



CalAIM Academy for Hospitals and Health Systems

Session 2: Hospital's Role in CalAIM Leadership
Wednesday, February 26, 2025 | 12-1:30 p.m.



Academy Facilitators



Dora Barilla, DrPH
PRESIDENT, CO-FOUNDER
HC² Strategies



Rick Rawson, MBA
CHIEF STRATEGIST AND CO-FOUNDER
HC² Strategies



Julie Miller-Phipps
CEO, PRINCIPAL CONSULTANT
Collaborative Innovation Partners



Introduce Yourself!

Chat in your...

- Name
- Role
- Organization
- Location
- & *Your favorite place to vacation within California*



The aim of the CalAIM Academy for Hospitals & Health Systems is to create a **broad cadre of hospital and health system leaders** who understand the unique **opportunities presented by CalAIM** transformation efforts and are **primed to partner** across the health care sector to collectively **improve the health of Medi-Cal members.**

Our Six-Session Arc

1

Introduction &
CaAIM Overview

2

Hospital's Role in
CaAIM
Leadership

3

Building CaAIM
Infrastructure

4

Coordination in
Community-
Based Health Care

5

Payment Models
for the Future

6

Bringing It All
Together

Academy Logistics

- Continuous participation
- Discussion-based breakouts
- Recording calls (not breakouts)
- Accessing resources
- End of Call Feedback Survey
- Participants may earn:
 - 1.0 ACHE Qualified Education Hour per session
 - 1.0 BRN Credit per session for sessions 2, 3, and 4

The screenshot shows the website for Communities Lifting Communities. The header includes the logo, a search bar, and navigation links: WHO WE ARE, WHAT WE DO, EDUCATION & DEVELOPMENT, NEWS & EVENTS, SUPPORT US, and CONTACT US. The main content area is a purple banner with the text "EDUCATION & WORKSHOPS" and "Roundtables, Webinars, Podcasts, Workshops". Below this is a "View All" button with a dropdown arrow. Three event cards are visible: "Education and Workshops" for "BUILDING BRIDGES: ADVANCING SUPPLIER DIVERSITY IN HEALTH CARE" on Thursday, September 26, 2024, at Quiet Cannon; and two "Workshop" cards with images of hands.

<https://communities.hasc.org/education-workshops/>

Academy Norms

1. **Build connections** – use the chat box to connect and exchange contact information with others.
2. **All teach, all learn** – we all have something we can learn, and we all have something we can teach others.
3. **Create a safe space** – for sharing of learnings, challenges, and vulnerability.
4. **No sales, please** – this is not a space to sell your product or technology to others.
5. **Own this with us** – bring your questions and ideas for improvement.



Today's Objectives

- Define the hospital's role and leadership in community-wide delivery systems.
- Strategize how to gain buy-in and will from others around CalAIM.
- Illustrate a coordinated, multi-departmental, systems approach to CalAIM implementation within the hospital.
- Discover how ECM and Community Supports providers can be integrated into the hospital to accelerate connection to services.



Today's Agenda

Welcome to Session 2

Hospital's Role in CalAIM Leadership

Bright Spot: Rady Children's Hospital

Questions/Full Group Discussion

Closing

Breakouts



Hospital's Role in CalAIM Leadership

What We'll Cover

- Building a Connected Community of Care
- The role of the hospital in building an ecosystem for serving Medi-Cal patients
- The role of key players in the hospital setting in CalAIM and how they come together
- Gaining buy-in around CalAIM
- A takeaway tool for board engagement
- Peer to peer learning

CalAIM Overview: Goals

CalAIM is a long-term commitment to transform and strengthen Medi-Cal, making the program more equitable, coordinated, and person-centered to help people maximize their health and life trajectory.



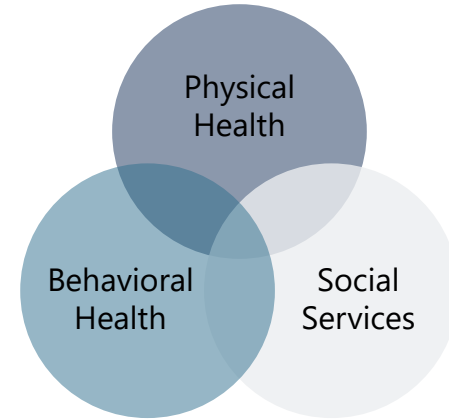
Implement a whole-person care approach and address social drivers of health.



Improve quality outcomes, reduce health disparities, and drive delivery system transformation.



Create a consistent, efficient, and seamless Medi-Cal system.



Our journey to a healthier California for all

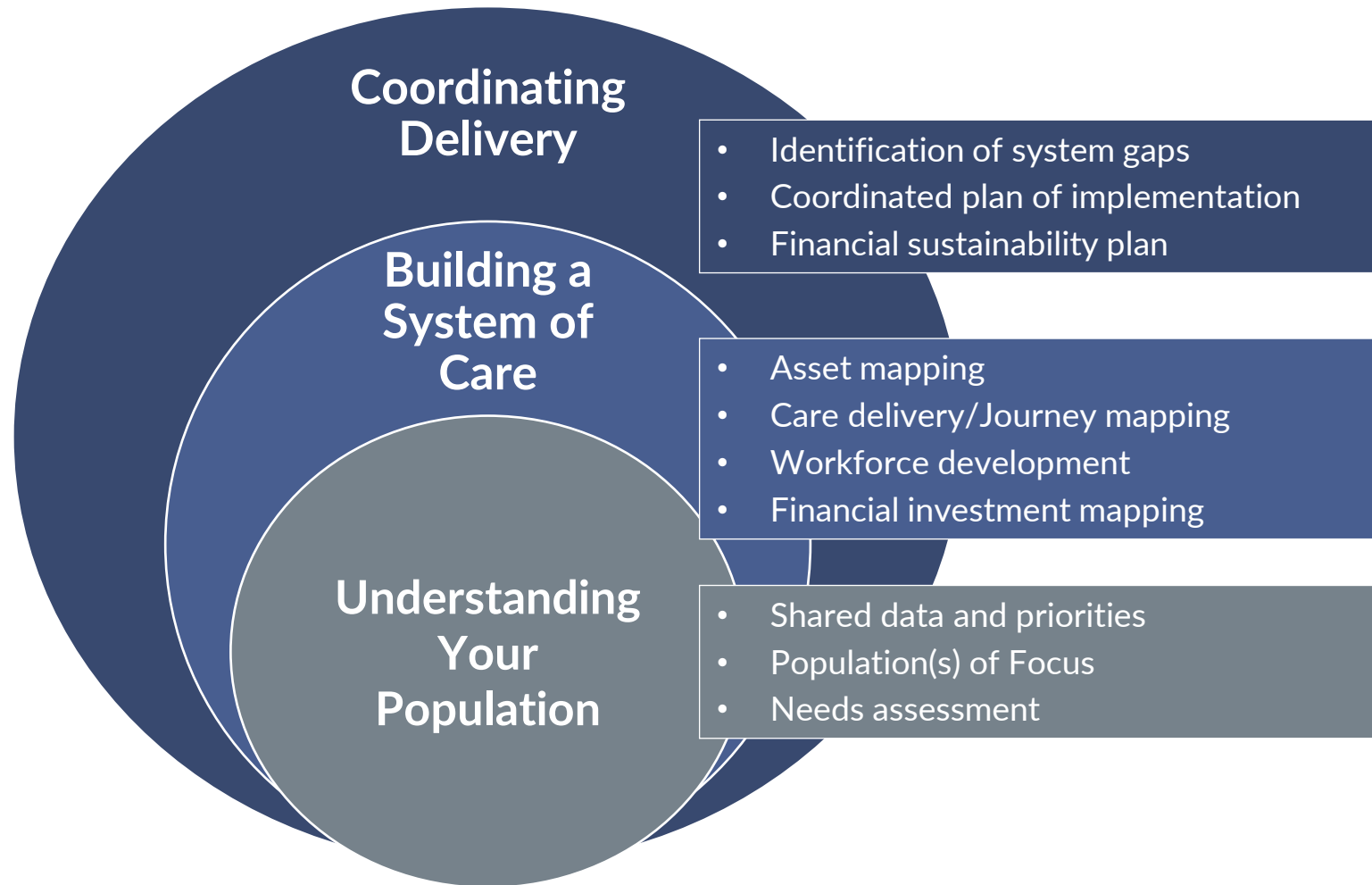
Building a Connected Community of Care



Providers from different organizations who care for their community members together by structuring, coordinating, and integrating their services for maximum effectiveness.

