CalAIM Academy for Hospitals and Health Systems

Session 3: Building the CalAIM Infrastructure
Wednesday, March 12, 2025 | 12-1:30 p.m.

COMMUNITIES LIFTING COMMUNITIES®

HOSPITAL ASSOCIATION of Southern California

HC² STRATEGIES HEALTHY CONNECTED COMMUNITIES

California Health Care Foundation

Let's Hear From You!

Chat in your…

- Name
- Role
- Organization
- Location
- *& Something that makes you proud to live in California*

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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.

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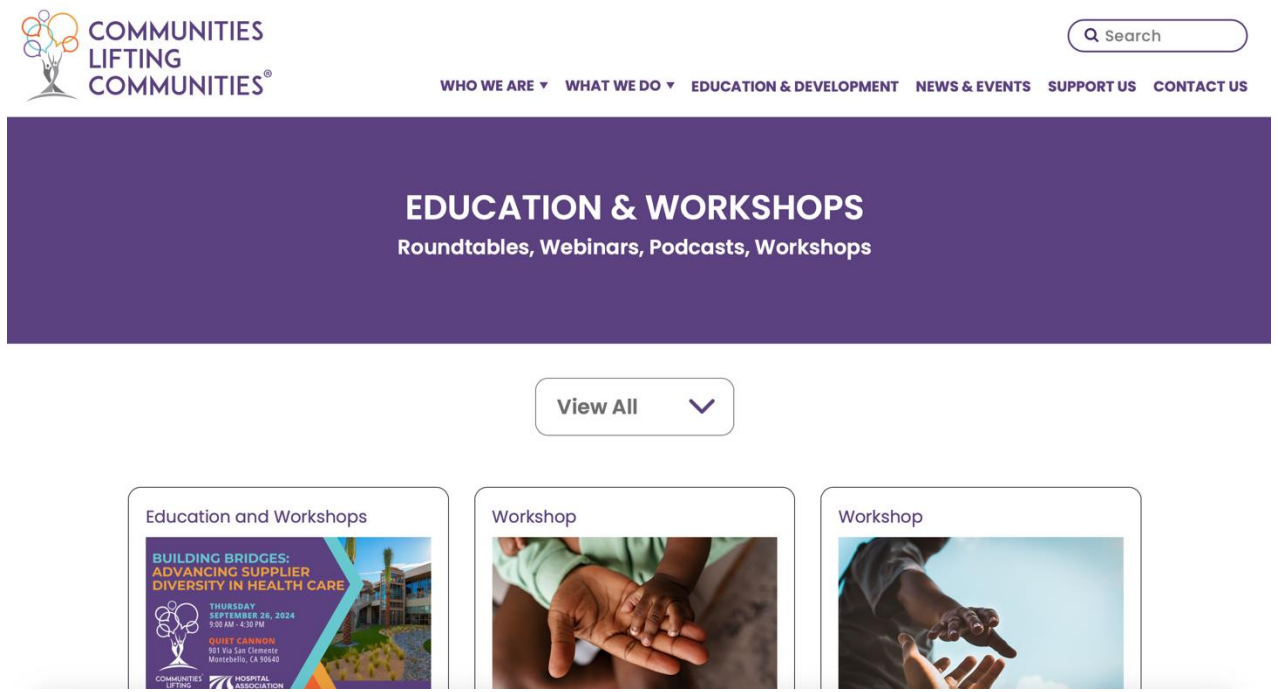
Academy Logistics

- 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



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

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Our Six-Session Arc

1. Introduction & CalAIM Overview
2. Hospital's Role in CalAIM Leadership
3. Building CalAIM Infrastructure
4. Coordination in Community-Based Health Care
5. Payment Models for the Future
6. Bringing It All Together

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Today's Objectives

- Illustrate a coordinated, multi-departmental, systems approach to CalAIM implementation within the hospital.
- Articulate redesigned, coordinated workflows for population identification, care delivery, and care coordination models in the context of planned and political 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.

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Today's Agenda

Welcome to Session 3

Building the CalAIM Infrastructure

Bright Spot Example: Adventist Health

Discussion/Q&A

Closing Announcements

Breakouts

Building the CalAIM Infrastructure

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

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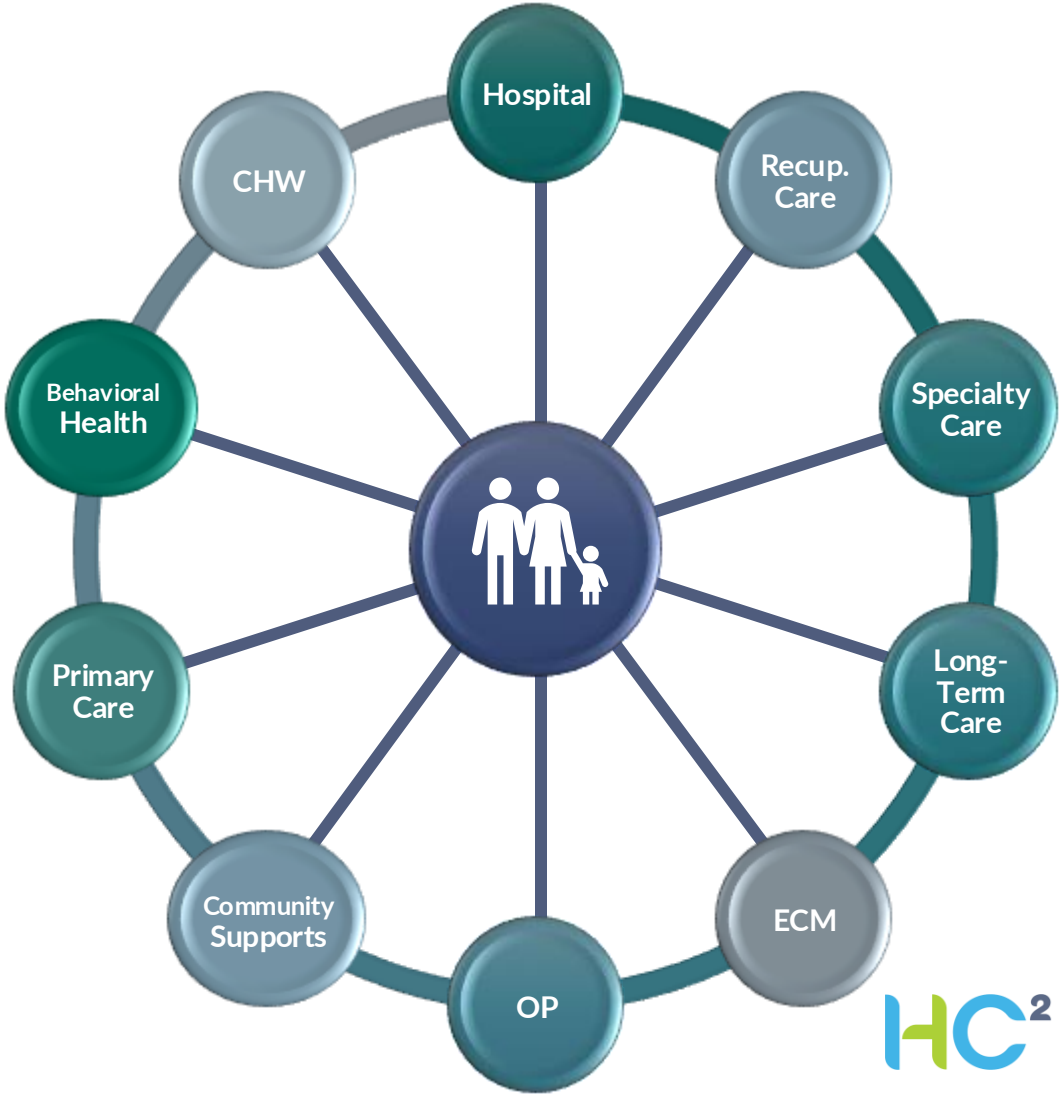
System Integration as a Pre- and Post-Acute Care Strategy

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



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The Hospital's Role in CalAIM

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

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Alternative Approaches to Integration

Set up a care delivery system with community partners (Horizontal Integration)

Contract and deliver services under CalAIM (Vertical Integration)

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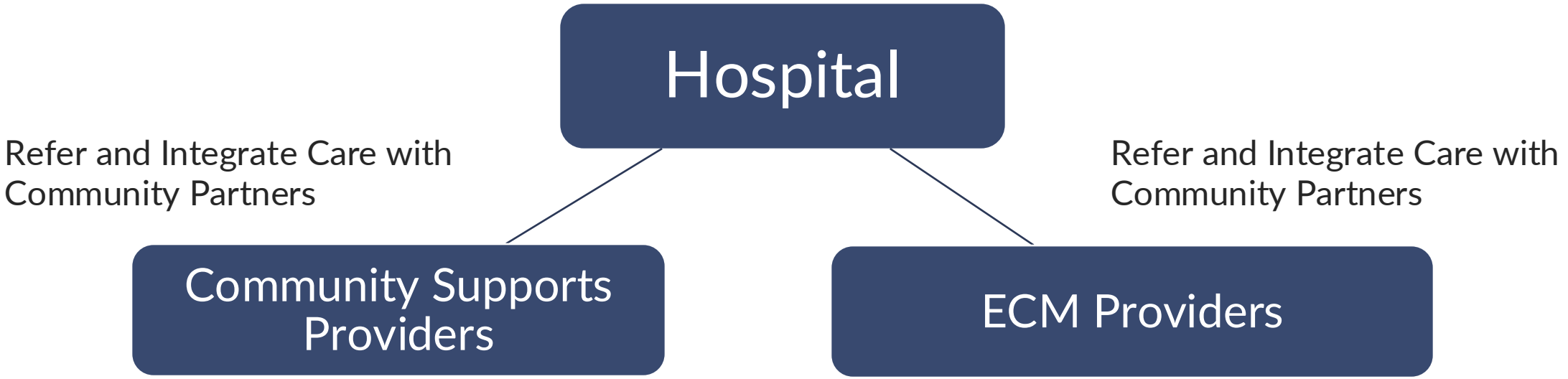
Horizontal Integration



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Getting Started: A Care Delivery System with Community Partners

1. Understand Patient Needs

- What services are available through CalAIM that meet the needs of your patient population?

2. Assess Your Environment

- Conduct an inventory of providers who are providing ECM and CS services in your service area.
- Understand what new services have been funded and do you make referrals to them.
- Learn how your region is building new systems of care with the CalAIM funding streams.

3. Build Partnerships with …

- Your county on behavioral health and substance use disorders.
- Your county and managed care plans on a regional community health needs assessment.
- Providers who are serving your local community and integrate their services.

More coming soon in Session 4!

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Vertical Integration

Develop ECM Services for targeted Populations of Focus (POF)	
Identify POF and develop services	Contract with Managed Care Plans

Develop Community Supports aligned with your members' needs	
Identify and develop community supports	Contract with managed care plans

Coordinate with community partners for other services not provided internally	
ECM services for POF not provided by hospital	Community Supports needed by members but not provided by hospital

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Getting Started: Contracting and Delivering CalAIM Services

1. Governance/Leadership
2. Assessment
3. Partnerships
4. Financing
5. Operations

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Governance/Leadership

- Build consensus with your internal leadership team
- Review existing committees and teams to see where CalAIM fits—or build an internal CalAIM team
- Identify existing meetings to support ECM/Community Supports implementation—or create one that collaborates across key departments in your hospital.

Key Roles for CalAIM Implementation

- Executive Sponsor
- Project Lead
- Case Management
- Finance/Reporting & Revenue Cycle
- Managed Care Contracting
- Project Leadership
- IT
- Other aligned departments

Assessment

How does CalAIM align with your mission?

What are you already doing that aligns with CalAIM?

What Populations of Focus stand out in your data?

What populations of focus or Community Supports reflect work you are currently doing?

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Partnerships

Build relationships and contract with Medi-Cal managed care plans (MCPs)

Coordinate with other CalAIM providers and referral partners

Join the PATH Collaboratives (CPIs)

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Operations

Build your team; understand staffing needs, workflows, trainings, and IT requirements.

- Value candidates with lived experience

Integrate the CalAIM work at all roles/levels.

- Case Management/Discharge Planning
- Emergency Department
- Social Workers

Develop policies, processes, and procedures around CalAIM implementation.

Take advantage of the TA Marketplace for off-the shelf resources that support program development.

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Finance

Understand the billing, reimbursement, and reporting necessary for services.

Assess available start-up funding opportunities (grants, CITED, IPP).

Align funding with existing value-based initiatives and community health strategies.

Access expertise and technical assistance to support implementation.

Develop service line financial reporting to monitor performance.

