CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

CALAIM FOR INDIVIDUALS AND FAMILIES EXPERIENCING HOMELESSNESS WEBINAR

Date: May 31, 2024

Number of Speakers: 7

Duration: One hour, thirty minutes, six seconds

Speakers:

- Alice Keane
- Palav Babaria
- Susan Phillip
- Kelly Bruno-Nelson
- Andrew Kilgust
- Mia Arias
- Jillian Marks

TRANSCRIPT:

VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Alice Keane – 00:00:18	Hello, and welcome. My name is Alice and I'll be in the background to support with Zoom. If you experience technical difficulties, please type your question into the chat. We encourage you to submit written questions at any time using the chat. Finally, during today's event, live closed captioning will be available in English and Spanish. You can find the link in the chat field.
Slide 1	Alice Keane – 00:00:40	With that, I'd like to introduce Palav Babaria, chief quality and medical officer, and deputy director of the Quality and Population Health Management Division at DHCS.

VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Palav Babaria – 00:00:52	Hi, everyone. Thank you so much, as always, for joining us on this lovely Friday afternoon, after a long weekend to boot. We're really excited about the panelists and the presentation that we have today to really dig in on how CalAIM and ECM and Community Support specifically can be really transformational for our Medi-Cal members who are experiencing homelessness. You can go into the next slide.
Slide 2	Palav Babaria – 00:01:21	So, really excited that I am also joined by my fellow deputy director, Susan Phillip, who oversees the Community Supports program, and I oversee our Enhanced Care Management and Population Health program here at DHCS. You can go to the next slide.
Slide 3	Palav Babaria – 00:01:38	Just a reminder, I think everyone is already tracking this, but continuous coverage for Medi-Cal enrollment ended with the sunsetting of the public health emergency provisions. So, Medi-Cal redeterminations started about a year ago, and we'll be closing up this month. And so, please continue to spread the message if there is anyone who is impacted by the redetermination process, and we want to keep everyone who is eligible for Medi-Cal on Medi-Cal. And go to the next slide.
Slide 4	Palav Babaria – 00:02:10	These slides will all be posted, but you could obviously click on any of these links to both access resources and data as to what is happening now, and also share them with any Medi-Cal members who may still be going through this process. We can go to the next slide.
Slide 5	Palav Babaria – 00:02:27	So, today, we're really going to start with an overview of what DHCS is trying to accomplish through CalAIM to reduce homelessness and its impact on the well-being of Medi-Cal members. Then, we're going to do a deeper dive specifically into Enhanced Care Management and Community Supports and how some organizations, including some of our panelists today, are really innovatively connecting the dots and integrating these services to truly transform care for our individuals and families who are experiencing homelessness.
Slide 5	Palav Babaria – 00:02:58	And then, the panel discussion, you will get to hear directly from Community Health Works, who is an ECM and Community Supports provider, as well as one of our plan partners, CalOptima, about their experiences standing up services for this population of focus. And as you'll hear directly from them, we recognize this isn't easy work. The devil is often in the details. And they're here to share their journey and how they got to a place where they're really doing some amazing work on the ground.

VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Palav Babaria – 00:03:25	And then, we hope to leave ample time for Q&A. I know we often shortchange this part, but we really do want to hear from all of you. And the chat will be open throughout today's conversation for you to drop in questions, comments, and suggestions, as well as using the Q&A function. Also, a reminder that we are recording today's webinar and we'll be posting the recording as well as the materials onto our website.
Slide 5	Palav Babaria – 00:03:51	So, before we kick off, we want to actually do a poll to learn a little bit more about all of you who have joined today's Friday afternoon webinar. So, we're hoping for a really interactive session. And if all of you who are not joining by phone, can click on one of the questions here for our poll and we'll wait to get a sufficient response that we can share with you, who we're talking to today on our call.
Slide 5	Palav Babaria – 00:04:25	Susan, I'll turn it over to you to maybe just introduce yourself and say a few words while we're waiting for the poll responses to come in.
Slide 5	Susan Phillip – 00:04:32	Sure. Yeah. First, I also want to second my gratitude for fellow panelists on the call as well. Really looking forward to the conversation. As Palav said, a lot of the work and effort being done on the ground is really thanks to the effort of our plan partners and the Community Support and ECM providers who are really doing the lion's share of the work. So, really want to appreciate the work and time here today.
Slide 5	Susan Phillip – 00:05:01	Also, just want to ... We're talking about Community Supports today. There's other initiatives that you might hear throughout the conversation like Housing and Homeless Incentive Payment Programs, PATH. Those are all related umbrella initiatives under CalAIM, that if you are interested in learning more, please make sure to drop it in the chat. We can also follow up with those, especially in terms of PATH initiatives, which is still ongoing. Happy to share more about that as well. Okay. Looks like the poll is ready.

VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Palav Babaria – 00:05:40	So, I will give a personal shout out to the Medi-Cal members, family members or caregivers who have joined today's meeting. Really appreciate you digging in and welcome your feedback throughout this presentation. And then, really exciting to see how many existing ECM or Community Supports providers, plan partners, some people who are interested in becoming ECM and Community Supports providers, and then other entities that are serving this population of focus, have really joined. And we hope to answer as many, if not all of your questions as we go through the next 90 minutes. Great. Susan, I'll turn it over to you.
Slide 6	Susan Phillip – 00:06:20	Great. Thanks, Palav. Okay. So, I'm going to start by providing some broader context on homelessness across California. So, as many of you might know, approximately 180,000 California residents experience homelessness each day, and many of those are those who also need to navigate services, right? Across different delivery systems. They need access to physical and mental healthcare services as well as substance use treatment services. So, individuals experiencing homelessness really do face a wide array of complex needs.
Slide 6	Susan Phillip – 00:06:59	Approximately 36% of individuals experiencing homelessness are experiencing chronic and prolonged homelessness as well. And as you can see on the right on this slide, the impact of homelessness also takes a toll on the physical health of individuals. So, that means increasing the likelihood that a person experiences conditions like hypertension, diabetes, and HIV. So, through services like Enhanced Care Management and Community Supports, which is what we really will be focusing and discussing today, we really are trying to promote care coordination and access to care that reduce the prevalence of the negative health and behavioral health outcomes for our members. We can go to next slide.
Slide 7	Susan Phillip – 00:07:47	So, as many of you may be aware, there really is a robust effort within DHCS, as well as across the administration across different state agencies, to really address housing and homelessness in California. Really, there's been an investment of billions of dollars statewide to connect individuals to stable, secure housing and work to improve their health and wellbeing.

VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Susan Phillip – 00:08:11	So, this slide provides a little snapshot of some key initiatives. It's not an all-inclusive list of all the programs, but we did want to mention a few key programs across the state. First, the Business, Consumer Services and Housing Agency operates the Homeless Housing Assistance and Prevention program. Then we have the Department of Housing and Community Development, which operates Homekey, Housing for a Healthy California, No Place like Home, and Veterans Housing programs.
Slide 7	Susan Phillip – 00:08:39	We have the Department of Social Services, which administers CalWORKS Housing Support Programs, Housing and Disability Advocacy Program, and Home Safe. Again, our focus today will be on two initiatives that DHCS has launched and starting in 2022 through CalAIM, Enhanced Care Management and Community Supports. So, again, that will be the focus of our conversation. So, we can go to the next slide.
Slide 8	Susan Phillip – 00:09:05	So, first, we wanted just to provide a quick refresher on the two critical services, again, that launched in 2022, and really how those two services are important for serving individuals and families experiencing homelessness and who are enrolled in Medi-Cal Managed Care. We can go to the next slide.
Slide 9	Susan Phillip – 00:09:25	Okay. So, both ECM and Community Supports are designed to reach members beyond traditional healthcare settings and into communities. Right? It really is intended to ensure that members are getting the care services where they're at. These are distinct set of supports for members. And often, for members that are experiencing homelessness, they really could benefit from receiving both ECM and Community Supports, depending on what those services are.
Slide 9	Susan Phillip – 00:09:59	So, ECM is a care management model, which really is intended to provide care management for those who experience the highest level of care need. The eligibility criteria is designed around populations of focus that include criteria for both adults and children experiencing homelessness. So, really, the idea behind ECM is that there is a lead care manager who will serve as a member's primary care manager and help support and navigate them to obtain services to help them address their clinical and non-clinical needs. And often, an ECM care manager may identify member's need for housing and then refer that member to a Community Support services or provider.

VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Susan Phillip – 00:10:49	Okay. To switch to Community Supports. In 2022, we launched 14 Community Supports, which are services that managed care plans have the option of offering in their service areas, and there's a wide array of services. They include medically tailored meals, asthma remediation, sobering centers, and others. And we'll be covering a subset of those Community Supports today, those that focus on housing or have a housing related component.
Slide 10	Susan Phillip – 00:11:19	Okay. So, I'm going to just briefly walk through seven housing-related Community Supports, and for those again, who might be less familiar with the total range of Community Support services that are offered under CalAIM, I really encourage you to take a look at the Community Supports Policy Guide, I see that's been dropped in the chat. But please do take a look at that, that it really provides a comprehensive view of the different 14 Community Support services. What is considered in the package of services in each of the Community Supports, eligibility criteria, providers that could participate, et cetera. So, it's really a great resource for you.
Slide 10	Susan Phillip – 00:12:03	So, Housing Transition Navigation Services. So, this Community Supports is really intended for members experiencing homelessness or at risk of homelessness, to help them to receive help finding, applying, and securing housing. So, it really is what it sounds like, to support individuals with the navigation services to find housing.
Slide 10	Susan Phillip – 00:12:28	Housing Deposits is really intended to support members once they've found housing, to receive assistance with housing security deposits. It could be used for utility setup fees, payments for the first and last month's rent, first month of utility, and it could also potentially be used for funding for medically necessary items that's related to setting up the home, like air conditioners and heaters and even hospital beds, to ensure that the new home is safe to move in. So, that's Housing Deposits.
Slide 10	Susan Phillip – 00:13:04	And then, Housing Tenancy and Sustaining Services. So, this is really intended to help members really maintain that afe and stable tenancy. So, that could entail having that oordination and support with landlords to maybe address sues that might come up with the landlord. Assistance th the annual housing recer tification process and linkage o community resources to really prevent eviction. So, really, helping that individual sustain housing.

VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Susan Phillip – 00:13:33	So, these three housing Community Supports are what we call the housing trio, you might hear that, but they're really intended to be available for members at different points of where they are in terms of acquiring housing and maintaining that housing that they have acquired. Okay, we can go to the next slide.
Slide 11	Susan Phillip – 00:13:57	Okay. And then, there are four additional Community Supports that support transition in housing for members that might have acute or intensive healthcare needs. So, Recuperative Care, also known as medical respite. This is really intended to be very short-term residential care for members who may no longer require hospitalization but still need a safe place to heal from an injury or illness. So, it's really intended to be that recuperative care for individuals who, again, are leaving a hospital or acute care setting.
Slide 11	Susan Phillip – 00:14:38	The next is Short-Term Post-Hospitalization Housing, and this is really short-term housing for members who don't have a residence and who have high medical or behavioral health needs while continuing their journey in terms of recovery for medical, psychiatric, substance use disorder services as well. The next is Day Habilitation, and these are programs that are provided in a member's home, or it could also be out of the home in a non-facility setting, within a community, designed to really assist a member in acquiring, retaining, and approving self-help, socialization, and getting that adaptive skill that's really necessary to reside successfully in their environment.
Slide 11	Susan Phillip – 00:15:27	And then, finally, we have Environmental Accessibility Adaptation or home modifications. This is a Community Support service which allows members to receive that physical modification to their home, to ensure that it's really a safe environment for them to really function with greater independence. So, these are the seven different Community Supports that really are intended to help people maintain housing and safe residence in the community. Okay. We can move to the next slide.
Slide 12	Susan Phillip – 00:16:06	All right. So, we want to share some data. So, each quarter we publish data that is related to Community Supports by tate and by the county and managed care. So, this is hrough our ECM and Community Supports quarterly plementation re port. And again, for those of you who re curious about the uptake of these Community upports in your county, we really encourage you to take a look at these public reports.

VISUAL	SPEAKER – TIME	AUDIO
Slide 12	Susan Phillip – 00:16:38	So, as you can see here on the right with the bar chart here, that a number of members are using the housing-related Community Supports. So, they really, the Housing Transition and Navigation Services, and Housing Tenancy and Sustaining Services are really the two most frequently ... Or, has the most volume of utilization of Community Support services.
Slide 12	Susan Phillip – 00:17:06	So, currently, we as a department continue to really encourage managed care plans to offer these services and contract with providers to ensure that there's a robust delivery system to provide Community Support services. And that having that robust delivery system is really what will enable members to be able to get the services that they need and then also improve utilization over time.
Slide 12	Susan Phillip – 00:17:37	Just generally speaking, I do want to mention that we are as a department, taking a look at where there's opportunities to really improve utilization of Community Supports, where there might not be as much as we think there's potential for, and really looking for ways to improve and drive just access to these services for members who need them. So, we have an action plan in place, and we are in the process of rolling that out. So, with that, I will hand it back to Palav.
Slide 13	Palav Babaria – 00:18:10	Thank you so much, Susan. We can go to the next slide. Now we're going to dig a little bit more into the Enhanced re Management benefit. So, ECM is a managed care enefit that anyone who meets the ECM eligibility criteria an receive as long as they're enrolled in a managed care lan. It's really part of a larger care management ontinuum. So, ECM is designed to really serve our most omplex members, who really have a lot of different care anagement needs, often because they have medical omplexity or b ehavioral health complexity or lots of social needs.

VISUAL	SPEAKER – TIME	AUDIO
Slide 13	Palav Babaria – 00:18:44	There are other tiers such as complex care management and basic population health management and transitional care services, which are outlined in our Population Health Management Policy Guide that are also additional services and benefits for members. In terms of the specific population of focus for individuals and families experiencing homelessness, there were several phases of rollout. So, in January 2022, this ECM benefit launched in 25 counties that had previously participated in our Health Homes and Whole Person Care pilots. In July 2022, it launched in the remaining counties across California. And then, a year later, in July 2023, we expanded to the small number of children and youth who weren't covered in that previous population of focus, largely the unaccompanied children and youth experiencing homelessness population. We can go to the next slide.
Slide 14	Palav Babaria – 00:19:41	So, specifically for this population of focus, I will call out that the requirements are different for children and youth and adults. So, for children and youth, any member who's experiencing homelessness, and this includes people at risk of becoming homeless or losing housing in the next 30 days, or exiting an institution to homelessness, or fleeing interpersonal violence, are eligible for ECM. And they do not need any other additional behavioral health or physical health qualifiers. For adults, they have to meet this homelessness criteria plus have at least one complex physical, behavioral or developmental health need, which would benefit from care coordination.
Slide 14	Palav Babaria – 00:20:25	And then, for families specifically, there's detailed language on this in the policy guide, but they're really strongly encourage ... We encourage our plans to make sure that the family, where possible, can be served as a unit. So, if there is multiple Medi-Cal members, parents, caregivers, plus children, that they don't have five different ECM care managers, but that it's really a single approach that is serving that entire family unit.

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Palav Babaria – 00:20:52	On the right, you'll see specific examples of eligible members. This is not an exhaustive list because again, that definition of who is either experiencing homelessness or at risk of experiencing homelessness is pretty broad. But in the first example, you'll see a member who is an adult is experiencing homelessness and has complex healthcare needs due to medical conditions. Second example is a member who has a substance use disorder related condition and just got an eviction notice, so will be imminently losing housing in 30 days. That individual qualifies because they're at risk of homelessness or will be in 30 days, and then also have a qualifying behavioral health diagnosis.
Slides 14-15	Palav Babaria – 00:21:34	Third example is a youth who was excluded from their home due to their gender identity or sexual orientation and is now couch-surfing. This meets our criteria because they do not have a stable, permanent location for housing. Last example is a parent and a child who are fleeing domestic violence from a spouse at home. That also meets these criteria of fleeing interpersonal violence. We can go to the next slide. So, similar to the Community Supports that Susan shared, we have been closely tracking quarterly data that we received from the plans. And you will see that over the last 12 months, we have served a large number of adults who are experiencing homelessness. Our children and youth population of focus expanded in quarter three, which is when this data is from, but is still relatively small.
Slide 15	Palav Babaria – 00:22:28	I will also lift up that we know about 180,000 individuals are experiencing homelessness across the state at any iven point in time, and many, if not most of those ndividuals are covered by Medi -Cal. And so, we know that have a long way to go in this space, and there are any more individuals out there who could be benefiting from ECM.

