Alameda CalAIM Children and Youth Workgroup

May 20, 2025

BluePath HEALTH

DHCS | PATH
Providing Access & Transforming Health

Workgroup Objective

Enable outreach, referrals, and enrollment for children into ECM and Community Supports

Addressing areas of opportunity

So far, we have discussed several areas of opportunity to address in order to improve access to CalAIM services for children and youth, including:

- Referral pathways and processes
- Consent
- Provider education & training

BluePath HEALTH

Today's Agenda

Time	Agenda Topic
11:00-11:10	Welcome and Introductions
11:10-11:30	Provider Spotlight: Full Circle Health Network
11:30-11:35	ECM Data Update
11:35-11:50	Planning ahead: Workgroup Priorities and Cross-County Workgroup meeting
11:50-11:55	Resource Development Updates
11:55-12:00	Poll and wrap-up

Introductions

Please share:

- Your Name
- Organization and Role
- Your role in CalAIM (provider, referral partner, youth-serving agency, etc)
- Updates from your organization you'd like to share

BluePath HEALTH

Full Circle Health Network

Full Circle
Health Network

Full Circle Health Network Overview

Alameda County CalAIM PATH Collab Meeting
May 2025

Who we are

Full Circle Health Network is the largest integrated network of community-based organizations in California delivering coordinated services to vulnerable children, individuals and families.

Full Circle is affiliated with the California Alliance, a public benefits corporation.

California Alliance
Empowering lives. Enriching futures.

Why we exist

- Full Circle improves the lives vulnerable children and families across California by connecting a high quality, culturally congruent, network of trauma-informed CBOs to Medi-Cal managed care plans and other child serving systems.

Our values

Health Equity
We are unwavering in our commitment to addressing racial inequities and disparities in health care.

Community Engagement
We believe in the power of community.

Collaboration
We believe in working with providers, clients, health plans and stakeholders to improve overall quality of care.

Cultural Responsiveness
We prioritize delivering culturally congruent care.

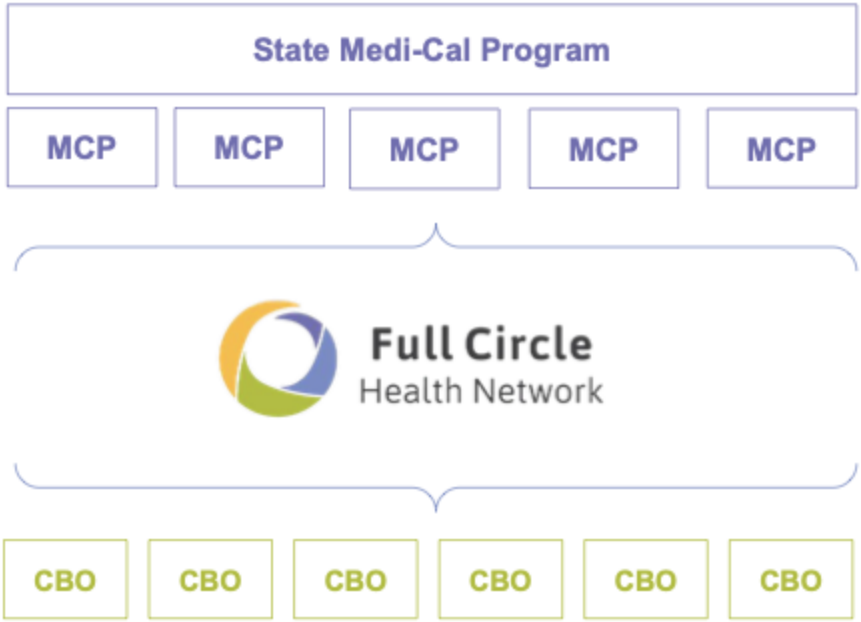
Innovation
We embrace innovation in technology and service delivery to improve care and adapt to the needs of our clients and communities.

Client-Centered
We design services around the needs of the individuals and families.

