CalAIM All Comer Webinar: ECM Panel Discussion: Forging New Managed Care Plan Partnerships with Counties and CBOs to Launch ECM for Children and Youth

June 23, 2023

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Ethan – 00:00:25	Hello, and welcome. My name is Ethan, and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please send me a direct message in the chat. We encourage you to submit written questions, and comments at any time. Finally, during today's live event, live clip captioning will be available in English, and Spanish. You can find the link in the chat field. With that, I'd like to introduce Dr. Palav Babaria, Chief Quality, and Medical Officer, and Deputy Director Quality, and Population Health Management at the Department of Health, and Care Services.
Slides 1-2	Dr. Palav Babaria – 00:00:56	Hello everyone. Thank you so much for joining our webinar on a lovely Friday afternoon. Really excited about the information that we're going to present over the next hour, and a half. We can go to the next slide. Before we kick off our webinar for today, we do want to remind you on behalf of the Medi-Cal program that as most of you are aware, the continuous coverage requirement that affected all Medi-Cal enrollees ended on March 31st, 2023, and Medi-Cal members may lose their coverage as we resume the redetermination process. This process began on April 1st, 2023 for those individuals who normally would've had a June, 2023 renewal month. Our goal is really to make sure that each, and every member who is still eligible for Medi-Cal services can go through the renewal process without any disruptions in coverage, or care. And that for those members who are no longer eligible for Medi-Cal coverage, that we can connect them to alternate sources of healthcare coverage, and to really minimize anyone who ends up without health insurance in our state. So, we need the help of every single person on this call. If you haven't already, please become a DHCS coverage ambassador. Links will be available in all of these slides. You can get updates from our mailing list, and also really share information directly with Medi-Cal members about how they can go through the redetermination process, and keep their coverage. We can go on the next slide.

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Slides 3-4	Dr. Palav Babaria – 00:02:24	The other piece that I'll put here is on February 8th, knowing this was coming, we launched our broad renewal campaign. So, you can download the phase two toolkit, which has information that you can customize for your use for broad-based messaging. And then we also have a new website KeepMedi-Calcoverage.org, which is really targeted directly at members that has resources for how they can navigate this process easily, and simply. So, please, for any of you who work in collaboration with Medi-Cal members, you can direct them to the centralized resource. And go to the next slide. So, with that introduction, really excited to kick off today's agenda. For many of you, we know there's a variety of folks on this call. Some of you may be more familiar with enhanced care management than others. And so we will provide an overview of our ECM program, and then specifically focus on the upcoming launch in one short week of our ECM for children, and youth population of focus.
Slide 4	Dr. Palav Babaria – 00:03:23	We then have a series of providers, and provider plan partnerships lined up for you to hear from directly. We'll be having Pacific Clinics who serves a number of our geographic regions across the state, talk about how they're implementing ECM for children, and youth in addition to other populations of focus. And then we'll have a really exciting panel of several provider, and plan partnerships focusing on county providers to really explain how they work through their contracting process, and partnership, and are collectively serving the children, and youth in their regions. And then we hope to leave ample time for question, and answer from all of you along the way. So, thank you so much for joining us. We can go to the next slide.

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Slide 5	Dr. Palav Babaria – 00:04:06	All of you already got introduced to me. I am our chief quality, and medical officer, and I will say despite being an internal medicine physician by training, the work that we are doing for children, and youth across the Medi-Cal program, I think is among the most important work that we are doing. And so really excited to support the launch, especially for this population of focus. And I will turn it over to Carrie Whitaker, who is one of our fantastic nurse consultants, and our maternal child health subject matter expert. Carrie, take it away.
Slides 5-6	Carrie Whitaker – 00:04:36	Thank you, Dr. Babaria. Hi everybody. I'm Carrie Whitaker. I'm a nurse consultant, a public health nurse in California as well. I work with Dr. Babaria, and team in quality population health management. And I'll be here just to orient everybody on this call to generally what ECM is first before we go into what that means to you all to ECM kids, and to our state. So, we can go to the next slide. All right. Oh, and here is how you can participate. We use the chat, go ahead, and use the chat to ask the questions, and share your experiences. I see 690, and climbing folks on the call, so please don't have your feelings hurt if we don't get to all of them, but we are going to spend most of our time with the panelists, and the Q&A, and less time orienting you so that we all get a chance to have a dialogue. So, then you can ask a question to raise your hand. I'll let my colleagues on the panel section guide you through when that might be a good time to do, compared to when you would maybe...

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Slides 6-8	Carrie Whitaker – 00:05:49	The open dial dialogue discussion might be another time where you could raise your hand, and come off mute. All right. And next slide, please. Okay. So, now we'll begin talking about ECM in general before moving into children, and youth populations of focus. That goes live next week. Next slide, please. Okay, so this slide does shows in a visual what ECM is. It's part of a care continuum for all managed care members in California, and ECM enhanced care management is the statewide managed care plan benefit to support comprehensive case management for members with complex needs that launched in 2022 for adults. And DHCS's vision for ECM is to coordinate all care for eligible members, including across the physical, behavioral, and dental health delivery systems with a community-based focus. ECM is disciplinary, it's high touch, person-centered, and provided primarily through in-person interactions with the members where they live. They seek care, or prefer to access services, which we know extends well beyond the four walls of primary care, and social sick care, social service care provider clinics, and facilities.
Slide 8	Carrie Whitaker – 00:07:17	So, ECM is in the highest tier of the care management continuum, but you can also see that we have complex care management for members at kind of a rising risk, and then basic population health management for all members. And then also on the right we see there is a transitional services. All members are eligible for transitional care services as well if they need to move between primary care acute care settings, and coming in, and out of the community. And then I do also just want to really highlight that ECM is a key component of CalAIM. So, that's California advancing, and Innovating Medi Medi-Cal, and that is our long-term commitment to transform, and strengthen Medi-Cal. So, we're very focused on ECM, and we won't be covering the other components of this huge program like Community supports very much in depth. But we will drop in the chat the links to where you can find more information about all of the services within the Cal AIM scope. Okay, and next slide.

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Slide 9	Carrie Whitaker – 00:08:35	So, these are the folks who would be eligible for ECM. So, I had mentioned that ECM for adults launched last summer, and we were adding populations of focus. Now, this benefit, although was available to children, and youth in whole person model, and health homes pilots that will be eligible... Those children and youth eligible for ECM, thus will have access to that service throughout the state of California on July 1st. So, ECM is available to members who meet the current criteria for the populations of focus. You can access those criteria in our ECM policy guide, the version that we released in December of 2022 to see the specifics. And then here on the infographic, the check marks indicate where the population of focus applies to adults versus children, and youth, or where there's an intersection. And then you will note, too, at the bottom, we'll point out that individuals with intellectual, or developmental disabilities, and also pregnant, and postpartum individuals are not singled out as a distinct population of focus here.
Slides 9-10	Carrie Whitaker – 00:09:49	In order to be more clear about the eligibility criteria for ECM. If they fit in other ECM populations of focus, we do encourage, and require that their ECM providers ensure that they have appropriate perinatal, postpartum, or intellectual developmental disability care providers involved in the care plan, if not the providers themselves. So, ECM has have been available to adults, oh, excuse me. And the populations of focus listed on the next slide, on the slide are launching in phases from January 2022 to January 2024. Those in January 2024 will be the birth equity population to focus, and also individuals transitioning from the incarceration systems. Okay, next slide, please. So, this is a timeline of ECM implementation. So, in January 2022, we launched ECM in the 25 counties that had the health programs, or Whole Person Care pilots that I referenced before. These programs were legacy programs for Medi-Cal managed care plan members that sunset in 2021, and eligible members from these programs then transitioned into ECM.

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Slide 10	Carrie Whitaker – 00:11:12	So, those 25 counties launched with three populations of focus, adults at risk for avoidable utilization, hospital, and emergency use, utilization, adults experiencing homelessness, and adults with serious mental health, and, or substance use disorder needs. And then at that same time, ECM for justice involved individuals launched in the smaller subset of the counties that had the Whole Person Care pilot. So, there is some of this service available at this time. And then in July 2022, ECM launched the remaining counties across California for the initial three populations of focus. And then preliminary data submitted by the managed care plans to DHCS last year showed that approximately 88,000 members received ECM across the first three quarters of 2022. And then my colleagues will drop a link to the latest data fact sheet available on the DHCS website that kind of explains that statistic in more context that I shared just trying to socialize, and celebrate the ECM launch, and expansion since we began this journey.
Slides 10-11	Carrie Whitaker – 00:12:27	And then we continue on our timeline in 2020 3rd of January, ECM launched in every county for the two long-term care populations of focus. That would be adults living in the community, and at risk for a long-term care institutionalization, and adult nursing facility residents transitioning into the community. So, then on the next slide, we can see what's ahead in this summer, and into 2024. So, implementation milestones coming in 2023. On July 1st of this year. ECM launches occurred in all counties, excuse me, in July 2023, ECM launches all counties for the children, and youth populations of focus. And that's what we'll focus on in our session today. Dr. Babaria will talk more in detail for the specific subpopulations of focus there. And beyond launching additional populations of focus, there are a couple of other important milestones coming this summer. The first is that DHCS will release a comprehensive data guidance on 2022 implementation. This will include a detailed county, and plan level data on ECM, and community supports implementation in the first year.