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Bright Spot Example: Adventist Health

March 2025

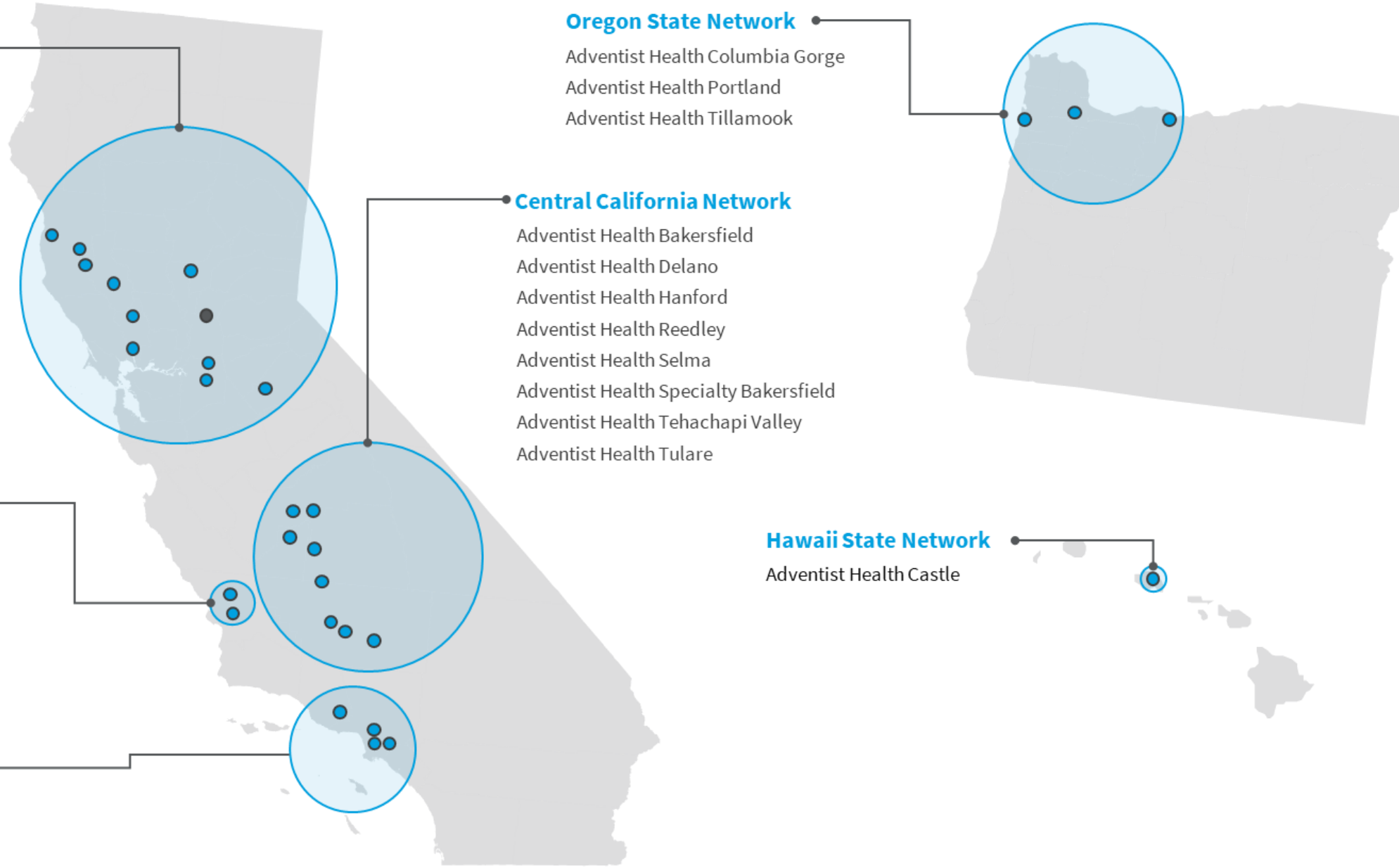
CalAIM: Building the local community continuum of care

AdventistHealth

Our Mission

- Emphasizes a holistic view of health, considering social, economic, and environmental factors
- Involves coordinated care that is customized to individual and community needs
- Aims at preventative care addressing root causes of health issues
- Focuses on health equity and reducing disparities among different population groups

AdventistHealth



Northern California Network

Adventist Health Clear Lake
Adventist Health Howard Memorial
Adventist Health Lodi Memorial
Adventist Health Mendocino Coast
Adventist Health and Rideout
Adventist Health Sonora
Adventist Health St. Helena
Adventist Health Vallejo
Adventist Health Ukiah Valley
Dameron Hospital*

Oregon State Network

Adventist Health Columbia Gorge
Adventist Health Portland
Adventist Health Tillamook

Central California Network

Adventist Health Bakersfield
Adventist Health Delano
Adventist Health Hanford
Adventist Health Reedley
Adventist Health Selma
Adventist Health Specialty Bakersfield
Adventist Health Tehachapi Valley
Adventist Health Tulare

Central Coast Service Area

Adventist Health Sierra Vista
Adventist Health Twin Cities

Hawaii State Network

Adventist Health Castle

Southern California Network

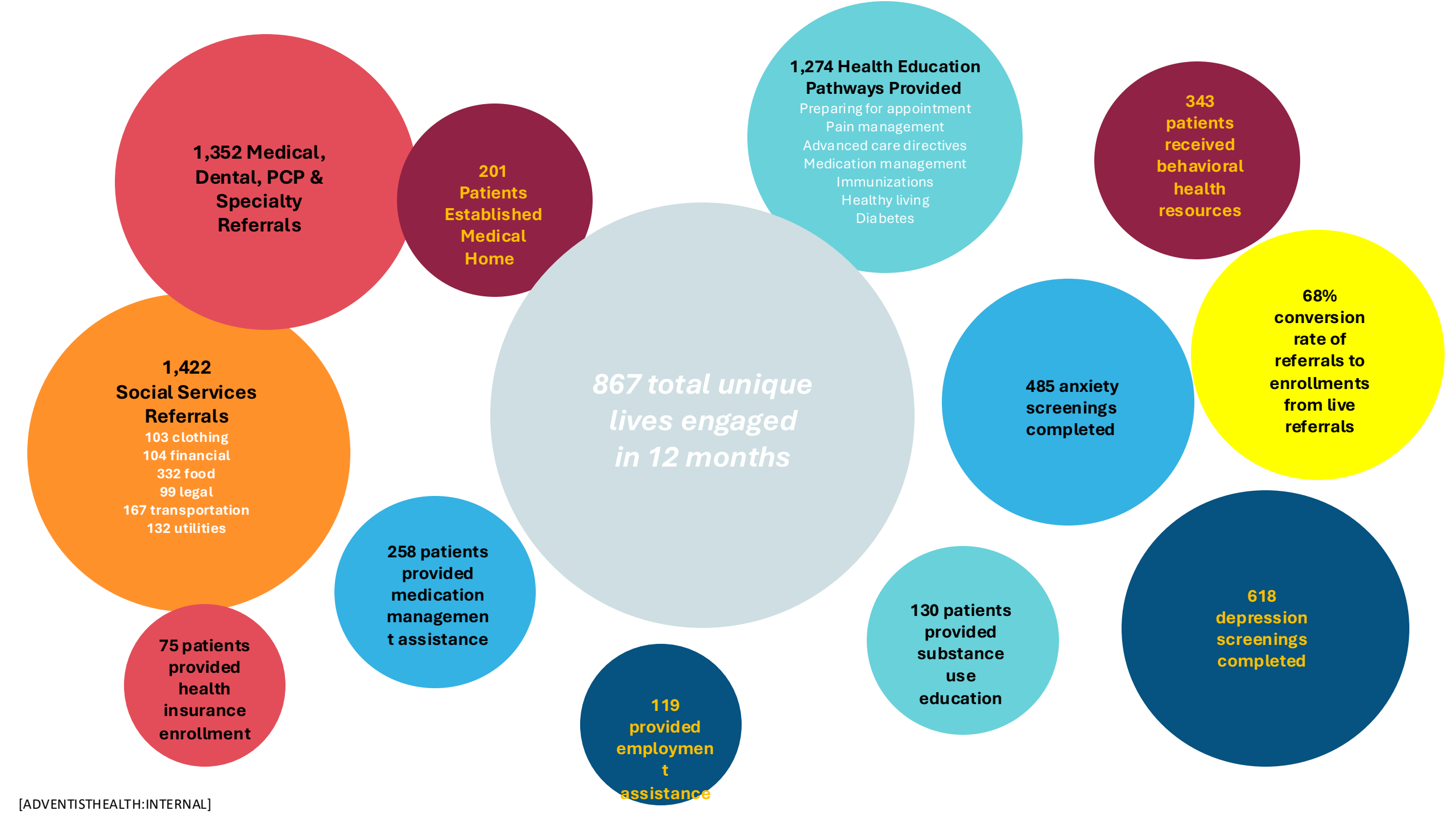
Adventist Health Glendale
Adventist Health Simi Valley
Adventist Health White Memorial
Adventist Health White Memorial Montebello

*Managed facility

AdventistHealth

DISCUSSION TOPICS

1. Care Model
2. Governance/ Leadership
3. Assessment
4. Operations
5. Billing & Reimbursement
6. Partnerships



Success Story

Mr. M was seen 25 times in the emergency department from June – October 2024.

- Reasons for visit: cough, weakness, cold-like symptoms, leg swelling, eye swelling, foot/neck pain, leg bleed

LCM engaged with Mr. M on 10/10/2024 and enrolled into ECM.

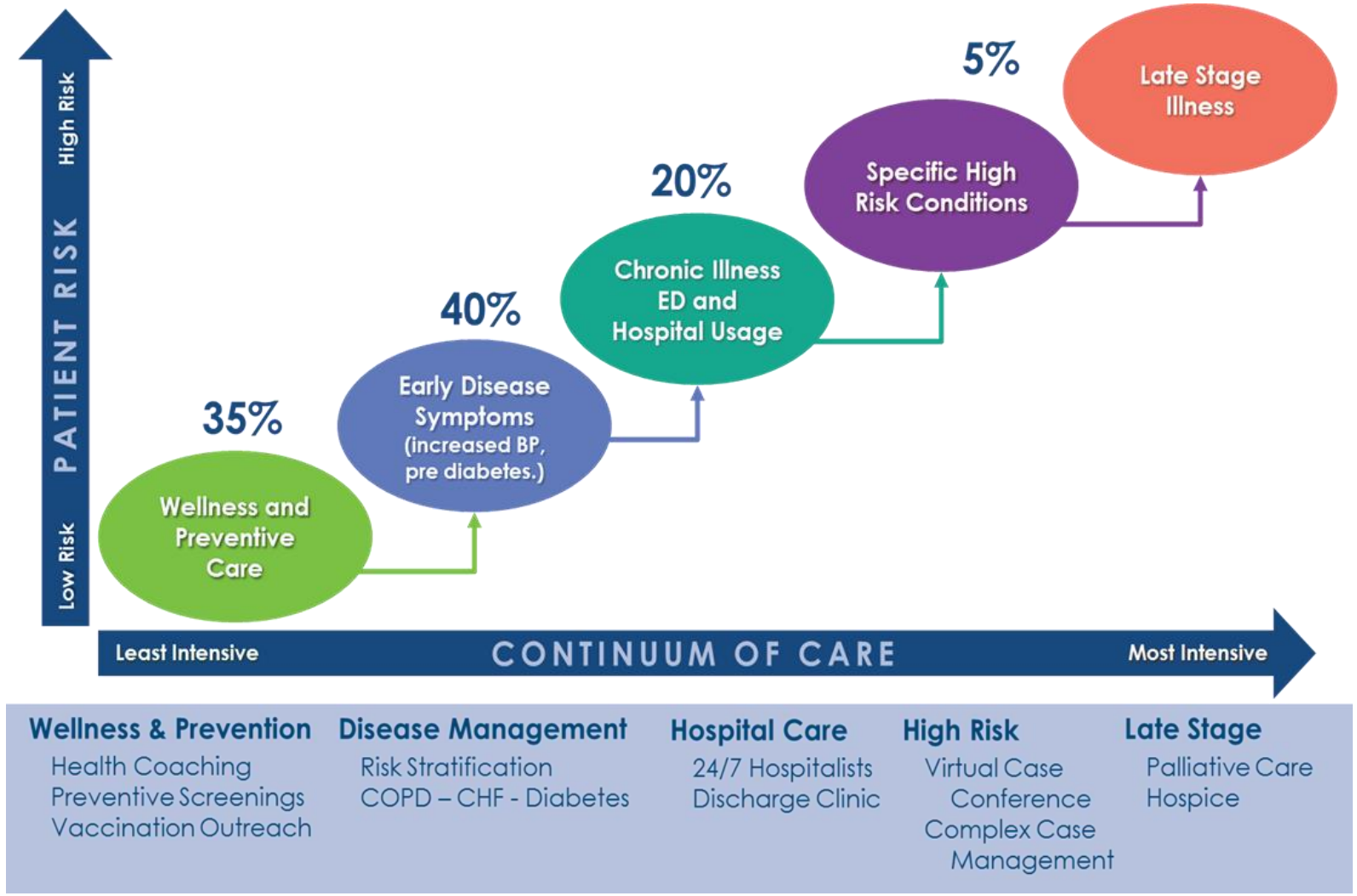
LCM secured temporary shelter on 10/14/2024. Since then, Mr. M has had only 2 ED visits. One visit led to admission for acute respiratory failure.

