**CalAIM Statewide Learning Collaborative**

Friday, December 1, 2023

12 PM - 1 PM

**Recording Available** [**HERE**](https://us06web.zoom.us/rec/share/z_jwBx7NtU1vwcellwiBjjhs_yL6_3NGUnmsngs-djEv8gfRxXLHQIrJ5mz1FQxO.A8hMuHLnyla-YRDn)(Passcode: BiH@j.a4)

1. **Welcome & Introductions**

* **David Panush: California Health Policy Strategies**
  + “Our goal today is to gather an understanding of the landscape [of care] and [explore] what kind of services are needed for the unique population we are focusing on today.”
* **Laura Rath: Archstone Foundation**
  + “Our mission is to improve the health and wellbeing of older adults, older Californians, and their caregivers.”

1. **White Paper: How CalAIM Supports Best Practices in Dementia Care (*Dr. Anna Chodos, UCSF)*** (<https://archstone.org/uploads/ARCHSTONE-CALAIM-WHITEPAPER-FINAL-Nov-2023.pdf>)

* This white paper was created through the efforts of Dr. Anna Chodos, Jackie Buente, Dr. Helen Chen, and Ashley Johnson
* **Laura Rath: Archstone Foundation** 
  + This level setting paper “puts the issues and challenges in perspective as well as the opportunities that we could hopefully work out together.”
* **Anna Chodos, MD: UCSF Dementia Care Aware**
  + “The goal of this presentation is to review some of the core elements of [meeting the needs of individuals with dementia] and to review some of the points of distinction we came to through the work of the white paper.”
* **Anna Chodos, MD: UCSF Dementia Care Aware**
  + California’s Dementia Challenges
    - Prevalence of dementia
    - Under-detection
    - Dementia and Medi-Cal
    - People Living with Dementia Health Care System Utilization Compared to People without Dementia
    - Costs of Dementia
  + Best Practices in Dementia Care: The Goals
    - Focus on personalized care
    - Contain costs
    - Delay or minimize institutionalization
  + Best Practices in Dementia Care: The Elements
    - Embrace collaborative care
    - Develop detailed care plans that include multicomponent interventions
    - Promote community living arrangements and support
    - Do more to support caregivers
* **Jackie Buente, LCSW: UCSF Dementia Care Aware**
  + “There are several different components of CalAIM that really help reinforce best practices in dementia care.”
    - Enhanced Case Management (ECM)
      * Outreach and engagement
      * Comprehensive assessment and care management plan
      * Enhanced coordination of care
      * Health promotion
      * Transitional care services
      * Member and family supports
      * Coordination of and referral to community and social Support Services
  + “Another great component that CalAIM offers is community supports”
    - Environmental accessibility adaptations (home modifications)
    - Respite services
    - Personal care and homemaker services
    - Medically tailored meals or medically supportive food
    - Nursing facility transition or diversion to assisted living facility
  + CalAIM provides Path funding to train dementia care specialists, extra help for dual eligible, and new opportunities in Medicare

1. **Reaction Panel: CalAIM and ECM Service Delivery**

**1. Rebecca Sullivan: Local Health Plans of California**

* **David Panush: California Health Policy Strategies**
  + “Rebecca, what would be your thought in terms of those activities that Dr. Chodos outlined? And is that compatible? Does that align from your perspective of of what CalAIM is supposed to be doing, and what are your reactions to what was presented?”
* **Rebecca Sullivan: Local Health Plans of California**
  + “So we represent the 16 Medi-Cal managed care plans in the state and, as was alluded to earlier, many of those plans have Medicare products that serve duly eligible beneficiaries today and others are work actively working towards that in 2026. So by then, you know, those plans will cover both the medCal and the Medicare component.”
  + “That visual that was put up was really, really helpful. And there is absolutely so much alignment...particularly on the community support side with what plans are working on and implementing best practices that have been outlined here today, particularly for things like home modifications, respite care, and medically tailored meals.”

**2. Patty Mouton: Alzheimer’s Orange County**

* **David Panush: California Health Policy Strategies**
  + “What's the experience in Orange County? We had a statewide perspective just now from the plans. What about boots on the ground in Orange County?”
* **Patty Mouton: Alzheimer’s Orange County** 
  + “Alzheimer’s Orange County is actively working with CalOptima on plans for enhanced care management...we fully intend to be in lock step with CalOptima, helping to provide that side of this ECM for people with dementia, and we are becoming more and more aware of the notion that many folks that would into the need for ECM for dementia have multiple comorbidities.”
  + “We’re going to have to be ready to balance that out and be able to address and provide the care and support that would go along with the ECM for dementia.”
  + “Most people who have dementia have three significant comorbidities. So, we have to be prepared to address those...[and] make sure that they’re being monitored appropriately.”
  + “We’re very early in our trajectory [towards ECM]. I can probably give you a lot more information in 3 months.”

