CalAIM Office Hours: Enhanced Care Management (ECM) and Community Supports Implementation in Rural Counties

September 29, 2022

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VISUAL	SPEAKER – TIME	AUDIO
N/A	Julian – 00:00:20	Hello and welcome. My name is Julian, and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q&A field, which is located on the Zoom panel at the bottom of your screen. We encourage you to submit written questions at any time using the Q&A. The chat panel will also be available for comments and feedback.
N/A	Julian – 00:00:43	Finally, during today's event, live closed captioning will be available in English and Spanish. You can find the link in the chat field. With that, I'd like to introduce Juliette Mullin, senior manager at Manatt. Juliette, you now have the floor.
Slide 1	Juliette Mullin – 00:00:59	Thank you Julian, and welcome to our Office Hours today on Enhanced Care Management & Community Supports Implementation in Rural California. Before we get started and we dive into the content for today, we do have a few DHCS announcements that we'd like to cover with this group. I'm going to introduce Neha Shergill with the Department of Healthcare Services to provide these announcements. Neha.
Slides 2-3	Neha Shergill – 00:01:22	Thanks, Juliette. As many of you know, the COVID-19 public health emergency will end soon. It's likely to be extended, but millions of Medi-Cal beneficiaries may lose their coverage. Our top goal of DHCS is to minimize beneficiary burden and promote continuity of coverage. A reminder, as how you can help, is by becoming a DHCS coverage ambassador by downloading the outreach toolkit on the DHCS coverage ambassador webpage and joining the DHCS coverage ambassador mailing list to receive updated toolkits as they become available. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 3	Neha Shergill – 00:01:54	We do have a two phased approach with the communication strategy. Phase one is designed to encourage beneficiaries to provide updated contact information in order to be able to contact beneficiaries with important information about keeping their Medi-Cal. This phase is underway. And phase two is designed to encourage beneficiaries to continue to update contact information, report any change in circumstances, as well as check for upcoming renewal packets. Phase two will begin 60 days prior to the end of the public health emergency. A phase 2.0 outreach toolkit will be released in the future. Next slide please.
Slide 4	Neha Shergill – 00:02:29	And also just want to highlight the ECM and Community Support Data Guidance Survey. With ECM and community supports now being launched statewide and MCPs and ECM and community supports providers utilizing the DHCS issued standardized data exchange guidance to operationalize the program, the department has released a required survey for all MCs and their launched ECM and community supports providers. This is to understand the status of data transactions between organizations in support of these programs and where persistent data exchange barriers may benefit from expanded to refined data guidance. Examples and links for the DHCS issued data guidance examined by the survey can be found on the slide and within the survey description.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 4	Neha Shergill – 00:03:11	The survey is an opportunity for stakeholders to provide feedback on early implementation and crucial input for DHCS to ensure the long-term adoption and success of the ECM benefit and community supports. This required survey's being distributed to MCPs and ECM and Community Supports providers via a Survey Monkey link, also provided on this slide. And we open through October 7th. Only one survey submission per organization is required. More information can be found on the ECM and community supports DHCS webpage or by reaching out to ECM and Community Supports mailbox. And now I'll hand it back to Juliette with Manatt to talk more about the overview of today's presentation.
Slide 5	Juliette Mullin – 00:03:50	Perfect. Thank you, Neha. So you may be wondering if it's your first time joining an Office Hours session with the DHCS. What is an Office Hours? So an Office Hours is a more informal Q&A discussion with DHCS leaders and stakeholders implementing CalAIM. And we really focus on a specific topic. So where in many of our webinars we might do a long presentation and showcase some different elements of the policy and implementation, here we're going to have more of a Q&A conversation. And today's topic is on rural implementation. So we are really going to take a look at what it takes to become a Community Supports provider in a rural area. Specifically today, we'll be talking to a Community Supports provider. We'll have a conversation about workforce development in rural area. So what does it look like to hire, to train and to retain staff when you're operating in a rural county in California?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Juliette Mullin – 00:04:47	And then finally, we'll also cover some key aspects of service delivery in a rural geography. What does it look like to provide in-person care in the community when there is hundreds of miles in that geography to cover? And so with that, if we go to the next slide, share a little bit more about who we're going to be talking to today. So today we are joined by several leaders at DHCS representing the ECM and Community Supports teams. So we have Aita Romain with the Quality and Population Health Management Division, and we also have Neha Shergill and Michelle Wong with the Managed Care Quality and Monitoring Division. And so they are here to address any questions related to ECM or Community Supports policy from a DHCS perspective.
Slide 5	Juliette Mullin – 00:05:35	Today we'll spend a lot of our time though talking to some featured panelists from the Central California Asthma Collaborative. The Central California Asthma Collaborative is a community supports provider of asthma remediation Community Supports in the San Joaquin Valley. And we'll learn a little bit more about that organization in just a moment. Today we are joined by Kevin Hamilton, the co-founder and co-executive director of the collaborative, as well as Graciela Deniz-Anaya, the associate director for the Comprehensive Asthma Remediation and Education Services Program within the collaborative. Next slide please.
Slide 6	Juliette Mullin – 00:06:15	So how can you be engaged in today's conversation? So I'm going to begin by walking through many of the questions that we have received over the past few weeks and months about rural implementation of CalAIM. And we'll start with those questions. So those are really sourced from previous webinars, questions you've submitted via email and different types of forums that DHCS has hosted over the past few months.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 7-8	Juliette Mullin – 00:06:41	In addition to that though, we invite all participants today to please use the meeting chat to ask your questions or to share your own experiences about the questions we're going to talk about today. We will also have an opportunity for you to raise your hand to get in line and ask a question. And if we go to the next slide, we'll explain a little bit how to do that. I will hand it off to my colleague Emma Petievich with Manatt events to explain a little bit about that process. Emma?