LCM coordinated with HDAP to transition Mr. M into a new hotel room. Social security paperwork was completed and allowed Mr. M to be on a high priority list for housing. LCM obtained a motorized scooter, shower chair and consent to speak with PCP. LCM brought him a sandwich and balloons to celebrate Mr. M's birthday.

Care Model

Adventist Health

Integrative Progression of Care Model



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Investing in Competencies to Effectively Engage Patients & Providers

IT and Analytics

- Disease registries
- Patient identification at point of care
- Cost analysis

Provider Support & Engagement

- Education
- Incentives
- SDOH capture
- Pre-visit planning

Care Delivery & Management

- Engaging provider care teams and CBOs
- Care coordination
- Process improvement

Patient Engagement

- Patient centered care
- Access based on patient needs (ie community settings)
- Link to PCP

New Requirements & Codes for SDOH Expansion

CA 1115 Waivers
Joint Commission
Medicare Physician Fee Schedule

2022 MediCaid Expansion

- CalAIM Enhanced Care Mgmt
- Community Supports
- $1.85B available state funds

2023 New Health Equity standards released

- SDOH screening required for hospitals participating in IP quality reporting program
- Stratify quality and safety data demographically
- CMS ACO health equity adjustment

2024 New Billable Codes

- SDOH Assessment & Screening
- Principle Illness Navigation
- Community Health Integration

CalAIM Benefits

Integrated care management addressing Health Related Social Needs (HRSN)

- 80% of AH patient population is MediCare/MediCaid
- Address disproportionately high rates of chronic health conditions and complex social needs

Strengthen primary and ambulatory care

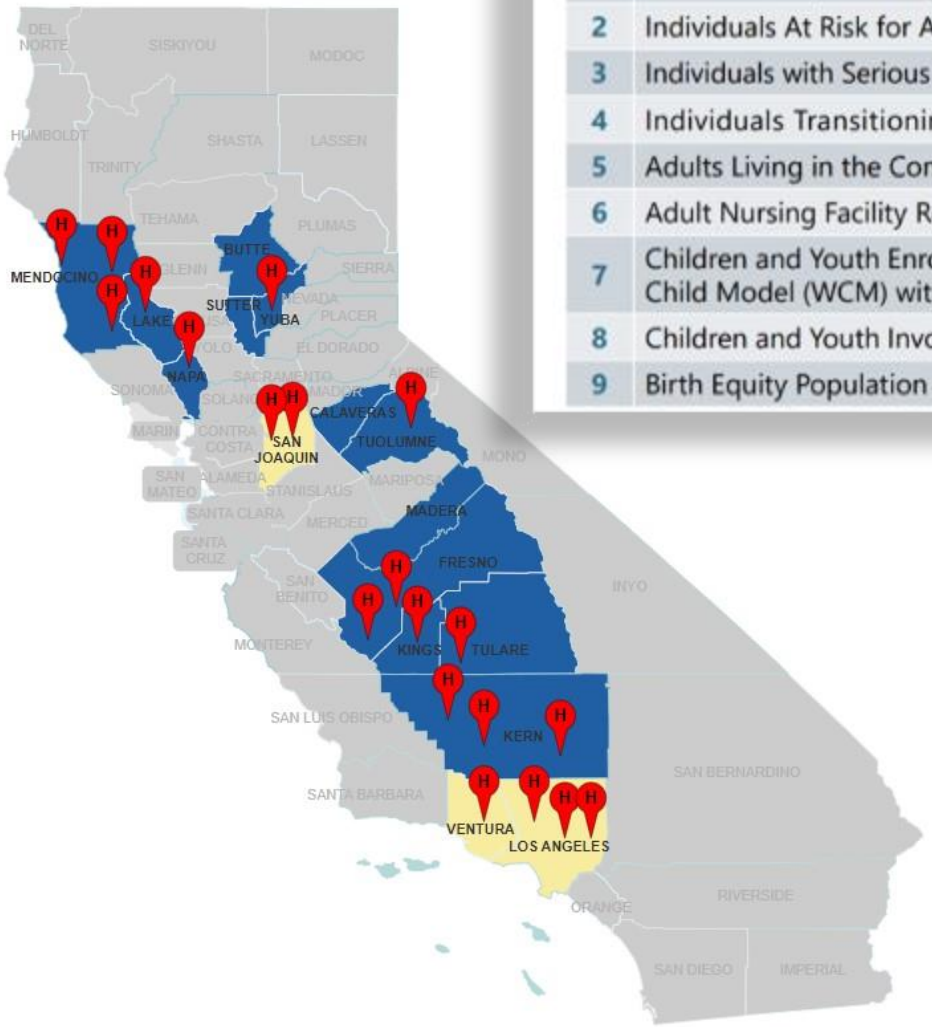
- 1 in 5 U.S. adults experience mental illness each year and estimated half are treated in primary care*
- Multi-disciplinary team approach to preventive care, individual goal-setting, treatment plan adherence

Scale programs and payment models to maximize core competencies

- Utilize existing PATH CITED state funds to launch services
- Partnerships with health plans and contracted ECM and CS providers
- New investments for emerging solutions and competencies from payers and funders

*Source: Mental Health By the Numbers, June 2022 | NAMI: National Alliance on Mental Illness

CalAIM Enhanced Care Management



ECM Population of Focus		Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization	✓	✓
3	Individuals with Serious Mental Health and/or Substance Use Disorder Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	✓
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

- DHCS' vision for ECM is to **coordinate all care for eligible Members**, including **across the physical, behavioral, and dental health delivery systems**.
- ECM is interdisciplinary, high-touch, person-centered, and **provided primarily through in-person interactions** with Members where they live, seek care, or prefer to access services.
- ECM is the **highest tier of care management** for Medi-Cal MCP Members.

Medi-Cal MCP Care Management Continuum

ECM

Complex Care Management
For MCP Members with higher- and medium-rising risk

Basic Population Health Management
For all MCP Members

Transitional Care Services
For all MCP Members transitioning between care settings

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Enhanced Care Management (ECM)

Case finding of eligible patients within Adventist Health:

- **Frequent utilizers of the ED** = High Utilizers, Adults experiencing homelessness
- **Expectant moms** = Pregnant & Postpartum
- **Pediatric patients on Medi-Cal** = Children and Youth
- **SUD/BH with MediCal** = Adults and children w/ mental health and substance use needs
- **SNF/LTC duals patients with long LOS** = Nursing Facility Residents Transitioning to home, Adults at risk for LTC
- **Street Medicine patients (Lake, Mendocino, Rideout)** = Adults experiencing homelessness
- **Patients with an income at or below poverty level** = Homeless families or unaccompanied children/youth
- **MediCal patients positive screenings for PHQ2 or PHQ9** = Serious Mental Health or SUD
- **Positive toxicology reports in the ED** = Serious Mental Health or SUD
- **5150 / BH patients** = Serious Mental Health or SUD
- **OBGYN MediCal patients** = Birth Equity (Pregnant/Postpartum)
- **Patients screening positive for SDOH** = Adults experiencing homelessness, Homeless families, Foster Youth

Adults experiencing homelessness

Homeless families or unaccompanied children/youth

Individuals with avoidable ED utilization "high utilizers"

Serious Mental Health or SUD

Individuals transitioning from incarceration

Adults at risk for LTC Institutionalization

Nursing Facility Residents Transitioning to home/community

Birth Equity Focus

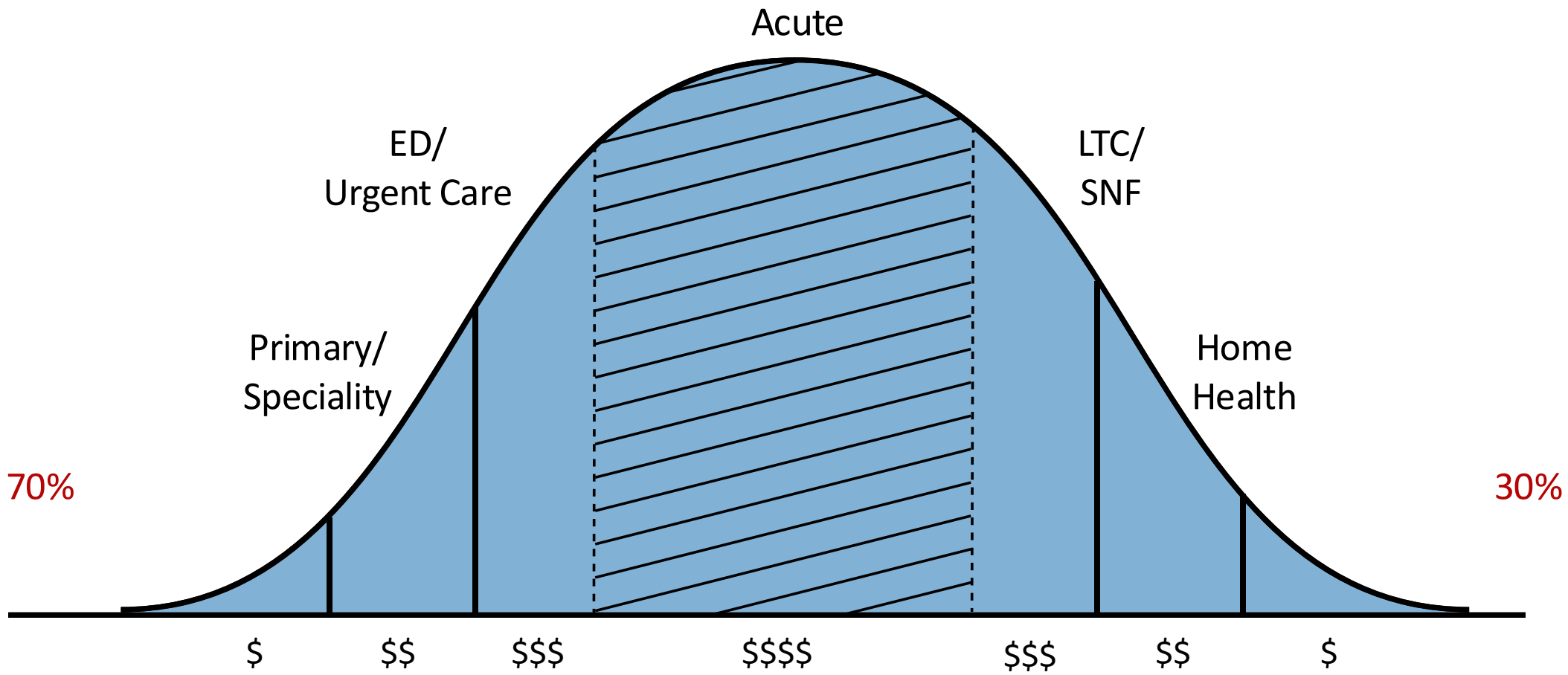
Foster Youth

New Billable Codes: CalAIM Community Supports

14 preapproved services offered under new MediCaid expansion:

- Housing Navigation*
- Housing Deposits*
- Housing Tenancy & Sustainability*
- Recuperative Care (Medical respite)*
- Short-term Post-Hospitalization Housing*
- Respite Services
- Day Habilitation
- Nursing Facility transition/Diversion to assisted living facilities
- Community Transition services/nursing facility transition to a home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically-Tailored Meals
- Sobering Center
- Asthma Remediation

