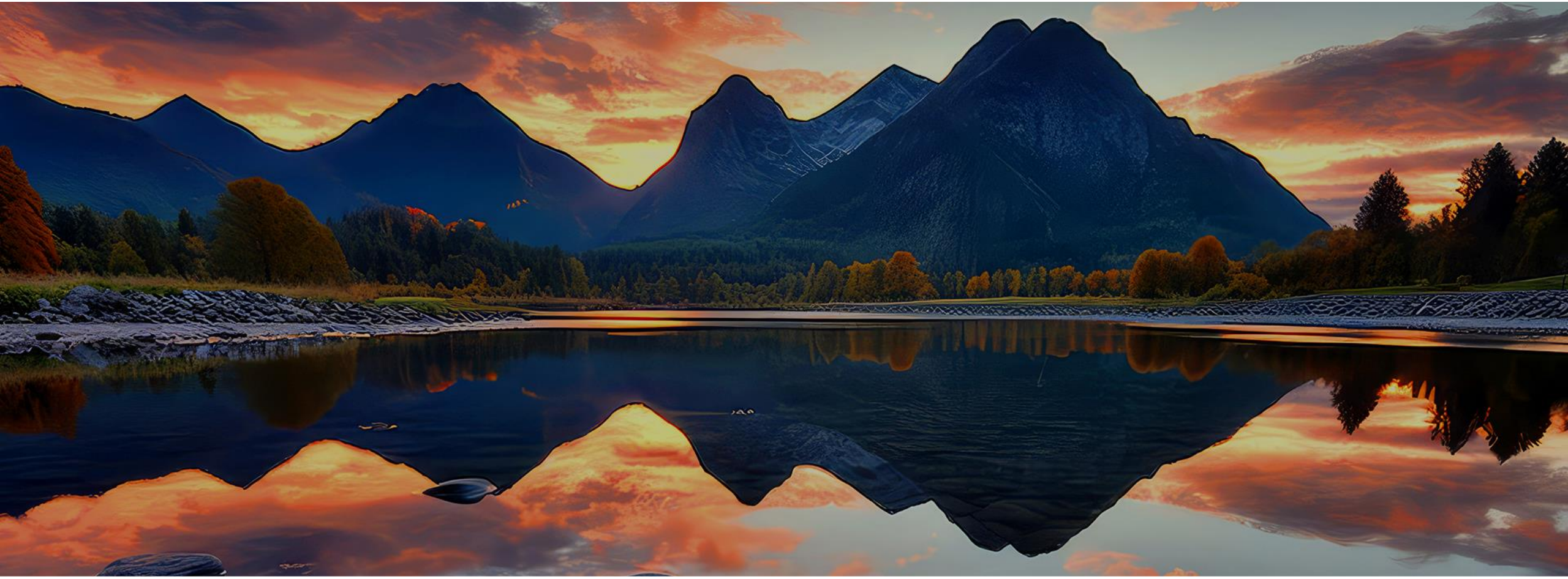

CalAIM Academy for Hospitals and Health Systems

Session 4: Coordination in Community-Based Health Care
Wednesday, March 26, 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
- *& What's an action (big or small!) that you have taken as a result of something you learned in the CalAIM Academy so far?*

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

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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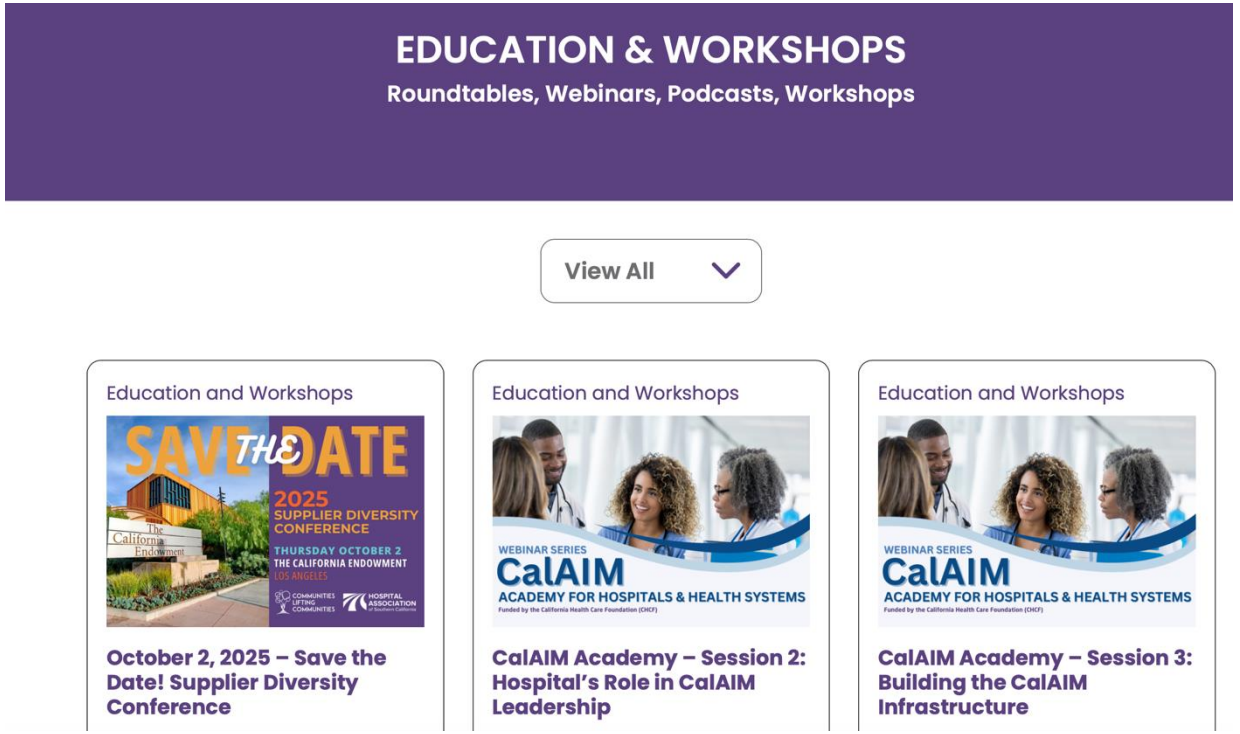
HEALTHY CONNECTED COMMUNITIES