Slide 8	Emma Petievich – 00:07:09	Thanks. Participants must raise their hand for Zoom facilitators to unmute them to share comments. The facilitator will notify participants when we take questions from the line. If you logged on via phone only, press star nine on your phone to raise your hand, listen for your phone number to be called. And if selected to share your comment, please ensure you are unmuted on your phone by pressing star six. If you logged in via the Zoom interface, press raise hand in the reactions area. And if selected to share your comment, you'll receive a request to unmute. Please ensure you accept before speaking.
Slide 9	Juliette Mullin – 00:07:43	Great, thank you. And with that, before we dive into our conversation today, I'm going to invite back Neha to provide an overview of CalAIM, ECM and Community Supports. Neha?
Slide 10	Neha Shergill – 00:07:56	Thank you. So just to CalAIM recap, Medi-Cal is a cornerstone of California's healthcare system. And CalAIM success can set the pace for transformation of the entire healthcare sector. Everyone has a stake in a better Medi-Cal program and many of us know someone whose life depends on it. Medi-Cal covers one in three Californians, just over half in California school age children, half of births in California and more than two in three patient days in California long-term care facilities.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Neha Shergill – 00:08:23	CalAIM's bold medical transformation expands on the traditional notion of the healthcare system. It's much more than just a doctor's office or hospital. It also includes community based organizations and non-traditional providers that together can deliver equitable, whole person care. CalAIM transformation means implementing a whole person care approach and address social drivers of health, improving quality outcomes, reduce health disparities and drive delivery system transformation, and creating a consistent, efficient and seamless Medi-Cal system. Next slide please.
Slide 11	Neha Shergill – 00:08:57	And then just two key CalAIM components that we launched in January 1st of 2022. Enhanced care management, which we refer to as ECM and Community Supports. Members with complex needs most often engage in several different delivery systems and it's hard to navigate those systems. ECM is a managed care benefit that provides comprehensive managed care to the most complex Medi-Cal members. And Community Supports are services provided by medical managed care plans to provide medically appropriate and cost effective alternatives to utilization of services, such as hospitalization or skilled nursing facility stays.
Slide 11	Neha Shergill – 00:09:34	And now I'll hand it off to Michelle Wong, Community Support Team and chief, to provide an overview of ECM and Community Supports.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Michelle Wong – 00:09:42	Thanks, Neha. So ECM is a Medi-Cal benefit to support the comprehensive care management for members with complicated health needs. These members are currently engaged with or should be engaged with several delivery systems to meet their health needs. ECM is intended to address both the clinical and social drivers of health needs of those highest need enrollees through intensive coordination of health and health related services. The services should meet enrollees wherever they are. This flexibility is essential to the design of the program. And there are seven core services of ECM for all populations of focus. And these are outreach and engagement, comprehensive assessment and care management plan, enhanced coordination of care, coordination of and referral to community and social support services, member and family support services, health promotion and comprehensive transitional care. ECM is part of the broader CalAIM population health management system, which is designed through which MCPs will offer care management interventions at different levels of intensity, based on member needs, with ECM as the highest intensity level. Next slide please.
Slide 11	Michelle Wong – 00:11:04	The launch and expansion of ECM. So since January of 2022, ECM has been launching in phases by population of focus. As of July, three populations of focus have launched statewide. These are individuals and families experiencing homelessness, adults at risk of avoidable hospital and ED utilization and adults with serious mental illness and or substance use disorder. Some former whole person care counties are also providing ECM for members who are transitioning from incarceration. In January of next year, two long-term care populations of focus will launch for ECM. Members at risk for institutionalization and eligible for long term care and nursing facility residents transitioning to the community. And in July of 2023, the children and youth population of focus will launch and the adults transitioning from incarceration population of focus will roll out statewide. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 11-14	Michelle Wong – 00:12:16	So Community Support provides the opportunity to address the combined medical and social drivers of health needs, as well as to help avoid those higher levels of care and the associated higher costs. Things such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. And Medi-Cal health managed care plans are strongly to encourage, but not required to offer community support. They are designed as cost effective alternatives or substitutes to those traditional medical services or settings and are intended to address the social drivers of health. And different managed care plans can offer different combinations of community support. The plans must follow the DHCS standard Community Support service definitions in the policy guide, but they may make their own decisions about when it is cost effective and medically appropriate. And Community Supports are not restricted to the ECM populations of focus and should be made available to all members who meet the eligibility criteria for a specific community support. Next slide please.
Slide 15	Michelle Wong – 00:13:25	So on this slide you will find a list of the 14 Community Supports that have been pre-approved by DHCS. MCPs can select from these 14 to offer in the counties where they operate, including housing services, community transition services, medically-tailored meals, and the one we're going to talk about a little bit today, asthma remediation. And to see what Community Supports are available by the plans in your county, you can look up the final elections list on the DHCS website.
Slide 16	Michelle Wong – 00:13:55	And now I'm going to pass it over to Kevin Hamilton, the co-founder and co-director of the Central California Asthma Collaborative.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Kevin Hamilton – 00:14:11	Hi, good afternoon. Hopefully my camera will actually turn on in a moment here. There it is. Great. Thank you. I appreciate it, Juliette. Thanks for the opportunity to be here today. So Central California Asthma Collaborative was originally started as a project that looked at the importance of continuing a home visitor program that had been started in the local hospital based clinic system. Back in 2007, 2008, the hospital decided to step away from a lot of these outpatient type services, as it was incorporated away from its county roots and privatized.