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Slide 11	Carrie Whitaker – 00:13:47	And it'll be based on data that plans have submitted to DHCS. And then another key development to expect this summer is that DHCS will be making programmatic adjustments based on the feedback from the first 18 months of our launch. So, DHCS to that note, consistently has been soliciting, and responding to the feedback from our stakeholders on ECM, including from members, providers, counties, managed care plans, and others. Probably there are some folks on this call where we've really appreciated your feedback, and participation in those types of key informant interviews, and other ways of providing feedback. And a key theme that we have learned from providers, and counties has been there's been significant administrative burden on ECM, and the challenges navigating operational differences between managed care plans. So, we at DHCS in 2023, we are taking steps to address, and reduce administrative burden, and variation to make it easier for you all to participate in the ECM program, either as ECM providers yourselves, or in collaboration with ECM providers.
Slides 11-12	Carrie Whitaker – 00:15:01	And those details will be forthcoming. So, stay tuned. And then finally on this slide, there are a couple of major milestones in 2024. Again, I referenced when ECM will launch in all counties for individuals transitioning from incarceration, and the birth equity population of focus. Again, those definitions for kids, and adults is located in the ECM policy guide that we released last December. So, those are not the focus of today's webinar. But I will note that managed care plans currently are developing their models of care, and building their networks for the birth equity, and justice involved populations of focus. So, next slide please. And here is a list of the ECM core services. So, ECM Avail is available to members until their care plan needs are met, or they opt out of the benefit, whichever comes first, and they can opt out at any time. And then across all of the populations of focus members, and ECM receive seven core services listed here based on their individual needs. These should be tailored to those.

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Slide 12	Carrie Whitaker – 00:16:13	So, that's outreach engagement, comprehensive assessment, and care management plan, enhanced coordination of care, which would be including in coordination with other providers that would contribute to that comprehensive assessment, and care management plan, and help us monitor outcomes. And then member, and family supports health promotion, comprehensive transitional care when needed, and coordination, and referral to community, and social support services. And on this particular service, I do want to spotlight the important connection between ECM, and community supports. The ECM Lead care manager, so that individual point of contact that is employed by the ECM provider, and is the members champion, they are strongly encouraged to screen ECM members for community supports, eligibility, and needs, and refer those supports when those are eligible, when the child, or adult is eligible, and available.

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Slide 12	Carrie Whitaker – 00:17:19	And then for context, community supports are medically appropriate, cost-effective alternative services, or settings that are provided as a substitute for more costly services, or settings such as hospitalization, skilled nursing facility admissions, or ED use. We can leverage housing navigation, housing vouchers, medically tailored meals, and more earlier in a preventative manner to prevent these. And so with that being said, and acknowledging California, we have different resources in different areas in communities. Plans will offer different combinations of communities supports based on that availability. And they're working hard to build those networks up, and provide more diversity, and availability of those throughout the state. And I'll also say that members don't need to be eligible for ECM to receive community supports that is available for anybody at need, whether they're in the care continuum with considered basic population health management, or complex care management, or ECM, and more information on the pre-approved DHCS community supports can be found on that community supports policy guide that I'm sure one of my colleagues will drop in the chat.

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Slides 13-14	Carrie Whitaker – 00:18:43	And then we can move on to the next slide. So, how is ECM provided? This gives you an organizational structure of what that looks like. For context, ECM is administered through Medi-Cal Managed Care Plans. And then in turn, those managed care plans contract with community-based providers to deliver ECM, and community supports. So, for example, managed care plans can contract with a community-based organization who has expert, or expertise in serving children, and families with social needs. And then later in today's session, our panel of managed care plans, and ECM providers who do just that, will share more about this process for contracting informing partnerships to serve the diverse needs of children, and youth populations that focus specifically. Okay. And then the next slide, keeping going with the ECM organization structure, ECM is provided... It's administered through managed care plans who then in turn contract with the providers as I mentioned. And then the managed care plans may contract with CVOs, and other experts, and also non-contracted providers as well. Anybody that is involved in the individual's care plan.

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Slides 14-15	Carrie Whitaker – 00:20:05	And we note that managed care plans should provide prioritize providing partnerships with a diverse group of organizations that have those specialized skills, and expertise for each population of focus. Also, the managed care plans are responsible for providing training, and overseeing, and monitoring the ECM service delivery across the network. And next slide. And then here we see again how ECM is then provided via net network building, and provider requirements. ECM providers need to be community-based entities. They have to have experience providing care to members of specific populations of focus they serve in addition to clinic-based providers who may serve a generalist role. They also need to have expertise in providing culturally appropriate, intensive, and in-person, and timely care as we mentioned in the course services slide. And then they need to agree to contract with managed care plans as ECM providers, and negotiate rates.
Slide 15	Carrie Whitaker – 00:21:16	And just to emphasize, DHCS would not be negotiating, or setting provider rates that is between the managed care plan, and the individual provider candidates. And then they also, these providers must either be able to either submit claims to manage care plans, or use a DHCS invoicing template to bill managed care plans if unable to submit claims, and must have a documentation system for care management, and know that ECM providers are not required to submit claims. So, we know that that is been identified as a big barrier, especially in counties that aren't used to provide needing to do billings, and claims in the ways that managed care plans expect. So, we'll talk some more about some resources later on. And then ECM providers that will then assign a dedicated, and individual ECM lead care manager to each managed care member moving along this structure enrolled in ECM.

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Slides 15-16	Carrie Whitaker – 00:22:20	And so that person is responsible for meeting with the managed care plan member in person to form trusting relationships, and coordination of care across systems. They're the point of contact for other systems as well, and they would provide consistency for that member, their family, and all of the other providers, and be the tie to the managed care plan as well. And then, although in some cases it's appropriate for an ECM lead care manager to be a license licensed clinically DH supports, and actually we encourage ECM providers to leverage skills of other types of staff, such as community health workers, [foreign language 00:23:01], and tribal representatives, as well as whatever is appropriate for the member, and will be the most likely to have a successful trusting working relationship with the families, the members, and the other providers. And now I will transition to the next slide, and hand it off to our DHCS QPHM Deputy Director Dr. Babaria, a leader of the vision of this population health management program. Thank you.
Slide 16	Dr. Palav Babaria – 00:23:33	Thank you so much, Carrie, and I have been tracking all of your amazing questions, and comments in the chat. We're going to try to keep this a little bit high level, and really focus on the vision, but we will get links distributed that have lots of more information. So, I think two questions that come up often. One is sort of how do eligible members access ECM? And so we wanted to lift this up, because it comes up over, and over again, and I do think we want to underscore that the department's vision is that whomever is working with these members. And this is really pertinent for our children, and youth population because we know they're already being touched by multiple other programs, and potential other care managers that most of the referrals for ECM come from the community in some way, shape, or form.

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Slide 16	Dr. Palav Babaria – 00:24:16	Whether that is members self-referring themselves, which is completely allowed for every single population of focus family members, or others referring them, their primary care providers, or other medical providers referring, or other care management county agencies. Anyone who knows what that member's needs are, and thinks they may be eligible for ECM should absolutely refer them to the managed care plan. And we also know that when a trusted person in that member's life makes that referral, and talks to the member about ECM, the uptake is also much higher. We also require all of our managed care plans to scrub their data, and identify potential members who would qualify, and do outreach. But we really see that process as in addition to, and not instead of community based referrals, and is really designed to catch...
Slide 17	Dr. Palav Babaria – 00:25:03	... not instead of community-based referrals and is really designed to catch people who would otherwise fall through the cracks. We can go to the next slide. There's also lots of questions, and I saw several people asking about this in the chat as well, about how are eligible members assigned to an ECM provider? And we get this question from our MCPs as well who are actively growing our networks for the populations of focus across the state. So especially for the children and youth population of focus, our vision is that if possible, that member should be assigned to a care team that is already involved in that member's care. So you'll hear later today in our panel where there are care teams that are serving these members in some of their capacity who have also become ECM providers that when they identify this child or youth is eligible for ECM, the child and youth just stays with them, but with added benefits and added funding to support that additional care.