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/

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

New Resource from Adventist Health!

AdventistHealth

Resources

[ADVENTISTHEALTH:INTERNAL]

Contents

[ADVENTISTHEALTH:INTERNAL]

Community Connect Referral Form

CommunityConnect | AdventistHealth

REFERRAL FORM

MEMBER INFORMATION

First Name*
Last Name*
Date of Birth*
CIN/Member ID*
Health Insurance*

- ☐ Anthem Blue Cross
- ☐ Kern Health Systems
- ☐ Partnership HealthPlan of California

MEMBER CONTACT INFORMATION

Phone Number
Email Address
Street Address
City, State, Zip

REFERRER CONTACT INFORMATION

Referrer Name
Email Address
Phone Number

EXCLUSIONARY CHECKLIST

Members enrolled in the programs below are excluded from ECM:

- ☐ Cal MediConnect
- ☐ Hospice
- ☐ Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
- ☐ Program for All Inclusive Care for the Elderly (PACE)
- ☐ Family Mosaic Project Services (FMPS)
- ☐ California Community Transitions (CCT)
- ☐ Money Follows the Person (MFTP)
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Assisted Living Waiver (ALW)
- ☐ Home and Community-Based Alternatives (HCBA) Waiver
- ☐ HIV/AIDS Waiver
- ☐ HCBS Waiver for Individuals with Developmental Disabilities (I/DD)
- ☐ Self-Determination Program for Individuals with Developmental Disabilities (I/DD)
- ☐ Basic Case Management (Medi-Cal Managed Care Benefit)
- ☐ Complex Case Management (Medi-Cal Managed Care Benefit)

NOTES

ECM PROVIDER ASSIGNMENT

Select only one of the following:

- ☐ Member is not working with any other ECM provider that they are aware of
- ☐ Member is already assigned to another ECM provider and chooses to switch to Adventist Health as the ECM provider
- ☐ Member is already assigned to another ECM provider and does not choose to switch providers (member is excluded)

CONSENTS

- ☐ Member verbally consents to receiving ECM services
- ☐ Release of Information (ROI) is attached

REFERRAL SUBMISSION Fax: (916) 406-2557 Email: CommunityConnect@AH.org

[ADVENTISTHEALTH:INTERNAL]

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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HEALTHY CONNECTED COMMUNITIES

Today's Objectives

- Describe the roles of managed care plans, community-based providers, and counties as key partners in a hospital's work in CalAIM.
- Bridge the language and data used by community-based organizations, managed care, 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.

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

Today's Agenda

Welcome to Session 4

Coordination in Community-Based Health Care

Bright Spot Examples:

- Sharp Coronado Hospital & Serene Health
- Adventist Health - Clearlake

Discussion/Q&A

Closing Announcements

Breakouts

Coordination in Community-Based Health Care

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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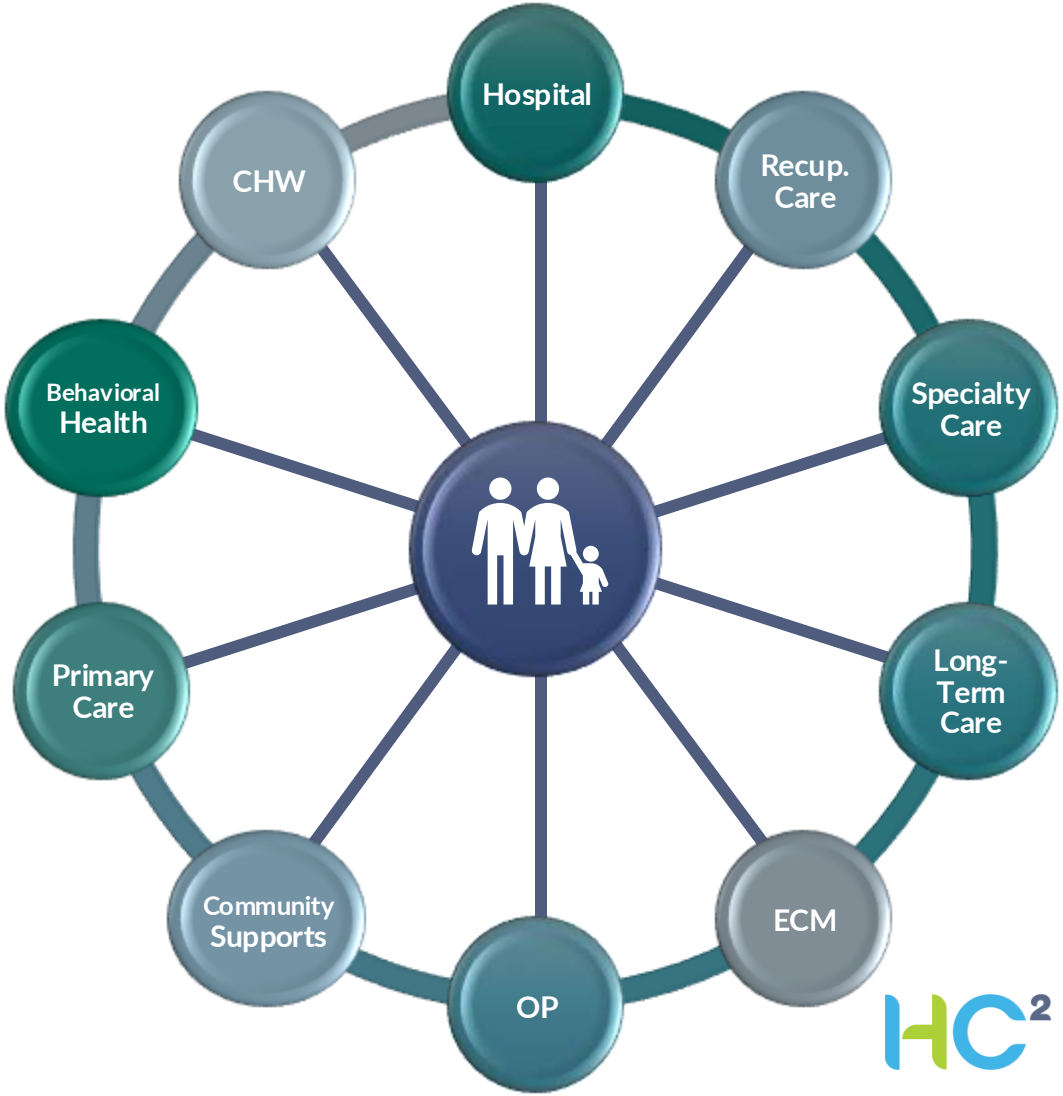
HEALTHY CONNECTED COMMUNITIES

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



HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

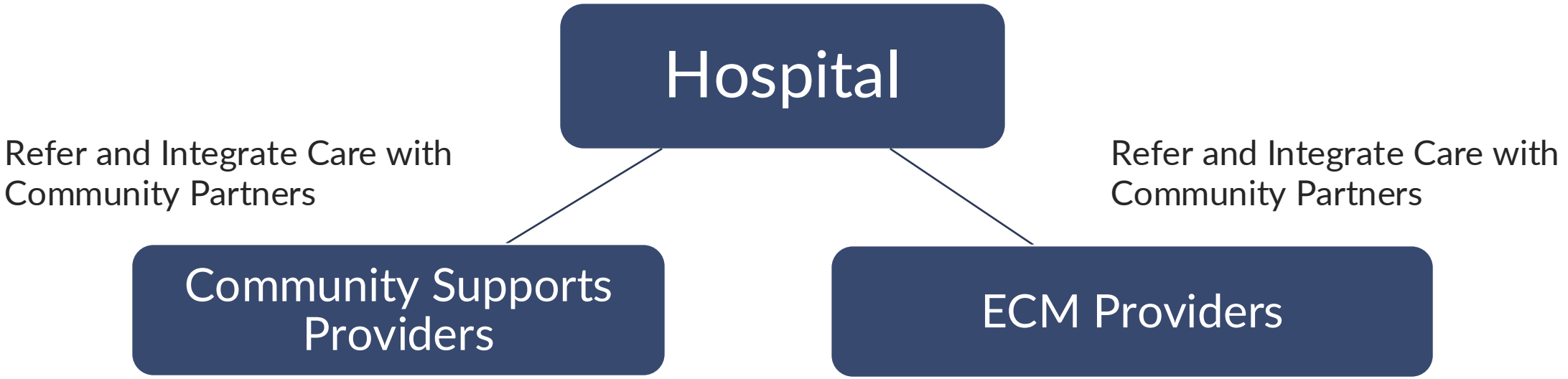
Alternative Approaches to Integration

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

Contract and deliver services under CalAIM (Vertical Integration)

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

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 Community Support services in your service area.
- Understand what new services have been funded and how you make referrals to them.
- Learn how your region is building new systems of care with 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.