VISUAL	SPEAKER – TIME	AUDIO
Slides 15-16	Palav Babaria – 00:22:51	The other thing that I will also lift up, we've been having a lot of conversations specifically about our children and youth rollout for ECM, and we know that especially older age children and adolescents may not be interacting with their healthcare providers as regularly if they're healthy, do not have any healthcare specific needs. And so, to identify which of these children and youth are experiencing homelessness becomes much trickier because they're not going and filling out a social determinants of health screening necessarily at a pediatrician's office. We do know that our schools across the state all have McKinney-Vento liaisons who are screening and identifying all school-aged children who are either experiencing homelessness or at risk of experiencing homelessness. And so, I just put that out to everyone on this webinar that really making those strong connections with local schools and other local entities serving children and youth is going to be critical if we're really going to find all of the children and youth who would benefit from ECM and enroll them. We can go to the next slide. I will also say... Sorry, on the last slide...
Slide 16	Sarah Allin – 00:24:27	I think Palav may have just frozen for a second, so we'll give her a minute and see if she comes back. Hold on one second folks.

VISUAL	SPEAKER – TIME	AUDIO
Slides 15-16	Palav Babaria – 00:24:55	I'm so sorry everyone. Technology, you got to love it. Can everyone hear me okay? Perfect. Okay. Apologies for that. I was going to put in a plug that our next quarterly update of Q4 2023 data for ECM and community supports will be released over the summer. So please keep a lookout and you can break down that data by health plan and county to really get a sense of what uptake looks like locally. We can go to the next slide. So, I saw earlier questions in the chat about, "Okay, benefits sound great. How do you actually get this?" And so MCP members can receive both ECM and community supports at the same time. And we also have requirements that for anyone who is enrolled in ECM, that the lead care manager is really doing a comprehensive assessment for all of that member's needs and wherever a member has needs and is eligible for community supports that they're putting in referrals so that a member gets everything that would benefit them and that they're entitled to under these CalAIM programs. So, you can see an example here. For example, if there's an ECM provider such as an FQHC, their job is really to make sure that they do a comprehensive assessment, understand what those members' needs are really understanding what their medical and behavioral health needs are, but also their social needs because ECM is really designed to be a whole-person care program. They would then identify if an individual needs housing support that they can put in those community supports referrals. Sometimes that entity also provides community supports. Oftentimes, those referrals need to go to a different organization who is providing the community supports. Then the example here, they would partner with the community supports provider such as a housing CBO and that that community supports provider would help the individual find, apply for, and secure housing and could also provide assistance with the housing security deposits, utilities set up fees, first and last month's rent, and can also get medically necessary items like air conditioners and heaters.

VISUAL	SPEAKER – TIME	AUDIO
Slide 17	Palav Babaria – 00:27:05	We can go to the next slide. So, the way that members access services is that every single managed care plan across the state that provides these services is required to have a dedicated ECM and community supports website. We, DHCS, personally check those websites on a regular basis and the websites have information for how providers can refer as well as how members themselves can self-refer. So, you do not need a provider referral if you are a Medi-Cal member or if you're an individual that works with the Medi-Cal member such as a teacher or a case manager or working at a CBO. You can also put in referrals on behalf of the members. As our entire state and our plans have been gearing up for CalAIM and ECM and community supports, in the beginning, a majority of our referrals really have been coming from data mining where our plans are looking up, "Hey, do we know from data and information we have who's eligible for ECM and community supports," and then outreaching to those members.
Slide 17	Palav Babaria – 00:28:09	We know that that is not the most effective or efficient way to get member services. If you get a cold call, sometimes people think that is spam, it's a robo-call. And we also know that the needs of each individual are so different and often it is either the members themselves, family members, or providers or CBOs or other nonprofits that are already serving these individuals who really know what their needs are and are best positioned to make a referral and also talk to the member about why this program is important and how it can help them. So, we expect over time that 100% or as close to a hundred percent as we can get of all ECM and community supports referrals are coming from the community and are not plan generated. And yes, I think there's a question in the chat for both community supports, and ECM members can self-refer.
Slide 17	Palav Babaria – 00:29:02	Obviously, they still need to meet the eligibility criteria, but there's information about self-referrals on all managed care plan websites, and you'll see on the right examples of where we want these referrals coming from. And many of you who participated in our opening poll, you fall into this list. So, whether you are an ECM or community supports provider today or just working in this space or interested in working in this space, we encourage you all to start making ECM and community supports referrals today or tomorrow or Monday whenever you're engaging with members. You can go to the next slide.

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Palav Babaria – 00:29:40	So, a few things on outreach and engagement. Again, we know that oftentimes our members have a lot going on in their lives and it could sometimes be hard to actually reach members, find members especially when they're experiencing homelessness and get them enrolled in these programs that over time can help them. And so, we have a few tips from our amazing panelists and other partners who've been working on this. And so all of the managed care plans do have contact information that they receive from DHCS. And so really using as much information as you can get, whether it is information that you get from the plan, trying to find out who their primary care provider is. Often clinics and hospitals have more updated information or may have relatives' information or emergency contacts. Many of our ECM and community supports providers also know where these members may be hanging out, what neighborhoods they may be sheltering in and just going out in person as well.
Slide 18	Palav Babaria – 00:30:40	And so many of our teams, in addition to doing outreach are also engaging street medicine teams who are working in these communities to identify members. The other major theme that we have heard is that doing outreach with individuals with lived experience often is much more effective, that if you have community health workers or other staff who have lived experience, they're often able to connect and relate to members in a way where these benefits are much more welcome and better received than people who don't have that experience.
Slide 18	Palav Babaria – 00:31:13	And that part of this takes time. We've heard stories from our partners where they attempted outreach dozens of times before a member was in a place where they could really engage and accept these benefits. And so not taking the first no or the first barrier as the answer, but really bringing water, showing up consistently, bringing other material resources that are really needed. And then there are a number of entities across the state working with this population both in and outside of the healthcare system. And so really leveraging other community partners, regional homeless coordinated entry systems, et cetera, to find contact information and locations is often really when you're looking for these numbers.
Slide 19	Palav Babaria – 00:31:58	We can go to the next slide. So as Susan...

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Palav Babaria – 00:32:11	As Susan mentioned earlier, we are really trying to improve ECM and community supports to the fullest degree possible to make CalAIM and this transformation of Medi-Cal successful. We know we're not going to get it right the first time. And so having continuous feedback from everyone who is involved in this effort is really critical so that we can take that feedback and make policy adjustments. And so, we have had numerous stakeholder advisory groups. We do regular surveys, we've done interviews, we get quarterly data from MCPs so we can understand trends and then follow up and see what's working that needs to be scaled, what's not working so well that needs to be changed. And then there have been numerous DHCS leadership listening towards statewide because we also know the challenges really vary depending on what part of the state you're in. We can go to the next slide.
Slide 20	Palav Babaria – 00:33:04	All of that really resulted in our ECM and community supports action plan, which we released last summer, which was sort of our first batch of data that we got 18 months into the program that led us to revise a number of policies and really improve them. And so, a few new policy developments that are coming, we have heard loud and clear that having lots of different referral forms and standards, and often if there are multiple plans operating in a county and each one has a different referral process, that is really challenging. So, ECM statewide referral standards will be coming soon. We have also heard that for some populations of focus, especially those experiencing homelessness, having to wait to get an authorization before you start serving a member means sometimes you lose your opportunity to do so. And so, we are working on presumptive authorization to really streamline this process for key populations of focus and ECM providers.

