CalAIM Office Hours: Enhanced Care Management (ECM)
Long-Term Care Populations of Focus

September 22, 2022

Transcript

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VISUAL	SPEAKER – TIME	AUDIO
Slides 1-2	Juliette Mullin – 00:00:10	Thank you, Julian. And welcome, and thank you for joining today's Office Hours session on Long-Term Care ECM Populations of Focus, and on Community Supports for Nursing Facility Transitions and Diversions to Assisted Living Facilities, and Community Transition Services and Nursing Facility Transitions to Home. We're excited to have a great conversation with you all today about these topics. Before we dive in, I'm going to introduce Michel Huizar with the Department of Healthcare Services to walk us through a few key announcements before we get started. Michel?
Slide 2	Michel Huizar – 00:00:45	Thank you so much, Juliette. And thank you everyone for joining us today. So, before we get started with our Office Hours talking points, we just need to cover a little bit on the public health unwinding. Many of you may be familiar with this information, but we are making it available here and in other platforms. So, the COVID-19 Public Health Emergency will be ending soon and millions of Medi-Cal beneficiaries may lose their coverage, and our goal is to minimize any beneficiary burden and promote continuity of coverage for our beneficiaries. We're asking all of you to be DHCS coverage ambassadors and check out the website that is linked here and will be also provided in the subsequent slides. But, there is a whole host of information on that webpage including flyers and other things that may help you to get some of the word out in offices and in other avenues, websites, and so forth.

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Slides 2-3	Michel Huizar – 00:01:40	Also, you can join the DHCS coverage or master ambassador mailing list, again with this link and it's also posted on our webpage. We can to the next slide. So, with PHE unwinding we are launching it in two phases. The first one currently underway, and this is done through multiple channels to get the word out, as I said previously, via flyers and other social media or call scripts and website banners. And again, I just want to encourage you to go to check out the website on the DHCS webpage to leverage some of that information in those flyers. There's a nice ZIP file that's very helpful and you can leverage those elements for the communication campaign. The second phase, it just includes the renewal packets that will be in the mail and we're encouraging you all to remind members at that time to update contact information and it will be launched 60 days prior to the Public Health Emergency termination.
Slides 3-4	Michel Huizar – 00:02:37	So, just again, remind folks to be on the lookout and update contact information if they have not done so yet. So, we can go to the next slide. So, related to this slide with the ECM or Enhanced Care Management and Community Supports now being launched statewide and managed care plans and Enhanced Care Management and communities support providers, utilizing the DHCS issued standardized data exchange guidance to operationalize the program. DHCS, we've released a required survey for all managed care plans and their launched ECM and community support providers to understand the status of the of data transactions between organizations and support of these programs and where persistent data exchange barriers may benefit from expanded or refined data guidance. So, examples and links for the issued data guidance examined by this survey can be found on this slide, and within this survey description also on the webpage. 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 Enhanced Care Management benefit and community support.

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Slide 4	Michel Huizar – 00:03:54	The survey, this required survey, is being distributed to the managed care plans and Enhanced Care Management and community support providers via a Surveymonkey link. And again, I'll provide it on the slide, and we'll be open through October 7th. So, look out for that date. It's coming up. Only one survey submission for organization is required. And finally, as I said, the more information can be found on the DHCS Enhanced Care Management Community Supports webpage, or by reaching out to the Enhanced Care Management and Community Supports mailbox. So, that does it for my round of slides. I will hand this over to Juliette.
Slides 5-6	Juliette Mullin – 00:04:37	Thank you, Michel. So, for those of you who are joining us for the first time at a DHCS Office Hours, we'd like to give you a little bit of a run through of what this session's going to look like today. First of all, what are Office Hours? Office Hours are a Q and A discussion with DHCS leaders and stakeholders who are implementing CalAIM focused on specific implementation topics. So today, we will be focused on long-term care populations of focus, and the key elements of the discussion today are listed here so you can see them, the ECM for new long term care populations of focus. We'll be talking about nursing facility transitions, diversions to assisted living facilities, and we'll be talking about community transition services and nursing facility transitions to home. Next slide please. Before we dive into those questions, I'd like to introduce our wonderful set of panelists today who will be answering questions.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 5-6	Juliette Mullin – 00:05:35	So today, at BHDS, we are joined by Joseph Billingsley with the Long-Term Services and Support Operations Branch, by Aita Romain with the Quality and Population Health Management Division. And with the Managed Care Quality and Monitoring Division, we're joined by Dana Durham, Michel Huizar, and Michelle Wong. We also have a series of featured panelists. And if you were at one of our earlier webinars this month, you may have seen them present and share the experience of their organizations implementing CalAIM. So today, we are joined by Ed Mariscal, the Director of Public Programs and Long-Term Support Services at Health Net, by Anwar Zoueihid, the Vice President of Long-Term Services and Supports of Partners in Care Foundation, Jorge Medina and Jeannine Nash, the Director of Business Development and Director of Operations respectively at Serene Health, and Nicole Bell, the Community Supports Program Manager at Santa Clara Family Health Plan.
