CalAIM ECM: Housing Supports Technical Assistance Webinar

October 13, 2022

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VISUAL	SPEAKER – TIME	AUDIO
Slides 1-2	Michel Huizar – 00:00:09	Thank you Julian. Good afternoon everyone, and welcome to today's Enhanced Care Management and Community Supports webinar with a special focus on housing services. We're very excited. We have quite a lengthy slide deck and presentation also from our partners LA Care. So a lot of helpful information today. But before we do that, we'll cover a little bit of housekeeping items and the public health unwinding. You'll see this slide deck covered in other presentations, and we do it so that we can just make sure that we're getting the word out to our members that the COVID – 19 public health emergency will end soon. And with that millions of Medi – Cal beneficiaries may lose their coverage.
Slides 2-3	Michel Huizar – 00:00:52	And with our goal to minimize that, we want to get the word out. And one of the ways that we are looking to do that is engaging our partners to serve as DHCS coverage ambassadors to deliver important messages to Medi – Cal beneficiaries about maintaining Medi – Cal coverage after the public health emergency ends. The ambassadors are trusted messengers made up of diverse organizations that can reach beneficiaries in culturally and linguistically appropriate ways. Additionally, DHCS coverage ambassadors will connect Medi – Cal beneficiaries at the local level with targeted and impactful communication. And those ambassadors could include, but are not limited to, local county offices, health navigators, managed care plans, community organizations and so forth. We can go to the next slide. Thank you.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 3	Michel Huizar – 00:01:38	So, as we unwind the Public Health Emergency we do have a strategy in two phases. The first one that's currently underway is utilizing multiple channels to encourage beneficiaries to update their contact information with county offices. We have flyers that we have posted on our website that you can download and post in the provider clinic's offices, and utilize for your social media campaigns and so forth. The second phase is designed to encourage beneficiaries to continue to update their information, reporting any change in circumstances, as well as check for upcoming renewal packets. The phase two will begin 60 days prior to the end of the public health emergency, which we will be releasing forthcoming guidance in the near future. Next slide.
Slide 4	Michel Huizar – 00:02:33	Okay. The Enhanced Care Management and Community Supports data guidance survey. So the department released a required survey for all of our plans and their launched Enhanced Care Management and Community Support providers to understand the status of data transactions between organizations and support of these programs, and where persistent data exchange barriers may benefit from expanded or refined data guidance. Examples, links for the DHCS issued data guidance examined by the survey can be found on this slide within the service description. But the survey is an opportunity for our stakeholders to provide feedback on early implementation and crucial input for DHCS to ensure long – term adoption and success of the Enhanced Care Management and Community Supports benefit. You'll notice... I'll actually just call out right away that the due date says October 7th, but then at the bottom you'll note that we did extend the survey period to October 14th, Friday, October 14th. So just keep a look out. The actual due date of when it will be closing is on the 14th.
Slide 4	Michel Huizar – 00:03:36	And again, just directing you all to the links at the bottom here. More information can be found on the Enhanced Care and Management Community Supports webpages, or by reaching out to our joint mailbox, the Enhanced Care Management and Community Supports mailbox. So the next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Michel Huizar – 00:03:54	All right, so earlier I talked a little bit about the meat of this presentation along with the presentation from LA Care. So we will also start with a brief overview of the Homelessness and Statewide Housing Programs and Resources. But the focus of our webinar today will be the programs that DHCS has for addressing the housing and homelessness issues, it's specifically through Community Supports, Enhanced Care Management. Building Community Supports and Enhanced Care Management capacity through the Providing Access and Transforming Health, or PATH, or the Incentive Payment Program also known as IPP. The Building Housing Capacity through Housing and Homelessness Incentive Program or HHIP as well as the Behavioral Health Bridge Housing program that's currently housed within our mental health or behavioral health teams here at DHCS.
Slide 5	Michel Huizar – 00:04:48	And then as I said, we will spotlight LA Care who will share an overview of their housing supports they provide through Enhanced Care Management and Community Supports, as well as a broader look at their effort to support individuals experiencing homelessness. And then we will close and round everything out with a question and answer period. So that gives you a bit of a glimpse into today's presentation. And go to the next slide.
Slides 6-7	Michel Huizar – 00:05:15	All right. And actually one more. So we'll be covering Homelessness and Housing Resources in California. Okay, thank you.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Michel Huizar – 00:05:20	California accounts for more than half of all unsheltered people in the United States. Every night in California, more than 160,000 Californians are facing homelessness. And in 2020 alone, in California nearly 52,000 individuals experience chronic homelessness. 44% of individuals experiencing homelessness were also experiencing chronic substance abuse. 42% we're experiencing untreated mental health conditions. And we know that homelessness has a major impact on health in a variety of ways. And compared with the general population, unsheltered individuals have higher rates of hypertension, diabetes and HIV, have 4 to 10 times higher mortality rates. So I just wanted to share those critical pieces and statistics of information with you all. We can go to the next slide.
Slide 8	Michel Huizar – 00:06:13	Housing organizations in California are organized through Continuums of Care. A Continuum of Care is a group, some of you may know this, is a group of organizations and agencies, including community based organizations and local government agencies that collectively coordinate homeless assistance activities and resources in a community. The Continuums of Care were established by the United States Department of Housing and Urban Development in 1995 and there are currently 44 Continuums of Care in California. Most cover a single county, but a few of them also cover a single city or two or more adjacent counties. And the HUD awards homeless assistance grant funds to Continuums of Care annually. Many of the state funded housing related programs award funding to counties, cities, and CoCs. And finally wanted to share that the state programs are often administered through the Continuums of Care. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 9	Michel Huizar – 00:07:18	All right. So California has invested billions of dollars and undertaken a multi – agency effort to address housing and homelessness across the state. As Governor Newsom said last month, the state is tackling this foundational challenge with an innovative, all of the above "approach". This includes programs through the Business Consumer Service and Housing Agency, the Department of Housing and Community Development, the Department of Social Services and the Department of Healthcare Services. But today we will focus on the housing related programs through DHCS. But my colleagues will add some links to the chat with additional information... I do see them coming. Additional information about those programs run by the other agencies listed.
Slides 9-11	Michel Huizar – 00:08:05	All right. We can go to the next slide. The DHCS programs addressing... Okay. Thank you, yes. So we can go ahead and progress. So under the DHCS umbrella, there are several programs designed to address homelessness or housing instability through the CalAIM or the California Advancing and Innovating Medi – Cal Initiative. Enhanced Care Management and Community Supports are our reform efforts to address Medi – Cal enrollees' needs through coordinated and community based whole person care. Enhanced Care Managers will engage Medi – Cal enrollees experiencing, or at risk of experiencing, homelessness to help them access coordinated healthcare, housing services and other services collectively known as Community Supports. The CalAIM Incentive Payment Program and the Providing Access and Transforming Health, or PATH, programs provide funding to build capacity for providers of Enhanced Care Management and Community Supports, including those focused on supporting individuals experiencing homelessness. In addition, the department, DHCS has launched or is launching all programs to build housing capacity in communities, namely the Housing and Homeless Incentive Program and the Behavioral Health Bridge Housing. And we're going to be reviewing each of these programs in depth for today's session.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 11-12	Michel Huizar – 00:09:28	So we'll start with a brief overview of CalAIM and I think that will bring into my next slide. Yes, thank you very much. So as I said, the California Advancing and Innovating Medi – Cal Initiative is a bold Medi – Cal transformation initiative that expands on the traditional notion of the healthcare system. It is much more than a doctor's office or hospital. It also includes community based organizations and non – traditional providers that together can deliver equitable whole person care. The CalAIM initiative transformation means meeting the needs of the whole person, including health providers who are trusted and relatable, includes expanding Community Supports and proactive upstream services. It includes community engagement and making the best use of our partners, our valued partners and resources.
Slide 12	Michel Huizar – 00:10:24	The initiative requires a sustained focus and long term commitment because we all realize it is new, challenging and innovative. The implementation that is currently underway, it is anticipated to take approximately five to seven years. We do have information on our timelines posted on our webpage if folks are looking to see how we will roll in these waves of implementations. But when complete, it will fundamentally improve the millions of lives of Californians. It requires the commitment and hard work of many partners, asking each to move beyond traditional roles and embrace a new and more collaborative role in providing care and needed services. And as with any transformation of this scale, we understand there will be challenges, and as we do encounter those challenges, we will adapt and we will evolve. But CalAIM includes many components, and as I said earlier, we today we'll really be focusing though specifically on those needs for the unhoused population. So, we can go to the next slide.
Slides 13-14	Michel Huizar – 00:11:39	Okay. So we will be starting with the community supports initiative under CalAIM, which includes several supports specific to supporting those individuals experiencing homelessness. Excuse me. So with that, I will hand it over to my colleague Neha Shergill, to dive in a little bit more into what our Community Supports. Neha?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Neha Shergill – 00:11:59	Thank you Michael. Hi everyone. So just getting into what are Community Supports. Community Supports are services that Medi – Cal Managed Care plans are strongly encouraged, but they're not required to provide as medically appropriate and cost effective alternatives to utilization of other services or settings. This may be such as, hospital skilled nursing facility admissions. So Community Supports are designed to address social drivers of health. Addressing social drivers of health is key to advancing health equity and helping people with high healthcare and social needs. So we do have 14 pre – approved Community Supports that MCPS may offer to members. And our team will add a link to the Community Supports policy guide in the chat and this includes the list of those supports. Different MCPS offer different combinations of Community Supports, and a list of elections by MCP and county can be found on our DHCS website. Our team will also drop a link to that chat.
Slide14	Neha Shergill – 00:12:53	MCPs must follow the DHCS standard Community Support service definitions in the policy guide, but they may make their own decisions about when it is cost effective and medically appropriate. Following the restrictions set in the Community Supports policy guide, rates and maximums for community supports are established and contracts between MCPS and Community Supports providers. Next slide please.
Slides 15-16	Neha Shergill – 00:13:16	So of the 14 pre – approved community supports, several are designed to provide support for housing, and these do include Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, recuperative care or medical respite and short term post – hospitalization housing. Next slide please.

