Department of Health Care Services California Advancing and Innovating Medi-Cal (CalAIM)

TITLE: CalAIM Community Supports Spotlight: Sobering Centers and Day Habilitation

DATE: Wednesday, June 15, 2022, 1:00 PM to 2:00 PM

NUMBER OF SPEAKERS: 8

FILE DURATION: 1 hour and 3 minutes

SPEAKERS

Jill Donnelly
Neha Shergill
Shannon Smith-Bernardin
Tyler Brennan
Michelle Wong
Nancy Shipman
Aulina Bradley
Eddie Hathcock

Neha Shergill:

... supports. Community Supports are medically appropriate, cost-effective alternatives to services Medi-Cal managed care plans may provide in lieu of services traditionally covered by Medicaid. Community Supports services are designed to potentially decrease utilization of other Medi-Cal benefits, such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. Managed care plans are strongly encouraged but not required to provide community supports. CalAIM currently includes a robust menu of 14 pre-approved Community Supports to address the health needs of members. The list of pre-approved Community Supports is informed by the work and lessons learned under the Whole Person Care Pilot and the Health Homes Program. Managed care plans selected Community Supports to offer when CalAIM went live on January 1st, 2022 and have the option to add new community supports every six months. Managed care plans in all counties are encouraged to offer at least one community support by January 1st, 2024. Next slide, please.

Neha Shergill:

In Lieu of Services authority 101. The Community Supports, or often referred to In Lieu of Services, which are medically appropriate and cost-effective services or settings offered by a managed care plan as a substitute for a Medicaid state plan covered service or setting. Under regulatory requirements, in lieu of services must be authorized and identified by plan contracts and offered at plan and enrollee options. This allows for Community Supports to cover a broad range of social and support services for eligible populations. These are financed through capitated rates to plans in the same way as state plan services does not require 1115 waiver savings.

Neha Shergill:

This slide outlines the 14 pre-approved Community Supports. This webinar is intended to provide information about the sobering centers and day habilitation supports and help inform you as you consider offering the support to plan members and patients.

Neha Shergill:

MCP elections: sobering centers and day habilitation. Many MCPs have already elected to provide sobering center and day habilitation community supports. And by January of 2024, 38 counties will be live with sobering centers, and 37 with day habilitation.

Neha Shergill:

We'll now provide a summary of guidance on sobering centers. Dr. Shannon Smith-Bernardin, a leading researcher on sobering centers at the University of California, San Francisco will share DHCS guidance and her expertise on sobering centers.

Shannon Smith-Bernardin:

Hello, everyone. I am Shannon Smith-Bernardin as she mentioned. I've worked in sobering center work since 2007, so about 15 years now. Look forward to kind of chatting with you about sobering centers, and I'll be available at the end for additional questions along with everybody else. So, general question, what are sobering centers? I know this is something that's a new concept to many, many people, and I'm extremely excited that there are 38 counties who are looking at putting this together. So basically, sober centers are alternative destinations for individuals who are intoxicated in public. They're in alternative typically to emergency departments and the jail services. They offer basically a safe, supportive environment to recover from acute intoxication. We'll move forward to the next slide. The other direction. Yay, there we go. Okay, perfect.

Shannon Smith-Bernardin:

Big thing to clarify is, sobering centers are not treatment. They are a fantastic way to get people connected to treatment, but they themselves are not. Most importantly to mention at this point, there's often confusion between what a sobering center is and what detox is. So kind of looking at here, a sobering center, I think the best way to say it is, it's a pre detox per se. Detox itself is, the goal, typically over three to seven days, is for an individual to remove all substances from their body related to drugs or alcohol. Treatment is then usually after that point or sometimes on top of that point, of basically continuing on 30-day treatment, 90, 60 days, cetera.

Shannon Smith-Bernardin:

And then lastly, sober living. Many individuals, in their reentry back to the community, will go to a sober living facility, which could be a home, usually filled with many other individuals who are also practicing sobriety and abstinence. Sobering center is not on that level. It's kind of before that. Same level as individuals who go to jail or emergency department for the acute intoxication themselves with the main goal of reducing the harms related to acute intoxication. Next slide.

Shannon Smith-Bernardin:

There's so many different things you can do with the sobering center. So things that are offered here, you can see them all on the screen, from triage, temporary shelter. Everything's under 24 hours for a sobering center. Average length of stay across the country is typically between seven to eight hours. Typical stays are around four to 12 hours. They offer rehydration, usually oral rehydration, food and or snacks, treatment for nausea in case someone's having issues with their intoxication, and certain level of urgent care light practices, such as wound dressing changes, depending on the level of staffing. And most importantly, a lot of the work around substance use education, counseling screening, et cetera. We can go to the next slide.

Shannon Smith-Bernardin:

Eligible populations for a sobering center are adults age 18 and older. At the moment, I know of no sobering centers in the country that have underaged individuals in their active sobering center itself. Folks have to be intoxicated but conscious, ideally able to participate in some level of conversation or be able to agree to be there. However, they don't necessarily have to be able to walk. If your sobering center will be contracting with the health system with an ambulance agency to take ambulances directly, people may be able to get brought in directly on a gurney and does not have to show an ambulation ability. Free from medical distress. We don't want anyone with trauma. We don't want anyone who doesn't want to be there. So if the individual insists that they don't want to be at the sobering center, then they can be brought to what the other option would be in that community, whether that be jail or the emergency department. You can switch to the next slide.

