CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING TRANSCRIPT

POPULATION HEALTH MANAGEMENT (PHM) WEBINAR: SUPPORTING MEDI-CAL MEMBERS WITH LONG-TERM SERVICES AND SUPPORTS (LTSS) NEEDS EXPERIENCING TRANSITIONS OF CARE

Date: August 21, 2024

Number of Speakers: 5

Duration: 1 hour, sixteen minutes

Speakers:

- Alice Keane
- Susan Phillip
- Palav Babaria
- Chris Esguerra
- Anwar Zoueihid

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VISUAL	SPEAKER – TIME	AUDIO
Slide 1	Alice Keane – 00:29	Hello and welcome. My name is Alice and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the chat. Questions and comments are welcome at any time during the program in the chat as well. Live close captioning will be available. You can find the link in the chat field. With that, I'd like to introduce Susan Philip, Deputy Director of Healthcare Delivery Systems at the California Department of Healthcare Services.
Slides 2-3	Susan Philip – 01:03	Great. Thanks, Alice. Good afternoon everyone, and welcome to today's presentation. Today, we are going to be providing an overview of transitions of care for Medi-Cal members with long-term services and supports, needs. I will be providing an overview, an introduction, and also joined by Dr. Palav Babaria, our Chief Quality and Medical Officer and Deputy Director of Quality and Population Health Management. We can go to the next slide. So first, we'll start with an overview of our efforts through California Advancing and Innovating, Medi-Cal or CalAIM. And our initiatives to support individuals with long-term services and supports needs, especially at that point where they are experiencing transitions of care. We'll provide a brief overview of the services and supports available for Medi-Cal members with LTSS needs through the Transitional Care Services and as well as Enhanced Care Management and Community Supports.

VISUAL	SPEAKER – TIME	AUDIO
Slide 3	Susan Philip – 02:09	Then we're going to have a conversation and it'll be an interactive discussion with an ECM and Community Supports Provider, Partners & Care Foundation, as well as a Medi-Cal Managed Care Plan Health Plan of San Mateo. They'll be talking about their experiences standing up supports for individuals with LTSS needs, again, especially as they are transitioning between levels of care, and we'll close with DHCS resources available for technical assistance as well as an audience question and answer time. So as a reminder, these slides today and webinar recordings will be posted on DHCS's Population Health Management Website for those who wish to access materials after the session, and I believe we're dropping that link into the chat. And then again, we'll hold a little bit of time towards the end of the session for Q&A after our provider panel.

VISUAL	SPEAKER – TIME	AUDIO
Slides 3-4	Susan Philip – 03:06	And then I will flag, we do have a lot of participants in today's session, which is really exciting. We'll do our best to answer questions, but acknowledge that that might not be possible. But we will make sure to provide contact information at the end of the session today to make sure you know where to submit any questions that are not addressed by the end of the webinar. Okay. We can move on to the next slide. Okay. So today's focus, we are wanting to really provide an overview again of Transitional Care Services and how it really fits in with Enhanced Care Management and Community Supports. DHCS' vision is that Medi-Cal members that need long-term services and supports can remain in the least restrictive setting that meets their preferences needs, and really optimizes their quality of life. Our Medi-Cal managed care plan partners really have flexibility to leverage different services and supports to meet each individual's unique circumstances.

VISUAL	SPEAKER – TIME	AUDIO
Slide 4	Susan Philip – 04:13	But there are very complex and there's a lot of variety in terms of the services that's available as well as the population needs for individuals that require long-term services and supports. So stakeholders have requested some technical assistance to support this point in time of transitions of care for population and really how relationships between managed care plans, skilled nursing facilities and other providers in the space can be supported. So today, we're focusing again on that integrating that Transitional Care Services under the Population Health Management framework, which includes our Enhanced Care Management benefit as well as those Community Support services available under CalAIM to really best support members with long-term services and supports needs as they are experiencing those transitions of care. So with that, I will turn it over to Palav to step through the Transitional Care Services.

VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Palav Babaria – 05:16	Thank you so much, Susan, and thank you all for joining. I think as Susan highlighted, and you'll see as we go through the next few slides and through the fireside chat, a big reason why we're all here today is because we've intentionally designed our Transitional Care Services policy, our ECM populations of focus and our Community Supports to be complimentary to really wrap around the complex needs of this member population. Susan's going to get into the data in a little bit, but we also know from recent data that there is still a lot of opportunity in this space and the vast majority of individuals who are receiving TCS are not getting both ECM and Community Supports that they're eligible for. And so in the field, the ways in which plans and providers are weaving these things together is an opportunity for us all to really strengthen the entire suite of services we provide members. And you'll hear about some of the best practices later in our fireside chat.

VISUAL	SPEAKER – TIME	AUDIO
Slide 5	Palav Babaria – 06:12	So for those of you who may not be as familiar with our Transitional Care Services policy, this is a part of our overall Cali Population Health Management Program and really lays out a series of requirements for what we expect when members are transitioning from one setting or level of care to another. The overarching goals is that we want to get members to the least restrictive level of care that meets their needs and aligns with their preferences. And we want to do this in a timely fashion without interruptions in care. And we know that when this actually happens, it results in improved clinical outcomes, improved satisfaction for members, and often allows them to remain in the community for longer periods of time. We also want members to get their needed support and coordination in a timely fashion and in a safe and secure transition with the least burden on the members possible.

