

CaAIM ECM Webinar: Operationalizing Whole Person Care Management

June 2, 2022

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Mario – 00:00:19	Hello and welcome. My name is Mario, and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q and A. We encourage you to submit written questions at any time using the Q and A. During today's event, live close captioning will be available in English and Spanish. You could find the link in the chat field. With that, I'd like to introduce Dana Durham, chief of the managed care, quality and monitoring division of DHCS.
Slide 1	Dana Durham – 00:00:51	Thank you so much, Mario. And we're excited to have you all as part of this webinar. Really excited to be able to talk about enhanced care management overall, and really talk about our vision for that and have some speakers who will be going through ways that enhanced care management has been enacted on the ground. So next slide if you don't mind.
Slide 2	Dana Durham – 00:01:22	We start off with a couple slides just talking about the public health emergency unwinding. And the end of the public health emergency is coming, and so Medi-Cal continuous coverage requirements, really necessitate a coordinated phase communication campaign to reach beneficiaries with messages across multiple channels using really what we have as we're going to call DHCS coverage ambassadors. So as California really plans to really go into normal Medi-Cal operations, beneficiaries will need to know what to expect and what they need to do to keep their health coverage. Most beneficiaries willing to remain eligible for or qualified Medi-Cal or really have the ability to have tax subsidies that will allow them to buy coverage through Covered California.
Slide 2	Dana Durham – 00:02:21	So as I said, we will be looking to engage community partners to serve as coverage ambassadors, and we want them to help us deliver important messages to Medi-Cal beneficiaries about really maintaining coverage as the public health emergency ends. These coverage ambassadors will help us to deliver the message, and they'll be made up of really diverse organizations that can help reach beneficiaries where they are, and in culturally and linguistically appropriate ways.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 2	Dana Durham – 00:02:59	A list of who may be included in that, it could include local county offices, health navigators, managed care plans, community organizations, advocates, stakeholders, providers, clinics, healthcare facilities, legislative offices, or other state agencies. That just is an idea of who we are seeking to be part of the coverage ambassador program, but we really want you to join that program. So if you're interested, we will make sure that you have the information to join our mailing list. And we just encourage you to sign up. Next slide, please.
Slide 3	Dana Durham – 00:03:44	There is a two-phased approach to what we're doing. Phase one is really designed to encourage beneficiaries to provide updated contact information, such as their name, address, phone number and email, so that we can contact beneficiaries with important information about keeping their Medi-Cal. This phase is really currently underway. So if you've not been involved yet, just get involved as soon as you can.
Slide 3	Dana Durham – 00:04:14	Phase two is designed to encourage beneficiaries to continue to update contact information and report any change in circumstances, as well as remind them that the renewal packets will be coming. And phase two will begin 60 days prior to the end of the public health emergency. A phase two outreach kit will be released in the future. And next slide, please.
Slide 4	Dana Durham – 00:04:45	So really excited to have everyone that we have here for this webinar. The people, I just want to give you a highlight of what we'll be doing. We'll be looking from a state perspective about what ECM is and where we are in implementation. And then we'll look at how ECM looks on the ground. And to help us facilitate that discussion, really, we've asked two partners to join. One is the Community Health Center Network, who's done a great job with implementing ECM, and that they work in partnership with some of our health plans, and one of which who has joined us, which is Alameda Alliance for Health. And after we have them go through how ECM is working on the ground, then we will have a question and answer session, and then we will conclude after that. Next slide, please. Thank you. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Dana Durham – 00:05:54	Sorry, just had a technical difficulty. Medi-Cal really is the cornerstone of California health system and CalAIM success really can set the pace for the transformation of the entire healthcare sector. So everyone has a stake in the Medi-Cal program. And many of us know someone whose actual health depends on Medi-Cal. Medi-Cal covers one in three Californians, and just over half of California school-aged children, half of the births in California, and more than two in three patient days in California long term care facilities.
Slide 6	Dana Durham – 00:06:37	So CalAIM's bold Medi-Cal transformation expands on the traditional notion of the healthcare system. It's much more than really a doctor's office or hospitals. Also includes more participants than we've ever had, bringing in community-based organizations and non-traditional providers that really can work together to deliver equitable, whole person care. CalAIM transformation means meeting the needs of the whole person, health providers who are trusted and relatable, expanding community supports and proactively upstreaming services, really engaging the community as a whole and making the best use of partners and resources that we can today.
Slide 6	Dana Durham – 00:07:27	Today really Medi-Cal enrollees are challenged to navigate a pretty complex system, and the idea of CalAIM is that enrollees will have the tools and support to get the care they need when they need it. Enrollees can expect consistent, integrated access to services and care, no matter their zip code or language that they speak. The CalAIM transition requires a sustained focus and long-term commitment, really because it's new, it's innovated and it is challenging.
Slide 6	Dana Durham – 00:07:58	So implementation, we really expect to take between five and seven years. And when it's complete, we think it will fundamentally improve the lives of millions of California. It requires the commitment and hard work of many partners, and we're asking everyone to move beyond the traditional roles and thoughts of Medi-Cal but embrace this new and more collaborative role. As with any type of transformation on this scale, there are going to be some challenges and we'll adapt and evolve as we move forward. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Dana Durham – 00:08:36	What is ECM? Well, if you look overall at what ECM is, it's really kind of the beginning of the journey for CalAIM overall. ECM aims to be a community-based care management program for the highest needs, most complex Medi-Cal enrollees. It builds off the success of two programs that we've engaged. One is health, and the other one was whole person care. So ECM has been active for about six months, and those six months are providing us an opportunity to improve on lessons we learned from the previous two programs, but also to continue learning. Currently, we have over 90,000 enrollees, and thousands more are expected to join ECM as ECM goes statewide for all Medi-Cal enrollees in July 2023. Next slide, please.
Slide 8	Dana Durham – 00:09:39	So ECM overall is a new benefit, and the idea behind it is to provide comprehensive case management for enrollees with complex needs, that often have to kind of move through several different delivery systems to access care. So those delivery systems can include primary care, specialty care, dental, mental health, substance use, and/or long-term services and support. So ECM is really designed to address both the clinical and nonclinical needs of those highest need enrollees through intensive coordination of health, health related services, and meeting enrollees wherever they are, in the streets, in the shelter, in the doctor's office, or at home. And really, we're trying to make sure that we do what we can through ECM to address the social drivers of health as well. And those are things that keep someone in a health situation or contribute to someone's having a health situation.
Slide 8	Dana Durham – 00:10:44	ECM overall is part of the broader CalAIM population health management system. So as I said, it's the beginning. The broader CalAIM population health management system is where MCPs will offer care management interventions at different levels of intensity, based on member needs, with ECM being that highest level. So there are three levels that are involved in population health management, but this is the highest level. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 9	Dana Durham – 00:11:20	ECM, along with community supports, really was informed by those previous tests that I talked about. So you're looking at whole person care and health homes. And just to give you an insight into what whole person care and health homes were as § programs, whole person care was a limited pilot program that was allowed by one of our waivers. It's section one, 15 waiver, 1115 waiver, and coverage and delivery system for whole person care was agnostic. That means that you could have Medicaid managed care. You could be fee for service or uninsured, but eligible for whole person care. And there were really no requirements in whole person care for interfacing with managed care plans. Whole person care pilots were mainly administered by county-based local entities.
Slide 9	Dana Durham – 00:12:19	The health program, on the other hand, was a state benefit that was operated in several counties, and only had Medi-Cal managed care members and managed care plans administered, the health and programs with the care management contracted out to local providers. So those are the two kind of programs that were fundamental to enhance care management and community supports. And the way that they had morphed into enhanced care management and community support is that enhanced care management is care coordination as a managed care contract requirement. So it is a benefit in managed care. And it's for managed care only, managed care members only. And the managed care plans administer enhanced care management by using community providers, as they did in health homes.