Slide 17	Kevin Hamilton – 00:15:01	So the Fresno/Madera Asthma Coalition, which was very active at that time, got together. I was part of that, as well as my co-executive director here, Tim Tyner, who's also the director of research for UCSF'S medicine program here, along with the rest of the members, and actually created what is now CCAC today. We wrote some grants, we got some funding and we got a couple of staff so that we could continue this approach of providing these home visits that were so critically important to the communities that we serve, where people are often living in really desperate circumstances and low income housing that's very poorly maintained.
Slides 16-17	Kevin Hamilton – 00:15:48	So at any rate, the program kept growing and more people kept wanting the service and we were able to provide more funding. And in 2011, the entity formed a nonprofit of 501(c)(3) and incorporated at the same time and became an actual company. And we named it at that point Central California Asthma Collaborative. Moving forward, we worked with various academic institutions to test the intervention because that's where our roots are in a university based clinic system and determine whether or not it was effective.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 16-17	Kevin Hamilton – 00:16:31	Each time we did that, we found that after one year, which our intervention is a yearlong, and even with CalAIM we are still continuing that practice of following our patients up quarterly for a year. We actually repeat an additional home visit at six months and again at 12 months. Even though this doesn't reimburse us for that yet, we're using the new codes for asthma education that DHCS just approved. And this has allowed us to determine that in fact the program outcomes reduce emergency room visits by 71%, decrease hospitalizations by about 60%. But on the other side, increased participation in prevention visits, which is our big focus, getting kids and adults in for vaccinations, physicals and preventative tests, increased it in this population by 41%.
Slides 16-17	Kevin Hamilton – 00:17:27	So we're very comfortable that this focus and this idea of asthma remediation, which is something that again, this organization was partnered with a number of organizations statewide, who've been doing this for a while, to advocate to be added to CalAIM and to see other processes happen and move forward with the legislature that have happened. And out of those have come things like the community health worker reimbursement and the asthma education benefit. And so that's really our history and what we've been doing for a long, long, long, long, long time now it seems.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 16-17	Kevin Hamilton – 00:18:12	Our model involves an initial home visit of about two hours, where we do a room to room walkthrough. And the staff actually take pictures in each room of the areas of concern that maybe asthma triggers. At the same time, they're carrying a magnet that shows temperature and humidity and explaining to patients that the humidity in the room can actually cause problems like mold growth. So we're educating patients as we're going along, there's health education there. We're documenting their medication and we're making sure they have the other tools they need to both follow their physician's care plan, use their medication appropriately and understand it, because quite often they're completely confused about which medication does what, and ensure that they essentially, as much as possible, have a safe place to breathe indoors.
Slides 16-17	Kevin Hamilton – 00:19:10	And that's what the program does. If a member has just been referred for the Careers Program, then they would be scheduled immediately for an evaluation, as is required by CalAIM. The evaluation approval would be provided by the health plan. Once they approve that, the patient would be seen and that claim would be processed. The results of the evaluation would be forwarded to the patient's provider with the request for approval of asthma remediation. Once that's received, we would proceed with the asthma remediation that was planned out during the initial assessment. And that's how it works.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Juliette Mullin – 00:20:05	Ah, next slide. Great. So Kevin mentioned CARES. So what is CARES? It is actually one of the programs under Central California Asthma Collaborative. And as he mentioned, we've been conducting home visits for the past, almost 11 years or so. CARES actually has evolved. Even just in this last year, the program itself used to just be a model, the Asthma Impact Model. And it was recently renamed to CARES, which stands for Comprehensive Asthma Remediation and Education Services. We just felt like this was a really great opportunity to expand, not only doing projects and doing a model, but actually having a standing program. And as you can see, we've received the US EPAs National Environmental Leadership Award for asthma management. So we feel that we can potentially scale this and hopefully help other organizations to provide asthma remediation services. Next slide.
Slide 19	Juliette Mullin – 00:21:23	So currently CARES is contracted with seven managed care plans all in the San Joaquin Valley. We're located in six different counties, up and down from San Joaquin, oh seven counties, I'm sorry, from San Joaquin to Kern. And these are the health plans that we are currently contracted with in each of these counties. So in every single county we have all the managed care plans that exist.
Slide 19	Kevin Hamilton – 00:21:55	So the question was also asked, we've been working with these MCPs for years and we have. The MCPs have been core partners in our work since it began. In fact, our very first contracts were with HealthNet. And so those partnerships were formed out of concern for high risk asthma patients. In the beginning it was children, now it's children and adults. And so those relationships have been built across the years and based on quality work provided for a really vulnerable populations in a culturally sensitive and appropriate way. And that's our reputation and we feel proud of that.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Kevin Hamilton – 00:22:43	Other people have told us that that's our reputation. And the fact that, early on, all of these health plans reached out to us to see if we'd be willing to work with them on this project. And we appreciate that and the relationship that we have with them. But really, a relationship is all about a partnership and giving and receiving so that we can each leverage each other's assets and our background and knowledge, learn from that and evolve. And CalAIM, the asthma remediation piece is an evolution of that long term relationship.
Slide 19	Juliette Mullin – 00:23:25	Great. And I think that actually segues really nicely into my first question for you. So Julian, if we could go to the next slide. Perfect.