Shannon Smith-Bernardin:

There are certain service requirements that have been outlined by DHCS within the community port system. So when utilizing this service, it is a requirement for everyone to be contracted with, or have a good collaboration with the county behavioral health agency. Basically, this is one of the biggest benefits of a sobering center, is you brought in individuals who are intoxicated in public and they... This is I think the big distinction between treatment and sobering also, is the person's being ideally given to this situation when they're not necessarily looking for help. We have the fabulous opportunity of bringing to them services and tell them a little bit about all the substance use programs, where partnerships exist in the community and where they can potentially get help to ideally reduce the harmful use that they have to anyone who's been brought into sobering centers, been in a situation that's probably unsafe for them individually. And within the sobering center with these contracts, being able to provide linkage, screening, services, to get someone at a warm handoff to another level of care.

Shannon Smith-Bernardin:

Most ideal partnerships around law enforcement, emergency personnel, outreach teams, and pretty much really any entity in the community who may receive someone who's actively intoxicated. And with this, we want to work with... It requires a partnership around best practices for members, and we'll get into best practices in a moment for the sobering center. And a lot of the work that goes into this, the sobering center concept, is around individuals with chronic alcohol use or drug use disorders. Many of those individuals are homeless. Homelessness is not a requirement to go into a sobering center, but many, many individuals, especially repeat visitors, are individuals who are experiencing homelessness at the time. We can go onto the next slide.

Shannon Smith-Bernardin:

The allowable providers. So the DHCS outlines the different types of providers that we can contract with. But basically, the services that we're looking at are ones that can provide substance use disorder facilities. So ideally, if it's an organization that already has a detox, et cetera, then the sobering center could be collaborated with that, could even be co-located depending on where the program is at. Of note, sobering centers, currently, they are not licensed facilities. This does not fall under any type of licensing. It's not an FQHC, et cetera.

Shannon Smith-Bernardin:

However, we do have standards that are being developed. There is the National Sobering Collaborative of which I lead the National Sobering Collaborative also. It's a nonprofit in the United States, and we are in the process of developing standards for sobering centers, with a work group of individuals from around the country, and are working also on an accreditation program for later on this year or early 2023 for individuals that may be interested in this. Of note, and I know the legalese is going to definitely come from other people than myself, who's with UCSF and the collaborative, but everything must be approved through DHCS and the managed care providers in providing these services. That's the closest I'll get to legalese. Now we can jump to the next slide.

Shannon Smith-Bernardin:

Individuals who come into the sobering center, so many different ways they can be referred in. I think this is the other benefit. Sobering centers are typically 24/7, around the clock, 365. There are very, very few other organizations that offer this level of service for these range of conditions with behavioral health, between mental health, substance use, individuals who are homeless, and this level of staffing that are really premier in terms of what they can do for motivational interviewing substance use disorders, et cetera. Agencies across the county can bring individuals in, will have people can be sent over from emergency departments, ambulances, if that is something that your county contracts with, managed care plan teams, shelters, other treatment programs if someone happens to resume consumption when they're in a treatment program or sober livings facility. If those collaborations are worked out, there really is no closed door for getting into a sobering center. You can work out pretty much any relationship you'd like. On the next slide.

Shannon Smith-Bernardin:

So I think the best part of all of this is the best practice for sobering centers. I think the main four things which you can see here on the slide is that we strive to have everything be extremely low barrier. We want individuals to be able to come in where they're at. Whatever state of mind that they're in, in terms of their substance use, they may or may not actually need to change their substance use in a big way or a little way. We are really there to find out who this individual is, how did they end up in that situation that particular day or evening, and how we can help them prevent that from happening again. That's it. That's the big picture, reduce the harm in the moment and ideally reduce the harm in the future.

Shannon Smith-Bernardin:

Sobering center best practices, having clear guidelines and protocols around how do you find that individual in the community to identify who's appropriate to come to a sobering center; when they actually show up, making sure they're safe to be there; and then the ongoing monitoring and observation and engagement with the staff. Those three things are extremely important. Having these protocols throughout can help a lot with this. The continuum care, we've talked about a lot and we will talk about it more, but this sobering center really fits into a hub, 24/7, being able to offer these services and collaborate with a number of providers throughout the county. And then ideally, again, the legally side of it that I will let the DHCS people talk about are authorizations being expedited and relationships created in the process of creating your sobering center. There's so many different ways to do this in general, and DHCS is providing such a fabulous opportunity to bring sobering centers to a lot more spaces. Next slide.

Shannon Smith-Bernardin:

Okay. So program benefits at this point. I've already mentioned, reduce the risk of injury related. Especially if individuals typically may be left on the street, they can be brought in and just not have to be outside and be subject to potential assaults, potential inclement weather, et cetera. The services in general also provide the ability for someone to rather than going to a criminal justice system response, being in jail, they get to be with individuals, ideally peer level staffing, who can share with them different ways that they can help change their behavior, or just be in a safer space. And get this critical care pretty much immediately from the moment they arrive throughout their stay. Many sobering centers actually can provide follow-up ongoing after discharge for an individual so that they can stay connected to the services.

