CalAIM ECM Outreach and Engagement: Technical Assistance Webinar

August 25, 2022

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Julian – 00:00:12	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. 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 Michel Huizar from the DHCS Managed Care, Quality and Monitoring Division. Michel, you now have the floor.
Slide 1-2	Michel Huizar – 00:01:00	Good afternoon, everyone. And thank you for joining us for today's CalAIM Enhanced Care Management Outreach and Engagement Webinar. This is a technical assistance focus webinar. We have a tremendous amount of information to cover, but before we do that, I did want to cover a little bit on the Public Health Emergency Unwinding. It will be ending soon and millions of medical beneficiaries may be losing their coverage. And with that, our top goal is to minimize any of that burden and promote the continuity of coverage for our members.
Slide 2	Michel Huizar – 00:01:34	So how you can help as you can become a DHCS Coverage Ambassador. You can also download the outreach toolkit on the DHCS Coverage Ambassador webpage linked here, and/or join 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	Michel Huizar – 00:01:54	So there is a multi-pronged unwinding communication strategy that we are endeavoring on. The first one, which is currently underway is to encourage beneficiaries to update their contact information. This is done through a multi-channel campaign and done through flyers in provider clinics and offices, social media campaigns, calls scripts, website banners and the like. The second phase will occur upon notice of the PHE termination, which we have not received as of yet. So we do anticipate that this will continue through and past October. But again, we do want to remind our members at the time to update their contact information as necessary, and to also watch out for their renewal packets in the mail, where they can update contact information if they haven't done so yet. Next slide.
Slide 4	Michel Huizar – 00:02:54	So for today's session, we do have a lot of information to get through, but we will be covering the Enhanced Care Management policy and providing a recap of the policy under CalAIM Outreach and Engagement. And then, we'll have spotlight speakers from L.A. Care and Illumination Foundation in LA, as well as La Maestra in San Diego. And then, we will conclude and round out with a Q&A session at the end. Now, if we are, for whatever reason, not able to get to the Q&A or get through all of the questions in the Q&A, we will be answering questions during office hours next Thursday, next week. So we will be dropping in a link in the chat for you all to be on lookout for that. Next slide, please.
Slide 5	Michel Huizar – 00:03:40	Okay. A little bit on the California Advancing and Innovating Medi-Cal initiative broadly. It is a long term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated and person-centered approach to maximizing their health and life trajectory. It is a multi-pronged approach. The goals of which are to implement a whole person approach and address social drivers of health, improve quality outcomes, reduce health disparities, and drive delivery system transformation. Finally, one of the primary goals is to create a consistent, efficient and more streamlined or seamless Medi-Cal system. Next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Michel Huizar – 00:04:18	So for this, I know I will be handing off to Aita Romain who has joined us on the call. And I also stand there and hand it over to you. Aita.
Slide 7	Aita Romain – 00:04:30	Thank you, Michael. Hi everyone. As Michael said, my name is Aita Romain. I'm the section chief and the population health management division. Next slide please.
Slide 7	Aita Romain – 00:04:42	So ECM is a new Medi-Cal benefit to support comprehensive care management for members with complicated needs. These members are currently engaged with or should engage with several delivery systems to meet their health needs. ECM is to address both the clinical health and social drivers of health needs of the highest needs enrollees through intensive coordination of health and health-related services. Services should meet enrollees where they are, and this flexibility is essential to the design of the program. ECM is part of broader CalAIM Population Health Management framework, through which MCPs offer care management interventions at different levels of intensity, based on member need with ECM as the highest intensity level. DHCS has defined seven ECM core services, 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 supports, health promotion, and comprehensive transitional care. Today's webinar, we will focus on outreach and engagement. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 8	Aita Romain – 00:05:59	So here on this slide, the gray counties are where the Whole Person Care and Health Homes Program counties that went live in January 2022. Counties in pink began implementing ECM in July 2022, making ECM statewide. The populations of focus are outlined here, including individuals and families experiencing homelessness, adult high utilizers, adults with serious mental illness and substance use disorder, and those transitioning from incarceration. The population that will go live in January 2023, are those at risk for institutionalization and eligible for long term care, and nursing facility residents transitioning to the community. And finally, the last anticipated population of focus to go live is children and youth populations of focus in July 2023. And at that time, we anticipate the population transitioning from incarceration to also go live. Next slide please.
Slide 9	Aita Romain – 00:07:13	There are four key steps to outreach and engagement of members. Identifying eligible members, assigning eligible members to an ECM provider, outreaching and engaging members and enrolling members and completing care plans. The next five slides, I will run through these key steps. Next slide please.
Slide 10	Aita Romain – 00:07:35	Manage Care Plans are responsible for regularly identifying members who may benefit from Enhanced Care Management and who meet at least one of the populations of focus. Managed Care Plans can and should use available data sources to identify members, who may need criteria for at least one population of focus. MCPs may receive referrals for ECM from providers, community-based organizations and other entities serving members. However, members can also self-refer or be referred by family members. You can see some links to some tools below. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Aita Romain – 00:08:17	So once identified, MCPs assign every member authorized for ECM to an ECM Provider. The MCP provides member assignment files to that ECM Provider. However, if a member prefers a specific ECM Provider as that is where they have a trusted relationship, the MCP must assign the member to that provider. If a member's PCP is a contracted ECM provider, the MCP must prioritize ECM Provider assignment to that PCP, unless the member indicates otherwise or more appropriate ECM Provider is identified. For the adults with serious mental or substance use disorder, MCP should prioritize county behavioral health staff or behavioral health Providers to serve in the ECM provider role, if the county behavioral health staff or provider agrees and is able to coordinate all services necessary. Next slide please.
Slide 12	Aita Romain – 00:09:12	So ECM Providers are responsible for reaching out to and engaging assigned MCP members and continuing to engage them if they have pre-existing care relationship. So MCPs are responsible for defining outreach requirements for ECM Providers in their network, so that the number of required outreach attempts can be defined before an eligible member is enrolled and engaged with ECM or that attempt process has ended. So MCPs are required to reimburse ECM providers for outreach, as it is considered a core component of ECM as I defined before. Next slide please.