Slide 9	Dana Durham – 00:13:21	Community supports, which we're not going to talk about now, but we will be talking about more in upcoming webinars, are optional services that we're strongly encouraged, and it's for managed care plan members only. And they're managed care plan ministers with services delivered through community partners, and they can complement ECM, but you don't have to have ECM to be eligible for a community support. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Dana Durham – 00:13:53	So who is eligible for ECM and how does it work? ECM's available to Medi-Cal managed care plan enrollees who meet a population of focus, and enrollees can really be identified through a lot of different mechanisms. They can be identified through their managed care plan provider, family or caregiver, community-based organizations, or someone can refer themselves if they think they could benefit from ECM.
Slide 10	Dana Durham – 00:14:28	Once someone is identified for ECM, they're assigned an ECM provider who best meets their need, and that enhanced care management provider makes sure that the enrollee has a single lead care manager who coordinates their care and services across Medi-Cal delivery systems. The system overall can be a little unwieldy if you're not familiar with it. And so the lead care manager will help that individual instead of having to go through seven different people in different systems. This in lead care manager will help coordinate all the needs. Next slide, please.
Slide 11	Dana Durham – 00:15:12	What's included in ECM? Well, there are really seven defined ECM core services, and someone who is in ECM is provided them regardless of what county they live in or how they become eligible for ECM. Those services are outreach and engagement, comprehensive assessment and care plan management, coordination and referral to community and social support services, enhanced care coordination, member and family supports, health promotion and comprehensive transitional services. Next slide, please.
Slide 12	Dana Durham – 00:15:58	So as you'll see on this slide, we have various populations of focus that go live at different times. At a high level, those in whole person care and health homes who had the demonstrations began going live in January of this year. And those populations that went live immediately are individuals and families experiencing homelessness, adult high utilizers, adults with serious mental illness or substance use disorders. And those populations go live in all other counties. Those who didn't have health homes or whole person care coming up in July, which is just around the corner.

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Slide 12	Dana Durham – 00:16:41	Additional populations will begin coming up shortly. And you see on this slide that in January of 2023, those who are at risk for institutionalization and eligible for long term care, as well as nursing facility residents transitioning to the community, will be going live in January 2023. And then children and youth population of focus will go live in July of 2023. And additionally, the incarcerated and transitioning to the community population of focus will go statewide in alignment with pre-release Medi-Cal services, we will announce the timing on that as we get closer to it.
Slide 12	Dana Durham – 00:17:36	It's really been the goal of DHCS to work that together to make sure that pre-release services happen in the justice involved population before it goes live. And we've been negotiating with CMS on those pre-release services, and CMS has informed D HDS that the approval of the state's waiver request to provide the services is dependent on the following, which both have not occurred yet. One it's a submission of the HHS report to Congress and release of the state Medicaid director letter on justice involved 1115 waivers. As soon as we have an update on the status of those negotiations, and if we have any changes to really impact the date of the justice involved information, we'll share that information with you as soon as it becomes available. Next slide, please.
Slide 13	Dana Durham – 00:18:45	So where is ECM live today? Well, as I said, ECM went live January 2022 in the 25 counties that had whole person care or health home. And so approximately 95,000 Medi-Cal health members were eligible for and transitioned into ECM in January. And since January, there have been some new enrollees that have begun, begun to receive coverage, and those enrollees really typically fall into the populations of focus that are noted below, which is high utilizer adults, individuals and families experiencing homelessness, and adults with SMI or SUD. Next slide, please.

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Slide 14	Dana Durham – 00:19:34	Starting in July 2022, ECM will go live for those populations I just mentioned, and that is individuals and families experiencing homelessness, high utilizers and adults with SMI or SUD. Starting on January 1st, 2023, ECM will extend statewide to individuals at risk for institutionalization and eligible for long-term care and nursing facility residents transitioning to the community. Next slide, please.
Slide 15	Dana Durham – 00:20:14	I am going to turn this over to Edith Stowe who is going to introduce our guests and take us through the next few sections.
Slides 15-16	Edith Stowe – 00:20:26	Thank you so much, Dana. My name is Edith Coakley Stowe. I'm with Manatt Health and we work closely with DHCS and Dana's team on the implementation of ECM, so I'm delighted to get to facilitate this discussion on how ECM actually looks now that you've had the crash course from Dana on what ECM is. So next slide, please. I'd like to start with a round of introductions. We have a fantastic panel here today, so we're going to pass the ball around to one another. I'm going to pass it to Dr. Miller.
Slide 16	Dr. Laura Miller – 00:21:03	Yes. Good morning. Thank you so much. It's an honor to be here. My name is Dr. Laura Miller. I'm the senior medical consultant at Community Health Center Network. Aleida.
Slide 16	Aleida Kasir – 00:21:15	Hi, my name is Aleida Kasir. I'm an LCSW and the care neighborhood program director at [inaudible 00:21:22]. I'll pop it over to Jacob.
Slide 16	Jacob Deme – 00:21:23	Hi, everyone. My name is Jacob Deme. I'm the care neighborhood operations supervisor at CHCN, and I'll pass it over to Brenda.
Slide 16	Brenda Bautista – 00:21:32	Hi, good morning. My name is Brenda. I'm the community health worker at Native American Health Center. Rene.
Slide 16	Rene Soto – 00:21:42	Hello, good morning. My name is Rene. I'm the CN lead CHW with CHCN. And I'll go ahead and pass it over to Jyoti.
Slide 16	Jyoti Tripathi – 00:21:52	Hello everyone. I'm Jyoti. I am the senior health data analyst at CHCN. I'll pass it to Melissa.
Slide 16	Jyoti Tripathi – 00:22:13	Can you all hear me?
Slide 16	Dr. Laura Miller – 00:22:16	I can hear you, Jyoti. Melissa, are you able to unmute?

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Slide 16	Melissa Ramirez... – 00:22:20	Yes. Good morning, everyone. My name is Melissa Medina. I'm a registered nurse and public health nurse. I'm the care neighborhood nurse at Community Health Center Network. And I'll pass it to Dr. O'Brien.
Slide 16	Steve O'Brien – 00:22:34	Good morning, everybody. We're excited to be here, especially with our great partners at CHCN. I'm the chief medical officer at Alameda Alliance for Health in Alameda County. And I'd like to introduce Dr. Amy Stevenson.
Slide 16	Amy Stevenson – 00:22:47	Hi everyone. Thanks for having us. I'm Dr. Amy Stevenson. I'm a clinical nurse case manager by background and I'm the clinical manager of the ECM program at the Alliance.
Slide 17	Edith Stowe – 00:22:58	Okay. Next slide. And over to Laura.
Slide 17	Dr. Laura Miller – 00:23:01	Great. Thank you so much. We're going to dive into.
Slide 17	Dr. Laura Miller – 00:23:03	Great. Thank you so much. We're going to dive into Alameda County a little bit, and orient you to the world that we've done our work in. Many, many people live in Alameda County. We are in the East Bay where the sun is. 28% of residents in our county are Medi-Cal members. And in our county, we have two plans, Alameda Alliance for Health and Anthem Blue Cross.
Slide 17	Dr. Laura Miller – 00:23:27	So shifting to the other side of the slide, there are many primary care clinics, health centers, federally qualified health centers in Alameda County. The blue bubbles that you see on the slide are all health centers that are part of community health center network. So they're our world if you will. But there are many other primary care clinics within our county, including with our public health hospital system, Alameda Health System, Roots and Davis. But when the CHCN folks talk about our work, we'll be talking about patients and CHWs who are at the blue bubbles on the map. Next slide please.