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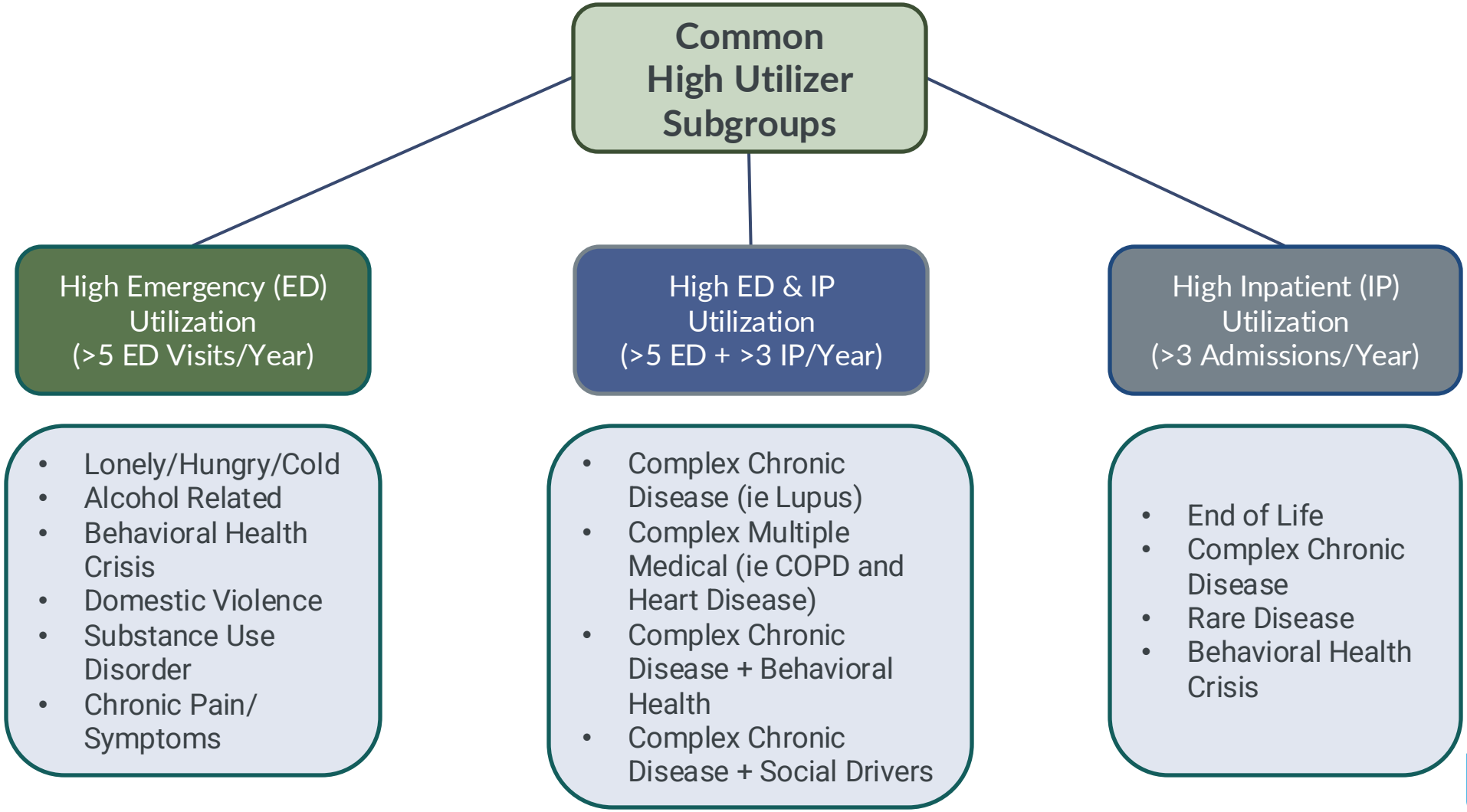
Sub-Populations That Stem from Data on High Utilizers



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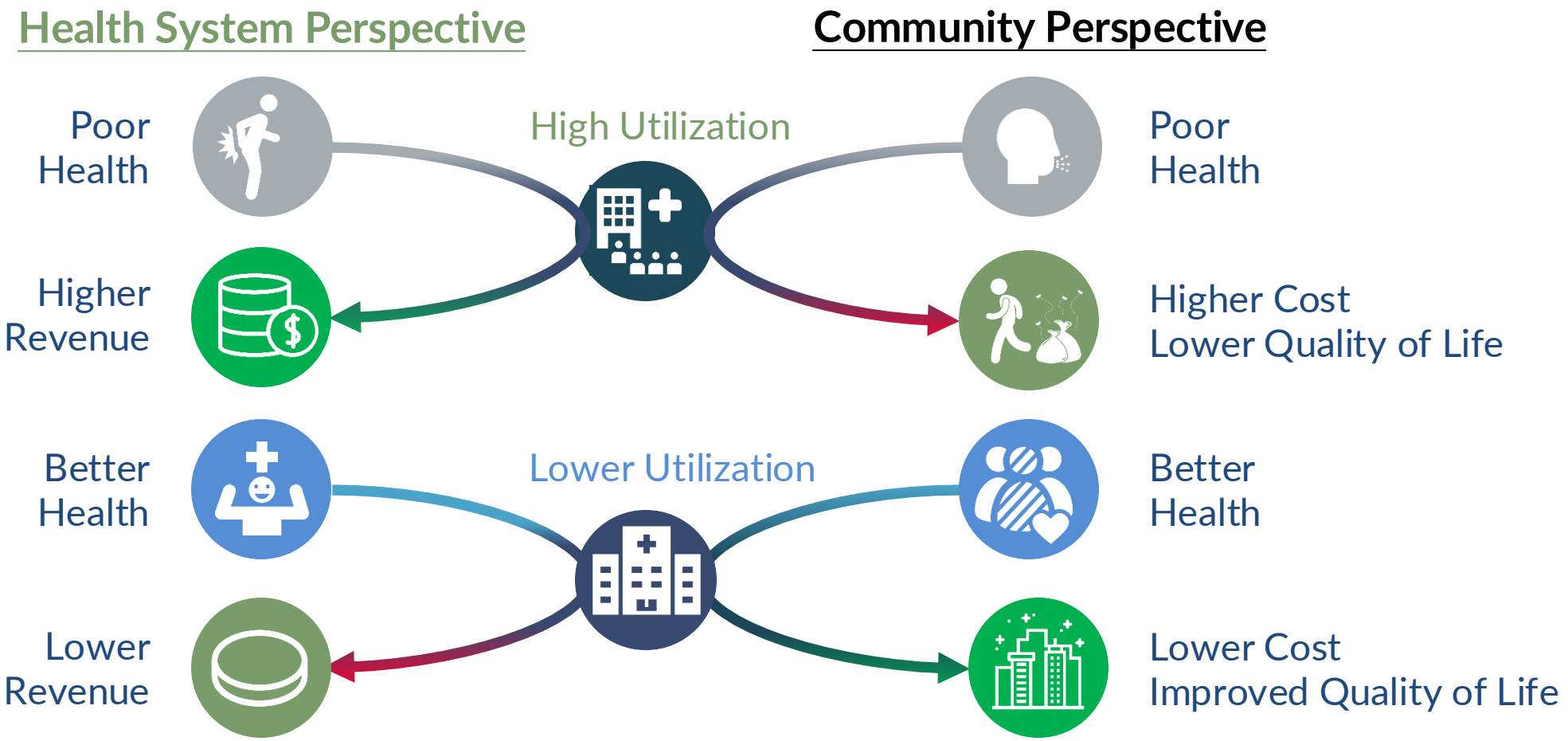
Vicious Cycles