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Neha Shergill – 00:13:38	So we'll start with the first set of supports listed here, those designed to support members in reaching long – term housing. Housing Transition Navigation Services provides support for finding housing. And once the housing is found, Housing Deposits provides support for identifying, coordinating, securing, or funding one – time services and modifications necessary to establish a basic household. Housing Deposits. And once housing is secured, Housing Tenancy and Sustaining Services assist members with maintaining safe and stable tendency.
Slide 16	Neha Shergill – 00:14:10	Let's take a closer look at each of these. And with that, I will give it over to my colleague, Tyler Brennan.
Slide 17	Tyler Brennan – 00:14:17	Hi. Thank you very much. Housing Transition Navigation Services assist members with obtaining housing. These services are based on an assessment of individual needs. Services include support with aspects of obtaining housing, such as searching for and securing housing, assistance with obtaining benefits and securing resources, assistance with moving arrangements and communication with landlords on member's behalf. Services do not include provision of room and board, nor do they include payment of rental costs. Next slide please.
Slide 18	Tyler Brennan – 00:14:51	Housing Deposits assist members with identifying, securing or funding one – time services necessary to establish a basic household after housing has been found. This service must be provided in conjunction with the Housing Transition Navigation Community Support, and must be identified as necessary in the member's housing support plan. Services may include security deposits necessary to obtain a lease, set – up feeds for utilities and goods, such as an air conditioner or other medically necessary adaptive aids designed to preserve health and safety at home. Services here also do not include provision of room and board, nor do they include payment of rental costs. Another important note here, this Community Support is available once in a member's lifetime with the possibility of a second approval with documentation as to what conditions may have changed to increase success. Next slide please.

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Tyler Brennan – 00:15:42	The Housing Tenancy and Sustaining Services Community Support assists members with maintaining safe and stable tenancy once housing is secured. This support should be provided in conjunction with the Housing Transition Navigation Community Support and must be identified as necessary to maintaining longer term housing and included in the housing support plan. Services may include education on tenant and landlord rights and responsibilities and coaching on relationships with landlords or property managers. Services may also include assistance with lease compliance and assistance with eviction prevention. Here again, services do not include provision of room and board, nor do they include the payment of rental costs. And as with housing deposits, this Community Support is available once in a member's lifetime with the possibility of a second approval so long as there's documentation as to what conditions may have changed to increase the success. Next slide please.
Slide 20	Tyler Brennan – 00:16:37	There are a few ways that members can be eligible for the three supports we've just discussed. They may be prioritized for a permanent supportive housing unit or subsidy through the local Coordinated Entry System or similar system. Or they might meet the HUD definition of homelessness or being at risk of homelessness and met having one or more serious chronic conditions and or are at risk of institutionalization or overdose or are already receiving ECM. For a full list of eligibility criteria, please refer to the Community Supports policy guide that's been linked in the chat. Providers of these Community Supports must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. Such providers may include, but certainly aren't limited to, vocational service agencies, life skills training providers, county agencies and other providers of services for individuals experiencing homelessness. You can find a list of additional potential provider types in the Community Supports policy guide. And with that, I'll pass things off to my colleague Shel Wong to continue.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 21-22	Michelle Wong – 00:17:45	Hey there. So now we will continue to transition into Community Supports that are designed to support members in reaching recovery focused housing. So Recuperative Care or Medical Respite, provides short term residential care to members who no longer require hospitalization but still need the support to heal from an injury or illness. And Short – Term Post – Hospitalization Housing provides short – term housing to members who do not have a residence and who have high medical or behavioral health needs with continuing their medical/psychiatric/substance use disorder recovery. And so now we'll jump in and take a deeper look. So next slide please. So Recuperative Care, also known as Medical Respite, provides short term residential care to members who no longer require hospitalization but still need support to heal from an injury or illness. It is designed for individuals who are experiencing homelessness or unstable living conditions who are too ill or frail to adequately recover from a physical or behavioral health illness or injury in their usual living environment. At a minimum, the service must include interim housing with a bed and meals and ongoing monitoring of the individual's health. So services may also include assistance with activities of daily living, coordination of transportation to post – discharge appointments, connection to other ongoing services and support in accessing benefits and gaining stability through case management relationships and programs. So it is important to know that services may not exceed 90 days in duration and do not include funding for building modification or rehabilitation. Next slide please.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Michelle Wong – 00:19:35	So Short – Term Post – Hospitalization Housing provides short – term housing for members who do not have a residence and who have high medical or behavioral health needs with continuing the recovery from an injury, illness or crisis. This Community Support setting must provide ongoing support necessary for recuperation and recovery. And this can include gaining or regaining the ability to perform activities of daily living, receiving necessary care in case management and accessing other housing supports, including the Housing Transition and Navigation services. And services are also available only once in an individual's lifetime and may not exceed a duration of six months.
Slide 24	Michelle Wong – 00:20:24	All right. So Recuperative Care is allowed for members if the Community Support is necessary to achieve... Oh, sorry. Sorry. Recuperative Care is allowable for members if the Community Support is necessary to achieve or maintain medical stability and prevent hospital admission or readmission. In addition, members must meet specific eligibility criteria outlined in the Community Supports policy guide. To receive Short – Term Post – Hospitalization Housing, members must have medical, behavioral health needs, such as experiencing homelessness upon discharge and would likely result in hospitalization, re – hospitalization or institutional readmission. In addition, members must meet specific eligibility criteria outlined in the Community Supports policy guides. And then... Sorry. We jumped a slide? Sorry. My computer's freezing. Tyler, Neha, do one of you think you can pick it up.
Slide 24	Michel Huizar – 00:21:46	I can. Here Shel, let me... I can go ahead and just pick it back up from here. So just to wrap up this slide here, just informing for the providers of these services should have experience, and I'm on the right hand side of this slide here, should have experience and expertise with providing these unique services and may include, but it's not limited to, the interim housing facilities with additional onsite support, shelter beds with additional onsite support, converted homes with additional support or county directly operated or contracted recuperative care facilities. So we can go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 25-26	Michel Huizar – 00:22:22	Okay. So for this one... You'll see this one, this is a recurring slide folks, so just to help guide our conversations. So previously we were talking about the Community Supports. We're now going be moving over into the Enhanced Care Management piece, which for those of you who may or may not know, addresses the clinical and non – clinical needs of high – need, high – cost individuals through the coordination of services and comprehensive care management. So with that, I believe we can go to the next slide and we'll be transitioning to our other valued colleague, Aita Romaine, from the Quality and Population Health Management team. Aita?
Slide 26	Aita Romain – 00:23:03	Hi...
Slide 26	Michel Huizar – 00:23:03	... from the quality and population health management team. Aita?
Slide 26	Aita Romain – 00:23:03	Hi. Thanks, Michael. Thanks Shell. I'm going to cover Enhanced Care Management today. So Enhanced Care Management is a new Medi – Cal benefit intended to support comprehensive care management for enrollees with complex needs who may often engage several delivery systems to access care. This benefit is designed to address the clinical and non – clinical needs of the highest need enrollees through intensive coordination of health and health – related services. ECM services should meet enrollees wherever they are and this flexibility is essential to the design of the program. DHCS has defined seven ECM core services for all the populations of focus. These are outreach and engagement, comprehensive assessment and care management plan, enhanced care coordination, coordination of and referral to community and social support services, member and family supports, health promotion, and comprehensive transitional care. ECM is part of broader CalAIM population health management system design through which MCPs will offer care management interventions at different levels of intensity based on member need. As I mentioned, ECM is meant as the highest intensity level. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 27-28	Aita Romain – 00:24:16	ECM is now live statewide for certain populations of focus and additional populations of focus will be going live in 2023. ECM for adults and their families experiencing homelessness launched in Whole Person Care and Health Homes Program counties in January 2022 and has been offered statewide since July. Through this benefit, members who meet the population of focus eligibility criteria receive comprehensive care management. Next slide please. So how does Enhanced Care Management and housing community supports intersect? Members may receive Enhanced Care Management and community supports at the same time. Through their Enhanced Care Management provider, a member will receive comprehensive care management including coordination of primary specialty and behavioral healthcare with social services coordinating as well.
Slides 28-29	Aita Romain – 00:25:11	Members in Enhanced Care Management are and should be referred to specific community supports based on their needs and eligibility, including housing supports. A member's Enhanced Care Management provider should help coordinate services provided to Enhanced Care Management enrollees by community supports providers. One important note I want to highlight here is that members do not need to be eligible for or enrolled in Enhanced Care Management to receive community supports. Community supports are available to all managed care members who meet their managed care plans eligibility criteria. Next slide please. Now I'm going to hand it to my colleague to explain some of the CalAIM programs designed to build provider capacity for Enhanced Care Management and community supports.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Michelle Wong – 00:26:02	All right. The incentive payment program, IPP, is a voluntary incentive program which provides funding to manage care plans to build their capacity to deliver CalAIM, including by building ECM and community supports provider capacity, providing access and transforming health, also known as PATH, is a five – year, $1.85 billion initiative included in the CalAIM 1115 waiver. PATH will provide funding and resources to county and community – based providers, including public hospitals, county, city, and other government agencies, justice agencies, community – based organization, Medi – Cal tribal and designees of Indian health programs and others to ensure successful implementation of ECM and community support and justice involved initiatives. PATH and IPP funding will complement and not duplicate one another, and both of these will help to build providers' capacity and for housing support. Then we'll transition over to Frances for the last section.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 31-32	Frances Harville – 00:27:14	Hello all. In the last section today we will look at DHCS programs that are helping to build housing capacity in communities across California. We will start with the Housing and Homelessness Incentive program, which provides $1.288 billion in funding to MCPs to develop housing partner capacity and build partnerships to connect MCP members to housing services. Next slide please. HHIP is a voluntary incentive program that enables MCPs to earn incentive funds for activities related to addressing homelessness and housing and security as social drivers of health and health disparities. The vision of HHIP is to improve health outcomes and access to whole person care services by addressing housing insecurity and instability as a social determinant of health for the Medi – Cal population. Is intended to reward MCPs for developing the necessary capacity and partnerships to connect their members to needed housing services and incentivize the MCPs to take an active role in reducing and preventing homelessness. To participate, MCPs in partnership with their local homeless continuum of care, local public health jurisdictions, county behavioral health, public hospitals and county social services and local housing departments must submit a local homelessness plan, LHP to DHCS.
Slides 32-33	Frances Harville – 00:28:47	The LHP must outline how HHIP services and supports will be integrated into the homeless system. The LHP should the build on existing local HUD or other homeless plans and be designed to address unmet needs. In counties with more than one managed care plan, plans would need to work together to submit one LHP per county. Next slide please. Here we are. We have HHIP began January 1st of this year of 2022 and will run through December 31st of 2023. The $1.288 billion in funds will be dispersed across four payments with the first payment being issued this month and the final payment being issued March 2024. Each MCP payment will be based on the successful completion and achievement of program measures from the local homelessness plan components and the investment plan.