Shannon Smith-Bernardin:

We offer additional improved quality of life, especially for individuals who are struggling through either homelessness, experiencing homelessness or marginal housing, everything from clothing, showers, hygiene supplies, food, connection to primary care, connection to referrals for health insurance, and all the different eligibility requirements that folks might need at that point. And lastly, reducing overcrowding of emergency departments, helping people either get out of the ED faster. Because individuals intoxicated research shows that they stay in emergency departments up to 20% longer than the average individual without intoxication for the exact same condition.

Shannon Smith-Bernardin:

So getting folks out of the ED faster and then also getting turnaround time. And I think across the state, this is a huge issue. Police can often take 45 minutes to six hours to drop somebody off at jail to be placed in there for intoxication versus the sobering center. The highest we have on record now of individuals who are being brought in from law enforcement across the country, it's usually seven to nine minutes, is how long it takes officers to go to a sobering center, drop someone off, engage with the staff, do a safe handoff and be able to depart and get back out to the field. Same thing for ambulances. Ambulances don't have a seven to nine because there's a lot more paperwork that they do internally, but we are showing that they are very quick turnover for ambulances to go to a sobering center rather than an emergency department. And it really helps those entities, those first responders focus on the priorities that they have at hand. Let's go on to the next slide. And this is the last slide for me.

Shannon Smith-Bernardin:

Impacts on utilization. Basically, we've done a lot of research around sobering centers. When I say a lot, it's medium to a lot, I'll be honest. We're working on it. There's a lot more stuff being published out there today. There's a link on the National Sobering Collaborative website. And I believe, as Elizabeth put in the chat, that we have research available for everybody afterwards that we can pass on. And by the way, these slides will be available in case folks have asked, and I'm also available for questions. Impacts and utilization, we've been able to show that a sobering center visit is less costly than going to the emergency department, looking at both costs and charges. And then we've been able to show that individuals who are brought to a sobering center do not... One of the biggest questions we have... Sorry, I was reading the

chat and totally got distracted.

Shannon Smith-Bernardin:

For individuals coming into a sobering center, one of the biggest fears, and I think the biggest concerns liability wise, is what if this individual comes to a sobering center and has a negative outcome? Maybe they have a brain bleed and they should be in emergency department. The most important part, I mentioned earlier protocols, and we have protocols that we can share, when I say we, National Sobering Collaborative, that you can build your programs on. But we have been able to see across the country that the rates of individuals who have a medical need, who are brought to a sobering center, and that at some point during their stay have a medical need is anywhere between less than 1% to just under 5%. And that's pretty much across the country, whether or not individuals take only from police or they take actively from 911 ambulance diversion. And so it's very, very safe model as long as you're following protocols and the staff are appropriately trained.

Shannon Smith-Bernardin:

Also, sobering centers should have some level of emergency response on site from Naloxone, for overdoses, not EKG machines, defibrillators so that in case someone has a cardiac arrest. Let's see here. And I did want to say that most of the people who went to the emergency department, some of the newer research, especially out of the Midwest, is showing that individuals do not require ED care even though they go there for intoxication and they discharge itself without any real medical intervention that's emergency level at this point.

Shannon Smith-Bernardin:

One quick thing I do want to make a note about is on CIWA protocol, and this is often another confusion. I think this is where it comes in also the detox confusion, is when individuals come to a sobering center, or actually anyone with intoxication who has a longstanding chronic use of alcohol, one of the risks is going to withdrawal. And that could be very minor from agitation, anxiety, and slight tremors to very severe outcomes where an individual will have seizures and delirium tremens, which includes an elevated body temperature and hallucination. So very, very dangerous situations. Sobering centers do not necessarily need to follow CIWA protocol, and CIWA protocol is developed as if someone is attempting to stop all intake. That's what they use at detox. And it's basically a clinical assessment of withdrawal is what CIWA stands for.

Shannon Smith-Bernardin:

And looking at this assessment of withdrawal, sobering centers can keep an eye on individuals to make sure they're not going into withdrawal, but we don't necessarily follow CIWA protocol in terms of trying not to go into withdrawal. We're not trying to cease them their substance use at that point. I see we have a lot of questions in sobering centers here. I will wait, and I'm going to transfer right now because I want to be cognizant of time and not run out of time. I'm going to turn it over now to Tyler who's going to discuss some pricing guidance, and we'll be back for questions at the end. Thank you.

Tyler Brennan:

All right. Thank you so much, Shannon. That was great. We really appreciate it. My name is Tyler, everybody. I'm with the Department of Healthcare Services, and I'm going to talk a little bit about the ILOS or Community Supports pricing guidance. The Non-Binding ILOS, now Community Supports, Pricing Guidance outlines a high-level pricing approach. The DHCS pricing guidance is not binding, and it's meant to help managed care health plans and providers develop contracting agreements. For more information on rates in your area, please reach out to the local managed care plans in your area. Next slide, please.

Tyler Brennan:

So now we're going to switch gears and hop over into the world of day habilitation and provide a summary of guidance on this community support. So what are day habilitation programs? Data habilitation programs are provided in a member's home or an out-of-home non-facility setting. Services are designed to assist the member in acquiring, retaining, and improving self-help socialization and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For members experiencing homelessness, who are receiving Enhanced Care Management, ECM, or other Community Supports, day habilitation programs can provide a physical location for members to meet and engage with their providers. Whenever possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management. Next slide, please.

