

CalAIM ECM Webinar: ECM and CS in Rural California

June 14, 2022

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Julian – 00:00:11	Hello and welcome. My name is Julian, and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q&A. We encourage you to submit written questions at any time using the Q&A during today's event. Live close captioning will be available in English and Spanish. You can find the link in the Chat field.
Slide 1	Julian – 00:00:39	With that, I'd like to introduce Dana Durham, chief of managed care, quality and monitoring division at DHCS. Dana, you now have the floor.
Slide 2	Dana Durham – 00:00:49	Thank you so much, Julian. We're really excited to have you here today. As we talk about ECM and rural communities.
Slide 2	Dana Durham – 00:00:57	Do want to start off by reminding you, or if you haven't heard, we're preparing for the unwinding of the public health emergency, because we do know that the public health emergency will end soon. And if we're not careful, millions of Medi-Cal beneficiaries could lose their coverage. So, our goal as a department is to minimize beneficiary burden and promote continuity of coverage for our beneficiaries.
Slide 2	Dana Durham – 00:01:28	So, how can you help? Well, we want you to become a DHCS coverage ambassador. And to become one, just download the Outreach Toolkit on the DHCS Coverage Ambassador webpage, and join our coverage ambassador mailing list. And that'll give you update to the tool kit as become available, and let you know more information that we have as it becomes available. Next slide, please.
Slide 3	Dana Durham – 00:01:59	We also have two phases to this campaign. The first phase really is starting right now. So, if you know anyone who is a beneficiary of Medi-Cal really let them know that they need to update their contact information with our county offices. There are flyers that you can find in that toolkit, and we do want those flyers spread as wide as possible. And the goal of it is just to make sure that we have up- to-date information on every beneficiary, and can make sure that their renewal of their Medi-Cal is seamless. And with talking about renewal, we do expect renewal packets to come in the mail.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 3-4	Dana Durham – 00:02:45	Once again, update contact information. I can't say that enough. It is the important point of these slides. The renewal packets phase will launch 60 days prior to the termination of the public health emergency. And as we head there, remind beneficiaries to watch for the packets in the mail, and update their contact information. And that really is the goal of those ambassadors. And we'd love for you to become one, or at least stay engaged with the process because it is so important that those we serve continue to have coverage if they're eligible and receive it. Next slide, please. With that, I want to quickly go over today's agenda. We're going to have a really great session, really talking about Enhanced Care Management and Community Supports for providers, and other stakeholders in rural areas. There are some things that are different about rural areas. And so, we want to make sure that we're able to talk about that answer questions and really have a dialogue. So, we'll start with an overview of CalAIM. Then, we'll talk about Enhanced Care Management and Community Supports, and what they are overall. Then, we'll go into the roles and responsibilities of the plans, the ECM providers, and community support providers.
Slide 4	Dana Durham – 00:04:14	And then, we are just so excited to have the Hill Country Community Clinic, which is in Shasta, who's going to talk about their experience, and really talk through some things that have been easy. Some things that have been harder. And some learnings that they've had overall. We'll have a question and answer after that, and then we'll finish up. Next slide, please. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Dana Durham – 00:04:41	<p>So CalAIM, or California Advancing and Innovating Medi-Cal, is a long-term commitment to really transform, and strengthen medical overall. And what we want to make sure happens is that Californians have an equitable, coordinated, and person-centered approach to how their health is managed, and worked with as they lead their management of their health to ensure that they have the best life trajectory. So, the goals of CalAIM are many, but three I want to highlight are that it's to implement a whole-person care approach and address those social drivers of health. By social drivers of health, what I mean is the components of our daily living that really impact how we're able to stay healthy, or things that may make it more difficult to stay healthy.</p>
Slide 6	Dana Durham – 00:05:41	<p>We also want to improve quality outcomes and reduce health disparities, and transform the delivery system overall. That really is creating pathways, which make the system easier for everyone to access. And so, that their quality outcomes for all who are recipients of Medi-Cal. And then, finally, create a consistent, efficient and seamless Medi-Cal system. And part of that is whatever part of the state you're in your Medi-Cal experience should be the same. And so, the goal of that is to make it that if you move to a different county, or move to a different plan that your benefits are the same and, basically, that you interact with the system in a similar way. So, you don't have things that are unexpected, or you have to learn as you change. With that, can you go to the next slide please?</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Dana Durham – 00:06:39	So we're pretty early in our journey for CalAIM. We began on January 1st, so we're just over six months in of this year. And we've launched with Enhanced Care Management and Community Supports. And some of the things that Enhanced Care Management and Community Supports are designed to address in California is members who typically have really complex health conditions. Some other things that happen in California that we're really trying to kind of address are that we have a lot of Californians who are food insecure, and they don't know where their next meal is coming from. So, about 20% of Californians live in that world. And we want to make sure that we at least have some awareness of who those individuals are, because your insecurity with food does impact your health, and help you navigate that in various ways.
Slide 7	Dana Durham – 00:07:43	Members with complex needs must often engage in several different delivery systems and it's hard to navigate those systems. So, we want someone who can help if you've got those complex needs and are working through all those systems, help you get to where you need to get to and help you know how to navigate the system. And then, also we have people who are experiencing homelessness. And those individuals tend to have higher rates of diabetes, hypertension, HIV, and mortality. And so as I talked about, those are the social drivers of health that really kind of impact how healthy someone can really live. And I also want to note that more than 65% of our members are from communities of color, and really addressing those social situations, as well as disparities, really we feel like will help us be more accessible and a better system to really help all Californians. Next slide, please.
Slide 9	Dana Durham – 00:08:53	With that, we're going to go through Enhanced Care Management, explain to you what that is, and community support. And so I will turn it over to Adrienne McGreevy who will explain Enhanced Care Management.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 9	Adrienne McGreevy – 00:09:08	Hi, my name is Adrienne McGreevy. I am a health program specialist under Dana, and I'm currently overseeing the implementation of ECM. And here to talk about it with you today. So, we want to give you the fundamentals of ECM, familiarize you with the program, make you feel comfortable in potentially becoming an ECM provider.
Slide 9	Adrienne McGreevy – 00:09:31	So, what is ECM? ECM is a new Medi-Cal benefit to support comprehensive care management for members with the highest need, complex needs, and are often engaged in several of our managed care delivery systems, including dental, mental health. They also need long-term services and supports sometimes, or specialty care. So, ECM is designed to address not only clinical, but non-clinical needs of those highest need members through intensive coordination of health, and health related services, meeting members wherever they are. And that is a real key element of ECM is in person contact with members on the street, in a shelter, in their doctor's office, or at home, meeting them where they are.
Slide 9	Adrienne McGreevy – 00:10:29	You may not know, ECM is also a part of a broader CalAIM Population Health Management system design, which MPCs will offer manage care management interventions at different levels of intensity based on member need, with ECM being the highest intensity level. So, next slide please.