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES



Curb costs through ambulatory and post-acute settings

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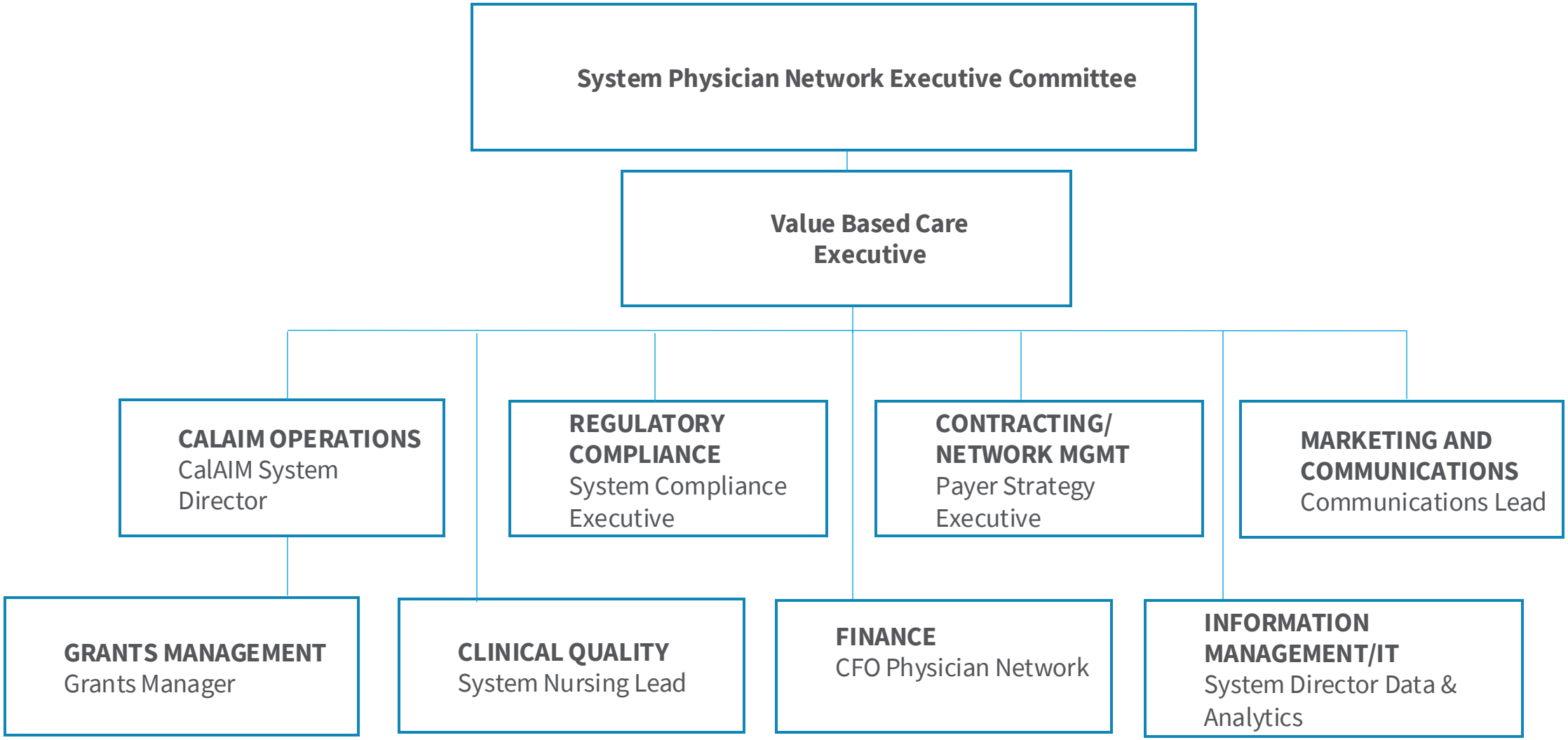
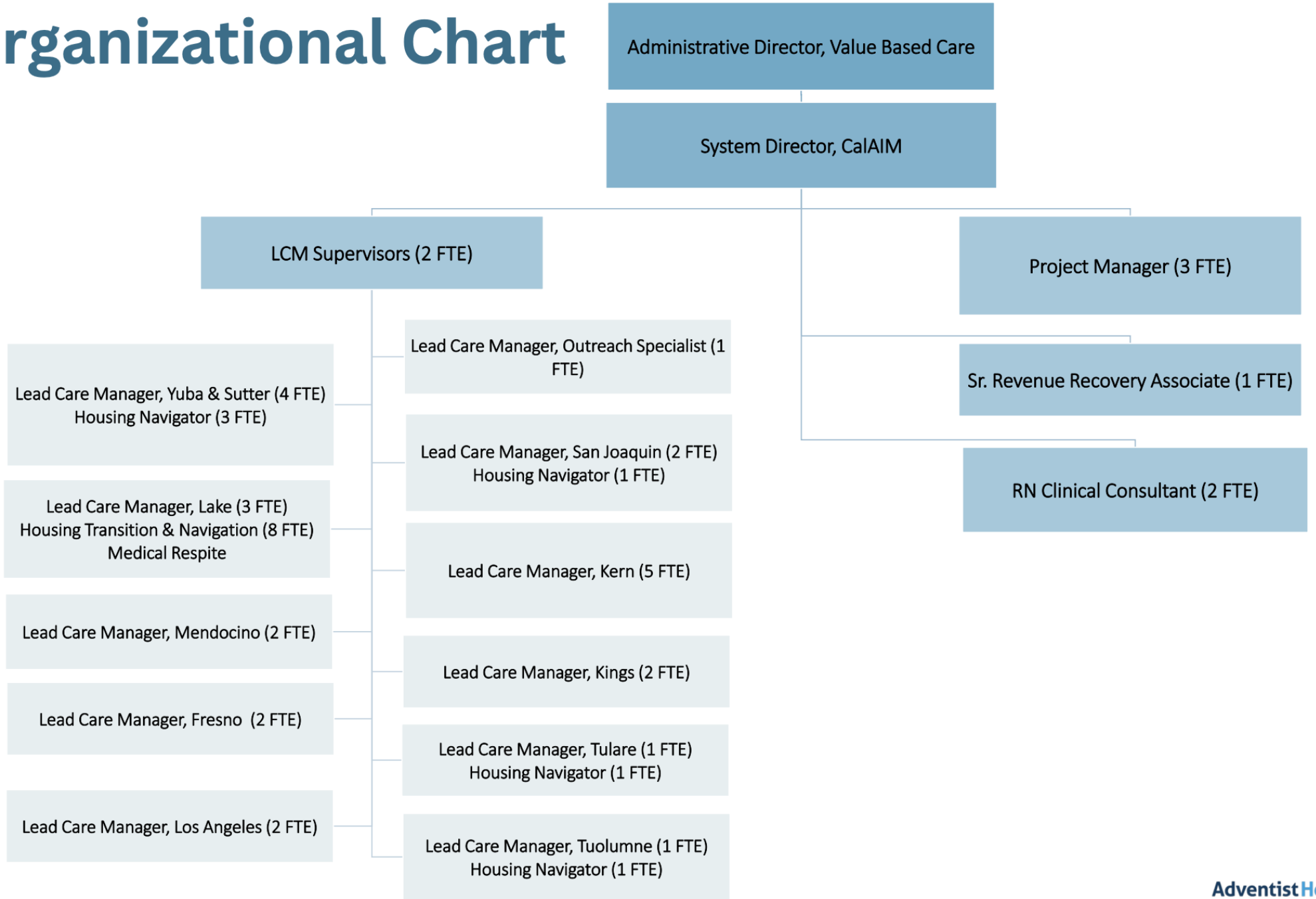
Governance

Adventist Health

CalAIM Internal Governance & Workstream Structure



CalAIM Organizational Chart



Staying Connected

Meeting Title	Frequency	Brief Description	Participants
Team Huddle	M-W-F 30 minutes	• 30 minute virtual huddle via TEAMs • Great time to ask questions, get answers and connect with Team • Operational announcements and patient care concerns	• All Team Members
TEAMs Chat	Daily	• Daily check ins • Team questions/concerns	• All Team Members
MDT Meetings	Weekly Mon. Tues. Wed.	• Organized by Payer • Consultation with RN for high acuity patients • 90 Day member MDT review • Guidance from Supervisor and/or Director on challenging cases	• LCM meets with RN, Supervisor, and/or Director
1:1 LCM: Director	Bi-Monthly	• 30 minutes • Address LCM questions/concerns	• Each LCM meets with the Director 1:1
1:1 LCM: Supervisor	Monthly	• 60 minutes • Address LCM questions/concerns • Goal setting/personal development • Documentation review/training opportunities • Caseload review	• Each LCM meets with the Supervisor 1:1
ECM Staff Meeting	Monthly 4th Thursdays	• 90 minutes • Interactive team meeting • Connection to Purpose • Program Review and Updates	• All Team Members
Workstream Meetings	Monthly or Bi-Monthly	• 30 minutes • Review monthly targets/goals • Provide updates & create implementation plan	• Workstream owners, Operations, Leadership team
Executive Presentations	Quarterly & Site Visits	• Operations, finance, clinical quality updates • High engagement to build care coordination	• Executive teams

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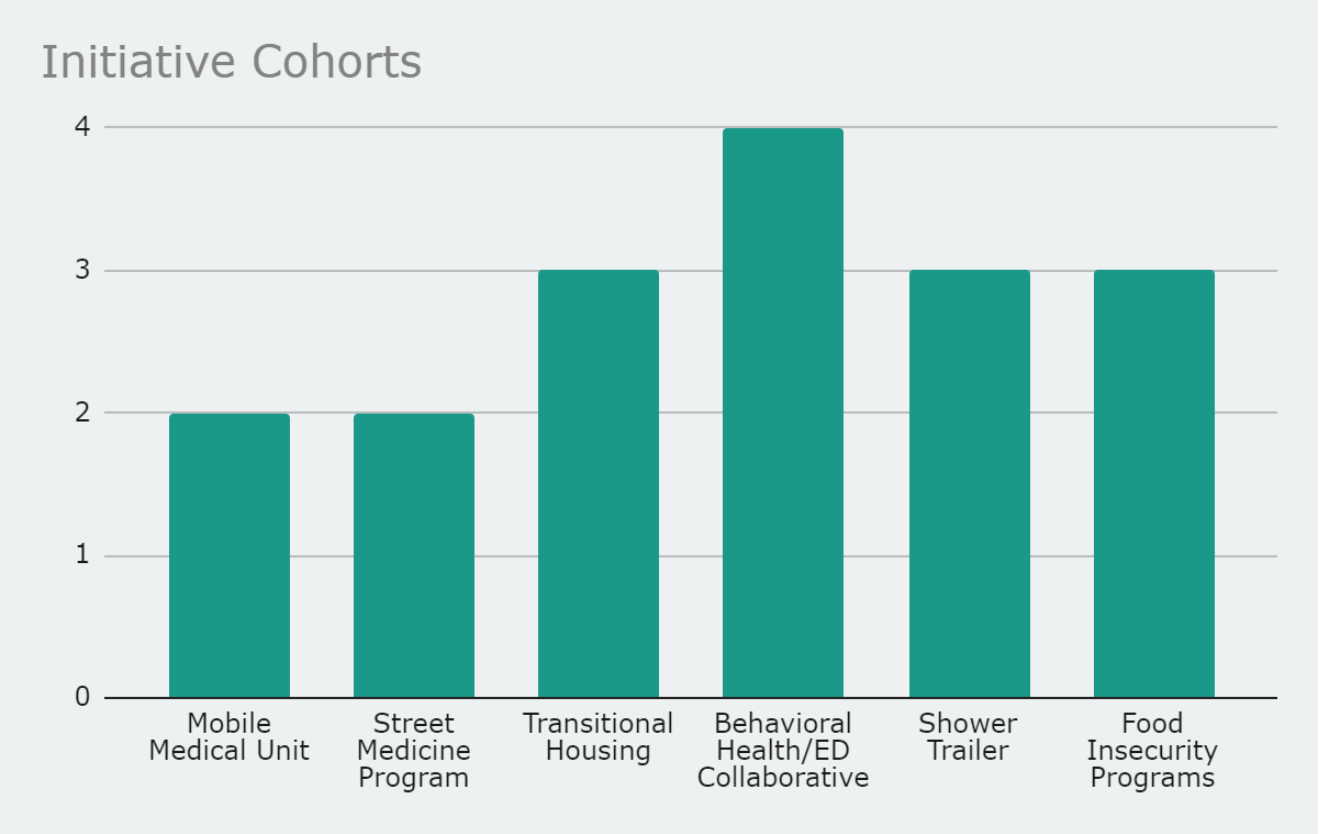
Assessment