Slides 6-7	Juliette Mullin – 00:06:33	So, these panelists today all together will answer questions that we have received over the past few weeks related to both DHCS guidance on long-term care populations of focus and Community Supports. And then, our feature panelists will give us some additional context and explain to us how they have implemented these community supports and how they are preparing to implement these new ECM populations of focus. So, with that, we go to the next slide. Where did we get the questions from today? So first, as we walk through this, you'll see that we'll go through a number of questions that we've prepared and we've prepared these based on your previous questions in webinars over the past month, as well as questions that have been submitted via email or the session's registration page. As well as these prepared questions, we invite everyone participating in today's session to also ask questions throughout the session.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Juliette Mullin – 00:07:33	So, we do invite you to use the meeting chat to ask questions. You can also use it to share your own experiences as well as we're walking through today's conversation. We will also provide an opportunity for you to get in line and ask a question out loud of our panelists. And I'm going to turn it over to my colleague, Alice, with Manatt events to explain how you can ask those questions. Alice?
Slide 8	Alice Hayes – 00:07:56	Thanks. Julian, can you go to the next slide? 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, you can press star nine on your phone to raise your hand, and then listen for your phone number to be called. If selected to share your comment, please ensure you are unmuted on your phone by pressing star six. If you logged on via Zoom interface, press "raise hand" and the reactions button on your screen. If selected to share your comment, you will receive a request to unmute. Please ensure you accept before speaking.
Slide 9	Juliette Mullin – 00:08:36	Perfect. Thank you, Alice. As I mentioned, today's topics focus on Enhanced Care Management and Community Supports. We'll, look at the new populations of focus and focus in on two of the community supports that are especially relevant in the long-term care space. We'll start first with Enhanced Care Management and then go into Community Supports. But, before we do that, we'd like to give a little bit of background on what these are so that we all are operating from a base understanding about the programs. So, if we go to the next slide, I will hand it off to Aita Romain to give us an overview of CalAIM, ECM, and Community Supports.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 10-11	Aita Romain – 00:09:12	Thank you, Juliette. Medi-Cal is a cornerstone of California's healthcare system. CalAIM's success can set the pace for transformation of the entire healthcare sector. All of us have a stake in a better Medi-Cal program, because Medi-Cal covers one in three Californians, just over half of California's school age children, half of the births in California, and more than two in three patient days in California long-term care facilities. CalAIM's bold Medi-Cal transformation expands on the traditional notion of the healthcare system. More than a doctor's office or a hospital, it also includes community based organizations and non-traditional providers that together can deliver equitable whole person care. CalAIM transformation means meeting the needs of the whole person, health providers who are trusted in relatable, expanding community supports and proactive upstream services, community engagement and making the best use of partners and resources. Today, Medi-Cal enrollees are challenged to navigate a complex system. Through CalAIM, enrollees will have the tools and support to get the care they need when they need it.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 11-12	Aita Romain – 00:10:32	Enrollees can expect consistent and integrated access to services and care no matter their zip code or the language they speak. Implementation will take approximately five to seven years. When complete, it will fundamentally improve the lives of millions of Californians. It requires the commitment and hard work of many partners asking each to move beyond traditional roles and embrace a new and more collaborative role in providing care and services. As with any transformation of the scale, there will be challenges, and we will adapt and evolve as we go. Next slide please. This slide highlights two key components of Medi-Cal launch this year, Enhance Care Management, ECM, and Community Supports. Enhanced Care Management is a managed care benefit that provides comprehensive care management to the most complex Medi-Cal members, community supports or services provided by Medi-Cal managed care plans to provide medically appropriate and cost effective alternatives to utilization of services such as hospitalization. Next slide please.
Slide 13	Aita Romain – 00:11:44	A little bit more about ECM. ECM is a new Medi-Cal health benefit designed to address both the clinical and nonclinical needs of the highest need enrollees through intensive coordination of health and health related services meeting enrollees wherever they are. The seven core services of ECM for all the populations of focus, including the long-term care populations of focus that we will discuss today, are outreach and engagement, comprehensive assessment and care management plan, enhanced care coordination, coordination of and referral to community and social support services, member and family supports, health promotion, and comprehensive transitional care. ECM is part of broader CalAIM population health management system design through which managed care plans will offer care management interventions at different levels of intensity based on member need with ECM as the highest intensity level. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 13-15	Aita Romain – 00:12:46	So, since January 2022, ECM has been launching in phases and by populations of focus. As of July, the three populations of focus that have launched statewide are individuals and families experiencing homelessness, adults at risk of avoidable hospital and ED utilization, and adults with serious mental illness/substance use disorder. Some whole person care counties are also providing ECM for members 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 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. Community Supports are services that Medi-Cal manage care plans are strongly encouraged but not required to provide as substitutes for utilization of other services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. They are designed as cost effective alternatives to traditional medical services or settings and to address social drivers of health. Different managed care plans offer different combinations of Community Supports.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 16-17	Aita Romain – 00:14:12	Plans must follow the DHCS standards Community Support service definitions in the policy guide, but they may make their own decisions about when it is cost effective and medically appropriate. Community Supports are not restricted to ECM population's focus and should be made available to all members who meet the eligibility criteria for specific community support. Next slide please. On this slide, you'll find a list of the 14 Community Supports that have been pre-approved by DHCS. Next slide please. This webinar is focused on members in the new long-term care population of focus. I want to take a minute to note that the entire menu of Community Supports may be applicable to members in this population of focus. Next slide please. And I'll hand it back to Juliette.