VISUAL	SPEAKER – TIME	AUDIO
Slides 5-6	Palav Babaria – 07:04	I think we have all heard the stories where there is a planned discharge, member arrives home and key oxygen, other durable medical equipment, other home visiting and home nursing services that are supposed to be set up are not actually in place when the member arrives home resulting in delays and sometimes readmissions. We also want members to continue to have the needed support and connections to services that make them successful in their new environment, recognizing that whatever led to that initial admission or other level of care may mean that they have different functional status or different needs when they're being discharged than when they arrived. We can go to the next slide. So the specific policy is outlined as mentioned in our Population Health Management policy guide, but we require managed care plans to deliver Transitional Care Services to all members, and we have different requirements for low-risk and high-risk members, which we'll get into.

VISUAL	SPEAKER – TIME	AUDIO
Slide 6	Palav Babaria – 08:05	And then for members specifically with LTSS needs, we require that the managed care plan assigns a single point of contact Transitional Care Services care manager, and this is really recognizing that members with LTSS needs need greater coordination are higher risk, and that these transitions from one level of care to another can really be risky times for that member. As you'll see here, the member is really at the center of this and needs the support of all of these different players in the ecosystem and the way that acute care hospitals and in-patient facilities are coordinating with the MCP as well as SNFs and other post-acute short-term stays as well as community-based settings, whether that is their home or residential living facility is really critical and that open dialogue and coordination and communication across all of these entities are really critical.
Slides 6-7	Palav Babaria – 08:58	And so we absolutely expect the MCPs to be a part of this, but are also ensuring that hospitals and SNFs are jointly accountable for these successful transitions. We can go to the next slide. So that is just a very high level overview of Transitional Care Services. Really wanted to share with everyone that hot off the presses. Our technical assistance resource guide, which is linked here, is now up and live on our Population Health Management webpage, and it's really a much more detailed dive is to all of the things that we're going to be talking about today. So what are the specific TCS requirements for plans? How do they apply to members with LTSS needs? What are some of the promising practices that we've heard across the state as we've engaged with counties and providers and plans who've implemented this really successfully?

VISUAL	SPEAKER – TIME	AUDIO
Slide 7	Palav Babaria – 09:50	You're going to hear from one of those collaborations today, but there's many more success stories from across the state and we really want to spread and scale those to every single member in every single county. It also provides an overview of other services and supports like ECM and Community Supports, which are really complimentary and a part of the larger puzzle that we need to solve here. And then it most importantly also has really concrete decision tree graphics that outline based off of member criteria, what services are they eligible for and are likely to be helpful in this situation. And those can be used at the point-of-care by care managers and other individuals who are making these decisions in real time. So please check out the website. It's live right now for those of you who are eager viewers, and I'll turn it over to Susan.

VISUAL	SPEAKER – TIME	AUDIO
Slides 7-9	Susan Philip – 10:38	Great. Thanks, Palav. So we're going to spend a little bit of time on a refresher of the two critical services under CalAIM DHCS launch back in 2022. We can go to the next slide. And the slide after that. Great. Okay. So we really want to talk about how these fit in terms of overall services that are available for individuals and families that really need that long-term services and supports. And again, really at that point in time of transition of car. Actually, we could stay on this slide. So both Enhanced Care Management and Community Supports are really designed to reach members beyond that traditional healthcare setting. That's really ultimately goal of CalAIM. It's really addressing whole person care and really ensure that we are reaching members when they need care and where they need it. So there are a distinct set of supports for members and there are often members that have long-term services and supports needs that might benefit from receiving both Enhanced Care Management and Community Supports at the same time or they might need it at different points in time.

VISUAL	SPEAKER – TIME	AUDIO
Slide 9	Susan Philip – 11:55	Enhanced Care Management is DHCS highest level of care management, right under that Population Health Management framework. Often an ECM care manager might identify a member's desire to say, for example, transition from a nursing home into a less restrictive setting like their home, and then also be referred to Community Support providers. There could be also Community Support providers that are potentially working with a member that's not yet enrolled in ECM, but they could be then enrolled in ECM. So the idea is that both of these services really complement each other and are there to provide the full suite of services that a member may need. So currently DHCS offers a 14 Community Supports. These are optional services for managed care plans to offer in the counties in which they operate. And we'll go into in a little bit more detail first on ECM can go to the next slide.

VISUAL	SPEAKER – TIME	AUDIO
Slide 10	Susan Philip – 13:06	Great. So again, ECM is that highest level of care management. It is designed, the eligibility for the populations of focus is for adults living in the community and at risk for Long-Term Care institutionalization and adult nursing facility residents transitioning to the community. So those are the two populations of focus. DCHS vision for Enhanced Care Management is really to coordinate the care for these eligible members. So that includes physical, behavioral, dental, healthcare needs, and again, connecting individuals to Community Support services as they need. ECM again, as a reminder, is really that interdisciplinary high touch person-centered services primarily to be provided through in-person interaction, really reaching members where they live, where they seek care, and where they prefer to access services. And then the aim of ECM for both of those Long-Term Care populations of focus is really to enhance our ability to live independently and safely and really remain connected in the community and to really honor the preferences of members.