Building a Connected Community of Care

CalAIM as a Community of Care for Socially Complex Communities



<https://pubmed.ncbi.nlm.nih.gov/34524769/>

A Paradigm Shift in Building Ecosystems

Culture

- Mission
- Executive sponsorship
- The external environment

Incentives

- CalAIM funding
- Appropriate utilization
- Quality improvement
- Value-based care



Structure

- Organizational Infrastructure and developing new service lines
- Building a system of care in partnership with community
- Data

Competencies

- Staff and team roles
- Integrating workflows to address high utilizers and ED challenges
- Integration of social and clinical care

The Roles of a Hospital in CalAIM

- Contract as an ECM and/or Community Supports provider
- Make referrals into the CalAIM ecosystem
- Co-create a community-wide delivery system

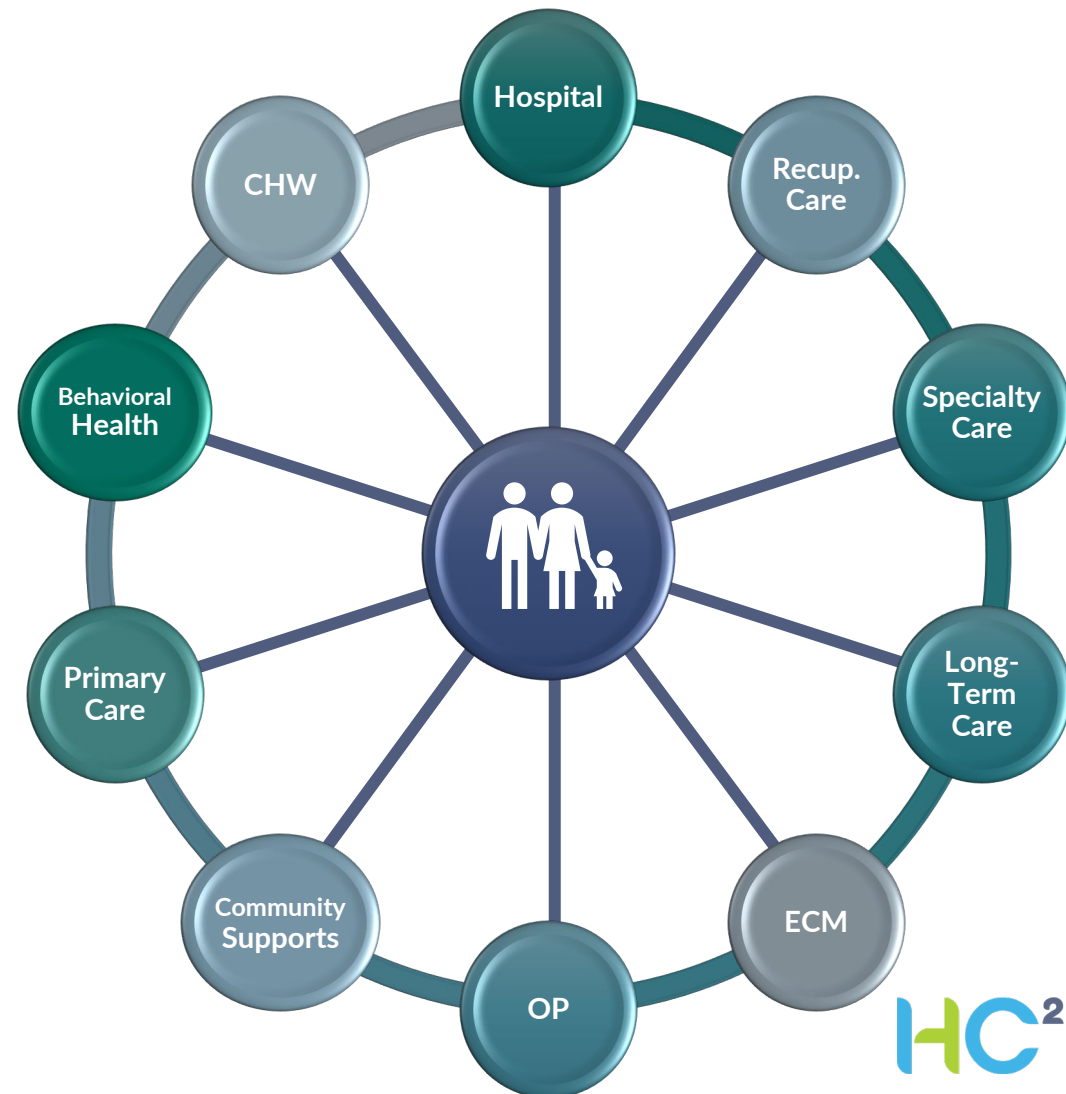
Every hospital has a role in Medi-Cal transformation!

System Integration as a Pre- and Post-Acute Care Strategy

Person-Centered Integrated Model

- Alternative, person-centered, intentional transitions and post-acute care strategies integrated into systems
- Value case: saves money and keeps members at home
- Build relationships to ensure successful transitions of care for patients.

[Transitions of care policy](#)



What are Community Supports?

Community Supports (CS) are non-medical, wrap-around services provided as a substitute or support to avoid other Medi-Cal covered services such as emergency room visits, an avoidable hospital or skilled nursing facility admission, or a discharge delay.

Supports for Housing Insecurity 	Supports to Keep People at Home 	Supports to Improve a Chronic Condition 	Support to Recover from Acute Intoxication 
Primary Audience: Individuals experiencing homelessness	Primary Audience: Individuals at risk for institutionalization in a nursing home	Primary Audience: Individuals who have certain chronic conditions and require support	Primary Audience: Individuals found publicly intoxicated to divert from jail or the Emergency Department
<ol style="list-style-type: none">1. Housing Transition Navigation Services2. Housing Deposits3. Housing Tenancy & Sustaining Services4. Short-Term Post Hospitalization Housing5. Recuperative Care (Medical Respite)6. Day Habilitation7. Transitional Rent (starting in 2025)	<ol style="list-style-type: none">8. (Caregiver) Respite Services9. Nursing Facility Transition/ Diversion to Assisted Living Facilities10. Community Transition Services/ Nursing Facility Transition to a Home11. Personal Care & Homemaker Services12. Environmental Accessibility Adaptations (Home Modifications)	<ol style="list-style-type: none">13. Meals/Medically Tailored Meals14. Asthma Remediation	<ol style="list-style-type: none">15. Sobering Centers

More information: [Community Supports Policy Guide](#)

