CalAIM ECM and Community Supports Technical Assistance Webinar

June 21, 2022

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Mario – 00:00:25	Hello and welcome. My name is Mario, and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q and A. We encourage you to submit written questions at any time using the Q and A. During the phase event, live closed captioning will be available in English and Spanish. You can find the link in the chat file. With that, I'd like to introduce Dana Durham, chief of the managed care of quality and monitoring division of DHCS.
Slide 1	Dana Durham – 00:00:57	Thank you so much, Mario. Welcome. We're excited to have you today as we talk more about CalAIM. And specifically today, we're going to talk about the intersection of community supports and enhanced care management. Next slide please.
Slide 2	Dana Durham – 00:01:15	Before we get into that, I do want to talk a little bit about our Public Health Emergency as it ends. We do realize that the Public Health Emergency will end soon and our goal is to make sure that no one loses coverage. So to minimize beneficiary burden and promote continuity of coverage for our beneficiaries, we're asking you to get involved and we want you to become a coverage ambassador. What that involves is a few things. First of all, we'd like you to download the Outreach Toolkit on the webpage and then we'd like you to join our mailing list to receive updated toolkits as they become available. Next slide.
Slide 3	Dana Durham – 00:02:03	Additionally, there are two phases to our unwinding strategy. The first really is to encourage beneficiaries to update their contact information. This happens right now. In any way you can get the message out that beneficiaries need to make sure that their contact information is up to date with the county. We want to encourage you to do that. That includes things like having flyers in offices, social media, having call scripts, a website banner, anything you think you can do to make sure that people are aware and would potentially stop them from losing coverage, we want you to be active in doing.

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Slide 3	Dana Durham – 00:02:43	And then phase two will be before the pandemic ends, that's 60 days prior to its termination. And at that point, we want everyone to remind beneficiaries to watch for the renewal packets in the mail and continue to update their information with the county office if they've not done so. And as I said in the beginning, it is very important that those who are receiving healthcare continue to receive healthcare through Medi-Cal if they're eligible. And so as much as you can help us get that message out, we would appreciate it. Next slide.
Slides 4-5	Dana Durham – 00:03:22	So let me give you an overview of what we'll be talking about today. We'll do the welcome and introduction, which I just did, and then I'll go over ECM and Community Supports, what they are, and just a really high level thought of what they are and how they came to be as well as we'll talk a little bit about how Community Supports and Enhanced Care Management fit together. What are some of the questions that you may have? And then finally, we're going to spotlight the Illumination Foundation and CalOptima and how they're working together on the ground to make that intersection work. And then we'll have a question and answer session. So next slide. I will begin with the recap of both. Next slide, please.
Slide 6	Dana Durham – 00:04:14	So as many of you are aware, we are doing CalAIM, which is officially California Advancing and Innovating Medi-Cal. It's really a long-term commitment to transform and strengthen Medi-Cal, really, in an effort to offer a more equitable, coordinated, and person-centered approach to maximizing health and life trajectory. And so the goals are really threefold. The first is to implement that whole-person approach and address the social drivers of health. The second is to improve our quality outcomes while reducing health disparities and really transform our delivery system overall. And finally, we want to create a consistent, efficient, and seamless Medi-Cal system so that wherever you are in the state you'll know what is available to you, and it looks the same. Next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Dana Durham – 00:05:10	So I'm going to give you a little bit of how specifically the programs of Enhanced Care Management and Community Supports came to be. We had two programs that preceded Enhanced Care Management and Community Supports. They were the Health Homes program and the Whole Person Care pilots. The Health Homes program was a benefit that was in select counties and it was only available to manage Medi-Cal manage care members. Then the MCPs administer Health Homes and Care Management was contracted out to providers. That was one of the programs. The other one was a limited pilot supported by our 1115 demonstration and it was called Whole Person Care, and it had coverage and delivery system. It really didn't matter which one you were in. You could be in Fee for Service, Managed Care, or just at the point where you are eligible but not insured yet.
Slide 7	Dana Durham – 00:06:12	There was no requirement for having to interface with the Managed Care plans and it was administered by the counties or local entities. Those two programs were smaller in that they weren't throughout the state, but they had a lot of great lessons learned. And from those lessons learned, two things really stood out that we wanted to carry forward. One was really coordinating care across the spectrum for those who needed additional support and who really were medically vulnerable as well as had some social concerns. That has gone into the benefit of Enhanced Care Management. That is a benefit and it's coordinated through Managed Care plans and the care provided is done through community providers.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 7-8	Dana Durham – 00:07:10	The second program was Community Supports. Community Supports are optional services, but they're not... They're strongly encouraged, but they're not required for a Medi-Cal Managed Care plan to uptake. And it's only available for Medi-Cal Managed Care plan members, and the Managed Care plan administers the services through community providers and well as coordinating with the Enhanced Care managers when someone is receiving Enhanced Care Management. So those are the two ways that we've taken these programs, which were in specific counties, and had them go statewide, which was really important because we felt like a lot of lives were really being impacted in important ways. Next slide, [inaudible 00:07:58]. So what is ECM? As I said, it's Enhanced Care Management and it is a new benefit and its goal is to support comprehensive management from enrollees with complex needs. That also must often traverse several delivery systems to access care, including primary and specialty care, dental, mental health, substance use disorder, and long-term services and support. And that's including but not limited to, because any type of care that someone's receiving, we want to make sure that's coordinated. ECM is designed to meet both the clinical and non-clinical needs of the highest need enrollees during intensive care coordination of health and health-related services.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 8-9	Dana Durham – 00:08:50	Meeting enrollees, really, wherever they are. They could be unfortunately on the street or in a shelter or sometimes they can be in their doctor's office or at home, but wherever the beneficiary needs care, the goal is to give care where they are. Enhanced Care Management really is part of our overall broader population health management system, which Managed Care plans will offer care management interventions at different levels of intensity based on member need, and ECM is that really highest level of need. Next slide, please. ECM went live on January 1st, 2022 and the 25 counties that participated in either Health Homes or Whole Person Care. With approximately 95,000 Medi-Cal members transitioning from those programs, and the individuals who transitioned were high utilizers, there were individuals experiencing homelessness and adults with SMI or SUD. If an individual was enrolled in one of those programs but did not meet the criteria for the eligibility that's described in our Enhanced Care Management, they were transitioned and will be assessed for whether or not they meet graduation criteria before they no longer receive ECM.
Slide 9	Dana Durham – 00:10:22	Starting soon, July 1st, 2022, ECM will go live statewide for individuals and families experiencing homelessness, high utilizers, and adults with SMI or SUD. So as it's just in the counties that we're already operating in Hudson Infrastructure, now it's going to go statewide. Then starting on January 1st, 2023, we're going to increase the number of individuals who are eligible by adding populations of focus. Two of those populations of focus that are being added are individuals at risk for institutionalization and eligible for long-term care, and nursing home facility residents that wish to transition to the community. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Dana Durham – 00:11:15	So that gave you a really good glance at a high level, and if you're interested in ECM, there are a lot of places you can find out more information, so I don't want to leave that out. But what is Community Supports? Community Supports are services that manage Medi-Cal managed care plans are strongly encouraged but not required to provide as substitutes for other services such as hospitalization or skilled nursing facility, admissions, not being able to be discharged or emergency room uses. And that doesn't capture all the things that they're substitutes for, but I will say that they're substitutes for things that are traditional medical services, and the services that they substitute for are part of the state plan.