Slide 13	Aita Romain – 00:10:01	So there are multiple strategies for outreach, which can include in-person meetings, postal mail, email, text, telephone and community and street level outreach. It's necessary that ECM Providers document outreach and engagement attempts and the different modalities that they utilize. And these outreach and engagement attempts are provided in a culturally and linguistically appropriate way, prioritizing outreach to members with the most immediate needs. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 14-15	Aita Romain – 00:10:37	DHCS does not require documentation of the MCP Member's consent before beginning to provide services. An individual may decline to engage in or continue ECM upon initial outreach and engagement, or at any time during their enrollment with ECM. And providers may opt to have a process for consent. After a successful outreach and engagement with an ECM Member and that ECM Member receives a comprehensive assessment and an individualized care management plan is developed. Next slide please. And now I'll be handing it back to Juliette.
Slide 16	Juliette Mullin – 00:11:21	Hello, my name is Juliette Mullin. I am a senior manager at health working with DHCS on the implementation of ECM and Community Supports. I'm thrilled today to introduce our first set of featured speakers. Joining us will be first L.A. Care and then Illumination Foundation to share details about their partnership and what the work that they have done to engage members in ECM. So we'll begin with the L.A. Care Team, and I'm thrilled to introduce Mary Zavala, the director for Enhanced Care Management at L.A. Care, and Melissa Wanyo the manager for Enhanced Care Management at L.A. Care. With that, Mary please take it away.
Slide 17	Mary Zavala – 00:12:01	Sure. Thanks Juliette, and we are delighted to be here. So a little bit of background about L.A. Care Health Plan. So L.A. Care is the largest publicly operated health plan in the nation, and we serve more than 2.7 million members. As a publicly operated health plan, our mission is to provide access to quality healthcare for LA County's vulnerable and low-income residents, and to support the safety net required to achieve that purpose. LA County has a two-plan model, so L.A. Care is one of the primary health plans and we have three planned partners or delegated sub plans that include, Anthem Blue Cross, Blue Shield Promise Health Plan and Kaiser Permanente. So I just wanted to be clear that what we talk about in terms of data and processes in our presentation are really reflective of the program that we run directly out of L.A. Care and not necessarily representative of our Plan Partners. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Mary Zavala – 00:13:02	All right. So a bit of overall about our ECM benefit. So L.A. Care did run Health Homes from 2019 to 2021, and also LA County was a participating county in Whole Person Care. So that meant when we started ECM at the beginning of 2022, we grandfathered lots of members from Health Homes and lots of members from Whole Person Care into our ECM benefit. As of today, we have more than 16,000 enrolled members with our L.A. Care ECM Program. And we have 49 contracted provider organizations that are over 200 different sites in LA County to serve our members. We have a wonderful internal team that makes all of this work possible. So we have staff that support Member Care, clinical oversight, and we have four really important program managers who are responsible for that provider relationship management. They are the ones who answer emails and answer phone calls within the big L.A. Care Organization, when our providers have questions.
Slide 18	Mary Zavala – 00:14:07	We also offer a really robust training and technical assistance program on ECM related topics, that are open to any providers across LA County, not just L.A. Care Providers for ECM. And then as a hallmark of what we do, we partner very strongly with our plan partners, but also with Health Net and their plan partner Molina in LA County as well. So the six plans, we put our heads together, we talk about a lot of things related to ECM, and that collaboration has gone a long way in executing the benefit in LA County. Next slide please.
Slide 19	Mary Zavala – 00:14:45	So the way we identify members is really kind of a three-pronged approach. We use data mining in alignment with what DHCS has put out, in terms of inclusion and exclusion criteria. We also encourage our ECM Providers to refer members into the program, and we also absolutely encourage and welcome referrals from the community. So we're going to dig into each of those three areas a little bit more on the upcoming slides. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Mary Zavala – 00:15:21	All right, so the data mining. So we use a lot of health plan data, as well as some data matches and data exchanges that we've been able to get established from external sources. So that could include local housing data for example, behavioral health data, where we're able to access it and data from health information exchanges. So those data elements come in. We are able to run our algorithm against the inclusion criteria identified for the ECM populations of focus. We run those eligible members against an exclusionary criteria for duplicative programs and other elements. And that's how we create our member information file, which gets shared with our ECM Providers, to begin their outreach activities.
Slide 20	Mary Zavala – 00:16:08	I will just say that, the health plan data is robust, but it does not cover all the areas that we need to identify everyone who's eligible for ECM. We are serving right now four populations of focus, and we don't have data readily accessible to help identify individuals who have transitioned from incarceration. So that's a really great example of where our health plan data doesn't give us the full breadth of what we would like to do to be able to prospectively identify members. So we absolutely need referrals.
Slide 20	Mary Zavala – 00:16:44	A little bit about how we match members to ECM Providers. So when we ran Health Homes, one of the things that we looked at very carefully was the opt-in rate. So we know members have to be engaged and then they have to agree to participate. We learned in Health Homes that when we're able to maximize preexisting relationships that members have with providers, that really increases the rate of opt-in. So sometimes we saw that providers who had a preexisting relationship with a member had twice the rate of opt-in than others. So we set up a process that was very deliberate on how we take members who we identify through our data and match them to ECM Providers. We do look at primary care relationships. We look at behavioral health relationships and where members are getting services. We look at populations of focus and area of expertise for our providers. So we do go through a really deliberate process there to match members to providers. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Mary Zavala – 00:17:48	All right. So referrals from ECM Providers who are already contracted in our network and already serving ECM Members. So as I mentioned, we have this network of 49 different providers. They come from a variety of different types of providers, community clinics, behavioral health, county mental health, county hospitals, homeless services agencies, recuperative care. And many of our ECM Providers are also contracted with the other MCPs in LA County. I will say one of the really big successes we've had with our countywide collaboration across the health plan is that, we have built out a single referral form that is able to be submitted to any of the LA County MCPs. So regardless of the institution, the provider, whether it's community provider or an ECM Provider, this form makes it really easy for providers to refer any eligible member to the right plan. It has instructions on the form, including email addresses, fax numbers, ways to get that information over to the plan. And so that has been great, because it minimizes confusion as we're really pushing these referrals to come in. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Mary Zavala – 00:19:06	So we know that's not enough, right? We work with the data that we have. We work with our providers that are already in the network, but we know there are more individuals that can be reached through community referrals. And so what we've done really at L.A. Care is building awareness about ECM through different relationships. We've partnered directly with our Internal Care Management Team, other internal departments. We do a lot of partnering with Community Supports teams, talking to primary care providers, IPAs, other community partners. And really have thought a lot about what are the best provider-facing materials to get the word out about ECM and really get people the information that they need, so we can support those referrals in. So things that we've gone to are, especially in this virtual world that we're all functioning in now, something that's easy to share, right? PowerPoint, flyers, electronic documents that can be emails and websites. Being able to point someone to a website that has great information and answers their question, is really critical. So we've taken those into account, as we've planned ways to share about the ECM benefit. Next slide please.