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Slide 17	Dr. Palav Babaria – 00:25:59	If that is not possible, and that's our definite number one preference, but we recognize that it isn't always possible, we want really tight linkages between other groups, whether that it's county behavioral health, public health nursing, or others who are already involved in this child or youth's care to really help ensure and inform who the best ECM provider is. And so I think why the child and youth population of focus went live a little later is we recognize this is complicated, right? For many of these children there are multiple agencies, departments, providers who are serving them and there does need to be some sorting process that occurs to determine out of all the ECM providers in the network, who is going to be best positioned to support that child and have that trusted relationship with the child and the family that they are serving.
Slide 17	Dr. Palav Babaria – 00:26:46	And so the vision is that ideally all referrals would come from the community or come from case managers or other people who know the child and youth and their family and can make a recommendation about what their needs are and who is best poised to serve them out of the managed care plans network of providers. We know that is not always possible. Sometimes plans are doing sort of cold outreach and calls and finding providers to take these members, but we've also heard from our managed care plans great examples where they work through that, where even if an ECM provider is assigned that child as they get to know them if they actually determine, hey, they were being seen at this other place that would be better for them, they're enabling transitions to those other providers.

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Slides 17-18	Dr. Palav Babaria – 00:27:28	And so really excited to dig into our panel because some of these are the challenges that they are working through right now, but the explicit goal is to make so sure that whomever knows the child and family the best and has a trusting relationship that we are building upon that relationship and not just adding more cooks to the kitchen. We can go to the next slide. So just to dig in a little bit about what is happening on July 1, which is coming up next week, these are the populations of focus for children and youth that will be launching on July 1st. Those experiencing homelessness, those who are at risk for avoidable hospital or ED utilization, those with serious mental health or substance use disorder needs and I will lift up for this one. It is anyone who basically meets county behavioral health eligibility criteria. And as many of you been tracking as a part of CalAIM, those criteria were recently revised. So it does include things like having a certain high ACES score so all of those children and youth will be eligible.
Slide 18	Dr. Palav Babaria – 00:28:28	I think we also recognize that not all of those children and youth ultimately due our no wrong door policy and others end up having long-term serious mental health or substance use disorders that are diagnosed. And so we do envision this is going to be a pretty broad group of individuals. Some of them may be best served in county behavioral health, but others may have other things that are leading to those criteria being flagged and may be best served by other providers in the community or CBOs. And again, this underscores really the need of that sorting system to understand why is this specific individual eligible and who is best poised to support that child or youth and their family. Also, we'll be including those who are enrolled in CCS or whole child model and there's specific additional eligibility criteria tied to that as well as those involved in child welfare.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 18-19	Dr. Palav Babaria – 00:29:21	And I did see that there's a lot of questions about these definitions. Please go check out the ECM policy guide. There's very detailed criteria. I also saw a question earlier in the chat about, for example, CCS with social needs, are we going to get more specific? At this point, we're really sticking to those written criteria, but like all programs, we are absolutely committed to improving and revising our program over time. So as we get feedback from all of you and our plans and providers, we are updating and adding specificity where it is needed. We can go to the next slide. And the things that you, sorry I should have said on the last slide, we don't have to go back, but obviously our justice involved in birthing populations of focus will go live a little later as Carrie mentioned earlier.
Slide 19	Dr. Palav Babaria – 00:30:05	So to double click on sort of what the vision is for children and youth, as we are all aware, and as we mentioned many if not most of these youth are receiving some services often from care managers, case managers, providers, other programs across the state. And so the goal of ECM is really one, to fill in any gaps of what is not occurring. And as we think about ECM, it really is whole person care. So this is a program that is not just focused on medical or clinical needs. It's not just focused on behavioral health needs. It is focused on all of that plus any social drivers of health or other needs that the member has.

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Slide 19	Dr. Palav Babaria – 00:30:43	So they're the quarterback of the team that really serve as air traffic control. We also know that in current state, because there's a lot of programs serving these kids, often there isn't a single point of accountability and it is often unfortunately parents and families that end up shouldering the burden of navigating amongst our fragmented healthcare system. So we really want the ECM lead care manager to take that burden off of parents, off of caregivers and off of families and to really serve as that single point of accountability who connects the dots, who coordinates everyone else and makes sure holistically that the individual child and family are getting the services that they need. We'll also underscore here that the way ECM is financed, it does not take away any funding from existing care management programs. And so those existing programs are not going anywhere. They're here to stay, but we really want this ECM lead care manager to coordinate and really make sure the buck stops with them on all of the needs that exist. We can go to the next slide.
Slide 20	Dr. Palav Babaria – 00:31:52	So the other thing which hopefully is evident in what we've been sharing with you all is we definitely think for enhanced care management, this is not a one size fits all approach model for any population of focus. The whole point of ECM is that it is really designed to meet the needs of our most complex members, whether that complexity is clinical or driven by social needs. And by definition, these members have a lot of things going on and really need customized tailored support. And so for children and youth, I think this is even more critical given how many subpopulations of focus we have. And so for some of these children and youth, having their primary care provider be their ECM provider may make sense, but if you are a child welfare involved youth and you don't have a lot of primary care needs that may not be the best ECM provider for you.

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Slide 20	Dr. Palav Babaria – 00:32:42	If you have mental health or SUD needs, really having a provider that is oriented in the behavioral health space or based out of a school-based clinic or a community-based organization that really specializes in this population is much better for you than a one size fits all approach. And so we really for each of these populations of focus in our policy guide have outlined the types of providers that we envision being best positioned to serve the children and youth and some of them are medical providers. But you will see in the policy guide for the most part it is county-based social services agencies, public health programs, community-based organizations, nonprofits, school-based clinics, other educational sector clinics. Because at the end of the day, that is who is for the most part interfacing with children and youth across our state. I'll also share, and you will see it on our fact sheets coming out, that most of our providers in ECM today are mostly clinical providers already enrolled in the Medi-Cal program.
Slides 20-22	Dr. Palav Babaria – 00:33:43	And so we really, really need all of you and all of the non-traditional providers out there who know the children in youth and Medi-Cal really, really well to become a part of this program and a part of that network. We can go to the next slide. So next thing, again, high level themes. How do we get there, right? We know these partnerships are new, it's really hard and there's a lot of operational and nitty-gritty details to work through. So we want to lift up a few themes and best practices that we have learned from talking to folks who are doing it and have worked through some of those challenges. We can keep going. So for all of the managed care plans, we know that you're already doing this, but please continue to outreach and contract with providers who know how to work with children and youth in Medi-Cal and who already have expertise doing this.

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Slide 22	Dr. Palav Babaria – 00:34:38	It may not be as a part of the Medi-Cal program, but there are many who've been serving these populations of focus for decades and longer. We are really requiring our MCPS again to not just have a one size fits all approach, but to work to create a network that can meet the unique individual needs of every child and youth. We also are encouraging everyone, and I just saw something in the chat about the CHW benefits. We know that similarly, the launch of our community health worker benefit has been hard because this is something that often exists in the community and isn't always embedded into the healthcare delivery system.
Slide 22	Dr. Palav Babaria – 00:35:13	And so we are really encouraging anyone who is an ECM provider, it would be great if they're also a community health worker benefit provider because both of those benefits are covered and reimbursable. You can't get them at the same time. But it allows for step down so that before people become enrolled in ECM or after they graduate or are discharged from ECM, it can provide as a part of the care continuum additional services. We also know that we need better data approaches and referral pathways to identify those children and youth who are eligible for ECM. And so as I talked about earlier, we really envision that the vast majority, if not all referrals really come from the community. I got a question yesterday where someone, I think it was at a county agency, was saying how do we refer? Do we send them back to County Behavioral Health? Do we send them to their PCP? And I think our answer is we want anyone and everyone to refer.