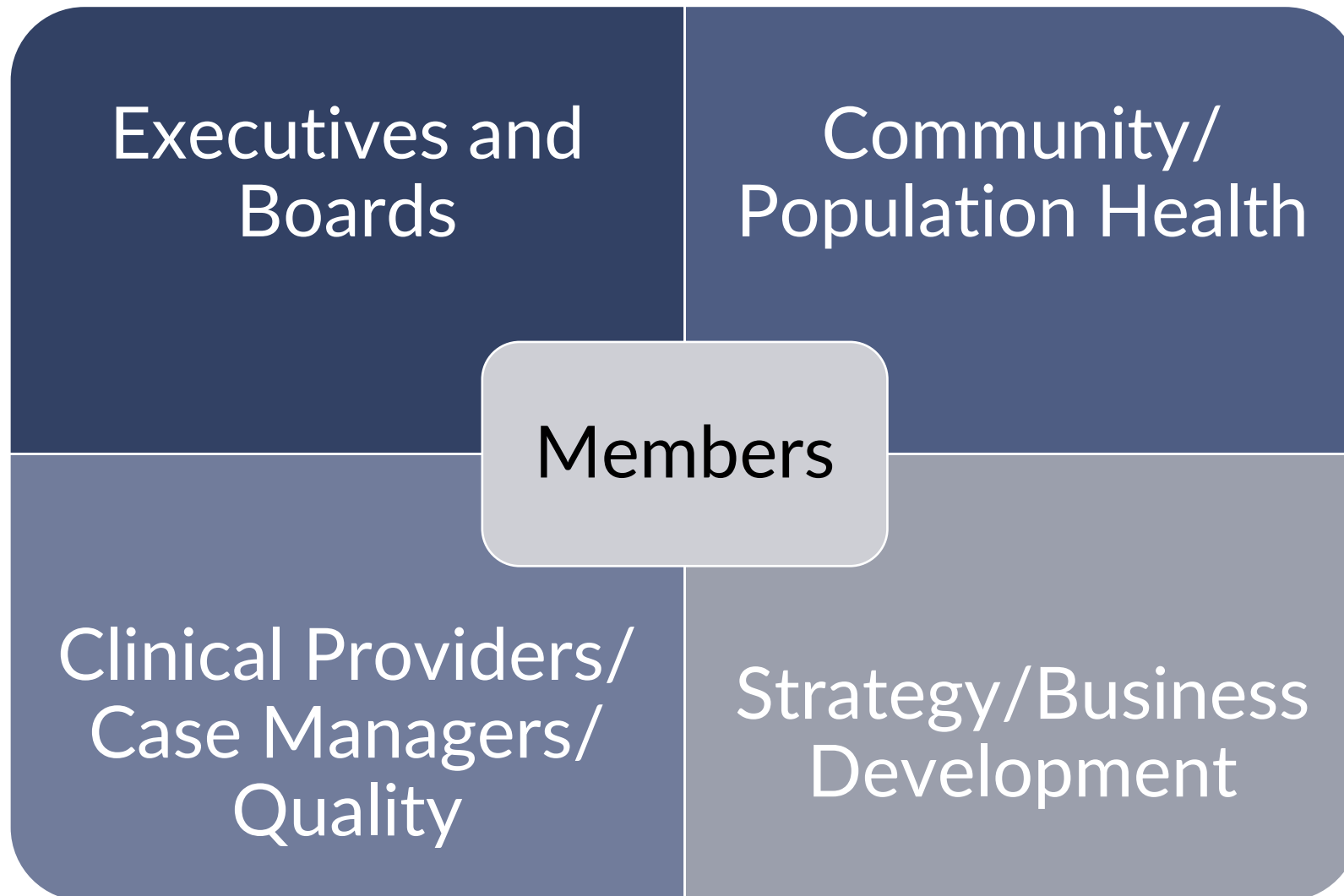
Poll: What Is Your Role?



Please select the answer that *most closely* aligns with your role

- a) Executives and Boards
- b) Community Health/Population Health
- c) Clinical Providers/Case Managers/Quality
- d) Strategy/Business Development
- e) Other (and chat in your role)

Roles of Key Players



All roles connect to the same strategic imperative

Real Examples of CalAIM



Enloe Medical Center
(Chico, CA)



Colusa Medical Center
(Colusa, CA)



Marshall Medical
Center (Placerville, CA)

Generating Buy-in for CalAIM



Speak their language



Present the key benefits



Use data and metrics



Address their concerns



Create a clear implementation plan



Leverage stakeholder support



End with a call to action



Speak Their Language



- CEO Focus:
 - ✓ Organizational growth
 - ✓ Competitive positioning
 - ✓ Community impact
- CFO Focus:
 - ✓ Financial sustainability
 - ✓ Cost reduction
 - ✓ Return on investment (ROI)



Present Key Benefits of CalAIM



Use Data and Metrics



✓ Show **ROI models & financial projections** comparing short-term costs vs. long-term savings

✓ Highlight **real success stories** with **quantifiable improvements** in:



Patient outcomes



Cost reductions



Patient Satisfaction

Address Their Concerns



For the CEO

- ✓ Reputation boost
- ✓ Innovation
- ✓ Leadership in Medi-Cal transformation
- ✓ Market position

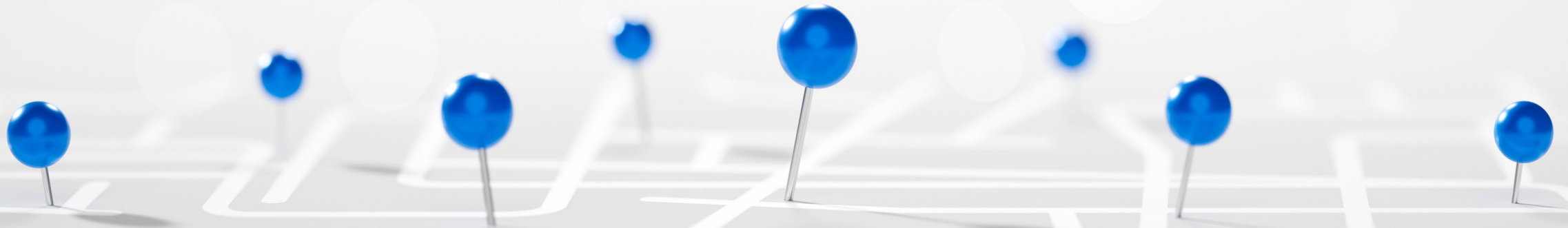
For the CFO

- ✓ Cost breakdown
- ✓ Funding sources
- ✓ Timeline for return on investment
- ✓ Risk mitigation

Create an Implementation Plan



- ✓ **Phased approach for gradual scale-up**
- ✓ **Key stakeholders, funding, and technical assistance**



Leverage Stakeholder Support



Endorsements
from industry leaders,
policymakers, and
community partners who
support CalAIM



Testimonials
from healthcare providers
or executives
with positive outcomes in
similar initiatives

End With a Call to Action



Emphasize **urgency**

- ✓ Act now to stay competitive and align with state initiatives!



Propose an **immediate next step**:

- ✓ Conduct a feasibility study
- ✓ Form a task force
- ✓ Engage a consultant

Takeaway Tool for Board Engagement

Look out for an example deck in the follow-up email that can be used/adapted in a presentation to your board