Slide 10	Adrienne McGreevy – 00:10:51	So, as you can see here, are three levels of care and Basic Population Health Management is the basic case management that all members receive in a managed care plan. And this includes health and wellness programs, this includes preventative services, and primary care services. And so, DHCS has specific requirements on what we expect for basic population health management. A step up from that is Complex Care Management. And this is intended for high-risk members who need coordination of services for a complex condition, or a temporary episodic need such as surgery.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Adrienne McGreevy – 00:11:38	And then, of course, what we are talking about today, Enhanced Care Management was intended for the highest risk, highest acuity members who need long-term coordination for multiple chronic conditions, social determinant of health issues, and utilization of multiple service types, and delivery systems. Next slide, please. So, who is eligible for ECM and how does it work? ECM is available to manage care plan members who meet seven different populations of focus criteria, which we will look at the populations of focus a little later on. But eligible members can be identified through their managed care plan, through their provider, through family or caregiver, community based organizations, or even through self-referral. And once the MPC, or the managed care plan determines that the individual meets a population of focus criteria, they are then assigned to an ECM provider who best meets their needs. And we will be talking about provider types later on. And you'll see that some providers have specialty focuses, but all providers will be providing certain services we'll discuss in the next slide. But the ECM provider makes sure that the member has a single lead care manager who coordinates their care and services across the Medi-Cal delivery systems beyond. Next slide, please.
Slide 12	Adrienne McGreevy – 00:13:12	So here is the core services that all ECM providers must provide no matter where they are located, or what population of focus they serve. So, what's included in ECM? Outreach and engagement. This is meeting the member where they are. Comprehensive assessment and care management planning, coordination of, and referral to community supports and services, enhanced coordination of care, member and family supports health promotion, and comprehensive transitional care for those times that members transition between one level of care to another. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Adrienne McGreevy – 00:13:59	<p>So, where are we at? Populations of focus and go-live timing? So on the left, you'll see are six populations of focus. And on the right-hand side, the go-live timing. And as you can see, as of January 2022, whole-person care counties and HHP counties went live with the first three populations of focus: individuals experiencing homelessness, high utilizers, and those with serious mental illness, or substance use disorder. If you don't know what whole-person care pilots are, or Health Homes Program was please visit DHCS's website and look at those programs because they really are tying into, and we have transitioned a lot of the people who were in those pilots into ECM, which is why those counties implemented first. Coming up in July 2022 all the other counties will be implementing the first three populations of focus. Come January 2023, we will have the long-term care populations of focus going live. Those are the at-risk for institutionalization and are eligible for long-term care. And then, those nursing facility residents transitioning to the community. And last but not least the children/youth population of focus will be going live in July 2023. Now, I know I said that there were seven populations of focus and there are because there is additionally an incarceration transition to the community population of focus that will go live in alignment with pre-release medical health services. And that was DHS's intent all along to align those implementations. And so, we currently do not have the timing for that as we are awaiting CMS approval of our [inaudible 00:16:09]. Next slide, please.</p>

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Slide 14	Adrienne McGreevy – 00:16:13	So, to kind of give you a picture of where it is ECM is live today. As you can see the rural whole-person county and HHP counties are in dark blue. On January 1st, it was 25 of those counties that had previously participated in those two programs. Approximately 95,000 medical members were eligible for and automatically already transitioned in ECM in January from those previous programs as I had mentioned. Since January new ECM members have begun to be served in these counties who are, of course, those top three populations of focus I previously mentioned, which is the high utilizers, those experiencing homelessness, and adults with serious mental illness, such substance abuse disorder. Next slide, please.
Slide 15	Adrienne McGreevy – 00:17:09	So, where are we're going from there? As I previously mentioned, starting on July 1st, we'll go live for all the other counties. As you'll see the ones in purple and the ones in dark purple are the rural counties. So, you still have a chance to become an ECM provider, and participate in our implementation upcoming, and we encourage you to do so. And, as I previously said, January 1 we'll be extending statewide to long-term care. And then, in July 2023 to the children/youth populations of focus. Next slide, please.
Slide 16	Adrienne McGreevy – 00:17:52	Okay so, now I will be handing it over to the staff services manager, Michelle Wong.
Slide 16	Michelle Wong – 00:18:00	Thanks Adrienne.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Michelle Wong – 00:18:01	So, now let's look at community supports. So community supports provide the opportunity to address those combined medical and social drivers of health needs that Dana talked about earlier, as well as to help avoid those higher levels of care and those associated higher costs. So, these are medically appropriate and cost effective services, or settings that are provided in lieu of, or as a substitute for more costly services, or settings such as hospital stays, skilled nursing facility stays, delayed discharges and emergency department use. So, Community Supports are strongly encouraged, but not required for Managed Care Plans to implement. And it's important to note that these are not plan benefits. Community supports are both optional for the Managed Care Plans to offer and optional for the members to receive.
Slide 16	Michelle Wong – 00:18:47	I do want to note that as of upcoming on July 1st Community Supports will be implemented by Managed Care Plans across the entire state. And so, as I mentioned also, that they are medically appropriate, and cost effective for the members. Implementation of Community Supports initially began on January 1st, 2022, along with the implementation of ECM. And with that, we can go to the next slide.
Slide 17	Michelle Wong – 00:19:16	And there are currently 14 pre-approved Community Supports as shown here that MCPs can select from, to offer in the counties where they operate, which include housing related services, such as housing transition, housing deposits, and tenancy services, as well as community transition services, medically tailored meals, and asthma remediation. Just to name some of the 14. Additional information about the Community Supports that are offered by MCPs in each county can also be found on our DHCS website. Next slide, please.
Slide 19	Michelle Wong – 00:19:54	Thank you so much. So now we're going to go over the roles and responsibilities of MCPs, Managed Care Plans, the Community Supports providers and the ECM providers. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Michelle Wong – 00:20:07	Or sorry, actually, you can go back. Sorry. So Managed Care Plans contract with ECM providers, community support providers, and ECM and community support providers. These are intended to be those community based providers who are contracted to provide these services. Okay, you can get to the next slide.
Slide 20	Michelle Wong – 00:20:28	So, MCPs are responsible for establishing the provider networks to deliver ECM and elected community supports. They also negotiate the rates with their ECM providers. We do want to note that DHCS does not provide the rates for ECM.
Slide 20	Michelle Wong – 00:20:48	Sorry, my computer froze. Sorry about that. And then, in addition, Managed Care Plans authorize the ECM and Community Supports for members, and assign the members to ECM and Community Supports providers. They also oversee and monitor the ECM and Community Supports delivery, or service delivery, and provide training to ECM and community support providers. And Managed Care Plans were required to submit a model of care for their ECM and Community Supports that they elected to offer, which provides all the information for how they're going to authorize EMC, and the Community Supports, assign members, oversee and monitor service delivery, as well as provide training for their providers. So, just to note, that counties that go live on July 1st, the MCPs have already filed their model of cares with DHCS, and now are actively contracting with providers.