Tyler Brennan:

The day habilitation is a commonly used term nationally for programs that promote independence and community integration, and is often used interchangeably with adult day health for older adults or people with intellectual or developmental disabilities. As a community support, this service has a similar intent, but it's focused on members who are experiencing or have recently experienced homelessness and also those at risk of homelessness. I will now hand things off over to Michelle who will speak more about the specific services offered via the Day Habilitation Community Support. Michelle?

Michelle Wong:

Hi. Thank you, Tyler. So, day habilitation service offerings. DHCS Community Supports policy guidance state set types of services that are offered in day habilitation programs may include but are not limited to training on the use of public transportation; personal skills development in conflict resolution; community participation; developing and maintaining interpersonal relationships; daily living skills such as cooking, cleaning, shopping, and money management; and community resource awareness such as police, fire, or local services to support independence in the community. Next slide, please.

Michelle Wong:

Program assistance. Day habilitation may include assistance with but is not limited to the following: assistance with home-related activities such as selecting and moving into a home, locating and choosing suitable housemates, locating household furnishings and settling disputes with landlords; managing personal financial affairs, including assistance with income and benefit advocacy, such as general assistance, general relief, and Social Security income if a member is not receiving these services through Community Supports or Enhanced Care Management; recruiting, screening, hiring training, supervising, and dismissing personal attendants; dealing with and responding appropriately to governmental agencies and personnel; asserting civil and statutory rights through self-advocacy; and building and maintaining interpersonal relationships, including a circle of support. Next slide, please.

Michelle Wong:

Day habilitation services also include referrals to non-Community Supports housing resources. If the member does not meet eligibility criteria for housing transition navigation services, Community Supports assistances with income and benefits advocacy such as general assistance or general relief. Oh, let's see. Coordination with the MCP to link the member to any Community Supports or ECM services for which the member may be eligible, as well as the coordination to healthcare, mental health services and substance use disorder services based on the individual needs of the member who are not receiving these links through Community Supports or ECM. Please note that Community Supports shall supplement and not supplant services received by Medi-Cal members through other state, local, or federally funded programs in accordance with the CalAIM STCs and federal and DHCS guidance.

Michelle Wong:

Eligible populations. For day habilitation providers to participate as Community Supports, they must meet the criteria... Sorry, one second. For participants to be in day habilitation, they have to meet the eligibility criteria. So those are those individuals who are experiencing homelessness, individuals who have exited homelessness and have entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in day habilitation programs.

Michelle Wong:

DHCS also outlines the requirements and restrictions for Day Habilitation Community Supports. The services provided should utilize best practices for members who are experiencing homelessness or formerly experienced homelessness, including Housing First, harm reduction, progressive engagement, motivational interviewing, and trauma-informed care. Program services should be available for as long as necessary. Services can be provided continuously or through intermittent meetings in an individual or in a group settings. This service must supplement and not supplant services received by the beneficiary through other programs, as we mentioned earlier.

Michelle Wong:

Allowable providers. DHCS also outlines which types of providers MCPs can contract with to provide this community support. MCPs may choose to contract with the following allowable providers who have the experience and expertise in providing the unique services such as mental health or substance use disorder treatment providers, including county behavioral health agencies; licensed psychologists; licensed certified social workers; registered nurses; health home agencies; professional fiduciary; and vocational skills agencies. Note that MCP network providers that have a state level enrollment pathway must enroll in the medical program as outlined in APL 19-004. If no state level enrollment pathway exists, MCPs must have the ability to vet the Community Supports providers to ensure they meet the required provider standards.

Michelle Wong:

Program benefits. So day rehabilitation programs can benefit clients by supporting independent living through training on self-help and self-care skills, develop self-advocacy skills, developing community integration and supporting skills in accessing services, and developing social and interpersonal skills such as the ability to interact with others in making one's needs known. And with that, I'm going to pass things to Jill to introduce our presenters for the day.

Jill Donnelly:

Thanks, Michelle. All right. So we're moving on to getting to hear from more people in the field. We will now hear from Nancy Shipman, director of Special Projects at Anthem. Nancy, I'll hand it over to you.

Nancy Shipman:

Okay. Good afternoon. Are you able to hear me, Jill?

Jill Donnelly:

Yeah, we can hear you.

Nancy Shipman:

Okay, perfect. My name's Nancy Shipman. I am actually a registered nurse. I work with Anthem Blue Cross, and I am a director in special programs. I actually oversee the clinical teams that are working with our members to deliver community supports. Next slide.

Nancy Shipman:

Okay, so I just kind of wanted to share where a managed care plan is at this point in time. I cannot believe it's already six months into the year. Anthem did go live with Community Supports, specifically the sobering centers, in January, in one county, Sacramento. We did go live with day habilitation in 11 counties, and we have a continued rollouts status through the January of 2024. We are already seeing that referrals are coming in for both sobering centers and day habilitation. I would say, for sobering centers being only in one county, we have received literally only one referral. But for day habilitation, we've received, as of this morning, 101 referrals.