Full Circle
Health Network

What we do

Full Circle connects a cohesive CBO network with Medi-Cal Managed Care Plans



Managed Care Plans Get:

- Access to a high-performing network of culturally diverse CBOs
- Assurance of competence and compliance
- Credibility with human services agencies
- Greater consistency in service delivery model
- Streamlined communication

CBOs Get:

- Less risk in trying something
- Distributed start-up costs
- Support with administrative & technology requirements
- Streamlined access to reimbursement
- Initial & ongoing program development support
- Connection to a community

Full Circle's Alameda Providers (all providers are not listed)

Full Circle's Partners

Alameda Alliance for Health
Santa Clara Family Health Plan
Kaiser Permanente
Contra Costa Health
Anthem
Molina Healthcare
blue california Promise Health Plan
CalViva Health
health net
San Francisco Health Plan Here for you
Gold Coast Health Plan A Public Entity
LA Care Health Plan
Health Plan of San Joaquin
Mountain Valley Health Plan

Full Circle Health Network

- **~95** Provider
- **~375** Site Locations
- **49** Initial Counties

Full Circle's Partners: Next Up

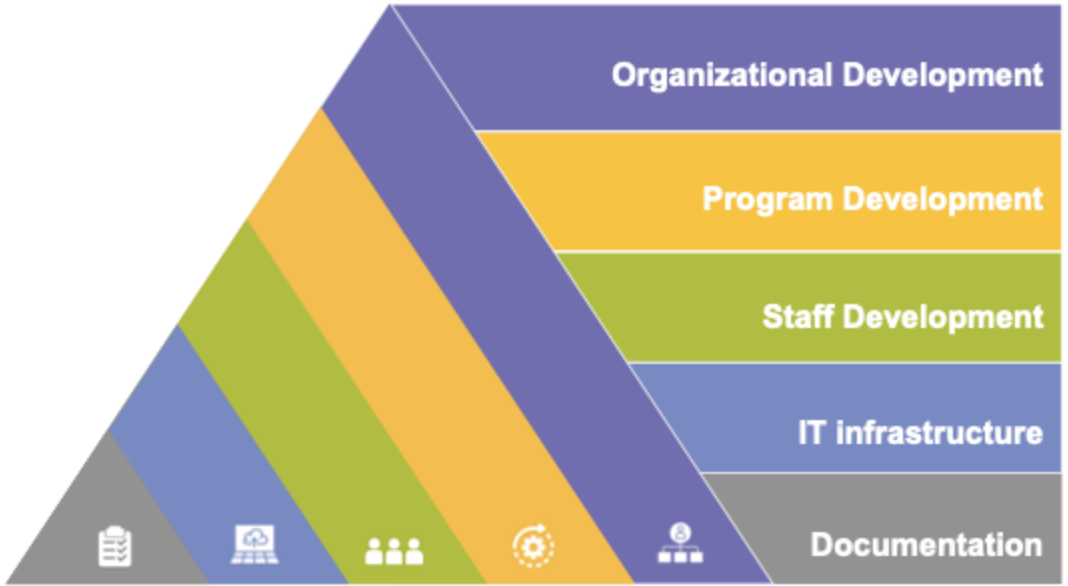
IEHP
Inland Empire Health Plan

PARTNERSHIP
HEALTHPLAN of CALIFORNIA
A Public Agency

Full Circle
Health Network

Building provider capacity to deliver CalAIM Services

- CBOs operate programs similar and complementary to ECM but need help going from inspiration to implementation.
- Full Circle's provider success team offers extra end-to-end support to launch and operate new services.
- Business model: Providers pay a percentage of collected revenue.



Full Circle's Suite of CBO Enablement Services

Organizational Development

- Managed Care contracting
- Certification & readiness process
- Financial planning help
- Revenue cycle mgmt.

Documentation/Quality Support

- Our pre-configured EHR
- Training
- Note Templates
- Customized Reporting
- Continuous quality improvement

Program Development

- Compliant P&Ps
- Privacy compliance program
- Intensive training
- Weekly office hours
- Audit support

IT Infrastructure

- Optional EHR Platform
- Eligibility verification
- Data warehouse
- Support data exchanges
- Interoperable with Provider EHRs

Staff Development

- Job description templates
- Job aides
- 1:1 coaching
- Case rounds

Provider Selection Criteria

1. Served children & families
2. Community-based nonprofit
3. Located in a county where we work and need capacity
4. Commitment to Medi-Cal readiness