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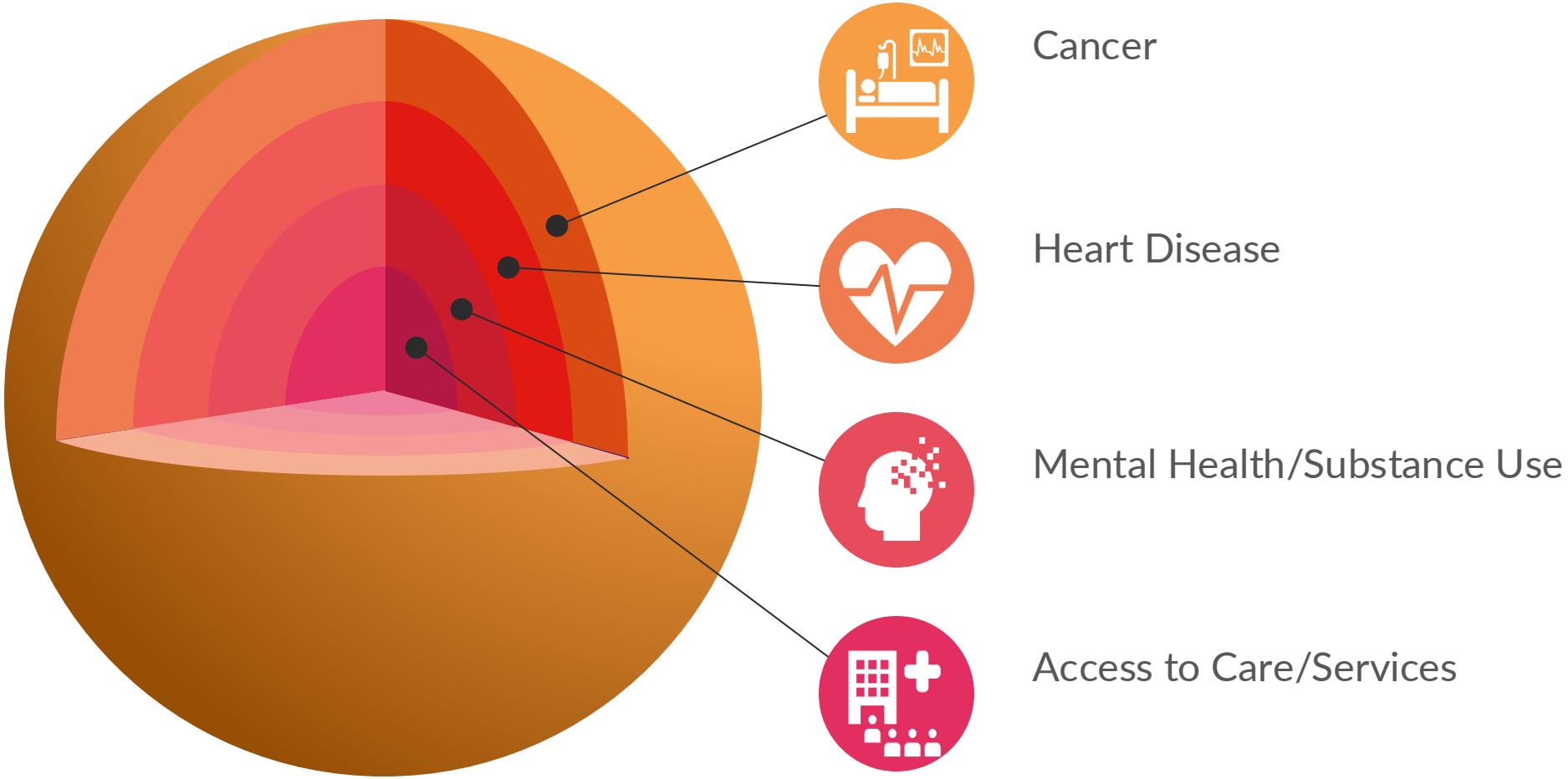
HEALTHY CONNECTED COMMUNITIES