Slide 23	Mary Zavala – 00:20:24	One of the things that we've done at L.A. Care is really try to take up those invitations, when they come to ask us to speak or share information about ECM. So my team, our senior director, myself, we've spoken at different conferences about ECM, different association meetings. So it would be community clinic, be at health associations, different team meetings and staff meetings and word of mouth, where maybe someone else at L.A. Care knows someone at a hospital, and they say, "Hey, you should know about ECM. Let me connect you." So really picking up those one-on-one conversations, to be able to help address questions and get individuals out in the community more familiar with ECM, who can be receiving ECM services, how they can be referred in, and what they get when they're in ECM.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 23-24	Mary Zavala – 00:21:20	So in those conversations, just like the elevator conversations sometimes, where you have two minutes, it's really important to hit what they want to know and make it relatable to the work that they're doing. So who is your audience? What is the information that they really want to know? And how do you get it to them in a way that is succinct, clean and really answers their questions. So on the next slide, we have an example here. Yep, perfect.
Slide 24	Mary Zavala – 00:21:52	So through word of mouth, so one of our medical directors does a regular meeting with one of the health systems to talk about high utilizers. And so, if she said to me, "Hey Mary, it'd be great if you could come talk to the ER at this hospital." And so that, a couple meetings down the line, ended up being a presentation to meet with this health system team of Case Managers and Social Workers in one of their staff meetings. This resulted in over 100 social workers and care managers from this health system in a meeting where I was passed with presenting on ECM and Community Support in 20 minutes. So not a lot of time, big topics, lots of information, and a really excited audience to know how they can help their patients.
Slide 24	Mary Zavala – 00:22:40	So as I sat down to really think about what I was going to put together for them, I decided that I am a social worker and in my past professional life, I did work in a hospital. So I kind of put myself back in those shoes, and what would I want to know about ECM and about Community Supports? First, I would want to know who's eligible, right? Because I need to know which of my patients are going to be eligible for this benefit. What is the benefit to them? What are they going to get out of being in ECM or Community Supports? And then as a social worker or the case manager, how can I refer them and where can I learn more or where can I get answers for my questions? And most importantly, if I need help or I have other questions, who can I contact?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 24	Mary Zavala – 00:23:23	So I put together a great high level slide deck. I pulled pieces from the ECM Policy Guide, from DHCS, put in information from the L.A. Care website where we have an ECM page, and went over each population of focus. I embedded the Shared Referral Form that we have with all the other MCPs. So this was great, because it wasn't just L.A. Care that benefits from this conversation. If that hospital is serving other members from other plans, guess what? They have that shared referral form. They can send that referral form to any plan in LA County to get those members referred into ECM. And then again, we gave them contact information. We sent them our ECM mailboxes. And like I said, we have a great team, and part of our team is really dedicated to making sure that we're responding to inquiries that come in, including myself.
Slide 24	Mary Zavala – 00:24:15	So we have been able to see as a result of these sharings and these conversations, that we've gotten referrals coming in from this health system, which is great. They were not familiar with ECM. And now we're starting to see traction and benefit from this kind of conversation. Next slide please.
Slide 25	Mary Zavala – 00:24:39	So we haven't really embarked on a formal process for spreading the word about ECM, but we know that this is really important. Back in Health Homes, before the COVID pandemic started, we had actually mapped out a plan to do hospital engagement and really we're starting to build process, build materials, things like that. But of course, when COVID hit, hospitals of course, pivoted and changed course. It was a lot more difficult to get attention. So we had to stop what we were doing. I think now is really a good time to revisit that for ECM. We're on the cusp of adding two additional populations of focus. We're going to be adding the seventh population of focus in July of '23, and expanding services for the individuals transitioning from incarceration. So I think there's a lot of interest. And the questions that we're thinking about right now is, what providers do we engage and how do we do that?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Mary Zavala – 00:25:39	So do we go to hospitals and health systems? Do we go to community organizations? What about patient advocacy groups? And do we do one-on-one presentations in the example, where we're really giving tailored information? Do we host large town halls? Or maybe we do both? I think there are pros and cons to each of these. And then thinking a little bit beyond educating providers is, how do we specifically educate our members about ECM? So thinking about some of the member groups that L.A. Care hosts, and there are other fora where we might be able to reach members directly. So these are some of the questions that we are thinking about right now, as we map out strategy for ECM going forward and additional engagement. And I think this might have been my last slide. So I'm going to hand it back to Juliette for our next speaker.
Slide 26	Juliette Mullin – 00:26:33	Wonderful. Thank you so much Mary, for that wonderful presentation. We are now transitioning into one of L.A. Care's ECM Provider Partners, Illumination Foundation, and they'll share a little bit about their experience in this space from the ECM provider perspective. So I'm thrilled to introduce Pooja Bhalla and Ryan Uhl from the Illumination Foundation. Pooja.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 27	Pooja Bhalla – 00:26:58	Great. Thank you Juliette. And it's great to be here with our planned partner doing this presentation together. So just to give you a little bit of background on Illumination Foundation, we started about 15 years ago with a goal to coordinate care for individuals and families experiencing homelessness. We started off in Orange County and at the time, this was obviously prior to the Affordable Care Act. We were seeing individuals in shelters, on the streets, and we were hoping to just connect them to whatever services were available, and organically grew the organization into developing a system of care where we started shelters, started to address those social determinants of health, to connect folks to services that they needed. And at the time, many of them were not insured. So we were very much a grant supported organization and built different services. And then another 1115 Waiver, we did start the Whole Person Care and the Health Homes Program. We supported Medical Respite, Recuperative Care. And now under CalAIM, we are working in four counties, providing a lot of the Community Supports, including Enhanced Care Management as well.
Slide 27	Pooja Bhalla – 00:28:20	One of the unique things on how we address homelessness for our individuals is, how do we make sure that they are moving on to the next step in their journey and not going back out to the streets, the shelters, emergency rooms. So we developed a Micro-Community Model, which really connects individuals into housing, where we rent, lease, purchase single family homes in different parts of the county, to move people into housing while they might have a voucher, some may be waiting for rental subsidy. And it really helped us alleviate that burden of trying to move folks into a system, rather than putting them back out on the streets. So Micro-Community Model really helped us move folks along. And while they were in the Micro-Community, they were also still working on the Permanent Supportive Housing piece as well. So when we look at a model over the years, we really had to address it all the way from meeting individuals from the streets and supporting them into housing. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 28	Pooja Bhalla – 00:29:36	So to date last year, we served about 43, 4400 individuals in all different counties, and in LA County 421 folks came to our program. And prior to doing Enhanced Care Management with our L.A. Care partner, we have been doing medical respite through L.A. Care as well. And also through DHS, we've been doing the Housing for Health Program. And then we were really excited to partner with L.A. Care to become that Enhanced Care Management Provider, because in many ways, along the years of doing the work, we've had to figure that out, how can we coordinate care for individuals? And I was glad to see that now there's a benefit that actually supports individuals in coordinating the care, and ECM really meets those needs.
