

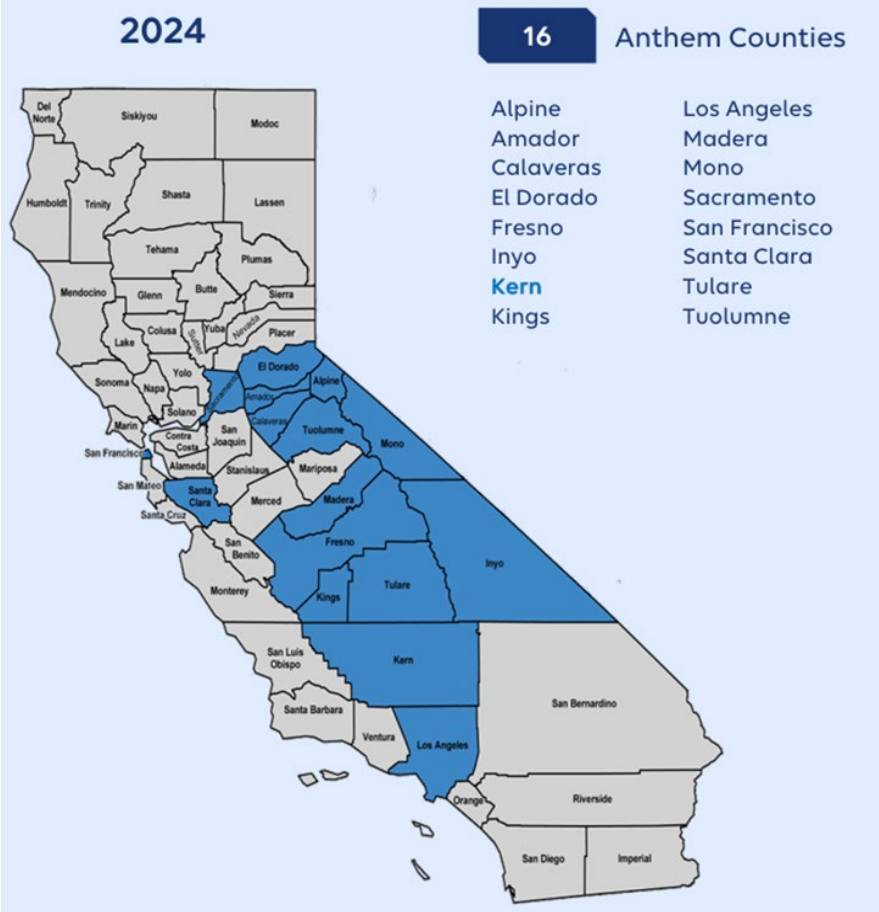
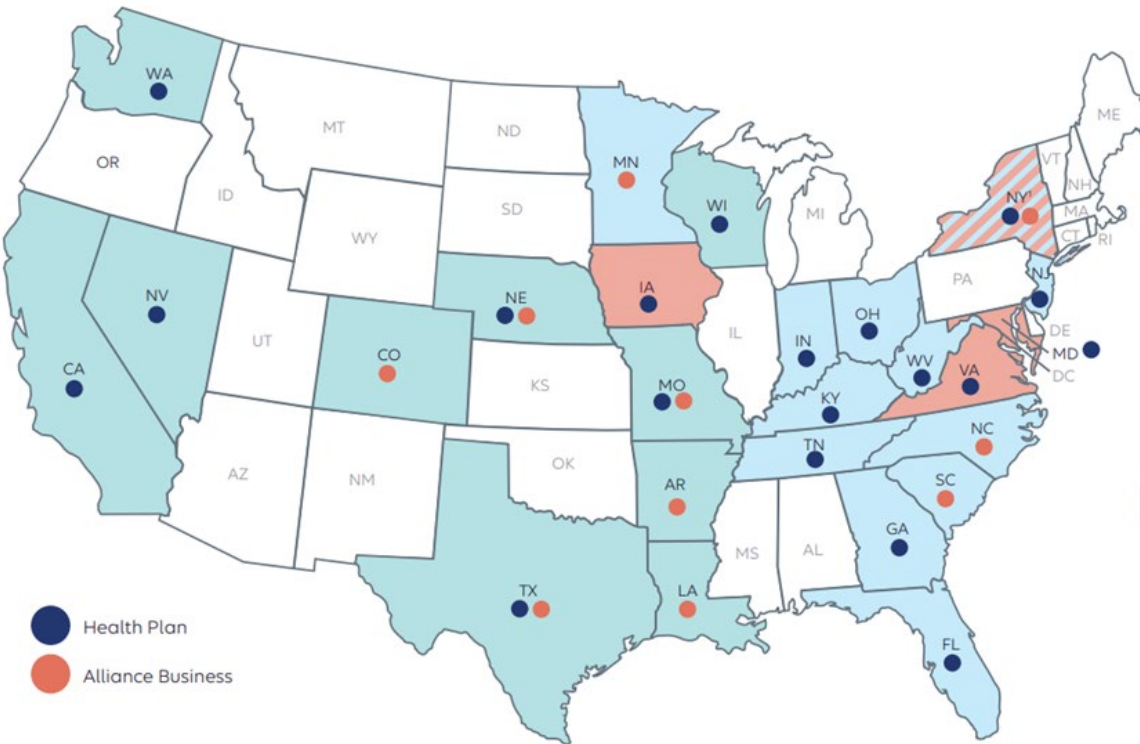


Supporting SDOH Efforts through Partnerships with Community Organizations and Primary Care

Anthem Blue Cross incentive programs (HHIP, IPP, & SBHIP) supporting California Advancing and Innovating Medi-Cal (CalAIM)

A presentation by Tara Brickey, Dieumi Nguyen, Noni Plasichuk, and Timi Leslie

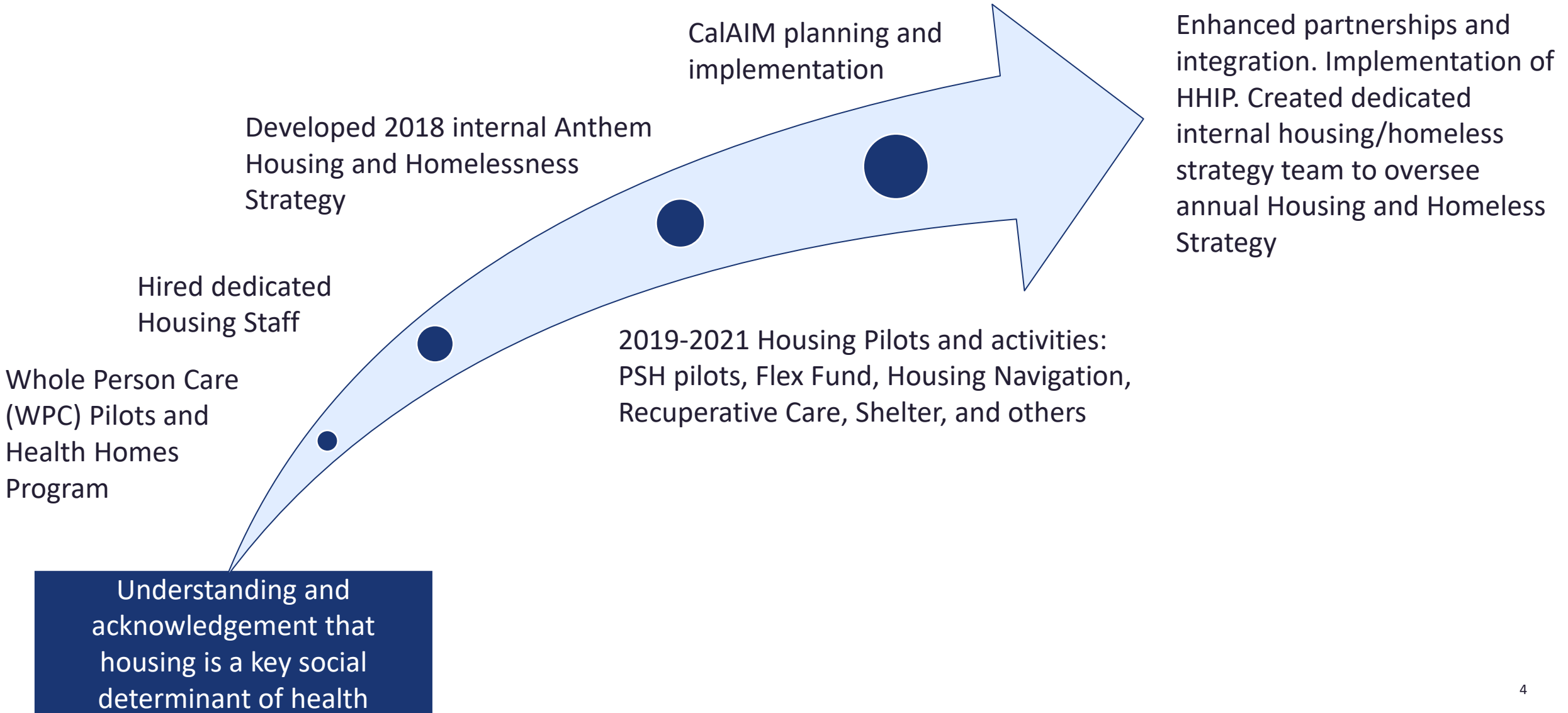
Elevance Health/Anthem Blue Cross Medicaid Overview