Connecting High Utilizers to CHNA Priority Areas



Cancer

Heart Disease

Mental Health/Substance Use

Access to Care/Services

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HEALTHY CONNECTED COMMUNITIES

Integration

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

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

Primary Audience: Individuals experiencing homelessness

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy & Sustaining Services
4. Short-Term Post Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Day Habilitation
7. Transitional Rent (starting in 2025)

Supports to Keep People at Home

Primary Audience: Individuals at risk for institutionalization in a nursing home

8. (Caregiver) Respite Services
9. Nursing Facility Transition/ Diversion to Assisted Living Facilities
10. Community Transition Services/ Nursing Facility Transition to a Home
11. Personal Care & Homemaker Services
12. Environmental Accessibility Adaptations (Home Modifications)

Supports to Improve a Chronic Condition

Primary Audience: Individuals who have certain chronic conditions and require support

13. Meals/Medically Tailored Meals
14. Asthma Remediation

Support to Recover from Acute Intoxication

Primary Audience: Individuals found publicly intoxicated to divert from jail or the Emergency Department

15. Sobering Centers

More information: [Community Supports Policy Guide]

Short-Term Post-Hospitalization Housing

Members who:

- Do not have a residence, and
- Have high medical or mental health and substance use disorder needs

Receive **short-term housing for up to six months to continue their recovery**.

To receive this support, members must also have been discharged from an inpatient clinical setting, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.

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HEALTHY CONNECTED COMMUNITIES

Recuperative Care (Medical Respite)

Members with:

- Unstable housing who no longer require hospitalization, but still need to heal from an injury or illness

Receive **short-term residential care**, including housing, meals, ongoing monitoring of the member's condition, and other services like coordination of transportation to appointments.

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Sobering Centers

Members who are:

- Found to be publicly intoxicated

Are provided with a **short-term, safe, supportive environment in which to become sober**.

Sobering centers provide services such as medical triage, a temporary bed, meals, substance use education and counseling, and linkage to other health care services.

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HEALTHY CONNECTED COMMUNITIES

Butte County Sobering Center Case Study

Case Study – Butte County Sobering Center

March 18, 2025

Rebecca Brandes, Lauran Hardin, Christine Pickering, and Jerilene Tibayan

HC² STRATEGIES
HEALTHY CONNECTED COMMUNITIES

The "Housing Trio"

	**Housing Transition Navigation Services**	Members experiencing homelessness or at risk of experiencing homelessness receive help to find, apply for, and secure housing.
	**Housing Deposits**	Members receive assistance with housing security deposits, utilities set-up fees, first and last month's rent, and first month of utilities. Members can also receive funding for medically-necessary items like air conditioners, heaters, and hospital beds to ensure their new home is safe for move-in.
	**Housing Tenancy and Sustaining Services**	Members receive support to maintain safe and stable tenancy once housing is secured, such as coordination with landlords to address issues, assistance with the annual housing recertification process, and linkage to community resources to prevent eviction.

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HEALTHY CONNECTED COMMUNITIES