VISUAL	SPEAKER – TIME	AUDIO
Slide 11	Susan Philip – 14:27	So now we'll get a little bit into some data. You go to the next slide. So this data shows Enhanced Care Management, Long-Term Care members who receive ECM in each quarter in the most recently available data takes us through the calendar year 2023. So if we take a look at this is looking at the data for both of those Long-Term Care populations of focus. So as you can see from quarter one to quarter four of 2023, the number of members in both populations of focus more than doubled. And then we also see that 92% of enrollment across the two populations of focus in calendar year 2023 were for those living in the community at risk for Long-Term Care, that population of focus. So in this chart, I just want to clarify that members that qualify for multiple populations of focus are counted in each populations of focus that they qualify for. So that's just a little snapshot of the data. And all of this information was just also published, went live in early office, so this is also hot off the press. Please also check that information out. Okay. Next slide please.

VISUAL	SPEAKER – TIME	AUDIO
Slides 12-13	Susan Philip – 15:50	We also just recently in June released the ECM for Long-Term Care population, the focus spotlight. This resource lifts up key DHCS policies and resources for those, serving these populations of focus again for those at risk for entering institutional Long-Term Care services. So this new resources is really helpful. I would encourage you all to check it out. This is the third in the series of spotlights for how providers can really deliver the ECM model tailored to the needs for different populations of focus. Okay. Next slide. So just to hone in a little bit on Community Supports now. So there are 14 approved Community Supports. Two are designed to support transitions of care into less restrictive settings for those at risk for institutionalization. All of this information is really in detail in our Community Supports policy guide, which we can also drop a link in the chat.
Slide 13	Susan Philip – 17:01	But so the two Community Supports here are nursing facility transitions, diversion to assisted living facilities. So this really facilitates a member's transition to Assisted Living Facility, Residential Care Facilities For the Elderly RCFEs or Adult Residential care Facilities or ARFs. And this is for members who are currently receiving nursing facility level of care or who meet the criteria to receive nursing facility level of care. And then the services that are really included in these Community Supports bundle, if you will, is limited time transitional coordination that enables a member to the establish residence in Assisted Living Facility and RCFE or an ARF. So then it also provides ongoing assisted living expenses except for women board that's not included and then includes that wraparound care, for example, assistance with activities of daily living.

VISUAL	SPEAKER – TIME	AUDIO
Slides 13-14	Susan Philip – 18:02	The second Community Supports really is focused on facilitating a member's transition from a licensed facility to a home. So private residence where the member is really directly responsible for their own living expenses. So that also includes services that are included in the bundle. Also includes limited time transitional coordination that enables a member to transition into a private residence. It also includes non-recurring set of expenses like a security deposit or set up fees for utilities. Those sorts of non-recurring expenses are also included in the bundle. Okay. We can go to the next slide. So we wanted to share a little bit of data on members utilizing these specific Community Supports. So currently, the nursing facility transition divergent to Assisted Living Facility as well as the community transition Community Supports have some of the lowest utilization across the 14 Community Supports as you can see from this graph.

VISUAL	SPEAKER – TIME	AUDIO
Slide 14	Susan Philip – 19:09	So we really have received some feedback from stakeholders that there might be some confusion about the Community Support service definition and the intended goals of the services, what services components might be included and how they relate to the 1915(c) Waivers. So we are looking at that feedback and information that we receive from stakeholders and looking to see how we might clarify and update those Community Supports definitions and really clarifying that in the coming weeks. So definitely want to raise this, want to share the information from the data. We'll say that based on our most recently available data, our health plan of San Mateo is really the only plan utilization of the community transition Community Support. So glad that they're able to join us on the call today and talk about their experiences. So with that I'm going to transition back to Palav.

VISUAL	SPEAKER – TIME	AUDIO
Slides 15-16	Palav Babaria – 20:14	Thanks so much, Susan. So as we often do for many of our Population Health Management webinars, we really want to ground our conversation today in a patient's story. We can go to the next slide. So full disclosure, Felix is a fictional patient for today, but the story really is a composite of actual real anecdotes and experiences that we have heard from providers and plans across the state. So Felix is a 72-year-old living with multiple chronic conditions who unfortunately has a stroke. He's admitted to the hospital and upon discharge is unable to go back to his previous level of mobility and functional status and needs to go to a skilled nursing facility for rehab. Him and his wife are also looking for more supports as he prepares to transition home from the skilled nursing facility. And so to walk through how the concrete examples of how these policies work together, when he is admitted for the stroke, he's identified as high-risk for our Transitional Care Services policy requirements.

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Palav Babaria – 21:15	Those who are low risk are still provided support but in a lighter touch manner, whereas those are who are high-risk at a dedicated care manager who really helps with that transition of care through the period of discharge and into whatever setting the individual is discharged into. So the managed care plan assigns a Transitional Care Services care manager to Felix who is solely responsible for Felix's case, who really works with the hospital discharge coordinators, make sure that Felix's preferences and desires for what type of skilled nursing facility would be appropriate, are honored and helps make sure that the sort of handoff from hospital to skilled nursing facility occurs. The Transitional Care Services care manager also really explores all of the services and benefits that Felix is eligible for. And in those conversations, Felix is identified as being eligible for Enhanced Care Management. He expresses that at some point when he is ready to be discharged, he does want to go back to residing in the community in his home.