Slide 18	Juliette Mullin – 00:15:16	Great. And with that, I'll introduce Joseph Billingsley to walk us through what's new coming to CalAIM in 2023.
Slide 19	Joseph Billingsley – 00:15:25	Thanks, Juliette. And good afternoon everyone. I'm Joseph Billingsley. I'm the Assistant Deputy for Integrated Systems within the Department of Healthcare Services to have this chance to connect the all of you today. So, just speaking two things that are coming to CalAIM in 2023. Good. We're already at the next slide. I want to quickly walk through five components that'll be going live in 2023 that will impact dual eligible members and seniors and persons with disabilities. So first, Cal MediConnect is ending, and Medicare Medi-Cal plans, also referred to as MMPs, are Medi-Medi plans. And formally referred to as exclusively aligned enrollment dual special needs plans will be launched in the coordinated care initiative counties, or CCI counties as we've referred to them. Also in 2023, Long Term Care carve-in is occurring in the remaining two plan geographic managed care and regional model counties. We will also be implementing statewide mandatory Medi-Cal managed care enrollment for dual eligible members. Additionally, our population health management program is going live in the Medi-Cal managed care delivery system.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 19-21	Joseph Billingsley – 00:16:45	And last but not least, because I'll be expanding on this a little bit more in the next couple slides, we will be launching new populations of focus for Enhanced Care Management that are specific to the long-term care populations. Next slide please. So, tying back to those two new long term care populations of focus for Enhanced Care Management, January 1, 2023, we will launch two new populations of focus for Enhanced Care Management. That includes adults living in the community who are at risk for long term care institutionalization, as well as nursing facility residents transitioning to the community. Next slide. So, just to dig a little bit deeper into the definition of each, first, for adults that are living in a community who are at risk for long-term care institutionalization.
Slide 21	Joseph Billingsley – 00:17:43	This population of focus will be covering adults that are living in a community who meet the skilled nursing facility level of care criteria or who require lower acuity skilled nursing, such as time limited and our intermittent Medi-Cal and nursing services support and our equipment for prevention diagnosis or treatment of acute illness or injury and who are actively experiencing at least one complex social or environmental factor influencing their health. These can include but are not limited to an individual needing assistance with activities of daily living, communication difficulties, access to food, access to stable housing, living alone, need for conservatorship or guided decision making, poor inadequate caregiving, which may appear also as a lack of safety monitoring.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 21-23	Joseph Billingsley – 00:18:39	And then also, are able to reside continuously into community with wraparound supports. This is important because some individuals may not be eligible because they have high acuity needs or conditions that are not suitable for home based care due to safety or other concerns. Next slide please. So, just to provide some quick notes on this definition. So, individuals that are living in a community, members who meet this population of focus may live in independent housing, residential care facilities. And that can include residential care facilities for the elderly or adult residential facilities are any average dwelling that meets the requirements established in the home of human based services settings final rule. For exclusions, specifically excluded our adults living in a community who are at risk of institutionalization into an intermediate care facility or a subacute care facility. Next slide please. And then, to talk about the second population of focus that'll be implementing in January, that is for nursing facility residents that are transitioning to the community.
Slides 23-24	Joseph Billingsley – 00:19:54	This population of focus is for nursing facility residents who are interested in moving out of the community or out of the institution and back to the community are likely candidates to be able to do so successfully and are able to reside continuously in the community upon their transition. And so then, going to the notes there, when we talk about able to reside continuously in the community, it's important to note that members transitioned into community may need to return to the hospital or SNF intermittently for short admissions due to changes in medical condition or other acute episodes. And so, that's okay. That's not something that should preclude those individuals from being considered able to reside continuously in the community. Exclusions include individuals that are residing in intermediate care facilities and subacute care facilities. Next slide please. All right. I'll turn back over to you, Juliette.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 24 Q&A to Slide 25	Juliette Mullin – 00:20:57	Great. And so, with that, we will start to dive into our questions for today. We can go to the next slide. As I mentioned at the beginning, we're going to start with Enhanced Care Management and then we'll move into Community Supports. So, in Enhanced Care Management, we've received, after our webinars earlier this month, a number of questions, clarification questions, from participants about these populations of focus. I'm going to walk through some of those now and take us off that way. So, let's start with the adults living in the community who are at risk of long-term care institutionalization. So, for this population, this is a question for Joseph, for this population of focus, for the adults living in the community who are at risk of long-term care institutionalization, does it include members who do not necessarily meet the skilled nursing level of care criteria?