Slide 28	Pooja Bhalla – 00:30:27	So when we started our work on ECM, we had close to about 900 members or so that were sent to us in a roster, and we've had about a 22% enrollment rate for these members. And I'll explain why those numbers are the way they are, because a lot of times, folks aren't really aware of that they actually have this benefit called Enhanced Care Management and why that's important. Next slide please.
Slide 29	Pooja Bhalla – 00:31:02	So the most important thing, before we started to go down this journey of becoming an ECM Provider, we attended every training that our health partners put up. And L.A. Care had done a bootcamp, which really allowed us to understand the program. We had the policy guide and we're going through it and writing up policies and protocols, but I think understanding it at the ground level was really important. And we identified a team who really understands the importance of outreach and engagement. All of them went through the L.A. Care bootcamp trainings. And then we also, prior to going live, had our own training to make sure staff understood what it meant to really take care of the population in this new benefit called ECM. A lot of it was around navigating the member information. We would get these lists from L.A. Care. We needed to understand what that meant and how to match clients and how to find clients.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 29	Pooja Bhalla – 00:32:07	A big piece of this is understanding the outreach piece, before we can actually get folks into services. And I can't stress that enough, because a lot of time, what we were finding is, as we were reaching out to individuals, they didn't really understand that they actually had this benefit. So we had to educate them and why this is important that they actually accept this benefit, because it will actually help them connect to the services that they really need. But as expected, there was a lot of trust issues. Folks didn't really understand what this was. So outreach and really talking to those clients was really important for us. And we definitely followed, as Mary was showing, there's different modalities to do outreach. You do the phone, you try to find them, you go to the places where we might know where they are.
Slide 29	Pooja Bhalla – 00:32:59	So that was important. We had to go through that and really establish our own target outreach list, before we could really enroll individuals. And one of the other key things is, how do we understand that our staff can make sense of a care plan? What does it mean once you outreach to somebody, and then you actually enroll a member? We started off with each staff member understanding outreach and engagement, and then had to pivot to, let's make sure we outreach to every eligible member, so we can actually find them and engage them. And once our staff kind of really mastered that, then they start moving on to the care planning aspect of the care. Next slide please.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 30	Pooja Bhalla – 00:33:48	How did we identify eligible members for ECM? Our organization runs many different services, so it involved a lot of care team conferences throughout our different departments, discussing what's happening in terms of where the clients are, what are the specifics, what are some of the programs that we need to be looking at to partner with, as we try to engage folks into ECM. A lot of education. Ryan who's on here with us, spent a lot of time writing curriculums, understanding so our staff understand, but also that the clients understand we put together flyers. So the clients really know why this is an important benefit and why it's important that they actually sign up for it. Also, understanding the population of focus. Early on, there was a lot of confusion around, does everybody just fall into this benefit? So we had to make sure we really looked at that exclusionary list and make sure everybody who was actually being referred, actually was eligible, and that involved a lot of education for our staff and our clients.
Slide 30	Pooja Bhalla – 00:35:01	The other piece, which really is important is, as we were meeting different care providers, full service partnership, board and care, stuff that Mary talked about, that we really needed to be out there and explaining what this benefit is and how it can really help the member and also how we can partner with these other agencies. Again, everyone's sort of doing the day to day staff. There's this new program. What does it mean? How can we actually work together? So it took a lot of us being out in the field and educating individuals and different partners. Next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 31	Pooja Bhalla – 00:35:44	Key thing, in-person introduction. We have a lead case manager who really has a caseload of the eligible members. Important that we meet the members as soon as we possibly can, to explain why this is important, what the steps are, they need to opt into this program, and then identifying the population focus and referring the member. What does it mean? How do we actually refer somebody and make sure that the whole process of care planning is being explained. And that important, getting the information out as soon as we can, to the sites where we are getting some of these members from. A lot of times, we would hear like, "well, they already have a case manager. They don't need this extra benefit." So explaining that ECM is a benefit through the health plan and what it means. And it's not just while they're at that particular location that we need this ongoing care coordination. Meeting and educating the program staff at all facilities, including our own was really important. Next slide.
Slide 32	Pooja Bhalla – 00:36:55	Again, outreach. I feel like that is the most critical step that we had to make sure it was happening in the right way, before we can engage the client into care, because a lot of times, you are trying to find the members. You might not have the right information in terms of their demographics and where they are in location. So our team, our care team had to really establish those roles like, "Okay, we're going to take this list of 50 members and really outreach, and this is going to be our targeted plan and how are we going to accomplish that." And really looking at the different platforms that are out there.
Slide 32	Pooja Bhalla – 00:37:32	The next step is let's connect to their care team in terms of primary care. Where was the last address? Were they in an emergency room? How else can we find them? And then we also use the different systems like HMIS, Recuperative Care Through Housing for Health. DHS uses CHAMP. We have Collective Medical, which gives us information around emergency room utilization. Looking at another closed-loop referral platforms, such as FindHelp and Unite Us. So a lot of it early on was trial and error. Let's look at different systems, what we can do and how can we streamline a lot of this information. Next slide.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 33	Pooja Bhalla – 00:38:19	What is the next step once someone has been outreached? And I think it's important that once that outreach happens, that engagement enrollment happens right away because clients do get confused. They get anxious. "Am I signing up for something? Am I going to have to pay for this? What does this really mean? I don't need to change my doctor." So ongoing education, what the goal of the program is and why it's important for them to enroll. And then after they enroll into the program, then we have to start with the risk assessment, which always a preference is, let's try to do it in person. But during COVID, we've had to do a lot of it virtually, where they sit down with their care team and go through the different aspects of the health assessment. And they were actually building the care plan to match the goal for each client.
Slide 33-34	Pooja Bhalla – 00:39:10	The care plan is a live document. So every week, Ryan sits down with all the lead care managers to go over client by client and look at the care plan and see, where are we at, what are some of the important things we need to be looking at. How can we move forward with this care plan of this client? I think, is this our last slide? Yep.