DHCS Housing and Homelessness Incentive Program (HHIP)

Noni Plasichuk, *Program Manager of Regional Housing Strategy Anthem Blue Cross*

Anthem Evolution of Addressing Housing and Homelessness

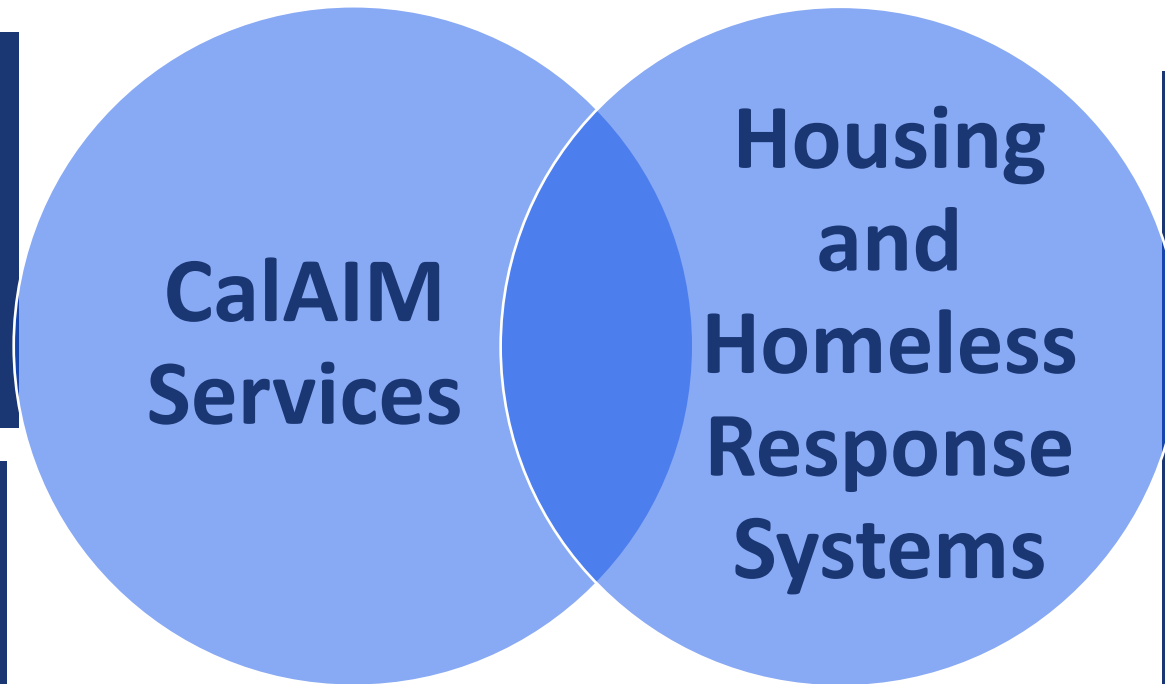


Main Focus in 2024: Integrating CalAIM into Housing/Homeless Response System

CalAIM presents an enormous opportunity to braid Medi-Cal funding to support and expand services as part of housing/homeless response system

In CA there is not enough funding from federal, state, and local partners through housing/homeless funds to meet the need. Communities need to embrace the use of Medi-Cal to support efforts.

People experiencing homelessness are target population for Enhanced Care Management (ECM) and many of the housing Community Supports (CS).



Anthem is focused on engaging local communities and providers to integrate CalAIM into various housing/homeless interventions.

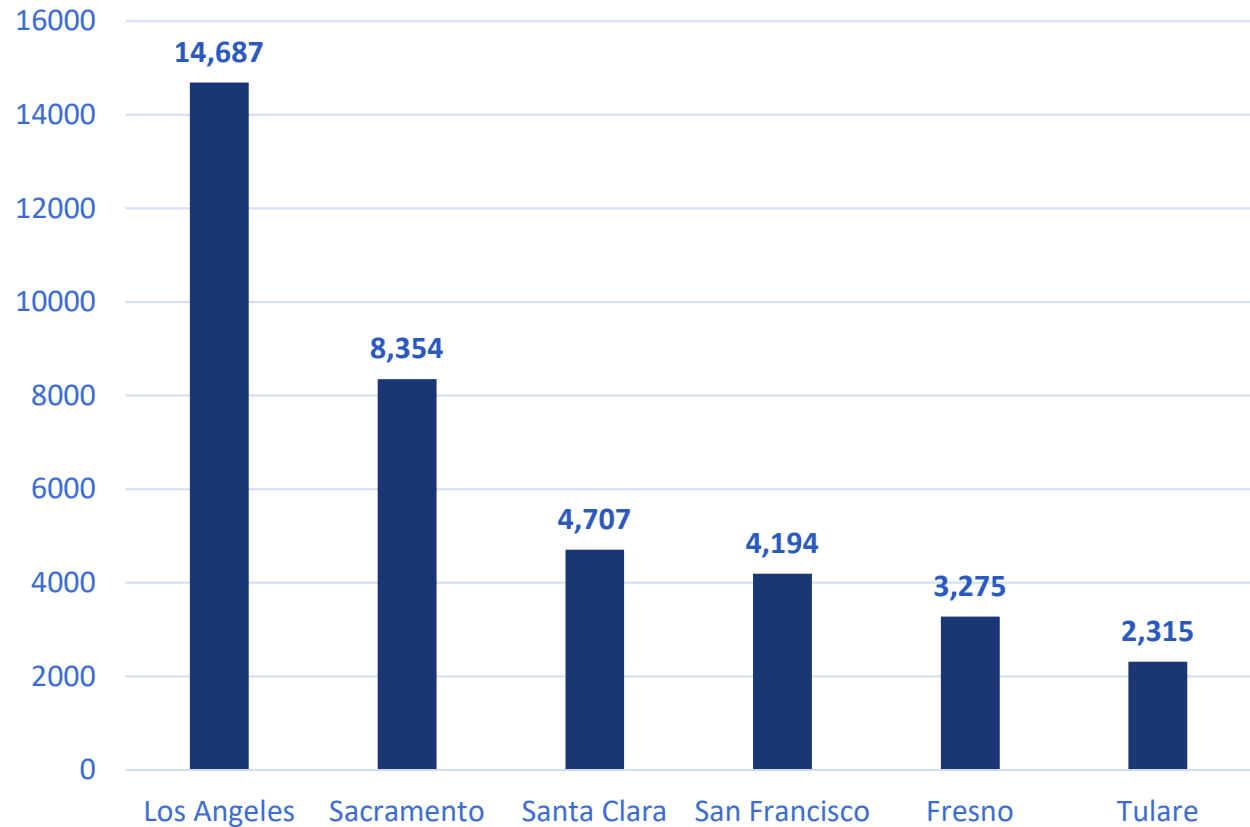
Anthem is using DHCS Housing and Homelessness Incentive Program (HHIP) and CalAIM Incentive Payment Program (IPP) to support uptake with exciting examples of successful models in both urban and rural counties.