Mapping System Initiatives

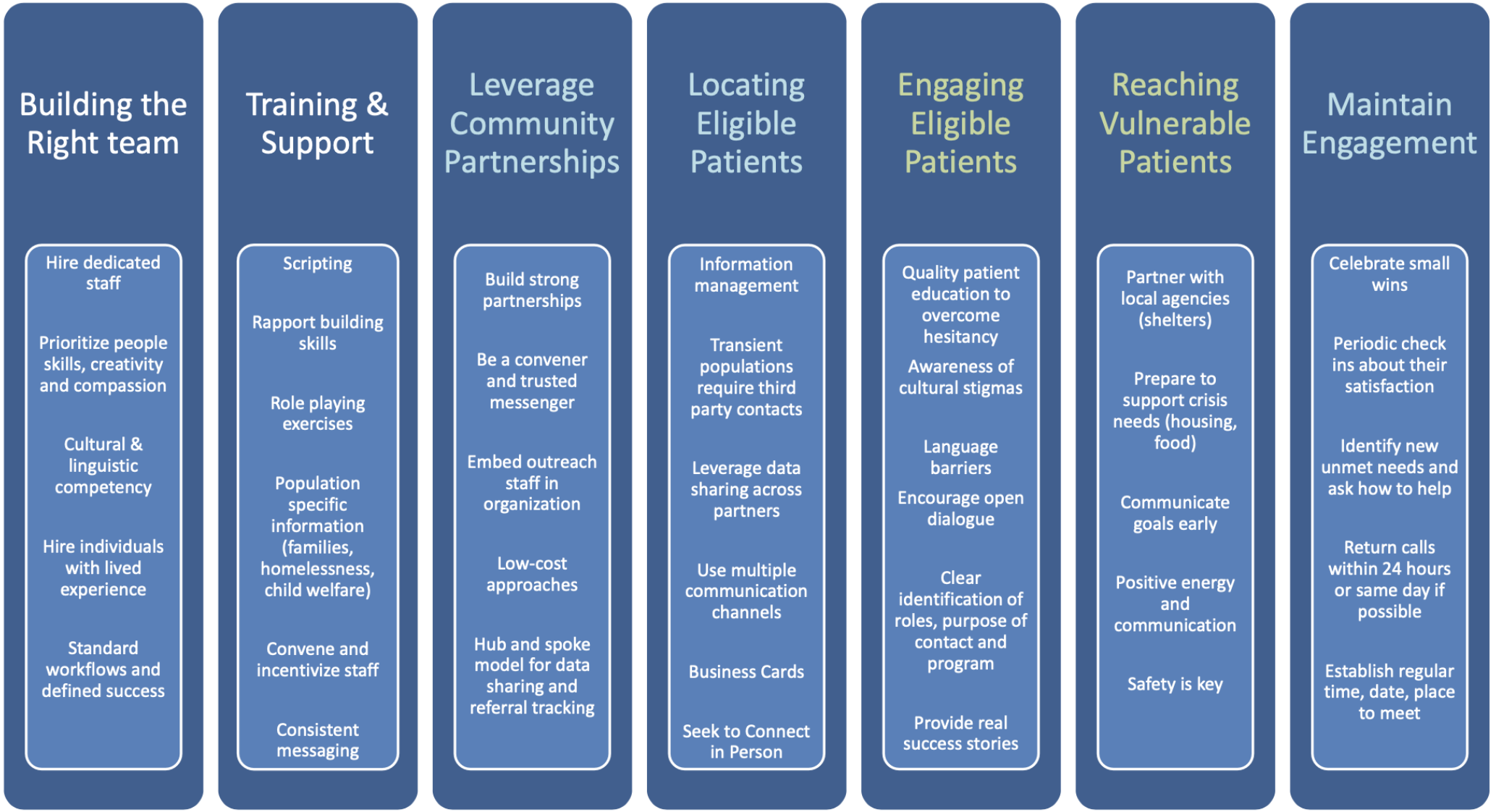
Current state analysis shows opportunity to convene system cohorts across these priority areas:



CHNA Response Initiatives

	Access to Care	Financial Stability	Mental Health	Health Risk Behaviors	Health Conditions	Food Security	Housing	Homelessness
Programs								
Street Healthcare/Mobile Healthcare	x		x	x				x
Transitional housing/recupertive care	x	x	x	x	x	x	x	x
ACEs Integration - ED	x		x	x	x			
ACEs Integration - Pediatrics	x		x	x	x			
ACEs Integration - OB/GYN	x		x	x	x			
Supportive Housing (community partner)	x	x	x	x	x	x	x	x
Community Case Conferencing	x	x	x			x		x
Complex Care Clinic	x	x	x	x	x	x		
Care Management/Navigator	x	x	x	x	x		x	
MAT in the ED	x	x	x	x	x			
MAT in Primary Care	x	x	x	x	x			
Criminal Justice Re-Entry Program	x	x		x		x	x	x
Trauma Informed Care Initiative	x		x	x	x			x
CalAIM	x	x	x	x	x	x	x	x
Food Security Initiative	x			x	x	x		x
Transportation Initiative	x							x
Patient Care Coordination	x	x	x	x	x	x	x	x

Outreach Strategies Drive Engagement



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Care Plan Assessment & Audit Tool

Enhanced Care Management
Internal Chart Audit

CommunityConnect | AdventistHealth

Member Information

Member Name	Reviewer Name	LCM Name
Member CIN	**Review Date**	**Due Date**

Eligibility

Met	Unmet	Measure	Notes
☐	☐	Opt-in to ECM Date	
☐	☐	Population of Focus	

Profile

Best practice is to complete profile within first 3 interactions and within 60 days of enrollment.

Met	Unmet	N/A	Measure	Notes
☐	☐		Date of Birth	
☐	☐		Gender Identification	
☐	☐		Preferred Name and/or Pronouns	
☐	☐		Nationality/Tribe/Ethnicity	
☐	☐		Preferred Language (spoken/written)	
☐	☐		☐ Preferred Method of Contact ☐ Phone Number ☐ Email Address	
☐	☐		☐ PCP Clinic ☐ Phone ☐ Address	
☐	☐	☐	☐ Emergency Contact ☐ Relationship ☐ Phone	
☐	☐	☐	Insurance Information ☐ Medi-CAL ID/CIN ☐ Plan	
☐	☐	☐	☐ Legal Guardian ☐ Family Member ☐ Caregiver ☐ Support Person ROI	
☐	☐		ROI for ECM Services and Data Sharing	
☐	☐		LCM Provided Name and Contact Information to Member	

Assessment

Met	Unmet	NA	Measure	Description	Notes
☐	☐		Culture	☐ Cultural beliefs ☐ Religious beliefs ☐Spiritual beliefs	
☐	☐		Health Literacy	☐ Understands medical problems ☐ Fills out medical forms ☐ Follows instructions for taking medications	

☐	☐		Physical Health	☐ Allergies/reactions ☐ Current (acute/chronic) medical conditions/treatments ☐ Past (inactive) medical conditions/treatments ☐ Current medical providers/specialists name and phone ☐Ongoing medications ☐ Vaccinations ☐ Tuberculosis history ☐ A1C Levels	
☐	☐		Oral Health	☐ Last dental visit ☐ Dental Provider Name ☐ Dental Office ☐ Next Visit Date	
☐	☐		Vision & Hearing	☐ Vision ☐ Hearing ☐ Diabetic vision exam	
☐	☐	☐	Medications	☐ Name ☐Dose ☐ Purpose or reason prescribed ☐Prescriber (name and phone)	
☐	☐	☐	Pain Management	☐ Pain experience ☐ Pain management specialist care, provider, and last visit ☐ Impacted condition or body part and treatment response	
☐	☐	☐	Behavioral Health	☐Anxiety (GAD-7) ☐ Depression ☐ Trauma and stress ☐ Cognitive functioning ☐ Developmental factors ☐ Any other mental health history	
☐	☐	☐	Substance Use Disorder	☐ Information about last use ☐ Referrals needed for counseling	
☐	☐	☐	Housing	☐ Location of housing ☐ Concern about losing housing ☐ Assistance with housing ☐Safety of housing environment	
☐	☐		Safety	☐ Physical and emotional safety ☐ Using residence without permission ☐ Someone using their money without permission	
☐	☐		Food Security	☐ Enough food ☐ Frequency of hunger ☐ Amount of food	
☐	☐	☐	Benefits and Other Services	☐ Government benefit programs ☐ Employment status ☐ Community based and social services ☐ Long Term Services and Supports	
☐	☐	☐	Legal Involvement	☐Court ordered services ☐APS or CPS	
☐	☐	☐	Life/End of life planning	☐ Advanced planning in place ☐ Ways to improve health ☐ Priorities and goals for the next year	

				☐ Barriers to implementation of plan	
☐	☐		Member priorities	☐ Member concerns about overall health ☐ Member chosen first steps to improve health ☐ Member chosen first steps to work on in ECM	

Tools

Tool	Notes	Met	Unmet	NA
ADL + IADL*		☐	☐	☐
Birth Information		☐	☐	☐
Caregiver PAM 13		☐	☐	☐
Edinburgh		☐	☐	☐
ED/ER Information Tool		☐	☐	☐
GAD-7		☐	☐	☐
Graduation Questionnaire		☐	☐	☐
Home Safety		☐	☐	☐
Life Satisfaction Survey*		☐	☐	☐
MDT*		☐	☐	☐
Medication Assessment		☐	☐	☐
Other Client Details-HH		☐	☐	☐
PAM*		☐	☐	☐
PHQ-9 (Partnership*)		☐	☐	☐
Blood Pressure Screening Tool (Partnership*)		☐	☐	☐

* Required Tool

Documentation & Reporting

Met	Unmet	Component	Description	Notes
☐	☐	Assessment	• Comprehensive assessment completed within 90 days of ECM consent/enrollment. Best practice is to complete assessment within first 3 interactions and within 60 days of enrollment. • ECM Provider utilized an in-person approach to complete the assessment when necessary	
☐	☐	Reassessment	Reassessment occurred due to a major change in health status according to the member's risk tier (see below)	
☐	☐	Care Plan	• Care plan created and updated according to member's individual progress or changes in needs as they are identified per risk tier. • ECM Provider utilized an in-person approach to complete the care plan when necessary	
☐	☐	Contacts	ECM Provider maintains documentation of all outreach (whether successful or unsuccessful) attempts within their EHR	

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Care Plan Assessment & Audit Tool

Risk Tiers

Tier 1 High Contact Care Management	Tier 2 Medium Contact Care Management	Tier 3 Low Contact Care Management
• Contact member 3-4 times per month • Contact every 7-14 days • In person visit or attempt once per month • Update Assessment and Care Plan every 3 months	• Contact member 2 times per month • Contact every 14-21 days • In person visit or attempt once per month • Update Assessment and Care Plan every 6 months	• Contact member at least once a month • Update Assessment and Care Plan every 12 months or as needed

Comprehensive Assessment

Met	Unmet	Measure	Description	Notes
☐	☐	Communication	• Provided communications to member appropriately, consistently, and primarily in-person as available • Utilized alternative methods of communication as necessary •ECM Provider makes 2 additional outreach attempts within 30 days at different times during the day and on different days of the week if unable to reach the member during initial outreach	
☐	☐	Annual Assessment	Annual comprehensive assessment completed to confirm eligibility and appropriateness for ECM enrollment	
☐	☐	Gaps in Care	Gaps in care are identified through the comprehensive assessment and address gaps in care within the care plan as appropriate. Complete list of gaps in care per DHCS	
☐	☐	Caregiver / Emergency Contact	Member's chosen caregiver or support person is incorporated in the creation of the care plan as member allows	
☐	☐	Readiness to Change	Member's readiness to change is assessed (PAM)	
☐	☐	Consent	Consent received from member or authorized representative to engage in services and to contact Caregiver / Emergency Contact	

Care Management Plan – Pathways

Component	Description
Goals	• Goals are chosen by the member based on the problems identified • Priority is assigned to each goal by the member • Goals are written in the SMART (specific, measurable, achievable, relevant, and timely) format
Interventions	Planned interventions to accomplish this goal are identified: • What the member does for themselves • What you do for the member • What you do with the member
Dates	Date the goal was initiated and date the goal was completed
Updates	Best practice is to update pathway notes monthly
Strengths	Strengths are self-identified by member and are incorporated when providing services to the member to remind and reinforce during readiness to change talks
Barriers	Potential barriers that may prevent the accomplishment of the intervention are identified
Encouraged & supported	Encouraged and supported member to make lifestyle choices based on healthy behavior and support the member's efforts to do so
Linked to Resources	Linked member to resources such as smoking cessation, self-help recovery and chronic condition management as appropriate
Evidence-Based Practices	Utilized evidence-based practices, such as motivational interviewing to engage and encourage the member to participate in their care and treatment plans

Outreach & Engagement

Met	Unmet	Measure	Description	Notes
☐	☐	Culturally Appropriate Communications	All communications were provided to the member in a culturally and linguistically appropriate manner (interpreter or translation used as appropriate)	
☐	☐	Outreach	ECM Provider outreached to member within 30 days of member being assigned	