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Slide 18	Steve O'Brien – 00:24:18	<p>Awesome. Thanks Dr. Miller. Alameda Alliance for Health is the Medi-Cal managed care plan. The county plan in Alameda County, we have about 82% of the market. Currently, as you can see in the upper left, we have about a little over 300,000 Medi-Cal members and then a small commercial IHSS line with 6,000 members. You can see from the ethnic breakdown. It's a very, very diverse population that we serve. On the right-hand side is a little graph that shows all the other managed care plans in California, our case management flows from our population health strategy, which also creates our quality and equity plan, our health education and disease management programs. But for case management, we really look at it internal and external programs, because we know we need to partner with our providers and others to really reach our members.</p>
Slide 18	Steve O'Brien – 00:25:12	<p>So we have care coordination internally, and then we have it through delegation with our partners at CHCN, who's our largest delegate with about a third of our overall membership. POC, we have a very large focus on transitions of care, both internally and through a grant with our partner again at CHCN through an excellent program that they have. And then for the most complex patients, this is a construct that we have ways internally of dealing with patients through complex care management, the state program, and for those complex patients, we now have ECM through this new construct. And then finally, preparation for ECM has been a multi-year process at Alameda Alliance. In 2017, we did a self-funded Health Homes pilot in anticipation of the Health Homes program. And we piloted it with CHCN, helping to sponsor and grow their care neighborhood program, which you're going to hear about in detail in just a second.</p>
Slide 18	Steve O'Brien – 00:26:11	<p>That really helped create partnerships, not only with CHCN, but also with Alameda County, and led in 2019 to an integration of the Whole Person Care case management program with the Health Homes pilot. So we created one care management program across the county that encompass both of the Whole Person Care and the Health Home pilot. And that really set us up well to transition into ECM.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Steve O'Brien – 00:26:39	So today for us, ECM, we look at it as a way to get out into the community. Very community-based, it's an intense case management program as Dana mentioned. For us it's intense in that focusing on people with a lot of social determinant of health issues, social drivers, and particularly the staffing model is mostly with CHWs at that sort of level up in the community. Although, you'll hear in their models, they have a lot of good clinical people to support them in their decision making. So we balance that with our complex case management. So in a plan, both of those are become very important in managing complex patients.
Slide 18	Steve O'Brien – 00:27:19	And finally, all of our community-based case management entities. So Lingo and Health Homes were able to transition to become ECM providers which set us up to start with a large population. I hand it off to Dr. Miller next.
Slide 19	Dr. Laura Miller – 00:27:34	Great, thank you so much. I'm going to dive a little bit into the ins and outs of Community Health Center Network or CHCN. We're actually founded in 94 as a managed services organization, really on behalf of eight federally qualified health centers. You can see all of their logos on the slide. And we have CHWs who are employees of all of those health centers reaching out and taking care of ECM patients, ECM members.
Slide 19	Dr. Laura Miller – 00:28:07	Little bit more about CHCN. In May of this year, we had over 180,000 members. And we contract on behalf of our eight health centers for professional risk. Our primary care network is the providers at the health centers. And then we also maintain a specialty network. We provide many services, including utilization management, provider relations, claims, and special projects. Care Neighborhood actually started out as a special project. And one of our secret sauces in the very early days was the fact that we had claims data and we were able to risk-stratify our population and try to really reach out to the most in need. Next slide please.

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Slide 20	Dr. Laura Miller – 00:28:58	I'm going to dive a little bit deeper into our history. It is long as Dr. O'Brien mentioned, we actually started out grant-funded in 2013, really looking towards the Health Homes legislation that was in the Affordable Care Act. And so we started iterating our program with an LCSW being the main driver of the care, the lead care manager, if you will. But we realized that CHWs were a much better workforce in a lot of ways, closer to the community. And so we piloted using CHWs as our care managers early on in 2016. We were grateful for support from both of our health plans. When a grant ended, that initial grant ended, our health plan stepped in and grant-funded us.
Slide 20	Dr. Laura Miller – 00:29:53	And so by 2018, we had expanded to 18 CHWs. And then when Health Homes and Whole Person Care came onto the scene, we were ready and were able to contract with both of our health plans. And we worked through HHP and Whole Person Care, continuing our growth, continuing all of our systems. Pivoting to COVID, when that hit. And then as of now we are an ECM provider under CalAIM with both health plans and we have 28 CHWs and 775 patients in care. We're stabilizing a little bit. There've been a lot of transition with ECM, but we're really internally poised to grow that number of patients. Next slide would belong to Aleida Kasir.
Slide 21	Aleida Kasir – 00:30:45	So Care Neighborhoods case management is solely and always focused on the patient. You'll see here on the right-hand side, our logo or our way to kind of center that the patient is the leader of their care. And then outside of that is the interdisciplinary team that's based at each clinic. The lead person in that is the community health worker, CHW. And then Community Health Center Network, CHCN, is the overarching trainer for the CHWs. We also provide direct support for the patients as well. And then outside of that, it positively affects the community.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Aleida Kasir – 00:31:26	We have over 750 patients, which doesn't sound like a lot, but we're affecting people's families, we're affecting people's children, we're affecting legacy of different patients that come along. We have many patients that come to us and say, "My friend is in Care Neighborhood. I heard about this program. Can I get in?" It's really limitless on the services that we can provide. And then of course there's also community supports that's not just for ECM members.
Slide 21	Aleida Kasir – 00:31:58	We do have clinic-based case management for high risk members or acute members, friendly faces in the ERs and inpatient. That's who we work with, and that's who Care Neighborhood has always worked with in the past. It sounds like because we are based medically, that's all we focus on. But as Dr. O'Brien mentioned, it's working with people that have social determinants of health needs. So that's our main thing with CHWs is to help coordinate to typical providers, non-typical providers, and maybe reconnecting them with families, et cetera. We'll get further into that in the future as the slides go on.
Slide 21	Aleida Kasir – 00:32:40	But as I mentioned, the CHWs employ a person-centered approach, the patient designs what goals they want to work on. They have to be full partners in attending their appointments and agreeing to receive care from Care Neighborhood, even though it's within the clinic that they are attending. And they have to be able to respond to the CHWs to receive the care. CHCN also provides technical training and support, which we're going to dig a little bit deeper into. Next slide, please.
Slide 22	Jacob Deme – 00:33:18	All right. On this picture here before us, some of the wonderful humans that are doing the on-the-ground work. These are some of our CHWs spread across our eight FQHCs, part of the CHCN network. These folks are helping navigate our patients through the complex healthcare system, connect them to community resources that address their social determinants. Many of our CHWs are bilingual and are coming from the communities that they're serving. And additionally, many of them go off to achieve degrees in higher levels of education and some even return to us as providers later on. Next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Edith Stowe – 00:33:55	Thanks so much, Jacob. Next slide, please. What we're going to do next for the next several minutes is break down the ECM model. And you saw this slide a few minutes ago when Dana walked through the ECM design, this is what DHCS says ECM must include the state sets minimum requirements and guardrails around what this service looks like. And what we're going to do is take it piece by piece and draw a line between what the state says needs to happen and then what is happening in real life at CHCN and with Alameda Health Alliance. So without further ado, let the unpacking begin. Next slide, please.
Slide 24	Edith Stowe – 00:34:44	Let's start with how do people actually end up in the ECM benefit? What does the state say? The state says that managed care plans have to proactively identify people that they serve to understand who meets populations of focus definitions. For example, take a look at who's been very high utilizers for the ER using their claims data.
Slide 24	Edith Stowe – 00:35:10	And then also another way to receive ECM is through referrals from people themselves, their families, and also providers, medical providers that are serving them. So that's what the policies say. I'm going to turn it over to Amy and Jacob who are going to talk a little bit about real life.