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Palav Babaria – 00:34:03	We're also working on improving the service definitions for housing deposits and really providing a little bit of clarity and improving standardization across MCPs. And then we are also proposing the addition of transitional rent under both of our 1115 Demonstrations so that this could be offered on the Medi-Cal managed care side and county behavioral health side. So much more to go on this, but currently it's slated to go live on a rolling basis starting in January of next year. But we're still working through our federal approvals. The concept paper for this will be coming out this summer, so please keep a lookout for that. And then we've also released a Medi-Cal Housing Support Services Data Sharing Authorization Toolkit because we know that especially in this space, really being able to share data across sectors between the social services and housing sectors and healthcare is so critical. Susan, anything else to add there?
Slide 20	Susan Phillip – 00:35:09	No, I think you covered it, Palav.
Slides 21-22	Palav Babaria – 00:35:11	Okay, great. So now I'm super excited. I know it took us a little bit of time to get through all of that background and context, but the heart of our webinar today really is our provider panel, and these are individuals who are doing the work on the ground locally every day and really transforming care for hundreds and thousands of Medi-Cal members. So, we can go to the next slide. I'm going to ask our panelists to come on camera, and if we can just do one round robin of each of you introducing yourselves, and then we will dig into our questions. And maybe to make it simple, we'll just go in the order top left across and then down.
Slide 22	Kelly Bruno-Nelson – 00:35:56	Great. I will start. Thank you so much. Looking forward to the conversation. My name is Kelly Bruno-Nelson. I'm the executive director of Medi-Cal and CalAIM for CalOptima Health.
Slide 22	Andrew Kilgust – 00:36:06	Hi there. Andrew Kilgust, Associate Director of Medi-Cal and CalAIM for CalOptima Health. Also excited to be here.
Slide 22	Mia Arias – 00:36:14	Good afternoon, everybody. I'm Mia Arias, Director of CalAIM Operations here at CalOptima Health.
Slide 22	Jillian Marks – 00:36:22	And I'm Jillian Marks with community-based organization Community HealthWorks in Sacramento County, and I'm our director of CalAIM.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Palav Babaria – 00:36:33	Perfect. So, we're going to go through four different themes, and I've already seen a lot of traffic in the chat covering how do you even become an ECM and community supports provider once you actually are a contracted provider? How do you engage individuals and families who are experiencing homelessness? How have you been able to weave ECM and community supports together, which can sometimes be tricky, and then really, how do we spread the word and cultivate referral partners to get to that vision of ultimately having all referrals come from the community? So, let's start with the first one, CalOptima. I'm going to go to you first and just here as a managed care plan, what practices have been successful for you in identifying potential community supports and ECM providers and building their capacity specifically for the housing trio and ECM for this population of focus?
Slide 23	Kelly Bruno-Nelson – 00:37:30	Sure. I'm going to start off and I'm going to popcorn it over to the team that does the work. I get to sit and talk about it, about how great it is, but me and Andrew are the ones that really make it happen. But I would say that what was really important to acknowledge and appreciate from the beginning is really the philosophy and the vision of the organization with which you work. So, I do not want to take that away from CalOptima Health. CalOptima Health from the beginning was dedicated to doing as much in the county space as humanly possible. Not all health plans are created equal. We know that they have different areas, different whatever. I just want to make sure that I acknowledge that because it was from that perspective that we were able to grow and develop in a way that we did.
Slide 23	Kelly Bruno-Nelson – 00:38:14	And one of the first things that CalOptima Health did was hire people like Mia and myself. We have absolutely no experience with health plans. We now have two whopping years of experience because they hired us specifically for this, but we came from the community-based organization space. Mia and I ran nonprofits for all of our professional career. It is almost like we've come to the dark side, coming to the health plan, it's like we were on the CBO side and now here we are working for the enemy, but we're not the enemy because CalAIM is what brings the community and health together. And so, it was absolutely... we think the perfect thing for CalOptima Health to do, to hire us. But we brought in a kind of a little bit of a different philosophy and a different way of working, which I think speaks volumes to what we've been able to accomplish.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Kelly Bruno-Nelson – 00:39:03	And one of the first things we did was really go out and listen to our providers in our community. We speak the same language, we understand what they were telling us, and we did massive amounts of listening to try to figure out how we could make changes or help them feel comfortable partnering with us, the big bad health plan.
Slide 23	Kelly Bruno-Nelson – 00:39:24	And Mia and Andrew are going to go through some of the examples of what we did. But the first one I will say is one of the things we've heard from the beginning was that our insurance thresholds were entirely too high. The little, tiny nonprofits, they didn't have that level of insurance. They weren't a chiropractor or a doctor's office or a health... they didn't have the levels of insurance. And so, I went to our finance department, and I said, "We have all these providers that want to work with us, who want to build this network and they can't afford the insurance." So, what our board did was our board lowered the insurance threshold, and then we as a health plan took on the risk that we took away from the community-based organizations. That immediately opened up a whole pool of providers that we could bring into our organization that our members would not have had access to otherwise. And I'm going to pass it on to Andrew to come up with a... tell us about another example.
Slide 23	Andrew Kilgust – 00:40:19	Thanks, Kelly. The other was that we really understood that as someone who has worked at the dark side for a while now, that sometimes it's really difficult for smaller CBOs and smaller providers and community-based partners to actually even get access to the plans. We wanted to make sure that there were staff both in management and at the kind of a liaison level to walk those CBOs and partners through the entire process from credentialing all the way through contracting, making sure they knew who they could get to if there were issues because there's always issues. That's just part of the work we do, but really making sure that they had a live person to walk them through that whole process. I'm going to pass it to Mia to talk about our academy.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Mia Arias – 00:41:16	Yeah. And so just sort of piggybacking off of what Andrew just stated in terms of really providing a high level of support to these organizations, again, going back to what Susan and Palav noted in the beginning of the presentation, we were really looking to identify organizations in the community who already had relationships with the members that we wanted to serve. That is such a critical feature of how we rolled out and implemented CalAIM really across the book. And so knowing that we were going to be contracting with and bringing in organizations that previously did not have experience working with an MCP, and also we were rolling out new benefits with new requirements, new components, we wanted to ensure again that they had a really high level of support to feel like they could be successful providing these services to our members. So, we created the UCM Academy, and really what the Academy is a six-month training and onboarding process and program for organizations who wanted to be contracted with us to provide ECM services to our members.
Slide 23	Mia Arias – 00:42:21	We actually contracted out with the National Healthcare for the Homeless Council, which is a leading advocacy, training, and education organization that focuses on the unhoused population in the nation. They provided a lot of our trainings that were focused on philosophies of care. And then we also provided a lot of internal administrative training that talked about things like how do you bill, how to submit claims, what are the documentation requirements, all those really critical components that on the inside are very familiar to us, but for organizations, again, that are on the outside, this is all new information. So once that six-month period was over, of course, these organizations were then contracted to provide services, but we didn't stop the support there. We continued to provide ongoing training, and we actually currently have what we call just the CalAIM Academy for all of our organizations that are contracted with us. They can participate in these trainings that happen on a monthly basis.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Kelly Bruno-Nelson – 00:43:20	The last thing that I'll add in this section, and then we promise we'll stop talking, but you said you wanted this. So here we go, is that we really took it very seriously to integrate our health plan into the community's strategy to end homelessness. So, to be a real partner in our community, not just to be on the peripheral, but to be a partner. So, what does that look like? I actually sit on the continuum of care board here. I'm an elected member of the board here in Orange County, and we also sit on the Commission to End Homelessness here in Orange County as well. We had to actually get the board of supervisors to approve a position for us to be on the Commission to End Homelessness. So, we lobbied for that saying that we felt we deserved a position there and we needed to be there. So as the health plan, we're not just saying, "We're going to sit by and do the best we can." We're taking ownership and responsibility of coordinating with our county to end homelessness here.
Slide 23	Palav Babaria – 00:44:15	I know we have to go onto our other themes, but I'll just say there's so much to reflect and react to. And I will just lift up that we know our current Medi-Cal system largely was really built for Medi-Cal providers, whether that is at the managed care plan level, the reimbursement level, contracting level, and a huge part of the vision for CalAIM and all of PATH and other technical assistance is how do we help support expanding that tent to really include community-based organizations and non-medical providers in our system.
Slide 23	Palav Babaria – 00:44:46	And we have known that it's going to take a lot of support to support those providers. And Jillian, we're coming to you next, I promise, but really loved hearing how you all also have had to make some of the same adjustments on the plan side and rethink how you as a plan engage with providers. And it really is a two-way street, and for all the plans on the call, clearly you have to go out and recruit and hire from CBOs to achieve this vision. So, thank you for sharing that. Jillian let's go over to you now. We'd love to hear just a little bit about your experience and how your organization became an ECM and community supports provider and what it was like contracting with the plans.
Slide 23	Jillian Marks – 00:45:29	We were participants in the pilot programs before CalAIM, so we had a little bit of a leg up in terms of already having partnerships with our local health plans because we did whole-person care and health homes both. But that's also when we expanded into the housing space. So as part of whole-person care, we were provided community health workers that did field-based services...