Enhanced Coordination of Care

Met	Unmet	Measure	Description	Notes
☐	☐	MDT/ICT Collaboration	Presented member's care plan, needs and preferences to MDT/ICT Team within 90 days of ECM enrollment and annually to ensure safe, continuous, and integrated care among all providers	
☐	☐	PCP Collaboration	Shared care plan, member's conditions, health status, medication usages and side effects to other PCP (if AH site is not the PCP)	
☐	☐	Care Plan Review	Reviewed the care plan with the member and offered a copy of the Care plan to the member, parent, caregiver, guardian, other family member(s), and/or other authorized support person(s) in their preferred language and format (i.e., Print, Email).	
☐	☐	Care Coordination	Coordinated essential aspects of care. Examples: • Medication reconciliation • Providing appointment reminders • Coordinating transportation • Accompaniment to critical appointments	
☐	☐	Referral Follow-up	Care coordination team followed-up on referrals in a timely manner with appropriate parties	

Comprehensive Transitional Care (only used if ED/ER is utilized)

Met	Unmet	NA	Measure	Description	Notes
☐	☐	☐	Post Discharge Follow-Up	Followed up with member with post-discharge follow-up care coordination contact within 48 hours of discharge from treatment facility	
☐	☐	☐	Transition Plan Coordination	Coordinated transition plan with discharge facility and member, member's chosen caregiver and/or support person upon receiving notification of member admit or discharge from treatment facility	
☐	☐	☐	Referrals & Services	Coordinated appropriate referrals and services, including, but not limited to medication reconciliation to meet individualized member needs upon discharge	
☐	☐	☐	Hospital DC PCP Follow-Up	PCP visit within 7 days post hospital discharge	
☐	☐	☐	Hospital DC SMI Follow-Up	Follow up visit with mental health provider within 30 days of hospital discharge for treatment of mental illness or intentional self-harm diagnosis	
☐	☐	☐	Post ED Visit Follow-up	Contacted member following ED visit to discuss visit and provide discharge follow up appointment	
☐	☐	☐	SMI ED Visit Follow-Up	Follow up visit with any practitioner within 30 days of ED visit with discharge	

CCS health®

CTI® Training
Enable clients to get back on the road to healthy living and care self-management in 30-days

CCS Health Training
Skill-up community care coordinators to manage clients, navigate challenges, build resilience, and support the community.

HealthBridge.care®
Assess clients' needs, make referrals to resource partners in the community, and monitor completion.

Community Health Record
Create tailored individual care plans based on risks, establish access to care, and track progress over time without paper shuffling.

Advisory & Consultation
Accelerate results with support from experts and a community with decades of combined expertise.

Health Education Materials
Access and assign hundreds of health content and patient-education resources.

Closed-Loop Referrals
Tech-enabled, real-time status updates for client monitoring through the entire workflow, from recommended to complete.

CTI+
Purpose-built technology that pairs with the Care Transitions Intervention® to easily manage clients, reporting, and invoicing.

Invoicing
Recoup a higher percentage of investment, invoice and secure payment in a few clicks; create sustainability.

Reporting
Monitor and update real-time analytics; connect individual and population metrics to decision makers to impact health care and public policy.

- ***Documentation criteria built using LA Care All Plan Assessment***
- ***New closed loop referrals supported in RTF***
- ***Data feeds established by payer***
- ***Successful contacts tracked monthly***
- ***Documentation matched to billing criteria***
- ***Cerner integration***

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Operations

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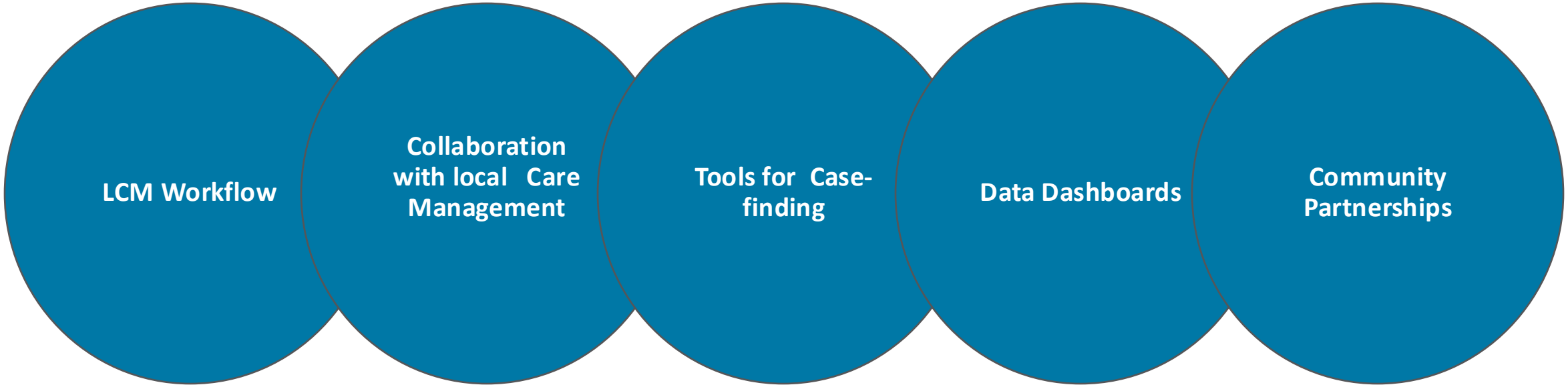
Creating Point of Care Visibility



ECM Scope of Services

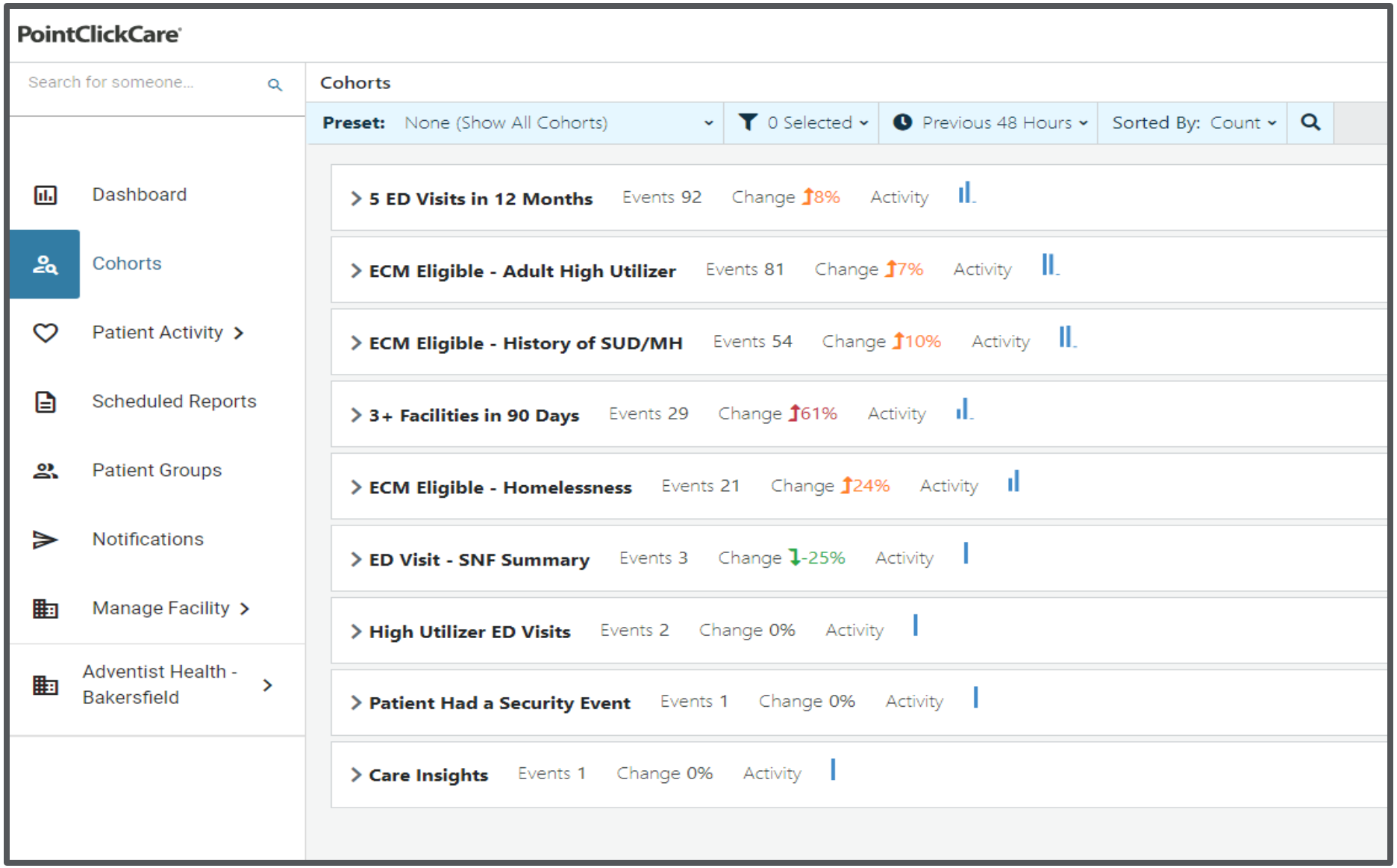
High-risk patients receive *1:1 community-based* case management and navigation services to reduce readmission and utilization

- Services approved up to 1 year after enrollment
- Comprehensive assessment for social needs (food, transportation, housing, social services, etc.)
- Care plan development using SMART GOALS
- Scheduling PCP appointments
- Health promotion & education
- Comprehensive transitional care
- Coordination of referrals and accompaniment to medical, community and social services appointments
- Facilitating and accompaniment to necessary appointments
- Phone calls with and on behalf of the patient
- Family support and coordination
- No limit on number of encounters per month with LCM and Clinical Consultant
- Services In-Person and Telephonic

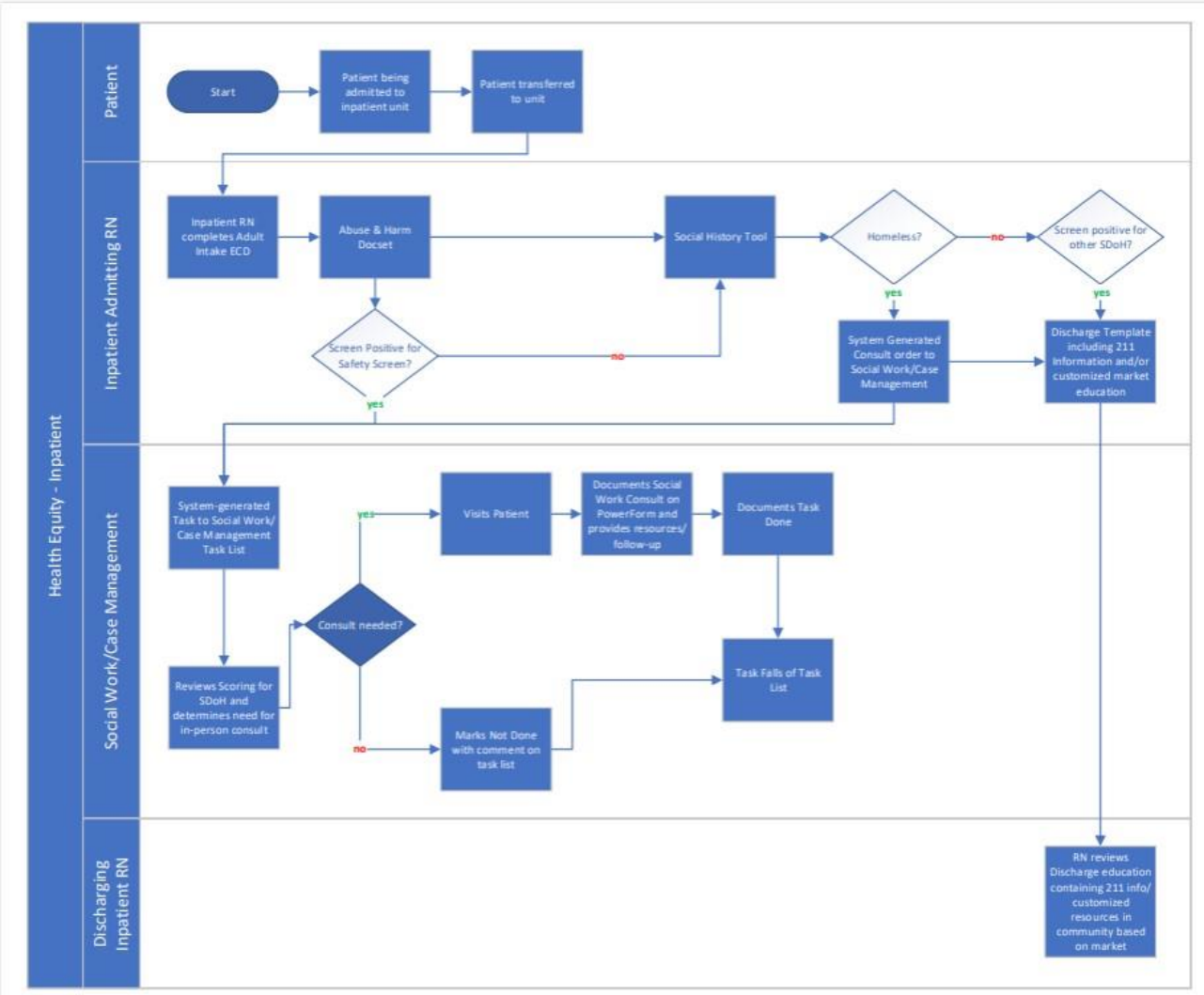
Outcomes

- Reduction in ED utilization
- Closing care gaps
- Patient is established with a PCP
- Patient is taking meds as prescribed
- Care plan goals met

