a contract right now that are figuring it out. I would recommend, there's many other shelters in my county that are not signed up for it and those are members that could be benefiting from services that aren't getting it now. I know that agencies would welcome having another entity come in and provide additional support services if they're not going to become an ECM provider. I'm aware that there are some people that don't want to be agencies, that don't want to be providers, and so it would be a great partnership for their participants to be able to get the benefits of ECM.
Slide [none]	Juliette Mullin – 00:48:35	Great. Going to the people who know where the patients are, be they the community health centers or the CBOs. That's great advice, thank you. I want to come back to the sobering centers. I'd love it, Sylvia, if you could tell us a little bit about the sobering centers that you all have and the work that you're doing to transition what you already have in sobering centers, to prepare to launch Community Supports with CenCal in that space in January.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Sylvia Barnard – 00:49:03	Sobering centers are a new program for us at Good Samaritan. I've been here for 25 years and we kind of have the whole gamut really of a continuum of care, but we did not have sobering centers. In February of 2020, three weeks before the pandemic hit, we opened up the one in Santa Barbara. It's a 10-bed facility, it's funded by the Board of Corrections through the state, through the county Behavioral Wellness. We opened it not realizing that the pandemic was coming. The sobering center's amazing. Every shift is covered by a medical support staff, usually either an EMT or CNA, and partnership with a sober coach. We have our program manager, is a certified drug and alcohol counselor. We also have had nurse, it depends on the program, but we have nurse and or doctor attached to the program and it's amazing.
Slide [none]	Sylvia Barnard – 00:50:03	We opened that up. At first, we didn't know what was going to happen, but because they didn't want to take people to jail, it is a diversion program. We received a lot of referrals through law enforcement, but the majority of our referrals, surprisingly, come straight from the emergency room. They have individuals that are under the influence, they need a safe place and a warm handoff. They hand them off to us. In our county, in order to be able to access services to get into the treatment programs, you have to call an access line. We're able to be able to provide that safe, medically stable place for them. When they're sober enough and if they decide to go onto a program, we're able to connect them through the access line, get them a bed, or connect them to the shelter.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide [none]	Sylvia Barnard – 00:50:51	We always have a warm handoff where we bring them to the next location. Sobering centers are supposed to be for 24 hours. However, if we get someone in on a Friday night and there's not a bed until Monday, we've been known to keep them during that time. Interestingly enough, we operated that for a year and we started running our data and realized that 80% of the clients that we were serving in the Santa Barbara Sobering Center were homeless. Our county received a lot of homeless funding. As the largest homeless provider, we approached them and said, "We want to be creative, and if we only serve homeless and one that we're going to open in Santa Maria, we're willing to do that to be able to start the program." They funded it. We've served more in that program in Santa Maria, which is a seven-bed facility than we have in the one in Santa Barbara.
Slide [none]	Sylvia Barnard – 00:51:42	That funding ended at the end of September. We did get some funding from the hospital, Dignity Health, to carry it for a couple months until we transition to CalAIM. I have to say, in all the years and all the programs that we operate, I feel like it was the biggest gap. What do you do with someone at 2:00 in the morning or someone that we're all housing first and they are having behavior issues? And instead of kicking them out, you can do a warm handoff to the sobering center, you can bring them back and save their bed. Same with residential treatment programs and withdrawal management. The sobering centers are an incredible gift and we're looking forward to opening one in Lompoc the spring as well. It's really exciting and it's really an amazing piece to the continuum of care that we didn't have in place prior.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Juliette Mullin – 00:52:33	Yeah, that's great. We look forward to hearing about your experience becoming part of Community Supports in the sobering center space too. As always, I've gone longer than I expected asking you all questions because I'm having such a great time having a conversation with you, but I do want to open it up to the participants who have joined us today via all the attendees in today's webinar. Julian, could I ask you to pull back up... You've read my mind. Pull back up the slide just reminding people how they can raise their hand. If you'd like to ask a question of the panelists out loud, please feel free to raise your hand and we will invite you to come off mute to ask a question.
Slide 21	Juliette Mullin – 00:53:15	I know it sometimes takes a minute for people to think through what they want to ask, so I will ask another question while people are raising their hand. I'm curious, just a general question for both of you or both organizations, as you're looking back on the past year of implementation or in the case of ECM for your county the past few months of implementation, what do you see as some of the key successes that you would highlight and the things you're really excited about to see moving forward with ECM and CalAIM? Do you want to go first, Suzanne?
Slide 21	Suzanne Eidson-Ton – 00:53:54	Do you want to answer that, Maira?
Slide 21	Juliette Mullin – 00:53:54	You're on mute, Maira.