Slide 25	Joseph Billingsley – 00:21:58	Off of mute here. So, to respond to that question, yes. It includes members that are not just determined to be at the nursing facility level of care. So, members at the nursing facility level of care living in the community would obviously qualify. But, we purposely expanded the eligibility for this population of focus to include those individuals that may require lower acuity skilled nursing. So, intentionally designing the population of focus to capture members who may not fully meet SNF level of care but are at risk for nursing facility or of a SNF institutionalization. And that's where, if you look back at the population of focus definition and where we really detailed that additional category of individuals that may have these additional needs.
Slide 25	Juliette Mullin – 00:23:06	Thank you. And I have a similar follow up question, another question about who meets the criteria. Do members currently enrolled in a CBAS and/or wait listed for the Multipurpose Senior Services Program, or MSSP, meet the criteria for this population of focus, that is to say adults living in the community who are at risk of institutionalization?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Joseph Billingsley – 00:23:30	Yes. Most likely, most members who are enrolled in a CBAS and are on a wait list for the Multipurpose Senior Services Program Waiver, or similar 1915(c) Waiver, are likely to meet the eligibility criteria for this enhanced case, or convention population of focus. There are some instances where this will not be the case. And to provide specific examples, instances in which you have individuals that are residents of an intermediate care facility that are also eligible for accessing CBAS, that they would not be eligible for this population of focus. And so, also want to advise managed care plans to not solely rely or not just rely on the MLTSS criteria, and instead really to work with your contracted network of Enhanced Care Management providers to confirm that each prospective member that's identified as potentially eligible for Enhanced Care Management actually meets the population of focus definition criteria.
Slide 25	Juliette Mullin – 00:24:44	Great. That's helpful. Thank you, Joseph. I have a question taking a different angle on this population of focus. We get asked a lot about the intersections of Community Supports and Enhanced Care Management. So, this is a question for Shell. For this population of focus, as we think about members who are going to be enrolled in ECM for adults living in the community who are at risk of long term care institutionalization, what types of Community Supports should be considered for members in this population of focus to stay and live continuously in the community?
Slide 25	Michelle Wong – 00:25:23	Yeah. So, members in this population of focus can actually benefit from any of the Community Supports offered by their managed care plan depending on their individual needs. But, specifically for this population of focus, managed care plans are strongly encouraged to offer environmental accessibility adaptations, also known as home modifications, respite services, which may also be called caregiver respite, and personal care and homemaker services.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Juliette Mullin – 00:25:54	Great. Thank you. All right. I think we've covered a few core questions in this first population of focus. Let's move into the second population of focus before I ask some questions of our featured panelists. So, looking now at ... Sorry. Could we go back a slide? Thank you. Looking now at ECM for nursing facility residents transitioning to the community. So, this is the other way. I'd love to ask just a couple more clarifying questions, Joseph, about the population of focus criteria. A big one that we get is "Does this apply for both members transitioning from a skilled or custodial SNF?" Are both groups eligible for this population of focus?
Slide 25	Joseph Billingsley – 00:26:41	Yes. Both types of SNF stay skilled and custodial are included in this population of focus. And as long as they follow the criteria that are defined for the population of focus, then they will be eligible. If it's okay just because it touches right back to what we were just previously speaking to, I saw two questions pop up in the chat that I wanted to just quickly address related to the end. And one question was "Can someone be enrolled in both ECM and MSSP?" And the response there is no, because MSSP is the Multipurpose Senior Services Program Waiver. It's a 1915(c) Home & Community-Based Services waiver. And we have, if you look back at the ECM policy that's been put out by DHCS, it specifically excludes Medi-Cal beneficiaries that are enrolled in 1915(c) waivers from being enrolled in ECM at the same time. So, beneficiary can be enrolled in ECM, or in a 1915(c) waiver, which includes MSSP, but not in both at the same time.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Joseph Billingsley – 00:27:50	Separately, there is a question around CBAS. Can a member be enrolled in CBAS and an ECM at the same time? Yes, they can. That's different. It's a different authority. This permits around what CBAS does. It's a more focused benefit than the HCDS waivers do. And so again, tying back to the ECM policy guide, something where we've identified that ECM can interact with individuals that are on CBAS as a wrap. So, recognizing the care management they're already receiving from resources like the managed care plan, care management specific to that CBAS benefit, but ECM can overlay that as a wrap to provide the additional supports necessary. So, as I saw those flash across, I thought I'd answer real quick.
Slide 25	Juliette Mullin – 00:28:41	No. That's great. Thank you. Another question we've seen a couple times is about what happens if someone does not successfully transition. So, if efforts to develop a plan to transition a member back to the community are not ultimately successful, such as for instance, adequate caregiver resources were not successfully secured, would the member then become ineligible for ECM and has to be dis-enrolled? And that's a question for Joseph again. Joseph lost audio. We will just give him a minute to come back. It's always when you're in a big meeting that you lose audio I find. Maybe as we're waiting for Joseph to come back, we'll put a pin in that question and come back to it.