Housing and Homelessness Incentive Program Overview

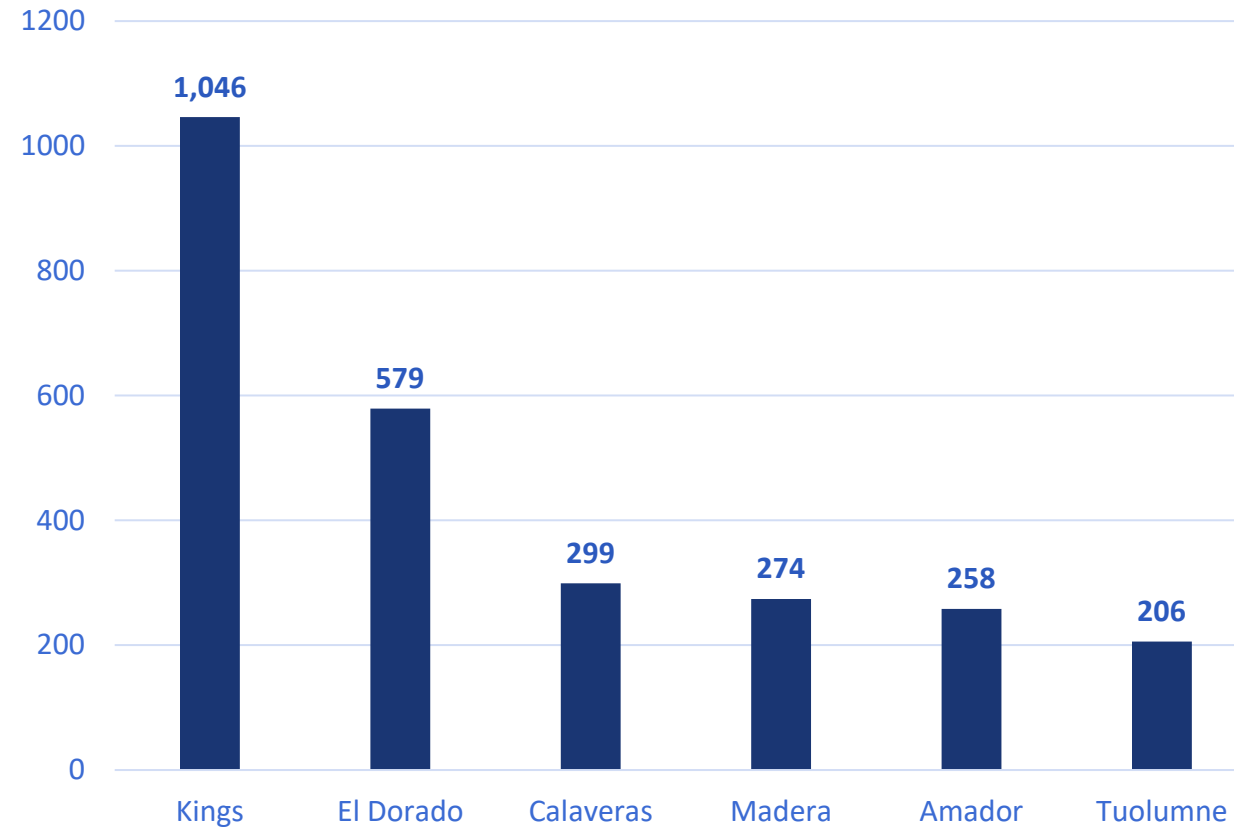
- Two-year incentive program from DHCS for health plans to earn dollars by building partnerships and addressing homelessness. Started in 2022 and ended in December 2023.
- Nearly \$1.3 billion statewide with allocations determined by homeless Point In Time Counts and MCP membership. One-time program and no ongoing funding.
- Key metrics included:
 - Partnerships with the homeless Continuum of Care (CoC) - Collaboration with the Coordinated Entry System, data sharing with Homeless Management Information System (HMIS)
 - Increased street medicine services
 - Increased CalAIM Enhanced Care Management (ECM) and Community Supports (CS) utilization,
 - Increased housing outcomes for members
- Been making significant investments to address housing and homelessness in our counties and integrating CalAIM supports as part of investments.

Anthem Members Experiencing Homelessness in CA

Larger Urban Counties



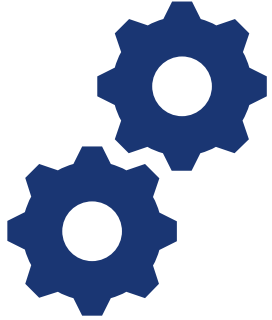
Smaller Rural Counties



Source: HMIS matched data with Anthem membership from 1/1/23-10/31/23 (DHCS HHIP S2 Reporting Period)

HHIP Strategic Investments – 3 Primary Areas

CoC Infrastructure



- CoC staffing and capacity
- HMIS capacity, technology enhancements, new software
- CES: Staffing capacity, CES redesign processes, incorporating health data
- PIT Count: Incentives, enhanced analytics
- Equity: Lived experience incentives, racial equity dashboards, trainings

Street Medicine Capacity



- Provider capacity and operations
- Supplies and vehicles
- Technology and data collection and reporting infrastructure
- Street outreach staffing in partnership with street medicine/health services
- Incentives for members to engage in street medicine services
- USC Statewide Street Medicine Collaborative

Housing Interventions



- Homeless prevention assistance
- Street outreach
- Diversion/Navigation services
- Safe parking programs
- Low-barrier shelter beds
- Recuperative Care expansion
- Flex funds for housing lease up
- Shared housing trainings
- Landlord engagement/unit acquisition services
- Supportive housing development and rehab

HHIP Investments: Homeless Continuums of Care (CoC)