Division of Roles and Responsibilities

Full Circle Health Network

- ✔ MCP Data Exchanges (SFTP, MIF)
- ✔ Outreach and Engagement
- ✔ Referral management
- ✔ Provider Assignment & ensuring linkage
- ✔ Authorization requests & tracking
- ✔ Claims Submissions
- ✔ Payment and reconciliation
- ✔ Training and provider support
- ✔ Health Plan reporting
- ✔ Contract management
- ✔ Quality improvement & oversight

Providers

- ✔ Direct service delivery
- ✔ Staff rosters and capacity reporting
- ✔ Assessments and care plan
- ✔ Core care management and service coordination
- ✔ Documentation
- ✔ Audit participation
- ✔ Managed care rounds/case planning
- ✔ Ongoing training

Full Circle's Provider Success Managers Help You Achieve Your Goals

PSM role descriptions

Support onboarding		• Explain all certification and credentialing requirements • Help develop your model of care and successfully launch new service line
Coach you to meet goals		• Guide providers through training, data and analytics, and workflow strategies • Create learning opportunities amongst similar providers to share best practices and overcome barriers together
Act as your internal advocate		• Act as a customer service point of contact to allow providers to navigate and troubleshoot any issues

Network Providers Get a “Plug and Play” Platform

Full Circle’s technology stack simplifies CalAIM service launch for providers.

EHR configured for CalAIM program documentation and billing.

Real-time reporting via Microsoft PowerBI Dashboards

Data Security & HIPAA Compliant

Interoperability via API connections to providers, plans, & community HIEs

Full Circle enables bi-directional referrals for at-risk children, youth and families

Medi-Cal MCPs

- Member Information File (MIF)
- Batch referrals; standard formats

Referral Sources

- Pediatricians
- 211
- Child abuse hotlines
- Schools
- Justice agencies

Community Based Providers

- Specialty mental health
- Family resource centers
- Justice-serving CBOs
- Child-welfare service providers

CASE STUDY: Non-minor dependent transitioning to adulthood

Jo, 20

Core Needs

SCENARIO: Jo is in extended foster care as a non-minor dependent. She lives in a transitional housing plus program and attends community college, traveling to and from school on the bus. She plans to transfer to a state university to complete a bachelor's degree and wants to be a teacher. She is suffering from frequent panic attacks and reports a constant feeling of anxiety. She acknowledges struggling with healthy eating to cope with her anxiety. She has some contact with her birth family but says she has not fully addressed her prior trauma exposure. After contact with her family, her anxiety increases. Due to her trauma history, Jo also struggles with developing trusting relationships and has few friendships. She does not engage in many clubs or activities outside the classroom.

Presenting Needs/ Child & Family Goals

- Start therapy and learn behavioral techniques to manage anxiety and cope with trauma triggers to reduce panic attacks
- Join social activities on campus and develop connections with peers
- Establish with a primary care provider
- Develop healthy eating and exercise habits
- Develop a plan to transfer to a four-year college with financial support

Role of ECM Care Manager

- Help Jo establish care with a PCP and connect to a mental health therapist contracted with her Medi-Cal MCP
- Teach Jo about the benefits available through her health plan and how to navigate them
- Engage with on connecting with the community college counselor and researching what social programs are available at school
- Help Jo research long-term housing programs to reduce anxiety about where she will live
- Support development of a plan to navigate the transfer to a four-year university

Expected outcomes

- Establish healthier habits and skills to manage her anxiety in coordination with her PCP and MH Provider.
- Access Community College resources to develop a clear path to a State School & get involved in a social activity
- Jo understands how to navigate her health plan moving forward

Leveraging ECM to Support Families: Example Referral Flow

1 Social worker (SW)/Public Health Nurse – Initial Referral

- Tells parent/caregiver about ECM
- Seeks permission to send a referral to a local ECM provider
- Uses closed loop referral system or emails agency & requests services in child/parent/caregiver preferred language

2 Provider – Intake

- Receives referral & connects with parent/caregiver
- Explains ECM and gets consent to participate
- Collects info needed for MCP referral (authorization request); submits to MCP
- Starts intake/assessment process
- Notifies County SW of referral status

3 Managed Care – Authorization

- Processes community referral/auth request within 5 days
- Notifies provider of decision