Slide 25	Juliette Mullin – 00:29:40	As we're waiting to come back to a couple DHCS guidance questions, I'd love to turn to our featured panelists who are starting work to build ECM for these populations of focus. And I'll start with Ed, Health Net. So Ed, you and your team have been helping to coordinate long term care transitions for a long time at Health Net. Can you walk us through what your process is when you first began working with a skilled nursing facility to support these types of transitions and these members?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Ed Mariscal – 00:30:22	Thank you again. Sorry. I started speaking before I came off mute. You'd think after two and a half years, right? So, thank you for the question, because we at Health Net have been doing this for quite a few years now. Fortunate enough to have the long term care benefit in our Los Angeles and San Diego counties. So, to make a very long story short, the work beginning with the nursing facilities, always when we look at transitions, transitions always begin really at the time of admission. Whenever someone is going into the nursing facility, we're already thinking of how to get them out of the nursing facility safely of course. And many times, that review begins with the MDS, the Minimum Data Set, the assessment that's completed by the nursing facility nurses at the time of admission or shortly after the time of admission. And more specifically there is section Q of the MDS, which really leads us to those members who are eager to transition, those members who may not be able to transition yet.
Slide 25	Ed Mariscal – 00:31:33	But, one of the questions is, "Would you like to have this conversation again in the future?" So, this is a very reactive strategy. We wait for the facility to tell us, but we also have some proactive strategies and how to work with the nursing facilities around this type of transition. We're constantly providing and building relationships with the social services designee in the nursing facilities. We have to build that trust. We're not going to try to take anyone away from them. We're not going to try to transition someone who is unfit or unable. We want to work with them, build that trust to make sure we're identifying the right person to safely transition. We also internally have built a team, a very dedicated team, around clinicians with nursing facility experience, Master's level social workers with nursing facility experiences, a licensed nursing home and RCFE administrator with a lot of experience to lead the team and partner with the facilities around these types of transitions.

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Slide 25	Ed Mariscal – 00:32:33	We also very proactively outreach to the nursing facilities monthly. Just because your decision was no in July, doesn't mean it's not going to change in August or September. So, we want to continuously have these conversations around the transitions. Pre-pandemic, we would go into the facilities in person every month and talk to our members, talk to our members' families, ask to be invited to care plan meetings to explore the possibility of repatriating back into the community. We pause to those in-person visits during the public health emergency and hope to be back in the field shortly, but of course, after January 1st, expand our footprint and be out in the field, not just in Los Angeles and San Diego, but in all 29 of our counties, where we're going to have the long term care benefit.
Slide 25	Ed Mariscal – 00:33:28	Medi-Cal and healthcare in general is of course very complicated. So, we talk to our members. We can't expect them to understand everything that is available to them at all times. We want to listen to them and we want to support them as best we can. And we have those same conversations with the nursing facility staff. Our experience has shown that once we talk about the available supports, more so now with a lot of the ECM and Community Supports available under CalAIM, they're very interested in exploring the opportunity to transition. I constantly hear, "I'd take mom home, but I just can't take care of her by myself." Well, now you don't have to, especially with CalAIM. DHCS has entrusted us with a lot of responsibility here and we want to take that responsibility. We want to be good stewards and good partners with the DHCS in making sure that we support all of our members.

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Slide 25	Ed Mariscal – 00:34:29	And finally, the last point I'll make here is there are many things we are not experts in, thus we partner with entities like Partners in Care Foundation and others to really support those transitions when we don't have the expertise or the resources available to us at that time. We always do an initial communication with the member. We try to do what we call a pre-screening for CCT or California Community Transitions, to make sure that they are eligible. And if so, we will call Partners in Care Foundation or Liberton or other CCT lead organizations and make that warm handoff and continue to be in the loop to make sure the community, the nursing facility feels supported, our member and the members' family feel supported, but also our community partners, like Partners in Care, feel supported by the health plan during the process.
Slide 25	Juliette Mullin – 00:35:26	Great. Thank you, Ed. I'm going to go over to Anwar and ask him a little bit about the work that's currently in flight at Partners in Care Foundation. Like Health Net and with Health Net in fact, you have also been doing work for a number of years to support members in this space, and you have a team that's been doing transitions for long term care for some time. Could you tell us a little bit about how you're leveraging your expertise, your infrastructure, your existing teams, to get ready for the launch of the new ECM populations of focus?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Anwar Zoueihid – 00:35:59	Sure. Thank you. And thank you for this opportunity once again. So, we noticed that there's a lot of community based organizations and health plans that are doing the same thing but working at silos. So, we worked with Health Net and other managed care health plans in Los Angeles to develop this pre-CalAIM-ish type of system where we all work together for one cause. And that's really to identify and discharge people back into the community if of course they've qualified. So, one of the first things that we noticed is it's key to a great partnership is to identify a lead care manager at the managed care health plan, and a lead care manager or point person at the skilled nursing facility. And like Ed said, it really helps to build trust with the skilled nursing facilities to have that one point person.