CoC	CoC Lead Agency – HHIP Recipient	HHIP CoC Funded Activities	HHIP Funds from Anthem
Alameda County	Alameda County Health Care Services Agency	PIT Count support, CoC infrastructure, CalAIM implementation	\$154,000
Butte County CoC	Butte County Department of Employment and Social Services	HMIS/CES enhancements, CoC infrastructure, PIT Count support, racial equity trainings	\$56,851
Central Sierra CoC (Amador, Calaveras, Mariposa, Tuolumne Counties)	Amador Tuolumne Community Action Agency	CoC infrastructure, HMIS/CES enhancements, Youth Lived Experience Advisory Board	\$133,407
Contra Costa CoC	Contra Costa County Health Services	HMIS/CES enhancements, matching funds for HUD CoC NOFO	\$668,000
Dos Rios CoC (Colusa, Glenn Counties)	Glenn County Community Action Department	HMIS/CES enhancements, CoC infrastructure, PIT Count support, racial equity assessment	\$79,623
Eastern Sierra CoC (Alpine, Inyo, Mono Counties)	Inyo County Health and Human Services Agency	HMIS/CES enhancements, CoC infrastructure, PIT Count support	\$87,261
El Dorado CoC	El Dorado County Health and Human Services Agency	PIT Count consultant, new HMIS software procurement, Lived Experience Advisory Board	\$166,711
Fresno Madera CoC	RH Community Builders, Poverello House, Fresno Housing	Development of new CES tool, CoC training platform development, new HMIS software procurement (pending)	\$106,947
Kings Tulare CoC	Kings Tulare Homeless Alliance, Kings United Way	PIT Count support, HMIS enhancements, HMIS racial equity dashboards,	\$168,080

Monterrey/San Benito Counties CoC	Coalition of Homeless Services Providers	CoC infrastructure, HMIS/CES enhancements, Equity Framework development	\$97,887
Nevada County CoC	Homeless Resource Council of the Sierra's	CoC infrastructure, HMIS/CES enhancements, PIT Count support	\$161,962
Placer County CoC	Homeless Resource Council of the Sierra's	CoC infrastructure, HMIS/CES enhancements, PIT Count support	\$312,647
Plumas Sierra CoC Advisory Board	Plumas Crisis Intervention and Resource Center, Sierra County Behavioral Health	HMIS reporting, PIT Count support	\$10,106
Sacramento County CoC	Sacramento Steps Forward	CalAIM CoC infrastructure, HMIS/CES enhancements, CoC training development, lived experience stipends, PIT Count support, CoC standards development, Homeless Action Plan development	\$1,290,000
San Francisco City/County CoC	San Francisco Dept of Homelessness and Supportive Housing	CES consultant for data integration	\$17,776
Santa Clara County CoC	San Clara County Office of Supportive Housing	CoC infrastructure, HMIS enhancements, PIT Count support, equity trainings	\$895,867
Sutter Yuba Counties CoC	Sutter Yuba Homeless Consortium	CoC infrastructure, HMIS/CES enhancements, PIT Count support, data warehouse planning	\$474,028
Tehama County CoC	Vitality Project	HMIS/CES enhancements, CoC infrastructure, equity strategy development, lived experience stipends	\$367,288
TOTALS			\$5,248,441

HHIP Investments: Street Medicine Capacity

County	Street Medicine Providers
Alameda	Alameda County Health Care for the Homeless Program
Amador	Wellspace Health
Contra Costa	Contra Costa Health Care for the Homeless Program
El Dorado	Marshall Medical Center
Fresno	Clinica Sierra Vista, Saint Agnes Medical Center (launched in Fall 2023)
Los Angeles	Various
Sacramento	Elica Health Centers, Sacramento County Dept of Health Services, Sacramento Street Medicine, Wellspace Health
San Francisco	SF Community Health Center, SF Dept of Public Health
Santa Clara	Valley Healthcare for the Homeless Program
Sutter	Adventist Health
Tulare	Kaweah Health
Yuba	Adventist Health



HHIP Investments: Housing and Services

- Homelessness prevention programs
- Street outreach services
- Interim housing programs: Low barrier shelter/Navigation Centers, Recuperative Care, Short-Term Post Hospitalization Housing
- Landlord engagement models
- Affordable/Permanent Supportive Housing Developments

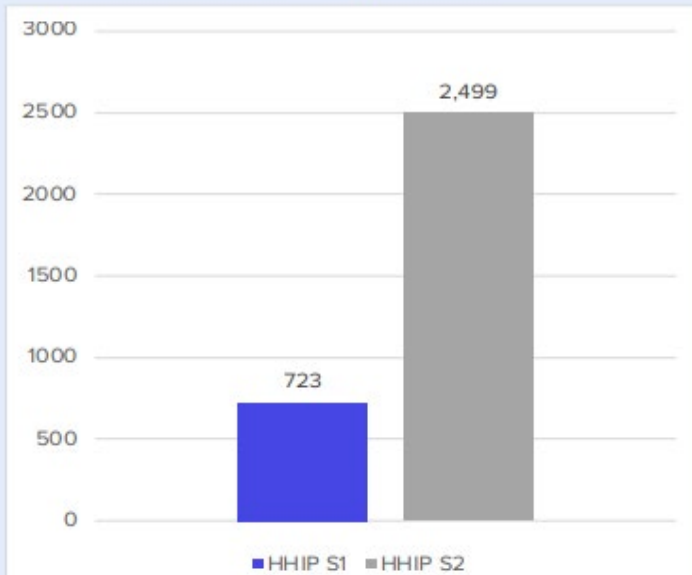


HHIP Investments with Local County Departments

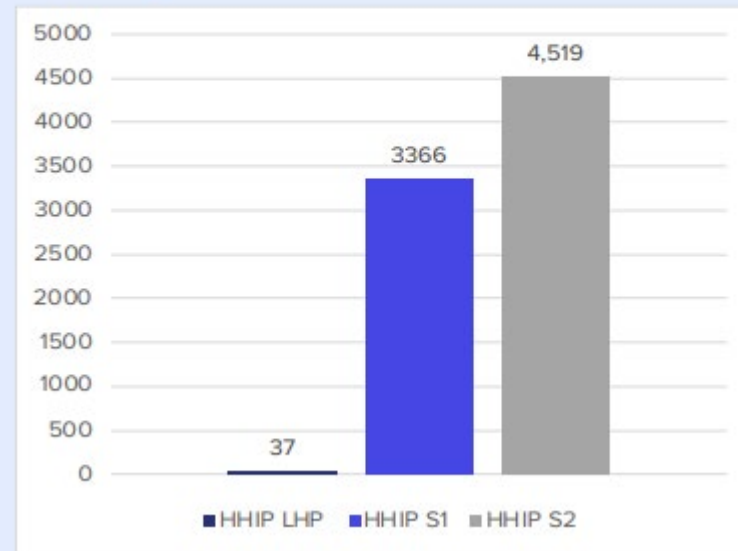
- Alameda County Health Care Services Agency
- Butte County Dept of Employment and Social Services
- Calaveras County Health and Human Services
- Contra Costa County Health Housing and Homeless Services Division
- El Dorado County Health and Human Services
- Glenn County Community Action Dept
- Inyo County Health and Human Services
- Plumas County Dept of Public Health
- Sacramento County Dept of Homeless Services and Dept of Health Care Services
- San Francisco Dept of Public Health and Dept of Homelessness and Supportive Housing
- Santa Clara County Office of Supportive Housing
- Sierra County Dept of Behavioral Health
- Tulare County Health and Human Services