Bright Spot Examples

Sharp Coronado Hospital & Serene Health

30 Referrals

13 Enrolled	**43% Enrollment**	10/13 Enrolled Patients are Engaging	**76% Engagement from Enrolled Patients**

10 Currently Outreaching

5 With another ECM

2 Non-Eligible

ADVENTIST HEALTH CLEARLAKE

COMMUNITY HEALTH DEPARTMENT

Community HUB

Shower Trailer

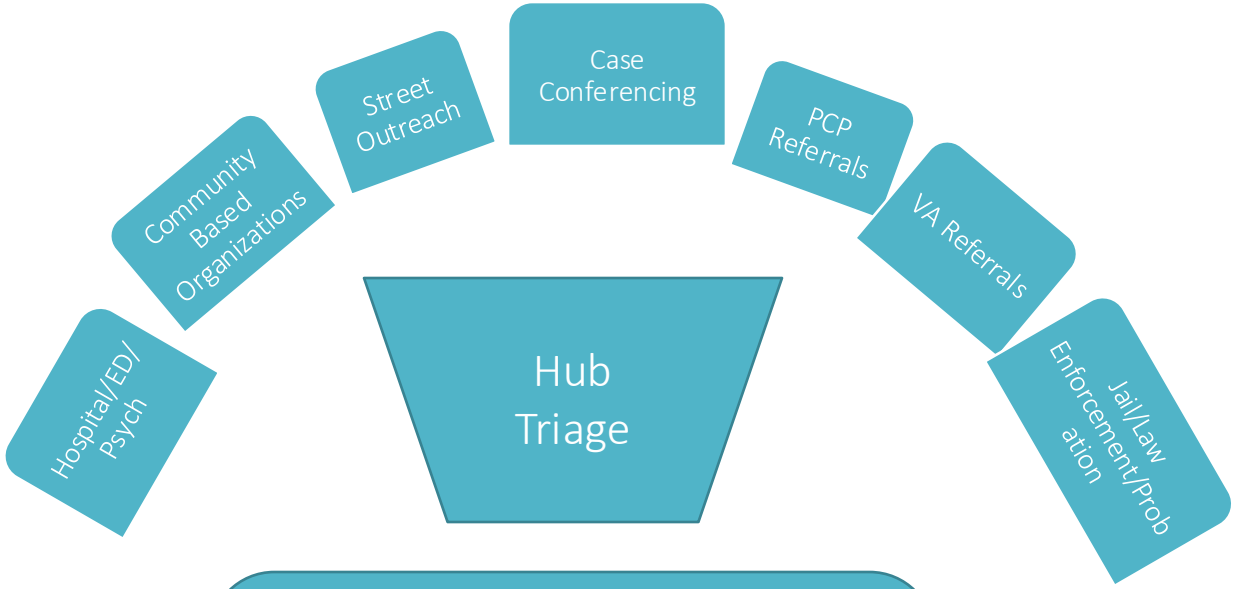
SUN

Restoration House

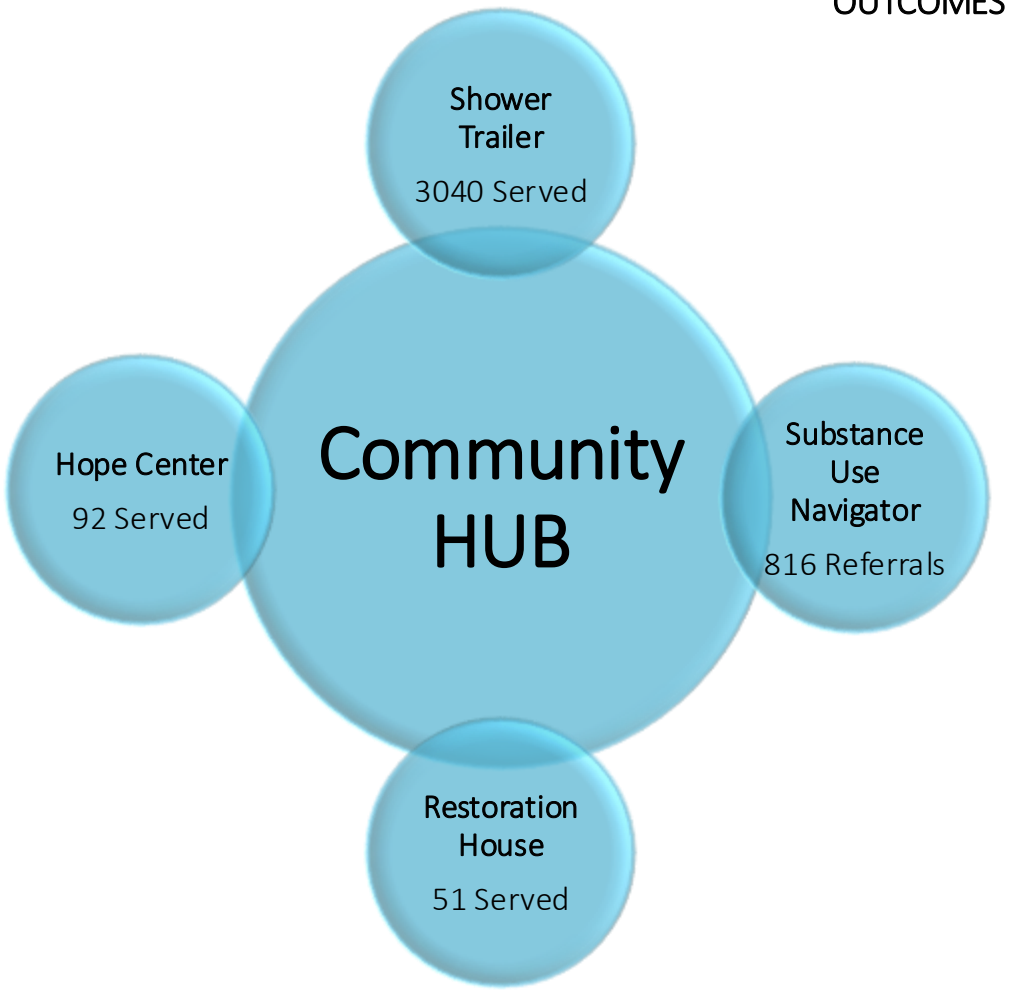
Hope Center

Community Supports

Housing Navigation, Housing Tenancy



Screen for Payer
Enter in CES/HMIS if unhoused
Screen for CalAIM ECM/CS/CHW
Screen for Current Care Services
Refer to appropriate Provider
Track referral through process and closed once needs are met