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Jillian Marks – 00:46:03	... Workers that did field-based services, and we connected to local clinics and hospitals and housing providers. And we ended up moving into the housing space ourselves. And that's how we started to really build a relationship with the continuum of care, and started to understand how HMIS works and how we can connect and leverage partnerships through that and find our clients when they're missing. And so, we started there and then through those relationships we built with the plans, we contracted with all the plans in our county, which at the beginning of CalAIM was five. Now in Sacramento we have four health plans, which is one of our challenges for sure.
Slide 23	Jillian Marks – 00:46:53	I think becoming a provider now that there's been a lot of lessons learned over the first, almost two and a half years of CalAIM. It's the best time ever to start, because I think all of us have been sort of building the plane as we're flying it in terms of figuring it out. I saw so many specific questions in the chat, and a lot of those specific questions don't necessarily have an answer. And they're plan dependent. When we're providing services in the field to clients, we come up with questions based on our experiences. It's not something that somebody designing the policy at the health plan necessarily foresaw.
Slide 23	Jillian Marks – 00:47:33	And so, a lot of our success has been with our continued engagement and advocacy for ourselves in our communication with the health plans, letting them know what our challenges are and what we need. And we don't necessarily have someone being as generous, maybe as Cal Optima is with their engagement, not going away and really insisting on getting the support that we need. So, did I answer your question?
Slide 23	Palav Babaria – 00:48:06	You did. And I'm going to do one follow up. If you had to pick one sort of just major pain point, it sounds like persistence really pays off and you know what you need now and are able to ask for that, but what's another concrete pain point that you experienced? And how did you solve it so that others on this call don't make the same mistake?
Slide 23	Jillian Marks – 00:48:23	Of becoming a CalAIM provider? I think we had such established relationship with clients. We really went big and wanted to make sure that we were contracted with every plan so that we wouldn't have to lose access to any one of our clients. And so, at the outset of CalAIM, we were the only community-based organization in our county to be contracted with all five plans.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Jillian Marks – 00:48:48	And it was definitely just an administrative headache. Headache is an understatement. And so, I think we underestimated in general the administrative challenge and support that would be needed with navigating different plan requirements and DHCS requirements and updates to the requirements and changes, and what's involved with billing. We're a grant recipient agency and we moved into Medi-Cal billing for the first time. So, understanding claims and how much work goes into claims, or how they're submitted, or submitting them wrong and then having to fix them. Understanding authorizations and the importance of that.
Slide 23	Jillian Marks – 00:49:35	I'm a registered nurse and they hired me on to manage this program. But for our agency, it was a whole new concept that we have to be pre-authorized for services. The client has to be eligible at the time. So, the time it takes to make sure, does this client still have Medi-Cal? Did they lose it and it needed to be renewed? How do we get them re-engaged? Aside from all the other challenges of working with really vulnerable populations, navigating these, overcoming this thing.
Slide 23	Jillian Marks – 00:50:04	It's amazing that we get to be considered healthcare providers under CalAIM, it's this total transformation where us in a community-based organization can be at someone's encampment by their American river and get paid for that work. So, it's phenomenal, but it doesn't come without its challenge of, how do we make sure we get paid? How do we document? How do we teach staff how to pay attention to the right things? Yeah.
Slide 23	Palav Babaria – 00:50:31	I really appreciate those insights, and apologies for all the administrative headaches, but hopefully you're over that hurdle. And I'll put in a plug for those of you on the webinar to our Path website, which has a lot of resources, technical assistance and vendors that the state pays for to help you off figure out the billing and invoicing and pieces which we know are very different than how most CBOs operate today.
Slide 23	Palav Babaria – 00:50:55	So, we could talk about this all day, but we have three other themes that we have to get through. So, we're going to move on to engaging individuals and families who are experiencing homelessness. And Jillian, we'll stick with you, and we'll love to just hear what are the approaches that you and your team use to do outreach and engage members? How do you build trust? How do you maintain contact, especially with the population that may or may not be in the same place every single time? And what advice and lessons learned do you have for our audience?