Slides 34-35	Juliette Mullin – 00:39:37	Wonderful. Thank you so much Pooja. With that, we're going to transition into another ECM Provider. This one based in San Diego County. We're thrilled to introduce two of the leaders at La Maestra Community Health Centers in San Diego County, Dr. Uchey Dijeh, the Director of La Maestra and Norma Van Drunen, Manager at La Maestra. So Dr. Uchey, take it away.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Dr. Uchey Dijeh – 00:40:05	Awesome. Good afternoon, everyone. Thank you for Juliette for the introduction. So I'm go over the slide to briefly give a background about La Maestra. La Maestra was formed in 1990. We are one of the most culturally diverse health centers in San Diego, California. As well as we also have our staff is well grounded and we come from a lot of very diverse background, culturally, linguistically, as well as more than 30 languages are spoken by La Maestra Staff. And right now we have over 500 employees. La Maestra, this has modeled into our mission. And also in our mission, we have driven days protocol and a well evidence-based model called, La Maestra Circle of Care, where all our healthcare services and Social Determinants of Health programs have elements focusing on education, on case management and social health services in an integrated approach. Next slide please.
Slide 37	Dr. Uchey Dijeh – 00:41:25	This approach has actually allowed us to be able to integrate into HHP, when we actually signed up for the program in 2019. And as we transitioned into Enhanced Care Management, we are also currently the only ECM Provider that is contracted with six health plans in San Diego County. We're also recognized as a HUB, where we provide both La Maestra patients and non La Maestra patients. We offer ECM services to them as well. And also, due to the comprehensive nature of ECM and also introducing our Cycle of Care, it was very important for us to learn what the challenges that we came across during health one's program and to improve on that. That improvement guided us in providing what we call the La Maestra ECM CS Care Coordination Standardization, and which we brought in the best practice of using a continuous improvement and evaluation process.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 37	Dr. Uchey Dijeh – 00:42:38	This process allowed us to develop a tool, a comprehensive centralized tracking tool, where we actually support the integration of ECM and CS requirements for all the six health plans that we provide, and ensuring that we meet up with the requirements of DHCS and also we meet up with the unique factors or requirements for each of those six health plans. This tool also allows us to make sure that we also maintain our quality of care delivery. The quality of care delivery guides our performance measures and goals, and also allows us to establish metrics for the structure of care, the process of care, and also to achieve our outcome metrics as well. Next slide please.
Slide 38	Dr. Uchey Dijeh – 00:43:30	Talking about the standardized tool for La Maestra. What does this mean for us? This actually allows us to look at our member as a La Maestra ECM enrolled member, regardless of which side that we are offering the services from, regardless of the care manager that is providing services, regardless of the referral and regardless of the health plan that we received this member. These members are received and all the care that we provide goes across to all members and they'll receive everything in a standardized form. So this has allowed us to build this tool, to be a living tool that we see our members, not just as this member from this help plan or from that help plan, or coming from this five sites or working with another care coordinator. With this tool, we are able to look at these members and provide services at once to them.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 38	Dr. Uchey Dijeh – 00:44:29	Currently, this tool actually was developed in Access database, but we are in the transition of moving it into a most robust EHR platform. Also in this tool, we are able to add all the information to building our outreaching. We know outreaching has been a big major barrier in terms of how we can capture outreaching, we can capture referral, we can provide care coordination, and we can track all those services that we're doing all those workflows, as well as the billing for the services that we have provided. This tool allows us to track all those things, to improve our care coordination delivery, to improve our team services, as well as to deliver policy care to our members and provide information and encourage a shared participation between us, the ECM, the member and their care teams as well. Next slide please.
Slide 39	Dr. Uchey Dijeh – 00:45:34	Like I said before, for identifying eligible members, we get six different tell lists from the six health plans that we do. We also encourage the participation of our La Maestra Providers. So what do we do with this? We try to make sure that we are not adding additional burden to our providers, that we streamline the process of referral. Once they see a patient that qualifies for this program, that the process of referral from the clinic to ECM services is actually streamlined in the process that we can capture that patient immediately and provide ECM services and enrollment to them. So what we did was, we increased the participation for awareness and education for our providers. Not just for the members, but also to show our providers and our staff in the clinic, what ECM services is all about, so that the providers are aware of this program coming from CalAIM and how we can be able to support them, in improving the health outcomes of their patients.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 39	Dr. Uchey Dijeh – 00:46:46	We do a collaborative partnership with the various practices and providers that we have in La Maestra. We engage our various Social Determinants of Health programs that we have. To [inaudible 00:47:01] process, we also added an option of referral in our EHR. So at the point of contacts with the patient, the provider is able to click on the referral and refer the patients directly to ECM. To cut down the referral time between the clinic and the referral team back to us, we were able to train a dedicated staff that actually goes into the referral and be able to generate the referral from the providers. And we're able to work, outreach to those patients and be able to enroll them to ECM.
Slide 39	Dr. Uchey Dijeh – 00:47:43	How we get referrals from the community? Going from our history of HHP, more than half of our enrolled HHP to ECM members were actually non La Maestra patients. So what this did for us was actually encouraged the participation for us to engage with a lot of non La Maestra organizations and private clinics or providers. So what we did was to have a team dedicated to us, going out to go introduce ourselves and be able to encourage the providers to know who we are and how we are supporting their patients. We also use strategies too, where enrolled members actually go out and they share their experiences, and can actually have family members or friends actually reach out to be enrolled in the program as well. We also develop the flyers and also we use our websites to actually share and communicate about ECM to the public as well. Next slide please.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Dr. Uchey Dijeh – 00:49:00	How do we spread the word on ECM? Like I said, we have fostered a lot of good communication and collaborative relationships with non La Maestra organizations. It has been really good for us to have a clear communication on what ECM services are, where we are coming and how we can support the patients, as well as the providers. We've actually had some good outcomes where non La Maestra providers have actually reached out and referred patients to us, because of how we have seen the work that ECM has done with their patients that work with us. So they have actually referred some patients that are actually non La Maestra patients to us, to be able to provide the services to them as well. So that is a good outcome for us. We also provide training support and information to our non-Lara providers.