Slide 10	Dana Durham – 00:12:02	So those are benefits, whereas Community Supports are options but not benefits in the same way. Community Supports are designed to be cost-effective alternatives to that traditional medical service that I was talking about. They're really designed to address the social drivers of health. So those are the factors that can influence someone's health, such as being homeless, such as having a place that really is prone to make someone's asthma worse. Those are just a couple of examples. Another one would be if you need food or sustenance that is healthy. That's another substitute, but next slide.
Slide 11	Dana Durham – 00:12:48	I'll go into them a little bit more. There are, really, 14 Community Supports that are pre-approved. Some of them focus on housing. So our housing transition navigation services, our housing deposits, and our housing tenancy and sustaining services are a suite of services that are geared towards those who have been homeless or are currently homeless to get them into a place that would be a home for them. There are a couple others that really try to transition someone as they're either leaving an institution or leaving a hospital. Those are short term post-hospitalization housing and recuperative care or medical respite, which would be at a time where you've been in the hospital or in somewhere where you need intense services and your need has really lessened some.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Dana Durham – 00:13:46	They're also respite services, which will give you a break just for a little while so that you can get some more support as you're delivering care. Day habilitation programs and then there's nursing facility transition or diversion to assisted living facilities. I always wonder why the number eight isn't up with four and five, and usually I skip it around, but I forgot to this time. Nine is true of that as well. Both of those really focus on getting you out of an institution and into the community, one from nursing facilities to assisted living and the other one to home. To enable someone to stay in a home, someone may need personal care services and homemaker services, so that's one of the optional Community Support.
Slide 11	Dana Durham – 00:14:38	And then there are two that really focus on the situation in your home that may need some adaptations so that one can stay in the home. Those are our environmental accessibility adaptations, which is number 11 and number 14. Asthma remediation, and both of those focus on how you can stay in the home you're in and making the environment a little more livable according to your needs. The last two are medically tailored meals or medically supportive food. When someone needs some extra sustenance or some healthy meals that would enable them to really be able to live independently, that's the goal of that. And finally, sobering centers, and those are places that for less than 24 hours, someone can go if they need some help with sobering up. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 12-13	Dana Durham – 00:15:35	So who is eligible for Community Supports? Each Community Support has specific eligibility criteria linked to each service. And enrollees who are in the Managed Care plan may be eligible for Community Support, but if someone's eligible, it doesn't mean they have to take up that Community Support, it means they can. Given that Community Supports are optional to the Managed Care plan, there's a mix of what Community Supports are available to each plan within each county. So on each plan's webpage, they have information about what Community Supports they offer as well as we do have a link on this slide to where we have a list of the Community Support that each plan and each county is choosing. Next slide, please. Where are Community Supports available today? You'll see that they're available throughout California. You can see that Community Supports elections really phase in 2022 and 2023 with over 10 of the 14 Community Supports offered in 16 counties. That's a lot, starting in just a little while. Now Riverside, Sacramento, and San Diego counties will offer some combination or all of the 14 Community Supports depending on the plan. But just to note that 97% of all California counties, so that's 56 out of 58 counties, offer at least six Community Supports. We're really excited about ensuring that people can be more independent and we really believe that this is the trajectory to keeping people independent and in the community. I do want to note that Managed Care plans can opt in to offering new Community Supports every six months, and that's either in July or January of each year. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Dana Durham – 00:17:49	So I'm going to talk a little bit about the relationship between ECM and Community Support. With two programs that we've started, one is called the Incentive Payment Program and the other one is Providing Access and Transforming Health, or PATH. We've realized that it is going to take a while and that we have some infrastructure to build throughout the state to enhance the availability of ECM and Community Supports. So the first program is our Incentive Payment Program, or IPP, and it's a program that is run through the Managed Care plans and they can earn incentives as they implement and expand ECM and Community Support. Now, the Managed Care plans work with providers who either have the capability or are going to do things to increase our capability to offer ECM and Community Supports through their plan.
Slide 14	Dana Durham – 00:18:52	There's also our PATH program, as I said. PATH is a five-year $1.85 billion initiative that's part of our 1115 waiver. It provides resources for community providers to really build that infrastructure up and to successfully deliver ECM and Community Supports. Now, the two aren't intended for the same provider for the same purpose, but they complement each other. We really feel like, together, those two programs will enable us to really embed ECM and Community Supports throughout the state so that no matter where you live in the state, you have some access to these programs, which we really feel like are very important for our beneficiaries. Next slide, please.
Slide 15	Dana Durham – 00:19:44	So how do ECM and Community Supports fit together? There are some frequently asked questions that you may have, so I'm going to go over those. Next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Dana Durham – 00:19:55	Eligibility. So if you're getting ECM, can you also be eligible for one or more Community Supports? The answer to that is yes. They do not conflict with each other, but they complement each other, and when used together appropriately, they do really add a lot to our ability to make sure that we lessen disparities and keep people in the situation in which they wish to be in. The second question is, does a Managed Care member have to be eligible for ECM in order to be eligible for one or more Community Supports? The answer to that is no. One can receive a Community Support and yet not be in Enhanced Care Management. Next slide, please.
Slide 17	Dana Durham – 00:20:42	Can a Community Supports provider also provide ECM? Yes, an organization can be both a provider for Community Supports and ECM or they can just focus on one of the two. So if a provider offers both ECM and one or more Community Supports to the same Managed Care member, will they be paid for both? Well, yes. DHCS expects that Managed Care plans reimburse for services that are offered, and that would include both ECM and Community Supports if they're offered by the same provider. Next slide, please.
Slide 18	Dana Durham – 00:21:21	This next one, we'll focus on services and the question is, are there any exclusions on a person receiving ECM and Community Supports at the same time? No, there really aren't. The lead manager for ECM really maintains that primary responsibility for the coordination of the member's care across the physical and behavioral health delivery systems as well as addressing the social support needs of the individual to make sure that they can access care appropriately and timely and in the way that individual needs. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Dana Durham – 00:22:02	Can a Medi-Cal Managed Care member receive help with housing through both ECM and Community Supports? The answer to that is yes, the ECM member may help connect the member to housing resources, but the housing Community Supports are really specific services that are geared towards that coordination of housing overall. So as I said before, those include the housing transition navigation services, housing deposits, and housing tendency and sustaining services. Next slide, please.
Slide 20	Dana Durham – 00:22:41	With this next slide, I'm going to turn it over to Edith Coakley Stowe, who's with Manatt, and she's going to talk to us about what ECM and Community Supports look like on the ground.
Slide 20	Edith Stowe – 00:22:54	Great. Thank you so much, Dana. My name is Edith Coakley Stowe. I'm with Manatt Health and we support Dana's team and DHCS more generally in the implementation-
Slides 20-21	Edith Stowe – 00:23:03	For Dana's team and DHCS more generally in the implementation of ECM and Community Supports. But some of you may have joined us at previous presentations in the last couple of weeks where we've really begun to bring to this audience organizations who are actually implementing these services today, so that they can paint the picture for you and for other parts of the state, what this looks like and be available to take your questions. So I'm very excited to introduce our panel. Next slide. I am going to ask our panel actually to introduce themselves, turning it over first to Paul Leon.
Slide 21	Paul Leon – 00:23:44	Thank you, Edith. My name's Paul Leon. I am a public health nurse, founder and CEO of Illumination Foundation. And I'll turn it over to Dr. Pooja Bhalla.