VISUAL	SPEAKER – TIME	AUDIO
Slide 16	Palav Babaria – 22:16	And so the Enhanced Care Management provider who is identified by the plan is one that has the skill set and expertise to work with Long-Term Care populations of focus and understands what are the sort of services and priorities they have for transitioning back into the community. So Felix gets all of those services and supports and is able to successfully leave the nursing facility and move back home. Once home ECM continues, this is not just a period of care management provided only in the skilled nursing facility, but really bridges the skilled nursing facility and home and additional Community Supports. Providers are brought on board so that Felix can remain at home and be successful in this new environment. So this is just an illustrative example, but you're going to hear directly from our panelists, the dozens if not hundreds of members that they have served in managing all these three benefits. We can go to the next slide. We can go one more.

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Palav Babaria – 23:20	So I'm honored today to have Dr. Chris Esguerra, who's the Chief Medical Officer for Health Plan of San Mateo. And as you heard Susan describe, literally San Mateo is the single plan responsible for much of the utilization in some of these categories. And Anwar Zoueihid, who's the Vice President for LTSS at the Partners & Care Foundation, we're going to go through, I'm going to ask them to come on camera and introduce themselves. And then we're really going to do a deep dive of how does this actually work? How do the MCPs and skilled nursing facilities figure out how to work together and work collaboratively to support transitions for members? How do we ensure that members that are being placed in the appropriate type of setting with the appropriate types of supports and how is San Mateo as a health plan pulling together all of the various programs and benefits and supports that are available and working with their partners on implementation. So Chris and Anwar, if you want to come on camera and just say hi to all of our audience.
Slide 18	Chris Esguerra – 24:21	Hi, everyone.
Slide 18	Anwar Zoueihid – 24:24	Good afternoon everyone. Nice to be here.

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Palav Babaria – 24:28	Great. And maybe we can take down the slide just so we can see everyone. Perfect. So I think as we've talked about, and to give context to our group, at the end of the day, DHCS makes the policy, but the policy on paper doesn't actually provide care to our members. It is the incredible hard work that is done by all of our local partners that transform our policy into actual real care that is provided to individual members and has the potential to transform their lives. And we know that that operationalization and implementation is critical to the success of CalAIM and more importantly to the quality and equity of care that we want to provide. As a part of that, DHCS last March hosted a Transitional Care Services summit that was for plans and some key partners to really dig into these policies.
Slide 18	Palav Babaria – 25:21	We see the potential here, but how do we work through the real practical barriers to implementation and roadblocks that exist throughout our state? And in that summit, I just walked away so inspired because we heard amazing stories of partnership and collaboration and I think one of the major takeaways is that nothing happens without relationships and trust and collaboration at the local level. And that especially that relationship between managed care plans and skilled nursing facilities and then community providers who are then ready able and willing to help support members leaving skilled nursing facilities are critical to making any of these services work in the real world.

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Palav Babaria – 26:02	We also know that under CalAIM, Long-Term Care in some counties was newly carved in starting in January 2023. Other counties like San Mateo have had much longer experience with this where we can really leverage those years of learnings to really inform areas of our state where maybe those relationships are needle. So Chris, we're going to start with you. We know and heard loud and clear that summit, that health plan of San Mateo has really robust relationships with the SNFs in your network. What is your secret sauce and how did you build those successful relationships? And since everything is about data these days, if you could also touch upon how has data been a part of that?
Slide 18	Chris Esguerra – 26:42	Yeah, absolutely. I think a way to think about it, Palav, you said it and many others have that. None of this happens at any speed other than the speed of trust and you have to build trust. And how do you do that? Well, so for those who are starting a relationship, say with a skilled nursing facility, your interactions are probably transactional. That's not trust, that's just you get something, I get something, we might have a dispute on a contract, might have a dispute on a payment, we might have to deal with grievances, we have all of these things. That's all transactional, that's not a relationship. And really then, one, you have to understand that there's these transactional pieces and then in addition to that, really start thinking about well what is this partner going to be like? How am I going to interact with this?

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Chris Esguerra – 27:35	How do I show interest? How do I begin to continue just to show up regularly? And I am just proud of how our staff take this really interesting and very intense interest of just getting to know our SNFs and knowing that, yeah, there's turnover. And so when we hear there's a new administrator, we're all ready to just meet this new person as an example. But the point there ultimately is that it's more than the transaction itself. It's really being there, showing up regularly, even if the facility's not ready yet to actually have a discussion, but knowing that we're able to show up and that we do show up where it matters. So where it matters is operational. So is our UM team working with the SNF to actually help them when it matters? So discharges and even when folks are transitioning from inpatient to SNF and ensuring that things are going to go smoothly, are we there when it matters? When they're going to get paid? So those are the pieces, too. So that's how you start building a bit of the trust. It starts to sound very foundational and fundamental and it is.