Nancy Shipman:

In looking at why did we, or what process did a health plan go to start covering sobering centers and day habilitation? And we can really say that for sobering centers, we looked at the counties that truly had existing programs. And based on their programmatic infrastructure of those particular providers and programs, we did see an opportunity to start early in Sacramento. And as far as day habilitation, we really thought that day habilitation, or we are using day hab for short, it truly is an integral part of housing transition navigation and housing tendency and sustaining services. So in counties where we had providers of these Community Supports, and we saw they were currently offering day habilitation like services, we made a decision to start concurrently because we truly feel that the day habilitation should increase the successes of our members staying permanently housed. Next slide, please.

Nancy Shipman:

So I'm going to be kind of jumping between looking at some best practices that we're seeing amongst sobering centers as way as well as day habilitation. For sobering centers, we are not authorizing these services, meaning the members have already received services. And then the health plan is being asked to provide an authorization after services are being delivered. We know that our sobering centers may not have visibility into which members are receiving enhanced care management or receiving other community support services that may be in progress.

Nancy Shipman:

So I think that we are... Excuse me. It is important to have referral partnerships and by having Community Supports as well as Enhanced Care Management under one entity. There's more visibility potentially into the members' services they're receiving or have received. We've seen that some of the best practices in sobering centers are a simple process for intake, not making it cumbersome. Also, streamlining the referrals to the county-funded treatment centers and those warm handoffs are truly best practices that we are looking at. In transportation, we know that it is very important for our members to have transportation to the sobering center, as well as when they leave the sobering center to return them back to their community or area of choice.

Nancy Shipman:

So looking at day habilitation, those referrals come into the health plan, and we are using a system where I call a hybrid approach, whereby each referral is managed by a service coordinator at Anthem. That service coordinator is a clinician. They are either a housing specialist, they are a registered nurse, or they're a licensed clinical social worker. We are working with the member to give them additional education, as well as what they should expect to receive under day habilitation, what are the eligibility requirements, and assisting with provider selection. We know that it's, data-sharing, really important to be able to share with our ECM providers, Enhanced Care Management providers, as well as our community support providers, information about our members in real time.

Nancy Shipman:

We know... Oops, I lost my place there. Okay. We know that we have many experienced provider, but we also have some inexperienced providers. And it is important to really do the care coordination and the provider support for new referral forms, new methods of authorizations, and learning what managed care

organizations, like Anthem, will and will not do. We know that provider engagement needs to be ongoing and continuous through the completion of the services for our members.

Nancy Shipman:

So I think there were some questions asked to Anthem about pre-authorization and authorization, referral processes, et cetera, in cases of emergency. So we need to remember that sobering centers, services can be delivered without an authorization. And once the member is leaving the facility, the provider can then ask the health plan for the authorization of services that were already delivered. And as far as day habilitation, we currently don't process those requests as an emergency. We are taking the time to talk with our members to make sure that they truly understand what services are going to be delivered. Next slide.

Nancy Shipman:

So we look at best practices, and some of these center around, what I call, provider partnerships. Our umbrella team is called Special Programs, but we have a specific team for Community Supports. Special Programs, as well as our Community Supports team, are engaging in many different activities, ongoing assessment process, as well as guidance and support, training and education, collaboration, program oversight, as well as looking at innovative ways to do business. We know that we need to get the basic things, right. And we've had some really intensive, deep dives to not only educate ourselves as a health plan, nurses, social workers but also to get feedback from our contracted providers because we have found that the most successful services for our members include partnerships and collaboration. Next slide.

Nancy Shipman:

So, when we look at challenges and opportunities as a health plan and for our members, for the sobering centers, we do see one of our biggest challenges is member data sharing. When members enter a sobering center, they have to consent to release their information to the health plan. Understanding that members are intoxicated, that consent may be difficult to obtain if they are not currently sober. Also, the challenges are building out a large network of local providers. And then looking at challenges of day habilitation. I think this is about education and understanding the connection of day habilitation to successful housing.

Nancy Shipman:

I will tell you from a personal perspective, coming into learning about CalAIM and the Community Supports that health plans were going to offer, I've been a nurse for 35 years, I truly did not know what a sobering center was. I did not know about day habilitation. So I've taken the time to have these deep dives, educate our staff, ask those hard questions, ask providers to share what they know. Even today, I'm learning more and more. The managed health care plans are invested and interested in providing these services. And we always say, "Okay, so how's the health plan really going to evaluate that these are cost-effective community supports?" We hope to take a multifaceted approach that includes monitoring service costs as well as utilization at both the individual level and a population level.

Nancy Shipman:

We realize that in the first several months of any Community Supports, that our utilization may be higher. But that over time, our members should become more stable in the community with the wraparound services offered by Community Supports. And that over time, the cost of Community Supports will be expected to decrease. And by year two, we're even going to know more. We're going to have more data. Data is important while we're offering services to look at a more broad spectrum, look at our populations. We truly expect to see an overall decrease in the per member cost across the populations and to really reevaluate the threshold for cost effectiveness. We want to increase the threshold for cost effectiveness so we have opportunities to reinvest. Next slide.

Nancy Shipman:

I shared a few success stories because I want to remember that this affects people's lives. As a nurse, as a healthcare company, having these community supports increases our toolbox. We can make a significant impact on members' lives. And these stories were shared by WellSpace who is an Anthem contracted provider for sobering centers. WellSpace has a health substance use and respite engagement program that is truly innovative and includes a behavioral health portion, providing members with short-term opportunities to voluntarily recuperate from the effects of acute alcohol and drug intoxication in a safe and truly dignified manner. They are staffed 24/7 by healthcare professionals who provide the medical monitoring and the SUD counseling.