HHIP Impact

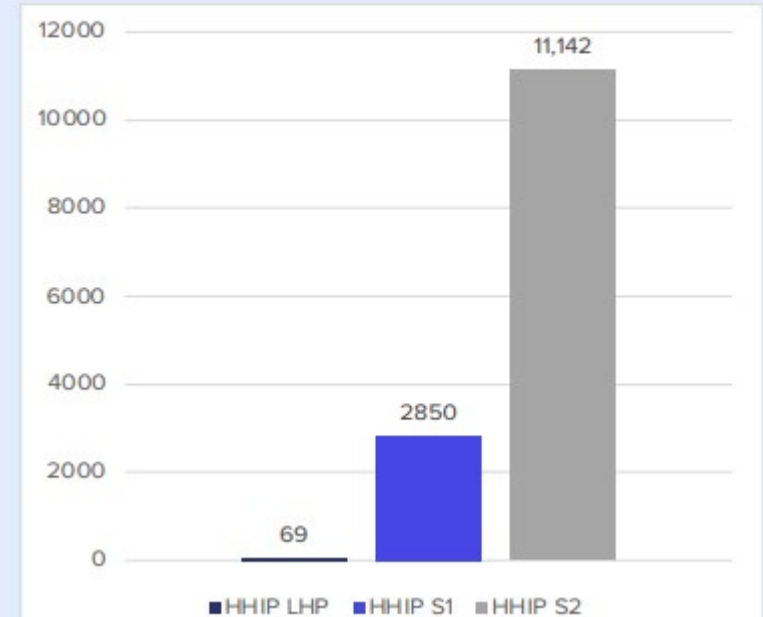
Anthem Members Receiving Street Medicine Services or Alternative Street Medicine Services in Rural Counties S1 compared to S2



Anthem Members Receiving CS Housing Navigation and Transition Services During HHIP Reporting Periods



Anthem Members who were Permanently Housed During HHIP Measurement Periods



- Supported development of 325 new units of Permanent Supportive Housing
- Finalizing details to bring on 54 units of new Permanent Supportive Housing dedicated to Anthem members through acquisition projects.

IPP

The Incentive Payment Program by Anthem

Presentation by Tara Brickey, MPH, PMP, *Business Change Director*

Incentive Payment Program (IPP Overview)

Launched in 2022, the Incentive Payment Program (IPP) is a \$1.5 billion three-year DHCS program to support the implementation of key CalAIM initiatives. Ultimately, IPP aims to support MCPs and providers in expanding access to and uptake of Enhanced Care Management (ECM) and Community Supports (CS).

How It Works

- ✓ MCPs drafted a Needs Assessment and Gap Filling Plan in 2021
- ✓ Every nine months based on a six month measurement period, MCPs submit a Progress Report
- ✓ MCPs earn funding based on demonstrated progress in four priority areas
- ✓ Funds flow from DHCS to MCPs
- ✓ MCPs reinvest IPP funding in ECM and CS providers to increase capacity and strengthen infrastructure

Priority Areas

- 1. Delivery System Infrastructure:** Health Information Exchanges, EHR, care management documentation system, billing and closed loop referral infrastructure
- 2. ECM Provider Capacity Building:** Workforce recruiting, onboarding, training and TA, compliance and oversight capabilities, etc.
- 3. Community Supports Provider Capacity Building:** CS take-up, workforce recruiting, onboarding, training and TA, etc.
- 4. Quality and Emerging CalAIM Priorities:** Baseline data collection to inform quality outcome measure

2022 Anthem IPP Provider Investment Snapshot



**\$8.5
million
invested**



**48
providers**



**\$177,957
average
award size**

Invested in DHCS' Priority Areas



IT Dollars

ECM Capacity

CS Capacity

Q

Note: 2022 Investment Snapshot does not include LA County. Please see slide 7 for LA County

2023 Anthem IPP Provider Investment Snapshot



**\$8.8
million
invested**



**56
providers**



**\$157,111
average
award size**

Invested in DHCS' Priority Areas



IT Dollars

ECM Capacity

CS Capacity

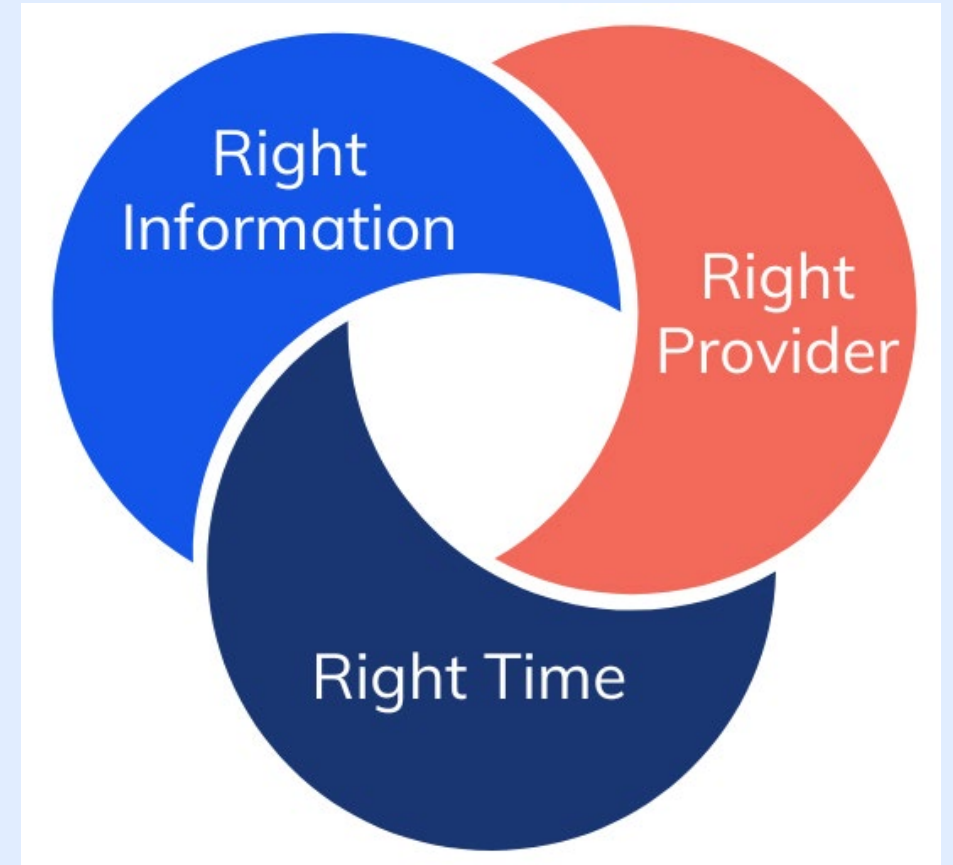
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Note: 2022 Investment Snapshot does not include LA County. Please see slide 7 for LA County snapshot.