Slide 20 Q&A	Juliette Mullin – 00:23:32	So we're going to move into a Q&A and a portion. We gathered a few questions from folks on implementation broadly and implementation in rural communities. And I would love, you just spoke a little bit to the partnerships that you've built with managed care plans over the years. And I think that segues nicely. In January of this year you became a provider of Community Supports for asthma remediation. Can you tell us a little bit about what that process looks like? Knowing you'd been working with managed care plans for a long time, what did the process look like to become a Community Supports provider?
Slide 20 Q&A	Kevin Hamilton – 00:24:11	So I have to tell you that we were all confused. We actually started working on this last fall with the health plans when it was first announced. And none of us had ever done anything like this before, as has DHCS never done anything like it before. So the beautiful thing was we all agreed that that was true and that we would respect that and be flexible and forgiving with each other. And that's what allowed us to come to contract as of, by certainly January 10th, we were contracted with five out of this six plans, ready to go on January 1. Now, the system wasn't actually ready for us to see patients at that point, but we hit our target, which for us is part of being excellent at what we do. Gracie, what are your thoughts on that?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Graciela Deniz-Anaya – 00:25:09	And I mean echoing on Kevin's comments, it really took a lot of learning with the health plans. I think we both gave each other that opportunity to grow and to understand what is being asked of us. So just that communication, constant communication, with the different MCPs, really understanding what the application process looks like and just being able to ask, does this fulfill this requirement? So luckily enough we were able to complete our contracts or complete our applications that led to contracting and just really going through the process together, the contracts, the negotiations, everything that we needed in order to be contracted as a provider. And I know for a lot of community based organizations, that's something that is so new and can be intimidating. But also given our experience, having worked in clinic settings, we understood a little bit about that practice and it really helped having that knowledge as well.
Slide 20 Q&A	Juliette Mullin – 00:26:21	That's great. And I'm wondering, so you talked a little bit about that you had some grace and you worked together with the managed care plans to figure out how to work together and set up these structures. Can you talk a little bit about the process you went through to establish new systems for communication or coordination with the managed care plans as you launched Community Supports?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Kevin Hamilton – 00:26:51	So I think that's probably one of the most difficult parts was, who are you talking to at any given moment? Health plans are a very, I don't know exactly what word, there's a lot of churning inside the plan, not so much, both with patients but also with staff. So I don't think they quite knew who was going to do what. So we would be talking to somebody for a couple of months and suddenly that person would be telling us, "Oh, I no longer have this job. I'm moving to this job." And the fact that they were really faithful about that was so helpful, because at least we always knew who we were talking to. But we also found ourselves often be the one who was educating the new person coming in, because again, their environment was trying to implement 14 of these and we are only one of 14.
Slide 20 Q&A	Kevin Hamilton – 00:27:52	So we always kept that in mind that we're 1/14th. Now I always raise the fact that we are the only actual disease that is within CalAIM. So that does deserve a bit of attention and people die from this disease or they get very sick. And again, because we're dealing with the high risk population, this intervention isn't for everyone. They've been hospitalized or they've been in an ER or their asthma's been out of control in some way within the last year, so they need this service. So there was a certain amount of urgency from our side as well that we need to get this settled. Who's going to run what. Who's going to do what. We even had one plan that we had contracted with we thought at the first of the year, it turned out they represented another plan as well. That plan had conceded to them to go ahead. And then in March they notified us, "Oh no, we need an individual contract with you."

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Kevin Hamilton – 00:28:48	But again, it's like, okay, so now at least we have a contract template, let's go ahead and move forward. And we were able to get that done within about a month and a half I would say. And then of course, we had one plan that chose not to do this particular CS until July, which I actually appreciated. So it gave us that time to finish all of that, take a breath and then feel like we were walking into this with pretty much all the information we need, would you say, to knock that one out pretty quickly.
Slide 20 Q&A	Graciela Deniz-Anaya – 00:29:25	And I just saw a question. So I wanted to reiterate. As far as the application process itself, it really is who you have available in your team for the application, to write it out. It was a pretty extensive application and making sure that you meet the criteria for each different element, it can be tedious. So I would say it took about maybe two to three weeks to write, to check and submit. And then after that, you probably heard within a couple of weeks that our application is being processed, they want to talk to us to identify any gaps.
Slide 20 Q&A	Graciela Deniz-Anaya – 00:30:08	So overall, I think within two months we started hearing about our contracts and starting the negotiation process there. With all MCPs, I would say they're all pretty similar, the applications are pretty similar. So it really just required us to really work out the details on one and use the same process for all the other MCPs. And then, setting up new systems. So we have a lot of staff who have never used things like data exchange portals like SFTPs or provider portals to learn how to request or refer patients out. So setting that up really took having myself go through the training with the MCPs and then making sure that I fully trained my staff to do that. It's all a process and it really requires a lot of attention to detail, especially if you're contracting with multiple health plans.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Juliette Mullin – 00:31:15	Great, thank you. That's helpful. I think maybe we can transition into having a bit of a conversation around your team and the people who are providing asthma remediation within CARES. Could you tell us a little bit about who's on your team, who's providing the services to members?
Slide 20 Q&A	Graciela Deniz-Anaya – 00:31:35	Currently our team is comprised of two different staff physicians. So we have our community health workers, as well as our program assistants. So our community health workers are the ones that are providing this actual asthma remediation assessment. They're determining what is the need, if the patients meet the requirements. They're doing the outreach to the providers, just trying to get those referrals. And then the program assistance are usually the ones who are helping with scheduling the appointments, making sure that they're confirmed for a home visit, since that's the way that we do our visits. And also, providing them with the tools that we are contracted to give out. So that's how we've separated the work that's being done under this asthma remediation.