Slide 25	Anwar Zoueihid – 00:37:05	The workflow begins with the managed care health plan lead a CM, identifying the member who is eager to transition back into the community. This information is typically obtained through the MDS as Ed mentioned, but can also come direct as a direct referral from either a family member or a skilled nursing facility. So, once the managed care health plan identifies a member or members who are eager to transition, the managed care health plan then works with partners in care lead transition coordinator and they began to strategize a plan of action. So, the lead transition coordinator is part of the nursing facility transition diversion program, which leverages both CCT program, the California Community Transitions Program, and the Assisted Living waiver. So then, we work with the point person at the skilled nursing facility to inform them about this referral or this group of referrals.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Anwar Zoueihid – 00:38:07	And the skilled nursing facility is really super helpful because they start working with their relationship to notify the member and their family members and to begin the coordination between partners and the managed care health plan to schedule an in-person meeting with both member or family members at the skilled nursing facility. And that is really one of the keys to success because if you go there without really the lead coordinator or the lead point person from the skilled nursing facility, the participant doesn't really trust you because they really trust the skilled nursing facility. So, it's a warm handoff and it works really well. So, both skilled nursing facility point person and managed care health plan will work with member demographic data that will assist determining eligibility, and in-person visit is then conducted. So, we exchange this information before we go there and we have all this data before we go there, so we know what to expect. This helps reduce administrative burden, increase efficiencies and insures appropriate reimbursement, meaning that there's not really a lost in-person visit.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Anwar Zoueihid – 00:39:29	We're trying to minimize that. So, we don't want someone to hop on the freeway, get there, and it's just a lost cause. So, this way, we're doing a lot of pre-work before we do that visit. Managed care health plan in partners, they conduct a pre-visit care conference to comb through the details of the member transitional needs, and then of course that joint in-person visit whenever possible. Not necessarily always happens, that joint visit, but of course the transition coordinator from partners must be present. Comprehensive Person Center Care Plan is then developed along with a plan of action. And this is where we start figuring out are they eligible to go into a community or go into an assisted living waiver, or at this point, a congregate living facility, and enroll in the Home and Community Based Transitions Program. So, this is a three level comprehensive care coordination model with Partners in Care transition coordinator taking the lead to execute the plan of action and safely discharge member from SNF to alternate setting. Of course, we coordinate with the PCPs, housing services, Department of Mental Health, whoever we need to.
Slide 25	Anwar Zoueihid – 00:40:54	It's not just the three of us. We will of course coordinate with anyone else. So, notice that utilizing a more comprehensive care coordination model and not working as silos always provides a much better overall outcome that are sustainable, meaning that they are not readmitted. Our data shows that when you work as a team, you're not only successful but they're not readmitted. And to answer your other question, we are really leveraging this past model of enhanced care coordination to really help bring on the Community Supports program. So, we're looking at the lessons learned, we're starting to get to reengage with the skilled nursing facilities. I'm bothering Ed a lot again to help me with that, and even with their conference, but also working with other community based organizations and waiver programs who would be able to help for a smooth transition.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Juliette Mullin – 00:42:08	Great. Thank you, Anwar. I do want to make sure that we have an opportunity to talk through some of the Community Supports as well. So, I will transition us into a conversation about some of the Community Supports. I have a couple questions for the panelists on that, and then we will open the line for questions. So, if we could advance two slides please. Thank you. So, shifting into Community Supports a little bit, first of all, I'd like to ask a question of our DHCS colleagues here, our DHCS leaders here, if they could tell us about the intersection between Community Supports and ECM. One of the things we hear a lot, one of the questions that we get a lot is you have to be an ECM to get Community Supports. So, could you answer that for us? Do you have to be an ECM to get Community Supports? And either Dana or Michel want to take that one?
Slide 25	Dana Durham – 00:43:11	Sure. I'm happy to take it. You don't. So, the two are independent programs, and one can receive Community Supports and not be enrolled in ECM. However, I will say if one is enrolled in ECM, they should be at least evaluated for appropriate Community Supports. So, that would be part of coordinating care, but it doesn't mean someone is automatically eligible for community support. I hope that answers ...
Slide 25	Juliette Mullin – 00:43:44	Absolutely. And we get the question a lot, so we always like to make sure that we address that in these sessions, because I think it helps people understand the interactions. A follow up on that one, and this is a question for Joseph, given that we're going to have these new ECM long-term care populations of focus, and given that we have two Community Supports that are listed here, the nursing facility transitions, diversions to assisted living facilities, and the community transition services, nursing facility transitions to homes, all of those things, those two Community Supports, the ECM populations of focus, they can be implemented together, separately, simultaneously in any of those iterations, could you walk us through a little bit about how they complement each other in implementation?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Joseph Billingsley – 00:44:33	Sure. Sorry. I was having some technical difficulties real quick, but yes. So, the care management that's included in these community support services is focused on securing and transitioning members into community based housing, such as assessing members housing needs, presenting options, assisting with securing and moving into housing, and connecting the member to other complimentary services that are needed for the member to be safely and stably housed. By comparison, secure management that's included in ECM is more broadly focused on coordinating all primary, acute, behavioral, oral, social needs, and long term service supports for members. And that includes administering a comprehensive assessments and care management plan. So basically, the type of care management that's provided by ECM and these Community Supports services is distinct and complimentary, and a member can receive both.