Slide 21	Pooja Bhalla – 00:23:57	Hey, everybody. I'm Pooja Bhalla, I'm the executive director of healthcare services at Illumination Foundation. Turning it over to Francis.
Slide 21	Francis Angeles – 00:24:07	Hello everyone. My name is Francis Angeles. I am the manager of CSS Housing Services here at Illumination Foundation. And I'll pass it to Kelly.
Slide 21	Kelly Bruno – 00:24:17	Good morning, everyone. So happy to be here today. My name is Kelly Bruno, and I'm the executive director of Medi-Cal and CalAIM for CalOptima.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Edith Stowe – 00:24:30	Kelly, you're going to keep the mic if you can go to the next slide.
Slide 22	Kelly Bruno – 00:24:33	Alright, let's do it. Let's go to the next slide. So I'm excited to give you a little bit of an overview about CalOptima and how we have started to implement the CalAIM program and work collectively with Illumination Foundation. So this first slide just gives you a little bit of an overview of who we are. CalOptima's mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We are Orange County's only medical health plan out here, serving low income family, seniors, and people with disabilities. We actually serve one in four adults, and one in three children in Orange County, so that's quite the reach. And we are just only as strong as our provider network. And so I've just listed some of the many provider network partners that we are proud to work with here in Orange County. We're also quite an employer, have an influence here in Orange County with over 1,500 employees and an annual budget of just under $4 billion. Next slide, please.
Slide 23	Kelly Bruno – 00:25:36	We are very proud to have a very diverse member pool here. You can see here the ages of our members are very vast, as well as the ethnicities that we serve. And we feel that this just definitely represents the communities that we serve and the county that we're in. Next slide, please.
Slide 24	Kelly Bruno – 00:25:59	So implementing ECM and Community Supports, as with all of you, was a huge priority for CalOptima. And while we are dedicated and committed to providing all 14 of those services, including ECM, in the next several months, we had to start somewhere. So in January 1st of 2022, CalOptima opted to start with these particular community supports we provided enhanced case management, and then opted to start with the housing services, which included recuperative care, housing navigation, housing deposits, and then of course, housing sustaining services. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Kelly Bruno – 00:26:41	Now we do have some additional services, as I mentioned, coming on in July. Just a few weeks away or even just a week away. And we tried to group them together in a way that we thought made sense. And so this was the second set of services that we'll be launching in just a few weeks, which is the short-term post-hospitalization, the day rehabilitation programs, personal care, homemaker services, the meals, and the sobering centers. And part of the reason that we grouped them the way we did, was the first group obviously had to deal with housing, and the last group of services more so with the long-term care population. And our feeling was that some of these other services in the middle, while also community focused, were also networks that we wanted to make sure that we had up and running in preparation for that long-term care population.
Slide 25	Kelly Bruno – 00:27:32	So the personal care and homemaker services specifically, and the meals, are things that potentially those individuals may need for a smooth transition. And so felt that getting those services in the second piece and get those up and running would help us prepare for the third piece. Next slide, please.
Slide 26	Kelly Bruno – 00:27:51	And here's the third piece. So these are the services that we'll be providing as of January 1st of 2023, which are the respite services, excuse me, the environmental accessibility, the nursing facility transitions, the community transitions, and then the asthma remediation. So by the time January 1st of 2023 rolls around, CalOptima will join that small group of exclusive health plans that are offering all 14 community services to our members. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 27	Kelly Bruno – 00:28:24	So how does one become eligible for ECM services? So the first thing is, of course, they have to be a CalOptima member with no share of cost. They need to meet the DHCS criteria and be a part of the populations of focus that have been defined by DHCS. And while our hope and desire was not to exclude anyone or to exclude as few people as possible, there are a couple of groups of folks that are not eligible, and those are listed there, specifically those that are enrolled in our OneCare Connect or PACE program or that are part of the 1915 Waiver. Next slide, please.
Slide 28	Kelly Bruno – 00:29:05	So this is what our ECM referral form looks like. And we receive referrals, as you can see here, from providers, community-based organizations, of course from the County of Orange, and then others as well. It should be noticed that in order for us to create this form, we had to do two things. One, we had to partner with our health networks, which we'll talk about it a little bit, to try to create a form that was easy to use, and that it did include the information that we needed. We also needed to create a closed loop referral system here in Orange County, which we did, which we affectionately call CalOptima Connect. And that is how the majority of these referrals are received and tracked. Next slide, please.
Slide 29	Kelly Bruno – 00:29:52	So this is our current ECM Service Provider Network. And we've listed all of those on the left there and then showed you who is currently in the program. It is worth noting that many of these folks did transition from the Whole Person Care program, which is why they were immediately enrolled. We are of course wanting these numbers to go up because we, CalOptima, is dedicated to ensuring that everyone who's eligible for ECM services is actually enrolled.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Kelly Bruno – 00:30:18	Now, currently the way we are providing ECM is through our health networks, which is why you'll see CalOptima listed there as well. That's because of the structure that we have, but we are excited to really expand this, because we do recognize and realize that ECM services, while they can be successful at the health network level, they also can be quite successful at the community level. And so we are not restricting ourselves to one model or the other. We're hoping to embrace an expansion when it comes to our ECM services. Next slide, please.
Slide 30	Kelly Bruno – 00:30:59	So, community supports referral and authorization. Who can refer for a community support? While we have listed shelters, community providers, and families, I think the one that's most important is to say, anyone can refer somebody. And the more the merrier. We've been out, I feel like I've been on the road on like a dog and pony show, going and telling everyone about these supports, anyone that could be appropriate. We've been to police departments, health agencies, you name it, anyone can refer. And I think that's the most important message here. Next slide, please.
Slide 31	Kelly Bruno – 00:31:35	So this is our community support referral, which looks very similar to the one that you saw for ECM. And in the same way that we work with our health networks to create that form, when it came to our community support referral form, we had to also make sure that we engaged the community based organizations who would be using this and to ensure that it met their needs, that it was easy for them to use, and that it, again, could be incorporated into our CalOptima Connect, which is the closed loop referral system. So when we utilize this form and we contract with our community-based organizations, we have to include the training necessary for them to be able to use that system. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 32	Kelly Bruno – 00:32:19	So who is our community support network to date and what services are they currently providing? Again, until July 1st of this year, we are just implementing the four community supports, but you can see the list of providers that we have to date and the services that they provide, highlighting appropriately Illumination Foundation, which is one of our few members that are offering all four services that we have currently in the pipeline. Now, a couple of things to note here is the majority of these organizations are either navigation centers or shelters, and that's why they're appropriate for these services, but it also should be noted that there are many other community based organizations in Orange County that provide these services. And CalOptima's absolutely dedicated to expanding our network of providers so that we can reach every corner of the county and be able to provide culturally appropriate services to all of our members.