Slide 20 Q&A	Juliette Mullin – 00:32:35	Fantastic. And could you tell us a little bit, so when you're recruiting, let's take them both. When you're recruiting for the community health worker role and you're recruiting for the program assistant role, what are the qualifications that you're looking for? What's the background you're looking for, for those roles?
Slide 20 Q&A	Kevin Hamilton – 00:32:49	So for the community health worker role, when we started this, we determined early on, that since we were talking to patients about a disease, and this wasn't just a health fair, this is in home, working with them, helping them manage their medication, we needed a certain level of education there. So we decided that our community health workers preferentially would have a degree in public health or some health related field, preferably a bachelor's degree or an associate's degree with commensurate experience. And we've stuck to that over time and we think that, again, that shows in the outcomes that we have and the professionality of our team.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Kevin Hamilton – 00:33:34	The other thing was finding leaders within the team, and one of them is sitting right beside me, who was a really lucky hire from my perspective, who had been leading teams in community health centers both in LA and up here in the valley. And thanks to COVID, she was leading health ed teams. And they were laying off their health education teams. And there was Graciela there looking for a job and us looking for somebody who met that criteria. And that's been almost three years ago now.
Slide 20 Q&A	Kevin Hamilton – 00:34:08	And when she came here, she was going to nursing school, and a year in she said, "I'm here. Never mind the nursing school. I'm here." And loving the job. So since then we've grown and expanded. We have a management team now. We have a coordinator for the lower three counties and we have a manager in our current county office, because people deserve good leadership. Where they are in the valley is huge. So trying to serve folks across this entire region as we are, where we have communities that, maybe as far as 70 miles away from where we are, and they experience all the other things that go with that.
Slide 20 Q&A	Kevin Hamilton – 00:34:54	So our teams have to be very confident in what they're doing and are traveling alone quite often. So we have to make sure they're safe, so they have everything they need, or at least whatever Gracie says we need, that's what we need and that's what we get. So our people carry tablets that have their own phone numbers. So wherever they are, they're connected into our system. So as they're seeing a patient, collecting information, it's uploading into our tracking system live. And they're geo coded and located, so we always know where everybody is at the same time. And they can make a phone call from those tablets as well.
Slide 20 Q&A	Juliette Mullin – 00:35:36	That's great, Kevin.
Slide 20 Q&A	Kevin Hamilton – 00:35:39	This is really amazing.
Slide 20 Q&A	Juliette Mullin – 00:35:40	Oh sorry, what was that?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Kevin Hamilton – 00:35:40	They have hotspots as well.
Slide 20 Q&A	Juliette Mullin – 00:35:45	Also important.
Slide 20 Q&A	Graciela Deniz-Anaya – 00:35:46	And just to add to it as well, our community health workers, we're not just looking for people who have the degree, but also the experience of working with these communities, especially in the rural areas. And Fresno County for example, we have so many rural towns and so a lot of our community health workers come from those towns that they know what access, what not having access to certain healthcare looks like.
Slide 20 Q&A	Graciela Deniz-Anaya – 00:36:18	So it's not necessarily a requirement that you have to come from these towns, but that you understand, that you speak the language, that you understand the cultures that are out there too. Because it's not just one set of a group of people out there, it's a variety, it's a diverse population and very often those who are missed by urban healthcare.
Slide 20 Q&A	Kevin Hamilton – 00:36:47	But one of the things I worry about a lot with these folks is they do carry a lot on their shoulders. And we worry about burning people out. And the question was asked about how do we retain people? Well, one way we retain people is we pay people a living wage and we make sure that their benefits are taken care of. We pay 100% of the health benefits of not only our staff but their families as well. We make sure again that they have all the tools that they need and then we determine, using standard methods, that I learned and Tim learned working in a constructed healthcare system and being leaders there, that we would set an expectation for how much anybody could be expected to do in a day.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Kevin Hamilton – 00:37:38	And we test that constantly, constantly against what they're experiencing. We meet with our teams regularly. I do case management with the really difficult cases monthly, it's available. And the teams are always talking and meeting with each other and being supported with each other. Gracie meets with her teams once a week. And we find that keeping that open communication, even though one team is 115 miles away from the other team and another one's about to be another a hundred miles away in the other direction, thanks to this wonderful technology, which is one of the few benefits COVID brought us, we're able to do those kinds of things.
Slide 20 Q&A	Juliette Mullin – 00:38:26	So I'm curious, you've talked a little bit about giving your staff the tools that they need. Can you tell us a little bit about what that looks like? So if I'm new and I've just joined your organization day one as a staff member, what does my training look like from that point forward?
Slide 20 Q&A	Graciela Deniz-Anaya – 00:38:43	So a lot of the training starts with, specifically for us it's asthma. We-
Slide 20 Q&A	Kevin Hamilton – 00:38:47	Or the onboarding.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Graciela Deniz-Anaya – 00:38:50	Yeah, well the onboarding, yes. So the normal onboarding, they understand what their benefits look like. So in doing so, they see how much they're actually getting paid. It's not just their actual paycheck, but their benefits are covered. And that could be very enticing, especially in this day and age right now. But for the most part, we have a structured training program, where initially, we do focus a lot on asthma. So what is asthma? Making sure they understand. Kevin here, who's a registered respiratory therapist, provides us a lot of those trainings. And so they feel confident enough to talk about asthma, even if they are just community health workers. It really brings in a lot of value for them. And then we move into our assessments. So how do our assessments work? How do we take this information and compile a care plan? What is it that we need to do for this patient to make sure that they not only receive the care that they need when they go to the doctor, but also, what can they do at home? How can they feel confident in their own self-management?