VISUAL	SPEAKER – TIME	AUDIO
Slide 22	Dr. Palav Babaria – 00:36:08	If you take care of a child in Medi-Cal and if you think that child is potentially eligible for ECM, you don't have to be sure, please refer them to the managed care plan. Each and every single one of our managed care plans maintains a website with information about how to refer to ECM. Every Friday when I'm in clinic and I see a member who I think is eligible for ECM I go to that website, I put in the referral. And so it does not have to come from a single source and we accept member self-referrals as well. We also want to make sure that we are leveraging data sharing in current state. We know that people don't always know which programs children and youth are involved in. The providers don't always know which managed care plans people are enrolled in. And so really building out those information sharing pathways will enable us to better identify and refer members who are eligible for these services. We can go to the next slide.
Slide 23	Dr. Palav Babaria – 00:37:03	So on the provider side, there's a lot that you can do as well. We know that ECM has been alive in the state for almost a year and a half now, and yet there's still lots of people across the state who have never heard about CalAIM and never heard about ECM, which is why I'm so excited that you all showed up today. We'll be sending this out. All of these links will be provided but in one place. This is all the technical assistance resources that DHCS has put together. So our policy guide has all of the information about the whole program and eligibility criteria. There's an ECM provider toolkit that you'll see listed further down here, which if you are interested in becoming a provider, really frames it for what do you need to do? How do you get started in this process?

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Slide 23	Dr. Palav Babaria – 00:37:44	We also recognize if you've been a nonprofit or a community-based organization and have never been in Medi-Cal and you want to serve these children, it's hard to get started. How do you set up billing? How do you meet all the requirements? And so we have cited grants as well as the TA marketplace, which are really designed to help people with that. There's also regional collaboratives which are local to bring everyone together. Our plans participate in that. Many counties participate in that. There are really excellent trained facilitators who can help you navigate as well as additional funding opportunities through managed care plans through the incentive payment program. There's also data guidance once you're a provider and you have to meet all the data reporting requirements as well as data sharing authorization that can help set up those data sharing pathways between different organizations. We can keep going.
Slide 25	Dr. Palav Babaria – 00:38:37	So I know that it was a lot, but I really do want to get to our providers because they are the heart and soul of this webinar. So we can go one more slide. I'm really excited to introduce Jacquelyn Harlow Torres, who is the executive director for new business at Pacific Clinics. And Jacquelyn's going to go over really how Pacific Clinics is actually a real live in the flesh ECM provider and how they've gotten to this state. And then we'll have about 5 to 10 minutes at the end of her presentation to take a few questions. Jacquelyn, I'm happy to turn it over to you.

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VISUAL	SPEAKER – TIME	AUDIO
Slides 25-26	Jacquelyn Harlow Torres – 00:39:11	All right, one minute you're relaxing with your camera off and the next you're in the spotlight. You can go to the next slide. My name is Jacquelyn Torres. I'm an LMFT. My chair is in the Bay Area in California in San Jose, but my role at Pacific Clinics is as executive director of new business and I am overseeing our statewide implementation and operations for CalAIM and community supports. I've been with the organization for 15 years and started in wraparound direct services school-based in First 5, and that was really a launching place for us to decide to move into the CalAIM initiative of ECM. And I'm hoping today I can give you guys a little bit of texture for what ECM really looks like as a service. We started in the early days with the Health Homes program pilot. We served kids there. We have been serving kids into ECM and hopefully you'll pick up a few helpful tips. Next slide.
Slide 27	Jacquelyn Harlow Torres – 00:40:18	So quickly, who Pacific Clinics is. We're a large multi-service nonprofit organization. In March of 2021, we underwent a significant merger with uplift Family Services and Pacific Clinics. So combining together, we have become the largest provider of behavioral health services in the state. We cover a lot of grounds. So we have foster care and adoptions, we do crisis care. We're a certified community behavioral health clinic. We do neurodevelopmental services, ABA and diagnostic assessments, outpatient psychiatry. We do substance use disorder treatment. We have a large presence in school-based services across the state. And what I'll focus on today is ECM and I'll just mention that we also elected to move into community supports that made sense for us so that we can match for our member populations. Next slide.

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Slides 28-29	Jacquelyn Harlow Torres – 00:41:15	So we reach about 35,000 or probably north of that every year. About 75% of those that we serve are under the age of 25. We have a workforce of about 2000 employees. And you can see this is our reach in the state currently. We sort of break up the way that we have mobilized ourselves into regions. So we're in the north capital area, the Bay Area, Central Valley, Los Angeles, South Coast, and the very cool named Inland Empire region. I'll take the next slide. So this is really the how part. So how did we decide to become an ECM provider? So we decided to start with the Health Homes program back in 2020. We used this as a trial to really see how we could organize ourselves around this population. So we started with one managed care program, which was Santa Clara Family Health Plan and one county, which was Santa Clara.
Slide 29	Jacquelyn Harlow Torres – 00:42:15	And in that year plus we enrolled about 400 members into the ECM, into the Health Homes program. So as Health Homes was going to Sunset and ECM was going to come online, we started to really evaluate did this make sense for us? And the answer was yes, it was aligned with our mission. These are already our consumers. We're already serving these populations, we're getting positive outcomes. It's a complex care population, especially for kids, and we really understand how to screen, do assessments and create good action plans and do community linkages. I will mention here a learning and that is that ECM is a care coordination program. It's not designed to be a treatment program. So I mentioned that because we launched this with a cohort of very skilled wraparound peer partners and family partners, and they really were the backbone to the service delivery piece.

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Slide 29	Jacquelyn Harlow Torres – 00:43:18	But some of them made the decision to go back to wraparound full-time versus the ECM program. And why they did that is because you have to decide how close you want to be to someone's journey of healing. So some folks really want to be in treatment and some are really good at assessing need and providing linkage and still that great rapport. And still today we have peer partners and those with lived experience doing ECM, but they want to be in this part of the journey. So then we launched in 2022, we decided to go all in, as we say on ECM. We moved 385 folks from Health Homes into ECM. We are serving all populations of focus and we actually carried over about 200 kids from Health Homes into ECM who are still in services today. I'll take the next slide.
Slide 30	Jacquelyn Harlow Torres – 00:44:14	So this is a quick look of what we're doing. The populations that we are serving and have served homelessness and at risk of homelessness, avoidable hospitalizations and emergency room visits, SMI and substance use at risk for long-term care and also transitions to the community from nursing facilities. And the coming online populations are of course the children and youth population, transitions from incarceration and also the focus on birth equity. So when we launched, we decided to go beyond that one county and that one health plan. So we now have five executed health plans that we work with and a number that are in various stages of the contracting process. Some are close to execution, some are exploration, but we have coverage now in 20 counties with ECM and community supports. We're over 750 enrolled in services and we still have about 185 kids that we're carrying into this launch in July. Next slide.

VISUAL	SPEAKER – TIME	AUDIO
Slide 31	Jacquelyn Harlow Torres – 00:45:23	So what is our model of care? We have designed our ECM service delivery into two components because there are two components to serving ECM. There's the entry phase, the outreach phase of explaining the benefit to a member, getting them to sign up for the program, and then there's the actual service delivery part of it. What we found is when we were putting the outreach and engagement with our care team, it was harder for them to do those linkages and get folks enrolled and do the service delivery. So we just separated out the upfront part of that to a dedicated team. So there's really two ways to go with referrals. When you have your contract with your managed care plan, they send you eligible members for the benefits every month and then you do outreaches and offer the service to those members, or you may already be serving an existing population or market yourself to the community as an ECM provider,
Slides 31-32	Jacquelyn Harlow Torres – 00:46:25	We created an internal referral flow. What we didn't want is a bunch of different folks communicating to the same health plan, requesting authorizations. We wanted to streamline this both for our team and for the managed care plans. So we house it as a single call center, all the communications to the health plans go through this call center and they come back through it made it really easy for our team, even internally, other programs, which I'll share a little bit about how to know if the kid that they're serving qualifies, and then for us to go ahead and take care of that authorization process for them. Next slide. So this is what our actual care team looks like. We organized ourselves on what we call these pods. Each of our pods sits in a county and has the capacity for about 400 ECM enrolled members. We have a program manager and we use a licensed clinician in each of these pods. Some cases the manager is also licensed and in some cases they're not.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 32	Jacquelyn Harlow Torres – 00:47:34	And then we have these eight, what we call system navigators. These are the lead care managers. Each of them carries a caseload capacity ratio of about 50. I get asked a lot if we would use the same ratio for children and adults, and the answer is yes, because we use the same methodology that we balance caseloads based on acuity factors. So that's important regardless of the service and the scope and the population that you're looking at, their risk profile for folks that are coming in and matching them to the direct service team. So who are our system navigators? I saw a lot of this in the chat. These are non-clinical CHW, peer, lived experience folks for the most part. We made degrees preferred, not required. And the goal of this is to really have folks that are good at engagement and care coordination and can understand needs, make quick assessments and linkages for those served and so that's the way that we operate the direct service team. Next slide.
Slide 33	Jacquelyn Harlow Torres – 00:48:44	This is kind of the upfront part of the services for kids. So we do assessments with everybody, screenings for substance use and SMI, medical and complex care conditions, different social determinants of health. And especially when you're talking about kids, there are a lot of systems and experiences that you need to be looking at for kids and ACES screenings. Sometimes they come in with them and when you're serving this complex care population for kids, sometimes they're in the middle of living through their ACES. So you have to be really aware of the complexity of working with youth and how you're serving them. Then what we do in almost every case, if possible, if there is an existing child and family team meeting, whether it's ours or it's another organizations, we try to join it.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 33	Jacquelyn Harlow Torres – 00:49:33	So we identify who are the system partners in that care for the youth, who are the natural support members. And when you're going to work with kids, especially in child welfare, you need to understand what is their guardianship, who is the social workers involved, are there court orders? And then we move into the care plan development phase. So comprehensive care planning with those key members. I'll talk a little bit about what that looks like and you really want to ensure you're thinking about caregivers of the model, the educational system and placement needs.
Slide 33	Jacquelyn Harlow Torres – 00:50:03	... caregivers of the model, the educational system, and placement needs, when you're thinking about this complex population. Next slide.
Slide 34	Jacquelyn Harlow Torres – 00:50:10	So I put two sample stories in here, just to give some texture to what it looks like. So here's Gus, he's 17. He was getting services with our Hope Drop-in Center at Pacific Clinics, which is a drop-in center for youth and TAY-aged kids. His support team was his peer partners and his mental health supports. So he was identified as a good candidate for ECM, which was Health Homes at that time, because he had a complex needs in substance use issues. So how did the Hope Center even know about Health Homes, is that we do a lot of internal informational tours with our teams to talk about ECM, what it looks like and how to refer. And again, because we have moved everything to the centralized call center approach, they know exactly who to go to see if the kids qualify for services.