Slide 24	Amy Stevenson – 00:35:35	Great. Thank you, Edith. Yes. So as the plan, once each month, we send an eligibility list. And with that, we are looking at the claims, the encounters, any supplemental information that we may have. We produce that eligibility list against the eligibility criteria for each of those populations of focus. And we send that out to our ECM providers each month. If a member is on that list, they can begin to outreach and enroll to any of those members at any time.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Amy Stevenson – 00:36:04	But we also know that we don't always have all of the information that we need here at the plan. And so therefore, we've also created what we call a reverse referral process, and that's where any provider, community health worker, any of our hospital systems, really there is no wrong door. If a member calls in and they feel they would benefit from this service, we have a way of taking that, we evaluate that based upon the standard criteria. And if a member meets the eligibility, we issue an authorization to approve that service for ECM. And at that point, the member can be enrolled into the services. So with that, I'll turn it over to Jacob to talk about it at CHCN.
Slide 24	Jacob Deme – 00:36:46	Yeah. This process of identifying eligible members really speaks to the importance of the collaborative work we do inter-departmentally within CHCN as well. Our data team, our data and analytics team, they receive the eligibility files from the health plans, and they're able to upload these members' information into the electronic health record. And we use EPIC throughout our county and across our eight health centers.
Slide 24	Jacob Deme – 00:37:10	The CHWs are then individually able to run an eligible report within the EHR. And they're able to see who they can outreach to and enroll if they're looking to, if they have space in their panel, and are looking to fill out that panel. And so they have all the information that they need in order to outreach to a member and begin enrollment with them.
Slide 24	Jacob Deme – 00:37:33	Additionally, since we did talk about referrals, both in and out from the health plans, we do have an internal system, a weekly rolling schedule that our CHWs are aware of so that we can submit referrals in a timely manner and update CHWs as we begin to learn that folks are eligible and able to be enrolled.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 24-25	Edith Stowe – 00:37:56	Thank you, Jacob. And we're getting some good questions in the Q and A, so please keep them coming. We're going to hope to have some questions for the panel at the end. Next slide please. So once somebody has been identified for ECM in the ways that were just described, there is an engagement step. So the state policies say very clearly that this is the responsibility of ECM providers normally rather than the health plan, so that this is as community-based as possible. And the state also says in its policies that outreach is so important that it's considered an ECM core service, and there needs to be payment for that core service from the plan to organizations like CHCN that are acting as ECM providers. So I'm going to turn this one over to Brenda and Amy again, who will describe real life. Brenda, are you there? Can I turn it to you?
Slide 25	Brenda Bautista – 00:39:04	Yes. Hi. So prior to CHWs meeting with patients, we do a pre-outreach assessment. And what that is, is that we look into the EHR and the community health record to see who's connected to the patient, what's going on medically with the patient, if there's any recent or past history of hospitalizations. We review that prior to meeting to the patient. Just to have an idea of what's going on.
Slide 25	Brenda Bautista – 00:39:39	And then from there, we do outreach to the patient. We can either do that by phone, we can do hospital visits, we can follow up in clinic during their primary care appointments. We also interact with the providers at the time of meeting with the patient, just to letting them know who we are, what we're doing. And then from there, it typically tends to take anywhere from three to four interactions, sometimes it may be less, sometimes it may be more, to fully engage with the patient for the patient to agree to receive services or even wanting to talk to us just because of having mistrust around the health system. From there, we do typically check in with our clinical staff, that can include a nurse from the clinic, an LCSW, and then we also have our team with Care Neighborhood.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Amy Stevenson – 00:40:47	Thanks. And then I'll talk about for the payments as related to the outreach. And so we at the Alliance recognize the tremendous effort, as Brenda mentioned, that it takes to get a member enrolled. And therefore, we have a tiered payment structure for outreach based upon the complexity. It's a tier-based off of pricing reimbursements, as well as the effort that's involved. So street outreach, we classify one way, then other face-to-face outreach differently. And finally, then other modalities such as phone, email, text, other ways to outreach to the member.
Slide 25	Amy Stevenson – 00:41:24	Several of those do require that be a successful outreach or what we call a bidirectional contact. Even if the member does not agree to enroll, but that there is a bidirectional contact. Others, we do not require it to be bidirectional such as by phone, and therefore, we do have a payment to reimburse at a different rate when they're unsuccessful at reaching a member.
Slide 26	Edith Stowe – 00:41:52	Thanks Amy. Next slide. Keep the questions coming. We're going to move on. All right, so when somebody has received some outreach to enter the ECM benefit, what's next? And the answer is some kind of assessment and care plan. So again, there are some state guardrails that the ECM lead care manager must develop, what's called a comprehensive assessment, and that should include of course, a person receiving ECM and their family, and providers that they see regularly. Importantly, the development of this care plan should be very comprehensive across all of the person's needs, whether that's healthcare or social needs. And that care plan needs to be regularly reviewed. So over to our panel. And I think back to Brenda, to describe how this looks.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 26	Brenda Bautista – 00:42:48	So once a member engages with a CHW, we do what's called a super visit. And what that super visit is, is questionnaire with questions about social determinants, family support, family, friend support, any other organizations that are connected to the member. We often look at mental health, any history of mental health, where they're connected to, where they're receiving services. We also do a PHQ-9 to assess, which is a depression screener. We talk about and look into any substance use, any history of substance use. And then we also talk about any specialist referrals by their primary care providers that they have been needing help getting connected to, or scheduling appointments. Based on that assessment that we do, we could either do it in clinic out the community where the patient feels comfortable, or even in their own home.
Slide 26	Brenda Bautista – 00:43:53	From that super visit, we create goals with a member depending on what they want to work on, what they feel is priority. From there, we create those goals with the patient. And then from there, they're inputted into the electronic health record. We often review with the patient whether it's weekly or as things change, the care plan does change depending on the need. We also do discuss it as needed with our care teams in-clinic, as well as with Care Neighborhood staff.
Slide 27	Edith Stowe – 00:44:34	Next slide, please. Then we get to what's called the enhanced coordination of care itself, the care management itself. Which DHCS understands can look very different for different members who have different needs. But at minimum, it needs to involve keeping track of different types of needs that the person has, making sure that information is shared across the care team, maintaining regular contact with the providers that are serving the member, providing support for care coordination, which could look a lot of different ways, communicating across the care team, and obviously checking in regularly with the member and perhaps the family themselves. So over to Melissa and Amy. Melissa first, I think.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 27	Melissa Ramirez... – 00:45:29	Thanks Edith. So in the Care Neighborhood program, the patient has an interdisciplinary care team that's based at their clinic, like Brenda and Aleida pointed to earlier. And as part of that team, the CHW is really considered the primary care coordinator. And new CHWs are trained and onboarded primarily by the Care Neighborhood central staff at the Community Health Center Network. And in some cases, also trained by a fellow community health worker at their home clinic. In addition to the clinic-
Slide 27	Melissa Ramirez... – 00:46:03	... or at their home clinic. In addition to the clinic-based team, the LCSW and RN at CHCN, they also provide clinical support. And that usually is at interdisciplinary team meetings, or on a one-on-one, or as needed basis. And the CHW provides care coordination by helping the patient navigate medical appointments, scheduling and transportation among many other things. In some cases, the CHW will also join the patient in their primary care or specialty appointments to help the patient better understand their health status and translate medical jargon. And this is a really important point because it helps to reinforce the patient's engagement to their healthcare.
Slide 27	Amy Stevenson – 00:46:52	And from the health plan standpoint, I see our role as being really the concierge service for our ECM providers. While they're out providing all this great care to our members, we want to be behind the scenes helping them out. So, if there are any challenges that they're facing navigating the system, getting an authorization approved, a DME item approved, we want to know about it so that we can really help get that through the system and approve. So we can really get the services that these particular members need.