Enhanced Care Management

CaAIM Academy

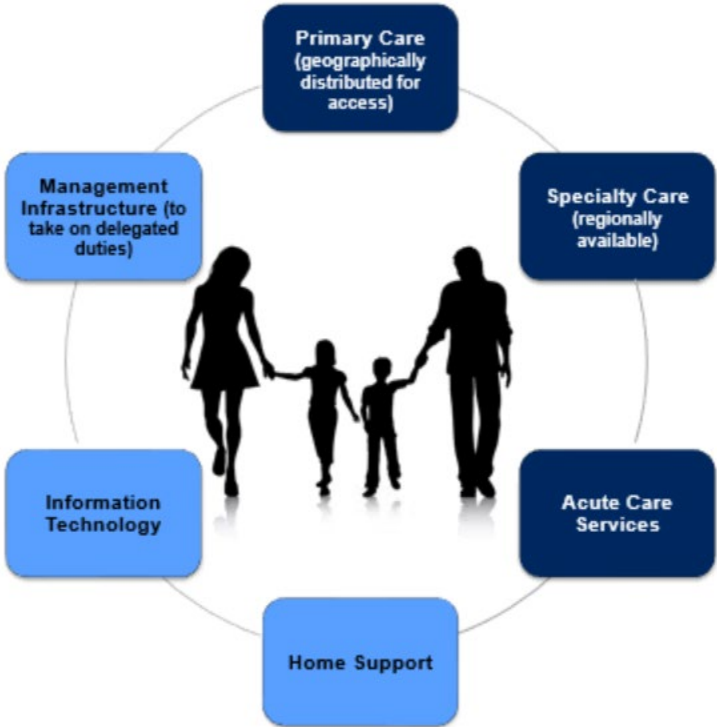
Keri Carstairs, MD MBA

VP of Network Operations & Clinical
Integration, Chief Population Health Officer

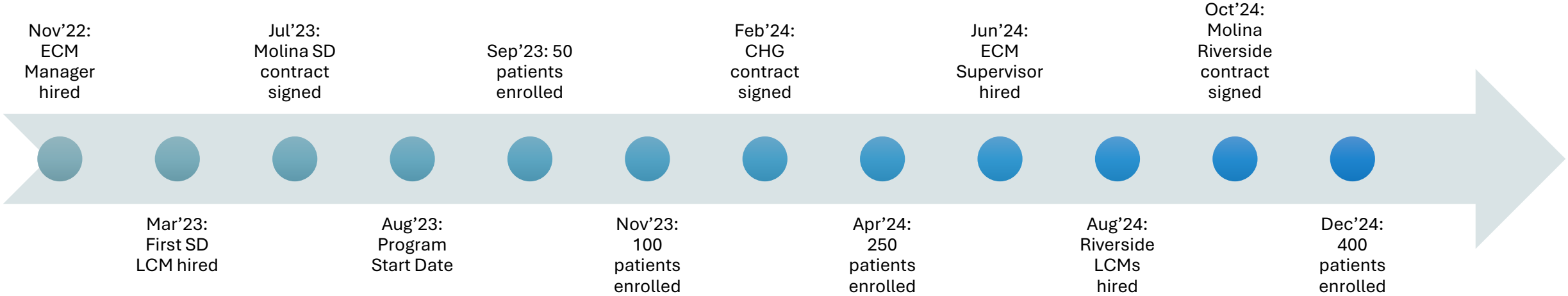
February 26, 2025



Clinically Integrated Rady Children's Health Network



Rady Children's ECM Program Timeline



Who We Serve For ECM

Contracted Plans

- **Molina – SD County** (July 2023)
- **Molina – Riverside County** (October 2024)
- **Community Health Group** (February 2024)
- **Blue Shield Promise** (finalizing contract)
- **Inland Empire Health Plan** (finalizing contract)

Regions Served

- **San Diego County**
- **Riverside County**

Populations of Focus

- **Children & Youth Enrolled in CCS**
- **Individuals at Risk for Avoidable Hospital/ED Utilization**
- **Children & Youth Involved in Child Welfare**
- **Individuals with Serious Mental Illness & Substance Use Disorder Needs**
- **Individuals & Families Experiencing Homelessness**
- **Pregnant & Postpartum Individuals at Risk for Adverse Perinatal Outcomes**





RCHSD ENHANCED CARE MANAGEMENT

Staff Tip Sheet



WHAT IS ENHANCED CARE MANAGEMENT (ECM)?

Enhanced Care Management (ECM) helps coordinate care for complex care and socially vulnerable populations using a whole child approach by including the patient, the family, and all providers in the care planning process regardless of setting (e.g., Primary, Specialty, Acute, Behavioral, Oral).

WHAT ARE THE ECM ELIGIBILITY REQUIREMENTS?

To be eligible, patients must be under 18 years old,* reside in **San Diego** or **Riverside County**, be an active Medi-Cal member (**Molina** or **Community Health Group**), and fall under one of the following populations of focus:

PHASE I

- Children and Youth Enrolled in California Children's Services (CCS) with Additional Needs Beyond the CCS Condition**
- Individuals At Risk for Avoidable Hospital or ED Utilization
- Individuals with Serious Mental Health and/or Substance Use Disorder Needs

Benefits of RCHSD ECM Services



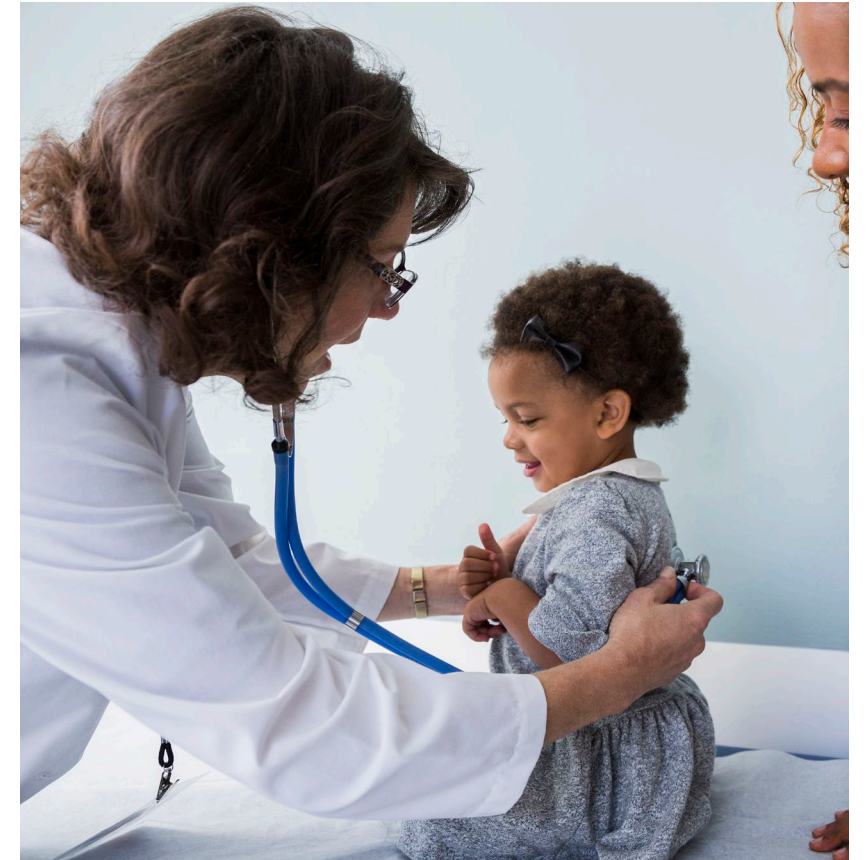
Identification of patients in need and ability to provide rapid interventions



Direct communication with care teams and reduction of clinic staff burden due to coordination of care



Resulting in improved patient outcomes



Enables clinic staff to devote more time and attention to direct patient care

Benefits of Rady Children's ECM

Partnership with our Clinical Care Teams

- Shared Electronic Medical Record
 - Built in referral process for expedited enrollment
- Shared Care Planning
- Quick Connections to Primary and Specialty Care Teams
- Ideal for kids with chronic illness being followed at Rady's
- **90%** referrals are internal
- **93%** enrollment rates after referral