Slide 21	Michelle Wong – 00:21:46	Next slide, please. And I will pass it back to Adrienne and [inaudible 00:21:52] who will go over ECM provider and Community Supports provider roles and responsibilities.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Adrienne McGreevy – 00:21:57	Thank you, Michelle. Back to ECM providers, we want to give you an overview of kind of what's expected of ECM providers, if you become one. So, just to kind of go over, ECM providers are community-based entities with experience, and expertise in providing culturally appropriate intensive in-person timely care management services to individuals they will serve. And that community-based element is the core of ECM in order to familiarize, and make the member feel more comfortable, build that relationship to be able to provide care management services to the individual.
Slide 21	Adrienne McGreevy – 00:22:43	So, ECM providers will assign each member a lead care manager, once they are enrolled, who's responsible for meeting with the members in-person, forming that trusting relationship, and coordinating care across medical, behavioral, and social service systems. ECM providers will be contracting with...
Slide 21	Adrienne McGreevy – 00:23:03	Stems. ECM providers will be contracting with their local medical managed care plans as ECM providers and will negotiate those rates. And another kind of qualification for ECM providers is they must be able to submit claims to MPCs or use the DHCS invoicing template. And we are aware that a lot of community-based organizations are not familiar with medical billing at all. DHCS has created an invoicing template to make the process easier for community based organizations who are new to me health. So they made bill MPCs if unable to submit claims and must have a documentation system for care management. Next slide please.

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Slide 22	Adrienne McGreevy – 00:23:51	So who are ECM providers? So this is the array I referred to earlier. So in addition to rural health clinics and Indian health programs and other community clinics that often serve members in rural California, Medi-Cal managed care plans may choose to contract with a wide range of provider types. And as you can see here, this is where the managed care plans refers to ECM providers that best fit the need of their members. So you're looking at county behavioral health plans, substance use disorder treatment providers, organizations serving individuals experiencing homelessness or justice-involved individuals. So there is a very wide array of ECM providers in order to meet members where they're at. Next slide, please.
Slide 23	Adrienne McGreevy – 00:24:51	So ECM provider capacity consideration. So in all truth, part of the reason we are here today is of course to encourage rural providers who have the capacity to provide the core ECM services to contract with their local managed care plans. So as established in the ECM and community supports contract template, MPCs must ensure sufficient ECM provider capacity to meet the needs of all ECM Populations of Focus, which is more difficult in rural areas, and which DHCS acknowledges. If the MPC is unable to meet the needs of ECM, Populations of Focus through contracts with community-based ECM enhanced care management providers, MPCs may submit a written request to DHCS for exception that authorizes the plan to use plan-based staff for ECM. And with those exceptions, we expect plans to still build their local capacity through incentive programs that will be mentioned later on, I think. If not, then go to the DHCS website. Next slide, please.

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Slide 24	Adrienne McGreevy – 00:26:11	<p>Oh, and the potential of telehealth in ECM in rural areas. And so this is acknowledging the difficulty of serving all ECM populations in rural counties. Because ECM is envisioned as a high-touch, in-person care management program, DHCS has considered how to serve this population. And our policy mirrors the guidance that was issued in January to minimize the risk of the spread of COVID, MPCs and their contracted ECM providers have been able to use telephonic or video calls to substitute for face-to-face AMC services. So, as such, DHCS is transitioning this policy as well in rural counties, where there may be challenges to support rural members with in-person care management, encouraging telephonic and video calls that may also be temporarily used. And next slide please. And now I will pass it on to the section manager for community supports, Neha [inaudible 00:27:30].</p>
Slide 25	Dana Durham – 00:27:31	<p>Thanks so much, Adrienne. So what our community supports providers, their organizations already deliver critical social services, including housing navigation, recuperative care, medically-tailored meals or community transitions. They contract with Medi-Cal MCPs and Community Supports Providers and negotiate rates. DHCS has published the pricing guidance, which can also be found on our DHCS website for the community supports to assist these organizations traditionally that have not contracted with Medi-Cal MCPs. And also noting that Community Supports is bringing change to what MCPs networks look like. They receive referrals from ECM and other providers, health plans or requests from individuals and families. Community support providers are either to submit 837 claims to MCPs or use a DHCS invoicing template to bill MCPs if they're unable to submit those claims. They must have experience and expertise in the provision of the services being offered and have a history of serving medical members in a community based manner. They must also have the capacity to provide culturally appropriate and timely in-person care management activities, and be able to communicate to the member in appropriate and accessible ways. Next slide please.</p>

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Slide 26	Dana Durham – 00:28:50	So who are Community Supports Providers? Community-based organizations, such as life skills training and education providers, home health and respite agencies, home-delivered meals, providers, affordable housing and supportive housing providers, and sober centers, as well as local governmental entities, such as social services agencies, counties, and local public health jurisdictions. Next slide please.
Slide 27	Dana Durham – 00:29:19	So regarding the Medicaid enrollment and vetting requirements, providers are required to be Medicaid-enrolled where a State-level enrollment pathway exists, as is required by federal law. And if no State-level Medicaid enrollment pathway exists, MCPs must vet the qualifications of the providers according to their DHCS approved policies and procedures. Next slide, please.
Slide 28	Dana Durham – 00:29:43	In order to support the successful launch of CalAIM, the department has implemented two incentive funding programs. So the incentive payment program referred to, IPP, which is incentive payment program, is intended to support the implementation and expansion of ECM and community Supports by incentivizing MCPs to drive the delivery system investments and provider capacity and delivery system infrastructure bridge, bridge the existing silos across physical and behavioral health care delivery, reduce health disparities and promote health equality, and achieve improvements in quality performance, and encourage the take-up of community supports. There is \$1.5 billion currently allocated for the incentive payments to MCPs. Next slide, please.
Slide 29	Dana Durham – 00:30:32	The other program is known as Providing Access and Transforming Health or PATH. As a part of the section 1115 waiver, demonstration renewal, PATH provides funding to maintain, build and scale the infrastructure and capacity needed to ensure successful implementation of ECM and Community Supports. More information on path can be found on our DHCS website. And I'll pause there and go ahead and give it back to Edith.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 30-31	Edith Coakley-Stowe – 00:31:06	My name is Edith Coakley-Stowe. I'm with Manatt Health working very closely with the DHCS team. Next slide, please. I am very happy to now introduce our two speakers for today who are going to talk to you about their experiences so far implementing ECM in a rural environment. They are from Hill Country Health and Wellness Center in Shasta, and they are Renee Brissey and Julie Jones. So Renee and Julie, over to you.