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Slide 34	Jacquelyn Harlow Torres – 00:51:02	So they made the referral for HHP, he was authorized. What we did with this kiddo was we went to the Hope Center to connect with him, we met him onsite there and we got to know him. This kid was really connected with his peer partner, and so it was important for us to start there with the rapport building. I'll just make a comment on serving kids. Do not hurry through the rapport building stage with them, they can absolutely detect how genuine you are, and I would suggest that you still show up, even if you think they're going to cancel an appointment, because they will ask if you came and it will matter if you showed up to them. Once you get through that connection and rapport building stage with kids, you'll get a lot more movement on successful linkages for them.
Slide 34	Jacquelyn Harlow Torres – 00:51:50	And so, that's what we did here, and we ended up coming with a really good plan of action. Once enough rapport's built, then we got to support this kid at home and in school, and he moved into a transition automatically into ECM. And very complex case, which I couldn't fit all here, but he did graduate from high school and now he's an active member of our youth advisory board. So next slide.
Slide 35	Jacquelyn Harlow Torres – 00:52:20	Now, this is a different look at Maria, who's 13, and I use this example because she was in our wraparound program getting intensive case management services through them. So her support team was behavior specialists, peer partners, facilitators. She was identified as a good candidate for Health Homes at that time, but would be ECM because she had a complex health condition, with cerebral palsy, and she had the SMI presentation of PTSD and anxiety. She was living in a non-relative foster placement and she had family finding in process. So the Health Home staff met with her at her existing CFT meeting and joined in the wraparound team in that process. We developed a care plan for her that coordinated with wraparound and other folks to implement it.

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Slide 35	Jacquelyn Harlow Torres – 00:53:08	So what we decided to do was wraparound, ICC was focusing on the SMI, the treatment part, and the family finding support with the social worker. While our system navigator coordinated primary care needs, there were some specialty physical and occupational supports that this kid needed linkage to. And really, what ECM is designed to do with ICC services is enhance the amount of services in the integrating complex care data sets from doctors, health and hospital systems. We were looking at more of the system of data for this kid than was being looked at before. She also moved into the ECM program.
Slide 35	Jacquelyn Harlow Torres – 00:53:46	Here's a highlight of what ECM can do is when youth are changing and levels of acuity and care. So this kid was doing really well in wraparound treatment, and she stepped down to outpatient. The ECM system navigator got to stay with her, and she's still open, and we still stayed with her. So there's this nice continuity of care that is with these kids who are moving through all these different systems, that ECM gets to play this role with them. Next slide, I got two more.
Slide 36	Jacquelyn Harlow Torres – 00:54:19	So this is a little bit of what it looks like for kids. So when you're serving youth in the ECM program, you got the youth at the center of services, you've got identified caregivers, and you also have bio-family. So I would just mention to everyone to not overlook bio-family when you're talking about children and child welfare. Even if they're not physically present in the child's life, they are emotionally present in that child's heart, so you have to consider all factors of bio-family, because you're going to potentially be with this kid across a continuum of care. Social workers, that there's a careful connection with their responsibility to the care of that child and placement.

VISUAL	SPEAKER – TIME	AUDIO
Slide 36	Jacquelyn Harlow Torres – 00:55:03	Teachers in school, so kids should be spending most of their day in school, and if they're not, that needs to be worked on. If you're doing a really good job of working with kids, if I ask you what school they go to, you should be able to answer without looking it up. And that is an opportunity, and for us, because of our reach in the education system, was a big advantage to how we're successful with youth. Primary care doctors, so use remote options to get them involved in the coordination of care. That's another untapped place that watches these kids across a continuum. So their placement changes and they move and they're all over here, but they may have had the same PCP, or they need to get connected to one. And then, of course, county behavioral health teams really doing the treatment work with kids. And last slide please.
Slide 37	Jacquelyn Harlow Torres – 00:55:57	So this could be a five-hour presentation in itself on this slide, but I'm going to try to give you a couple of things to think about, if you're thinking about launching ECM for kids. Get efficient with your data processing. So if you're with multiple managed care plans, data from those plans comes in multiple file formats, you've got to be able to consume that data and work with it so you could do efficient outreach for folks, because you want to be timely when you get referrals for ECM, like any other service, and you want to do as immediate as possible assignment.

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Slide 37	Jacquelyn Harlow Torres – 00:56:37	Also member assignment, looking at your data, we created a risk profiling, like I said, to balance caseloads. We built intentionally a customized Salesforce platform that consumes this data from the health plans, allows us to interact with it and manipulate it upfront, before members move into services. And then, it helps with communication back to the health plan. And then, as those members enroll in services, we house all of that data in our electronic health record. So there's a lot of data points that come for these populations, recent hospitalizations, medical factors, care settings, acuity, so it's really important to get in front of that, and at least be thinking about how you'll organize yourself in that process.
Slide 37	Jacquelyn Harlow Torres – 00:57:26	And then, be prepared for managed care plan billing and data collection. So there are different looks, and a lot of the plans, whether it's PMPM, fee for service, for us, the model of service delivery doesn't change, what does change is just being aware of the risk factors of those members coming in, so that you can continue to deliver congruent services for us, regardless of which county or which health plan is coming in the door.
Slide 37	Jacquelyn Harlow Torres – 00:57:56	So final thought on this is, it's complex. I hope that some of that gave a little bit of flavor of what it actually looks like, especially for the kids population of focus. And I would encourage you to define the role of the care coordinator in your model, and just build your team to execute on that model. Next slide, I think, is questions if we want to have them here, or I will also stay on for the end for the Q&A, whichever is preferred.
Slide 38	Dr. Palav Babaria – 00:58:29	Perfect. Yeah, just given the interest of time, and I agree, I feel like we could all be here for hours and really get into the weeds on this. So let's go to our panel, and then we'll have questions for both Jacqueline and our panel. And Jacqueline, I think there's some specific questions in the chat, feel free to respond to folks directly there as well. So we can go to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Dr. Palav Babaria – 00:58:48	So I'm going to have, panelists, I'm just going to kick us off on questions, and the first time you speak, if you can introduce yourself to our group, I think that will be great. We can go one more slide. And as we alluded to, this is our illustrious panel for today, and we really want to just get into the weeds about how are our plans and our county partners specifically today focusing on those that serve the CCS population, as well as child welfare, really thinking about ECM, thinking about non-duplication of services, and coordinating the care of the individual. So I think we can take the slides down and just go straight into our Q&A, and I hope I'm not the only spotlight on here. Great. So we're going to start with our colleagues in Alameda County and San Mateo, really who are focused on the CCS population of focus. And maybe we can kick us off with, if you could just tell us about how you came to contract for the CCS population of focus, and what were the key factors that influenced your decision on whether or not to even become an ECM provider? No pressure on who goes first.
Slide 40	Anna Gruver – 01:00:15	I can start. I can share that in Alameda County, we had some organizational infrastructures that were really influential and helpful in our process. Our healthcare service agency had a CalAIM steering committee, a CalEngine work group, our public health department had an internal group as well, and the forums really allowed for sharing of information, technical assistance, and connecting to other departments within our organization that were already implementing ECM, like our behavioral healthcare department.
Slide 40	Anna Gruver – 01:00:51	Additionally, in Alameda County, we had been partnering with Alameda Alliance for the last seven years to really problem solve and collaborate already on CCS, and I think that relationship was also so pivotal for us. And we had dedicated staff who were really able to look at lessons learned and start to plan and shape a model for the launch, and deciding about becoming an ECM program, and developing a model that could match the PMPM rate for us.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Dr. Palav Babaria – 01:01:28	And Anna, could you just give us a one-liner on your role?
Slide 40	Anna Gruver – 01:01:31	Yes, I'm sure that would be helpful. My name is Anna Gruver, I work for the Alameda County Public Health Department. I'm the interim family health services division director.
Slide 40	Dr. Palav Babaria – 01:01:54	Susana, Tejasi, Amy, how's the journey been for you becoming an ECM provider, and what words of wisdom and lessons learned do you have?
Slide 40	Susana Flores – 01:02:06	All right. Hello, everybody. I am currently the interim CCS administrator here in San Mateo County, and what I could share with you all is, as we are getting ready to launch ECM July 1st, one of the things that motivated us to do this is that we're already serving CCS clients, so it just made sense for us to be the ones for continuing to provide this additional support. So going back in the history, in San Mateo County, we're in a very lucky position where we were able to pioneer the Whole Child Model since 2011, 2013. And so, having had the opportunity to contract with Health Plan of San Mateo, since we pilot the Whole Child Model, has allowed us the opportunity to already have a relationship that will facilitate for us to be able to roll this out in an easier way, per se.
Slide 40	Susana Flores – 01:03:09	Also, we have been providing already ECM-like services in San Mateo County. We've always had social workers and community workers who work with our children that have the highest needs. They partner with our medical therapy unit as well to meet these clients in person, and help them in connecting them with the resources that they need, whether it is housing, whether it is any type of core services that they need at the moment, and also connect them with behavioral services.