Slide 32	Kelly Bruno – 00:33:21	Also, when you look at the housing numbers and you see who we're helping right now, we can see that it's vastly majority towards the upper end of age, which of course makes sense knowing that the unhoused population is rapidly aging, and that is the fastest growing cohort, but we also know that there are individuals that are unhoused that are also younger as well. So CalOptima will be making a huge effort to try to make sure that we are reaching this population as well. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 33	Kelly Bruno – 00:33:55	So this is kind of the magic slide. And this is to shows when it comes to ECM and it comes to community supportive housing services, CalOptima's perspective is that it really is a two way street and that we should not only be receiving community support referrals from the ECM, but it should go the other way around as well. That our community support providers, our community-based organizations, should also be referring into the ECM system. When that happens, then we feel that our members get the best services possible. Not only are the referrals coming from the top down, but they also need to cut from the bottom up. And part of that work that we need to do, and we recognize that we have some work here to do, is really to embrace and bring in our community-based organizations into the ECM space. And so we are definitely looking forward to making that happen in the future, and know we have a lot of hard work ahead of us but are looking forward to the opportunity. Thank you.
Slide 34	Edith Stowe – 00:35:03	Thank you so much, Kelly. [inaudible 00:35:07] it again. Next slide, please. So you've heard the plan perspective from Kelly from Orange County. We're going to switch gears now for the next few minutes and hear from Illumination Foundation, who is operating in Orange County, but not just Orange County. And they will explain what that looks like and how it intersects with the system that Kelly has just described from the plan perspective. So I'm going to turn it back to Paul.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 34-35	Paul Leon – 00:35:37	Thank you, Edith. And thank you, Kelly. Want to tell you a little bit about Illumination Foundation. We are a grassroots safety net organization that was started back in 2008 as the response to the homeless situation. And what you're seeing in front of you is basically a shelter back in 2007, where you see individuals were families with children, baby on an apnea monitor, and people with mental health, substance abuse, is all in one facility and only there during the day. So as a response to that, we started Illumination Foundation, and next slide, please, and you'll see in front of you just a brief history of how we started in our path where one of the key things to note on this history is probably about 2010, when recuperative care, medical respite, started in Orange County, that was funded by grants and hospitals.
Slide 35	Paul Leon – 00:36:51	And we began there actually in a hotel, really grassroots, basic recuperative care, and then just built on that. One thing to note is that in 2012, we started receiving other grants that worked on housing, rapid rehousing, both mostly in Orange County, but you can see the start of integration towards healthcare and housing. And then of course, in 2015, we opened up in Los Angeles, 2016, open in Inland Empire, and then really became a Southern California medical respite facility. And so when in 2017, when the waiver came through and Whole Person Care began in Orange County, we were elated, because we understood that for us healthcare was housing and it was that continuum that we continued to build. 2020, the Health Homes program began and we really started piecing together that integrated system that we have today. But both those programs, Whole Person Care and Health Homes really allowed us to build the infrastructure through trial and error and really put forth what we have today. Currently we have five recuperative care facilities with about 340 recuperative beds throughout Southern California. Next slide, please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Paul Leon – 00:38:44	So I think the most important thing that we want to stress is that that system of care and that continuum really follows what CalAIM is doing. From street outreach into a navigation center, family emergency center, medical respite, and then into a micro-community or permanent housing. That continuum we've found, through trial and error imperative, because you really needed to address multiple symptoms for our complex clients. And trust me, we have pretty complex clients that we're taken care of. One thing that also to note is that when we began this, we had to figure out innovative ways to fund it. We used City County ESG money, we used hospital charity funds to fund part of it, and then obviously HUD for the housing portion of it.
Slide 36	Paul Leon – 00:39:48	It was really a fragmented system. And at that time, years ago, institutions weren't talking to each other. Now the advent of the 11-15 waiver, CalAIM, and others that came forward, we can see the benefit of now having an integrated system, including funding. So we're really excited to move forward on CalAIM and feel that in the years to come, it will be really a game changer for us providers in the field. So with that, I want to turn over to more of the operations and the nitty gritty of how we're implementing on the level that we're doing within Illumination Foundation. So I'll turn it over to Dr. Bhalla.
Slide 36	Pooja Bhalla – 00:40:42	Right. Thanks Paul. Hey everybody. So Paul just sort of took us through the beginning of how Illumination Foundation came to fruition. It's important to note that when the organization started, it was actually pre-ACA. Here we are talking about CalAIM, at the time when the organization started, California was not a state that had the affordable care act. I worked on the East Coast for many, many years and worked in a state that was an early adopter of the affordable care act. So when this organization started, it really relied on a lot of the funding from different partners, different organizations, to build a system.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Pooja Bhalla – 00:41:26	And as you can see, at the time, we were trying to connect folks to a system of care, but very quickly had to organically start addressing those social determinants of health, so we can actually bring people into a system, start taking care of them, getting them into stability. So started off with a motel setting that Paul described, ran some street teams, going out doing outreach. In fact, we ran a program for the healthcare agency about four years ago, where folks were living in the Riverbed here in Orange County and were being asked to move out of the area and be inside. And we were called to action to bring folks in, and we started to sort of put pieces together and how are we going to actually bring folks in, but then connect them to a system of care.
Slide 36	Pooja Bhalla – 00:42:18	And that's where we started to really look at housing navigation, housing retention. We were already getting some HUD funding. We were looking at our inventory of housing. So over the years, we've had to look at different ways to build that system. And along came Whole Person Care, and we participated in that as well. And a point to be noted, here in Orange County, the Whole Person Care program at the time for recuperative care was ran by the healthcare agency. CalOptima was administering it, but it was actually ran by the healthcare agency.
Slide 36	Pooja Bhalla – 00:42:53	So we were working closely with the healthcare agency who would work directly with the hospitals at the time. The hospitals would go through Whole Person Care just to refer patients over to the medical respite recuperative care. And then in 2020, we started to work directly with CalOptima on the Health Homes program, which again, allowed a lot of those social issues to be addressed in a way where we could actually take folks to a system of care. One of the things early on we wanted to address, is how do we keep people out of the hospital system and the shelter system? We started working on innovative housing solutions.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Pooja Bhalla – 00:43:35	So what you see here is that fourth circle is what we're calling a micro-community housing program. And this was another innovation that Illumination Foundation started with working with our communities, with our neighbors, to bring folks into places where they normally wouldn't have access to where we started to rent single family homes with five, six bedrooms, and each room would be a unit for an individual experiencing homelessness, where they could move in while they waited to get connected to a voucher. As many of you I'm sure are aware, it takes a long, long time, months, sometimes up to a couple years as someone to actually get connected to a housing voucher, and that way it gets them moved into permanent housing. So you can see at the bottom of the slide, the different funding sources along the way that we had to piece together to make this continuum work. Next slide.
Slide 37	Pooja Bhalla – 00:44:39	One of the things as we were building our system, we wanted to be mindful of is the system working? Is it working for the mainstream healthcare system? Are we actually affecting and impacting people's care? Is it saving dollars? So what we did was we worked very closely with our wonderful partner, CalOptima in Orange County, the managed care organization, to look at the Whole Person Care program over a three year period where we looked at 1,250 members who came through our system of care that we just described, and see what was working, where did we need to make changes? But we needed to kind of really look at the data to help us inform where we needed to focus our energy. And while we looked at it, we noticed that there is ED reduction utilization, when folks using the emergency room. When they are coming in through the streets, they go through a shelter, they get connected to Health Homes, Whole Person Care, now CalAIM, that you are seeing the impact of the system reducing cost in the emergency room, and obviously in the inpatient side as well. Next slide.
Slide 38	Pooja Bhalla – 00:45:55	And here it is in terms of the overall cost to the Medi-Cal system in one county, where we saw about a 31...