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Chris Esguerra – 28:52	And the really cool thing is from that you get to build other things. And I am reflecting back recently, I'd say, a couple months ago now that we had a virtual convening of our Hospital SNF Collaborative. We actually ran this for a couple of years and this was this whole thing where the hospitals and SNFs determined what they wanted to do and they created their own checklist between themselves and how they want to work together. We had a whole different plan, that did not want to do that plan. They wanted this instead. Totally cool. And so we had a debrief. I'm like, "Hey, how's it working with you all?" They're enacting it, they're using it, they're calling each other out when they don't use it. And more important was they asked us, "So are you going to keep this going? We really like meeting and we really like meeting this group." And so those are the things you get to build on top of that. But it starts with building up that trust, becoming a partner, not just a transactional agent of some kind.
Slide 18	Palav Babaria – 29:53	Thank you so much. Definitely, hearing you have to think about where your roles are and where the support is that you can build upon and resolving some of those practical issues. And sometimes, when the group wants to go in a new direction that is not in your agenda, that you pivot and you roll with it. We'd love to hear a little bit as you've built these sort of trusting relationships, what is the role of data sharing and how has that played a part in this? And then it also sounds like some of this is really human-to-human contact and labor-intensive. And so what kind of staffing structure do you use to ensure the success of these teams?

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Chris Esguerra – 30:28	Yeah, absolutely. So data sharing, I mean, I'll say we go old school, we're not doing APIs, our SNFs are not there. And frankly, it is at the level of the human interaction, it's the level of phone calls, it's the level of, I mean, frankly, the biggest compliment our SNFs provide is they know who to call and we answer pretty quickly. Well, actually, these days they know who to text and we answer pretty quickly. So it is really at that level. But the point of the data sharing is that we as the plan have so much information about that individual. We also have so much in terms of resources that we could bring to bear to support that individual. And we make that clear and we're constantly sharing, these are the programs, we're constantly reintroducing. This is what enhanced case management is, this is what Community Supports are, here's how you can access and do that. I think every convening we've had on the hospital SNF Collaborative and even previously with the SNF Collaborative was, and by the way, these are the programs and it's just repetition.

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Chris Esguerra – 31:36	And that's to us is where the data sharing matters because it's the data sharing of information, not just broadly of resources, but also specifically of that individual member. And so what does that look like? Well, so we have our inpatient post-acute utilization team, and each nurse is actually assigned to their facilities. And so they have their collection, they're tied to specific hospitals, they're tied to specific SNFs, and they join those specific IDTs at the various hospitals and SNFs and actually develop those individual relationships at that operational level. And yet we also keep thinking about what are the other levels of these relationships? And so we have a SNF program or senior medical director, Dr. Moore helps lead that and he has those relationships with the various SNF-ists with our provider services, myself, the rest of our team, we have those various relationships with the leadership of the skilled nursing facilities.
Slide 18	Chris Esguerra – 32:38	So again, thinking about it as a very layered approach in how we bring these things together and at the operational level, absolutely. We have one nurse, one SNF, and whenever we have changed, staff turnover, it is really that introduction of that relationship as well and really continuing to build on that. In the prior to the public health emergency. Sure, we did that in person of course with the public health emergency, we all had to do that virtual. You know what, we've been able to continue that virtually and still keep that relationship because these run deep and have been very productive.

VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Palav Babaria – 33:16	Thanks, Chris. Yeah, I'm definitely hearing if you're a plan and don't have assigned nurses to skilled nursing facilities or if you're a SNF and doesn't know who your plan point of contact is, that's maybe a critical place to start and scale. Anwar, let's come to you, because I think we recognize that partly why transitions of care are so challenging to get right and even more so for the LTSS population is that there's really a lot of players in the mix. There's no one single entity that can solve and meet all of the needs that an individual has. So we'd love to hear from your perspective, how does your organization serve as that intermediary? How do you build relationships with the plans and with skilled nursing facilities and other partners? And what are some of the lessons that you've learned over the years playing this role?

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Anwar Zoueihid – 34:05	Sure. Well, thank you for the opportunity to speak about this. One my favorite subjects actually. And Dr. Esguerra was really point on. It really starts with relationships with all stakeholders involved with the member's care, including skilled nursing facilities, including joining folks at their conferences where really it's the best setting to get to know them and start that relationship. We have ongoing outreach efforts to educate folks about the home and community-based service, LTSS, educational forums, trainings including discharge planning, leveraging the Community Supports, services, establishing secured health information exchange, ADTs, if possible. But just like Dr. Esguerra said, a lot of SNFs are not there yet. Portals, e-faxes, security emails, anything to make it a bit easier for us to coordinate, identifying campaigns for each SIF, communicate solutions for SIF that allow them to actually serve more people by offering them Transitional Care Services and solutions to their needs.

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Anwar Zoueihid – 35:19	And allowing them to do what they do best rather than serving as a temporary housing a provider for those that are eligible for discharge, establishing contracts, BAAs, MOUs, establishing weekly, biweekly or monthly check ins or ICT meetings, and leveraging the robust services that we have throughout the state to solve the Transitional Care Services. Our primary goal and tool is actually collaboration and it's also training, and that also includes internal staff. Even our program ECM or waiver staff really need to know that you could cross pollinate with different services and also SNF staff and the hospital staff, and that really makes an effective coordination. Speaking about coordination, we try to make coordination easy and fun. And we all know that coordination is always, "Oh, my God, additional complicated administrative burdensome process." But we try to avoid all that and make it easy touch points, let's get down to work and solve the same problem, but also we would like to be a little bit more proactive.