Slide 32	Michelle Wong – 00:31:45	Hello, everyone. Hill Country is really excited to be able to talk about our experiences with both whole person care and enhanced care management. So thank you very much for inviting us here today. I have over 18 years of experience working with individuals with complex needs. I am a licensed clinical social worker and also a licensed SUD counselor and have a lot of experience treating individuals with addiction and co-occurring mental health issues. One of the focuses of Hill Country that I'm really excited about is how we integrate substance use services within a primary care setting. And what this allows us to do is to reduce the stigma that's attached to substance use and start to look at addiction and substance use as another chronic condition that impacts health.
Slide 32	Julie Jones – 00:32:47	Hi everybody. I am also really excited to be here. My name is Julie Jones and I am the Director of Integrated Operations here at Hill Country. And I have around 20 years of experience in a multitude of helping professions. But I will say that I am super excited about CalAIM and the enhanced care management portions of this, because I've been largely involved with therapy and case management in all of those 20 years. And it's really wonderful to really be able to tell the story of case management, which is what we're getting to do in the enhanced care management process. So with that, I'm going to turn it back over to Renee and we'll kind of move through our presentation.
Slide 33	Renee Brissey – 00:33:39	This is a snapshot of the population of Shasta county, how many individuals are enrolled in our Medi-Cal system. And it's to be noted that Shasta county has one MCP and that is Partnership Health Plan. Pardon me.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 33	Renee Brissey – 00:34:05	This gives you a little bit a snapshot of the total number of patients we serve and the population. Over 80% or more are at or below federal poverty levels in Shasta County, and specifically at Hill Country. And one of the things I wanted to point out about the size of Shasta County is that it covers over 3,800 square miles. And so when you're looking at a county of this size, when you look at Redding as our largest town and out of the 180,000 people, 90,000 people live in inside the city limits of Redding, but the rest of the population lives outside in the outlying towns. And so it's really expansive when you think about how can we meet the needs of the individuals that live within our county. Next slide.
Slide 34	Renee Brissey – 00:35:16	Shasta County launched Whole Person Care back in 2015. There was a lot of time and attention spent on how to deliver the services and a lot of collaboration between the Partnership Health Plan, our Shasta County Health and Human Services, in our partnering [inaudible 00:35:42] that Shasta Community Health Center. And so we decided that the way to pilot our program was to have teammates. And so that would be three team members with a housing case manager, a nurse, and a medical case manager that also worked for Hill Country. And so this really allowed us to provide services that we hadn't been able to provide before as a health center. We were able to provide housing support and showcase and pilot a housing-first model.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 34-35	Renee Brissey – 00:36:26	<p>We were able to like build and strengthen the relationship with Partnership Health Plan and with Shasta Community Health Center, which really helped us to kind of wrap around the county and provide healthcare services to the county, but also start to really understand the population that we served. We feel that the program was really successful. There was a significant reduction in emergency department visits. Over 32% secured permanent housing, which is out of 164 individuals. That's a pretty large number. And like I said, the community collaboration of the organizations that provided Whole Person Care Services and the collaboration that was needed to work with all the partnering organizations that we were accessing to help the Whole Person Care participants get their needs met and access services. And then at the end of 2021, Whole Person Care was winding down, and because we were one of the five pilot counties, Hill Country was able to become an ECM provider under Cal-AIM. And today we have three ECM case managers, and I believe we have a little bit over 40 patients currently enrolled. Next slide. So this is an overview of ECM at Hill Country. We are providing enhanced care management to the three population sets, and those are the high utilizers, individuals and families that are experiencing houselessness, and individuals that have severe mental illness with substance use issues. Currently approximately 70% of the population that we serve... I think that was 46, I couldn't see it on my computer. Sorry. So I think it's 46 participants. So 70% were female and 30% were male. So it has appeared, what we're experiencing, is that males are a little bit harder to engage with. So we're continuing to strategize together in effort to better engage with the male population. And the age range is largely between 35 and 60.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 35	Renee Brissey – 00:39:09	In rural Shasta county, there are some specific challenges that you will encounter if you're thinking about becoming an ECM provider. The scarcity of resources, limited resources that you have accessible to members in the small towns and outlier towns. Like I said, when I pointed out the size of Shasta County, we really do travel great distances to provide services to our members. One of our health centers is in Round Mountain and individuals have to travel 35 to 40 minutes to get healthcare services. And so with the gas prices, that can become a huge challenge. And as a case manager, when you're going out to serve your members, thinking about the cost of gas, when you're negotiating with your health plan, take that into consideration because that's one of the things that we have experienced just in the recent months with the gas prices increasing.
Slides 35-36	Renee Brissey – 00:40:32	Cell phones are incredibly important when it comes to contacting the individuals that we work with. Texting and the phone calls, like I said, is a lot of engagement and how you schedule appointments. And really just our case managers keep in touch and check in with them. And so individuals that don't have regular cell phones oftentimes get the free phones that are offered in Shasta County. Many times they can't keep the phones charged, or they lose them, or they break them and they're getting a new one quite frequently. And so we can find that our members, our participants have gotten three new phones in a month and three new numbers. And so that has really been a challenge to being able to stay in contact with the members. Next slide. Now I'm going to turn it over to Julie that's going to talk about the ECM workforce, what it looks like for us now.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Julie Jones – 00:41:44	<p>All right. Thanks, Renee. It has been moving along steadily since January. The first thing that I want to point out is that prior to this, we were doing whole person care, but we also had a lot of different types of complex care programs that were happening out of Hill Country. And those programs, enhanced care management, really helps with those in terms of things that are grant-based that move on and off. Enhanced care management has allowed us to pick up and hopefully serve those people consistently within the same program, providing awesome services as part of a complex care system, which is a really beautiful thing. We currently right now have three case managers that are dedicated to enhanced care management. And one of the key pieces that I want to point out for Hill Country is that we've been very fortunate to have a positive relationship with our managed care provider.</p>
Slide 36	Julie Jones – 00:42:48	<p>And I encourage all of you to reach out and be vocal as you're starting to think about doing these services with your managed care provider. Partnership has been very active with us and has been pretty responsive to help us move forward. We started out with a thought process of a caseload of 25 per individual care manager or case manager and we have since dropped that to 20 based on the complex needs, the amount of mileage that we're covering as Renee had pointed out, and being able to really provide hands-on quality services in a rural area. Many of you know, that busing systems transportation in general is difficult. And with the added complications of COVID, some of the transportation systems that we rely on have not been able to staff. So we dropped it to 20 for two reasons. One, quality care for our clients, and two, to prevent against burnout for our care managers who are really working with difficult people every day, one right after another, consistently.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Julie Jones – 00:44:12	Employee retention and staff retention right now is one of the biggest pieces for us and really honoring the work that we're doing. So we look to hire case managers or care managers with previous experience, but we do not require any licensure for our case managers. We are looking ahead. And when I say we're looking ahead, we are recognizing the importance of training. And a lot of times you look at case management and you think, oh, well, they need to be trained in the resources of the local area. But in terms of dealing with complex care patients, they also need more extensive training.