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 38-39	Pooja Bhalla – 00:46:03	... System in one county where we saw about a 31% decline in cost, total cost of care for this population of 1,250 members. What's not here is what we know. There's a lot of costs that's incurred by other systems. A lot of our clients do travel from county to county, other hospital systems, other medical systems that they were using, other MCOs that they may have also been part of. So you don't see that true cost savings here because this data is reflected through the CalOptima data set where the total cost over that three-year period was 31%. And when you break it down per member per month, that number's close to 23%. But if we were to add a lot of these other costs, the criminal justice system, the EMS, a lot of these things that don't always get captured through the managed care organization, that number is actually a lot higher. Next slide. And this is sort of the slide that really highlights what CalAIM is really talking about and is intended to do is how do we address the social determinants of health for individuals and what are those critical services that actually not only are the right thing to do for these patients, but also are saving the system money. So as part of our system of care, we provide all these services and then we wanted to look at the impact in terms of dollars. And you can see when you are starting to actually provide transportation for someone, someone may be living in a shelter, but they don't really know how to get to the doctors. They don't have transportation.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Pooja Bhalla – 00:47:44	So initially when you're starting to provide some of these services, you're actually going to see, you're investing money up front, you're actually going to lose money on some of these services, but overall, when you continue and over a year, you can start to see the savings sort of come about when you're actually offering behavioral health therapy in house, through medical respite. Folks are actually doing a lot of the medical coordination, substance use treatment, case management, a very, very critical role that they play in managing the care for these individuals long term. You can see that addressing the social determinants of health is not only the right thing to do but is actually impacting and saving thousands of dollars to the system. Next slide.
Slide 40	Pooja Bhalla – 00:48:36	So here we are, 2022 went live with CalAIM, building upon a lot of the work that we had been doing through different pieces, different grants, different organizations, but it did position us in a place to start working very directly with CalOptima to take on the new community support. So as of date, we are offering all four community supports that Kelly just described. And many of those members again, were grandfathered through the Whole Person Care Program and Health Homes Program, which we were already participating in. So we're offering Housing Transition, Housing Deposits, Housing Tendency and Sustainability, Medical Respite, started off early on with different funding sources, moved on to Whole Person Care. And here we are today under CalAIM. One of the things that I wanted to highlight is that we really appreciate CalOptima's eagerness to really provide quality effective care for this population.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Pooja Bhalla – 00:49:41	And what I mean by that is we have partnered together to really accept people directly from the hospital. So if we have someone who's experiencing homelessness and they're in the hospital and they're stable and they meet criteria that's been laid out by DHCS for recuperative care, we can go ahead and accept that patient and CalOptima's saying, we will cover that cost for 14 days because we know that service is needed. We do not have to go through a prior authorization process, which sometimes takes 72 hours, up to four days. And that patient is in the hospital occupying an inpatient bed where they could easily be in recuperative care. So that's something that we were able to work closely with CalOptima on, and I can tell you that we have seen a lot of success with individuals coming directly from the hospital and we get to start working on them, working with them right away.
Slide 40	Pooja Bhalla – 00:50:38	And then we work directly with the CalOptima team to see whether they need to be extended for 30 days or 60 days. But the ability to bring someone in right away has really helped us in engaging them early on and engaging their enhanced care managers in coordinating their care. We will be entering into Short Term Post Hospitalization Program coming up in July. In fact, we ran a similar program with one of our hospital partners in Orange County, where we took in 108 of the highest utilizers of the hospital system. And the pathway was, they come in through Whole Person Care and then the hospital partner decided to keep them in the post-hospitalization Program. That's being referred here for sometimes six months to seven months with a goal to get them into housing. So we're excited to see that DHCS and the MCOs are going to be offering this. Again, it's an optional service, but it is a much-needed component of the larger system of care.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Pooja Bhalla – 00:51:45	So while we continue to work on CalAIM, how did we get here? What did we need to do? Because we have been working with a lot of these pieces all along, we were able to take a lot of our existing staff, our case managers, our medical coordinators, and get them up and running for January 1, live date of this year. But it wasn't easy. It was a tall order in terms of trying to get them used to a whole new system of documentation, and in all these new systems that we need to do, what are some of the metrics we need to be paying attention to? And Francis will talk a little bit more about sort of how we needed to build that workforce, but we had to really plan early. And this is where I think it's really important to talk about the need of IPP and the path funding that Dana just described that organizations like ours have counted on that because it allowed us to build that infrastructure ahead of time and be ready on January 1 to actually get the program going.
Slide 40	Pooja Bhalla – 00:52:55	So we're really thankful and excited to see that there's more of that support coming from the state. Thankfully, we were an organization that had been doing a lot of these things. So we were able to fund some of it through grant money, but to do something at this scale, we needed that IPP funding and look forward to seeing what other resources we could take on as we build more of this program. And enhanced care management is absolutely the goal standard, the benefit that every individual needs to have to really get the care coordinated as they move forward in their journey of stabilization, getting into housing, moving forward in life. We at the current time are not doing enhanced care management in Orange County. However, we are doing it in some of the other counties.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Pooja Bhalla – 00:53:46	And we've seen a lot of movement with many of these complex clients. Engaging with our outreach team as part of enhanced care management outreach is a critical component, and a lot of it comes down to our staff really building those relationships with the clients out on the streets and explaining the benefit of enhanced care management. When we're talking to our clients, they don't even know they have access to healthcare. So having someone out there on the streets, in the shelters explaining what enhanced care management from someone who understands really goes a long way. And we're looking forward to partnering on doing more of these services in Orange County. And I will now turn it over to Francis for the next slide.
Slide 41	Francis Angeles – 00:54:34	Thank you, Pooja. Hi everyone. So here's a slide illustrating the charts of Illumination Foundation's scale to date of the community supports offered with CalOptima. So right now, for Housing Transitions Navigation Services, we're currently serving 193 clients. About 40% of those were grandfathered in from Health Homes Program. And for our Housing Deposits, which is a brand-new program, which we were very excited about, started with CalAIM. In the past with Health Homes Program, we had to use different funding sources, different grants to really gather housing deposits and moving in costs for our members. But now it's kind of all bundled up with the CalAIM package.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 41-42	Francis Angeles – 00:55:37	So with the Housing Tendency and Sustainability Services, we're currently serving 82 members in Orange County, which about 20% were grandfathered in from Health Homes Program. For Recuperative Care, Medical Respite, we've seen a huge increase in client intake, about 40 new members average per month. And then Short-Term Post Hospitalization will start on the first, but what Pooja was explaining, we have something similar already that we worked on in the past. Just with the four services, we've increased by over 150%, so we've served a lot more members. So in terms of staffing model and workforce, we've had to really up the case managers for the recoups at the shelters. The housing navigation for all of the CSS housing services, we had to create positions for lead housing navigators, referral administrators, or specialists to gather all those intakes from the health networks. And it's an open referral from anyone. So we want to be able to gather all of those. And then of course, a manager of CSS housing. Next slide. So I'm just going to explain the process and the progression it took to create CalOptima's referral pathway into our housing community support services. In the beginning, CalOptima hosted meetings twice a week for a few months.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 42	Francis Angeles – 00:57:36	And that meeting included all the housing providers and their health networks to really collaborate on how to better create a streamlined pathway to receiving these authorizations. And in turn, it really did create a more efficient and effective method of receiving those referrals and authorizations. We end up developing a referral pathway with a "no wrong door approach." So CalOptima is very flexible in creating different methods for that authorization referral to be received by us, the CSS housing provider. CalOptima affiliate health networks or healthcare providers can either send Illumination Foundation the referral directly through an encrypted email or a fax. Then my team can go into CalOptima's portal, which is CalOptima Connect and input those authorization ourselves. Or, the healthcare providers can go into the CalOptima Connect portal and assign Illumination Foundation as a CSS provider. And then all I have to do is wait for us to approve or accept that service.