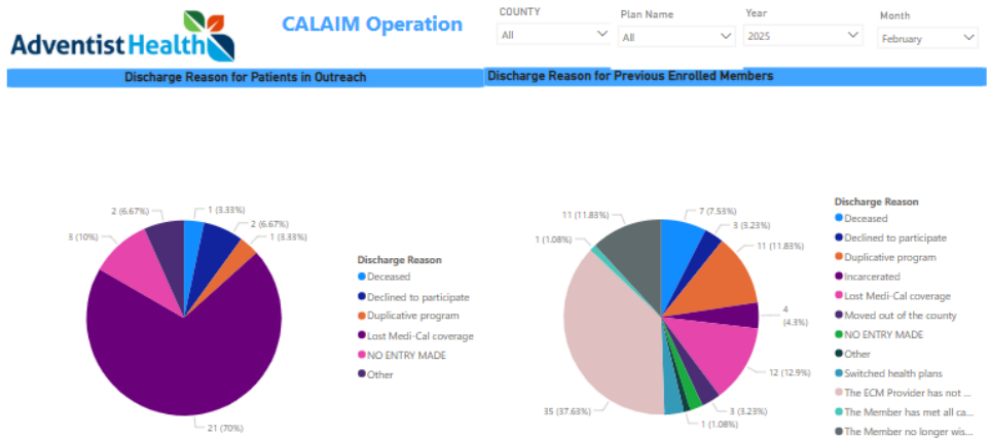
PointClickCare: Case-finding using CalAIM criteria



Care Management IP SDOH Screening

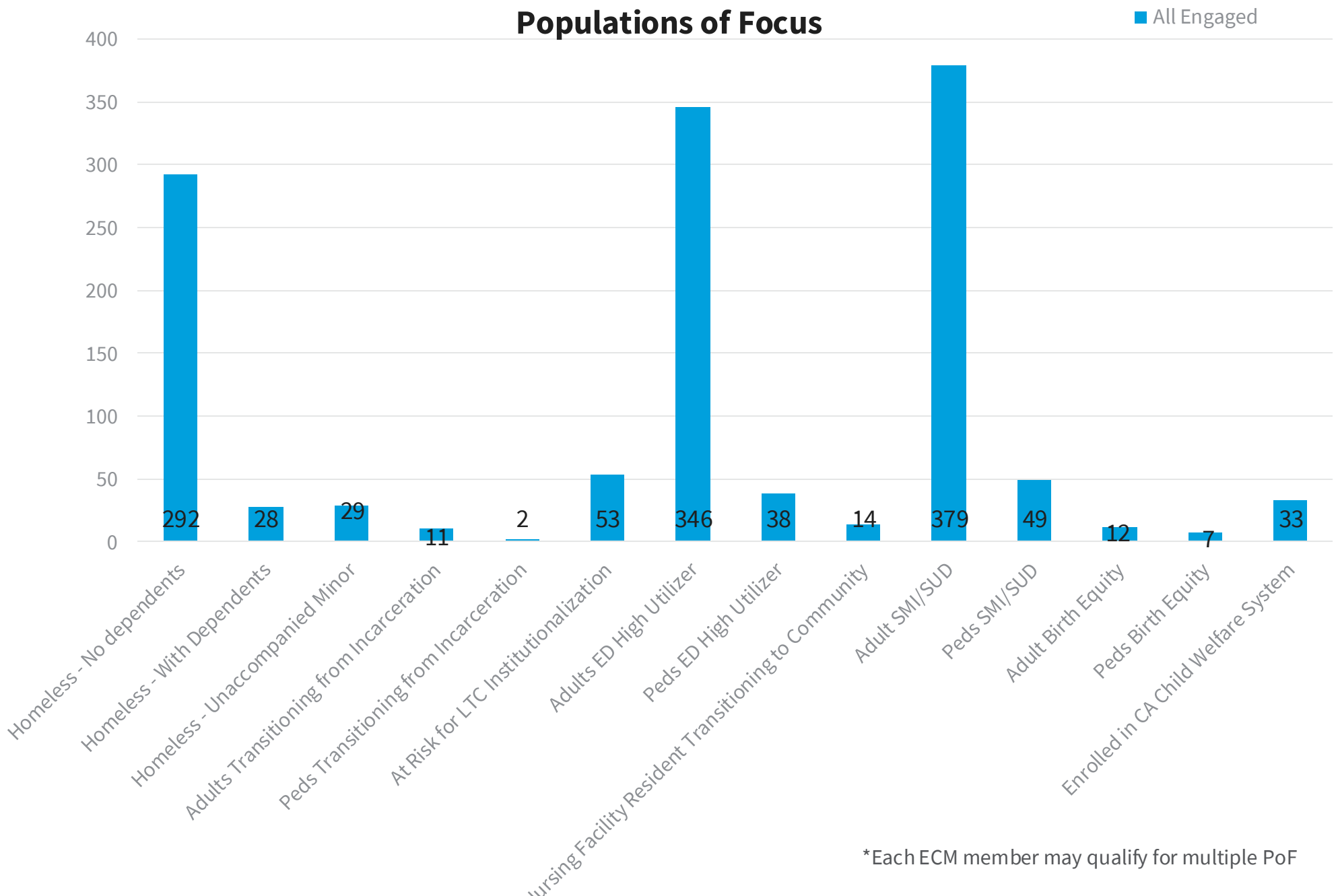


Data Dashboards & Analytics



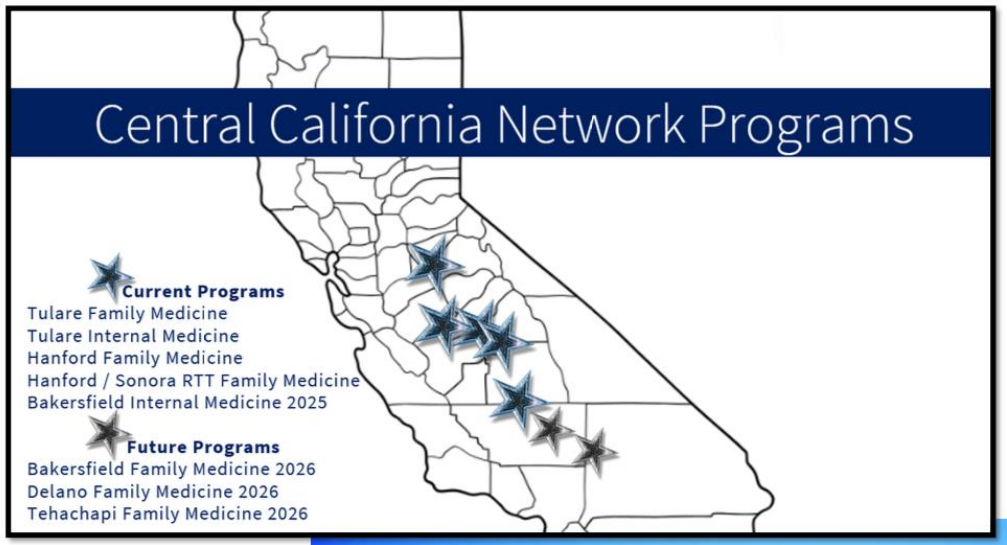
CALAIM Operation, Discharge Info
Live data
Data updated on 3/10/25, 11:37 AM

CALAIM Operation, Visual - Enrolled Members
Live data
Data updated on 3/10/25, 11:37 AM



*Each ECM member may qualify for multiple PoF

Residency Program and Advancing Community Partnerships



- **Funding awarded for Substance Use and addiction medicine ; Hep C, syphilis , no PCP , testing occurs in the ED ; Bridge program**
- **Financial stability addressed by partnering with Valley Strong Bank and Bank of America to offer financial literacy courses to students and families.**
- **Health Scholar programs offering educational opportunities for students interested in learning firsthand experience in clinical and administrative health care settings**
- **Free sports physicals and transportation services to and from health care services**
- **Food outreach services embedded in Emergency Departments and navigators to address high risk patients and long term care planning**
- **Growing over the next 3 years to 36 total more residents**
- **Health professional shortage area – significant community needs**

Local Programs

Lake & Mendocino County, CA

Homeless Populations

Healthcare:
Mobile Healthcare
Street Medicine
Shower Trailer

Transition to Housing:
Recuperative Care
Short Term Post Hospitalization
Day Habilitation
Transitional Housing
Permanent Supportive Housing
Navigation Center

Behavioral Health & Substance Use

ED Navigators

Street Medicine Team

Live Well Clinic

High Risk Populations: High Utilizers, Readmissions, Long LOS

Daily Case Finding

Case Management

Care Transitions

ACO

Community Health Workers

CalAIM

Enhanced Care Management
Community Supports

Clinic-assigned CHWs

Community Partnerships

Centralized Resource Hub

Consortium of non-profit partners

Coordinated Entry Referral System

Coordinated Care Management for Social Needs

Transportation

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Billing & Reimbursement

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Billing & Reimbursement Key Dependencies

Outreach

- Dedicated Outreach Role
- Outreach Targets
- Care plans initiated at time of outreach
- LCMs responsible for outreach & rounding IP, Clinic, Community settings
- 10-15% MIF vs 50-60% conversion rate on live referrals

Enrollment

- All contacts documented
- Only successful contacts billable
- Billing criteria & logic reviewed in workstreams
- Registration team workflows
- Caseloads tracked by LCM for monthly successful contacts
- MDTs conducted weekly
- Monthly reconciliation to review operations and finance reports
- Re-authorization process

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Rev Cycle

- Dedicated analyst role
- Twice weekly meetings to review denials & corrections
- Standard work to streamline documentation and authorization process
- Developed opportunity reports
- Increased visibility of processes across leadership team

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SMART Goals library for standard scripting