VISUAL	SPEAKER – TIME	AUDIO
Slides 33-35	Frances Harville – 00:29:55	Next slide please. Finally, we will highlight the behavioral health bridge housing program, which will invest $1.5 billion in bridge housing for individuals with behavioral health issues. Next slide please. The 2022 – 2023 California budget included a $1.5 billion investment in the behavioral health bridge housing program to fund clinically enhanced bridge housing settings. The program will address the immediate housing and treatment needs of people experiencing unsheltered homelessness with serious behavioral conditions, mental health and/or substance abuse use disorders. It is a one – time grant funding administered by DHCS. The goal of BHBH is to pay for housing and housing – related services that are not covered by Medi – Cal, including by community supports. BHBH will not pay for specialty mental health and sub – services provided by counties.
Slides 35-37	Frances Harville – 00:31:03	Qualified entities will be counties and tribal entities and there will be collaboration to complement ongoing state, county and tribal efforts to address homelessness. Next slide please. This summary slide here shows how all the key DHCS programs will just... we just discussed work together to address housing and homelessness across California. There are many programs and resources designed to address housing and homelessness across several other state agencies as well. You'll find additional information on those programs in the links we've dropped in the chat earlier in this presentation. With that, thank you for your time and I will hand it off to Juliette Mullen from Manatt.
Slides 37-38	Juliette Mullin – 00:31:57	Thank you, Frances, and thank you to the entire DHCS team for that overview. Next I would like to introduce the team at L.A. Care. They're going to give us an overview today of the housing – related CalAIM services that L.A. Care offers. I'd like to introduce Karl Calhoun, the director of Safety Net Programs and Partnerships with L.A. Care and Alison Klurfeld from Klurfeld Consulting who works with L.A. Care on their housing programs. With that, take it away.

VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Alison Klurfeld – 00:32:29	Great. So hi, this is Alison starting off and Karl's here as well. We're excited to speak to you today about what it's been like getting programs for people experiencing homelessness and to address housing needs set up at L.A. Care. One thing I just want to say is sort of just talking a little bit about ourselves. I worked at L.A. Care for some time and got to be part of the launch of our housing related – community supports, and I still work with L.A. Care very closely on the housing and homelessness incentive program, so that's me. I'll let Karl introduce himself as well and talk a little bit about how he's been on both sides, I'll say. He's been on the provider side and The MCP side. So Karl, I'll let you take it away.
Slide 39	Karl Calhoun – 00:33:13	Thanks Alison. Yeah, Karl Calhoun, director of Safety Net Programs and Partnerships here at L.A. Care. Relatively new, I've been on board for just under three months with the agency. But to Alison's point, I did come from the nonprofit homeless services community. I worked for a very large homeless service provider here in Los Angeles, and I do find there's some interesting realities associated with the move from the non – profit side to managed care. One of the big pluses that I find is that working with L.A. Care there's already preexisting networks in place, obviously in the healthcare network, which is extremely helpful in serving our members but also not so surprisingly there's some very strong existing relationships in the homeless service network as well. That's been proving to be a very valuable asset to the work that we're doing.

VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Karl Calhoun – 00:34:12	Some of the challenges are that we are integrating a relatively related but unique service into a very large existing primary care focused agency, and there are some challenges with that integration of course. Coming from the non – profit side, I was responsible for just one agency and making sure we were successful with the participants we served in our programs, but here it's a broader scope obviously. We're working with multiple agencies ensuring that their standards of care for our members are uniform and extremely high. That does bring up questions of alignment, uniformity of service, so that all of our members benefit from the CalAIM services and specifically the housing services as best they can. So that's a little bit about me and my introduction to L.A. Care's CalAIM services.
Slides 39-40	Alison Klurfeld – 00:35:16	That's great. Then this is just a slide on L.A. Care. For those who aren't familiar, L.A. Care is the public Medicaid plan in LA County and we're giant, so a lot of the information you're going to see is kind of information about what it's like to do this at a really big scale. It's a very different thing in smaller counties and smaller plans. But L.A. Care serves over 2.7 million people. Medi – Cal is the biggest kind of line of business, but we also serve others. Our mission is of course to support the safety net and provide quality healthcare and access for L.A. Care's low income communities, member and not member. Next slide please. Okay, so this is just a little bit of how do we think about things for people experiencing homelessness. So for a person experiencing homelessness, they need at least three things.

VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Alison Klurfeld – 00:36:04	They need a lot more. But this is kind of a no matter where they are in their journey of homelessness, into housing, out of housing, at any step along the journey, they're going to need these three things. One, clinical services, so healthcare treatment, physical health, mental health treatment, substance use disorder treatment. That treatment has to be accessible so often it has to come to the person instead of the person coming them. It has to be trauma – informed and culturally competent. So clinical services, kind of the traditional Medicaid bread and butter, is a big part of what people experiencing homelessness need, in some ways just like any other person, right? Supportive services, that's something that's often specific.
Slide 40	Alison Klurfeld – 00:36:45	Supportive services, I'll say the word case management, that means something different. It's like a Rorschach test. You ask a homeless services case manager what case management is and a healthcare case manager what case management is, and a social worker, you're going to get three different answers. But for people experiencing homelessness, some sort of case management that really addresses housing, health and social needs coupled with other enabling services, that's really important. Then the third thing, this is to state the obvious, people need housing. It's no good to give all the healthcare treatment and all the supportive services in the world if we don't have any housing. So how actually the system... I'm not going to say "we" and you'll see why later, provides housing. You need kind of both a combination of financial resources like money to pay rent or buy buildings or whatever it is and actual housing placement options where the member can maintain successful long – term tenancy. No matter where somebody is in their journey, think about these three things.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 40-41	Alison Klurfeld – 00:37:49	If we go to the next slide, we'll talk about how does that work for LA. Just to orient you to this big, crazy chart, the columns are stages in a person experiencing homelessness' journey. They might start out being unsheltered, so literally homeless living on the street, and move into interim housing. Some people actually start in interim housing, some people go straight from unsheltered homelessness into permanent housing. But those are kind of the three stages a person experiencing homelessness might be in. I'm going to kind of talk through some of the clinical services then give it to Karl talk a little bit about some of the other supportive services. At any stage, what's available for clinical services?
Slide 41	Alison Klurfeld – 00:38:34	I think a big thing is street medicine, so that's not something we've talked about as kind of a core component of CalAIM. But for someone experiencing unsheltered homelessness for years and years, there have been community clinics, often federally qualified health centers, county agencies, mental health providers, private and nonprofit providers who go out to provide street medicine, sometimes in mobile vans, sometimes just feed on the street with a backpack. There's going to be an all plan letter, or APL, coming out from the state to try to incorporate that more into managed care, so we are eagerly awaiting that from our DHCS colleagues. That's a big part of clinical services.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 41	Alison Klurfeld – 00:39:12	A second big part is making sure you have healthcare for the homeless providers, also known as 330H. A lot of federally qualified health centers do this specialized healthcare for the homeless providers in the network. As a public plan, L.A. Care's always had those safety net providers in network. Then for some people experiencing homelessness, they actually prefer to get care from their assigned PCP or community clinic and specialty care, so that's an option, but we know it's not always the most accessible option. It really depends on the person their transportation needs. Specialty care, I just point out in general, that's actually a real hard bugaboo we're kind of looking at, working, specialty care for folks who are unsheltered, because there are very few, almost no street medicine specialty services. So that's clinical services for someone who's unsheltered.
Slide 41	Alison Klurfeld – 00:39:59	To be honest, that's pretty similar to what's available and what we see for people who are housed in interim housing. The one difference is that street medicine providers, rather than going out to the streets, visiting the washes, people in their communities, often many street medicine providers co – locate one day a week, two days a month, whatever it is, with interim housing. They go inside at a shelter, a mission, whatever it is. However, for people who are housed in permanent housing, the model we do try to have for most people as they become housed in permanent housing is to try to see can we help you by that point really connect to your PCP clinic and specialty care to kind of access the standard Medi – Cal managed care model if possible, rather than focusing on bringing the care to the person to try and think about how can we use a mix of transportation and case management to bring the person to the care?

VISUAL	SPEAKER – TIME	AUDIO
Slide 41	Alison Klurfeld – 00:40:57	That's kind of the clinical services side. You'll notice there are no big stars on the clinical services because while CalAIM does a lot of important things and new programs, a lot of this is stuff that was kind of already in the Medicaid program. The one real new thing is the street medicine all plan letter. So we didn't add necessarily much in the clinical services area at this time. Okay, I'll go let Karl talk a little bit about supportive services.
Slide 41	Karl Calhoun – 00:41:24	Sure, thank you, Alison. So supportive services –
Slide 41	Alison Klurfeld – 00:41:26	Oh, wait, no, go back. We were still on that chart. Sorry.
Slide 41	Karl Calhoun – 00:41:29	Right, so for the unsheltered and pretty much for those in interim housing, the services focus on our Enhanced Care Management program of course and the first of our housing suites. I like to think of the housing suite of services as a continuum, starting of course with housing navigation. The idea is to first identify those eligible for the program who are unsheltered, and that does involve coordination with our COC and the CES, the coordinated entry system, and all of our homeless service network providers throughout the county. But once they're identified and proved to be eligible, housing navigation is the first step in that continuum of housing services, also co – occurring and working very well with Enhanced Care Management. The idea would be to focus on the challenges associated with finding housing in this notoriously, infamously difficult housing market that we have in California, period. But certainly in certain cities and counties like in the north, in San Francisco or middle of the state and certainly here in Los Angeles, the traditional hurdles are unfortunately still with us, meaning very low housing stock and that's for regular housing as well as low income housing and associated very, very high competition, and that results in a lot of challenges and difficulty for the unsheltered to even enter the fray of trying to find housing. Housing navigation is designed to address those major challenges. The same is true for folks who are in interim housing. We try to link them with both PCM and housing navigation services.

VISUAL	SPEAKER – TIME	AUDIO
Slide 41	Karl Calhoun – 00:43:36	To a point that Alison made earlier, unfortunately there is crossover back and forth. Obviously sometimes the folks in our interim housing do exit unfortunately and fall back into unsheltered status. There's some crossover back and forth there. But those interventions apply in both areas, ECM and housing navigation. Then once housed, ECM services absolutely continue and are valuable. We also have day habilitation services, personal care assistance, transition from nursing facilities into permanent supportive housing, and there's also a series of local and state funded housing case management services. So that's sort of a touch there. Did you want to comment on that further, Alison?
Slide 41	Alison Klurfeld – 00:44:30	Yeah, I more just wanted to say, I made a copy – paste error, so I apologize, folks, is when folks are housed in permanent housing, they actually switch from housing navigation to the tenancy services, community support, so that was a copy – paste error on our part. Just imagine that far right middle box saying "ECM tenancy services community support." One thought, L.A. Care is not opting into day habilitation. Actually, none of our plan partners have yet day. Day habilitation I think can be an important service for thinking about more skill development for folks as opposed to housing or clinical case management. But more on the lines of some of the things that happen in... It's almost like a social model of occupational therapy. Sorry, that's not a DHCS characterization, that's my characterization. But I think that's something we're thinking about. We just don't really have very good programs for that here in LA and we haven't focused on it.

VISUAL	SPEAKER – TIME	AUDIO
Slide 41	Alison Klurfeld – 00:45:28	I'll say we don't normally talk about personal care assistance or nursing facility transition community supports in the housing suite, but these are important enabling services. One thing we see in LA County is there are a lot of people experiencing homelessness who have real difficulties doing their activities of daily living and often their instrumental activities, daily living. They can't transfer, they can't dress themselves. We actually have this perverse terrible situation where they're sometimes too sick to come into interim housing because most interim housing shelters, missions, transitional housing, they're –
Slide 41	Alison Klurfeld – 00:46:03	Housing, shelters, missions, transitional housing, they're fairly lean staffing. They don't have medical folks on site and they can't have somebody who can't do their activities of daily living come and be at those facilities. So it's really important. And same thing for permanent housing. People need help to do those activities of daily living to be safe in permanent housing. So it's really important we have the in – home supportive services program of course, but that doesn't start right away. So having personal care assistance, community supports can help us get someone into housing faster. And we're even going to look at, can we do that sometimes in interim housing before IHSS starts? And in the future, we don't have the nursing facility transitioned to assisted living as part of our suite yet. But we see that as a potential important supportive service because someone who might need what's called care and supervision, a licensed level of care and an adult residential facility, ARF, or a residential care facility for the elderly, RCFE, they often need more services or a higher payment level for those services than what that ARF or RCFE could provide.