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Slide 40	Tejasi Khatri – 01:03:53	Thanks, Susana. I'll chime in next. My name is Tejasi Khatri. I'm the manager of integrated programs at the Health Plan of San Mateo, so I'll echo a lot of what Susana said in that we have a really long-standing and trusted relationship with San Mateo CCS. HPSM, as Susanna mentioned, was a demonstration pilot county. We were an early launcher of Whole Child Model, so we've worked very closely with CCS since those very early days. And Susana, thank you for walking through what the CCS team currently does, but we know just how much the public health nurses focus on fostering relationships with these kids and their families, and just how passionate they are about their work. So the CCS team was a really natural fit, from our perspective, to provide the care coordination, and the other ECM core services that team is already accustomed to doing.
Slide 40	Tejasi Khatri – 01:04:46	And then, I'll just say in addition, we do have a smaller subset of our CCS that serve by a program affiliated with one of our children's hospitals. And so, we're also in the process of contracting with them as well. So between those two providers, we have some pretty good coverage of all of our CCS children to encompass this whole population of focus as it launches.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Amy Stevenson – 01:05:10	Great. Hi, everyone. I'm Dr. Amy Stevenson, I'm a nurse case manager here at Alameda Alliance and the clinical manager of ECM. And just wanted to echo what Anna had said, yes, we've been partnering very closely with CCS for many years now, which has been great. And we've used, and that is a launching point, but we also realized that our network needed more than one provider to serve the CCS population. So we're actually contracting with many community-based organizations here who specialize in work with the CCS kids, and we're really interested in creating and fostering that relationship between all of our providers who are serving the CCS population, since they will be not only providing ECM and collaborating with their other needs outside of CCS, but they'll be also, of course, collaborating with Anna and the CCS team for their CCS needs as well.
Slide 40	Dr. Palav Babaria – 01:06:03	Thanks so much, Amy, and the group. And I will lift up, obviously you heard from our four panelists that there are longstanding collaborative relationships that you all have been able to build on to move into this new era of this benefit, and the Medi-Cal Program in CalAIM. For those of you who may not be tracking, our 2024 managed care contracts for Medi-Cal actually also include really robust provisions and requirements for all managed care plans to have memorandums of understanding with multiple local county and social services entities. And so, if you're in one of those regions, or maybe you don't have this longstanding collaboration, we are also working through other avenues to help build that foundation so that these types of relationships and successful partnerships can be scaled across the state.
Slide 40	Dr. Palav Babaria – 01:06:48	So I'm hoping, Tejasi and Amy, we talked a lot earlier about the sorting process and figuring out who is eligible for ECM, and then getting that eligible individual to the right provider. Would love to hear a little bit from the plan perspective, how are you spreading the word with referring providers? How are you working with your county partners to do this?

VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Tejasi Khatri – 01:07:05	I can chime in first, Amy. So as you know, we will have a two pronged approach. One will be that data driven approach, and the other will be really building out that referral pipeline. So to speak to the referral pipeline build first, as the POF launches, we are working with our network of child and youth providers, and just other associated partners, to help us identify and refer into ECM. So we have a couple of ways to address this. Currently, we're in progress of reporting ECM authorization statuses to all of our contracted PCPs. That's about as wide a net as we can cast with our entire PCP network. So we're hoping that them having that indicator of if a child already has an ECM authorization in place or not, we'll flag for them if they would be a potential candidate to connect to ECM services if they are not already. In addition, we're planning to do a lot of outreach presentations for various medical providers and other groups who we know are serving these children, and are intersecting with them in some way, and would definitely help in identifying if they're potentially eligible for us. So for example, I'll be making a presentation to our CCS clinical advisory committee meeting that we have coming up, which is widely attended by pediatricians that serve the CCS population, but also other POFs in that child and youth category that are going live. Our medical directors are pediatricians with the best networks that we're trying to tap into and spread the word through.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Tejasi Khatri – 01:08:38	Dr. Babaria, you mentioned before that we should work with our current ECM providers who are serving the adult populations of focus, as well as our community support providers, so that they too are aware that this new population is launching and that they can refer in for these new eligible categories. Another thing that we're hoping to do as we go live with the child and youth providers is we have biweekly operations meetings with all of our providers, and so we're really looking to get feedback from them about what referral trends are they seeing, what opportunities can they identify for us, and where we can outreach for other potential referrals that we might not be tapping into just yet. And CCS in particular, as Susana mentioned, is already working with all these members and these families, so we anticipate a large portion of our ECM referrals will be coming from them.
Slide 40	Tejasi Khatri – 01:09:34	And then, just on a very general level, we do have all the information on our website that we'll continue to get the word out through our provider services network, just to make everyone aware of how that referral process works.
Slide 40	Amy Stevenson – 01:09:51	And I'll say, for the Alliance, we're doing very similar. We're, of course, doing that data analysis and assigning those out to the ECM providers. But as far as also outreach as well, we've tried to do many different in-services at different providers, and if anybody else is here from Alameda County and wants an in-service, please reach out, we're happy to come in. We come in and we present an overview. Really, we have a no wrong door policy for referrals, so members can refer themselves, family members, by just calling member services on the back of their ID card. Just call a member services team and reach out.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Amy Stevenson – 01:10:28	Providers, any providers, hospital partners, community based organizations, we will take a referral from anywhere. And our message really is, when we come in, to go and... We do an overview of not just ECM and the associated community supports that might also fit very well with the ECM providers, but our entire case management overview of all of our case management services, because we want to really stress to people referring in, don't worry about the eligibility criteria too much. We don't want you to not refer because you're afraid they don't qualify. Please refer, we'll review them. If they don't meet ECM, they might meet a different case management program that we could offer them for additional support and services. So we can help with that to figure out which programs might be the best fit for them. So our message when we come in is always, "Please spread the word, please refer in. We have that no wrong door policy for anyone to please outreach and send in for ECM referrals."
Slide 40	Dr. Palav Babaria – 01:11:29	Fantastic. And then, Susana and Anna, in one short minute, could you just give us a high level overview of your model for ECM? Who are the ECM lead care managers? How are they going to work with the CCS teams, and how you're building out the infrastructure? No pressure, only 60 seconds.
Slide 40	Susana Flores – 01:11:52	So in terms of the staff that we are working with, we have hired a supervising community program specialist who is right now building the team. Right now, we have hired a senior community worker and we are in the process of hiring another one, and the plan is for each to carry a case load of about 30 cases each to start. Does that answer your question?
Slide 40	Anna Gruver – 01:12:23	Ours is similar. We have four family support case managers that will have a caseload of 25 to 30, and a senior program specialist and an administrative assistant who will be supporting the program as well.
Slide 40	Dr. Palav Babaria – 01:12:41	And if one or both of you could just talk about how they're working with the existing CCS teams, that would be great.