2024 OUTCOMES

329 Unique Patients Enrolled in Community Supports in 2024

134 Patients Housed Since 2023

1244 Clients enrolled in the HUB

KEY PARTNERSHIPS

Hospital Case Management
PCP Referrals
Palliative Care
Hospice
IHSS
Home Health

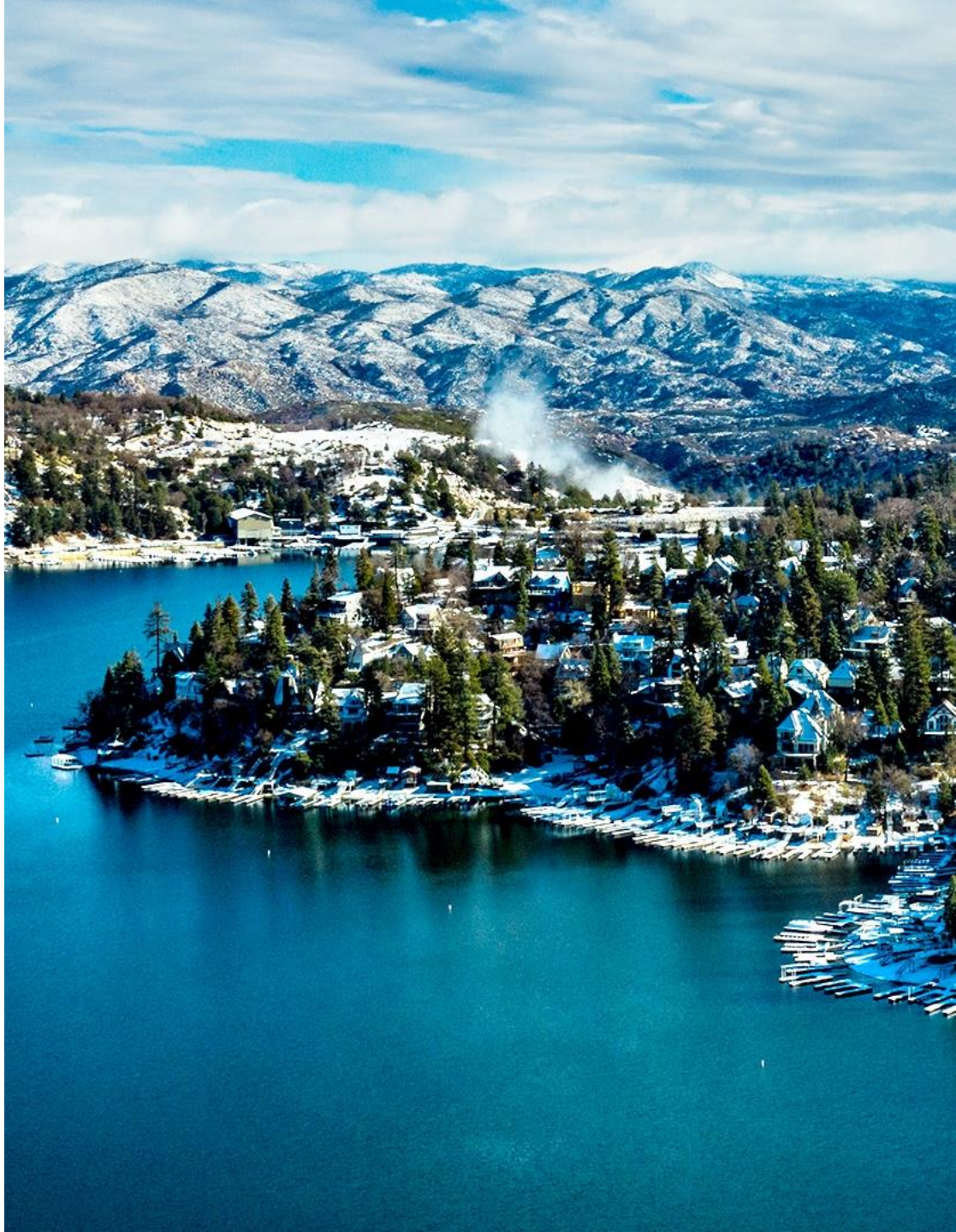
Jail Medical
Code Enforcement
Probation
Parole
City and County Law Enforcement
Fire/EMS

County of Lake, Continuum of Care
Behavioral Health
Social Services
Faith Based Community
Food Resources/Food Banks
Colleges
Office of Education
Landlords and Housing Programs

Q&A / Discussion

What questions do you have about coordination in community-based health care?

Please chat in your questions/comments



Taking a Pause

Suggested Actions

- Reflect:
  - What services resonate most for your patients?
  - Who are potential partners in your community providing these CalAIM services?
  - What do you need to proceed in engaging them as a referral partner? Who can you contact?
- Review the PATH On Demand Resource Library for more support.
  - Refer to the “Policy Guides” for detailed information on addressing ECM and Community Supports

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HEALTHY CONNECTED COMMUNITIES

Our Six-Session Arc

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- Interpret ways to make CalAIM financially strategic and sustainable in the context of planned and political developments in the field.
- Understand new revenue streams and incentives presented by CalAIM and how they relate to other funding flowing into a community.
- Connect blending and braiding funding to developing population health/value-based payment infrastructure for underserved populations.
- Strategize how to make the value case for CalAIM to your CFOs and leaders.

See you at Session 5!

Payment Models for the Future

Wednesday, April 9 - 12-1:30 PM

Stay on the line for optional breakouts

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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
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Breakouts

Reminder: Academy Norms

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We'll Now Open Breakout Rooms

The group will be split into three rooms for a discussion about coordination in community-based health care.

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Thank you!