VISUAL	SPEAKER – TIME	AUDIO
Slide 41	Alison Klurfeld – 00:47:06	And so we're looking to this community support might help us bring more folks indoors in the future. We just don't totally understand how the financing will work for that yet. So I guess the one thing I want to say is housing and aging in place. We've got to get together and have a little program baby for those two areas of care because that's going to be really important to our success. Especially because we know the population of people experiencing homelessness experiences, especially if they people who have had long term homelessness, premature aging and the homeless population itself as a whole is aging. We're spending a lot of time on a slide because this is our big framework. Just want to finish it out. Talking about housing. So we've talked about clinical services, what are people getting for treatment? Carl talked about supportive services. What are the wraparounds that keep somebody really plugged into their care in case management?
Slide 41	Alison Klurfeld – 00:47:57	I'm going to talk about where are they? So Colleen added some cool stuff for us in interim housing. So Recuperative Care is something L.A. Care had done as a pilot for a long time on a very small scale, and we were able to add it as a community support. So that's great. We have not yet added short – term post – hospitalization housing, but we're looking at that. We see the difference as like, "Do you need a place to go and you're sick still or do you need a place to go?" So recuperative care, you need a place to go and you're still sick versus short term post – hospitalization housing, you just need a place to go. There is some HUD local and state funded interim housing. There's Project Home Key, it's okay in terms of interim housing. It's hard to get in for beds, but I think everywhere has that. We'll talk about later why that is.

VISUAL	SPEAKER – TIME	AUDIO
Slide 41	Alison Klurfeld – 00:48:46	One thing I want to flag is when we kept talking about getting members into permanent housing, right? Interim is good, but only good if you got a permanent place for somebody, what's available? So we're Carl talked about how our housing suite works together, housing deposits, community support is really important for helping someone cross the gap to have funding to move in somewhere. We're opting into the home modifications community support in the future and that will also help us with folks who need accessibility adaptations, especially for their housing. But the big thing is that we are really, really dependent on our partners for tenant based housing vouchers, rapid rehousing placements, permanent supportive housing vouchers and placements, adult residential facilities and residential care facilities for the elderly, Project Home Key. So the actual housing is not something we have as much of. We'll talk about later what that gap means, but that bottom right is where we're feeling the gap the most and there's some reasons why that is.
Slide 42	Alison Klurfeld – 00:49:49	So next slide please. So that was a big framework. Let's take you now to our specific programs. So I want to give you a sense of L.A. Care's Scale. First is our enhanced care management program, which you'll remember was the comprehensive biopsychosocial case management program, L.A. Care we're talking about, this is L.A. Care, those who we serve directly. We can cover our plan partners separately, but for out of our about 1.2 million Medi – Cal members we serve directly, 16,000 are enrolled in ECM. And the little more than half of them are people experiencing homelessness. I want to tell you, it's really hard to get that data. We have done lots and lots of training. I need to do lots more on helping ECM providers track housing and homeless status. Because for example, they're very familiar with how to serve the population of people experiencing homelessness, but knowing what's HUD homeless, what is couch surfing, what is chronically homeless?

VISUAL	SPEAKER – TIME	AUDIO
Slide 42	Alison Klurfeld – 00:50:48	All of those nuances is really taken a lot of training. We did it in health homes and we're still doing it. One thing to know is that just because somebody is in the homeless population to focus, they're also probably in another population of focus. There's lots of overlap between people who have serious mental illness or substance use disorders, the high utilizer population, justice involved. Unfortunately we know social determinants, social drivers of health are a constellation of factors. Last thing to know about us is we started really giant. We had really big grandfathered populations from Whole Person Care and Health Homes. We started out at I think 11 or 12,000 already. I can get the exact number after if we need it, but just because L.A. County really invested big in those two programs. So next slide. So I'll let Carl do a little bit of an overview of our community supports. What have we got?
Slide 43	Karl Calhoun – 00:51:40	Sure. So we have grouped two of our three housing suite services, housing navigation and tendency and sustainability services into one coupling and we call that Homeless and Housing Supportive Services. HHSS is how we refer to it in house. And again, that includes housing navigation and tenancy sustainability. In the interest of time, I won't go too far into the details there on the right, but I do want to emphasize again the concept of a continuum here. Housing deposits and recuperative care also fit into that continuum. So if we think of, especially in terms of a discharge from a hospital that additional time necessary for healing post discharge would happen at a recuperative care. Those folks serving that member would immediately start thinking about the next stage of that member's transition or evolution toward permanent supportive housing. And that would be the stage at which they would engage for housing navigation. Housing navigation services begin working toward getting an individual vouchered for any eligible voucher subsidies.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 43	Karl Calhoun – 00:53:01	Also helping them with applications for those vouchers. And of course identification of potential units and engagement with landlords and applications and so forth. All of that would fall under housing navigation. Housing deposits then, once the unit is identified would be the next stage of that continuum. Assistance with first and last month's rent, move in requirements, accessories that would assist the person in getting settled in getting started in their new apartment. All would fall under housing deposit services. And then the final piece of the continuum would be tenancy and sustainability services. And as I've mentioned earlier, would be designed to help the stability of the individual in their new unit so that they don't fall back into interim housing, homelessness or unsheltered homelessness. The idea is to provide education about landlord engagement, education, about relationship stabilization with landlords and neighbors and so forth, all designed to ensure stability in that new unit. So just want to emphasize the notion of a continuum of services here from beginning initial contact all the way through to stable permanent housing.
Slide 44	Alison Klurfeld – 00:54:24	That's a great point. Next slide. So one thing we wanted to share with you is how did we build our ECM and Community Supports network? What does that overlap look like? So for our ECM program, we have 49 total providers right now. We'll have more in January. We'll have more for all of these actually in January and 80%, about 39 are certified to serve the homeless population of focus. But only 19, you'll see that 17 and two overlap. So only 19 out of the 39 also do housing navigation and tenancy services. So what does that mean? Well, a lot of our ECM providers are federally qualified health centers or other community clinics who have a lot of expertise doing engagement, trust building, clinical case management for people experiencing homelessness. So they're really good at working with the population, but they don't have the skill expertise in housing navigation and tenancy services.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Alison Klurfeld – 00:55:26	That's not all of our clinics. We've got plenty of clinics in our housing navigation and tenancy services programs. So we do have them, but not all of them. So that's just one of the things that we had to think about in building our network was "Are they really a fit for ECM and HHSS? Can they do both the engagement and care for people experiencing homelessness and also the housing piece? Or do they only have one of those skill sets?"
Slide 44	Alison Klurfeld – 00:55:54	So I think one thing to also just to know is we really were lucky to have a big grandfathered provider network from Health Homes and Whole Person Care. We had had a lot of relationships with community clinics, a lot of great relationship with our County Department of Health services, although there's a lot more billing work for them under you'll see later, there's a lot more billing under ECM and community supports. And there was under Whole Person Care. And then for our recuperative care providers, the county is one of those as well. I'll just say our network's pretty varied, but there are a lot of community clinics, a lot of traditional healthcare for the homeless providers, a lot of social service agencies that maybe do a lot of health focus case management. But one gap that Carl can talk about a little bit is we don't have that many traditional homeless services providers. So I'll let you speak to that one.

VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Karl Calhoun – 00:56:45	Yeah, and I think this is more engagement and education with the overall L.A. County network of homeless service providers. I think there's still a combination of hesitancy not understanding exactly how it pencils into their traditional homeless service financial structure. Also, I think there's just still an uncertainty and a newness about CalAIM that hasn't quite penetrated the collective conscious of the homeless service provider network. Although that's changing as busy as we have all been related to CalAIM, it has just been what, eight, nine, 10 months that we have been live. So I think there's still an awareness that is descending into the collective conscious of the Homeless Services Network. Part of my work and my job is to address that and try to get a lot more homeless service providers engaged and participating in the service.
Slide 45	Alison Klurfeld – 00:57:43	Great point. Okay, next slide. Okay, so that was an overview of our ECM program as a whole. Our community supports housing related programs as a whole and their network overlap. We're going to dive now a little bit into how the programs work. This is again, just scratching the surface. One thing we wanted to share is for ECM, that's the biopsychosocial case management program. There's different models for how they address housing needs for people experiencing homelessness. So we try programmatically to have people co – enrolled getting both ECM and HHSS or housing navigation tenancy services. The member, if they're experiencing homelessness, ideally gets both. But how does that get delivered? Well, sometimes the ECM team coordinates with a housing navigation team at the same organization. There's 19 that overlaps. So that's all in house. It's a little easier. But other ECM teams, they don't have that.

VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Alison Klurfeld – 00:58:38	So they have to incorporate community health workers, other staff with lived experience of homelessness or housing instability or other staff who have expertise serving people, experiencing homelessness. So they do that and then they'll maybe coordinate with an outside housing navigation and tenancy services provider. And then regardless, field – based outreach and engagement is a really big part of ECM success. This is something that's been a little bit, something we're coming back to. I think there was a big pause certainly in our health homes program during COVID where a lot of relationships that really had been in person shifted temporarily to phone based engagement. Good for maintaining relationships, particularly hard for people experiencing homelessness whose numbers often change every 30 days if not more, and whose phones get stolen, get lost, get wet. There's all sorts of problems people can have.
Slide 45	Alison Klurfeld – 00:59:33	So that field based outreach and engagement we see is critical for the population of people experiencing homelessness. One of the things that often happens, a lot of our ECM providers that also do street medicine, it's great combination. They'll just go out together and the clinical services building trust then can add this case management piece. Next slide.
Slide 46	Alison Klurfeld – 00:59:54	So this is something, this is similar to what DHCS already shared, but we wanted to share with you our housing navigation eligibility criteria and how we thought about it. So because L.A. Care is so, so big, we got permission from DHCS initially to narrow the criteria a little bit so that we would have enough bandwidth to actually serve the population and to run a cost effective program. So for our L.A. Care Cal Medi – Connect members, there's the green pathway in to the surfaces or the orange pathway. The green pathway is homeless and something's going on with your health. So the homelessness criteria, maybe they're HUD homeless or chronically homeless or they're exiting an institution after 90 days and they would be homeless. So experiencing literal homelessness, we're not really focused on couch surfing at this time. And we looked at different high utilizer and acuity criteria.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 46	Alison Klurfeld – 01:00:46	So how do we come up with these? One way was we wanted to align with ECM and the homeless population of focus to try to match those services. But we also look the two plus chronic conditions and our high utilizers, what we did was an analysis of L. A. Care's homeless population and what were the hallmarks of people who were in the top decile for costs where we'd have the most ability to tie housing navigation to healthcare cost effectiveness. So these were some of the markers that came up for that group. Seven plus ED visits. Okay. That was the common thread for people in the 10th decile for costs. Two plus inpatient or sniff total cost of at least 50 K healthcare costs in the prior year. So it's not perfect, but it allows us to start in a place where we could sustain the capacity and also the cost effectiveness.
Slide 46	Alison Klurfeld – 01:01:36	But we also wanted to have a pathway so that L.A. Care could really directly align our housing navigation program with those housing resources available in L.A. County. So we said either you get in through the green door or if you've been matched already to a publicly funded permit supportive housing resources program in L.A. County, there's Housing for Health, Section 8, some of those, then we'll take you for housing navigation. And we do that in partnership with our county Department of Health Services Housing for Health program. Primarily, there's some mental health department programs as well, but we do that because we wanted to align the Medicaid resource with the housing resource where possible. So that's it. And I think Carl, right, but that's where we started. But we're explaining to expand these over time, right?
Slide 46	Karl Calhoun – 01:02:26	Correct. Yeah, we're looking to align more with the straight DHCS standard of eligibility and I think that's probably going to be happening in the next one or two quarters I would imagine.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 47	Alison Klurfeld – 01:02:40	Great, so that'll give us a chance to expand. Next slide. So this is how people get into our housing navigation and tenancy services program. So primarily we are referral driven right now. We're looking to do some data mining, especially as we start to do more data sharing with our county partners probably in 2023. But right now, somebody, whether it's internal staff, a provider, a CBO partner, a member could self – refer, somebody identifies a member, submits a referral, we review the referrals at L.A. Care. If you're approved L.A. Care has to match to the right provider. So if a housing navigation provider is referring, we know they're the right one to serve, just refer, send the members straight back. But if somebody's coming because their PCP said, "Ah, they meet criteria, I got to get this person attached to housing navigation." You have to find the right provider based on geography, maybe based on PCP relationship, maybe based on any special skills or conditions or maybe past history with that provider.
Slide 47	Alison Klurfeld – 01:03:40	Then the housing navigation tenancy services, HHSS provider receives a member assignment outreaches within five business days. They have to opt in. So all community supports are voluntary services. And then we start out with a 12 month authorization and possibility for extensions every six months. That said, it's definitely something that range is different by plan and something we can look at. I think a big concern for us, we can talk about this later, but the permanent supportive housing model for tenancy services is as long as it takes whatever it takes really for as long as it takes. And that's real hard to do when you also have to ensure healthcare cost effectiveness. And we're not quite sure how that math is going to be measured by our DHS partners. Next Slide. I'll let Carl talk a little bit about the best practices.

VISUAL	SPEAKER – TIME	AUDIO
Slide 48	Karl Calhoun – 01:04:30	So yeah, we've touched on field – based engagement already. This is critical I think for a few very important reasons. First of all, there is the issue of the difficulty in maintaining relationships on a practical level. Allison referred to the difficulty with keeping phones on and staying in telephone communication. And that is an absolute reality. And then there's also the inherent trust building. I think that is much stronger in a face to face setting. That's just the kinesthetic back and forth. The energy between two people is what I feel contributes strongly to trust building relationship and trust is the glue to a continued connection with our members. So field based engagement I think is a critical component. I know it's not possible 100% of the time, but it should be an integral facet of all housing work in CalAIM. Engagement with the coordinated entry system as an initial point of contact is also critical.
Slide 48	Karl Calhoun – 01:05:40	Obviously the information and the data sharing associated with the coordinated entry system is critical because there's a whole lot of history about our members that we will find out. There's also some work in terms of acuity levels that is valuable to our team. And there's also just the piece of understanding the network where our members are. And also it helps in terms of providing access to our members, especially those who are unsheltered. And then in terms of referral and collaboration with ECM, I think this one is critical. We don't yet have the data because we haven't been in operation long enough. But I feel strongly that when we do have the data and we can compare the outcomes of members who are being serviced in the housing services and ECM, I expect those outcomes to be stronger than members who are served by just one singly.

VISUAL	SPEAKER – TIME	AUDIO
Slide 48	Karl Calhoun – 01:06:42	And then the reason is because of the layered care and support ECM providing healthcare related case management services and direct housing support from the community support housing suite. I'm convinced that the combination of the two will result in very strong outcomes. But again, we'll have to wait a little bit longer until we have the data to actually review that. And then lastly, partnerships help members access non – medical, non – Medi – Cal housing and other resources. This is also critical. Again, I think I started out with how impressed I am that working at a large MTP like L.A. Care, there are existing partnerships and networks in place. Allison talked about our strong partnership with the county, both the Department of Healthcare Services as well as Department of Mental Health, Department of Public Health as well. We have strong relationships throughout the county and those are very, very important in terms of providing a consistent high level of service to our members. Next slide.
Slide 49	Alison Klurfeld – 01:08:02	Great. So this is just going to be a little bit of a summary of where we feel like we are. The L.A. Care framework. We've talked through our clinical services, supportive services, housing. So for clinical services, there's stuff in Medi – Cal already, but there's not really a new source of ongoing clinical funding. We are looking at the housing and homelessness incentive program for one time funds to help build capacity and start us off. But we're working the rates are the rates for the Medicaid program, there's not really added clinical funding, at least on the physical health space. I will say we don't intersect as much. There are other programs on the mental health and substance use disorder side, but supportive services, CalAIM, we've got lots of new stuff to work with there. Housing itself, there are a few transitional programs, but this is where we're really hurting because just, this is sort of the data we're seeing here in L.A. County, a balanced homeless service system. And what that means is we want to make...

VISUAL	SPEAKER – TIME	AUDIO
Slide 49	Alison Klurfeld – 01:09:03	A balanced homeless service system. What that means is we want to make homelessness rare, brief, and one time. We would need five housing exits for every one shelter bed. So five permanent placements for every one interim. We only have about a one to one. So yes, it's great. I'm not discounting adding recuperative care. In future, adding short term post – hospitalization housing. That is awesome. We're so excited to be able to do that as part of the health plan. Yet, the gap we're seeing is much more on the permanent side than it is on the interim side, where we got resources added. However, it's not exactly DCHS' fault, this is not really... This is a federal issue. You'll see on the next slide, why is it that we're still having this gap and we haven't added more on the housing piece.
Slide 50	Alison Klurfeld – 01:09:50	Next slide, please. Why can't we? Because CMS said no. Federal financial participation is not available for room and board, except with certain exceptions. I know the state had to do special waivers even just to get some of the short term post – hospitalization housing in. So this is something we really see as a federal issue. That said, we're certainly hoping to see, can we do even closer alignment with our state housing resources, such as HAP and HEAP and others to really tie in.
Slide 51	Alison Klurfeld – 01:10:24	Next slide. Okay, so given that context that the Medicaid federal financial participation isn't available for room and board, how can we do funding braiding? This is just an example, just so you'll see... The idea, somebody starts on the left at housing... Sorry, at hospital discharge, they're experiencing homelessness and they're getting both the top and the bottom rows, housing placement and some supportive services, as they move along.