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Slide 40	Anna Gruver – 01:12:48	I think it's hugely important, and the team has been working really connected with the CCS nurses who are so devoted and know their cases so well, know the family so well, and so we are expecting a lot of internal referrals, as well as with the medical therapy program. So there's been some initial conversations, I will say, around how that can look like, how we can do this internal referral process because the staff know the family so well. And it'll be an opportunity for us to also relieve the social workers that have been doing the work, similar to what Susanna was sharing in San Mateo, in Alameda, it's very similar. And so, we're connecting and making sure that the collaboration and partnership is working smoothly.
Slide 40	Dr. Palav Babaria – 01:13:38	Fantastic. So Noah and Minsun, let's turn it over to you to learn a little bit about what's happening in LA as we work to launch the child welfare population of focus. So we understand that the LA County Office of Child Protection has not yet contracted to become an ECM provider, but that you're really working closely with L.A. Care on the launch. So would love to just hear how you're partnering and what issues you're working through right now.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Minsun Meeker – 01:14:05	Sure. I can start and then turn it over to Noah. Hi, everyone. My name is Minsun Meeker, I am the assistant executive director for the Los Angeles County Office of Child Protection. We are separate from our Department of Children and Family Services. We are a body that was created by our LA County Board of Supervisors in 2015 to increase collaboration and communication across DCFS and our system of care partners and providers and advocates here in LA County, to strengthen our child welfare system. So LA OCP itself is not a contracted provider, we are primarily working on really helping facilitate conversations between our managed care plan partners, our child welfare agency, DCFS, and our system of care partners, especially those that are working in healthcare, so Department of Health Services, Department of Public Health, which has our child welfare public health nursing program, home visiting programs, substance abuse prevention treatment programs.
Slide 40	Minsun Meeker – 01:15:03	... home visiting programs, substance abuse prevention treatment programs, and then also our department of Mental health. A lot of our work, I think, is really trying to bring partners together to think about shared language and understanding of each other's processes that impact potentially ECM on the child welfare population. I saw a lot of questions, comments in the chat that I think we are trying to work through now with our managed care plan partners around coordination and alignment of strategies, ensuring that we're not overburdening I think our families or our providers with services, assessments, things that are administratively burdensome for them or hard for families to navigate. I think for us, our role is really again, around creating that shared understanding and really identifying potential service gaps that we think ECM could fill for our children and families that are child welfare involved. Noah?

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Noah Kaplan Ng – 01:16:01	Yeah. Thank you, everyone. I'm Noah Ng, Director of ECM at LA Care Health Plan. Yeah, the Office of Child Protection has been really important for us as a matchmaker and translator. For us as a managed care plan, we recognized that we were kind of forging new ground here. Unlike with ECM for adults where we had the testing and piloting of Whole Person Care and HHP, Health Homes Program, this was very new to us and so we wanted to make sure we understood the landscape, and as Minsun shared, we don't want to overburden families and children with additional assessment, additional requirements.
Slide 40	Noah Kaplan Ng – 01:16:43	In order to truly do this work, we have to understand and engage, and I think this is the beginning part of it. It's definitely very, for the managed care plan, an act active humility to step back and try to understand who are providers, what is this landscape and what is this ecosystem so that we can truly implement ECM to be successful, because in order to have that air traffic controller to be able to navigate all of those different systems, they need to have relationships. We need to be in the same space and we need to be airplanes that are being air traffic controlled and not planes and cars and boats. There needs to be this understanding from everyone. That's been really, really helpful for the managed care plan to have the Office of Child Protection to support us in being that translator.
Slide 40	Dr. Palav Babaria – 01:17:34	If you could both talk a little bit just about how you've worked together to identify potential providers who really have the relevant experience that is needed for serving this population of focus and also how you're building out that referral pathway that we've also talked about with previous panelists.