Slides 42-43	Francis Angeles – 00:59:21	And once those authorizations are approved, the member will be assigned a Housing Navigator. And then the Housing Navigator will then contact the clients and conduct an intake process, that includes the individual housing plan and the health assessment. After that the Housing Navigator will maintain contact and really focus on the three areas that we found that the member needs to achieve permanent housing, which is one, stable income. Two, a rental subsidy that will help them pay for their rent. And three, is attain dwelling. Next slide. So I just want to tie this presentation off with a couple of success stories of illustrating how this program has really benefited some of our members and how successful it has been. So the first member to the left, he's been homeless since 2018. Member did not seek any help due to severe social anxiety. Member came to Illumination Foundation, Recuperative Care site at the start of 2020 in very, very poor health condition. Member was unable to speak any English and unable to understand how to take his medications properly and only resorted to go into the emergency room when in dire need.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 43	Francis Angeles – 01:01:02	When the client wound finally healed, he was transferred to Illumination Foundation Shelter, where the client opened up to the shelter staff. The shelter staff was able to get him connected to the doctors that he needed and assisted with sorting and scheduling his medication. Member was enrolled in Health Homes Program in mid-2021. My team was able to obtain a voucher and a one-bedroom unit to get the member housed towards the end of the year. It was very difficult to move this particular client in due to having grown fond of the shelter staff and dependency.
Slide 43	Francis Angeles – 01:01:45	The member was then grandfathered into CalAIM for Housing Sustainability Services. Right now, the member is actively working on family reunification and joining a community-based adult service to help him better socialize. Member has stopped going to ERs and has learned to really schedule his appointments and treatments. So you could see the return right there. And then for the client to the right, he's a professional boxer that became homeless and started living this car in 2017. Too proud to ask for help until the client starts to experience more and serious health conditions. At the beginning of COVID-19, client was enrolled in one of IF's, Project Room Keep Programs, and then the Health Homes Program after. Unfortunately the client self-exited the Project Room Key, but still continued to receive Health Homes Program services while he stayed in his car.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 43	Francis Angeles – 01:02:55	At the beginning of the year, of this year, the member received a voucher and was grandfathered in for CalAIM to receive Housing Navigation Services. And my team was able to attain a unit for the member. While utilizing the CalAIM's Housing Deposit. We were able to pay for the client's moving costs and were able to move him, move him in right away. We are still working with the member and he's receiving community housing, sustainability, and now he's thriving and very, very happy. As an athlete, he is so excited to be able to fully rest in a bed and have the energy to continue working out and training. Client is still considered the oldest active professional boxer and holds the world record. He still hopes to fight and host a charity event in hopes to inspire and give back. Next slide. So I will pass this to Dr. Bhalla.
Slide 44	Pooja Bhalla – 01:04:09	Great. Thank you, Francis. So, what is exciting about CalAIM and where we are today and what are some of the challenges? I think for us, right? We had been working on the system of care for many, many years. It's nice to see that it is all now being supported through CalAIM, that we can really now focus on taking care of the clients. The funding is aligned. The system is being built upon what we already were working on, and now it's all coming together. And that really is a healthcare system. We're recognizing the importance of social determinants of health and how we can provide timely interventions, right? When folks need it. What's more exciting is really that it provides a roadmap for many of our staff who joined us on the front lines, as client care associates, they have a pathway moving forward to become community health workers and work very closely with our clients in the community, teach them about the importance of getting timely care, how to access it, while they're also working on their career trajectory.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Pooja Bhalla – 01:05:23	They might start off with someone at the front desk or client care. Then they become a case manager or a community health worker, and they're getting experience and really building on as they move forward in their career. So that's been exciting to see. We've been able to bring on a lot of our staff who are now being promoted into these roles as well. It's great to see that the populations are going to be expanded, that kids are going to be included later on, families are going to be included. And that enhanced care management, there will be an opportunity for providers like ours to participate in enhanced care management with the MCOs. We already are doing a lot of this ECM services because we need to, to be able to manage the care of these folks, but being able to do it in partnership with the health plan will really make us stronger and better, as we all try to navigate the same goals for our patients.
Slide 44	Pooja Bhalla – 01:06:20	And that care coordination is actually happening because there is an integrated system of care. One of the other things that Illumination Foundation did about a year and a half ago is bring on onsite primary care services for this population, as well as part of a medical group. So not only are we addressing the social determinants of health through the system of care, we're now working very closely with our clients and bringing them into timely care into a doctor's office, which is housed right where they sleep, in the medical respite or the shelter without them having to go to the emergency rooms or inpatient settings. We have therapists, we have psychiatrists, primary care doctors who are now able to take care of them when they need it, where they need it. So really trying to coordinate the care in this integrated system has been really, really exciting.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 4	Pooja Bhalla – 01:07:15	And we've seen some wonderful success stories with clients getting the care that they need. What have been some of the challenges? God, there's a whole list. I think one of the biggest things to point out is the administrative burden of taking on some of these new systems workflows that we're having to get used to with the health plan. We've had to add more positions just to meet the compliance and the requirements for all these documentation standards that we need to report back to, all the managed care organizations, as I mentioned, we're working in different counties too. So taking that piece on has been a lot. And thankfully, thanks to the IPP funding that we were able to get some of those positions funded. What remains a big challenge for us, we are very happy to say that we've built the system of care, but what's really behind in terms of the system is the physical inventory of the housing.
Slide 44	Pooja Bhalla – 01:08:25	So in Orange County, we have hundreds of clients that are currently in Housing Navigation. They have a voucher ready. They have housing deposit that can be tapped into. However, when you think of a vacancy rate on rentals, it's less than 2% right now. So we have folks ready to move into units, but there's actually not physical inventory of the housing available. And that's why the model that I described, the micro community model, where we work very closely with landlords and, will rent five to six bedrooms is going to be the way we're going to continue to move on. But we're also looking at modular housing. We...
Slide 44	Pooja Bhalla – 01:09:02	But we're also looking at modular housing. We just a few weeks ago opened one of our other modular housing programs called Life Ark, which is in terms of building that modular housing is one-tenth of the cost of some of the other housing programs that are out there. So there's lots of work to do, but I feel like partnering together with the ACS and our health plans, we can really be stronger together as we build on the CalAIM forefront. I'll stop here.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Edith Stowe – 01:09:38	Pooja, thank you very much. This is Edith Stone again. And we've had a ton of excellent questions coming into the Q&A. So in the 20 or so minutes that we have left, I'm going to pick some of these out for different presenters. And I'm going to start with DHCS actually and ask Dana Durham a couple of questions. So the first one, Dana, if you're there... Actually, we've just had folks asking to clarify once more where in the state is ECM available, and then how is that different or the same as community support?
Slide 45	Dana Durham – 01:10:17	That's a good question. And I'm probably going to go back and look at these slides and see how I can make that a little bit clearer. So thank you for that. The answer is that ECM is a benefit. And being a benefit, it means if a beneficiary or someone enrolled in a Medi-Cal Managed Care plan is eligible for ECM, the plan must offer ECM to them. So like any medical benefit that anyone is offered a Medi-Cal, anyone who qualifies, or it's medically necessary, they have the right to that benefit.