Slide 40	Dr. Uchey Dijeh – 00:49:51	So we go out to their organization and go to their sites and we're able to share more information about La Maestra and the ECM Program and what we were able to do with their patients. We streamline the process for the ECM and Community Supports referral process, because we know that we understand that the referral might be a little bit challenging from there to understand how to fill out a form. So we break down the process and actually support them into providing those tools, so that we can get their members enrolled. The other things we have done is using the flyers and sharing information and sending out contact information for La Maestra ECM, so that anybody can reach out to us within the time to get more information from us as well. Next slide please.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 41	Dr. Uchey Dijeh – 00:50:50	So how do we assign members to case managers. Knowing that we get a very large volume of members, eligible members to us through the six help plans, it is very important to us that we identify these members and we assign them to the care coordinators that can provide services. One of the biggest barrier we have is language. How are we able to address this barrier? What we have done is that, we have created each individual, each help plan has a team of care coordinators that work with that health plan. So each help plan has English speakers, Arabic speakers, Spanish speakers and other languages as well, where whenever a help plan sends an eligible member to us, we are able to connect them with the team and the team's provider assigns them to a case manager that can provide services to them, minimizing the linguistic barrier. And as well as all our team members are trained in motivational interviewing, and they're all culturally competent.
Slide 41	Dr. Uchey Dijeh – 00:52:04	We have ongoing trainings from both from the health plans, as well as internally, as well as other care coordination services that we receive from George Washington University, on how to provide patient navigation and executive communication for high risk, high need individuals as well. Currently La Maestra ECM, all our care coordinators have about 100% English speakers, and we have the 5% Arabic speakers, 60% Spanish speakers and 5% other languages, including Somali, French and Vietnamese. When a member that is assigned to us and we don't have the language, we are able to utilize La Maestra language services as well. Next slide please.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 42	Dr. Uchey Dijeh – 00:52:59	For La Maestra Outreaching Eligible Members. We currently use the six outreach attempts, telephonic, in-person and mail out. And this is done within two months. And if we feel or the care coordinator feels that there's a need to repeat additional attempts, they also do that as well. Using the centralized tool, our outreach pool of that tool allows us to ensure that we track all our outreaching attempts. We document what was done. We are able to bill for all the outreach that is done. And we also ensure that no member goes through the cracks within that 60 days. In terms of, if a member is not successfully outreached by telephonic or mail-outs, we try to look at if the member is a La Maestra, we check to see if they have been in the clinic. If they have been in the clinic, they're active in the clinic, we try to see what are the next appointment and we try to be available to send someone to go, meet up with the member when they come in for their doctor's appointments.
Slide 42	Dr. Uchey Dijeh – 00:54:11	We also use the health plans outreach tell list, to be able to track the last provider on file. And we reach out to that provider to see if the member is still an active patient. And if they are, we explain ourselves and we are able to track when the next appointment is, and we can also be able to target the member and be able to share ECM. This [inaudible 00:54:39] improves our ability to outreach successfully, and it has been something that we have been using and have been working for us. The other thing is, we try to also provide health plans with consistent and clear documentation of all the outreaching attempts, as required by DHTS and by the Health Plans as well. And the outreach tool is also used to bill, to successfully bill for all the outreach attempts that is made at the end of the month as well. Next slide please.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 43	Dr. Uchey Dijeh – 00:55:14	For the next slide, what we have is best practice, where we go from an outreach member to an enrolled member. How do we support this standardization across all health plans for our members? What we do, each case manager is able to know how to document and highlighting what population of focus that the member qualified for. If they're eligible to receive ECM by checking the eligibility with the health plan, they have to summarize, go through the current care needs with the conditions verified and identified and Social Determinants of Health barriers that the member is facing. They have to verify if the member has an established PCP or not. They also have to confirm if there's no duplicative services at the time of enrollment, they have to confirm the member provided consent and was enrolled in ECM.
Slide 43	Dr. Uchey Dijeh – 00:56:14	We have to show documentation that they use motivational interviewing to identify problems and challenges faced by member and to note the care coordination recommendation, and the next steps for supportive interventions for the member. They have to create a care coordination progress plan to support member and ensure that applicable health screenings are initiated and completed. Some of these health screenings involve the ICP, the Care Plan, the Health Risk Assessment, all the SEOH. All these guys, the care coordinator and the member to know the next action steps towards supporting member to be successful in this program. They summarize the action steps and they inform the member that the care plan will be shared with PCP and care team. And if need be, that the clinical consult consultants will actually review, and if additional recommendations are made that the care coordinator will support member towards those interventions in place.
Slide 43	Dr. Uchey Dijeh – 00:57:13	The next thing is, that the member verbalizes understanding of care plan and the steps for how the care coordinator will be able to support them in this program and towards addressing their care gaps and as well as their social health barriers that they're facing. I think that's all for me. Thank you.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Juliette Mullin – 00:57:36	Thank you. That was wonderful. And thank you to all of our featured speakers today for sharing with all of us their experience implementing Enhanced Care Management and some strategies they've leveraged, to be able to outreach and engage members into the program. With that, we will transition into a question and answer section for today. I've been keeping my eye on the Q&A, and I will ask a few questions from the chat and a few questions that have come to mind for me, as we've been presenting to our various presenters.
Slide 44	Juliette Mullin – 00:58:10	I think the first one I'll start with actually, just top of mind for me and I'm seeing a couple questions on it in the chat just now, is for Dr. Uchey and the La Maestra Team. I'm seeing some interest in the chat about your Care Coordination Tool, and wondering if you could share a little bit more about how you created that tool and what goes into that tool, and how you leverage that to help support outreach.
Slide 44	Dr. Uchey Dijeh – 00:58:39	Yes, thank you for that presentation Juliette. So for the tool, I would say actually the tool was actually an idea that I came up with, because of the number of health plans that we had at the moment. And it was really difficult for us to be able to face those challenges in trying to meet up with all the requirements with the individual care plans. And how do we integrate this in a process that it makes the workflows easier for my team to understand why not taking away time from us engaging with the members, and improving on the quality of care that we supported.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Dr. Uchey Dijeh – 00:59:24	So the first thing we did was to create a workflow that we identified through an Excel Spreadsheet, where we looked at what are the eligible member list in outreaching. During that process, what are we looking for? What do we need to do? Okay, so that takes us from that eligible member list and outreaching is where we receive the tell. From the help plans, we create the monthly reporting for all the outreach encounters, and we are able to identify, are they La Maestra? Are they non-La Maestra? Did they decline? If they declined, it takes us to the workflow of now to report back to the health plan. However, if they accept, that now takes us to the next phase of the workflow, which is eligibility, criteria and enrollment. This is where we now check if the members, are they eligible to receive ECM? Have we identified their POF? And then have we completed the enrollment process? If all this is yes, they move into the next stage of care plan.