Nancy Shipman:

They shared some patient stories about, a member was referred to what they call their SURE from the Folsom Sheriff's mobile crisis team for an amphetamine and alcohol intoxication. Due to the acute medical conditions of the patient, they were discharged to the hospital, but they had the option of returning following their stabilization. Members can self-refer. This member self-referred nine times where he was provided services and supports. Eventually, he was transitioned to a residential substance use disorder treatment center.

Nancy Shipman:

And another story: A patient under the influence of heroin, alcohol, and methadone was referred to their program, a sobering center. After multiple visits, he was enrolled and completed a substance use disorder treatment plan. And he stays connected with the staff and has reported continued sobriety with daily aftercare and self-help support groups. And these stories go on and on. Right? And I think one of the key things that I learned is that many of our members may come through multiple times into sobering centers. And it's not going to necessarily be the first time that they're connected with treatment facilities, that they have to develop trust. I think that's the end of my presentation, Jill, so I'm going to hand it back to you. Thank you so much.

Jill Donnelly:

Okay. Thank you so much, Nancy. We'll now hear from Aulina Bradley, director of Care Management at Aetna. Aulina?

Aulina Bradley:

Hi, Jill. Thank you. I'm so happy to be here with you all this afternoon. As Jill stated, my name is Aulina Bradley. I am the director of Care Management for Aetna Better Health California. A little bit about me: I've been an RN for over 20 plus years. I'm right there with you, Nancy, with regards to CalAIM being new and just really the exciting offerings that the managed care plans can offer. I've been in the managed care space for nearly 10 years with an emphasis on the Medicaid population. I personally feel very, very connected to this vulnerable population, and I understand the challenges that they face. But I'm an advocate and I'm a conduit for change and so improving their current situation is really the right amount of support and engagement. And our care managers at the plan are here to walk alongside our members through their healthcare journey.

Aulina Bradley:

So we're going to talk about Community Supports, a little bit about Aetna. So Aetna's been in the Medicaid space for over 30 years, and we're in 16 states across the country. CVS Health is the largest health services company in the United States, and it encompasses all of the Aetna health plans, CVS Pharmacies, Caremark, and Coram. So we're considered a tested partner in healthcare. And so we were asked the question, on what scale are we covering services of Community Supports? Well, Aetna was one of the only managed care plans across the entire state of California to offer all 14 Community Supports

when it launched in January of 2022.

Aulina Bradley:

The decision to take this bold stance came from our visionary leader and CEO of the plan, Verne Brizendine, who simply stated in executive meeting, I'm using my air quotes, "that we're going to do this because it's the right thing to do and our members deserve it." So our network came quickly, rose to the challenge, and began recruiting and securing contracts for our counters that we currently serve in addition to the target areas that we are bidding for, for our upcoming award in 2024. So why sobering centers? Well, Dr. Shannon Bernardin really outlined very clearly the importance of sobering centers and our communities. Next slide.

Aulina Bradley:

So I just wanted to give you a high-level overview of our sobering center intake authorization process for our managed care plan. I think this is great. Even though it's our swim lines, maybe a little difficult to read, so we broken it down into a couple steps. Next slide, please.

Aulina Bradley:

As mentioned before, providers, law enforcement, outreach teams can all help identify members that are intoxicated. And our hope is that they will be connected with a contracted sobering center with Aetna Better Health in California. So sobering center has a process of where they intake the member, and our hope is that they send the clinical information at least five days after services have been rendered for that member. Next slide.

Aulina Bradley:

As the managed care plan, we received the clinical information and hopefully those referrals to follow up on as well. And we create an authorization in our system to offset the claim that we expect to come. We have a reconciliation process that allows for us to look for appended claim for any sobering center services. And if we haven't received that authorization to counteract that claim off match, then we outreach to the sobering centers and follow up with members. Next slide.

Aulina Bradley:

So, again, one of the decision points is, if an authorization is present, then of course the process just goes through as a regular payment. If there was no authorization presented, it could be a couple of reasons for that. We haven't received any of the clinical information in referrals that we would expect to receive from our contracted sobering centers, or if there was a member care issue. As Shannon had also mentioned earlier, that if members can choose to not really want to be receptive to the services, and in that instance, then there really wouldn't be anything that we'd be expecting to receive from our sobering centers, but we would try to also connect with the members to make sure that we determine the next steps in how we can make sure that no one's falling through the cracks. Next slide.

Aulina Bradley:

So just a little bit about our day hab programs. Michelle did a great job going over the ins and outs of all the different services that are offered, so I won't belabor that, and I think we are getting close to time. But next slide for me.

Aulina Bradley:

We did create a custom Community Supports referral form. And what this does is, it makes it easier for our contracted partners to realize that while they're making the referral request, that we've outlined those policy guides based on DHCS requirements. So as long as they are just addressing the member's housing status, the member's participation and other community supports that are wraparound services as well,

and that way it makes easier for them to really ascertain what services they are able to provide to the member. We, as a plan, have dedicated to make sure our providers can access all eight distinct HCPCS codes, try to say that five times, that are in line with the data rehabilitation services because we realize that this provides foundational knowledge and a skill set that helps the member with overall improvement and quality of their life. And we realize the importance of that as well.