Slide 36	Julie Jones – 00:44:57	We're really excited to be partnering with Shasta College, the local junior college that's located in Redding and has annexes throughout Shasta county. They are actually developing a case management certificate program, which is pretty cool and awesome and we're doing some internship opportunities with them. We've also partnered with a group called EM Consulting, and they are doing for us a lay counseling program. It's 14 weeks, it's three and a half hours a week with an additional two hours of homework. And we are hoping that our counselors and our case managers will pick up some skills that will help them engage people more effectively, and also build their confidence in talking with people to increase engagement and just really help our clients...

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VISUAL	SPEAKER – TIME	AUDIO
Slides 36-37	Julie Jones – 00:46:03	... just really help our clients feel that we're listening and that we're reacting appropriately to the challenges that they're facing. So we're super excited about these partnerships and we continue to grow. Next slide, please. So in terms of outreach and engagement, many of our referrals are coming from previous complex care programs, which I talked about earlier. They're also coming through our medical providers because we do provide medical, dental, chiropractic services, as well as what we call our care center, where the community is able to come in that's in crisis and receive services regardless of your connection to insurance. So referrals are coming in all over that way and our managed care provider has been very generous in allowing us to collect our internal clients and get them transitioned into the Enhanced Care Management system while working towards increasing our capacity for more and more.
Slide 37	Julie Jones – 00:47:17	And it is a little bit of a slow process in terms of that engagement so we have what we call an outreach coordinator and as the referrals come in, our outreach coordinator is reaching out to them. We find great success with texting our folks and I think part of that is that texting does not eat up minutes as it relates to free phones and the amount of minutes that those phones are allowed. Our clients or our potential clients are more easily engaged through texts often. Once we have them dialed in through the outreach, they are then assigned to a specific care manager and that initial appointment with the care management, whether we are driving to them, they are coming to us, we're meeting them in the community, those are face-to-face, and we are doing the assessment and we're spending time with them.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 37	Julie Jones – 00:48:21	That first initial visit is pretty lengthy and we don't often get all the way through it but it does give us an opportunity to get them engaged and often meet the initial pieces that are required by our managed care provider to begin the enrollment process. So that's how it's working for us. After they are engaged and we've got the consents signed so that we can work freely with the partners in our community, we're pretty much in touch with all of our enrolled clients on a weekly basis, either person-to-person through transporting them to medical appointments or getting paperwork filled out. We're frequently texting them and calling them. Next slide, please.
Slide 38	Julie Jones – 00:49:12	So far it's working pretty good. Probably my own ego, but our care managers kind of run the gamut in terms of their experience level. We've got some that are, one is super brand new, one's middle of the road, that transitioned and one came from the outside with an extensive amount of case management and they are really doing quality work. And some of the folks that we had been trying to move forward or get them to be even able to entertain going into a rehabilitation center or detox are actually starting to make movements towards that. And it's really exciting and it's uplifting to see.
Slide 38	Julie Jones – 00:50:02	Our previous collaboration through whole-person care, quite frankly, set us up for success moving forward. We're meeting monthly with Shasta Community Health Center, our partner, so to speak, I guess you could call them competition but we're really not in competition here, we do a lot of good work together, collaboratively. And we're also working with the county and we're meeting monthly with signed ROIs to be able to determine who is the best agency to serve these clients based on the supports that we're providing and the additional community supports that might be being served in another agency that we're not serving. So that's an exciting piece of the Enhanced Care Management program.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 38	Julie Jones – 00:50:51	It's an opportunity to really showcase the value of case management and fund these positions that have really been doing the hard work. And we're always trying to figure out how the next grant might work. And this is an incredible opportunity to tell the story of a client and a care manager and it's working. In addition, we are increasing our community outreach, which is going to allow us to increase our harm reduction efforts, hoping to engage on a more deeper level with those folks that are living out in camps or in their cars or in their vehicles and being consistent to get out there and increase our capacity to directly impact our community. And as a person in the helping professions, all of you that are out there listening, doing this work, it is exciting to be able to do it and so it's quite an opportunity.
Slide 38	Julie Jones – 00:51:56	The challenges engaging these complex care clients is time and labor intensive and it often takes a lot of touches. And I'm going to stress again, that texts are a good way to contact our folks. And I have ideas about it but they tend to be responsive. Some phone calls and some follow up texts, really help. Areas that are challenging, we are often off grid making sure that our team has quality cell phones with quality reception, that we know where they're going and we know when they're supposed to be coming back so that we can take care of our team. Making sure that we're focusing on things like retention because it takes a long time to get your skills up and be a quality case manager so obviously looking for training opportunities. We're considering going to a 4/10 schedule to help our care managers stay invested but making sure that we're allowing them the self-care time to recover and be effective when they are at work.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 38	Julie Jones – 00:53:08	We've been fortunate in that our managed care provider is offering some training in how to do quality care plans and we're also looking for other training opportunities to really develop a quality care plan. Keeping in mind that it might seem like the goal is to get them from being unsheltered to sheltered but the reality is there are a million tiny goals prior to that goal. And to develop a quality care plan that the client and the care manager sees those small successes moving forward, working towards a multitude of larger goals. But just the engagement and getting them successfully engaged and talking with you each week consistently is a huge breakthrough for many of these clients. And it's super exciting and writing a quality care plan that can point out those small successes is very important.
Slide 38	Julie Jones – 00:54:13	So I encourage you to look for opportunities for writing quality care plans. And I encourage you to work with your managed care providers to help you with that because partnership is reaching out and helping us with that. Changing payment models has been challenging. So understanding if you're using an electronic health record, having a champion in your organization to help you move, if you're going from a fee-for-service to a pay-per-month can be challenging. Renee is my best friend in this process, in teaching care managers how to document in the electronic health record.
Slide 38	Julie Jones – 00:54:51	And then we have billing people that are working proactively as champions in each of these areas. So I encourage you all to identify the champions in your organizations that can help you move through these pieces. Because many case managers aren't always invested in documenting because they're people, people and they're doing the people work. But in this, we have to remember that we're telling the story and we're telling the client's success story, one tiny goal at a time and so that documentation piece is very important. So finding your champions in those areas as well is super important. Next slide. All right. I hope that was helpful.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Edith Coakley-Stowe – 00:55:46	All right. Julie and Renee, you're right on schedule. That was great. We're getting a lot of questions in the chat and many of them revolve around your people, your care managers, your case managers. So let's see if we can ask you to break this down a little bit more. So what kinds of qualifications do your current case managers have and how did you find them and hire them?