Slide 28	Edith Stowe – 00:47:27	Next slide, please.
Slide 28	Edith Stowe – 00:47:30	Health promotion is so important that DHCS requires this in ECM. So that means really making sure that the care management that's provided encourages healthy lifestyle choices, healthy behaviors, building on successes, coaching, and things like addressing smoking or self-help, and something called motivational interviewing which Melissa and Amy will explain better than I can. So over to you, Melissa.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Melissa Ramirez... – 00:48:03	So our community health workers, they receive ongoing trainings throughout the year on various health topics, usually chronic health conditions like diabetes, heart disease, kidney disease, and many others. And the trainings are intended to prepare community health workers to provide health coaching to patients on developing and sustaining healthy behaviors. And that includes training on motivational interviewing, which we do annually to help keep our CHWs sharp on those skills. Our community health workers can also request home visits for their patients by the Care Neighborhood nurse, which in this case is me, for additional education and support. And home visits are commonly requested for support with things like diabetes management, medication management, or helping a patient better understand their diagnosis. A big part of our health promotion strategy is to help the patient feel empowered and capable of managing their health so that they feel motivated to stay connected to their primary and specialty care providers.
Slide 28	Edith Stowe – 00:49:16	Amy?
Slide 28	Amy Stevenson – 00:49:17	Right.
Slide 28	Amy Stevenson – 00:49:17	And at The Health Plan, we're really here with our health education team that we have available to help support our providers. And that's so we can help link them to the additional services that we might have available to them, additional education materials. Or for example, if CHCN has a member who needs something translated into particular language, it's not a threshold language for us, we're here to be able to support and get those resources to CHCN to assist our members.
Slide 29	Edith Stowe – 00:49:50	Next slide.
Slide 29	Edith Stowe – 00:49:54	Transitional care is all about when Medi-Cal Managed Care members are experiencing transitions typically between different treatment facilities. So, for example, they've had an inpatient stay. So ECM includes the concept that there should be careful management of those kind of transitions, including a transition plan.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Edith Stowe – 00:50:19	So again, over to Melissa.
Slide 29	Melissa Ramirez... – 00:50:22	So our program has its own transitional care procedure for when an enrolled patient is admitted to a hospital, skilled nursing facility, medical rehab, or really any other long-term healthcare facility. The community health workers are notified in real time through the health record when their patients are in the emergency room and/or if they're admitted to the hospital. And at the Community Health Center Network, the nurse, me, uses our internal data analytics system to compile a weekly list of enrolled patients who have recently been discharged from one of those facilities. So then the MDs at Community Health Center Network, they write up a brief overview of the patient's hospitalization and they make recommendations to the community health worker for follow up. And the overview is usually one to two paragraphs that have been distilled down from what is usually a multiple page discharge summary to give the CHW the main highlights. And then the CHW reviews and discusses the summary at the interdisciplinary team meetings.
Slide 29	Amy Stevenson – 00:51:43	Here in Alameda County, we have a great Community Health Record that was created by our partners in the county. And that really is beneficial for many of our ACM providers. Many of them are not as large as CHCN. They're small community- based organizations who may not even have access to a medical record system. And therefore, they rely on the Community Health Record. In the Community Health Record, they will find their members and they can create a watch list and be notified when that member is admitted into the hospital or emergency. They can then track and follow that patient and be able to outreach to that facility in order to help coordinate care for transitions of care as they discharge. And then also, again, our support here back as the plan, if for some reason, they're not able to get access to those medical records for that discharge summary, we, at the plan, have access to that, and would be able to provide that to them for follow up.
Slide 30	Edith Stowe – 00:52:45	Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Edith Stowe – 00:52:48	Member and family support really boil down to the concepts that people exist in context usually of their family, or other close friends, or neighbors even. And so ECM acknowledges this and requires that care managers who are working on ECM are a primary point of contact, but make sure that they're documenting what the family needs are. And even extend education about care not just to the person, but to their family.
Slide 30	Edith Stowe – 00:53:24	So over to Rene on this one.
Slide 30	Rene Soto – 00:53:28	So I'll speak a little bit about one key aspect of our program, and it's this patient-centered approach that we take especially within care planning. We use various techniques that we teach our CHW, such as interviewing, harm reduction, trauma-informed care, and cultural humility. In practice or on the field, what that may look like is a provider may refer a patient for services based on medication adherence. For example, they may not be taking their medication properly, and so they're referring this patient to you to try to improve health outcome.
Slide 30	Rene Soto – 00:54:07	But when we do our assessments, like Brenda mentioned earlier around the super visit, we get to know the patient situation and more in-depth details. And oftentimes actually financial stress and other stressors like housing, paying rent, food security, those may take priority in many cases. And so we would focus on those things first, what the patient prioritized, and then circle back to that medication adherence. And so that's what it may look like in practice and in care planning. And oftentimes, we are working with family members, not just the patients. We're working with their family members and helping them, so we'll need to make sure that, if needed, we have our Release of Information, ROI form, signed for patients and family members are involved with that patient care as well. Next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 31	Edith Stowe – 00:55:00	I'm going to talk now. The final component is coordination and referral. So ECM includes the concept that the ECM provider may not themselves be able to meet all the needs of the person extending beyond healthcare, but the role includes hand-off. And that can include the new community supports that Dana mentioned a few minutes ago.
Slide 31	Edith Stowe – 00:55:29	So I'm going to ask Rene to come back and explain a little bit about this, and then we'll turn it over to Amy.
Slide 31	Edith Stowe – 00:55:38	Oh, you're on mute, Rene.
Slide 31	Rene Soto – 00:55:40	Thank you.
Slide 31	Edith Stowe – 00:55:40	Here you go.
Slide 31	Rene Soto – 00:55:41	Absolutely.
Slide 31	Rene Soto – 00:55:42	So during CHWs training and onboarding, we give them access to a Google drive, which has a... It has a resource library as well as Care Neighborhood staff contact information. And in that resource library specifically, there's resources around housing, rent assistance, utility discount programs, food, transportation. So that will be one source that CHWs can use to find resources for patients. But oftentimes, CHW will be required to even do some research outside of that resource data bank for resources. And also, as Edith mentioned, the community supports' connecting patients to their health plan benefits. And some of those resources include transportation as well as assistance around housing. So we'll also help with that as well. And the way that may look like can be in-person, in clinic, over the phone, also via home visits for patients that have mobility issues or patients where transportation is an issue, we'll try to accommodate for that.
Slide 31	Rene Soto – 00:56:54	And before the pandemic, we used to do this more often, but we'd also do community visits and that's visiting patients at the resource. For example, if they're applying to SSI, going to the social administration office with them, walking them through that process to help them navigate those resources.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 31	Rene Soto – 00:57:13	And with that, I'll pass it over to Amy.
Slide 31	Amy Stevenson – 00:57:17	Thanks, Rene.
Slide 31	Amy Stevenson – 00:57:18	As I mentioned that Community Health Record, within there is also a resource directory called Elemeno that is maintained by Alameda County, that is available for all of our providers. At Alliance, we are also working towards and working with Aunt Bertha to create a closed loop referral system that will be coming in the future, working... We can't wait for that one to launch. We're very excited.
Slide 32	Edith Stowe – 00:57:44	Next slide, please.
Slide 32	Edith Stowe – 00:57:44	And Amy, can I invite you to continue a little bit to discuss these community supports that Dana introduced, and how Alameda Health Alliance is offering those?
Slide 32	Amy Stevenson – 00:57:57	Absolutely. Thank you, Edith.