**3. Jenna LaPlante: Institute on Aging**

* **David Panush: California Health Policy Strategies**
  + “From what you’re seeing, tell us the challenges you’re facing. Is the model that Dr. Chodos and her team presenting consistent with what you’re doing? Does it work or are we missing something here?”
* **Jenna LaPlante: Institute on Aging**
  + “Well, it is consistent. We’ve also had the luxury of being contracted with some of the health plans that were at the forefront of doing the transitions within diversions to residential care facilities previously. So, we have some experience prior to CalAIM as well.”
  + “What we have found is especially for those that Patty was speaking to with multiple medical comorbidities is that we have created a centralized clinical team that helps consult and support our lead care managers across our calendar programs. This consists of an RN, an OT, and an LCSW. Now, this this staffing model is not necessarily supported under or directed right for ECM. Specifically, there's lead care managers, right? But it is really helpful for us when our clients get admitted or discharged to have an RN who looks over the discharge summary...and provide some kind of understanding with that to our lead care manager, who then can take those steps to help address the entire biopsychosocial picture.”
  + “We really do find, you know, when independent living is exhausted...those small-scale group homes really do help support [patients] staying out of the nursing facility for a prolonged period of time. So, any way that plans could be supported to help continue service will be a really strong benefit to our population of adults with cognitive impairments.”

**4. Michelle Johnston: Department of Aging**

* **David Panush: California Health Policy Strategies**
  + “Do you have any thoughts from a statewide perspective of what you’re seeing?”
* **Michelle Johnston: Department of Aging**
  + “It’s great to see the work being done on CalAIM at the state level and it gives me hope for this growing population and what supports are going to be there for folks. It ties in really nicely with the goals in the Plan for Aging as well.”
  + “Goal 2 which relates to health reimaged, and that talks about caregiving at work...it all ties in. We’re all looking to achieve the same goals.”
  + “What I love about this work is that if we can reduce unnecessarily hospitalizations and emergency department visits through improved care, education, and support for both the person with dementia and their caregivers, everyone wins. The system wins. We reduce costs. The caregivers win because we reduce their stress and burden. The person with dementia wins because they have better quality of life.”

**5. Laura Miller, MD: DHCS Quality and Population Health Management**

* + “I do absolutely think that when I look at the long-term care population definition, the population of focus definition, that's all the people I was trying to take care of in East Oakland...[with] cognitive impairment and at least one social or environmental factor influencing their health...So ECM, for that, is just really beautiful.”
  + “I think we all have collective work, though, to really socialize this idea in terms of the dovetail of ECM.”
  + “We've recently done some work on continuity of care for ECM for those in Medicare Advantage. So let me know if you want a little snippet on that, and I can do it.”

**6. Cindy Skoygard: Pathways**

* + “Pathways has been a CBO doing ECM before ECM was vogue and had nice initials and, more specifically, we’ve had an amazing partnership with the Archstone Foundation.”
  + “We got really good at doing the ECM and interventions. We piloted a program with our local meals on wheels. We documented that we did assessments, home assessments. We are in their homes, and we are with people hand to hand.”
  + “We didn't go in just for dementia. We went in to keep older adults safe and independent in their own home. And the only reason I'm telling you all this is because I'm not quite sure where I fit in here in that. But I do think we're sort of a trailblazer in this arena. The shortfall is that we don’t know how to get the attention of the managed care companies...because my organization runs completely on donations and grant writing.”
  + “[ECM] in real time works. It really, really works in real time, because we've been living it.”

**7. Amy Phillips: Little Tokyo Service Center**

* + “Our staff is really a subset of the population. Our staff is thinking about how ethnic minority populations access some of these services because the referrals and getting the services that our populations need have been kind of challenging...getting [the referral] in the right language, and supports, especially for [those] that live alone.”
  + “I want to understand more about how that’s going to work and be integrated and maximize some of the community supports that are out there.”

**8. Jennifer Schlesinger: Alzheimer’s Los Angeles**

* + “We believe, you know, there's a lot of different entry points to get to community supports, and if people kind of have no wrong doors, there's no wrong way to get to them. Hopefully, we'll see a greater uptick. But we've had a really hard time going to the health plans website. Some of them have the information, some do not. We have spent hours and hours trying to collect information and are getting nowhere. So I can only imagine what it's like for families.”
  + “Of those health plans that have shared with us the referral form, I wouldn’t be able to fill it out, let alone someone who may have less education, less health literacy skills, or speaks another language.”
  + “We’ve been talking about what it would be like if there were a county specific guide to quickly look up which health plan is offering what and what the process is to get that service. Our CBO’s would be a great referral source to community supports. We want to use those community supports, but we can’t figure out how to navigate them.”

1. **Next Steps/Next Meetings**

* Next Statewide Collaborative: Friday, January 12th, 2024, 1 PM – 2 PM
  + Register Here:
* Upcoming Workgroup Meetings
  + CBOs interested in contracting: Thursday, December 14, 2023, 3 PM - 4 PM
    - * Register Here: <https://us06web.zoom.us/meeting/register/tZUuc-iorzkvHtSZADNJ6zjk0o-UdJWsYCv4>
  + Dementia-specific workgroup: December 15, 2023, 12 PM - 1 PM
    - * Register Here: <https://us06web.zoom.us/meeting/register/tZIsfuGqqjkpHNB9QWxWcIQUpo4emMprP9iD>