VISUAL	SPEAKER – TIME	AUDIO
Slide 51	Alison Klurfeld – 01:10:57	With CalAIM, we could provide recuperative care if it's appropriate for that client and start ECM and housing navigation, of hospital discharge. That's great. Once we add in the future, short term post hospitalization housing, I think one of the questions we have is for how long can we show cost effectiveness for that? Yes, it could be up to six months or 180 days, but what's the cost effectiveness bar we have to meet? That said, we'll say for L.A. County, this is actually data that's a couple years old, used to be about 150 days or if not more, between being entered into the coordinated entry system and match. The idea is we want to partner with L.A. County, they have through a local tax Measure H, some interim housing beds. The idea is maybe we start off with a client, but we need a partnership that'll get them all the way to that housing match through the coordinated entry system and the member being housed.
Slide 51	Alison Klurfeld – 01:11:58	To help the member become housed, we can offer move in assistance in housing deposits and then they stay in the ECM as Karl mentioned, switch over to tenancy services. But what's the housing placement? Well, we're looking at, for example, right now there are a lot of emergency housing vouchers or EHV's out in the community. We're looking at how can we master lease more buildings with the HHIP program, backfill support we'll talk about in a second, for permanent housing. So how are we looking at that?
Slide 51	Alison Klurfeld – 01:12:27	The last thing we'll talk about is we actually haven't had enough time with the programs up to get there yet. But for measure... Sorry, for tendency support, as I mentioned, it's a very long term model, but we still have to ensure cost effectiveness. There's a question basically how long, how many years, how many months can the health plan cover and still meet the required cost effectiveness bar? Before maybe shifting over to tenancy services through a local funding support.

VISUAL	SPEAKER – TIME	AUDIO
Slide 51	Alison Klurfeld – 01:12:56	I think... I'll just say we're awaiting and excited to have further conversations with DHCS about how do we actually do the math on cost effectiveness? Because it's pretty new and I don't know that many states have tried it at scale. New York does a lot of this, but they also spend almost twice per capita what we do on Medicaid. They have a lot... It's easier to save money if there's more money around. I'll just say that. That's our funding braiding example is moving from the stars to the non – stars or blue to the orange. That's where we see our resources in county or local resources often working together. Next slide. We're almost here. Two more slides.
Slide 52	Alison Klurfeld – 01:13:39	I started to talk about HHIP or the Housing and Homelessness Incentive Program. We've talked a lot about our new ECM services and community supports for people experiencing homelessness.
Slide 52	Alison Klurfeld – 01:13:50	HHIP is a chance for health plans, as I think Francis mentioned earlier, to earn a bunch of money and then spend it to address the needs of members and the address the needs of housing and homelessness in your county more generally. We at L.A. Care have been partnering closely with our private plan competitor and partner, Health Net, and our continuums of care, ECM and CS providers, county agencies, community based organizations, clinics. We've talked to our local lived experience advisory board for our continuums of care a couple times to come up with priorities. As we try to earn HHI money, what should we spend on? Here's what we're thinking we'll do and we want that to complement our ECM and community support strategy. One thing is infrastructure, investing a lot in data exchange with HMIS and other partners. Also workforce development, because we do not have enough people and people are leaving the field in droves, for housing navigation and tenancy services.

VISUAL	SPEAKER – TIME	AUDIO
Slide 52	Alison Klurfeld – 01:14:44	Another priority is street medicine, funding for both services and capacity building. Maybe in the future we'd look at behavioral health and public health partners or potential health information exchange. Then, programs to get and keep people housed. We want to be expanding both our housing related community supports and our enhanced care management. Those programs are already funded, but we're trying to see how can we use HHIP, whether it's through incentives or TA or capacity building, to grow those programs. Then we have two big strategies we're working on in partnership with the county, really excited about.
Slide 52	Alison Klurfeld – 01:15:16	One is unit acquisition. We want to be master leasing buildings and partnering with COCs in the county to increase utilization of tenant – based vouchers. So how do we do that when we can't pay rent? I said that earlier. Well, the tenant – based vouchers, like the Section Eight or the Housing Choice Voucher, that will pay the rent. But when you're master leasing saying, "Hey landlord, can I have your whole floor or this whole building?" You also need to cover things like the months in between tenants or trash costs or repair costs, building insurance, different types of things.
Slide 52	Alison Klurfeld – 01:15:53	Our HHIP dollars will cover that stuff so that we can get more units into the pipeline and then the tenant – based vouchers can cover the rent that we can't pay for. So we're really excited about that. We're going to be learning a lot from other counties. San Francisco does a lot of this and as soon as we figure out exactly how we'll do it, which we're doing right now, we'll tell you all about it. Then the last thing I mentioned is we have a strategy to try to increase housing accessibility overall, for people experiencing homelessness, who need help with their activities in daily living.

VISUAL	SPEAKER – TIME	AUDIO
Slide 52	Alison Klurfeld – 01:16:25	For that we see that those folks have a longer duration of homelessness, harder to find good interim and permanent housing placements. We're thinking of a three – prong strategy. First is a field – based team to go out with clinicians, nurses, social workers, maybe psychiatrists depending, to actually go out and assess what does this person need, what does that person need? Then we'd add some interim housing services. Because of licensure issues, we can't do ADL assistance in recoup care or short term post hospitalization housing. The state community care licensing board doesn't allow that, but you can bring services in. You can't have them at the facility but you can add them. We see that as also working with our personal care and homemaker assistance fee support. Then the last thing is we'll also be doing some enhanced services funding to get members placed in adult residential facilities or residential care facilities for the elderly.
Slide 52	Alison Klurfeld – 01:17:19	Quite frankly, this is folks who aren't sick enough to qualify for the assisted living waiver. Maybe they don't meet the nursing facility level of care or they can't get in yet, but they're still too sick to really live safely in permanent housing. It's probably going to be a small program, but of really vulnerable folks. I'll just put in my own personal plugs, stepping outside of L.A. Care, is that perhaps if we could address the low payment rates for ARFs and RCFEs generally, $75 a day is not really a lot to care for really sick people. That's maybe a statewide long term strategy to address this, because otherwise we're just going to be doing stop gaps.
Slide 53	Alison Klurfeld – 01:17:56	Okay, back to L.A. Care. Let's take it away. Last slide and then we'll get to Q&A. Sorry about that. What are all of these opportunities and challenges? That was a lot of information. Maybe let me pause. Let me... Karl, why don't you do opportunities and I'll do challenges? I'll give you the positive.

VISUAL	SPEAKER – TIME	AUDIO
Slide 53	Karl Calhoun – 01:18:12	All right, well, for sure, the opportunities... In the interest of time, I'll just maybe highlight one of each, Alison. I think for the opportunities, the one at the bottom is the one I'd like to highlight, is improving housing stability and access to housing for our members. Again, we've touched on the realities of housing in Los Angeles County. Not saying that there aren't other counties and cities in California where it's a significant challenge, but it's notoriously so here. Improving the ability for our members to find housing and then crucially, improving their ability to sustain, maintain that housing and become stable is critical. That first year of housing is incredibly important for stability. I think there's a lot of data out there that shows if members make it past the first 12, possibly 18, months, their stability is far more ensured than if they struggle in those first 12 months.
Slide 53	Karl Calhoun – 01:19:12	I feel like that that is a huge opportunity for us in this program. If I could, Alison, I'll just highlight one of the challenges that is near and dear to my heart, that I think we should focus on, which is the second bullet there. In terms of providing capacity and especially improving the administrative capabilities of the smaller CBOs. Certain regions of L.A. County, service planning area one and two, the outer reaches of those two service planning areas. Even in service planning area six, which is in the heart of South Los Angeles, there are a lot of services provided by very small CBOs who struggle administratively. Just completing the certification application for some of these CBOs is a major challenge, just because of the staffing capacity that they have and the capabilities of those that are providing these administrative responsibilities. I just feel like that's a challenge that should be highlighted and get some attention going forward. But I'll turn it back to you Alison, to focus on some others.