Slide 45	Dana Durham – 01:10:51	On the other hand, community support is a little different because it's not a traditional benefit, but it substitutes for traditional medical benefits. So for instance, if you're eligible to be in a nursing home, but some community supports could be offered that would enable you to stay in the community, then that community support can be offered if the plan chooses to offer that community support. So I think that's the basic difference, is one is optional and one is a benefit. But thank you so much for that question. I'm going to look at how I can clarify that. So thank you.
Slide 45	Edith Stowe – 01:11:33	Yeah. And the benefit is available everywhere in the state from July the first. So if anyone still has questions about-
Slide 45	Dana Durham – 01:11:40	If someone's in the managed care plan. Right.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Edith Stowe – 01:11:42	If in a managed... Right, right, right. Great. Okay. So then double clicking on the optionality. So Dana, a number of questions about different flavors of the question. So if a plan decides to opt in every six months and add more, can they also decide to opt out? And that's one flavor of the question. And what about, why is the state not standardizing that all the plans in a county, for example, have to have the same selection? So maybe that would be a question of you describing how this has been worked out with CMS a little bit.
Slide 45	Dana Durham – 01:12:17	Yeah. Yeah. I mean, and I'm going to start with the second part of your question and then I'll answer the first. And I may forget. But the second part of your question is why is it not standardized? And the reason is because it's not a benefit in the traditional sense. One of the things you have to do, as Edith pointed out with the benefit, is make it available throughout the state in the same way. But we don't really have the capacity to offer all of the community supports or services to everyone throughout the state. It's part of the reason that we're undergoing PATH and IPP. And those are really important foci of what we're doing moving forward. And the reason is we want to grow these things so they could possibly be benefits in the future. But because we can't offer it on that wide scale, then we had to look for a different way to offer these services.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Dana Durham – 01:13:14	And so we've done that through a mechanism called In Lieu of Services. And that really, as I kind of explained before, means instead of a service you would be entitled to, this is a substitute. And there are two things that must happen for that substitute to be available. It must be medically appropriate. Medically necessary really is dependent on a benefit. But medical appropriateness is what is appropriate for an In Lieu of Services. And the second one is it must be cost effective. The community support can't be so expensive that it just is cost prohibitive. So those are the two things that the plan looks at and it has held accountable to, and the state is held accountable to for CMS for those services that are given. I hope that kind of... You know? Our hope is that one day all of these community supports do become benefits, but we've got some work to do before we're there. But that's the reason it's a little bit different. And I did... I knew I'd forget the first part of your question, Edith, so you're have to remind what that was again.
Slide 45	Edith Stowe – 01:14:20	Well, I think you answered it right. The question was can a plan opt out?
Slide 45	Dana Durham – 01:14:26	Oh, okay. So just a little bit more about that. A plan can opt out if they choose to. But as they can add a benefit... I mean, In Lieu of Services. Now I'm getting myself confused. As they can add a community to support on a six-month cadence, they can only stop a community support once a year. So it's not every six months that it can happen. And it is a trajectory that a community support could be stopped. First of all, the plan would have to let the state know, the beneficiaries that we're receiving that community support would have to be noticed appropriately and given the benefits to which they're entitled. So it's not like that's an easy process. And we'll have a lot of conversations before a community support would be stopped, but there is a process for doing that.
Slide 45	Edith Stowe – 01:15:22	Great. Thank you. One more for you, Dana, and then we're going to turn back to the panel. Couple of questions about dual eligible. So if somebody's in an MCP and also enrolled in Medicare, can they receive ECM? Can they receive community support? And is it different for D-SNPs?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Dana Durham – 01:15:43	Yeah, and that's a really good question. They can definitely receive community support. Now, there are some instances in which a person could not receive ECM. And that really is when Medicare is offering a product or a benefit that does that care coordination. And oftentimes when you're in a managed care plan or a D-SNP or something else in which Medicare is paying for coordination, we can't pay the same for the same service. So if an individual is in a Medicare product that has that coordination component, they cannot be receiving the ECM component of CalAIM, but they can always receive the community support component.
Slide 45	Edith Stowe – 01:16:33	Right. And just for folks who are curious about that, if you go on the website, the ECM program guide that's just been re-released kind of spells that out if you're interested in the details there. Thanks so much, Dana.
Slide 45	Edith Stowe – 01:16:44	Okay. Last questions here about staffing. So these functions for both CalOptima and for the Illumination Foundation. So, Kelly, if I can turn it back to you from the perspective of CalOptima... I'm just checking if you're still here. Great. You are. Can you say a little bit about how you at the plan staff the ECM and community supports functions? Have you had to grow to do that?
Slide 45	Kelly Bruno – 01:17:10	Well, part of that growth is me. Here I am. So my position was created specifically for this, but clearly, I'm not doing all the hard work. So there are other folks that have been hired as well. But I think that also goes to what CalOptima is hoping to accomplish in the future, which is an expansion of the ECM services to the community, which will and what will end up happening as CalOptima will have to staff up as far as authorizations and things of that nature. Right now, the responsibility for most of that has gone to the health networks, but that's going to be changing. So yes, there is going to be some definite staffing up necessary.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Kelly Bruno – 01:17:51	There's also going to be some additional staff necessary for us to try to manage and support our community-based organizations. As our community-based organization network expands, they need service. You know? They need support is what I meant. They're out in the community doing all the hard work and they should not be expected to know the ins and outs of the bureaucracy that is a health plan, right? So we need to have almost care managers for our community-based organizations to be able to support them, look at their data, help them with possible denials, getting those things approved, expansion of services, et cetera.
Slide 45	Edith Stowe – 01:18:31	Right. And then many staffing questions for Pooja, you and your organization. Can you talk a little bit more about the recruitment pathway for case managers, Pooja, and also a little bit about the staffing ratios for the different housing services?
Slide 45	Pooja Bhalla – 01:18:45	Yeah. As part of our Continuum of Care, we've been running shelters and recuperative care. So we had case managers working in our system and also in our housing part of the organization. So when we moved onto this transition, a lot of those case managers were graduated into this new role because they already had sort of the experience working with the other community partners, the health plans, the county, the Continuum of Care, and Health Care Agency. So it made sense for many of them to assume this new role while we hired up new case managers.
Slide 45	Pooja Bhalla – 01:19:23	And again, some of those case managers came up the ranks. They might have started as a site assistant in our recuperative care provider, really are dedicated to this population. We provided training in-house to train them to become a case manager and connected them with mentors. And in terms of caseloads, a case manager, depending on the acuity of the patients, can range anywhere from 25 to 35 for a case manager. And maybe Francis can talk a little bit about housing navigation because those also come with different caseloads.
Slide 45	Francis Angeles – 01:19:58	Yeah. So for housing navigation, the caseloads up to 30 per staff. And then for the sustainability, we have 45 per staff.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Pooja Bhalla – 01:20:13	And I saw a question about referral team in there as well. Yeah. We've had to triple our referral team because initially we were getting just hospital referrals for a Whole Person Care program through the county, but now Francis has had to build a whole new team just for referrals for the community support side. And we're now working with hospitals directly for medical respites. We've added more referral coordinators that are part of our team. And one of the things that's been wonderful to kind of work together on, we work very closely with the Hospital Association of Southern California. So we attend their meetings along with CalOptima and Health Care Agency to really talk about the referral pathway. What does that look like? Is it working? What do we need to be doing? So a lot of outreach and education is happening by our referral team, hence the growth of the referral team to do all of those pieces.