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Anwar Zoueihid – 36:35	ID members at risk before hospitalizations, work directly with the hospitals to provide Transitional Care Services via CalAIM, CHW, ECM services and follow the patient to the SNF so that they don't lose their household. We can manage that situation and start preparing for a safe discharge. The key is to really break away from the old ways of working in silos, we are really stronger together. And I've worked as a social worker manager for many, many years and I understand the difficulties of care coordination. And during my high days, there was hardly any. And this is why we've been working really hard to kind of break the silos and ensure that we are finally coordinating with the managed care health plans, the medical groups, hospitals, SNFs, assisted living waivers, congregate living waivers, and all the other CBOs that are available PACE programs.
Slide 19	Anwar Zoueihid – 37:33	I feel like they're underutilized. So if you really think about that, those of you that have been around as long as I've been, remember the days where there was zero care coordination and things have changed now with CalAIM and the upcoming MLTSS and we'll continue to change with the California data exchange framework. So never, I think in history have we had such an experimental opportunity called CalAIM right now. And for the first time we have all the tools needed to provide all kinds of services to our community, including TCS traditional care services through blending and braiding services to address and coordinate both social and clinical care.

VISUAL	SPEAKER – TIME	AUDIO
Slide 19	Anwar Zoueihid – 38:14	And for me, it seems like the days of siloed care is finally, finally over with or almost over. And in terms of major challenges, the lack of knowledge, hospitals and SNFs are not necessarily aware of all the great supportive services that the State Department of Healthcare Services has to offer for Transitional Care Services, let alone non-Transitional Care Services and the lack of real-time communication, the lack of data utilization, alerts, like PointClickCare, all of these. And if you don't have PointClickCare to identify people that are put into an institutional care setting. The health plans have ways to identify people that are in SNFs and currently eligible or wanting to transition out, including the SNFs. So I would always leverage those.
Slide 19	Palav Babaria – 39:09	Thank you so much, Anwar. And we may have to have a whole other webinar on how you make care conditions fun because those two words don't always go together.
Slide 19	Anwar Zoueihid – 39:17	It took a lot of work. Yeah.
Slide 20	Palav Babaria – 39:20	Okay. And you also lift up and point out that we are in this really incredible time where there are so many options and resources and it's really about being thoughtful and coordinating among them and leveraging all of those tools in the toolbox. I'm going to move us onto our next topic, which is really ensuring appropriate member placement because I think despite all of the resources and tools that we have in our toolbox, we know across the state that skilled nursing facilities are a limited resource and it can be really challenging to find beds for individuals often resulting in individuals staying hospitals for much longer than they should be or having to be placed very far away from home and from loved ones.

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Palav Babaria – 40:03	And so want to think a little bit about how do we leverage all these tools both to maybe avert skilled nursing facility placement and get people home more safely or to help expedite acceptance and how we can address some of those barriers. So, Chris, let's go back to you. As you and your team try to wrestle with this, you have someone ready to go needs to go to a skilled nursing facility and the really hard time finding a place for them, what types of alternative arrangements have you all thought about and leveraged to solve this problem? And if you can share the operational nitty-gritty of what did it take to get there and actually implement some of those alternative plans?
Slide 20	Chris Esguerra – 40:44	Yup. Definitely. Definitely. And I think it depends on the groupings of the situation where we have worked to get creative and actually really questioned the status quo, because technically there is, if you look at all the criteria that we use as plans of what gets approved for what and what is approval, what's all that stuff, you could see a technical path going on. I'm like, "Sure, this is hospital stuff, this is SNF level stuff, this is all that stuff. These are the things." And we've questioned that and really centering the member in all of this and wondering, I mean, even just that basic empathy for the member, "Would I want to be in the SNF just to have IV antibiotics for six weeks?" Probably not. And so that's one level or empathizing with the SNF. How am I going to help manage an individual who is way more complex than I can staff up to and knowing that I'm going to get a certain rate in the health plan that's probably about the same as someone else who's actually relatively easier to manage?"

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Chris Esguerra – 41:53	Or, "How am I going to accept somebody that I know will probably stay here a really long time and maybe convert to custodial, but I need to actually have this bed for something else?" So those are the points of empathy that we started thinking about. It allows us to start questioning a lot of these things. And so on the SNF avoidance side, really questioning, "Does this member actually need to go to SNF?" Starting with the IV antibiotic example, we really started questioning that of, "Hey, one, if it's a once a day thing, can we just do that as outpatient? Can we do these other things? Can we work with home health or infusion centers?" Lo and behold, the answer is yes. We had willing home health providers, our infusion centers were like, "Sure, if we need transportation issues, we have a transportation benefit." Okay. It's totally doable. We ran into, "Oh, wait, we have some providers that sometimes complicated IV antibiotic regimens," so we can go in at the hospital phase and ask the question, "Does it need to be four times a day? Does it need to be this?"

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Chris Esguerra – 43:03	And lo and behold, they obliged and found something much more creative and easier for the member to actually be at home. So it took more than just, "Oh, they don't need to be in a SNF." It's what about the system that we can start poking at to actually think differently for these types of use cases? On the other side of things where we have very challenging placements, so really helping out the hospitals, we tend to think about this to the next placement reassurance strategy like the, "What's the hospital reassurance strategy? What's the SNF reassurance strategy?" And it's really hard for a SNF to think about accepting someone who's really complex knowing and therefore high-cost knowing that they're going to be paid the same. So where there and flexible and in terms of helping them actually address those costs, whether it's medications, it's the sitter, it's dialysis capabilities, it's the need to deal with the logistics of transportation for those particular pieces. Do we need to be thinking about enhanced rates?