Slide 32	Amy Stevenson – 00:57:59	So here at the Alliance, the community supports that are highlighted in bold are the services that we went live with in January of this year. Those are the ones that are available to all of our members as long as they qualify for those particular services. A member does not need to be in ECM in order to qualify for community supports. But we do make sure that our ECM providers are well versed in these services, what the criteria is, and how to make the referrals to those particular programs.
Slide 33	Edith Stowe – 00:58:37	Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 33	Edith Stowe – 00:58:40	We mentioned payment in the context of outreach, but we're getting a lot of questions already about payment in the chat. We're not going to talk about rates on this presentation, but we do want to lay out some information about how payment looks. So let's talk first about the DHCS guardrails. The rules of the road are that obviously managed care plans pay ECM providers for ECM, and they make a contract and negotiate that contract. DHCS does not set the rates. And DHCS encourages plans to come up with ways to tie these payments to value, so they could vary them based on outcome measures if they wanted to have a design like that. But really, as I said, the state does not micromanage or set these rates.
Slide 33	Edith Stowe – 00:59:34	So I'm going to turn it over to, I think, back to Amy to lay out, to a certain extent, I think minus the dollar amount, what the payment model is.
Slide 33	Amy Stevenson – 00:59:46	Okay. Thanks, Edith.
Slide 33	Amy Stevenson – 00:59:48	Yes. As we mentioned, we generate that eligibility list and we also take in those referrals. So any member that enrolls in ECM... So what I talked about with that pre-enrollment outreach tiering, that is different than this tiering, and the different payments. So there's two different payments that we do. One for pre-enrollment outreach. Then the other is after the member is enrolled, and the ongoing work for while the member is enrolled. And so we call that a Per Enrollee Per Month, so a PEPM is what we refer to as the payment amount. And within that, we tier that. We have tiered our eligibility between a high risk and a low risk. And with that are also tiered payments to reflect the amount of work that is required for working with those members.

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Slide 33	Amy Stevenson – 01:00:39	For example, a high tier person, a member who's enrolled, in order to receive the high tier rate, the provider needs to have four successful bidirectional encounters with that member per month. One of those encounters must be face-to-face. We're temporarily suspending that due to the public health emergency, but other forms of communication should be used during that time. And if they don't have the four encounters per month, they receive the low tier rate for that Per Enrollee Per Month payment rate. All of the other members are classified at a low tier rate, at a low payment rate... A lower payment rate, I should say. And that requires just one encounter per month of any modality that the member prefers.
Slide 33	Edith Stowe – 01:01:40	Thank you.
Slide 33	Edith Stowe – 01:01:43	Let's switch gears... Seeing a lot of questions, we'll come back to it. Let's switch gears to data sharing.
Slide 34	Edith Stowe – 01:01:50	Next slide, please.
Slide 34	Jyoti Tripathi – 01:01:55	Hi.
Slide 34	Edith Stowe – 01:01:56	Yeah, it's great. Jyoti, you're up. Thank you.
Slide 34	Jyoti Tripathi – 01:02:01	So here, this is the high-level view of data sharing between the health plans and the Community Health Center Network. The health plans share the monthly member information file with the list of eligible members, their demographics, their chronic illness indicators, homeless indicators, and their tier all sort of details that we need to connect with the patients. Then community health center data team treats this data and makes it EHR friendly and uploads it. Here, it becomes available for all the health centers, community health workers, providers, LCSW, and their care team. The care team takes action and work on eligible members, and take cares of their health needs, and help them, and document the whole process in the Epic EHR. Again, this CHCN data team post that data, and put it in a format that is defined by state, and make return transmission file, which is again the monthly submission. And sends it back to the health plan.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 34	Jyoti Tripathi – 01:03:47	Here, we complete the cycle of getting the eligible member list and enrolling them or outreaching them, and sending the data back to health plan with all the efforts, all the assessments, all the visits, and the clinic and the health center that has worked on that.
Slide 35	Jyoti Tripathi – 01:04:11	Next slide, please.
Slide 35	Jyoti Tripathi – 01:04:15	Here, we can see the whole process, which is very, very tedious. It took us years to implement this. And here, you see the difference in colors, the blue and the purple. The blue one indicates the process, which was previously in action, which is HHP WPC. And the purple one is the transition from HHP WPC to ECM. It's been a tedious and a complex journey for us, but we have achieved it. So yeah, here we go.
Slide 35	Edith Stowe – 01:05:02	Thank you.
Slide 35	Edith Stowe – 01:05:05	Let's keep moving, the questions continue to roll in.
Slide 36	Edith Stowe – 01:05:08	Next slide, please.
Slide 36	Edith Stowe – 01:05:12	We've had a number of questions about training for the workforce for ECM lead care managers. And you've heard that at CHCN, the lead care managers are community health workers. So I'm going to turn it over to Aleida to talk a little bit about how those individuals are trained... supported.
Slide 36	Aleida Kasir – 01:05:33	I'm going to actually bounce it over to Amy to kick us off, and then I'll do the other part.
Slide 36	Edith Stowe – 01:05:37	Great, okay.
Slide 36	Amy Stevenson – 01:05:38	Thanks, Aleida.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Amy Stevenson – 01:05:40	Here at the plan, we are creating a standardized onboarding for all of our new providers and any new hires. We'll give them the training of these core functions that we're reviewing today. We create a video library recording for folks to be able to view those and train for new staff as they come on board. We also host monthly learning collaboratives. This is something we've been doing actually since 2017. In order to continue ongoing training for our providers, we have various topics that our providers want to learn more about as , could be related to something technical, or something disease related, or soft skills training, endless training opportunities and topics come up for our learning collaboratives that we host each month.
Slide 36	Amy Stevenson – 01:06:28	With that, I'll turn it over to Aleida.
Slide 36	Aleida Kasir – 01:06:32	So this is one of my favorite topics. I think Care Neighborhood, one of the biggest reasons why we are successful is because of how much Community Health Center Network Care Neighborhood, invest in our CHW training. So just to be sure, I've been seeing a lot of questions about the acronym, CHW is community health worker, and then CN is Care Neighborhood. We provide extensive training. Rene is our lead trainer for CHWs. He actually was a former CHW at La Clinica prior to that. And then even before that, he was an EMT. He's been another health worker at a different location. He's got a lot of services in his back pocket. And Jacob, who is our operations supervisor, was also a community health worker at LifeLong. So we have quite a lot of legacy at CHCN to help support our CHWs. Some of the biggest reasons why I think that we're also successful in training our CHWs is that we lean on other CHWs within our program that have a lot of experience. I was seeing some questions about what size panels certain CHWs have. A very tenured panel would be somewhere between 35, sometimes up to 50. I don't think I've seen anybody over 50 patients on their panel. That's quite a lot of work. A brand new CHW that has no panel whatsoever, they're starting from scratch, roughly enrolls about four people per month for Care Neighborhood.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Aleida Kasir – 01:08:08	With that, if they're enrolling four people per month, they do at least five different shadowing events to review the assessments, to learn Epic, to learn all of the things that we need to do to create trust. That's probably the biggest part. There's one thing to learn Epic, there's another thing to learn our systems and protocols. But there's a whole other learning curve of how to talk to patients, build trust, get them reconnected with their providers. And as Brenda was mentioning, sometimes that takes more than three or four times, and could even take a year. And then, of course, your family after that.
Slide 36	Aleida Kasir – 01:08:47	We also have a lot of elbow support from me. I'm an LCSW. Melissa is a registered nurse. Dr. Miller and Dr. Do at CHCN are always pinged frequently to help us decipher some more medical education to escalate...
Slide 36	Aleida Kasir – 01:09:03	... for some more medical education to escalate some medical issues that we just don't know what to do. They've got personal cell phones that they can reach out to people in the community to gather more support. It's been very helpful.