Slide 44	Dr. Uchey Dijeh – 01:00:37	So it has been looking at the workflow, at all the activities that we do with each health plan and seeing where do they align, where do they meet. And where they meet is where we have used to now expand on their services and expand on our workflow, but with the idea that, in the end of the process it's actually providing a quality care delivery to the member. The second is actually providing a unified tool for my staff to be able to do their work, provide care coordination, training and community resource linkages, and as well as provide a platform to do performance evaluation and an appreciation support for the team as well.
Slide 44	Juliette Mullin – 01:01:32	Wonderful, thank you for sharing that. And I know you and I had a chance to talk about that tool a couple days ago, and I was very interested in it as well. So I'm not surprised to see some conversation in the chat about that one. Following sort of a similar theme of a standardized tool, I saw some questions for L.A. Care in the chat, and this is specifically, I'm seeing some interest about the LA referral Form. Mary, I'm wondering if you could speak a little bit to how that came to be and how you were able to make that a reality in LA?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Mary Zavala – 01:02:08	Sure, absolutely. I think, I can't say enough good things about having a Standardized Referral Form for the whole county. It's so tremendous and it just makes things easier for anyone who's referring a member in. We had really great partnerships from the other health plans in HHP and we had a universal referral form for Health Homes. So once we got the eligibility criteria for ECM, we all collectively knew that this was the direction we wanted to go. And so we, like I said, had really great partnerships, great input from all the plans contributions to make sure that we're asking the right information on the referral form, and I'm happy to share the link. We can definitely put that in the Q&A, so that everybody can have it. It is long, because it includes the inclusion and exclusionary criteria as well. We want to make it as clear as possible about really who would be eligible for the ECM benefit. So this is a little labor of love in 2021, as we neared the end of 2021 and got ready to launch ECM, but it has been a valuable tool for all of us.
Slide 44	Juliette Mullin – 01:03:27	Thank you for sharing that. A question that I have for the Illumination Foundation. So this is one actually that I was thinking of when Dr. Uchey was sort of sharing their process for determining which care manager is going to be assigned a patient or a member, when they're assigned to La Maestra. Could you speak a little bit to how Illumination Foundation approaches that and how you determine which care manager to match to a patient?
Slide 44	Ryan Uhl – 01:03:55	Yeah. Yeah. So when we outreach members, we have a screening tool and the screening tool kind of assigns them like an acuity index, based on their needs and what's going on with the member. And each care planner has a sort of point system where collectively based on the index, you're assigned a certain score and that score's aggregated for each care plan's caseload. So that kind of gives us the ability to sort of triage and distribute members, based on their needs across the care planner's caseloads. We want to try to avoid as best we can, a certain lead care manager being overloaded with very high needs, high complexity clients. So we do use a screening tool and an indexing system for this.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Juliette Mullin – 01:04:47	That's really helpful, thank you. A question for Dr. Uchey. I'm seeing a question in the chat. In your 10 Point Plan or your 10 Point Best Practices for a Care Plan, you mentioned one of the steps was confirming non-duplication of services. Could you share a little bit about how you do that?
Slide 44	Dr. Uchey Dijeh – 01:05:09	Sure. So in the referral form, they have the programs listed out that the members cannot receive at the same time when they're receiving ECM. So we use those lists to go over with members, "Do you have MediConnect? Are you receiving these services at the moment or not?" And if the member doesn't know, just like someone mentioned, sometimes our members might come with several other care coordinators or case managers. So we want to make sure that your case managers that you say you had, which services is that? So when we go through that bubble and verification, "Oh, I have this case manager or I have that" And they're not in the listed programs in the referral form, to verify, to be very sure that the member might qualify, we also reach out to the health plans and say, "Can you verify if member is in one of these programs?" So we can do a two-way check verification, to be sure that the member doesn't have a duplicative service at the time of enrollment.
Slide 44	Dr. Uchey Dijeh – 01:06:15	Sometimes the health plans might come back and say, "Oh, member has these services. However, they can opt-out of these services to receive ECM." We bring that back to me to member and say, "This is what these services is doing for you. This is what ECM is doing for you." We leave that member to decide if they want to continue with the services or if they want to move over to ECM. So this helps us to be able to have a well-rounded clear communication with the member or with their primary caregiver, as well as moving forward to opt them into the program or to let them know that they can maintain their services that they're currently receiving, and reach out to the health plan, to get a lower level of care that can support what they're already receiving at the moment as well.

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Juliette Mullin – 01:07:08	Great, thank you for sharing that. A question for the Illumination Foundation. When you were speaking to your process for outreaching members, you noted kind of the coordination with the primary care provider and working with them as part of the outreach process. Could you elaborate a little bit on how you work with primary care providers throughout outreach, and how you leverage that relationship to build trust with the patient?
Slide 44	Ryan Uhl – 01:07:35	Yeah. Yeah. So the goal is obviously to reach the member directly. And so oftentimes, when we try to make direct contact, we're faced with an outmoded kind of contact information. And because most of our clients are higher needs, higher complexity, most of them have had recent PCP contact. So it's often the case that if we're running into any barriers, as far as contact, us pivoting to PCP contact is oftentimes a good way for us to kind of ascertain current contact information. And it's also a good way for us to build better rapport and relationships with members' care team. So we often use this to gather information, to help us find the member and it's been a very fruitful endeavor so far.
Slide 44	Juliette Mullin – 01:08:45	Great, thank you for sharing. I am wondering if L.A. Care, this is the question that's going to pivot just a little bit here, but you mentioned in your presentation a little bit about the boot camps and the training that you host for the ECM providers you work with. And I know Illumination Foundation spoke a little bit to the fact that they participated in those boot camps, when they started to get launched with ECM. Could you share a little bit more about what those boot camps look like and how you've organized those?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Mary Zavala – 01:09:18	Absolutely. So this was a really exciting endeavor for us. And again, this was an all-plan collaboration. So we had several iterations of bootcamp to get our ECM provider workforce ready for ECM. This was ... I believe it was six hours of Zoom training. We had two or three different offerings, different courses, six hours each. In the first offering, we exceeded 1,000 enrollees. So this gives you a sense of the number of workforce, ECM provider workforce in individuals that we had trained. And it was really to go over what they needed to know about grandfathering from Health Homes, grandfathering from Whole Person Care, ECM eligibility, services, requirements, exclusions, and really digging into outreach and engagement, as a first step.