Slide 21	Suzanne Eidson-Ton – 00:54:02	Oh, you're muted.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Maira Fernandez – 00:54:05	There you go. Yeah, I'll take it. Yeah. ECM is almost a year. I think some of the successes that we've had is just the smooth transition between having the opportunity to have IOPCM and then just transition into ECM, having the staffing to take on caseloads, and just the referral process internally and externally too. Just having those relationships with outside agencies that allow us to get outside referrals to our case managers, having the ability to have implemented care plans and just being prepared for what's asked with ECM. Once you're a provider for ECM, you have to submit care plans and ROIs along with your TARs, along with uploading to Collective Medical and stuff like that. Everything was, on our end, electronically. I think on just a TAR submission and us being able to be trained on that, was a success and the turnaround time for TARs approvals.
Slide 21	Maira Fernandez – 00:55:34	I think the challenges, going back to just the billing side, it was new to case management. It wasn't new to the agency, but it was new to case management. Training the case managers to understand the billing, understand the TAR process, understand the back and forth with the RTF and IOTs. I know it's a lot of acronyms, but just understanding that side of it, that it's more the admin side of things and just generally implementing, making sure that they had the time to have that admin time along with the case management portion of it. Also, one of the challenges with ECM, it felt like it was a little bit more of duplication of documentation just because of the TAR submission and just care plans within your ECW, and at the end of the month, it's submitting all that.
Slide 21	Maira Fernandez – 00:56:34	But I think, overall, it's just a creating and streamlining workflows that can handle it. But I think, just in a general, we see the impact that ECM has on our patient population, and just in general, the many patients that have graduated the program. We manage to not only address the medical, dental, behavioral health aspect, but also social determinants of health, and housing, and food insecurity, and all that stuff. Just ECM, as an overall, it's a good thing for our patients.

CalAIM Enhanced Care Management & Community Supports Office Hours: Implementation of "New" Counties

November 17, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Suzanne Eidson-Ton – 00:57:17	Yes. I just want to add a quick thing that I think the other thing is that the primary care teams feel really supported also by the case managers in the ECM program because you can feel overwhelmed as a primary care provider trying to provide care for people that have so many social issues that are impacting their ability to improve their health. It's really helpful from that perspective, which is why I'm encouraging all of everyone to reach out to the medical providers in their community because I'm sure that they would really appreciate that support. Yeah.
Slide 21	Juliette Mullin – 00:57:53	They have plenty of referrals to make, I'm sure. Yeah. Sylvia, same question for you. What do you see as some of the big challenges you face as you implemented, and then what are some of the big successes and things you're most looking forward, too, going forward?
Slide 21	Sylvia Barnard – 00:58:08	I think that one of the challenges that we've had is we're also new to it in our county, that it's been a process of figuring out the referral process. Sometimes, in the beginning, the referral process takes so long for the approval process that by that time our clients would be not accessible in that location that we had requested it. I'm looking forward to us streamlining the process. I think that having an ECM manager is going to be very helpful to be the gatekeeper of the referrals and the approvals. I'm really excited. I went to a learning collaborative a couple weeks ago in L.A. and there was some great communities that have really nailed it. Anaheim with their Illumination Foundation did a great job, and PATH in San Diego had shared their story.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Maira Fernandez – 00:58:58	It was very, very encouraging that I can see the big picture of what we already do, but how we can provide even better services and more enhanced services to the clients that we serve. This is really the ticket to get there. We have had the same challenges as far as we have case managers who aren't used to putting in a billing note. That's not something that they've ever had to do before. We're at a point where funding regular shelters, especially congregate shelters, is not something that there's funding for. In order for us to case manage, things are going to change a bit, and we're providing those services, but we have to figure out the documentation side. That's a transition for us as well.
Slides 21-23	Juliette Mullin – 00:59:43	Great. Thank you, Sylvia. I want to say thank you to all of our panelists today, Suzanne, Maira, Sylvia. Value so much to sharing your experience and I'm glad you made that note, Sylvia, actually about the importance of learning collaborative. We know that sessions like this are so helpful for people who are beginning to implement or interested in implementing, and understanding what it looks like, and what some of your advice would be. Thank you very much for joining us today and sharing all of that. With that, we will wrap today's session. Up on the screen today, you can see our remaining CalAIM, ECM, and Community Supports webinars through the end of the year.
Slides 23-24	Maira Fernandez – 01:00:19	On December 1st, we are coming back for an Office Hour session on data sharing. That's a follow up to a webinar we did last week on how to set up data sharing and invoicing for Community Supports and ECM. We will also have a Community Supports spotlight on December 8th looking at Community Supports for pediatric populations. And then we will close out our year of webinars with a 2022 year in review on December 15th. With that, thank you all for joining today. Thank you to our wonderful panelists and I hope everyone has a great rest of their day.