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Slide 40	Minsun Meeker – 01:17:53	Yeah, sure. I can start. One of the things that our office does is we are part of our county system of care inter-agency leadership team and we partner really closely, as I mentioned earlier with DCFS and many of the departments and partners that are part of our system of care. We coordinate a group that meets regularly between Department of Children and Family Services and again, some of these health agency departments who are funding providers in the community and also offer some services themselves.
Slide 40	Minsun Meeker – 01:18:22	I think our role there again, is really to try to map out and crosswalk what services already exist for the child welfare population, where there might be subpopulations within child welfare who are eligible for ECM, where again, this might be a benefit or a value add on top of the services they already are receiving. We have also been able to connect LA Care and some of the other managed care plans to existing provider networks primarily through our department partners. We have in LA county a really robust network of CBOs that are contracted with the county and also just working directly with children and families in the community, so really linking the managed care plans to those existing collaborative meetings or department facilitated provider meetings so that they can share out about what ECM is and how they could potentially sign up to be a provider.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Dr. Palav Babaria – 01:19:19	I'll just lift up from what both of you have said, really the vision of ECM and Community Supports is really to bring in non-traditional providers who have been serving the Medi-Cal population for decades outside of the healthcare delivery system and to be able to use this funding and this benefit to expand that reach in a whole person care way. Noah, just appreciate the humility that you're bringing to that experience as we recognize that is not the core strength of healthcare in general. Then really, we want everyone on this call to be an ECM provider, but if you can't do that yet, I think really serving as, Minsun, really a subject matter expert in helping to convene and link is so critical for that capacity building. Thank you both for sharing that. We've seen a lot of questions in the chat about this, but as you begin to map out these roles and responsibilities and coordination workflows, how are you dealing with that overlap with other existing programs like Wraparound or ICC?
Slide 40	Minsun Meeker – 01:20:15	Yeah, we haven't figured it out yet. We're in the process I think of having all of these conversations. I think the biggest thing that I think we're learning is I think several of the previous speakers alluded to this, LA County's really large. We have incredible services in place, a really, again, strong network of providers and I think we still have service gaps. Not every child and family is able to access the services we have in place or even the services we have I think can be strengthened. I think we're concurrently looking at how do we strengthen our system of care and existing services to ensure that kids and families' needs are met and then how can we again tap into new benefits, new services including ECM to benefit our kids and families. A lot of the work we're doing again is having conversations trying to break down silos between our departments and providers and map out which children are enrolled in managed care plans. It's really hard to figure out some of the data in a county as large as LA, so doing that data analysis and again, I think trying to identify where there's potentially service gaps and just better ways for us to integrate our work.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Noah Kaplan Ng – 01:21:29	I can add to that. One thing that has been really, really helpful is in LA County, all the managed care plans have gotten together to try to streamline as much as the administrative burden that providers face to try to streamline them as much as possible and simplify that. One tool that we did with the adults was having a one standardized ECM assessment that was used across all the managed care plans in LA County; that's six plans. When we came to think about children and youth trying to develop that assessment, partnering with OCP and others to try to think about, okay, as a kid who's in child welfare, what types of assessments would they have, and just building that list was so helpful for the managed care plans and everyone to kind of think, okay, this lead care manager may have to think about all these different types of assessments that the member of their family may have taken. Just doing that activity itself is really, really helpful.
Slide 40	Noah Kaplan Ng – 01:22:22	I also want to just recognize the importance for managed care plans to go to stakeholder meetings. Meetings that are already existing in the community with key stakeholders has been really, really helpful for us to get our message out but also share the questions and concerns that providers that are serving these kids and their families have so that we can think about that when we build out our model of care.
Slide 40	Dr. Palav Babaria – 01:22:46	So helpful. Jacquelyn, I don't know if you're still with us, but if you have anything to share on specifically that wraparound ICC sort of non-duplication issue because I know that you all have worked through this as well.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Jacquelyn Harlow Torres – 01:23:00	Yeah. The key is to understand what everyone's role is going to be in the care of the youth. How we delineated this when we match ECM or Health Homes, but with Wraparound is that we just clearly define what everyone's going to role's going to be. Wraparound or ICC is really there to do care coordination but around the treatment part of it, and the ECM is really to live just one level higher to look at the entire system pieces. Sometimes there's needs beyond Wraparound for that youth that that's where the ECM partner comes in to make some of those linkages. That's how it's worked nicely. All of our Wraparound teams have been appreciative of having this second layer in the care coordination and being able to tie in a couple of pieces that was already on their map for this youth, but they weren't sure how to make the connections. That's how we have operated.
Slide 40	Dr. Palav Babaria – 01:24:00	Perfect. Then I know people have been waiting patiently to ask questions, so we're going to do a rapid fire round. If you could just have one single piece of advice for MCPs and counties and other partners on this call who are interested in engaging in this work, what would it be? I'm going to ask each of our panelists to respond.
Slide 40	Jacquelyn Harlow Torres – 01:24:21	I'll give a quick response. I would say lean in on the design of the system. I have found every managed care plan that we've worked with wants to collaborate on this model, wants it to work, wants it to be successful so you know how to serve community members and they're looking for you to serve them, so go ahead and design something that makes sense for you and present it and really come up with a solution together. Don't sit and wait for I think the guidance to come out A to Z. That would be my advice.
Slide 40	Dr. Palav Babaria – 01:24:59	Minsun, we'll go to you next... Sorry, go ahead.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Anna Gruver – 01:25:04	I will just add to what Jacquelyn was saying because I thought it was connected. Especially for county systems, I would, if it's possible to know what your per member per month rate is early on to make sure that the model and the staffing structure and the feasibility of what you're doing matches and then be able to identify what in-kind support you might need.
Slide 40	Minsun Meeker – 01:25:30	I can jump in next. I think for us here in LA County we're finding with this work, particularly for child welfare, it does feel very like you're building the plane while flying. I think that can feel really scary, but I think echoing what Jacquelyn shared, I think we are really leaning into trying to break down the silos, increase communication across our partners, across our system of care and also our provider community because we really want to try to figure out how we can align strategies and figure out the best ways to benefit our kids and families. I think the biggest thing we're learning is we have to go out to talk to the real experts on the ground, which are our providers, and I think also it's really important to listen to our kids and families about what's going to help them and again, what services they're already receiving, trying to, as Noah mentioned, not overburden them with duplicative or what might feel duplicative to them assessments or services. For us it's just really listening and talking with one another.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Tejasi Khatri – 01:26:30	Yeah, I would definitely echo that last comment for sure. I would just reiterate that go live dates often feel like the date when you need to have everything up and running and going smoothly without, but really it should be treated as the launch point that it is and it really marks the beginning of an informed and prepared process and plan, but ultimately an iterative one and one that you'll learn as you go and fine tune as you go. I would say to anyone attending here who is on the cusp of thinking they might be interested in being an ECM provider or anyone that's in that tentative plan, I would trust in that we all have a shared goal in serving these children and there are many opportunities to learn from each other, like this one, and trust that MCPs and providers do work really closely and productively alongside each other to support each other as we launch these things.
Slide 40	Noah Kaplan Ng – 01:27:29	Yeah, I echo that too. From the managed care plans, I know it can be intimidating to join a managed care and to think about joining Medi-Cal, but I think it's incredibly valuable if you're already doing this work to participate in this kind of revolutionary program. As it was just said, this is not going to be perfect the second we launch it, but I think with the collaboration and work with the experts that are doing this, it can have a decade long impact on future generations in Medi-Cal. I think there's a really big undertaking, so it makes sense that it's hard. It should be hard as we all try to figure this out, and if we keep the member, the kid and the family at the center, the model of care should not be designed what the managed care plan needs or what the providers need, but really what that child and what that family needs. I think that's going to help us do this.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Susana Flores – 01:28:23	What I will add, since everybody's already touched on the same sentiments, echoing on what everybody else is saying, what I will add is just if you have not had an opportunity to have a good relationship with your managed care, start with that and also have good relationships with the providers and all the different organizations that are already in touch with these families. All of that. It's definitely what will help in developing a plan that has some really clear goals for the team and just continue the communication and the focus of serving the children in the best way that we can.
Slide 40	Amy Stevenson – 01:29:11	I'll just second that with Susana. I would say that the first thing I always tell providers is please look at the ECM provider toolkit that the state has provided to get a good understanding of what ECM is, and then please reach out to your health plans. Like everyone's mentioned, we want to hear from you, we want to partner with you, so please reach out to us. If it's a mutual agreement that we move forward with contracting as plans, we are here to help you stand up because you're successful for our members and that's our ultimate goal. I'd also encourage you to explore the different marketplaces for the support, either the PATH funding or the TA marketplace because there's staffing and structural support like that, but then there's also technical support. For many of our community-based organizations, they might need a little bit of both, so I really encourage you to really take advantage to those because we do want to partner with our providers in the community.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Dr. Palav Babaria – 01:30:08	I couldn't have said it better myself. The major take home message is this really has so much potential to transform how care is delivered for children and youth across our entire state and especially for the Medi-Cal program. We hope that you all join us in this journey. There's a lot of really smart people working on solving these challenges and we also, we've captured all your questions in the chat. DHCS will update our FAQs as needed to address some of these and then we encourage you all to go to your local learning collaboratives where facilitators will also be digging into some of these questions and helping people solve them. I know we're one minute past time. Happy to stay for two more minutes if there's any people who want to ask a live question, and then otherwise we will wrap. Rick, I see that your hand has been up patiently for a long time, so we can start with you.
Slide 40	Juliette Mullin – 01:31:06	Rick, you should be able to take yourself off mute at this time.
Slide 40	Rick Hodgkins – 01:31:12	Can you hear me?
Slide 40	Dr. Palav Babaria – 01:31:14	Yes, we can.

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Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Rick Hodgkins – 01:31:16	I thought I unmuted myself because I hit the tab. I'm blind by the way, so I use the keyboard commands instead of the mouse. Sorry, my computer's talking. If we can be quiet in the chat so my computer doesn't say anything. My questions surround ECM's enhanced care management for people with disabilities. I represent the IDD population as well as other disability because I'm a disability rights advocate and activist even though I don't get paid for it. What services are provided to children and youth with disabilities? I will note and report that the county I live in, that which is Sacramento, that the children get the cream of the crop. However, once they transition into adulthood, they no longer are assigned, let's say, a specific psychiatrist if they're getting a behavioral health through way of the county. They only can see whatever psychiatrist is available, so that relationship with the same provider is gone. The county mental health, also what county are there any... I represent 10 counties, Alpine, El Dorado, Nevada, Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba Counties.
Slide 40	Rick Hodgkins – 01:32:44	Although I'm based in Sacramento and I represent Capital People first, which is an organization run by and four people with the IDD community and the city and county of Sacramento and the regional center I receive services from, those are the counties that they represent. My question is are there any ECM providers in Sacramento and the nine other counties I mentioned that not only provide ECM services to children and youth with disabilities, but also neurodevelopmental services? I would mention Sacramento County does not, at least for adults. I think they do for children. Like I said, children get the cream of the crop, as do youth, but once they age out... Sacramento County is good at providing services to people who struggle with food insecurity as well as homelessness, but that if they need anything else, it's just not good, because I have Medicare, so I'm able to get my mental health services elsewhere and not have to use the county. Thank you.

CalAIM All Comer Webinar: ECM Panel Discussion: Forging New Managed Care Plan Partnerships with Counties and CBOs to Launch ECM for Children and Youth

June 23, 2023

Transcript

VISUAL	SPEAKER – TIME	AUDIO
Slide 40	Dr. Palav Babaria – 01:33:49	Thank you so much, Rick, for asking your question. I'll say obviously a lot to unpack there, but really appreciate you being on our webinar today. I think from the ECM perspective in particular, I think as one of our panelists said it best, we are really at the launch and not the finish line of what this program is going to look like. In the policy guide there's more information, but anyone with intellectual or developmental disability is eligible for ECM if they meet additional criteria in those populations of focus. We do recognize that, I think to your point, a provider that serves everyone may not necessarily be the best provider to meet the specific needs of this population, so we have been talking with our state partners and regional centers about exactly what they're doing in LA County. How do we find the right providers who are really experts and already serving the IDD population and bring them on as ECM providers. I think we acknowledge we've started that process, but it is by no means universal or statewide and is definitely the journey that we're on.
Slide 40	Rick Hodgkins – 01:34:48	Okay, because my issue is, my other question is have you reached out to other regional centers besides those in LA County? I mentioned the regional center I get services from is with Alta California Regional so that they would be, as you are aware, that the Lanterman Act requires, and I don't know if this is federal law or state law, but the Lanterman Act, which is state law, requires that regional centers only pay for something as a last resort. This is going to be an important issue.
Slide 40	Dr. Palav Babaria – 01:35:22	100% agree. I think if you or any of the participants today are from a regional center, please email us. All of the email information will be in the PowerPoint slides and on our website and we can definitely work through some of those nuances. I don't see any other hands up. Thank you all, especially those of you who stayed a few minutes over. We are really so grateful for all of our panelists and for all of you joining today and hope to see you at our next event.