Slide 44	Mary Zavala – 01:10:18	So this was a great again, opportunity to bring individuals into a shared space. We have since made that training available on our L.A. Care University, so that new providers as they hire additional staff, are able to have that staff take that training through the Learning Management System. They don't have to wait for us to offer another Zoom training to be able to do it. But it was really important and a great way to have people virtually get to see each other and learn about ECM together. And also a great way for the health plans to really see the size of the workforce that was going out in LA County to start to work with our members. It was great.
Slide 44	Juliette Mullin – 01:11:02	Great, thank you. Dr. Uchey, we have a question in the chat about ... Oh, if I find it. I just scrolled away from it, sorry. We have a question in the chat about what you think the impact of having such a linguistically diverse team has on your ability to effectively outreach members.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Dr. Uchey Dijeh – 01:11:25	Definitely, I would say that has been one of our biggest advocates for our community, knowing that we serve a very diverse community and removing the language barrier or minimizing the language barrier would help us be able to engage better with our members, our patients, our community, and be able to target and know what is going on and how we can be able to support them. So that has been the mission where La Maestra has focused on that cultural competency and linguistic competency, to be able to get to our members and to be able to get to our community and our patients as well, for better engagement.
Slide 44	Dr. Uchey Dijeh – 01:12:04	That has been the model that we have used for also for our ECM Program, that when we started, that it was important for us to look at the language of the members that we were receiving and making sure that the members, even when they say English and we ask them, they're bilingual, "Which language are you more comfortable with?" They would be like, "Oh, I prefer Spanish." So that way, the care coordinator knows to engage with the member in that language. So that way they don't feel burdened or they can be able to express themselves better and be able to share in more details, or their care coordinators are able to make sure that they participate in their informed care decision and they are part of the process and they understand the process.
Slide 44	Dr. Uchey Dijeh – 01:12:58	So definitely integrating the members with the care coordinators that speak the same language has been a good positive outcome for us in better engagement, improving quality of delivery that we offer to our members.
Slide 44	Juliette Mullin – 01:13:18	Great, thank you. And we have a follow-up question for Illumination Foundation about engagement with primary care. So you spoke a little bit to the value of engaging with primary care. Could you speak a little bit to how you go about having that conversation with a primary care physician, introducing yourself, building that connection, so that you can have a partnership in caring for the member?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Ryan Uhl – 01:13:43	Yeah, yeah. So we try to approach it as professionally and as best we can. We haven't ran into many roadblocks, but we have to try to educate them as to the nature and dynamics of the program and to how it's going to serve the member. We have had a couple instances where they didn't want to share too much information, and we were able to recruit the help of Los Angeles Care and they were actually able to reach out and kind of help us out a little bit. But I think as the word has gotten out about the program and about our partnership with the Managed Care Plans, that's helped a lot. In the beginning, there was a little bit of turbulence, but I think the past three or four months, I don't think we've hit any roadblocks as far as getting contact information or kind of building a relationship with the PCP offices. But yeah, we just try to educate them as best we can and explain the program thoroughly, and that tends to work out.
Slide 44	Pooja Bhalla – 01:14:54	Yeah. If I can just add, I think the key has been a lot of the entities are not aware that this is a benefit, how great it is. So now that it's starting to get out that this is a benefit that members can avail, we're having to explain to the PCPs why it's so important. And once they realize, "Oh wow, this is the gold standard." You have a care manager, who's going to take care of all these things. And as a primary care doctor, you don't have time to do all those things.
Slide 44	Pooja Bhalla – 01:15:21	So it's really educating them on what ECM is. And like Mary was saying, that outreach to the rest of the entities about what ECM means and what it can do, is really going to go a long way. And early on, I think we ran into issues. People were like, "Who are you? And what is this benefit? And why are you calling me?" So we had to explain and then point to the guidance like, "Oh, it's a program that your clients can actually really benefit from." So the more the word gets out, I think everyone's going to want to work on this together.
Slide 44	Juliette Mullin – 01:15:55	That's great and I think emphasizes the importance of some of what we're talking about today, doing those road shows, getting the word out, making sure that this is front of mind for people. So thank you for sharing that.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 44	Juliette Mullin – 01:16:09	I think we are coming probably to the end of our core questions that we have here in the chat. And we do have a few requests to drop flyers, links for flyers and links for referral forms in the chat. So if any of our panelists want to drop those in or have any available that they could share, please feel free to do so. With that, if we can go to the next slide. I'll just share a few things coming up for people.
Slide 45	Juliette Mullin – 01:16:40	So today, we were thrilled to have this webinar on Member Engagement, and we heard these wonderful presentations from L.A. Care and Illumination Foundation and La Maestra about how their engaging members. Next week on Thursday at 2:00 PM, we will have an Open Office Hours Session. So this is really an opportunity bringing this group back together to have an open conversation about some of the successes, some of the strategies that they've been able to implement over the past few months since ECM launched, to really reach members and be effective in onboarding them into Enhanced Care Management. After that, we will be continuing to host a number of different sessions, over the course of the next few weeks.
Slide 45	Juliette Mullin – 01:17:32	On September 8th, we will be hosting a webinar on ECM Long Term Care Populations of Focus. So this will be dedicated to these new populations of focus that go live in January. And we will be explaining the details of those populations of focus and bringing in some providers to share what they're doing to get ready for these populations of focus. Similarly, we will then host an Office Hours on that topic, an open conversation with them based on many of the questions that we receive in the chat.

CalAIM ECM Outreach and Engagement: Technical Assistance Webinar

August 25, 2022

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 45	Juliette Mullin – 01:18:07	At the end of September, we will also be hosting an Office Hours specific for Rural Health. And so this is really focused on how providers have implemented ECM and Community Supports in rural California and addressed some of the unique challenges that you can see in those very large geographies. And then the last two that we'll call out here are two sessions in October on Housing Supports that we'll be hosting. And so that again is a Webinar and an Office Hour Session on Housing Supports in the month of October. We will continue to have webinars going into November and December, but they did not fit on this slide.
Slides 45-47	Juliette Mullin – 01:18:51	So these are the core webinars we want to share with you all today. And if we go to the last slide, we have a few resources and materials for people who want to learn more or see more about ECM and Community Supports. If you have some more technical questions about the different data elements or data forms, we have guidance documents here for you on things like billing, coding, et cetera, as well as the broader policy guides for ECM and Community Supports. And with that, we will wrap a few minutes early today. Thank you to all of our presenters today for sharing their time, sharing their experiences with us. And we wish you all a great rest of your afternoon.
Slide 47	Julian – 01:19:42	Thank you for joining. You may now disconnect.