Slide 39	Julie Jones – 00:56:12	Well, I think, and Renee can talk to this too. I think what we are looking for more than anything is we are looking for people that have an awareness of what's going on in our society around us. People that can talk to us specifically about de-escalation and areas of expertise in de-escalation. I interviewed somebody yesterday who happens to work at Safeway and folks that work at Safeway in our environment here are often doing de-escalation. Some of our service areas are very close and so this person was able to give us very detailed experiences of de-escalation, working with the exact population that we're working with and being able to not personalize that escalation and asking questions related to that so that you know that they're not going to escalate when a patient is frustrated. Obviously we're looking for people that have case management experience because sometimes they've learned that over time but in rural areas, it's a struggle.
Slide 39	Julie Jones – 00:57:40	So when I said, we kind of run the gamut, we have one person that had been working specifically in an ophthalmology office but seemed to have the right skill sets, was involved in her church and local organizations dealing with different folks with complex issues and she was obviously aware of what's going on around her and has been invested. The electronic health records and that sort of thing has been a struggle but she's the right fit because she has an understanding of the population and she is not caught up in stigma. And that piece related to stigma is incredibly important. Renee, I'm going to hand it off to you for anything I might have missed in my rambling.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Renee Brissey – 00:58:36	I think that what I would add is that we're looking for people and I think it's important that anybody that's going to do this work is that the individuals that are doing the work really have the passion to really care for people and come with a lot of non-judgment. And can recognize what their individual biases are and have really good awareness of that and can operate regardless of what their own personal beliefs are and can engage with an individual and help them to identify their own goals and work alongside them because really it's meeting the individual where they are at. Motivational interviewing skills is great to have. That's one of the things we're hoping that we're going to accomplish through the lay counseling program and/or the case management certification program. It's really important to be able to have that empathy and reflect back what the individual's saying to you and really just build that trust and engagement with them so that you can help them see the value in themselves and motivate them to want to change.
Slide 39	Renee Brissey – 00:59:58	And so we work alongside them to do that. And so I think a lot of the things can be trained but there's a certain someone that it takes to actually get down in the dirt with these individuals and really help them because it's hard work and you have to want to do it. And so we want to hire. And I really encourage anybody that is doing this work that you really, when you interview and you think about who you want as a case manager to really talk about, what is it that you value? What is it that you want to do? Because that's really one of the most important things. I think that's part of the secret sauce of doing case management.
Slide 39	Edith Coakley-Stowe – 01:00:46	Yeah. And Renee, since your licensed, are you the line manager for all the case managers?
Slide 39	Renee Brissey – 01:00:54	Definitely, I oversee them. Yeah.
Slide 39	Edith Coakley-Stowe – 01:00:56	Okay. Yeah. And what does that oversight look like? Is there a daily huddle or? Say a little bit more about that, if you would?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Renee Brissey – 01:01:05	I check with them each morning that I'm at the clinic and we have the internal messaging system and so I'm constantly checking in with them. I review their documentation, which really gives me huge insight of the individuals they're working with. And we have a weekly case management meeting where we do case consultation. But the case managers I'm accessible to them anytime, they can Teams me anytime and ask me any questions and I'm happy to help them. They're really doing some great work.
Slide 39	Edith Coakley-Stowe – 01:01:38	And obviously COVID's a confounding factor right now, are they on site with you or are they at home or are they out in the field? What does that breakdown look like at the moment?
Slide 39	Renee Brissey – 01:01:50	Well, our case managers are out in the field, in the clinic and everywhere. They're transporting clients. We follow our guidelines, the CDC guidelines within Hill Country that we're supposed to, we follow those protocols. But we're just in there doing the work.
Slide 39	Edith Coakley-Stowe – 01:02:16	There're lots of questions about training. So maybe you could break down for us what does it look like for a brand new case manager to be trained? And how much of that is you versus the MCP? And then what does the ongoing training look like?
Slide 39	Renee Brissey – 01:02:35	Julie, do you want to start that and then I'll fill in any gaps?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Julie Jones – 01:02:39	<p>So we initially start and the size of every organization is a little bit different. It's very important to us that everybody who comes into Hill Country has a firm understanding of the culture. So we have an onboarding process for all employees. And then we have a pretty extensive internal shadowing program that occurs. And we have a multitude of different types of case managers, map case managers, community engagement case managers, just different types. But we are having our Enhanced Care Management people shadow all over so that, as an example, we have people that are called behavioral healthcare coordinators, that work on our medical floor and they are an immediate connection to the team for Enhanced Care Management. So they'll go shadow on the medical floor with multiple reasons in mind. Number one, to develop relationships with the medical assistants and providers.</p>
Slide 39	Julie Jones – 01:03:39	<p>To learn some of the basic strategies that are helpful to know, like EDD paperwork that comes through the medical office, they'll learn how to process that, how to work with the provider, how to work with the MA. Just a multitude of how to get medical equipment ordered and all the different pieces for health, how to do referrals, work with the MA. So there's an extensive shadowing process at each location, they'll shadow over in our medicated-assisted treatment program to learn about the Suboxone and how it affects this and how do you get into that and how do you bridge and all of those types of things. So we go through that, we have specific trainings that are set up in-house, such as de-escalation, motivational interviewing.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Julie Jones – 01:04:34	We kind of contract out for things like Mental Health First Aid and assist. I always get the wording wrong but that's a suicide prevention or a suicide awareness training that we do. And those are taken care of out in the community. And then our managed care provider is doing, I don't know, I think they're biweekly now, specific trainings on care plans and that sort of thing but it's mostly been with us. Those trainings are good and I think they're great and I think that they'll get better and better. But it is on us now to take it to the next level. And I'm going to let Renee talk about the EM Consulting, because she's been really key in getting that set up.
Slide 39	Renee Brissey – 01:05:28	So EM Consulting is Elizabeth Morrison Consulting. So it's a grassroots organization, she works in health, she has 20 or more years of experience working in community health centers, she's a licensed clinical social worker. And her goal is to really spread how to use empathic communication. So motivational interviewing to meet patients' needs, well, to work with the staff. So to build the staff strengths and skill set so that we can work with the patients that we work with because a lot of them have experienced a lot of hardship and trauma. And so her focus is on how do we build a staff skill set to be able to treat and care for individuals in healthcare settings and in other organizations?