Slide 36	Aleida Kasir – 01:09:14	So we also provide biweekly training for our CHWs. That includes motivational interviewing, trauma informed care, a lot of substance use education. Eventually, we'll be talking more about reintegration into the community for justice impacted folks. Of course, we'll be focusing on pediatrics. And then it's also medical education. How to manage diabetes? What does congestive heart failure really affect a person and their family? How can we support family members to support the patients that we're supporting? And then, of course, mandated reporter trainings, things like that too. And check-ins. We just do check-ins and Bright Spots with our CHWs. We want to make sure that they're feeling fulfilled, appreciated, and valued, and also get their questions answered.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Aleida Kasir – 01:10:02	<p>The ongoing all-day training that happens for our brand new CHW takes about roughly two weeks with Renee, and also with Melissa and with Jacob as well for operations. And then to get up to speed, it takes about eight months of training and support. So after eight months, we hope to see that CHWs will have about 30 patients on their panel at minimum. So it's quite a long time, a good investment. So we really hope that people are in it for the long run and stay longer than a year.</p>
Slide 36	Aleida Kasir – 01:10:37	<p>The biggest thing that I want to say is that when we support clinics to hire the community health workers, so CHCN is not the employer of CHWs. However, we do support clinics in the hiring. We really want to focus on a diverse community health worker workforce. So people that are from the communities that they're serving, definitely people that can speak the same languages of the people that are serving, if possible. People that have a range of qualifications. I was seeing a lot of questions come up, "Well, what are the qualifications of CHWs?" And that's really determined by each clinic.</p>
Slide 36	Aleida Kasir – 01:11:13	<p>We have some people that have a high school degree or associate degree. We have some folks that this is their first job out of college. And then we've got some folks that go on medical school. And of course, we have many people that have come through CHCN. So it really just depends on a person's lived experience is what we focus on. We don't really care if a person has gone to an Ivy League school. We want to care that they want to work with people and that they don't get tired of having a lot of back-to-back people interactions. They care about people's health. If they have been impacted in their families with some help disparities, that's always a plus. And yeah, like I mentioned, just focusing on a person's lived experience as opposed to their education that's being brought on, that's what makes us the richest type of CHW workforce. So we've got people that range from 25 years old, I don't know what the oldest CHW we have, probably 55 years old. And I encourage everybody to look into that. That's what makes us really successful.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Edith Stowe – 01:12:17	Aleida, can you talk about your recruiting strategy? What's the pipeline look like?
Slide 36	Aleida Kasir – 01:12:22	Yeah. A lot of our pipeline comes from within the clinic, I would say. So there are some clinics that have programs, like La Clinica has Promotores that are unpaid, volunteer, basically community health workers that maybe working on like Green Card or in transit with their papers, and then once they get their papers, for example, they can get hired on. We, of course, reach out to all of our other resources in the community and just let them know that we're hiring as well. And then friends and family.
Slide 36	Edith Stowe – 01:13:04	Great. Next slide please. I'm going to invite Dr. O'Brien-
Slide 37	Steve O'Brien – 01:13:11	Thank you.
Slide 37	Edith Stowe – 01:13:11	... to just zoom out a little bit, talk about the entire county and the network.
Slide 37	Steve O'Brien – 01:13:18	Awesome. As you could see from the presentation, Care Neighborhood from CHCN is an extremely robust and outstanding program. It's been developed by our CHCN partners, but in partnership with accounting and partnership with the plan. Not all of our ECM providers are quite as robust, but we do serve a diverse population across the county so we have other medical clinics.
Slide 37	Steve O'Brien – 01:13:42	In this chart, you can see on the left are the populations of focus, above the red line are the ones that are live now. And you can see CHCN has members from all three of the currently live populations of focus. The other medical clinics, as described by Dr. Miller earlier, throughout the county, also see high utilizers and homeless patients. We have community-based organizations, also, housing organization, and organization that works with disabled people. And those are going to become increasingly important as we look to additional populations of focus coming up.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 37	Steve O'Brien – 01:14:20	We're just about ready to go live July 1st with the County SMI Program, Alameda County Behavioral Health. Again, that's going to be a key focus for us for SMI, although we have other ECM providers who also see SMI. And then we work with the county safety net, the county health system to see they're a significant ECM provider also. As we look to January, when we're going to take on those at risk for institutionalization, those transitioning out of long-term care, want to transition out of long-term care, we're looking at community-based organizations. We're also looking at [inaudible 01:14:56] center. I think that was a question earlier. That's definitely where they may come into if they're interested in being an ECM provider. Also looking at them for some of the community support activities that may come down the road.
Slide 37	Steve O'Brien – 01:15:08	For the high risk children that are going to be coming in July of '23, we're looking on having conversations with CCS, with our children's hospital, absolutely the regional center, which is a key, key partner, not only for these high risk children coming to ECM in July of '23, but also for those of us looking at taking in intermediate care facilities when that goes live. And then finally the reentry population, whenever that comes, that's a whole new group of community-based organizations and talk about having to be centered in the community. We're really looking to partner with those who are key players and key partners in that very robust and important area. Next?
Slide 38	Edith Stowe – 01:15:52	Thank you. Next and final slide. I'm going to ask, first, Amy, and then Dr. Miller to sort of sum us up. What would you say about what's exciting and what's difficult? And perhaps also say, what would you just say to your counterparts in other counties that are going live with ECM in the second half of this year, but perhaps haven't done it before? So I'll start with Amy.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 38	Amy Stevenson – 01:16:19	Oh, great. Thank you, Edith. For me, the excitement comes from really being able to create a different way of engaging with our members, really reaching them where they're at, partnering more with our community partners like CHCN in order to be able to extend our reach and serve our members, and being able to really focus on those social determinants of health, those drivers that are really impacting people's health. Things that we've never been able to do before as a health plan. So that's very exciting.
Slide 38	Amy Stevenson – 01:16:49	Challenges wise, I would say, as Dr. O'Brien mentioned, we have a very diverse population of our providers, and many are not as a robust and have an Epic EHR system and things like that. So I'd say, from the plan standpoint, there is more planning, more time, more support, more training that we need to provide to support our community-based organizations in order to help them stand up. Many of them have never lived in the insurance world before, so it's a whole new ball of wax and a whole bunch of alphabet soup they need to learn. So we really try to help support them with technical support, as well as additional training and onboarding to really make sure that they can stand up a successful program.
Slide 38	Amy Stevenson – 01:17:39	Turn that to Dr. Miller.
Slide 38	Dr. Laura Miller – 01:17:41	Thanks. And I think for me, the excitement is around really helping people get care. Our systems are really fractured, and it takes a helper to navigate through, especially when the folks who are in ECM are really dealing with many, many complicated medical and really life challenges. So I think just being able to coordinate that care is really, really exciting. We've seen really good outcomes in terms of decreasing admissions, decreasing ER. It is what needs to happen. Having done primary care for 20 plus years, this is what has needed to happen for a very long time.
Slide 38	Dr. Laura Miller – 01:18:31	I think one of the challenges that we've worked on for a long time is supporting CHWs as they navigate the hierarchy. Medicine is very hierarchical, and we need to really support CHWs as they are incredibly important actors and advocates for their patients, but that can be a complicated nuanced situation.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 38	Dr. Laura Miller – 01:18:57	And I do think that there was a question in the chat about, "What do you do when you don't have resources to give?" And that's really challenging. So for instance, like everywhere, we have a housing crisis. What do we do if somebody's main challenge is housing and we don't have it? And I think that those are big challenges to work on. And I think it boils that boils down in some ways to relationship as well. We may not have a house, but we will walk the road with you as we try to work the system to get you housing. And it's good work. And it's an honor to do it with everybody.