Slide 45	Edith Stowe – 01:21:13	Great. And Pooja, you and Francis and Kelly have described the presumptive authorization pathway that you've worked out for recuperative care. We've had a couple of questions. Can you really unpack sort of what did it take to get to the place that you're at?
Slide 45	Pooja Bhalla – 01:21:28	Right. So a social worker from the hospital will call our referral person directly. We go through the checklist in terms of the criteria, the form that Kelly showed. If the client meets criteria, within two hours they can actually show up at our facility. They get transported directly to our facility. And from there, it's our case manager and our medical team who works directly with Kelly's group to get beyond that 14-day prior authorization. But this just allows us, saves three, four days while the patient is in the hospital bed to come directly over. So it's really one person connecting with the other and the patient gets here versus trying to do this paper trail up front and going through the pieces. The key thing is they have to meet criteria.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Kelly Bruno – 01:22:18	And I would add to that, just how do we get here. How do we get here? I think the way we get here is health plans, though I can speak from CalOptima's perspective, listening to its partner providers. But we don't understand and know all of the hoops that they have to jump through. We need to listen and then try to make changes based on what we learn from the experts in the field. So I'm hoping that this is just one example of what CalOptima is going to be able to do as it tries to take the requirements from DHCS and try to layer on top of that what we know and in expertise that we learn from our partners.
Slide 45	Edith Stowe – 01:22:58	Great. Along the same lines, Pooja [inaudible 01:23:03] explained very clearly that these housing services are on a continuum for you and they're often provided to the same person over time. How have you worked out with CalOptima which pieces are bundled together versus built separately from a reimbursement perspective?
Slide 45	Pooja Bhalla – 01:23:19	Yeah. Francis, do you want to take that?
Slide 45	Francis Angeles – 01:23:21	Sorry. Can you repeat the question?
Slide 45	Edith Stowe – 01:23:24	Yeah. So you've got housing navigation and recuperative care, for example. Do you build those totally separately when they're for the same person or do you have a model where you bundle them together for billing purposes?
Slide 45	Francis Angeles – 01:23:37	Yeah. So for if a member is at recuperative care and receiving housing navigation or housing services, we do bill separately because there's case managers on site fulfilling their medical needs on top of my team fulfilling our housing navigation duties as well. So those are two separate services that are working in tandem together. Right? And it's more of the case management on site will get all their documents ready. So by the time they're ready to exit the recoup, they should be on coordinated entry. They should have some kind of housing plan that they're waiting on, like waiting on a voucher or some rental subsidies or at least building on that income, stable income. Right?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Edith Stowe – 01:24:31	Great. Nearly at time. Got so many good questions. Pooja, maybe this one. You've mentioned in the presentation that not in Orange, but in other counties, you're beginning to provide ECM as well. So can you give your vision from Illumination's perspective how ECM differs from the housing community supports? How is it going standing up ECM as a housing provider?
Slide 45	Pooja Bhalla – 01:24:58	Mm-hmm. Yeah. So we started to receive a roster of names early January. And what we learned very early is that many of those clients actually aren't even active as part of their health plan. So we had to really work with our outreach team to go through that list, look at who's still active in the system because, as Dana mentioned, they actually have to be actively involved in that health plan to be able to be eligible for that benefit. So that was something we realized that, "Oh wow, we actually got to make sure before we start making these phone calls that they're still active in the health plan."
Slide 45	Pooja Bhalla – 01:25:42	And second was, once we verified that we really relied on our outreach team to find where these folks are, get them to understand what enhanced care management is. And that I would say was probably the hardest part to do because a lot of our clients don't understand the benefits of the ECM benefit. And then it was getting them to enroll in it and then starting to provide the services. So we had our care management team go through a very intensive training program of what care planning needs to look like in terms of the ECM benefits. You know? The eight different services that are offered.
Slide 45	Pooja Bhalla – 01:26:20	And then every week, our care manager is sitting with our entire team with our clinical consultant to understand the needs of each client and we case conference on every single one of them. So the first couple of months, we were just trying to build our team and make sure we had the right clients, finding them, enrolling them. And then we work very closely with the health plans. Every couple weeks, we have a check in with them where some of the things were around the claim submission. A big piece of CalAIM, that everybody should be prepared for, you need a strong claims department.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Pooja Bhalla – 01:26:58	And we had experience with that early on because of the health homes program. So we had to, again, double our claims team as well. So we had to learn all those HCPC codes as we were billing. So when we started the ECM program, we had to work very directly with the health plan on a regular basis saying, "Can we test a couple claims before we send you hundreds of claims," because if you're going to reject them we're going to do the whole thing all over again. So it's a lot of collaboration upfront with the health plan and then ongoing care coordination between our care manager and the health plan's care manager.
Slide 45	Edith Stowe – 01:27:38	Yeah. And you went to my last question actually, which I'm going to ask you already, which is what advice do you have for counterparts, other CBOs who would like to begin offering community supports or ECM with health plans that are much less far along than you are?
Slide 45	Pooja Bhalla – 01:27:55	Yeah. I mean, I think having that infrastructure built in as much as you possibly can, getting your referral team in order, really getting the claims department, having your staff really understand what CalAIM is about. I think our staff obviously, they all want to do the right thing, but there's now a different space we're working in in terms of healthcare. There's rules and regulations and compliance issues. So I think if you're starting to think about that, really looking at the DHCS guidance, familiarizing yourself with all the documents. We met for weeks. You know? We started actually preparing in September of last year saying, "What are the things we need to do? Let's put workflows down together. Let's build our team."

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VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Pooja Bhalla – 01:28:41	So that way, we weren't so crazy. I mean, we were still crazy till a couple weeks ago and trying to figure out things, but planning ahead, looking at some of those documents from DHCS. And then most importantly, getting on to collaborate closely with their MCO, building those relationships. You know? Who's the person, the point person at the managed care organization you're going to work with? One of the things we are still struggling with: each MCO has their own system. You know? The EMR system that they use. We have our own system. So we had to all get on the same page as what are the must haves that the health plan needs from us, what are the things DHCS is requiring in terms of reporting, we all have to report those, and how can we try to connect the different systems together in terms of IT. And that continues to be in an ongoing struggle.
Slide 45	Pooja Bhalla – 01:29:38	So lots of pieces, but starting off small with your claims, referral team, training your staff, familiarizing yourself with some of the DHCS stuff.
Slide 45	Edith Stowe – 01:29:51	Pooja, thank you so much. And thanks to all who were here. We're over time. I'm just going to say to those of you who are left. If you have questions either for the state or for those that you heard from, if you go onto the ECM and community supports website, there is a mailbox that you can use to send your questions in. And we can route them in the right way. That's also the place to check for this recording and other similar webinars from the past. And this will be all posted with the recording on there for future reference. Thank you so much to our panel for an excellent presentation. And we will see everybody soon. Have a great day.
Slide 45	Pooja Bhalla – 01:30:36	Thanks, everybody.
Slide 45	Francis Angeles – 01:30:36	Bye, everyone.
Slide 47	Mario – 01:30:36	Thank you for joining. You may now disconnect.