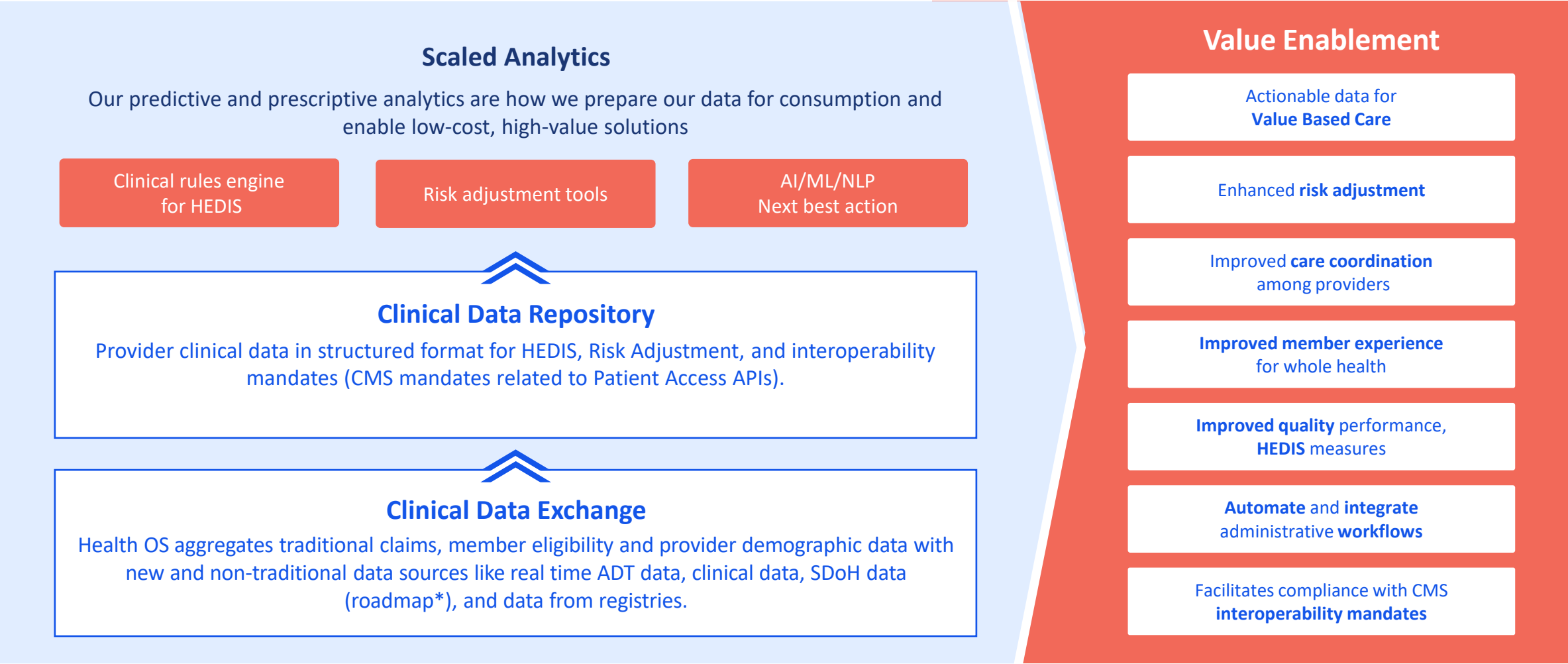
Anthem's Data Exchange Vision

Going beyond the four walls of traditional healthcare, Anthem hopes to equip all members of a person's care team with the right data, tools, and access needed to provide care of (and for) the whole person.

We believe that the best care is only possible when the **right set of health information** is available to the **right provider** at the right time.



Health OS Is an interoperability platform, connecting providers, payers, and members



*Capability is on the roadmap for future development and is not live currently. Capability is subject to change and designation should not be viewed as a commitment to deliver by a set date

Anthem Connectivity – Multiple Platforms, Common Goals

- Why We Signed – All Elevance/Anthem Businesses in CA are signatories to the DxF!
 - Builds on Federal Interoperability
 - Will evolve over time
- For CalAIM, Data Exchange is a critical piece of the puzzle as new populations, new services come online
 - Incentive Payments are available to encourage provider partners
- Working with your EHR vendor to minimize the effort required for connecting
- Participating in Health Information Exchanges (HIE), QHIN, QHIO etc.
- Encouraging partners to connect

Community Transformation in Data Exchanges (Community TiDEs)

Anthem's Community Transformation in Data Exchanges (TiDEs) Project

Greetings from Our May Visioning Session!

Anthem's Overarching Vision:

Going beyond the four walls of traditional health care, Anthem hopes to equip all members of a person's care team with the right data, tools, and access needed to provide care of (and for) the whole person.

We believe that the best care is only possible when the right set of health information is available to the right provider at the right time.

Our Definitions:

An inclusive data ecosystem:

- Has comprehensive data integration to 'see the whole picture' of health
- Is a platform that caregivers from all social & economic backgrounds can utilize
- Has adaptive functions to ensure everyone can engage
- Facilitates collaboration amongst providers
- Has bidirectional data flows & is interoperable
- Is available to access at any moment.

An accessible data ecosystem:

- Has equitable access based on community resources
- Includes the financial resources for folks to participate
- Allows care team members to have visibility and access to other care team members, including members/caregivers & across sectors
- Is available to communities that struggle with stable internet connections



The ___ Collaborative hopes to create a data sharing ecosystem that facilitates seamless care coordination between community members' health and community service providers and is equitably accessible by community members and service providers in health care and community setting. This data sharing ecosystem will:

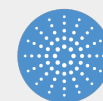
- Have bidirectional data flows
- Be interoperable across a diverse pool of community partners and their technology systems of choice / requirement,
- Provide data analytics to identify trends, track outcomes, and manage populations more effectively in key areas, and
- Operate within compliance of applicable laws and regulations

communitytides@intrepidascend.com

About Connecting for Better Health



Founded in 2021, C4BH is a nonprofit coalition of providers, caregivers, health plans, patient advocates, innovators, and community based organizations working to improve the state's data sharing infrastructure with a goal of transforming health and social outcomes for all Californians.



Connecting for Better Health

Advancing data sharing to improve the health of all Californians

Available C4BH Technical Assistance

	Level of DxF Readiness	C4BH Supports	What it is	Outputs
1	Planning	DxF Bootcamp	Half day education of what the DxF is, overview of Policies and Procedures, and help with identifying priority use cases	Develop a DxF Roadmap and Identify Priority Use Cases
2	Assessment	DxF Community Design Studio	6-8 weekly sprints to design real-world community use cases	Technical and Functional data exchange workflows, test data and reports
3	Ready to Connect!	DxF Community Sandbox	Real-world testing environment for DxF priority use cases.	Test and Validate Use Case to Establish Workflows



Goals of the ECM Provider Community Design Studio

What type of information?

We wanted to understand what type of information was most useful to the ECM provider and the larger network of providers/ partners who all served the ECM recipient. For example, hospital notifications were critical but just as important were getting post-discharge instructions.

Are there work stream enhancements?

We wanted to understand what processes in their current work streams could be automated, or at least more efficient. We heard from a lot of staff about the manual, unnecessary steps that were taken to perform their roles and wanted to workshop ideas to streamline them.

Can the ECM enrollment process be streamlined?

We wanted to understand how ECM benefits were being utilized by the ECM Providers' members and how members were able to access them. From past work, we have heard that there is often a duplication of ECM services by accident and we wanted to mitigate that.



ECM Provider Community Design Studio Learnings

What We Learned

Variability in ADT Notifications

The level of detail in the ADT notifications CBOs receive from hospitals varies significantly and impacts the patient's course of treatment

ECM Care Plan Available to All Entities

Access to and integration of electronic care plans will benefit all parties and reduce administrative burden

Real-Time Data Exchange

Getting real-time information and then getting it to the right person in a timely and efficient manner is a challenge

Privacy Concerns

Capturing and exchanging consent, mental health, and substance use disorder (SUD) data is difficult to incorporate into use cases but remain critical to support high need populations.