Slide 39	Renee Brissey – 01:06:31	And so we were able to send, I believe, 13 of our staff to her training. So it was a Train-the-Trainer. And so we have 13 Hill Country staff that are trained to train our staff in motivational interviewing. So we're doing that, that's a part of onboarding. And now EM Consulting has identified that there's a need to train individuals that don't necessarily have degrees or certifications or licensure because these are the staff that are on the front lines interfacing the most with the clients that we serve. And so they're really wanting to build up their skill set.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Renee Brissey – 01:07:17	<p>And so I'm super excited about this 14 week program and in each category, how it's going to really enhance the services that our case managers, our behavioral healthcare coordinators, enhance their skill set. And one of the things I don't think that Julie said is one of the onboarding trainings is harm reduction. We have a couple of harm reduction specialists that work at Hill Country. And specifically because this program we're meeting them where they're at, it's really important that they have that knowledge. And so we have a three part harm reduction training where they meet and really get an overview and then go through a really detailed training on harm reduction.</p>
Slide 39	Edith Coakley-Stowe – 01:08:13	<p>We had a specific question about safety. So when people are out visiting homes and things like that, how did your training encompass that?</p>
Slide 39	Julie Jones – 01:08:22	<p>Funny that you say that because it is the thing that keeps me awake at night. So we have gone to an app called Life360 because we don't have the luxury of really sending people in twos because we just have too much ground to cover. When we can, we do but we don't get to do it often. So I'm often concerned about where people are going. And so we do have the app Life360 and we are implementing a safety person on the team that can kind of keep-</p>
Slide 39	Julie Jones – 01:09:03	<p>... a safety person on the team that can kind of keep an idea of where everybody is at any given time and, in my words, making sure that at the end of the day, all the cubs are in the den. If they're not, that phone is handed off to the supervisor to have communication with that one case manager that might be still out in the field in a distance and we're making sure every evening that we're staying in communication. One of the challenges that I'm having with training is that I'm looking for a specific how to safely drive in your car with people that may be challenging at times, or may be experiencing some sort of psychosis and you're not always aware of it. I've not found something that I'm comfortable with yet, but I am looking for that and I'm looking for it feverishly because some of the agencies in doing these trainings are perpetuating stigmas that I don't want to perpetuate.</p>

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Julie Jones – 01:10:07	I want to continue to look for dignified ways to help keep our case managers safe. A lot of it is planning out your route, letting somebody else know where you're going and what route you're taking and really being aware and making sure that your phone is working. Things that we're doing because of our rural area that are significant is our IT team is looking at ways to boost our signal by attaching a stronger ... I don't even know what my IT guy called it. I'm going to say booster for lack of better, but it's I guess a little bit pricey, but for about 500 bucks a car, you can add a greater signal to your vehicle. We are looking at going in that direction because of the rural environment that we have. It's probably not going to take us everywhere, but it is going to help and we're hoping it will extend our range. So we're going to pilot that on a couple cars and see how we do.
Slide 39	Julie Jones – 01:11:22	So that safety in cars piece is alluding us at this moment, and we may have to develop some stuff ourself. That's what we're looking at now.
Slide 39	Edith Coakley-Stowe – 01:11:36	We've got questions about the phone. So for your case managers, do they use their own phone or do they use your phone and is it definitely ... I assume it has to be a smartphone to be able to use the app you just talked about.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Julie Jones – 01:11:48	So they have an option here. They can either get a stipend if they want to use their personal phone. In ECM, I'm kind of wanting them or we will give them a phone. I'm encouraging the company phone because of the use of Life360. I don't necessarily want to use Life360 on people's personal phone. They might have it for their own family members. I think case managers at Hill Country in different departments are doing different things, but for ECM specifically, because they're going so remotely and I want to make sure that all cubs are in the den at night, I'm really wanting them to use the company phone and just be able to use those apps. The other piece is that I want them ... if I had my way, I'm not there yet, but I would like them plugging their phones in when they leave work and not coming back to them until they return to work, because that quality of life, self-care, is huge. When you're using your personal phone, it's hard to identify who's calling you and it can quickly eat up your weekend.
Slide 39	Edith Coakley-Stowe – 01:13:12	Yeah. Staying on the topic of phones, what is the balance between the case managers talking audio only with clients versus telehealth video style?
Slide 39	Julie Jones – 01:13:36	The weekly contact, I'm going to say the drop-ins at the clinic, at least at Center of Hope, and it used to be more so at the Care Center, are increasing and they're increasing because of the case management. Some of it's because we're offering incentives such as a gas card. They know if they're living in their car, they might have the potential to get a gas card so they'll reach out and say hey, but I'm going to say 60% phone and text, 40% in-person. The other thing that we're doing that is increasing client engagement is that with our new building here, we have the ability to allow people to come in and shower. So they're coming in and they're showering, they're getting some food, we can provide food to them and we're kind of decreasing some of the unsheltered challenges and it's increasing our engagement opportunities as a result.
Slide 39	Edith Coakley-Stowe – 01:14:52	To connect this back to what DHCS is saying about telehealth, I wonder if I ask you to come back to this Dana or team just what the policies are about ECM providers being able to use telehealth.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Dana Durham – 01:15:08	Yeah, that's a good question. Right now, we're really at a point where we're operating on flexibilities that are offered through the public health emergency, so the use of telehealth providers is available. The ECM in general is an in-person experience that you have with the client and that really is one of the basic tenets of enhanced care management overall is that relationship where you know someone, can talk to them, feel comfortable around them, that's a little harder to do when you're not in person. So as it is a requirement, although we have some relaxed flexibilities now, the expectation of ECM is to be in person. Now, there will be some telephonic interactions if you're setting up appointments or doing a check-in, but the basic tenet of ECM is in person or interaction.
Slide 39	Edith Coakley-Stowe – 01:16:14	Yeah. Several people, Julie and Renee, are asking for you to say again a little bit more about the Lay Counseling Academy and also which of the schools that are building the case management module program.
Slide 39	Julie Jones – 01:16:34	So the school that we're partnered with for case management certification is Shasta College. We also have internship opportunities with Cal Poly Humboldt and Chico State, but those are more to build our resources for future LCSWs and MFTs. Renee, you probably want to talk more about this. This is more you.
Slide 39	Renee Brissey – 01:17:02	About the certification program at Shasta College?
Slide 39	Julie Jones – 01:17:12	Yeah. I don't know a lot about it. Do you have background?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Renee Brissey – 01:17:17	There was a group of us, a subcommittee of a different committee, the Integrated Care Committee in Shasta County. So that was myself, someone from health and human services and another colleague from Shasta Community Health Center. We got together and really developed competencies for a case manager, looking at our individual organizations and doing a case management summit and looking at what the case management needs are in the community. So we were able to develop these core competencies that we thought case managers should have. Then we were able to communicate with Shasta College and what they have done is they have integrated those competencies to cover that information within ... I believe it's their sociology track. So within the sociology classes, they're going to integrate all of the competencies that we pointed out and highlighted, and so at the end of completing all the classes needed for the case managers, they're going to receive a certification.
Slide 39	Edith Coakley-Stowe – 01:18:37	Great. We've had questions, which we often do on these events, asking for clarification about the distinction between ECM and community supports and can a person have both or just one at a time. So I'll turn to Dana for the ground rules on this.