Pathway	Goals	Interventions	Updates
GENERIC TEMPLATE	▪ Member will [indicate goal] for [indicate reason] by [indicate date].	▪ LCM will [indicate action]. ▪ Member will [indicate action].	▪ Member [indicate goal] on [indicate date].
Adult Learning			
Adult Learning	▪ Member will obtain their GED by [indicate date].	▪ LCM will provide resources on where Member can obtain their GED. ▪ Member will register for classes to work towards obtaining their GED.	▪ Member obtained their GED on [indicate date].
Behavioral Health			
TEMPLATE	▪ Member will establish care with [indicate agency] for [indicate condition] by [indicate date].	▪ Member and LCM will work together to schedule appointment. ▪ Member will attend appointment and provide an update to the LCM. ▪ Member will maintain care with [indicate agency] and provide updates to the LCM. ▪ Member will ask to have medications refilled. ▪ Member will ask to reevaluate medications.	▪ Member attended appointment with [indicate agency] on [indicate date] and [indicate outcomes].
Example #1	▪ Member will establish care with Sutter Yuba Behavioral Health for Depression and PTSD by [indicate date].	▪ Member and LCM will work together to schedule an intake appointment. ▪ Member will attend the intake appointment and provide an update to the LCM.	▪ Member attended SYBH intake appointment on [indicate date] and scheduled a follow-up visit for [indicate date].
Example #2	▪ Member will establish care with Behavioral Health for developmental delay and ADHD by [indicate date].	▪ Member's mother will ask PCP for a referral for mental health services. ▪ Member's mother will schedule an appointment for mental health services. ▪ Member's mother will ensure Member attends the scheduled appointment and will provide updates to the LCM.	▪ Member attended appointment with Behavioral Health on [indicate date] and was prescribed medications for ADHD.
Education			
TEMPLATE	▪ Member will verbalize understanding of [indicate topic] by [indicate date].	▪ LCM will provide education and materials. ▪ Member will spend time to read and understand materials. ▪ Member will explain their understanding and ask the LCM any questions regarding the materials.	▪ Member verbalized understanding of [indicate topic] on [indicate date].
Advanced Directives	▪ Member will understand advanced directives by [indicate date].	▪ LCM will educate Member by providing online resources, online informational sessions, and consulting with PCP to understand the importance, options, and process of creating advanced directives. ▪ Member will spend time to read and understand materials provided. ▪ If Member decides to create advanced directives, LCM will provide assistance if needed.	▪ Member verbalized understanding of advanced directives on [indicate date].
Diabetic Meal Plan	▪ Member will verbalize understanding of a diabetic meal plan and begin to implement by [indicate date].	▪ LCM will provide materials on healthy eating for a diabetic. ▪ Member will spend time to read and understand materials. ▪ Member will decide what diabetic friendly foods they prefer and develop a menu and grocery list. ▪ Member will begin to implement the diabetic meal plan. ▪ LCM will follow up on progress towards goals, provide support and praise for successes. ▪ LCM will refer Member to a Medically Tailored Meals provider to	▪ Member verbalized understanding of a diabetic meal plan and began to implement on [indicate date]. ▪ Member qualified for Medically Tailored
Lead Testing for Pediatrics	▪ Member will verbalize understanding of the importance of lead testing for children and adolescents by [indicate date].	▪ LCM will provide education on the importance of lead testing for children and adolescents. This education will include information on the sources of lead exposure, the potential health effects of lead poisoning, and the importance of regular lead testing for young children. ▪ Member will spend time to read and understand materials and ask LCM any questions. ▪ LCM will educate Member on how to obtain lead test results from pediatrician. ▪ Member will obtain lead test results from their pediatrician.	▪ Member verbalized understanding of the importance of lead testing for children and adolescents on [indicate date].
Risks of not being vaccinated for the flu and Covid-19	▪ Member will verbalize understanding of the risks of not being vaccinated for the flu and Covid-19 by [indicate date].	▪ LCM will provide education on flu and Covid-19 vaccines. ▪ Member will spend time to read and understand materials. ▪ Member will decide if they will get vaccinated. ▪ LCM will provide the Member with a list of vaccination locations. ▪ Member will discuss with their PCP if it is appropriate for them to get vaccinated considering their health conditions.	▪ Member verbalized understanding of the risks of not being vaccinated for the flu and Covid-19 on [indicate date]. ▪ Member was vaccinated for the flu on [indicate date]. ▪ Member was vaccinated for Covid-19 on [indicate date].
Sleep Habits for Pediatrics with ADHD	▪ Member will verbalize understanding of methods to facilitate better sleep habits for children and adolescents with ADHD by [indicate date].	▪ LCM will provide information on sleep habits for children and adolescents with ADHD. ▪ Member will spend time to read and understand materials. ▪ Member will implement better sleeping habits with their child.	▪ Member verbalized understanding of methods to facilitate better sleep habits for children and adolescents with ADHD on [indicate date].
Parenting	▪ Member will verbalize understanding of what good parenting is by [indicate date]. ▪ Member will verbalize understanding of how they can improve their parenting skills by [indicate date].	▪ LCM will educate Member on how to register their child for school. ▪ Member will work with LCM to create a transportation plan and schedule to ensure children arrive at school on time and make it home safely each day. ▪ LCM will educate Member on the importance of regular medical care for children including staying current on vaccinations and attending checkups annually. ▪ LCM will educate Member on how to maintain proper dental care for children including brushing teeth twice a day and attending dental checkups bi-annually. ▪ LCM will educate Member on how to establish and maintain good routines for children such as daily bedtime routines including brushing teeth and reading a book before bed. ▪ LCM will educate Member on how to meet all basic needs of the children in their care.	▪ Member verbalized understanding of what good parenting is on [indicate date]. ▪ Member verbalized understanding of how they can improve their parenting skills on [indicate date]. ▪ Member started implementing a regular bedtime routine for their child on [indicate date].
Stress Management	▪ Member will reduce the number of times they experience severe stress from [indicate current frequency] to [indicate desired frequency] by	▪ LCM will educate Member on reducing perceived stress. ▪ LCM will provide education on coping skills for stress management. ▪ Member will practice stress reducing coping skills such as breathing, yoga, listening to music, drawing, crocheting, and other calming activities. ▪ Member will practice removing themselves from stressful environments so they can reset. ▪ LCM and Member will work together to assess stress causing triggers in	▪ Member reduced the number of times they experienced severe stress to [indicate desired frequency] on [indicate date].

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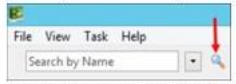
CalAIM Registration Overview
3.2025

To add a new/established patient, first search for the patient to prevent duplications

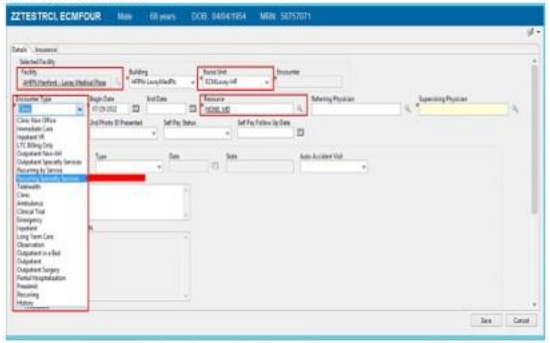


- Search criteria should always be **Patient's name** and **DOB**
- If no match is found proceed with adding new patient **(Referred to the Cerner Training Steps (Pg. 14&15)**

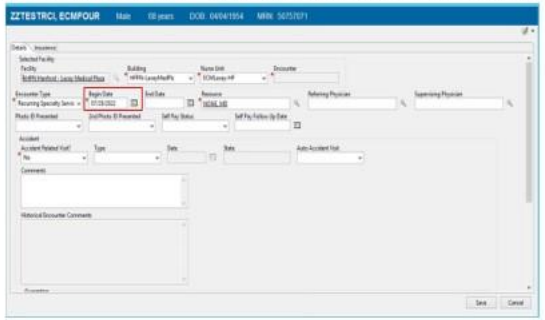
Adding Recurring Encounters

- Selecting Encounter Tab and click the +

- Select Facility/Org – (obtain from report)
- Nurse Unit/Location – (obtain from report)
- Encounter Type – Recurring Specialty Services
- Resource – NONE.MD



Selecting the Date of Service – can be found on the File Report under Eligibility Date



Title: CalAIM Registration Job Aid
Owner: Client Management Team
Date: July 2022
CONFIDENTIAL

AdventistHealth

Thank You

Let’s stay connected!

Ashten Phillips

System Director, CalAIM Operations

phillia@ah.org

Yesenia Mock

Administrative Director, Value Based Care

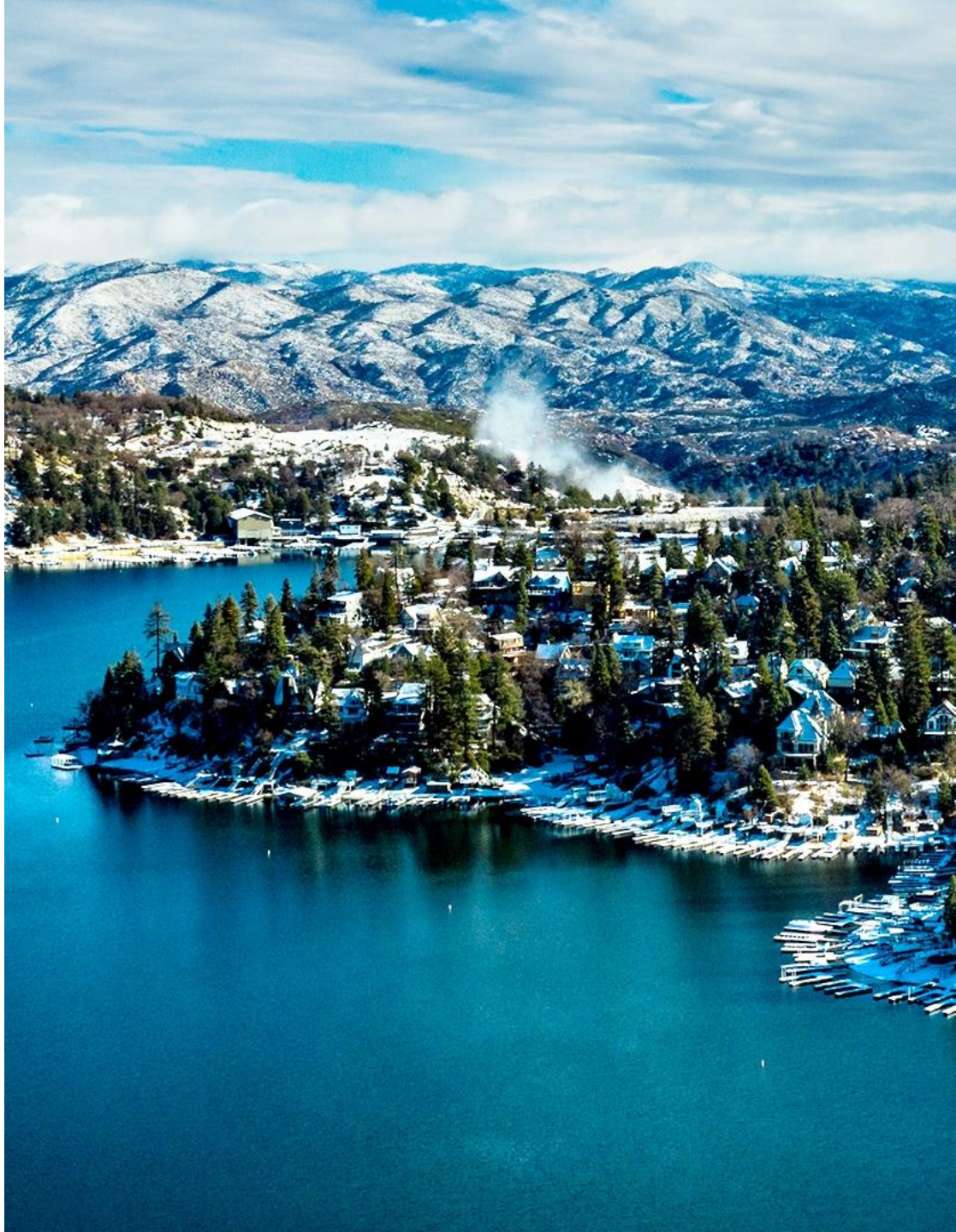
Yesenia.mock@ah.org

AdventistHealth

Q&A / Discussion

What questions do you about building the CalAIM infrastructure?

Please chat in your questions/comments



Taking a Pause

Suggested Actions

- Join the PATH CPIs to gain access to coaching/support and timely updates.
- Review the biggest needs in your current infrastructure or anticipated infrastructure and browse the TA Marketplace for support.
- Review the PATH On Demand Resource Library for more support.
  - Refer to the “Policy Guides” for detailed information on addressing ECM and Community Supports

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

Our Six-Session Arc

1. Introduction & CalAIM Overview
2. Hospital's Role in CalAIM Leadership
3. Building CalAIM Infrastructure
4. Coordination in Community-Based Health Care
5. Payment Models for the Future
6. Bringing It All Together

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

- Describe the roles of MCPs, providers, and counties as key partners in a hospital's CalAIM work.
- Bridge the language and data used by CBOs, MCPs, and health care organizations for improved collaboration.
- Identify cross-sector collaboration and communication structures that accelerate community change and population impact.
- Understand closed-loop referral systems and how to redesign and coordinate workflows across organizations.

See you at Session 4!

Coordination in Community-Based Health Care

Wednesday, March 26 12-1:30 PM

Featuring guests from Sharp Coronado Hospital and Serene Health, plus more from Adventist Health.

Stay on the line for optional breakouts

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

Looking for Volunteers

Are you willing to participate in a 30-minute interview with the HC² Strategies team so they can learn more about your CalAIM journey, your experience to-date in the CalAIM Academy, and your needs for future sessions/iterations?

If so, please reach out to Rebecca@HC2Strategies.com.

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

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

The survey will open as you exit out of the Zoom. We will also send a link in our follow up email.

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

Breakouts

Reminder: 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 confidential 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.

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

Self-Select Into A Breakout Room

Where are you in your CalAIM journey?

Room 1	Room 2	Room 3
• *Interested in exploring contracting*	• *Currently contracted*	• *Engaged or interested in engaging as a referral partner*

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

Please fill out our survey

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

The survey will open as you exit out of the Zoom. We will also send a link in our follow up email.

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

Thank you!