Aulina Bradley:

So as Nancy may have mentioned in her presentation, we are looking at some specific key metrics to look at reduced inpatient days, reduce ER visits, and just overall medical costs, realizing that it's only six months into ECM, but we have our informatics and finance team working on putting some of those dashboards in place so we can really see the effectiveness of the offerings of Community Supports. I think that is the last slide, and we may be back on top.

Jill Donnelly:

Yes, we are. Thank you.

Aulina Bradley:

I was trying to do it a little faster. Thank you, Jill.

Jill Donnelly:

All right. We have one more presenter today. We'll now hear from Eddie Hathcock, program director at Sun Street Centers Sobering Center. I'll hand it over to you, Eddie.

Eddie Hathcock:

Thank you. Good afternoon, everyone. I'm glad to be a part of this presentation. My name is Eddie Hathcock. I am the program director for Sun Street Centers Sobering Center, located here in 119 Capitol Street, beautiful Salinas, California, which is under Monterey County. What you see right there is a picture of our facility. It's a beautiful adobe home that we leased when we received the contract from Monterey County Behavioral Health to partner with them to provide this new service of sobering center.

Eddie Hathcock:

I want to thank really quick Shannon and Nancy for all of their very helpful information regarding sobering centers. Sun Street Centers has been in business over 50 years, providing residential treatment, outpatient treatment, DUI services, sober living, prevention services, just a whole host of drug and alcohol treatment and recovery services. So when we were asked to partner with the county to open the sobering center, I too kind of had to do my homework on sobering centers, what they were and what they did. And Shannon was very helpful to us.

Eddie Hathcock:

So, as the slide says now, we provide a safe alternative for... It says medical detox, but as Shannon said earlier, it's basically just helping people sober up. Our sites are quiet, safe place to begin. All of the staff here, we have medical assistants and recovery specialists. Some of our medical assistants are certified medical assistants, and some of our recovery specialists are certified AUD counselors, myself. I'm a man in long-term recovery, and I'm also a board-certified alcohol and drug counselor. Next slide.

Eddie Hathcock:

There's our program's mission. Our whole purpose in being is to prevent alcohol and drug addiction by offering education, prevention, treatment, and recovery to individuals and families regardless of their income level.

Eddie Hathcock:

Here's a slide on who we serve. In our program, you have to be, as Shannon said earlier, 18 years or older to receive our services. You have to be verbally responsive, at least able to communicate with us. And most importantly is, be non-combative. Our program is completely voluntary. We don't force or make anybody stay. We accept all people regardless of their insurance status. That doesn't matter to us at all. Now, our program, due to our contract and our grant and the way it's written, we can only serve clients that are brought here by law enforcement. We don't accept walk-ins and we don't accept ambulance drop-offs at this time. So because of that, and we're completely voluntary, I can tell you that to date, we have served 1,344 clients. And of those clients, we've had seven clients walk away before discharge, which I think is just truly amazing.

Eddie Hathcock:

It really is an opportunity for us to... When we talk about meeting people where they're at, we truly do meet people where they're at because they're intoxicated when they come here. I don't know of another service anywhere, especially in Monterey County, where someone who's intoxicated can receive service. Most of the time, when people are looking for help either in a program, or trying to get housing, or just trying to get any kind of service, they're always told to come back when they're sober to receive help. Actually, we're the only place that people can come to us completely intoxicated. We meet them right where they're at. We welcome them into the program. We have a very low barrier intake assessment process. It's short. It's simple, very meaningful to the point, and it works very well.

Eddie Hathcock:

As it says, our clients are diverted from jail or the emergency room for public intoxication or DUIs. As I just mentioned, all the referrals that we accept are from law enforcement. However, because we are located across the street from an elementary school, we are unable to accept any 290 registrants or anybody who's on Megan's Law because of the school being across the street. As Shannon mentioned earlier, law enforcement, when they bring somebody in, the entire drop-off process for law enforcement is right around seven to eight minutes. We do the necessary paperwork. It really is a warm handoff. I think one of our challenges, our biggest challenges, is that because we are new service, we've been doing this for about five years now, is that there's still a number of law enforcement departments or officers who still have that belief that if you broke the law, you're going to go to jail. And I, for one, know that thinking doesn't work. But we do have from CHP to a number of different law enforcement agencies here in Monterey County really like our service, support our service, and use us very often.

Eddie Hathcock:

So there's just some of the things of what we do during someone's stay here. The staff here, there's two people on staff here at all times, the medical assistant and the recovery specialist. Every client, their vital signs and their overall health conditions are monitored throughout their stay here. About every 20 minutes, providing on the person. We provide referrals. We have a couple of new referral systems actually. In the beginning, we were just referring everybody to our local services as we knew them, either through the SAM guide or our local resource book. But now, we have a referral system called the smart referral system through Goodwill, which is a referral system through the 211 agency process. And we have another Prop 47 referral system, so all the programs that receive the Prop 47 grant and funding, we have a referral system with them. So every client that comes to our service gets referrals appropriate for them upon discharge.