Slide 38	Edith Stowe – 01:19:36	I'd love to follow-up with, what would you say to providers who are probably listening now in other counties who might be starting this for the first time?
Slide 38	Dr. Laura Miller – 01:19:46	You know what? Work it through. It is a long process. I think that basing yourself on those elements that we walked through is really important. Tailoring it to your community, talk to your target audience, your patients, what do they need? And that will help you, in turn, tailor the program as you match it to the outlined elements that are required. And just keep at it. We've been iterating and reiterating over many years, and we're happy to share anything we've developed. We're super happy to share it. And then you'll have to adjust it to where you are. But yeah, keep on keeping on.
Slide 39	Edith Stowe – 01:20:42	So we have about nine minutes, and we have just, I want to say, an explosion of excellent questions in the chat. A very good question, which I think I'll send your way, Dr. Miller, first, and Amy might want to chime in is, what are the criteria for discharge? How do we know when somebody doesn't need ECM anymore?
Slide 39	Dr. Laura Miller – 01:21:09	It's a good question. There are definitely criteria that have been put out by the plan, but at its core, it's like, have we reached all the goals? That patient centered care plan that's developed, have we done everything? And when we have, then that's certainly time for discharge. On the less rosy side, there are folks who really don't engage, and they may have enrolled, and then it just sort of fades away. It's hard to know when to call it on those. But yes, there are criteria. And Amy-
Slide 39	Edith Stowe – 01:21:51	Somebody actually had-

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Dr. Laura Miller – 01:21:51	... you can probably-
Slide 39	Edith Stowe – 01:21:52	Something actually had... Yeah. Why don't we turn to that over-
Slide 39	Dr. Laura Miller – 01:21:54	Amy could probably be more specific.
Slide 39	Edith Stowe – 01:21:57	Yeah.
Slide 39	Dr. Laura Miller – 01:21:57	Great.
Slide 39	Edith Stowe – 01:21:57	Maybe put a finer point on that question because people have specifically asked that, "What if somebody becomes unreachable? What are the rules around that about disinvolvement?"
Slide 39	Amy Stevenson – 01:22:07	We do. Yeah, it's a great question. Because we did struggle with that as a plan. We also partnered, and we do partner closely with our sister plan Anthem, because many of our providers are contracted under both providers. So where we can, we do try to have some similar processes. And in this case, we are using a similar discontinuation criterion, and it is, as Dr. Miller said, looking at all of these core things. If it came up in the care plan, did they achieve it or not? Did it change where we're at, at this point? Could this be transitioned to maybe our telephonic case management at this point to step them down? Maybe they're not quite ready to totally leave case management, but maybe they need a lower level at this point, and that might be another option that's available.
Slide 39	Amy Stevenson – 01:22:49	As far as the non-responsiveness, we do have it written into our policies that if a member is unresponsive for 90 consecutive days, the ECM provider can disenroll the member for lack of contact. And we leave that though at the discretion of the provider, we the plan never disenroll anyone. We want to make sure that the provider has all exhausted, what they feel, all efforts in order to reach that member.
Slide 39	Edith Stowe – 01:23:25	Yeah. We had a question for Dr. Miller, perhaps your team. You talked about Epic for your EHR. What is the system of record for the care manager for the community health workers? What are they entering information into?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Dr. Laura Miller – 01:23:40	Yes, it's actually within Epic. We worked with OCHIN Epic, which is our vendor for Epic, to develop a care neighborhood module within Healthy Planet that has all of our assessments, our goals. That's where I, as the MD, write in my transition of care summary. So it's all within Epic. And I think that, to me, feels like Nirvana, in that the CHW and the PCP and the BH provider, behavioral health provider, they're all on the same record, and they can see what each other is doing. So we initially had a stand alongside program that the CHWs were in, and it didn't marry with our electronic health record at the time. So when our health centers went to Epic, we really wanted to try to integrate that. And we did. So we use Epic's Healthy Planet with our own custom module.
Slide 39	Edith Stowe – 01:24:44	And folks in the chat are curious, do you serve only patients of the CHCN FQHCs, or do you also serve people who have different or independent primary care doctors?
Slide 39	Dr. Laura Miller – 01:25:00	CHCN do not. That's where, actually, Amy and the Alliance can answer well. So for the other primary care docs, providers, within our county, if they're with Alliance, they would access via Alliance.
Slide 39	Edith Stowe – 01:25:22	Several questions about in-person contact and what that looks like during COVID. At least one question about hospital visits. Are they allowed? Perhaps that's changing. What about home visits? How are you managing all of that in the pandemic and deciding when to do it, when to hang back?
Slide 39	Dr. Laura Miller – 01:25:43	I think that question can be really beautifully answered by Melissa and Brenda. Melissa, do you want to start?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Melissa Ramirez... – 01:25:51	Yes, I can hop in. So in the pandemic we have left it up to two things, the policies of the health center to which the CHW belongs, because that is their primary employer so they'll have to follow those policies first and foremost. And then beyond that, if the policies of that health center do allow for the CHW to do home visits, then we leave it up to the comfort level of the CHW themselves. So at this point, I think it's sort of been mixed, but I think in the last year, I want to say, we've had a big return back to home visits. Me because I'm employed by CHCN, I've been given full access to doing hospital visits and home visits. And my personal comfort level is okay with that. So I also try to step in, especially for those CHWs who don't feel as able to go out in the community, I try to be that point of contact for the patients.
Slide 39	Edith Stowe – 01:26:58	Melissa, what do you find about preferences of your clients and members themselves around home visits? Is it very popular to receive a home visit?
Slide 39	Melissa Ramirez... – 01:27:08	Yes, actually. I think it is pretty popular for a couple of reasons. And I think one of the big ones is just transportation, because that's such a huge barrier that comes up to accessing healthcare. And a lot of our patients have so many comorbidities and multiple specialists that they see, so they're running back and forth to appointments all the time. So when we offer the opportunity to just meet them in their home, they usually really appreciated it.
Slide 39	Edith Stowe – 01:27:46	So got a couple of questions about dental and oral health. So for somebody on your side, Dr. Miller, how do the community health workers assess for that and connect to oral health?
Slide 39	Dr. Laura Miller – 01:28:01	We are lucky that there are dental services in all of our health centers. So when the need arises, that's a relatively easy linkage for dental care. I saw a question in the chat about the need for general anesthesia. Again, that would be dentist in the health center identifies the need. It actually gets authorized at our level. But for our FQs, it's relatively smooth for dental care.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Edith Stowe – 01:28:33	Do one more, nearly at time. Assessments, we talked about assessments. How long does that take? Is it a one and done at one appointment, or is it a longer process? Dr. Miller, who you'd want to answer that one?
Slide 39	Dr. Laura Miller – 01:29:06	I think Brenda would be an awesome person to answer that.
Slide 39	Brenda Bautista – 01:29:10	So for the super visit, it can vary depending on patient and their comfort of what they want to talk about. For the most part, we can finish it within an hour. Normally, home visits are scheduled within an hour, and we normally typically get that done within the hour. However, there are some patients where there's a lot going on, and we can't. Or there are physical limitations where the patient can't sit for an hour and talk to us for an hour. So we often can divide that in different days, or just anything that the patient is needing. So it all depends on the patient, but yes, we can definitely accommodate multiple days in completing the assessment.
Slide 39	Edith Stowe – 01:29:59	Thanks so much, Brenda. And here we are at the top of the hour, there are a lot of great questions. So I can see, think people are needing to run at the end of the hour. But many, many thanks to this panel for just unpacking the model with such thoroughness. I think we learned a lot. I certainly did. Thanks everybody so much. Bye-bye.
Slide 39	Mario – 01:30:28	Thank you for joining. You may now dis-