Our Lead Care Managers

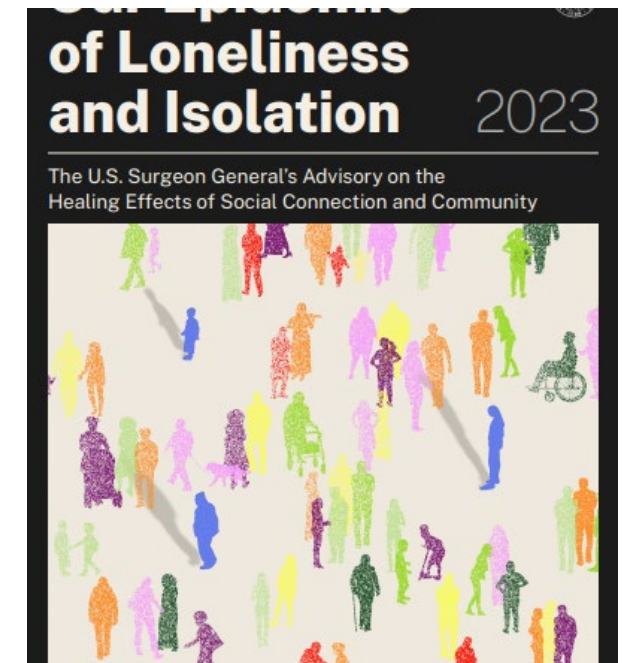
Lead Care Managers (1 LCM: 45 Patients)

- Connected to the Community
- Diverse Lived Experiences
- Experience in Patient Populations Served (Dev Services, Mental Health, Autism, Mother/Baby, Justice Involved, Resettlement)
- Multiple Languages Spoken (English, Spanish, Pashto, Dari, French, ASL)
- Trained in Person Centered Care and Cultural Sensitivity



Improving Peer and Community Connections

- Youth transitioning from social isolation due to the pandemic, still reporting concerning levels of loneliness, communication issues, social anxiety, bullying, and high-performance expectations
- Fostering Peer Connection (music, art, physical activity, support groups, community events)
- Patient Spotlight
 - Teenager living with schizophrenia referred to ECM from outpatient psychiatry, with justice involved mother, not attending school, not taking medications
 - LCM connected him to an all-inclusive scholastic learning environment with focus on academic behavioral and mental health support systems



ECM Program Summary

Start Date: August 2023

612 patients enrolled historically

- Active: 457
- Disenrolled: 119*
- Graduated: 36

62% Molina, 38% CHG

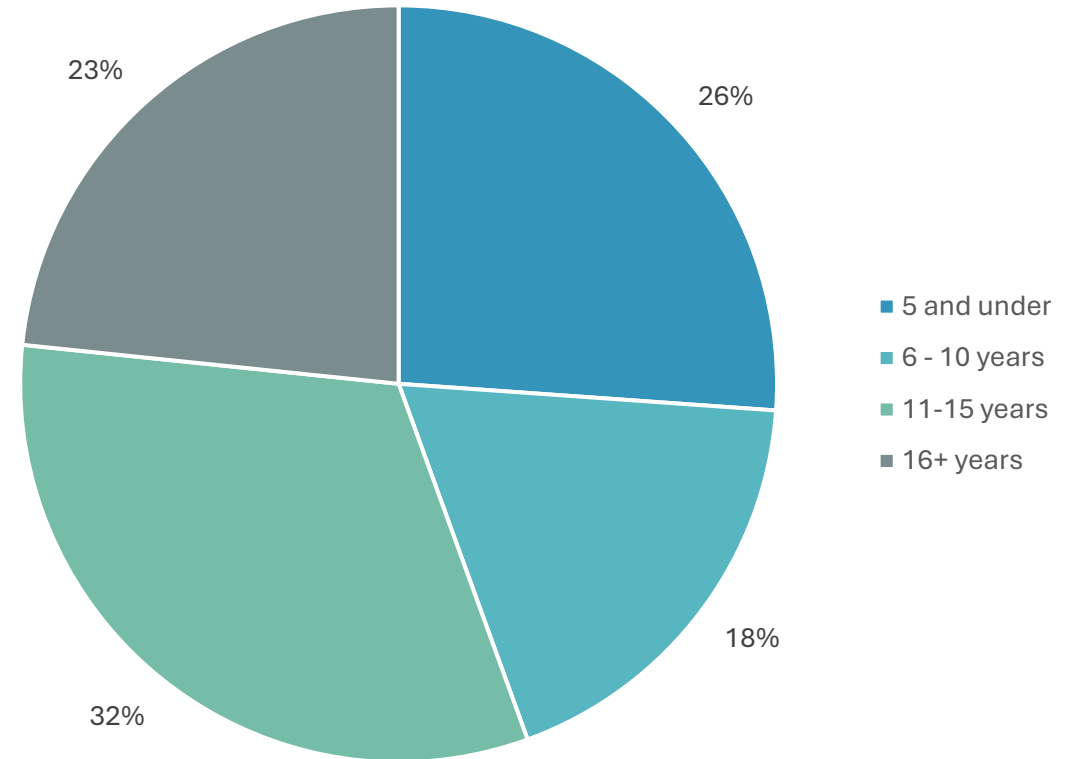
97% SD County, 3% Riverside County

60% enrolled in CCS

45% non-English speaking

967 referrals received (90% Internal, 10% External)

Ages Served (N=612)



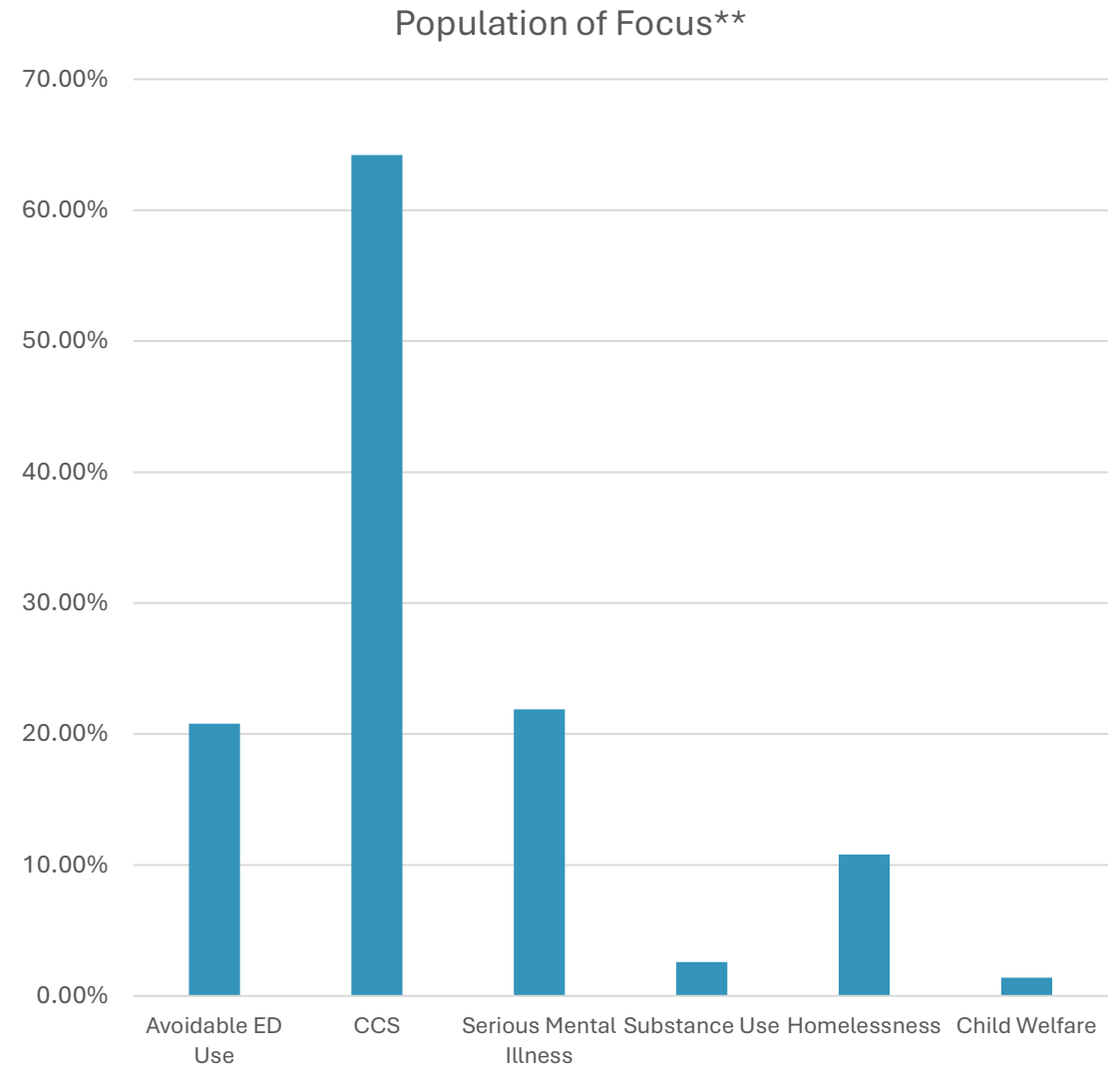
*Reasons for disenrollment include Loss of Coverage, Moved Out or Area, Opted Out, Unable to Contact, Deceased