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Jillian Marks – 00:51:25	Historically, our organization did Medi-Cal eligibility and enrollment going as far back as 25 years ago. And so, as we've grown into the needs that existed in the community, and built teams based on where we found vulnerable populations needed support. And so, we've been building our partnerships in the community for a really long time, and I think a lot of CBOs have a really established niche in their community.
Slide 23	Jillian Marks – 00:51:58	And so based on the partnerships that we've built over time, we are in local hospital emergency departments. We're in some FQHCs, we partner with schools, local libraries. We built a street outreach team in partnership with our county, and with some of the health plans, we've expanded that street outreach team. So, we have community health workers who do outreach and engagement in the community to people at encampments and provide resources and build trust and let people take whatever time they need to engage.
Slide 23	Jillian Marks – 00:52:36	We don't force anyone to get involved with us, and sometimes it takes months or even years for someone to be willing to receive a service. And it might just be that we give them an ID voucher, but it's a lot of us showing up and showing back up and being available at the places where people are. Sometimes our clients will disappear. They don't have a phone. We'll help them get a phone, they lose it, they can't charge it. But connecting as much to any available resources, being ready when it's needed. Providing transportation has been huge because we'll help people get to the place that they need to go.
Slide 23	Jillian Marks – 00:53:17	Partnering with pet resources and vets in the community, that's huge for a lot of our unhoused clients. I think also, even sometimes... This is maybe similar scandals, but sometimes partnering with law enforcement agencies that may be removing people to start to build that relationship and build rapport and prevent the harms of that if possible, and really trying to get on the same page. So, I think, obviously engaging in any case opportunity that's available and participating in the coordinated entry system and HMIS, engaging in that space as well with anyone that we can see has interactions with our clients. Making sure that we keep that updated with our client enrollments so that people know, if they encounter our client, they know how to find us. I'm sure I forgot a dozen, but those are a lot of the different things that we do.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Palav Babaria – 00:54:15	Fantastic. Cal Optima team, we'll see if you have any pearls of wisdom or lessons learned to add on how to best engage individuals and families experiencing homelessness, or we can move on to the next topic.
Slide 23	Mia Arias – 00:54:29	Yeah, I think the only thing that we would add is that, and I kind of mentioned this in the previous question, is that for us, in order to engage those individuals in that population, we needed to bring in the right partners and we needed to bring in the right organizations. And I think partly what actually was in our favor is that many of our team members on the CalAIM team here at also Optima Health were not necessarily from Orange County, so we didn't exactly who all the players were, but that allowed us to really look and to see all of the different organizations and agencies that we may want to contract with.
Slide 23	Mia Arias – 00:55:05	We didn't just continue to say, "Hey, we're going to outreach to the same organizations that we always outreach to." We're really going to look and start building partnerships and having community-based conversations to say, "Oh wow, this maybe smallish nonprofit organization serve this specific population and they do it really well. Let's start having a conversation with them. Let's start building a relationship so that we can bring them in, contract with them and have them offer this service."
Slide 23	Mia Arias – 00:55:32	Because we know, again that the relationship with the member is the most critical to ensuring that these services are successful. I think we've been pretty successful in that. Again, as Kelly mentioned in the opening, we have contracted with over 120 organizations across the county to provide one of the community supports or ECM services. So, I think going back to what Julian said too, having that trust with the MCP and the CBO and the organization is incredibly important.
Slide 23	Mia Arias – 00:56:01	Also, being accessible because Julian, a lot of the questions that she was bringing up, we don't necessarily have the answers to. Andrew and I are going to be like, "Hey, we've got to think through X, Y, Z, let's bring in Kelly. Let's have a discussion." And so really relying on our partner organizations also to be patient with us. Knowing that, again, to Julian's point, and we say the same thing all the time. We are building the plane at the same time that we're flying it. And so having just that mutual understanding I think also goes a long way.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Palav Babaria – 00:56:31	Super helpful and so many common themes of, how do we build trust and how do we bring humility, and working across silos to get to that end goal? So, thank you both for sharing. Cal Optima team. We're going to stay with you and really focus a little bit on how to effectively braid and leverage both enhanced care management and community supports to serve this population most effectively.
Slide 23	Palav Babaria – 00:56:55	You all get the shout out, because your plan has among the highest use of housing deposits statewide. So would love to hear a little bit about the secret sauce. What were the challenges to really delivering the housing trio of community supports, and how have you gotten to such robust uptake in your communities?
Slide 23	Mia Arias – 00:57:16	Yeah, I can start off just by saying, one of the things that was important to us when we were contracting with organizations to provide these services is that we really wanted those organizations to provide all three, because we felt that that was... All three being housing navigation, the housing deposit, and housing tenancy and sustainability. Because we wanted our members to experience that continuum of care. Again, going back to the relationship, I know we talked a lot about that, but we felt that it was important that once they got through the navigation component, they went, they received a deposit, and then they continued to have that relationship with the organization.
Slide 23	Mia Arias – 00:57:54	Again, we felt like that would be a really successful part of how we implemented this service. We also did a lot of listening to our community-based organizations about these services specifically. So, I'll hand it off to Kelly to talk a little bit more about what resulted from those listening sessions.
Slide 23	Kelly Bruno-Nelson – 00:58:09	The listening part was super, super important, and we were able to learn a lot about barriers that existed to be able to use the benefits or the supports. And what we kind of did, what I think we did is we took advantage of the incentive dollars, the HHIP and the IPP dollars, and we kind of blended that together with what we heard our providers needing. So, I can give you some examples.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Kelly Bruno-Nelson – 00:58:34	So, one thing we did is anybody who contracted with us, whether they be a community support provider or an ECM provider, was eligible for $100,000 of IPP funding. This was a huge lift for us as a health plan because then we have 120 grants that we've given out for IPP, but that allowed us to spread the wealth. If we want people to build capacity to be able to provide the services, we have to give them the money to build capacity.
Slide 23	Kelly Bruno-Nelson – 00:58:57	Again, as a nonprofit executive, I recognize that I don't have a zillion dollars in the bank to be able to build this capacity. I need the health plan to recognize and appreciate that I need support in that. So, we tried to do that, and then we also listened to some of the other gaps that they told us they had. And one of them was, "Listen, y'all's deposit is great and we're really excited to have it, but if you think that it covers every single barrier that exists for a person to get unhoused, you are sadly mistaken." There are other tiny little things that can come up that the deposit doesn't neatly cover. And so, we said, "All right, we get it." And we created something called the Whatever it Takes fund, and those were HHIP dollars that we gave to our local United Way to create the Whatever it Takes fund.
Slide 23	Kelly Bruno-Nelson – 00:59:41	And it does literally just that, it works in collaboration with y'all's deposit to say if there's something that's sneaking through some sort of crack, that this will cover. It's literally whatever it takes. And 290 of our deposits, I think have been done in conjunction with Whatever it Takes fund. So just to say that, that has been massively helpful. We also used our HHIP to try to fill gaps as well with organizations. So, we spent over $50 million invested in capital for permanent supportive housing, because again, what good is navigation if you have nowhere to navigate somebody to?
Slide 23	Kelly Bruno-Nelson – 01:00:19	We've done some massive system change grants trying to identify those that are at risk of becoming unhoused, that are children, that are the elderly. We've done some great stuff there. So, we tried to use our dollars to braid it and to provide gaps and to provide services where our providers have told us that there are issues.
Slide 23	Kelly Bruno-Nelson – 01:00:42	We've spent a tremendous amount of time listening to our providers. We believe in the design thinking process, and we believe in inclusion, and that is how we build trust. But it's one thing to listen, but if you don't do something with what you've heard, it doesn't mean anything. It's like, thanks a lot for Y'all telling us how hard it is, sucks to be you. Now we're going to go continue being a health plan.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Kelly Bruno-Nelson – 01:01:03	If we don't do something with what you've told us and try to make changes to make your jobs easier, then the listening means nothing. Right? And so, I think we've done a really good job. We're not perfect. We've got a lot more to do. But I do think that that goes with, that's how we've been able to build trust is because we're not perfect either. We have things we need to learn, but how can we use our dollars to help you get what you need and vice versa?
Slide 23	Palav Babaria – 01:01:31	Thank you so much. And yes, I see a lot of questions in the chat. For those of you who don't live in our alphabet soup world, HHIP is the housing and Homelessness Incentive program, and IPP is the Incentive Payment Program. Both were statewide incentive programs with dollars that DHCS gave our managed care plans to then distribute and use in their communities to really build out capacity. Both for housing supports as well as for ECM and community support.
Slide 23	Palav Babaria – 01:01:59	So, thank you for those questions, and reminders to always speak in plain English. And Kelly just really appreciate you bringing up the importance of listening. I think that is a lesson that we learn at every level, the same way DHCS needs to listen and really receive the feedback about what is working and not working and revise our policies. Plans are clearly doing the same so that those dollars are really solving needs that people have and you're not guessing as what those needs are.
Slide 23	Palav Babaria – 01:02:26	And then certainly that is also the same thing we try to do in our interactions with individual members when providing services. Jillian, let's come back to you, and we'd love to have you walk us through on the ground example of how you've seen ECM and community supports work well together when serving a member?
Slide 23	Jillian Marks – 01:02:49	One of the ways that we made engagement participation in CalAIM more cost effective for us, honestly, is by providing both benefits in-house. And sometimes we'll have one community health worker that's providing both ECM services and community supports, housing transition navigation services. It's more administrative documentation time, but it also goes a long way with trust building with the client.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Jillian Marks – 01:03:24	Our street outreach team may be engaging with someone and start the process of getting them DOC ready for permanent supportive housing, and then do a referral into CalAIM for community supports, and we'll continue to work with the client. And then by getting them placed into housing, we really build trust. And even that can just be a jumping off point into them wanting to be more interested and engaged in enhanced care management. A lot of our clients who are unhoused don't want to think about anything except getting inside.
Slide 23	Jillian Marks – 01:03:58	And so, us trying to do a care plan that has them prioritize going to the dentist because they haven't been in 10 years, is the last thing that they even want to think about. And so, a lot of it is meeting the clients where we're at and leveraging the trust that we can in whatever way we can. And then we also have instances where, as an ECM provider, we've connected someone to housing through the coordinated entry system. And so, we didn't end up being the housing provider, but we handed them off the housing piece, because through behavioral health prioritization, they ended up in the highest level of care, behavioral health, PSH housing.
Slide 23	Jillian Marks – 01:04:45	And then sometimes we will get a referral for ECM from a community partner that's providing community supports and we'll engage with them. And so, our most success is the more that we can engage, the better. We don't have shared data yet, which I know is on its way. I think that's going to be a game changer. I think a lot of our barriers are us not knowing who's who, or who's working with the client, and not having a place to find that consistently.
Slide 23	Jillian Marks – 01:05:20	HMIS does more than anything else. We don't only work with people experiencing homelessness, so we work with some of the other populations of focus as well. But I think case conferencing when we can, asking for meetings, anytime someone wants to check in with us, making sure we're returning calls, outreaching to organizations so they know who we are. And I think sometimes, for Recuperative Care, CS benefit, for example, one of our clients that we were working on housing and ECM got discharged from Recuperative Care and they didn't let us know. And then didn't answer, because of HIPAA wouldn't tell us what was going on with the client.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Jillian Marks – 01:06:04	It was just because that staff person didn't realize who we were. And so, what we found out who the leadership was, addressed that, built that bridge so that we were on the same page. And now we're case conferencing with them regularly. And so sometimes the challenges we're able to use as a way to move forward and get closer and build better relationships. And we've done also a lot of education in the community about... Well, anyway, I'll stop. More people can answer.
Slide 23	Palav Babaria – 01:06:36	So much to follow up on. But I do think that segues really into our last and final section. So, we leave enough time for Q&A, which is really around spreading the word. So clearly, such amazing work is happening here, and yet every time I'm interacting with different parts of the state, it's clear that there are entire pockets of our state organizations and members who've never heard of ECM and community support. And really are not getting the benefit of these programs.
Slide 23	Palav Babaria – 01:07:03	So, Cal Optima, let's turn it to you. In our last few minutes of this panel. What advice do you have for how we get the word out and how you build really those robust partnerships, especially for referrals, even with organizations that are not themselves providers?
Slide 23	Kelly Bruno-Nelson – 01:07:20	Sure. I think overarching the way you do that, and then I think Mia could give you a great example of something that we've done just recently that supports us, is that we feel that, first off, we feel a responsibility with this. And we feel a responsibility to not necessarily just build a network, but to build a community.
Slide 23	Kelly Bruno-Nelson – 01:07:41	So, our job is to build a community here in Orange County that's taking care of our members because we don't do any of it. Cal Optima Health doesn't do any of it. It's the network of community providers that do it. So, it's our job to help build that community, to make sure that we have a trusting relationship, not just with us, but with each other, but there's no competition. We're all in this together. And so, building that community is very important. And Mia, I'll pass it to you to give an example of how we've done that.
Slide 23	Mia Arias – 01:08:11	Yeah. So, one of the things that we actually launched this year was we held our first annual all provider and grantee summit, where we brought together all of our contracted ECM community supports providers and everybody who received funding from us, whether that was through IPP or HHIP. And the purpose of that was just to say thank you, to show them gratitude for partnering with us, for coming along on this journey with us, for being patient with us when we don't know the answers.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Mia Arias – 01:08:41	And it was really successful. People loved just talking to each other. Just having that opportunity to be face-to-face, too, was really important, because we've been Zoomed out throughout the last two years. And we had a really excellent keynote speaker that we brought, Rishi Mishanda. Many of you may know him in the public health world. So yeah, that was just...
Slide 23	Mia Arias – 01:09:03	... in the public health world. So yeah, that was just another way for us to, again, acknowledge the fact that we're not just transactional, that we're not just bringing in people, contracting with them, asking them to do a service and then saying, "Bye-bye." It's like, oh no, no. We continuously want to build this and build these relationships, and that was just one of the ways that we did that.
Slide 23	Palav Babaria – 01:09:23	Jillian, same question to you. What advice or lessons learned do you have in trying to build some of these referral streams?
Slide 23	Jillian Marks – 01:09:33	Like I mentioned earlier, in addition to the different locations I mentioned, we also do in-reach at the county jail. And so, a lot of our referrals are coming from our work, from our own organization, street outreach or from an FQHC or at the medical van with the providers that are doing street medicine. We have a little location set up so that when people are discharging from jail, they can come see us and have a cup of coffee and a snack and we'll try to connect them to services. And so, a lot of the referrals come from ourselves, but there's other places we've been partnering. There are some providers, medical providers, who are hungry to have ECM services for their clients and they have a trouble accessing them. They'll do a referral, but then the ECM provider that gets assigned can never find the client.