Eddie Hathcock:

One of the special things that we do when someone comes to stay with us, upon admission, we let them use their phone or use our phones. They can call their loved ones. Let them know where they are, that they're in a safe, sober place. And upon discharge, people are able to become picked up by family members or loved ones. And if they don't have someone to come pick them up, we provide transportation

to each and every client who needs it or wants it. It's usually the following morning after discharge. So nobody walks away from our facility. All clients are either picked up by their family members or we drive them home. We provide referrals for physical, mental health. We provide referrals for just about every aspect a person has or want or need. We provide referrals for a whole list of services.

Eddie Hathcock:

So, there are some of our client outcomes as our last program evaluation noted. It's really something to say now, that now that we're starting to provide this service, I think we're slowly starting to shift some of the thought away from public intoxication shouldn't be a crime and people sent to jail for it, but people are actually getting the help that they need. And I'm referring to mostly of the homeless population. Part of the alcohol use and or the drug use that people use when they're homeless, is because they're just trying to survive out there. So now we're starting to hopefully change that mindset about, these aren't bad people that need to go to jail. They're sick people who need some help. And hopefully we continue on with that change. 97% of our clients as of last year accepted referrals through other agencies or other departments. Each client we have do a simple survey upon their discharge. We had a hundred percent client satisfaction based on their experience and their stay while they were here with us. And again, there's our facility. Is this where I could tell a client story?

Jill Donnelly:

Yeah, that would be great. We have about one minute left.

Eddie Hathcock:

So let me tell you about one fine story real quick.

Jill Donnelly:

We'd love to hear one. Yeah.

Eddie Hathcock:

Sure. We were brand new. I was doing a lot of presentations to all the different law enforcement agencies here in Monterey County, introducing them to sobering centers and then asking them to please use our service. A few months after being open, I come to work one morning and I noticed both of my staff were on the floor instead of sitting in their chairs, where they usually are. And as I looked why they were on the floor, they had a tub of warm, soapy water. And we had an elderly woman here who had been brought in the night before. They were literally slowly pulling the socks off of her feet and washing her feet. Come to find out, this lady has had these socks and shoes on for months. So staff was down there taking the socks off and washing her feet up with the soapy water, which was just really something to see.

Eddie Hathcock:

After several hours that day, we discharged her and I drove her home or to her spot that she was living because she was homeless. And when I came back to work, I wanted to meet with my staff, and we had a little group meeting about what I saw when I came into work that morning. And the staff, without missing a beat or a lick, they said, "Eddie, that is somebody's mom. That is somebody's sister." And they said that, "We can only hope that if our mom or our family was ever in the same situation somewhere, they would receive the same kind of love and support that we showed this morning." I'm happy to say that this woman became one of our regulars. Even though she was drunk in public all the time, most officers knew exactly what they do when they found her because she was typically in a bad situation or in a situation that could cause her harm. So they would always pick her up, bring her to the sobering center.

Eddie Hathcock:

It wasn't long before she knew everybody's name. We knew her name. So every time she came, she was

highly intoxicated, never a problem. She came in and she was just really the warmest, loving person you'd ever want to meet, who just had a lot of hard things go her way in life. And she ended up on the streets and homeless. Last year, we had heard that she had passed away. So I'd like to believe that during her last years of life, that she has some very positive memories and experience while she was here at the sobering center.

Jill Donnelly:

Eddie, thank you-

Eddie Hathcock:

One other quick one, really quick. We had a gentleman come to us one night. He was from out of town. Upon his intake, he was telling staff about not only was he an alcoholic and had huge alcohol issues, but lately he had been introduced to heroin so now he's got heroin problem. So upon his intake, he made it clear that if he could get himself into a program or if we could help him, he would very much appreciate that. It wasn't long afterwards staff took him to the bed. He went to the bed and he passed out. And because he mentioned he had done opiates along with alcohol, staff kept a really close eye on him. And during the middle of the night, they noticed that his breathing became very labored and wasn't stable. Staff called 911. 911 was here in about a minute and a half. They picked the gentleman up, and it was a good call. They took him to the hospital.

Eddie Hathcock:

So the next day, because he did give us consent to share that information and try to get him into a program, we contacted our residential program. And so our residential staff went to the hospital to meet with him. He was in the hospital actually for three days before becoming stable enough to be discharged. So staff picked him up upon his discharge, took him back to our residential program. He not only went through our guest room in detox there, but he entered into the program. He did our 90-day program. Just became a huge success. Everybody liked him in the program. He had the right attitude. He had the right motivation. He ended up getting a job in Alaska on a fishing boat.

Eddie Hathcock:

And last I knew, which was a couple of months ago since his departure from us, he gives us a call about every three months just to check in with us, to let us know how good he's doing. He's paying his child support. He's got a new place to live. And he is just so grateful and happy that he came to the sobering center because his words were, "If no law enforcement picked me up that night and brought me there, I might have died, ended up being on the street somewhere." So every few months he gives us a call just to let us know how good he's doing and how appreciative he still is of our services even a couple of years later.

Jill Donnelly:

Eddie, I think I could listen to you tell these stories all day. We are so grateful that you shared them. I know we are over time. Thank you to everyone who attended today and to everyone who presented. We will be sharing slides and a recording following the presentation in the next couple of weeks. There is another webinar coming up on July 20th at 12:00 PM, featuring asthma remediation and home environmental modifications. We hope you'll join us then. Thank you to you all, and have a wonderful rest of the day. Thank you.