**data as of 02/19/2025

Current ECM Membership

- 457 Active Members*
 - 14 Riverside, 443 San Diego
 - 64% Molina, 36% CHG
- 257 referrals received last quarter (Oct – Dec 2024)

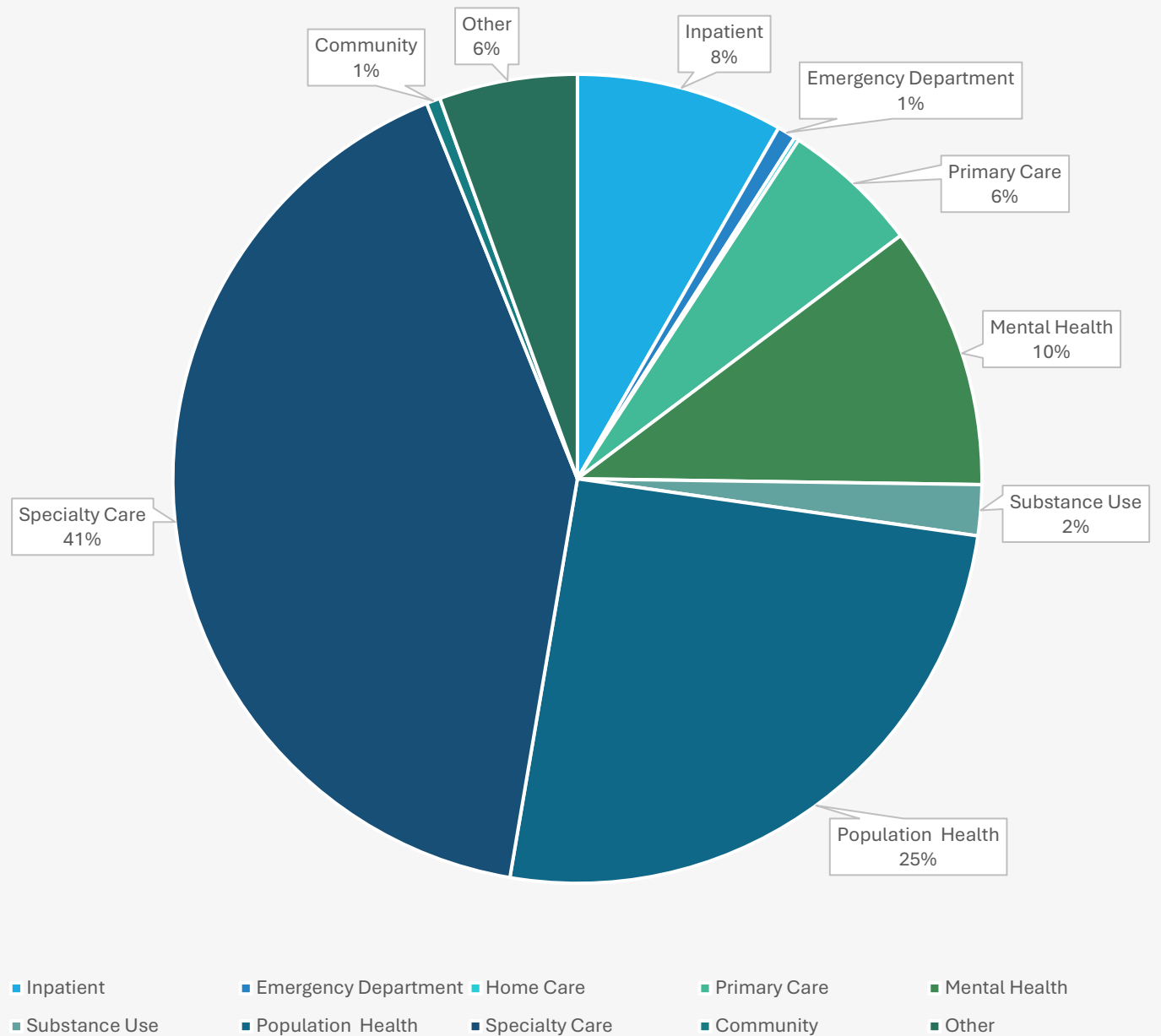
Time from referral to authorization request ~ 17.5 days (Range: 0-64 days)



*data as of 02/19/25

**patients may fall under multiple populations

Internal Referral Source Breakdown (N = 543)

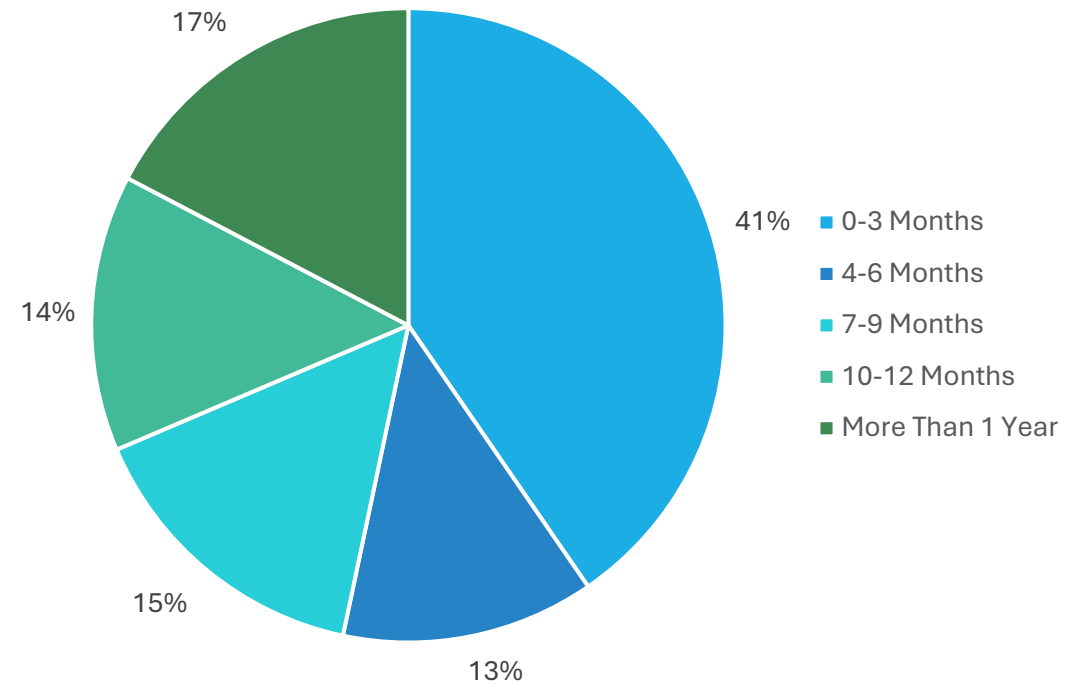


*data as of 02/13/2025

ECM Member Retention

- 68% of Members Retained after 6 Months (Since September 2023)
- 102 Members Enrolled More Than 1 Year
- 36 Members Graduated
 - All care plan goals were met, and member is ready to transition to a lower level of care