VISUAL	SPEAKER – TIME	AUDIO
Slide 23	Jillian Marks – 01:10:33	And so, we've been trying to be more proactive and partnering with some of those providers where they'll do a referral and we'll tell the client, "Come back in a week, and we'll send a staff person out, we'll send a community health worker out to come meet you," so we can engage them and not lose them. And then we're building that rapport also with the provider, so that's been a great way. And then another thing is a lot of people, I saw someone that said skilled nursing facilities need to learn about the services. We try to be a branch to CalAIM for anyone in the community. And so, we've talked with case management departments at different local hospital systems. We've talked in places where we don't necessarily work, but maybe we met someone, and they asked a question. At certain clinics, with harm reduction services. I did an office hours for our COC last summer.
Slide 23	Jillian Marks – 01:11:38	Basically, educating anybody that wants to know about CalAIM, so we have a little presentation, and we'll talk about what it means to be a provider and how to do referrals and what our best practices for successfully referring clients in our county has been. And then I think over time, that just continues to build the partnerships and trust we have with other organizations in the community. Yeah.
Slides 23-24	Palav Babaria – 01:12:01	Fantastic. Thank you all so much for just sharing your wisdom, really all of the blood, sweat and tears that have clearly gone into building up these programs and making them what they are today, and for joining us. I'm sure there will be some questions directed at you, so don't go anywhere. We can put the slides back up. And I saw a lot of questions in the chat about just what are the nuts and bolts? How do you get started? How do you connect? And so, we'll walk through just some of the technical assistance that is available through CalAIM and then move into our Q&A.

VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Palav Babaria – 01:12:35	Great. So again, all of these slides will be posted. You could also Google these terms and find them if you need it sooner. But first-stop shopping, we really recommend the TA Marketplace. If there are specific aspects of becoming a provider that you are struggling with, you can apply to have technical assistance from an expert in the field who has done it or knows how to do it. We also have regional learning collaboratives, the CPIs, and these are really great and often great sort of first-stop shopping for just, you're not sure if you want to be a provider, you're not sure what it entails. Our facilitators are fantastic and can really do some of that orientation. And Jillian, appreciate that you all have been doing it too. But really, they can walk you through just some of the basics and how you get started.
Slide 24	Palav Babaria – 01:13:22	And then the most important thing is the only road to actually becoming an ECM or community supports provider is by contracting with your Medi-Cal managed care plan that operates in your community. And so, in addition to the centralized state resources that we mentioned, please reach out to your local health plans. We know our plan partners are really eager to develop their networks to grow capacity and are in this CalAIM journey with us, and so they're ready to receive your outreach.
Slide 25	Palav Babaria – 01:13:54	We can go to the next slide for Q&A. So, before we just open it up, please use the chat. Please share your own experiences, ask questions. If you did happen to call in by phone and not Zoom, you can press star nine to raise your hand and then we will call on you. And then when you hear your phone number called by the moderator, you will know it is your turn. And if you are selected, then you can press star six to unmute yourself if you are muted. Great. Well, I know we have some of our events team who've been teeing up questions, so let's open it up.
Slide 25	Sarah Allin – 01:14:31	That's great. Thanks, Palav. Thanks, Susan. And panelists, really, really wonderful presentation, and just a lot of gratitude to those of you who have put questions in the chat. I thought Palav, maybe we could just start with some eligibility questions, start at the very top, and have you and Susan answer. So maybe Susan, this one is for you. So, we've had some questions about whether ECM and community supports eligibility are the same across the state. And I think there may be a little nuance here on the community support side, so can you talk through whether these are consistent or may vary a little by managed care plan?

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Susan Phillip – 01:15:09	Yeah. So just to clarify, because I did see a number of questions in the chat for community support. So, plans are encouraged to offer, so not every plan offers all 14 community support. So, there's that first layer, right? Does the plan offer that service in the first place? If they do offer that service, then they are required to adhere completely to our community supports policy guide, which has very specific eligibility criteria for the different community supports. So, I do want to mention that when we first started rolling out community supports, there was some variation allowed where plans could be a little bit more restrictive in terms of what the community support eligibility criteria was. But at the end of last year, we made it really clear they can't be more restrictive. They have to adhere to what's in the guide. So, just want to make sure that folks were tracking that.
Slide 25	Susan Phillip – 01:16:15	And one of the other pieces that I should mention with community supports, under Medicaid, Medi-Cal in general, it is a health insurance program by CMS lens. And we as California has really pushed and saying, " Well, housing is part, making sure people are housed and have that service, is really part of ensuring people are healthy." And so that's how we got these services approved by the federal government. It is still considered a service that's supposed to be medically appropriate and cost-effective, and it is under a broader lens of where providing a community support, making sure people have housing, making sure that they have a safe place to recover after hospitalization will actually save the healthcare system dollars as well. And so that is the paradigm under which CMS reviews Medicare and Medicaid services. Sorry for the acronyms.
Slide 25	Susan Phillip – 01:17:21	But those are our federal partners and they do pay a line and share of a number of these services. So, I do want to share that that's a larger context and that's where the eligibility criteria, where individuals, it does really have to demonstrate that it's medically appropriate and cost-effective for these services to be provided in general. And then the eligibility criteria really has to stick to what we as a department clarified, and plans can't narrow it any further.