VISUAL	SPEAKER – TIME	AUDIO
Slide 53	Alison Klurfeld – 01:20:24	No, that's great. I really agree with you. I guess I'll just highlight, take my prerogative and highlight one more challenge. The admin and the billing, that third bullet. It's amazing to have Medi – Cal funding for housing – related services. Thinking about this from a policy perspective, the state of California, as was mentioned earlier, we're just talking about DHCS programs today, but there are programs the state of California is doing out of multiple state agencies to really try to address this challenge. There's a huge opportunity to decrease the cost for housing – related services by getting Medi – Cal matching dollars, federal matching dollars. But those dollars come with strings attached. The requirements to do contracting, especially through managed care, billing, reporting, that is adding a huge administrative cost to providers. I think it's really hard, we're trying to bring the social determinants or social drivers of health into healthcare. That's amazing, to really put our money where our mouth is, as a system.
Slide 53	Alison Klurfeld – 01:21:23	Yet, we're trying to also kind of medicalize and administratively turn all these other type of systems to say, "Oh, just do it all our way." But our way is really complicated and it adds a lot of cost. I think that's a question in terms of thinking about it for our big picture strategy. At the plan level, we're trying to say how can we try to decrease some of those costs. Our IT, at a really early stage, we really think there's some opportunity to do that through IT. But are there other opportunities statewide, to think about what is the right Medicaid structure? Where we maximize the federal reimbursement, but also minimize the real provider burden? Because it's high and we don't... Encounter data's encounter data. We don't get to come out of that. I'm sorry, very last one, cost effectiveness. This is something that I'll say L.A. Care has really struggled with, because community supports by definition have to be cost effective with relation to healthcare dollars.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 53	Alison Klurfeld – 01:22:27	We have a long time frame, we can do it over a group. It doesn't have to be for that particular person. That's great. But we want to move upstream. I guess from a programmatic level, there are plenty of people who are members experiencing homelessness or housing instability, who have extremely low healthcare costs. Will have extremely low healthcare costs no matter what we do, even for the next 10 or 15 years. They're relatively healthy people, but man, do they need help with their housing! How can we serve them? What would it take to get us upstream? Is it moving from community support to benefit? What are the ways we could get there? That's it. Our contact info's in the presentation and some links to also more info about our ECM and community supports program. You can skip ahead to that and we'll turn it over back to Juliette.
Slide 54	Juliette Mullin – 01:23:17	Fantastic, thank you so much Alison and Karl for sharing your experience implementing CalAIM and all of the broader work you do in L.A. Care around housing support for your members. We'll leave up the contact information for just a moment, which you've generously provided, for anyone on this webinar that has any follow up questions for Karl and Alison. We have about five minutes left today. What we'll do with our last five minutes is I'm going to go through some of the questions we've been receiving in the Q&A. I just want to acknowledge we know we've received quite a number of them in the Q&A and so thank you very much for your engagement. I know our DHCS team and leaders have been going through and responding to them as they can, as they come in. What I'll do now is I'll actually just touch on a few of them for us to address out loud and in our last five minutes. If we could go to the next slide?

VISUAL	SPEAKER – TIME	AUDIO
Slide 55	Juliette Mullin – 01:24:14	Before we do that, I do just want to note for everyone that we do have two additional housing webinars coming up this month. We have one next week, that is Community Support Spotlight specifically. That will focus on housing navigation, deposits and tenancy. That's on Thursday and we just dropped the link for that in the chat. We also have an office hour session the following week on the October 27th. This is actually going to be an opportunity for us to just have a conversation and a discussion with the DHCS leaders. The L.A. Care team will join us for that as well. We'll ask them some questions, as well as a few other organizations implementing CalAIM in the housing space. This will actually be an opportunity for us to answer a number of the questions that we might not be able to get to today.
Slide 56	Juliette Mullin – 01:25:08	Just wanted to highlight those two things for everyone to join later in this month. With that, I'll go to just a couple questions. We've got a few questions about some policies related to community support that I'd love to ask of our community supports team. The first is sort of at a high level, we got some questions about a community support we didn't cover in today's presentation today, rehabilitation. The question for our NCQMD team is how do you see day rehabilitation as part of the suite of DHCS housing community supports? I'll open that broadly to the DHCS team.
Slide 56	Michel Huizar – 01:25:51	I would say, and the team can also jump in, we did give this one some thought, and it is for those members experiencing homelessness who are receiving enhanced care management or other community supports. The day rehabilitation can provide a physical location for members who are to meet with and engage with providers. It is just also noting that it is, day rehabilitation can be provided continuously as a community support, in conjunction with enhanced care management. Just making sure to note though the avoidance of duplication, but just wanted to provide some context there.

VISUAL	SPEAKER – TIME	AUDIO
Slide 56	Tyler Brennan – 01:26:33	I'll just add a little bit. The day rehabilitation programs community support is really designed to assist the member in acquiring, retaining, and improving self – help, socialization, and adaptive skills necessary to reside successfully in their environment. As such, the provision of the service compliments the housing services very well, in helping members better develop habits with the goal of maintaining safe and stable tenancy once housing is secured.
Slide 56	Juliette Mullin – 01:26:57	Great, thank you both. Actually I'm going to kind of add to that question, a question that I saw a couple times in the Q&A and that we actually get pretty often, can members receive multiple community supports at the same time?
Slide 56	Michel Huizar – 01:27:11	Absolutely. Yes, they can.
Slide 56	Juliette Mullin – 01:27:14	Great, thank you. One question I saw from a couple different people in the Q&A is about the distinction between recuperative care and short term post – hospitalization housing. Could we elaborate a little bit on what the distinction is and when someone might be appropriate for one versus the other?
Slide 56	Tyler Brennan – 01:27:36	Sure, I can take that one. So recuperative care, it's also known as medical respite. It's short term, really underlining the short term aspect of that. It's short term residential care for individuals who no longer require hospitalization, but they still need to heal from an injury or an illness, including behavioral health, and if their living situation would exacerbate their current situation. Whereas short term post – hospitalization housing, is available one time in an individual's lifetime and it's really for members who do not have a residence and who have high medical or behavioral health needs, so that they have the opportunity to continue their recovery immediately after exiting an inpatient hospital or other facility. Really short term post hospitalization housings for those exiting facilities and is a little bit longer term, once in duration. Whereas recuperative care, really the only restriction there is that it cannot be any longer than 90 days in continuous duration.

VISUAL	SPEAKER – TIME	AUDIO
Slide 56	Juliette Mullin – 01:28:31	Great, thank you, Tyler. My next question, and I think probably our last one, given the time, it's for the L.A. Care team. You mentioned in your presentation that you were growing your network of ECM providers and community supports providers. Can you tell us a little bit how you go about building relationships, especially in the housing space, with CBOs that are entering into the Medi – Cal world, what that looks like and how you work with them to support them?
Slide 56	Karl Calhoun – 01:28:59	Yeah, so I'll take that. I'll start off with that. I think I would say that it's a lot more perspiration than inspiration, if you know what I mean. We have connections in the field and we maintain those connections. Promote the service as much as possible. Network engagement, provider engagement, member engagement, all of the above, talk about the quality and the value of the service to the provider network, but there's also high level engagement as well. Alison, I don't know if you want to take that part.
Slide 56	Alison Klurfeld – 01:29:37	Sure. I think one of the things that we really benefit from in L.A. County is that over, I think it's from 2017, right up until 2020, as the pandemic started, actually the Corporation for Supportive Housing and our local county CEO homeless initiative convened a meeting of managed care plans and homeless service system partners. We started to get to know each other, figured out how to do some initial HMIS data sharing, things like that. I think that's helped to build some system relationships. We're now actually... I want to shout out, I know some of our CSH colleagues are on the call, thank you guys for that. But I think that helped us to get started and now we have pretty regular partnerships to try and figure out, okay, what do you guys need for your head? What do we need for HHIP? That's helped us to do the system level partnering, but there's still a lot more to do. We just have to keep at it. Perspiration is key in both areas.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 56	Juliette Mullin – 01:30:32	Fantastic. Well, thank you both so much for sharing all about your experience today. Thank you for our DHCS leaders for walking us through all the key DHCS programs in this space. If we could just pull up one more time the slide with the upcoming webinars? We will close on this. For questions that we were not able to get to today, we will be grouping those up and having a conversation about many of those in the office hour session on the 24th or sorry, the 27th. That will also be an opportunity not just to come and sort of hear responses to the questions that you've put in the Q&A today, but also to ask questions during that session itself. That's a more open conversational session where we just answer questions. With that, thank you everyone for joining today. Have a wonderful rest of your day.
Slide 56	Julian – 01:31:25	Thank you for joining. You may now disconnect.