Total Time Members Enrolled in ECM (N=588)



**data as of 02/13/2025*



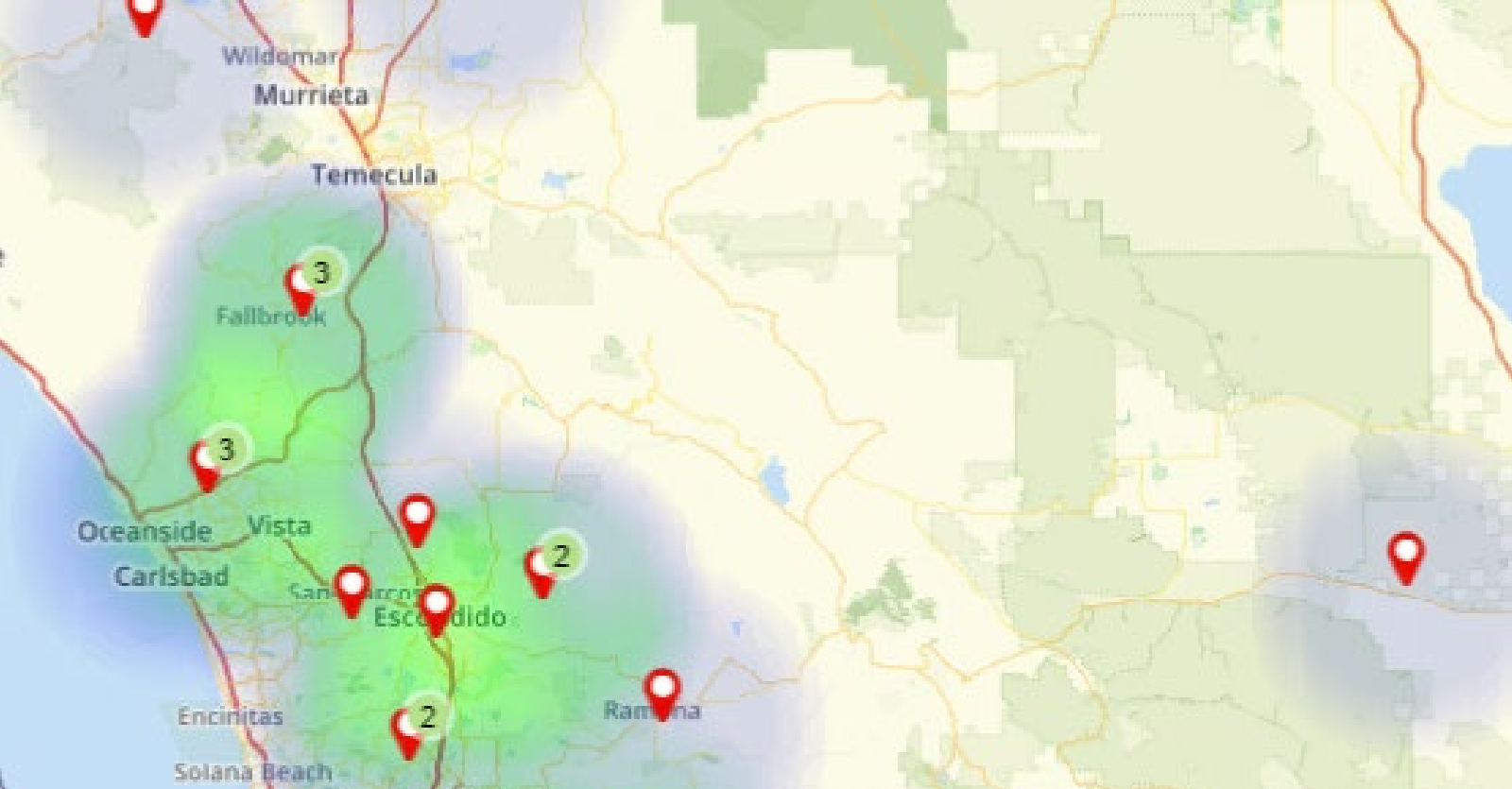
Social Drivers of Health (n=448)

66.7% of members screened positive for at least one SDOH:

- Food Insecurity: **53.5%**
- Transportation Issues: **31.8%**
- Housing Instability: **47.2%**



**data as of 02/13/2025; of those who were screened for SDOH*



Food Navigation Program

- **92%** families that engaged with Food Navigation and were successfully connected to at least 1 resource.
- **2,208** patients have been outreached to for Food Navigation Services since program launch in 2021
- Aided in the distribution of **approx. 6,818 pounds of food**
- Emergency food funding (gift cards) provided to **90 families**



“
Thank you for your services!
I didn't realize there were
so many food banks less
than a mile away from my
home!
- Rady Children's Family

After using our services,

- **90%** of families were successfully connected to at least one resource
- families reported feeling **more comfortable** using food banks near their homes
- families felt comfortable **seeking assistance** with Hunger Free Navigators



CONTACT US

858-966-1700 ext. 241283
foodnavigation@rchsd.org
 3020 Children's Way,
 MC5149
 San Diego, CA 92123

FOOD RESOURCE ASSISTANCE
 at Rady Children's Hospital

Here to help you access Cal Fresh, WIC, local food banks, and more!





Closed Loop Community Referrals

- **Resource/Donation Distribution**
 - 250 backpacks
 - 150 therapeutic toolkit bags
 - 275 food bags
 - 100+ holiday gifts
- **Community Supports (Housing)**
 - 100+ families have been referred for housing via MCP Community Supports and community-based organizations (i.e., La Maestra)
 - 31 families were successfully connected to housing/housing navigator
- **Social Drivers of Health**
 - 145/170 (85%) members were successfully reached by the Rady Children's Food Navigation Program
 - 350+ rides to appointments were arranged by LCMs (approximately 3-7 per week)
 - 100+ referrals to "Other" resources such as IHSS, CalWorks, utilities, legal, internet, gas vouchers, hotel vouchers, diaper banks, conservatorship, etc.

Community Connections

La Maestra Community Health Centers

- Housing
- Transition to Adult ECM

Center for Autism and Related Disorders (CARD)

- ABA Therapy Services

Equip Health

- Eating Disorders

Community Research Foundation (CRF)