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Sarah Allin – 01:17:53	That's great. That's really helpful, Susan. And we just put the link to the specific criteria and the policy guide in the chat. Palav, this question is a little bit for you. So, you've probably seen in the chat we've gotten a few questions about ECM's application to maybe not just specifically the individuals experiencing homelessness population, but populations like those that are engaged in child welfare or foster care. Karina just put a great question in the chat about how ECM might benefit older adults. Do you want to just talk a little bit about the different POS and how you think about the vision of ECM for those populations as well?
Slide 25	Palav Babaria – 01:18:33	Absolutely. We have nine different ECM populations of focus, and today's webinar was really just focused on one of the nine. The goal of ECM across those nine populations of focus is to really find nuanced, tailored providers who understand the unique challenges of each population of focus. So, to provide effective care management for an individual or family experiencing homelessness is very different than the type of ECM care manager who potentially needs to work with a foster child or one that is working with pregnant individuals who are going through their pregnancy journey. And so, a lot more information is in our ECM policy guide. There is also cheat sheets where you can get high-level overviews and fact sheets, and we have lots of resources available.
Slide 25	Palav Babaria – 01:19:24	And I'll just call out the two spotlights that we published, one on children and youth. That one has many more specific, understandable, digestible examples about the child welfare population. And then the other one that we recently published on those who are at risk for institutionalization or who are institutionalized and reentering into the community really touches on some of those unique needs for our geriatric population and especially duals. So, we can drop those in the chat but encourage you all to read them. And then obviously, ATHCS and your plans are available to answer additional questions on those other ops of focus as needed.
Slide 25	Sarah Allin – 01:20:02	That's great. Thanks, Palav. Susan, I know you think a lot about community supports and the intersection with older adults as well and how those may be really important services. Do you have any additional reflections on the community supports intersection with older adults?

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Susan Phillip – 01:20:19	Yeah, I'll just add that there are two community supports that is available right now in the market, and that is essentially to support individuals that are in nursing homes and can safely transition into the community, and then individuals that are at risk for institutionalization, basically to be able to stay within the community. So, those are two community supports that are available. Now, I will say that if you look at our data, those are two that aren't used that widely. So, we are currently undertaking a review of those community supports, really trying to understand, okay, what can we clarify? What confusion there is. If there are specific questions that you all have, definitely share that with us because one of the things we are looking to do in the next few months, really in the next couple of months, so before the end of the summer, is to put some clarification out to the market about using those and providing additional clarification on the service definitions.
Slide 25	Susan Phillip – 01:21:25	But those are two community supports that are available in the market right now. And again, we're looking to refine those service definitions. Ben would welcome any questions or pain points that you might've experienced as you were trying to obtain those community supports. And while I have the mic, I did just want to mention one item related, the technical assistance marketplace. As Palav mentioned, that is an area where, folks, if you're looking for specific hands-on support, we have preselected those vendors. So, I saw a question in the chat about when applications for vendors was going to be open again. If you are an entity looking for technical assistance, the marketplace is open. You can go there now, and you can find a vendor and you can work with them directly on a project, submit an application, and the whole idea is that the TA Marketplace is available, and we'll pay for that project. So, there is a pathway for vendors to come online where we vet them, but in terms of entities that are looking for TA, that's available and open continuously. Just wanted to clarify that.
Slide 25	Sarah Allin – 01:22:41	That's great. Thank you, Susan. Susan, I know we also got a lot of questions about how do I know which community supports are offered within my county. I know there was one that was mentioned about transitions in community supports, providers in a particular community, and maybe one not being available. Just wanted to give you an opportunity to share how managed care plans elect to offer community supports and any reflections you have about when maybe a community support transitions out of a community.

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Susan Phillip – 01:23:15	Sure. Yeah. So, plans can elect to offer or add community supports once every six months, and so they submit that through a model of care submission. However, if a plan decides, "Okay, we are no longer going to be able to offer this community support," they can only do that once a year. It can't be a once every six months thing. It can only be once a year. And they are required to notify the department at least 90 days in advance before that is effectuated. And there are also continuity of care essentially requirements. So, if there are members that are currently getting community supports, they can't just stop providing that because they're going to stop providing the community supports like that individual. And the member that is receiving that community support service has to continue to have that authorized service, and there has to be a transition plan.
Slide 25	Susan Phillip – 01:24:09	So, plans are allowed to have an off-ramp for community supports if they're finding there's difficulty in a specific market in getting providers, but it can only happen once a year. And again, the goal with all the PATH dollars is to make sure that we're building capacity in the delivery system as well. But we did want to clarify that, A, they are to inform the department and there's a clear set of requirements in terms of continuity and how that off-ramping will happen for community supports.
Slide 25	Sarah Allin – 01:24:46	That's great. Thank you. Thank you, Susan. I'm trying to switch it up a little bit. So, Palav, one of the other questions that came in was about members who are pregnant and whether that would help them meet the criteria for the ECM POF for individuals experiencing homelessness. Just wanted to give you an opportunity to talk about that and maybe ECM for individuals who are experiencing pregnancy generally.
Slide 25	Palav Babaria – 01:25:11	So, we have a number of ways that individuals who are pregnant qualify for ECM. So, there is a birth equity population of focus, which is targeted at those pregnant members who experience disparities in maternal morbidity and mortality on the basis of race and ethnicity based off of public health data. We also know that many of our pregnant individuals come into other buckets, whether it is having complex medical conditions and numerous ED visits, experiencing housing instability as described here, as well as a few of the others, which now I'm blanking on what those are. And so essentially, if they meet the criteria for any of the normal population of focus, then they are eligible, and then also the birth equity population of focus they can join.

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Sarah Allin – 01:25:58	Great. Thank you, Palav. I'm going to do one more question, but I will again put in the chat the email addresses for the DHCS inboxes for ECM and CS. If we did not get to your question and it's important for helping members connect to care, please send an email to those inboxes as well, so we'll put that back up. But the last one, Susan, I was going to ask you is about, we talked some about the short-term post-hospitalization housing and recuperative care, and there are a number of questions that people seem like trying to grapple with the difference between those two and the length between them. My novice understanding is recuperative care is a little more intense and perhaps shorter-term, and then the short-term post-hospitalization is a little longer, maybe a little less intense, a longer duration. Can you talk a little bit about the vision for those two supports and how they're different so many people understand it a little more?
Slide 25	Susan Phillip – 01:26:59	Sarah, yeah, you summarized exactly what I was going to say. That is exactly right. The recuperative care is really more intensive, and it is considered a shorter time. And then the short-term post-hospitalization housing is a longer period of time. So, if you think of recuperative care, it is really supposed to support that member right after an acute stay, so when otherwise they might be just staying in a hospital bed for a longer period of time. So, it really is to provide a more appropriate setting for them to have that recuperative care, where short-term post-hospitalization services and housing is really after that acute care phase. But then there's still a place for that individual who does not have an appropriate a residence for them to have that stable setting and where they do need that wraparound and intensive care services still. So, there's also the issue of that individual not having a residence and experiencing homelessness at that time, so that is also a component for short-term post-hospitalization housing.
Slide 25	Sarah Allin – 01:28:24	Great. Thank you, Susan.
Slide 25	Palav Babaria – 01:28:25	And Sarah, I'll just add on the previous question, I was looking it up while Susan was talking. So, it's on page 12 of the ECM policy guide, "But pregnancy is a qualifying complex medical condition. So, for any individual who is pregnant and experiencing homelessness or at risk of homelessness, they automatically qualify for ECM."
Slide 25	Sarah Allin – 01:28:47	Thank you. That was a fast lookup, Palav.
Slide 25	Palav Babaria – 01:28:51	It's like, I know it's in there. I just have to find it in the 200 pages of that policy guide.

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Sarah Allin – 01:28:55	Fantastic. Okay. Well, Palav, I'll hand it back to you to close this out, but again, just highlighting for folks, we really appreciate your time today. Really appreciate the questions. And please, if you have additional lingering questions, the email addresses are now in the chat for you. So, I'll hand it to you, Palav.
Slide 26	Palav Babaria – 01:29:11	I would just express my gratitude. I think we know this work is not easy. It's really hard. It takes a lot of relationships, coming out of our silos, and collective problem-solving. Hopefully we have all walked away with that there is no dark side, it takes a village, and we are all on this journey together. And so just thank you for attending, and an open invitation that we want everyone who really cares about transforming health and wellbeing and outcomes for our communities to really participate in CalAIM. Susan, you got the final word. Anything to add?
Slide 26	Susan Phillip – 01:29:47	No, just again reiterating our gratitude for the partnership and for all the work that you all are doing every day in the community. Really appreciate it. And of course, we're here and you know how to reach us. Thank you all.
Slide 26	Alice Keane – 01:30:06	Thank you.