Slide 20 Q&A	Graciela Deniz-Anaya – 00:40:05	So those are the kinds of trainings that we're doing, along with just HIPAA. We do a lot of HIPAA training, we do a lot of cultural competency training, things that people need the skills to understand and be able to do the work here. Motivational interviewing, especially in this type of setting is a big deal. So we make sure that they have access to all of that. And as we go, we find that some of our CHWs are natural leaders, so we want to work on that. And there's opportunities for us to send them to leadership trainings or any other trainings that would be helpful to them, not just as an asthma educator, but also as a person who's growing in an organization.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Kevin Hamilton – 00:40:56	And we pay for that. For instance, some of the team wanted to learn to write grants. And there's a six week grant education program at the local state university. So we'll go ahead and pay that fee. It's not a lot of money compared to if they write one grant, the benefit that it brings the organization. And as a result of that, we've had several great proposals go out and get funded from these same folks. So they're invested in their own job long term. And as I tell people, write your salary in there and get funded and that's what we'll pay you.
Slide 20 Q&A	Kevin Hamilton – 00:41:33	And then they learn reality if they get too crazy with it because they won't get funded. But I think it's important that they we're very transparent internally about everything. Pretty much our budgets, all of our staff can see our budgets. We feel it's important to do that. Tim Tyner, my colleague, and I've always felt that was important and we've continued that. Now we have a little over 20 employees, totally. And five years ago we had five, six years ago there were five. So there's been a lot of growth here and I think that's made a difference for folks. Wouldn't you say, overall?
Slide 20 Q&A	Kevin Hamilton – 00:42:19	We want people to understand that this is a career, not just a job. So we want people also who want to be here. So we learn that and they learn that pretty quickly. But you're going to spend a month training when you first come on board. It's going to be a month before you see a patient. And when you do, you're going to be with somebody who has experience, for as long as they think you need to be with them, before you're safe to be let go on your own. And then that's all very organized and documented. And there's different metrics that have to be met there. And once that happens, it can be anywhere from six weeks to two months. Then you're ready to go, as far as we're concerned. That's how it works and that's what you could expect if you came here.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Juliette Mullin – 00:43:14	Great, thank you. And so you actually, what you just said about it's a career, it's not just a job. One of the things that we hear a lot is the challenge around building a big enough community health worker workforce, especially in rural counties and communities. Can you tell us a little bit about the work that you've participated in or that's happening more broadly in your counties around helping to build that workforce and get more people engaged in that kind of career path?
Slide 20 Q&A	Kevin Hamilton – 00:43:46	This has been very challenging. I would say probably one of the most challenging pieces of this work has been finding staff. Here in the San Joaquin Valley, it's well known that we have a significant air pollution problem. Younger people are not as interested in staying here. There's a lot of demand for jobs, for people to work in health centers and other places. So we're competing on almost an uneven playing field there. As far as workforce development, there hasn't been a lot of movement on workforce development in this arena in our area to participate in.
Slide 20 Q&A	Kevin Hamilton – 00:44:33	So we have not participated a lot in that area any more than from a policy perspective, which is my job. I spend a lot of time working on that with state agencies like yours. And how we fund that and how we develop that, working with CalWORKS and other groups to try to see that happen. But this designation of community health worker, officially with reimbursement behind it, is very new. So I think as that rolls out, we're right on the leading edge of that. So talk to me about this next year when it's a year old and once the health centers and others realize there's some reimbursement behind it, let's see what happens with that workforce at that point. I have great hopes for this.
Slide 20 Q&A	Juliette Mullin – 00:45:23	Great, thank you. I do see a question in the chat that relates, as you think about the billing component of this.
Slide 20 Q&A	Kevin Hamilton – 00:45:29	Sure.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Juliette Mullin – 00:45:30	As you look at staff. So we got the question, who on your team is managing that billing process and how have you worked with the managed care plans around that to make sure you have alignment on workflows and know the process for each of your managed care plans?
Slide 20 Q&A	Kevin Hamilton – 00:45:46	So we have an accountant on staff, inside accountant who has been doing our billing, doing claims for us. As far as working with the plans, again because we're a rare beast out here, if you will, where we come from a place where I had to oversee billing for instance at one point and understand it very well. So we wanted to move right away to use a standard billing form called a CMS-1500. But because of the way the CS program works and because there's so many folks in it who have never done anything like that, the health plans have preferred an invoicing approach. So that's pretty simple. And I've told people, "Don't make such a big thing out of the billing." It's really not difficult. It's basically an invoice. As long as you can connect to the portal, you can upload it electronically and it really is point and click all the way through.
Slide 20 Q&A	Kevin Hamilton – 00:46:52	And now we've made the next step, and thanks to IPP funding, we're able to purchase an electronic health record. So we'll be going live the middle of the month with eClinical, which makes a lot of sense because again, we're seeing patients across multiple counties and working with multiple health plans. So once you have the EHR nested within it is that ability to build directly. And so to us that's our goal is, it's already becoming challenging for the accountant to keep up with. And Gracie's team provides some help there. You want to talk about the piece that you guys take care of?
Slide 20 Q&A	Graciela Deniz-Anaya – 00:47:32	All the MCPs really trained us pretty well since the beginning on every aspect.