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Chris Esguerra – 44:11	Those discussions happen early because we know already what's happening because that person's in the hospital, we know the situation, the team's already working on trying to find that. And that's where we've actually acknowledged that body of work. Previously, it just fell on our supervisor for the inpatient team to really do that kind of negotiation. I love Melissa. She's always talking about how do we get to, yes. Now she has two folks that actually help her. It's a long title, but complex care clinical liaisons, that's their job, their main skillset as much as their nurses is negotiation. And how do we get to, yes, and knowing the various ways we could be flexible. In addition, we're always thinking about, and this is a relatively new term I learned, is the secondary discharge. So there's the primary discharge from the hospital, but we also need to think about what's that secondary discharge from the SNF so that the person doesn't sit there? And that's the SNF reassurance strategy, so to speak.

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Chris Esguerra – 45:12	And that if we know that housing's going to be an issue or that person cannot return to their home in the way that they are currently, can we start working on that now? That's where we bring in all the various programs and various partnerships to actually do that and know that that's happening already, not just at the hospital, but while at the SNF level so that the SNF knows that they can comfortably take this individual knowing something is happening to help facilitate that secondary discharge. So it's really thinking about these various layers in the various scenarios, and they tend to fall into those buckets, and lo and behold, you all of a sudden then really make the capacity more efficient at that particular level because we really see it as we have all these other resources, let's bring them to bear. We just need to actually have those extra layers. I mean, as Anwar put it's that coordination layer that actually makes this a lot smoother and with the added creativity of addressing the pain points, whether it's operational or financial.

VISUAL	SPEAKER – TIME	AUDIO
Slide 20	Palav Babaria – 46:18	Thank you so much, Chris, for walking us through that. So much of what you said really I think highlights why transitions are hard because historically we have just tackled them in the silos. Your job at the hospital discharge, the patient done, your job at the SNF, discharge done, and the way you all have approached it is really putting the member at the center and tracking out that entire member journey, which does involve everyone to do things differently at every single stage and really collaborate and coordinate and maybe is sort of the exact precision medicine that we need for these cases. So it also is great to hear that the plan is really driving that holistic long-term journey, which makes sense as you all are ultimately fiscally responsible for the entirety of that journey. Would love to hear a little bit just about how financial incentives have played a role. You mentioned this in terms of especially for those complex individuals, what are some of the lessons learned with how you really make the finances work for you?

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Chris Esguerra – 47:17	Right. Right. So at the individual sort of case level, yes, we have our base contract. We do a PDPM payment model for our SNFs that's very much like Medicare and yet at the same time, we're flexible. We know when someone's going to come in with likely a high-cost med or they're going to need some sort of complex DMA. Of course, we're going to provide all those pieces and again, get to that reassurance. And so those are extra things that are on top of the base contract that we'll work through before the admission happens. So that's routine work and really identifying that and what the needs are and it actually reassures the SNFs significantly because they know they're not going to have a financial hit. The other piece actually on the backend, and I find it funny, but it's always a nice reminder when we actually get to reward our SNFs, but they always forget that it exists.
Slide 21	Chris Esguerra – 48:18	So we have this incentive that actually helps and incentivizes them to work with us to actually help with transitions from SNF back to the community and in particular those members, individuals that were at risk of turning into more Long-Term Care custodial situations. And really all that we ask is like, "Hey, work with us and work with our partners to actually get that secondary discharge going so that they're not going to stay at your location for a long, long time." And so one of the metrics of that is, "Yes, you're working with us and that person, that member stays in the community for at least nine months." And so every time we give that financial reward back to especially our high-performing SNFs, they're always one, it gets them in the black. And two, they're always reminded and surprised, "Oh, yeah, this money was here." And so we actually try to make a big deal out of it just because it's so easy to forget.

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Chris Esguerra – 49:12	It's this routine thing that they're used to. And so that flexibility on the front-end and then this incentive to really help work with us to do the community replacement on the back end, although we do a lot of reminding, has definitely been helpful as financial levers. And the other piece too is, again, the work here is this is transitions. There's this greater work of how do you help keep members healthy broadly and how do you do things that are preventive in the first place? The way I'm talking, it sounds like, "Oh, my gosh, your SNF budget must be ballooning." It's actually been trending either flat or down over the last several years. And that's really cool for us. And we've been also happy to see our readmission rates have generally been pretty decent, so it's not an area I'm too concerned about from a financial perspective.
Slide 21	Palav Babaria – 50:06	Thanks so much. Anwar, I would love to hear from you sort of in this vein of how do we get members to the right setting that will really meet their needs and be best for them? How do you work with managed care plans both to divert SNF's days and maybe take some of those individuals, as Chris was talking about, who don't need to be in a skilled nursing facility, but support them elsewhere. And then also, what are some of the tools that you can do to help support transitions out of a SNF to home, and what are the services that you offer to help really make that community setting as successful as possible?