- Transition to Adult ECM

Anderson Center for Oral Health

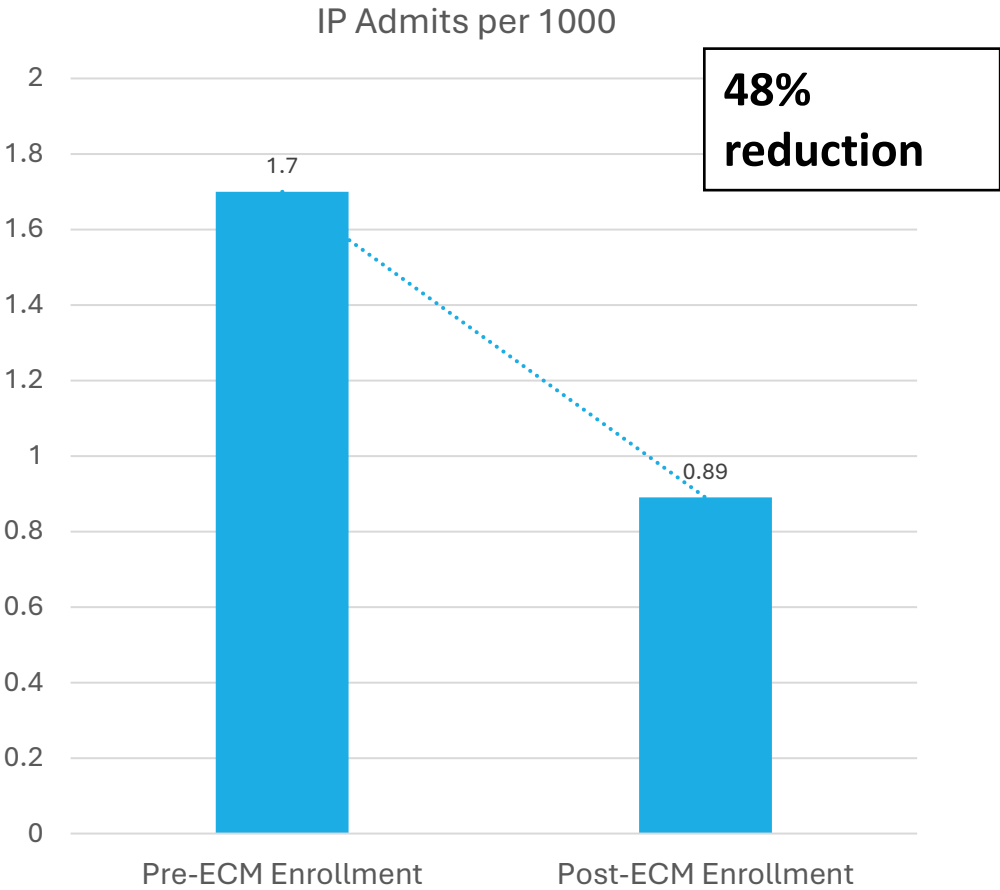
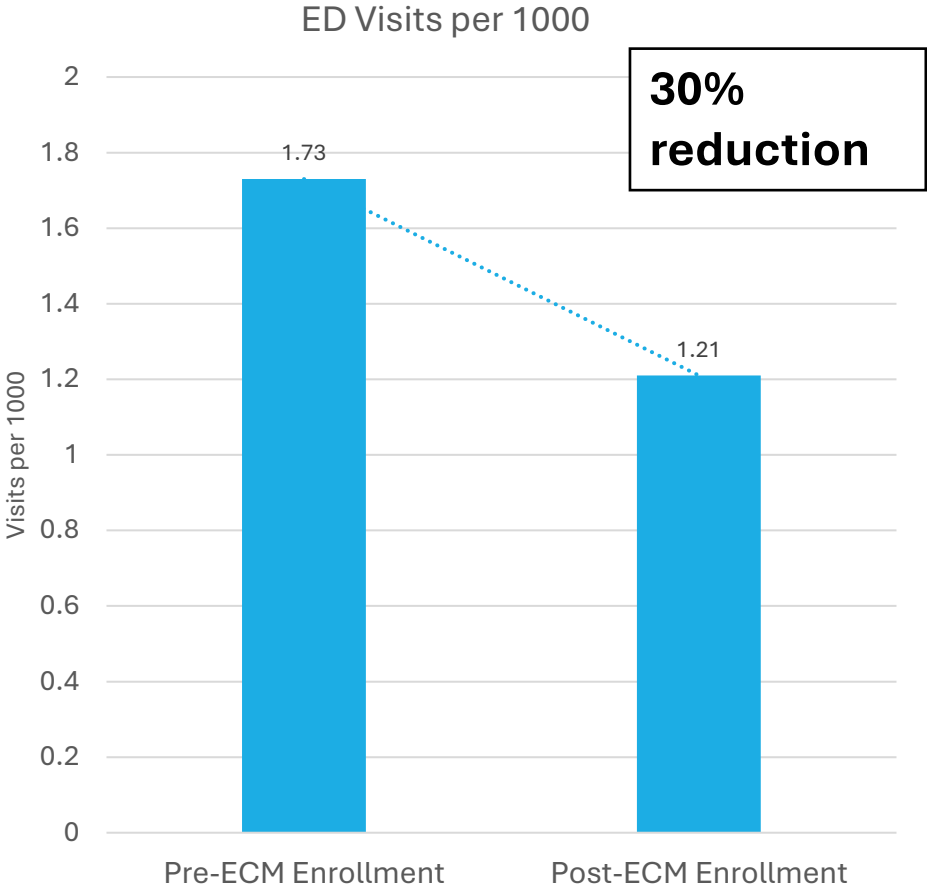
- Dental Navigation

Emilio Nares Foundation

- Connection to Basic Needs (i.e., Food, Housing, End of Life Care, Transportation)

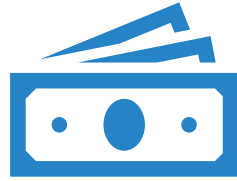
Established closed-loop referral workflows with direct point of contacts for follow-up

ED and IP Visits per 1000 Pre v. Post ECM Enrollment



*data as of 02/13/2025

Fiscal Sustainability of ECM



Revenue Lines

Outreach Incentives

PMPM Capitation

Grants

- *CalAIM IPP Funding*
- *CITED (Round 2 and TBD Round 4)*
- *TBD TA Marketplace Vendor certification*

In-Kind

- *ECM fills a need for donors who wish to give in-kind to the Hospital to support social drivers of health and populations of focus*



Cost Containment

Reduction of costly ED visits

Reducing workload on Hospital clinical staff

Maximized LCM patient loads

Efficient task distribution between clinical/non-clinical staff

Grant spend down monitoring and regular reporting

Improved capitation performance for risk contracting agreements



Questions & Discussion

Discussion

What questions do you have about the hospital's role in CalAIM leadership?

Please chat in your questions/comments





Taking a Pause

The Hospital's Role in CalAIM

1	Contract as an ECM and/or Community Supports provider.	6	Align financial and administrative functions.
2	Make referrals into the CalAIM ecosystem.	7	Integrate data sharing and care.
3	Identify frequent inpatient and ED utilizers.	8	Advocate for Medi-Cal infrastructure in your community—partner with MCPs, county leadership, and CBOs.
4	Educate clinics and physicians on CalAIM services.	9	Send a representative to join local PATH CPIs to connect to information and supports.
5	Train providers and develop workforce	10	Integrate systems with other initiatives (i.e., transitions care policy).

Suggested Actions & Additional Resources

- Review existing committees and teams in your organization to see where CalAIM fits—or build an internal CalAIM team. Start talking internally about how to effectively integrate the CalAIM work at all roles/levels.
- [Join the PATH CPIs](#) to gain access to coaching/support and timely updates.
- Assess the current ecosystem for CalAIM in your community.
- Use the slides in this presentation as a takeaway tool to engage your Board, senior leadership, and others to buy into CalAIM.
 - We will ask for a report back in the next call from anyone who used the slides

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Bringing It All
Together

- Illustrate a coordinated, multi-departmental, systems approach to CalAIM implementation.
- Articulate redesigned, coordinated workflows for population identification, delivery of care, and care coordination models in the context of developments in the field.
- Relate CalAIM's alignment with solving health system pain points such as throughput, workforce, behavioral health and homelessness crises.
- Recognize the ways to build CalAIM infrastructure with sustainability at the forefront.

See you at Session 3!

Building CalAIM Infrastructure
Wednesday, March 12 | 12–1:30 p.m.

Stay on the line for optional breakouts



If you are not staying on for breakouts...

Please fill out our survey

Feedback will be incorporated into upcoming sessions and future iterations of the CalAIM Academy

*If you are staying on for breakouts...
do not complete the survey now and
stay on the line.*



Breakouts

Reminder: Academy Norms

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Self-Select Into A Breakout Room

Join the room that most closely aligns with your role

Room 1

- Executives and Boards

Room 2

- Community Health/
Population Health

Room 3

- Clinical Providers/
Case Managers/
Quality

Room 4

- Strategy/
Business Development



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Thank you!