Slide 20 Q&A	Kevin Hamilton – 00:47:41	Their portals, especially.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 20 Q&A	Graciela Deniz-Anaya – 00:47:41	Their portals, doing the billing. So I was able to do that with our lead CHWs here so that they can provide the support to the accountant to actually do the billing themselves. So again, these are people who have never seen EHR system, who have never billed for to a health plan. And that can be intimidating as well. But the process that's been laid out for us is very easy to understand and really to the point where I have actual community health workers helping and support that.
Slide 20 Q&A	Juliette Mullin – 00:48:18	Great, thank you. I have one more question for you. And as I'm asking it, I'm actually going to ask if we can go to the next slide. And what I'd love to do is, I'd love to welcome people who are participating in today's session. If they would like to ask a question of Kevin and Graciela to raise their hands. And we'll keep an eye on that. And as we start to see people raising their hands, we'll call on you and bring you off mute. As people are thinking about their questions, I will ask one.
Slide 21	Juliette Mullin – 00:48:47	So moving off of workforce a little bit into some of what you started to talk about around navigating a large geography. And Kevin, you talked about the safety aspect and how you make sure you're staying in communication and coordination with your teams. Could you tell us a little bit about some of the logistical elements around navigating a large geography? One of the really unique dimensions about rural implementation is to provide that in person service in the community in a large geography is very complex. So could you share a little bit some of your strategies around how you do that effectively and how you're able to cover a large area?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Kevin Hamilton – 00:49:27	So our people get great mileage checks, that's how we cover a large area. So we don't have connected transportation systems here to speak of in the valley. Unlike the Bay Area in Los Angeles, which have multi-county cooperating transportation agencies, each county here is its own. And quite honestly, their public transportation systems are weak, to say the least. So our folks have to dry. And we are taking care of patients out as far as Mojave, Rich Crest. For anybody who knows anything about California, that's out in the desert on the other side of the mountains. From Bakersfield, because Kern County is one of the largest counties in California. Mountain communities, wherever these patients are, we have to go.
Slide 21	Kevin Hamilton – 00:50:26	It is not unusual for... One of our folks had a visit with a patient on Saturday in Terra Bella, which is a 49 minute drive according to Google Maps, which is what we use to look at, to estimate how far someone's going to have to go. Our breakeven point is two visits in a day. If we see fewer than that, then we're going to lose money. So we know what that number is. And if you're a business out there trying to do this by the way, if you don't know that number, learn it. Otherwise you're going to go out of business.
Slide 21	Kevin Hamilton – 00:50:59	And so we know how far somebody can travel in a given day, but we were able to set that. So in an eight hour day, if somebody can see two patients, do two home visits, then we're okay, we'll break even. And that's all we're really looking to do. We never expected to get rich doing this and we won't. That's how we deal with it. Somebody mentioned how do you define rural? Some of the communities we go to have less than 50 people and 50 houses in them. Terra Bella has 1,200 people, according to the census. It's an unincorporated community, but Ducor just south of it has 200. Gracie's from Rich Grove. How many people in Rich Grove?
Slide 21	Graciela Deniz-Anaya – 00:51:41	Not that many.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Kevin Hamilton – 00:51:41	150, 200 people, right? I mean that's just north of the two Larry Kern County line. So she mentioned that we hire community health workers who are from these communities and whose families live in these communities. And from my perspective, they are the only folks even really talk intelligently and advise us about how to serve these communities. And so they're dedicated to that. They want to give back to the communities they were born in and make sure that again, they're not left behind as they watched happening as they were growing up, for things like this, for these kinds of really amazing assets that normally would be beyond their reach.
Slide 21	Kevin Hamilton – 00:52:31	They certainly wouldn't be able to afford to buy an air purifier. They can't afford to buy a HEPA vacuum cleaner. So with this program and medical necessity, we can provide those things to them. And deliver them to their front door and show them how to maintain them, change filters, that kind of thing. If they're lucky enough to have an HVAC system, we can give them the best filter for that system that it can stand and again advise them what to do with that. And those other tools when there's a wildfire and there's danger from that or the particulate matter is very high that day.
Slide 21	Kevin Hamilton – 00:53:06	So we're able to provide a lot of resources like that to folks, spread out across some really incredible geography. The biggest argument I've had over the years is with funders, where we're putting in our budgets these large amounts for mileage and not seeing as many patients as our colleagues in Los Angeles let's say, and up in the Bay area. And I say, well you have to consider geography as just the biggest factor as the number of patients you see. So again, the health plans understand that here. And so, as we were setting up the very first pricing schedules for this service, that was taken into account as well. But again, they know that they have to do that as well. It is much more expensive here to do these kinds of things than it would be in a urban area that's highly dense.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Juliette Mullin – 00:54:02	And I was just seeing some questions in the chat and the Q&A about how you had those conversations with the managed care plans. So thank you for covering that. I see that we have a question in the line.
Slide 21	Emma Petievich – 00:54:17	That we do. Lisa, you should be able to unmute at this time.
Slide 21	Lisa Tadlock – 00:54:23	Great, thank you. It's been a great presentation. I am working with the DSS Housing and Homeless Division. And so we're looking at how the CalAIM supports, could support our already existing housing and homeless. But my question for the asthma group is, when you have all of these folks, and I'm very familiar with the area that you are traveling in, and yes, it's a lot of miles, is, is there any other assessment being done at that time of maybe additional supports they need, say maybe access to food or something of that? Or is the direction, you're just providing asthma services and the case manager may be directing other support services through other means? I just didn't know. Or if you're the first visit they're having of this some sort, like I say, is there an assessment being done on other supports they may need?