Double-Enrollment in Medicaid

Often there are multiple sources of information referring a patient to ECM and/or other waiver programs

Designing as a Community is Encouraging

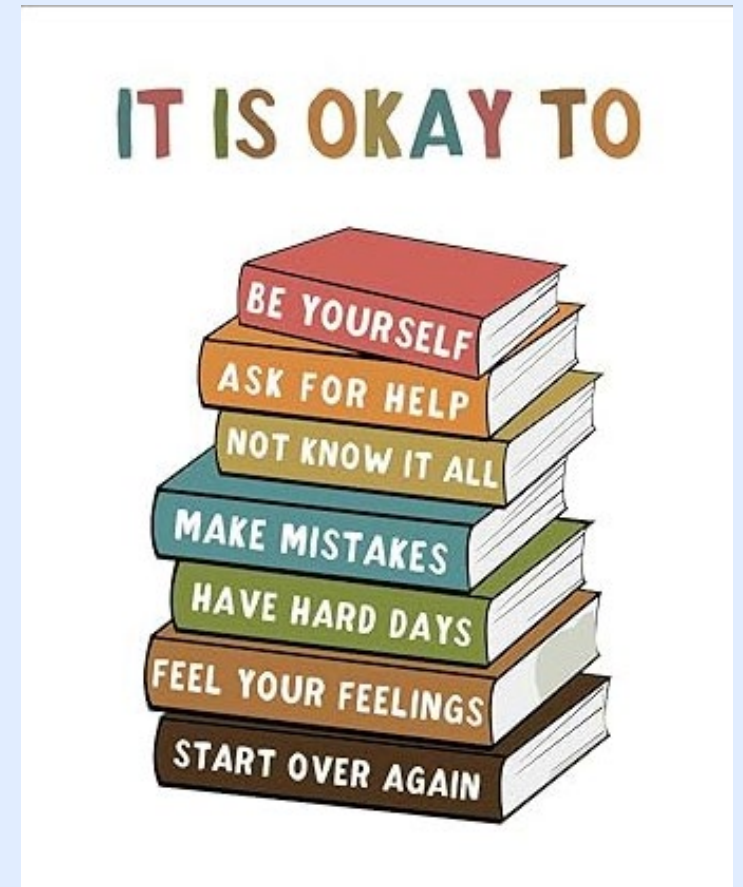
Organizations want to work together to make improvements and ultimately serve their communities to improve health outcomes



Children and Youth Behavioral Health Initiative: SBHIP

The Student Behavioral Health Incentive Program by Anthem

Presentation by Dieumi Nguyen, *Program Director of Children and Youth Behavioral Health Initiative*



C Y B H I

Workforce Training and Capacity		Behavioral Health Ecosystem Infrastructure		Coverage	Public Awareness
Certified Wellness Coaches HCAI	Trauma-Informed Educator Training CA-OSG	School-Linked Partnership and Capacity Grants DHCS	Student Behavioral Health Incentive Program DHCS	Enhanced Medi-Cal Benefits – Dyadic Services DHCS	Public Education and Change Campaigns CDPH
Broad Behavioral Health Workforce Capacity HCAI	Youth Mental Health Academy HCAI	Behavioral Health Continuum Infrastructure Program DHCS	Youth Suicide Reporting and Crisis Response Pilot Program CDPH		ACEs and Toxic Stress Public Awareness and Healing-Centered Campaign CA-OSG
Behavioral Health Virtual Services Platform and Next Generation Digital Supports DHCS		Healthcare Provider Training and e-Consult DHCS		Statewide Multi-Payer Fee Schedule for School-Linked Behavioral Health Services DHCS	Focused Youth Suicide Prevention Grants and Outreach Campaigns CDPH
Scaling Evidence-Based and Community-Defined Evidence Practices DHCS		CalHOPE Student Support and Schools Initiative DHCS			Parent Support Video Series DHCS
Mindfulness, Resilience and Well-Being Supports for Children, Youth and Parents DHCS		Youth Peer-to-Peer Support Program DHCS			DHCS DMHC

Student Behavioral Health Incentive Program (SBHIP)

SBHIP

Details

Managed by

DHCS

Strategic area

Behavioral Health Ecosystem Infrastructure

Funding

\$388.99 million

Timeline

2022 – 2025

Goals



Increase non-specialty services on or near school campuses.



Increase the number of TK-12 students enrolled in Medi-Cal receiving behavioral health services provided by schools, school-affiliated providers, county behavioral health departments and county offices of education.



Break down silos and improve coordination of child and adolescent behavioral health services for those enrolled in Medi-Cal through increased communication with schools, school-affiliated programs, managed care providers, counties and mental health providers.



Address health equity gaps, inequalities, and disparities in access to behavioral health services.

Student Behavioral Health Incentive Program (SBHIP)

Who: Medi-Cal students

What: aims to address behavioral health access barriers for Medi-Cal students through targeted interventions and provide additional avenues to access behavioral health services

Where: in school and school-affiliated settings—a critical point of access for these preventive and early-intervention behavioral health services

Why: early identification and treatment through school-affiliated behavioral health services are critical for improving children’s mental health outcomes and can reduce emergency room visits, crisis situations, inpatient stays, and other high-cost placements

How: increase access to preventive, early intervention or other behavioral health services provided by school-affiliated behavioral health providers for TK – 12 children in public schools

Anthem's key SBHIP achievements & timeline

- 01/2022 – 12/2022: completed needs 29 assessments and 63 project plans in partnership with County Offices of Education (COEs) across all service counties
- 01/2023 – current: partnered with COEs to implement 63 targeted interventions across counties, complete 15 transition plans for transitioning counties, and submit biquarterly reports and project outcome reports, earning 100% from DHCS every time
- 12/31/2024: final project outcome reports and SBHIP Memorandum of Understanding (MOU) with remaining COEs due 12/31/2024; funding disbursement expected 04/2025
- 12/31/2024: SBHIP operations conclude
- 04/2022 – current: Anthem will have distributed over \$34 million in SBHIP funding to COEs by 2025

Targeted interventions in Anthem's service counties from program start

Behavioral Health Wellness Programs

- Develop infrastructure, capacity building, partnership development, materials, training programs, and staff time for BHW programs
- Build a dedicated school BH team to engage schools, address issues for students with BH needs
- Expand greater prevention and early intervention practices in school settings

Selected by:

Alameda, **Alpine**, **Amador**, Butte, **Calaveras**, Colusa, Contra Costa, **Fresno**, **Kern**, **Madera**, Nevada, Placer, **Sacramento**, **San Francisco**, **Santa Clara**, Sierra, Tehama, **Tuolumne**, Yuba

Expanding Behavioral Health Workforce

- Expand the school-based workforce with emphasis on grades 5 – 12
- Use community health workers and/or peers to expand surveillance and early intervention of behavioral health issues in school-aged children
- Certify peers to provide peer support services on school-based sites

Selected by:

Alameda, Butte, **El Dorado**, Glenn, **Inyo**, **Kings**, Mariposa, **Sacramento**, San Benito, **Santa Clara**, Sutter, **Tulare**

Building Stronger Partnerships and Increasing Access to Medi-Cal Services

- Strengthen partnerships between schools, MCPs, and county behavioral health plans via technical assistance, training, toolkits, and/or learning networks
- Build or expand capacity of Medi-Cal services for students, integrate local resources, implement proven practices, ensure equitable care, and drive continuous improvement
- Improve Medi-Cal access

Selected by:

Alameda, **El Dorado**, **Kern**, **Sacramento**, **San Francisco**, **Santa Clara**, **Tulare**

IT Enhancements for Behavioral Health Services

- Implement information technology and systems for cross-system management, policy evaluation, referral, coordination, data exchange, and/or billing of health services between the school and the MCP and county behavioral health department

Selected by:

Contra Costa, **Kings**, **Madera**, **Sacramento**, **San Francisco**, **Santa Clara**, **Tulare**

Bolded counties are 2024 service counties

Substance Use Disorder

- Increase access to SUD prevention, early intervention, and treatment
- Expand the capacity for providers to conduct SUD activities on or near school campuses. adolescents

Selected by:

Contra Costa, **Kern, Kings**, Placer

Telehealth Infrastructure to Enable Services and/or Access to Technological Equipment

- Increase behavioral health telehealth services in schools
- Ensure all schools and students have access to equipment to provide telehealth services

Selected by:

Fresno, Madera, Plumas

Care Teams

- Build or expand care teams that can conduct outreach, engagement, and home visits, as well as provide linkage to social services to address non-clinical needs identified in behavioral health interventions

Selected by:

Contra Costa, **Fresno**, Sutter

Parenting and Family Services

- Providing evidence-based parenting and family services for families of students

Selected by:

Kern, Mono, Tulare

Culturally Appropriate and Targeted Populations

- Implement culturally appropriate and community defined interventions and systems to support initial and continuous linkage to behavioral health services in schools

Selected by:

Alameda, Contra Costa, **San Francisco**

Technical Assistance Support for Contracts

- Medi-Cal managed care plans execute contracts with county behavioral health departments and/or schools to provide preventive, early intervention, and behavioral health services

Selected by:

Placer, **Tulare**

Behavioral Health Screening and Referrals

- Enhance ACES and other age and developmentally appropriate behavioral health screenings to be performed on or near school campuses
- Build out referral processes in schools

Selected by:

Fresno

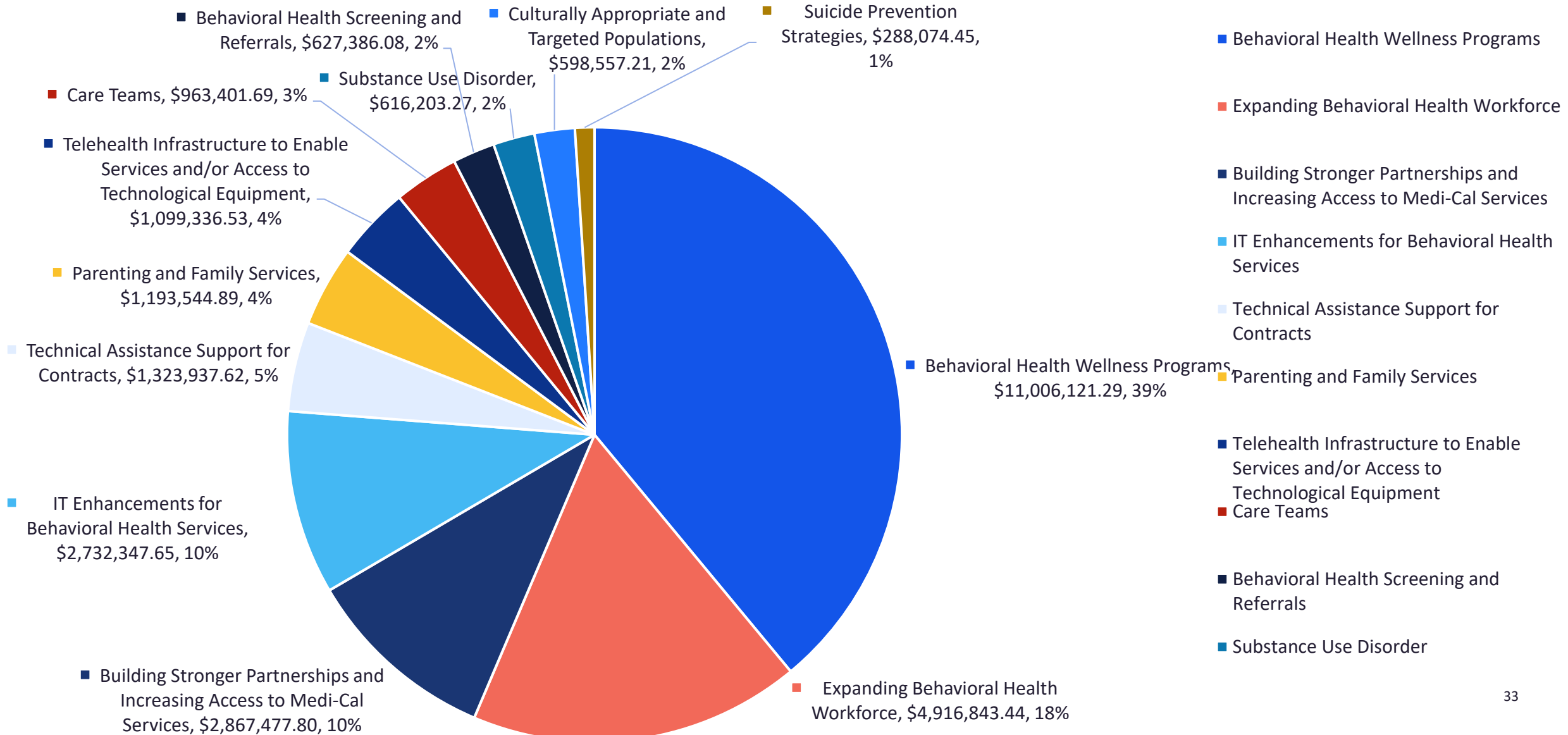
Suicide Prevention Strategies

- Implement a school suicide prevention strategy and improve upon existing LEA suicide prevention policy obligations

Selected by:

Placer

Where Anthem's SBHIP dollars go: \$28+ million to date



Impacts of SBHIP

For students

For all others

1

Made wellness accessible

- Increased number of wellness centers and presence of staff creates an adequate, physical, positive, supportive, safe space and survey tools for students to better support them

- Increased collaboration, education, and engagement for staff + improved relationships with community partners

2

Growth in behavioral health workforce

- Increased student involvement, enhanced programs and services, and improved collaboration
- Raised trust in school's commitment towards student interests
- Fortified mental health infrastructure
- Reduced need for external BH services

- Hired for specific roles, introduced peer-to-peer support, developed dedicated teams, and outlined career pathways to grow workforce
- Increased capacity for better care coordination and effective referrals
- Staff became more attuned to student needs and equipped to identify and address student BH concerns

3

Improved access to Medi-Cal services

- Increased access for students to take advantage of Medi-Cal services available to them

- More collaboration among LEAs and stakeholder involvement
- Increased knowledge on Medi-Cal billing and programs

Impacts of SBHIP

For students

For all others

4

Leveraged technology

- Data-driven approaches for better care coordination
- Technology to support higher utilization of services
- Better data exchange infrastructure to collect meaningful data to support needs of students
- Additional avenues for access to services

5

Strengthened ecosystem of support

- Increased access to prevention and early intervention services
- Promoted culturally responsive information and resources
- Expanded family resource centers, parent programs, and parent training sessions
- Lowered barriers for families

6

Produced better outcomes for students

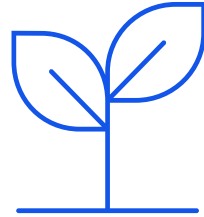
- More resilient socioemotional foundation among students
- Improved attendance / reduced truancy
- Reduced incidents of hospitalization and psychiatric emergency
- Improved educational experience and overall wellness
- Higher utilization of student resources
- Maximized attendance-based funding
- More academic engagement
- Fewer students referred for disruptive behavior
- Focused resources on students in need

The future of SBHIP



CYBHI multi-payer fee schedule

- COEs, LEAs, school-linked designated providers will be able to bill and be reimbursed
- Multiple payers: Medi-Cal MCPs, Medi-Cal FFS, Commercial Health Plans, Disability Insurers
- Increase BH access, eligible practitioners, funding + reduce administrative burden and complexity



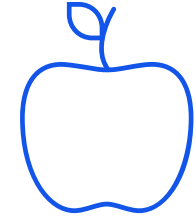
Wellness coaches

- New certified provider type to come
- Focus: preventive and early intervention supports for young people
- Provides an additional avenue of reimbursement in multi-payer fee schedule



CalAIM connection

- Clarified access criteria for specialty mental health (SMH)
- “No Wrong Door”
- Enhanced Care Management (ECM) Medi-Cal benefit



Maintaining partnerships

- Will continue to collaborate with education partners
- Expansion of infrastructure
- Leveraging cross-sector partnerships

Thank you



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