Slide 25	Juliette Mullin – 00:45:33	Great. Thank you. Since we're running a little low on time today, we're not going to go into a deep dive on what each of these Community Supports are, but we will drop in the chat the Community Supports policy guide. Thank you, Carly. I see you've just done that. And folks can look through that to see additional details about these individual Community Supports if you're not familiar with them. With that, I'd love to turn over to some of our featured panelists here today and ask you some questions about the implementation of these Community Supports. So, I will start with Jorge and Jeannine at Serene Health. You are a provider of these Community Supports for transitions in the long-term care space. Could you give us a high level overview of how you provide these Community Supports? Who is your Community Supports team? What does that look like?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Jorge Medina – 00:46:26	Yes. So, on a quick high level, because I know we're pressed on time, the background in our organization is we're broken down into three components. We have our ECM Services Department, Behavioral Health Department, and our CS Department. Our Community Supports Department is managed out of our San Diego County office. And we have Community Supports team members in our various office locations throughout the state to provide support, not only telephonically, but also in person for members that would actually also like to meet in person. The way we support our MCPs is by designating certain lead case managers to certain health plans and having internal support systems to place to make sure that our team, if they're out, we're able to pick up right where they left off. And we find that this is, for our team, much more effective way in being able to provide support across the state.
Slide 25	Jorge Medina – 00:47:26	This is also able to happen because we utilize our own proprietary custom platform that's designated around our specific behavioral health, ECM and CS services. So, we're able to communicate on a high level effectively throughout all our teams. And I can let Jeannine quickly touch as well on what and how we provide those community supports.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 25-27	Jeannine Nash – 00:47:49	So, our community support services are actually provided by doing a full assessment on our members. Once we receive the referral from the health plan or even if we get it directly from the nursing facility, then we have that ability to meet with the member. We can either meet with the member in person or on the telephone. It's really good to meet with the member in person and also involve the social worker, the case manager, anyone who's going to be a part of that discharge plan. So, we get an assessment. Once the assessment is completed, we're able to take that information as far as what their healthcare needs are, knowing what their physical capabilities are going to be, what their social needs are, and then also what their financial capabilities are. That way we can put that information, once we populate that information, we can utilize that to match them up with the appropriate community.
Slides 25-27	Jeannine Nash – 00:48:49	Through our relationships that we have with communities throughout California, we're able to match them with the appropriate community and also we're able to reach out to those communities to make sure that they have the availability to accept our members. Once we find the facilities that are able to accept our members, then we offer the member at three locations. We try not to overwhelm them with a full load of 20. We offer them three at a time. That way it gives them the ability to tour, to be able to see the facilities, to speak with the staff, get introduced to the staff. And if they don't have the ability to go and tour the facility, then we can bring pictures or videos to the members so they can see them. We like to make sure that they get actual pictures, not the pictures that when the building was brand new, the ones that are on the website. We want to make sure they get the actual pictures so they know exactly what the facility and the community is like.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 25-27	Jeannine Nash – 00:49:51	We assist a member with getting all their documentation in order, working with the physicians, getting the physician order, getting all the documentation to move into if it's an RCFE, to move into that RCFE, getting their room straight, making sure that their personal items are being placed in their room so they can be comfortable and know that they are at home when they get there. We also have the ability of asking for a personal care attendant to escort them and at least be with them the first week to help them get acclimated into the community. If a member is actually going to transition home and to the community, the personal care attendant can also be at home. They can help them at home, give them everything that they would get inside the skilled nursing facility, or what they would get in the assisted living facility.
Slides 25-27	Jeannine Nash – 00:50:43	And that personal care attendant can assist them with their personal care needs, their hygiene needs, bathing, making sure that they're getting all their meals, making sure they're taking their medications, transportation to and from doctor's appointment. And they can also do light housekeeping and also help them. Some people like to garden and keep their social life going because it's important to keep their social life going so they cannot go into a depression. So, that is very important. And also, keep them communicating with their friends and family members as well. So, that's been some of our successes as far as working with people that are transitioning from nursing facility to assisted living or to an RCFE, or transition out into the community from a nursing facility.
Slides 25-27	Juliette Mullin – 00:51:34	Fantastic. Thank you. My last question that I'll ask and then I'll open the line for folks is for Nicole. We get a lot of questions from people from managed care plans and providers about how to identify members in these populations. Could you share some of the approaches that Santa Clara Family Health Plan has used for identifying members who are in SNF who are ready to transition?

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 25-27	Nicole Bell – 00:51:58	Yeah. So, basically we've worked off of our lessons learned and best practices from CCI implementation. We have a very good relationship with all of our skill nursing facilities in the county, and we work really closely with our care manager and that is actually assigned to each discharge or potential discharge. Based off of those criteria and her lessons learned, we've created some key components or key characteristics for appropriate discharge. And so, we've based most of the identification off of those. And it does go into levels where it starts with "Do they have somewhere to go? Do they have assistance in the community? Do they want to go? What are the specific barriers to discharge?" And then, work very closely with the rest of the community to put those in place. For the services and for the ECM population that's going to be launched in January, we're really going to be heavily focused or heavily leaning on the referrals into the health plan for those identifications just to make sure that the right people are actually getting assigned.