Slide 39	Dana Durham – 01:19:00	Sure. The basic answer is you can have both ECM and community supports. ECM really is about coordinating your care overall and community supports are about specific things that are substitutes for state plan benefits that can be an add-on. They are not dependent on each other, so an individual could just get community supports and an individual could just get ECM, but they also aren't ... they don't conflict. So you could have ECM and then a community support on top of the ECM. So they don't conflict, you can have both, even the parts that coordinate care, because if you're doing housing navigation, that is about specifically navigating for housing needs, whereas ECM really focuses more on the navigation around the health needs, as well as the social drivers of health.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Edith Coakley-Stowe – 01:20:09	Great. So let's translate this little bit into real life, Renee and Julie. We asked you to talk mainly about ECM today and not community support, but I think as I understand it, you are working on offering some of the community supports and that's a little bit earlier in the game. So can you just talk briefly about that, and then how is it that you'll separate the billing for the two? That's what somebody's asking in the chat.
Slide 39	Julie Jones – 01:20:33	Okay. So that's one of the challenges of the program and with our previous whole person care, it's allowed us a little bit more time to work through that. So we spent the first part dealing with enhanced care management and the monthly billing process related to that. Because of whole person care, many of those folks that were grandfathered in, the county has taken on the community supports portion for us from that initial 18 to 20 that came through at the end of the whole person care piece. The thing that I want to lay out here is that it's important that you work with your managed care provider as it relates to the training and the different pieces that are needed to be eligible for community supports versus enhanced care management.
Slide 39	Julie Jones – 01:21:33	One piece that I didn't talk about today is that you need treatment authorization requests to do both enhanced care management and community supports, and that's a training issue for the care managers and it's a training issue on both sides, whether it be community supports or enhanced care management. You do have to learn to do good tars and you still have to learn to do good notes and that sort of pieces. We are getting ready to pilot our community support piece in billing. Okay? So what I'm going to do is I'm going to have four community supports people going into billing. We've been working with our managed care provider to get the coding correct and get everything laid out. Community supports, the three that we're doing, are housing navigation, deposits, and housing, sustainability.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Julie Jones – 01:22:34	Shasta Community, our partnering federally qualified health center, is doing more. So they're doing recuperative care and respite in addition to the ones that we're offering and the county is also offering the same that we are. So getting the coding correct in your billing system to show the right codes, to be able to build community supports versus ECM is very important. The coding has been a challenge because some of it is old coding that doesn't necessarily match the supports that we're providing. Okay? There are codes that are used for other definitions in the past. So that's been a little bit challenging and I'm not going to tell you at all that we are experts at community supports yet because we're not. We're just getting to that pilot piece. We've been doing the work for community supports all along, and that's why we have the people to pilot them.
Slide 39	Julie Jones – 01:23:46	We brought over about 18 to 20 from whole person care and we have 46 now. We have plenty that we could move into it, but based on the agreement that you do with your managed care provider, it's important that you understand that because in our particular situation, community supports requires more often tars and there's limits to how long you can be on community supports. We want to make sure, as an example, housing deposits is a one-time only benefit. So if we're helping a client, using the housing deposit is going to be a last resort. We want to make sure that every other resource is utilized before we go to that housing deposit if somebody's at that point to be able to move into housing, because we don't want to use that lifetime benefit.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Julie Jones – 01:24:46	With housing navigation, we're careful with it right now and we haven't been in a hurry because a challenge in Shasta County based on the close Butte County fires, the car fire, the fawn fire, we don't have housing. So doing the work leading up to getting a person ready to do housing is super important, but how we're working with our managed care provider and being good stewards of taxpayer dollars, we don't have a lot of housing to put people into. So tars going on and off based on looking for housing for us has been a little bit dicey. Does that make sense? Because we can get people ready and we're doing that work, but there is such limited housing that we're not rushing to use that resource just yet.
Slide 39	Julie Jones – 01:25:46	What we are doing is we're trying to really build up and focus on housing sustainability services and doing quality groups that will help people stay housed once we start to utilize that service specifically. So we're getting ready to bring on ... we're calling them a housing navigator, but really they're going to be focusing on developing those skills to keep people housed once they're in. Otherwise, we will have a revolving door. While we believe in housing first, we also know it's the very tip of the iceberg for these complex folks, so we're being very cautious about how we approach community supports with the limited timeframes that we can have them on community support services.
Slide 39	Edith Coakley-Stowe – 01:26:38	Yeah, it's a lot, and it's a hard one to put in the last five minutes of the webinar. I will say to those of you on the call, there's more webinars planned specifically on housing community support, so check the website, that are coming up. Maybe this will be the final question, given the time. Can you say more, Julie and Renee, about do clients tend to accept ECM or do you sometimes find that they decline? If so, why do they decline and what does the acceptance rate look like roughly?
Slide 39	Julie Jones – 01:27:14	Do you want that one, Renee?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Renee Brissey – 01:27:16	I mean, I can try, I can give a shot at it. I think with the ECM program, we haven't experienced individuals declining. So I want to say the percentage is pretty low of people that aren't engaged in and decline the services. I could speak a little bit about whole person care. On whole person care, with ECM too, one of the main requirements was the willingness. The individual had to be willing and volunteer to engage in services. So I couldn't tell you the percentages of whole person care, but we did ... I mean, there was quite a few individuals that decided that they didn't want to engage or were disenrolled due to lack of engagement. It was a small number, but I mean, there are those individuals that for whatever reason, they're just not engaged in services.
Slide 39	Renee Brissey – 01:28:25	Maybe they're actively using, maybe they have untreated mental health and they're really hard to keep in touch with and engage with. But a lot of those individuals we were able to connect with at a later date and engage with. So I think it's all about timing.
Slide 39	Julie Jones – 01:28:42	Yeah. I think I can add here too, in that some of the challenges ... when our managed care provider provides a referral, it's a little bit harder to get them engaged. Okay? That's because we're at that point doing some cold calling and we haven't done a lot of that because our managed care provider has allowed us to enroll our own folks first. But we did a little experiment where we opened our capacity a little bit more and they sent us some. Because our referrals are mostly coming internally, our medical providers or our BHCCs are setting the client up for those initial calls. But the ones coming off of the capacity report directly from partnership, that's a lot of cold calling because they're not our clients and so our rate at engaging them, while we're not doing a lot of it yet, we didn't have any success with the few that they gave us because they didn't know who we were at all, or we weren't able to contact them because their contact numbers weren't up to speed.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39-41	Edith Coakley-Stowe – 01:29:58	Great. We're at time, Julie. Anne or somebody, could you put the last thank you slide up on the screen, because that is just going to give everybody some additional email addresses. Thank you. Next one, please. The ECM and community supports DHCS website is your one stop shop for information from DHCS. There is an email address at the bottom here where you can direct your questions and even if that's to ask if there are ways ... some of these questions that have appeared in the chat, if you didn't have it answered, feel free to send it that way. We want to thank Julie and Renee, especially for your time this afternoon. I wish we could have got through more questions. People were really curious, as you can see. Thank you very much, and we'll send everybody on their way on time. Thanks again.
Slide 41	Julian – 01:30:53	Thank you for joining. You may now disconnect.