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Anwar Zoueihid – 50:40	Sure. Sure. And you're exactly right. It's really about leveraging our relationship with the managed care health plans to obtain those referrals while they are working on Transitional Care Services at their level, be a bit more proactive to identify members that are at risk and even be embedded within the hospitals, letting them know that you exist so that they could provide you this information. Sometimes people are in the hospitals and the health plans are not aware of it, and we are aware of it beforehand because of our relationship with the local hospitals. We like to focus on person-centered care by assessing and identifying the needs of services. And again, blending and braiding is always key for us to make sure that they're receiving the appropriate services for any SNF diversion services. When you look at the services that are available right now in the state, a lot of them are really focused on SNF diversion services and leveraging the health plans to tap into some knowledge that we are not aware to care coordinate.

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Anwar Zoueihid – 51:55	Like Dr. Esguerra was mentioning, the SNF service idea, the transfusion at the home, leveraging the state services, including the establishment of a medical home to ensure that the member receives the rehab services, the medical and social services in the comfort of their own home, including IHSS, home health, assisted living again, and concrete living facilities if appropriate. In terms of tools, we really leverage our relationships. It goes back to relationships and our knowledge of available programs, whether it be our programs or not, it doesn't really matter. We have a no wrong door approach to all services, so people know us. They would call us. If we don't have that Community Supports program because we don't do all 14. We know people that do. So we then coordinate that referral to them. We leverage the data and from the managed care health plans from the medical groups, medical groups are very underutilized, by the way. They have so much data that it really helps us do our job much better. Hospitals and SNFs again, and working with family and landlords to ensure that the home is ready for an appropriate transition of care service.
Slide 21	Palav Babaria – 53:15	Thank you so much. And I think we're running up on time. I think both of you touched upon this in this section about how you are holistically coordinating care, leveraging all the services, any sort of pearls of wisdom, top one or two lessons learned after years of doing this that you would like to share with our group today of how you coordinate across all the services and partners?

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Chris Esguerra – 53:40	I think Anwar and I very much have been hammering on the importance of the relationship and collaboration. I think there's also this other piece I go back to with two key mindsets I think that definitely it's been clear for us at Health Plan of San Mateo, the one is very much of a learning stance and curiosity and consistently questioning, "Does it have to be this way? Can we think about something else?" And so related to that is this other mindset of we actually have a lot more resources than we think we do. And so it's just really this coming from this place of abundance, and I totally get it Anwar, right?
Slide 21	Anwar Zoueihid – 54:20	Yeah.
Slide 21	Chris Esguerra – 54:20	That place where you're like, "Oh, my gosh, there's nothing I can do." Well, actually it turns out there is if we start asking questions in a different way and starting to ask of our partners different things. And so there is that systems level work. And I think that's the other component of bringing all the partners together. And we did that at the beginning. We have some of that still happening pretty regularly where, again, outside of the plan, outside of even our partners, we also work with the county and aging and adult services and all of that to be able to call on each other, to ask each other to do better and to give that kind of feedback. And I think that kind of trusted systems level partnership matters, too.

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Anwar Zoueihid – 55:04	And I echo what Dr. Esguerra said. It really comes down to relationship and very much transparency and working with all stakeholders. Other CBOs, we're not competing, like I mentioned earlier, we're better together. Learning how each other operate. How does a managed care health plan operate? I mean, I've never worked for a managed care health plan. I've always been at CBO level care manager type of guy, but now I know how each health plan works. And guess what? They work differently, too. They're not all standard. Same with CBOs, but being very transparent on how we're operating financially, showing them even our pay scales so that they could really help us and understand, "Oh, you need a little bit more of this." And we actually educate the health plans or hospitals about what's out there in the community for them to leverage as well. Communication, transparency, it's really so important. It does really make our services and our staff much happier knowing that they're not doing this on their own. They have a huge team from clinicians at the physician's office, from the managed care health plans. We're all in it together.

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Palav Babaria – 56:36	Perfect. Well, just thank you both so much for joining us today. I know we have these webinars and we always run out of time because I think we could spend all day really digging into all these details. But a few themes which you both have touched on is all of this works at the pace of trust. And I know individuals and you know who you are. Come to me often to ask for DHCS's help on something. And my first question is always, have you talked to your plan partner? Have you talked to your provider partner? And often the answer is no. And so it really starts with locally, how are we talking? How are we collaborating because it is going to take a village to implement these changes? And Chris, as you said, "How are we questioning some of that long-established convention and saying, does it truly have to work this way? Is there a better way?"
Slide 21	Palav Babaria – 57:21	And unless anyone on this call thinks our healthcare system is a well-oiled machine, there is a ton of-
Slide 21	Chris Esguerra – 57:26	Yeah.
Slide 21	Palav Babaria – 57:27	... opportunity for improvement. I recognize we did not get to all of the audience questions. We've captured all of those and where possible, we'll definitely issue FAQs and try to clarify some of the questions in future meetings. I also saw, I think there were some questions about individual members. If there's a specific member or patient question about a specific case, please reach out to your managed care plan, if that is ineffective, we also have a Managed Care Ombudsman. The phone number is listed on the DHCS website and we can definitely help navigate through individual situations. But thank you all so much for joining today and hope everyone has a lovely rest of day.

VISUAL	SPEAKER – TIME	AUDIO
Slide 21	Anwar Zoueihid – 58:09	Thank you.