Slides 25-27	Juliette Mullin – 00:53:37	Great. Thank you. I have approximately 20 more questions that I could ask you all, but I do want to go to our participants for our last set of questions here. Could we go to the next slide please? So, as a reminder, if you are listening today and you have a question you would like to ask, please use the hand raise functionality down at the bottom of the screen. We'll keep an eye on the panelist list or, sorry, the attendee list and see if anyone's raised their hands. And if you raise your hand, we will call on you and take you off mute to ask a question. So, I will give people a minute to do that if they have a question they would like to ask out loud.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 25-27	Juliette Mullin – 00:54:19	And as I'm giving people a moment to think about their question, I will come back to a question that I asked and then we didn't quite get a chance to get through. And this is a question, Joseph, for you, about what happens when the transition is unsuccessful. So, if efforts to develop a plan to transition a member into the community are not ultimately successful, would the member need to be unenrolled from ECM?
Slides 25-27	Joseph Billingsley – 00:54:51	Yeah. And that's a great question. Thanks, Juliette. So, I think that it's really important to note that transitioning members, individuals, from institutional settings back to the community can be an extremely complex and time intensive process. These things oftentimes take up to a year or longer based on the California Community Transitions program experience. And that's our state to money fall to person grant program, which we refer to as California Community Transitions that specifically was built to transition individuals from nursing facility settings back to the community. So, recognizing that managed care plans should make the best efforts to connect members to needed services such as community support services, other services available for community based organizations, local areas, local area agencies on aging, IHSS, and other programs to help that individual in transitioning home. And that's where also really, when managed care plans are working to contract with community based organizations for providing this service, we encourage managed care plans to contract with California Community Transition lead organizations because of their extensive experience in performing these types of transitions.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 25-27	Joseph Billingsley – 00:56:33	I mean, they perform all kinds of transitions but really specialize also in being able to work with those individuals that have been in institutional settings for longer and don't have a home to transition back to, because a lot of times that's where it takes time to identify where's a home that meets the individual's needs that they can transition back to. At the end of the day, after all resources have been exhausted, the managed care plan can dis-enroll the member of acquired notice of action, but really again, just making it clear that there's not a set timeframe on this. It really takes time to work to transition individuals back to the community.
Slides 25-27	Juliette Mullin – 00:57:14	Great. Thank you, Joseph. And I do see we have a question in the line.
Slides 25-27	Alice Hayes – 00:57:21	Jacqueline, you should now be able to talk.
Slides 25-27	Jacqueline Bender – 00:57:23	Hi. Can you hear me?
Slides 25-27	Juliette Mullin – 00:57:28	Yeah.
Slides 25-27	Jacqueline Bender – 00:57:29	Okay, great. Hi. I'm with Los Angeles County Department of Health Services, and we're particularly interested in the Community Supports for nursing facility diversion, so people who are not yet in SNFs. And I think the definitions of something like you need to be SNF eligible or something close to that, and we were wondering if there were going to be criteria or more specificity that the state could provide about what that determination would entail or look like or what criteria we would have to demonstrate to show that. Because we work with so many plans and plan with partners, having consistency across the plans is really valuable to us. So, we were looking for some more specificity there.
Slides 25-27	Dana Durham – 00:58:14	Jackie, thanks for the question. I think we're exploring possibly more specificity. But, part of the nexus that the plan must have is that they has to be cost effective. And so, at this point, there're some different ways that the plans look at it and different criteria that they have that meets within that general definition. So, we're having those conversations, but we're not prepared to land on anything more specific yet.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slides 25-27	Jacqueline Bender – 00:58:45	Okay. I appreciate the update. Thanks, Dana.
Slides 25-27	Juliette Mullin – 00:58:50	Great. And I see we have a second question in the line. I know we're coming up on time, but let's take this one last question.
Slides 25-28	Alice Hayes – 00:58:59	All right. Sean, you should now be able to talk.
Slide 29 End of presentation	Juliette Mullin – 00:59:01	We are not hearing you unfortunately. You may be double muted. Unfortunately, since we're coming up on time and we're not hearing you, we may have to move on unless you can type it quickly in the chat. But, thank you for raising your hand, and if you drop your question in the chat, we can try and address it that way. I want to acknowledge there have been a number of great questions in the chat. I know Joseph, other folks on the team have been going through and trying to respond to those as they come in. We will also review them after the end of this session and help inform our FAQs and any additional technical assistance that we provide around these new populations of focus and these Community Supports. With that, I want to thank everyone for joining today. I want to give a huge thank you to all of our featured panelists and our DHCS leaders for their time today for answering questions and sharing your experiences. And I wish everyone a great afternoon. Thank you.