Slide 21	Graciela Deniz-Anaya – 00:55:29	So we actually do multiple assessments while we're there. Some asthma focus, but we do what we call is the Patient Needs Assessment. So in there it does have a risk assessment questionnaire. So with regards to housing, safety, food insecurity, transportation, so those are other things that we're-
Slide 21	Kevin Hamilton – 00:55:50	Utilities.
Slide 21	Graciela Deniz-Anaya – 00:55:51	Utilities, rent assistance. So we also have created partnerships with other organizations in the community that can support these types of services. So we're already there. We're in their home, we can see what's going on in there, not just in their home but in their environment. So those are opportunities that we don't want to miss for someone in a more rural community, especially a hundred miles away to be able to access. So yes, we do do that.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Kevin Hamilton – 00:56:23	And another side, the medical side, just to mention, we also enumerate each chronic, because two thirds of our patient in some counties are adults, older adults and they have comorbidities. So the team lists all the medications that the patient has. Has them pull them all out, writes them all down, all the diagnoses, find out if they have congestive heart failure, are they seeing a doctor for that? Do they know what which medicine is for that? Help them organize their medicines. Their one a day is separate from their two a days and three a day, so to speak. And we'll buy them and provide them with the pill boxes, the daily pill boxes, if needed.
Slide 21	Kevin Hamilton – 00:57:07	We're meeting the true definition of case management with these folks. And when we say that we connect them to another agency, that means we get on the phone with them in a three way call and make sure that they are connected. And we help them fill out the paperwork that they need to for that agency or whatever that service is, if needed. And making sure, most recently we saw a patient for the first time who was about to be evicted. So we immediately got active, connected them with the local emergency housing agency, connected them with the local community benefit organization, it's CAPK down there. EOC up here.
Slide 21	Kevin Hamilton – 00:57:48	But make sure that they had, and to the local legal services. At that point down there it's again Greater Bakersfield Legal Assistance, I think, services in that county. Sometimes it takes longer than we think it's going to take. Quite often, we need to get back with them again in a few days or a month, whatever it takes. That's what we do. As I always say to people, that's what we do.
Slide 21	Lisa Tadlock – 00:58:21	I appreciate that. I just have, as a follow-up to that, so if you do refer them to other agencies for other supports, do those agencies need to be contracted with the managed care plan to be reimbursed? That's where I get confused.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Kevin Hamilton – 00:58:42	So are you talking about, just to clarify, are you talking about other Community Supports or you're talking about just other supportive services?
Slide 21	Lisa Tadlock – 00:58:50	Other supportive services that may be offered under CalAIM, but that you may not specifically be offered, but you've found to be in your assessment a need, say access to healthy food. So if that's a support you find that they need, you refer them to another organization. Does that organization need to be contracted with the managed care plan to provide those services? I'm just, I'm confused.
Slide 21	Kevin Hamilton – 00:59:21	So let's use food as an example. There's two ways to go with that. Are they on CalFresh? That's the first question we'll ask. And if not, making sure they're connected to a county worker so they can apply for Emergency CalFresh. If they don't have any food at all, we're going to connect them to the food bank. Again, no need for the food bank. The food bank doesn't need to contract with the health plan. I hope they are. I hope they're getting money for that. But generally they're not. We give them the places that they can go to get food today, if that's what they need. But none of that works through the health plan. We report it to the health plan, because when we finish with the visit, with the assessment, all that is documented and then uploaded to the doctor and the health plan through the portal, which can take a while for that upload to happen. Because it's not just one document, it's a stack.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Kevin Hamilton – 01:00:23	So all of that's documented. Did I miss anything there, Gracie? So yes, I'll be honest with you, we have not fully integrated all the CS services. We have integrated with partners who provide all of those services. As I mentioned, with the woman who had received a three day pay or quit eviction notice. But we didn't wait around to find out if that entity was connected to the health plan. Even though in the CS, I wrote the grant forum, ran the healthcare for the homeless program here in Fresno County for eight years as part of my work at Clinica Sierra Vista. And I would kill to have the CS services that are now available for homeless and also had behavioral health, for behavioral health.
Slide 21	Kevin Hamilton – 01:01:15	I haven't heard from any of those service providers, I don't even know who they are at this point, quite honestly. If there's any weakness here, it's going online. I guess they're listed there somewhere, but we just haven't done that because we know them all and they all took referrals before there was CalAIM. So we just haven't figured out. That's a good point, that referral piece of how we connect to our fellow or Sister CS providers out there. And I would say we have not done a good job with that.
Slide 21	Lisa Tadlock – 01:01:50	Thank you.
Slide 21	Juliette Mullin – 01:01:51	All right. Thank you so much, Lisa, for your question. Thank you everyone for your participation in today's session. This has been a wonderful conversation. And certainly not least, thank you very much Kevin and Graciela for sharing all of your experience and your wisdom with the group. We very much appreciated it.
Slide 21	Juliette Mullin – 01:02:08	On the slide here, you can see some upcoming DHCS webinars that are coming up in the months of October, November, and December. I will highlight that next month we have a series of three webinars and Office Hours focused entirely around housing in ECM and community supports. We hope to see many of you there. And with that, have a great afternoon and a great rest of your day. Thank you.
Slide 22 End of presentation	Julian – 01:02:35	Thank you for joining. You may now disconnect.

CalAIM Office Hours: Enhanced Care Management (ECM) and Community Supports Implementation in Rural Counties

September 29, 2022

Transcript