4 Lead Care Manager – Service Delivery

- Creates ECM care plan & goals based on assessment
- With permission, communicates with existing service providers like public health nurse, pediatrician and behavioral health
- Helps make medical, behavioral or dental appointments
- Arranges transportation to key appointments, as needed
- Links family to supports for concrete needs like transitional housing provider, hygiene banks, childcare
- Option to link parent/caregiver to additional support from Community Health Worker

Contact us

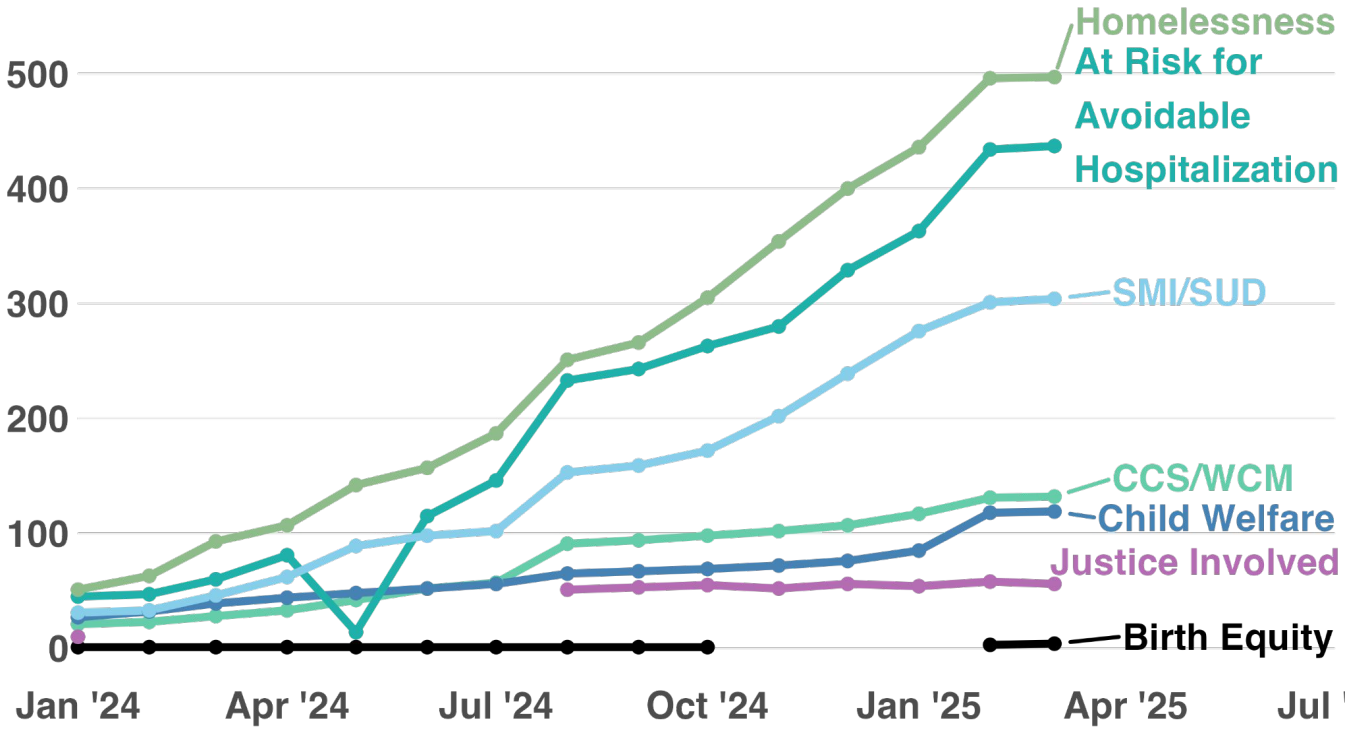
network@fullcirclehn.org

BluePath HEALTH

Data Update

ECM Enrollment by Children & Youth by Month

Alameda Alliance for Health



Top 3 POFs:

1. Homelessness
2. At Risk for Avoidable Hospitalization
3. SMI/SUD

Alameda County Q4 2024 ECM and CS Enrollment Data*

ECM Enrollment** by Populations of Focus (Total Members: 414)							
Adult – Individuals Experiencing Homelessness	Adult – Families Experiencing Homelessness	Adult – Avoidable Hospital or ED Utilization	Adult – SMI or SUD	Adult – Transitioning from Incarceration	Adult – at Risk for LTC Institutionalization	Adult – NF Transitioning to Community	Adult – Birth Equity
88	0	53	127	0	52	7	93
Child – Individuals Experiencing Homelessness	**Child – Families Experiencing Homelessness**	**Child – Avoidable Hospital or ED Utilization**	**Child – SMI or SUD**	**Child – CCS/CCS WCM with Additional Needs**	**Child – Child Welfare**	**Child – Transitioning from Incarceration**	**Child – Birth Equity**
11	**0**	**5**	**29**	**3**	**14**	**0**	**1**

Community Supports Received (Total Members: 612)						
Housing Transition/ Navigation Services	Housing Deposits	Housing Tenancy and Sustaining Services	Short-Term Post-Hospitalization Housing	Recuperative Care	Respite Services	Day Habilitation Programs
208	28	34	1	7	63	1
NF Transition to ALF	NF Transition to a Home	Personal Care and Homemaker Services	Environmental Accessibility Adaptations	Medically-Supportive Food	Sobering Centers	Asthma Remediation
5	6	91	17	306	0	7

County KP Medi-Cal Members	County Medi-Cal Population	KP % of Total Medi-Cal Population	Last Updated
71,017	478,715	14.83%	December 2024

* Data is sourced from the Quarterly Implementation Monitoring Report (QIMR) that is submitted by Kaiser Permanente to DHCS.
** The numbers reflect unique enrollments per quarter, with individuals re-counted if they remain enrolled in subsequent quarters. Those qualifying for multiple Populations of Focus may be counted more than once due to overlaps.

KAISER PERMANENTE

BluePath HEALTH

Planning ahead: Workgroup Priorities

BluePath HEALTH

Resource Development

In Development: Child Welfare Care Coordination Handout

Topic	Child Welfare Social Worker	HCPCFC Public Health Nurse Call (510) 618-2070 or email HCPCFCalameda@acgov.org	Lead Care Manager Contact MCP foster care liaison
Court Documents/Court Ordered Services	Lead	Support, as necessary	
Foster Youth Application	Lead		
Medi-Cal Application/Eligibility (CalSAWS)	Lead	Monitoring & Oversight	
CANS (Child and Adolescent Needs and Strengths Asessment Tool)	Lead	Access	Access
SDoH Support (Housing, Transportation, Education (including IEPs), Financial, Food Security, Mental Health/Behavioral Health Support)	Lead	Monitoring & Oversight	Support
Multidisciplinary Team Meetings (CFT)	Lead	Participant	Participant
Referrals	Community and Social Support Referrals	Medical Referrals	Community and Social Support Referrals
Medical, Vision and Dental appointments		Lead	Support
Health forms for doctor's visits/courts		Lead	Support
Health Promotion and Education		Lead	Support
Foster Youth Health & Education Passport		Lead	Support
Medication Management, including psychotropic medication	Support	Lead	Support
Interpretation of medical reports		Lead	
Coordinate health care services for children in out-of-county and out-of-state placements		Lead	
Coordinate mental health services for children in out-of-county and out-of-state placements	Lead		
Medi-Cal MCP Navigation		Support	Lead
Regional Center Navigation	Lead	Support	Support
Education and IEP Navigation	Lead		Support
Health Care Comprehensive Transitional Care		Support	Lead
Mental Health Comprehensive Transitional Care	Lead		Support

Poll time!

Please take a few moments to share your feedback!

BluePath HEALTH

See you on Zoom this Friday!

Alameda CalAIM PATH Collaborative

Friday, May 23| 10am - 12pm

On Zoom

Register now:

Thank you!

Let’s keep the conversation going:
madison.olmsted@bluepathhealth.com

BluePath HEALTH

Becoming a Full Circle Provider

Full Circle Health Network Provider Process

Submit Interest

- ✔ Complete online interest form
- ✔ FCHN assesses fit

Program Certification

- ✔ Self-assessment
- ✔ Program Certification/ model of care review
- ✔ Compliant P&Ps (Full Circle has templates)

Verification & Contracting

- ✔ Submit verification documents (insurance, license, etc.)
- ✔ Execute contract

Training & Onboarding

- ✔ Onboard training to ensure consistency
- ✔ Ongoing learning collaborative and technical assistance

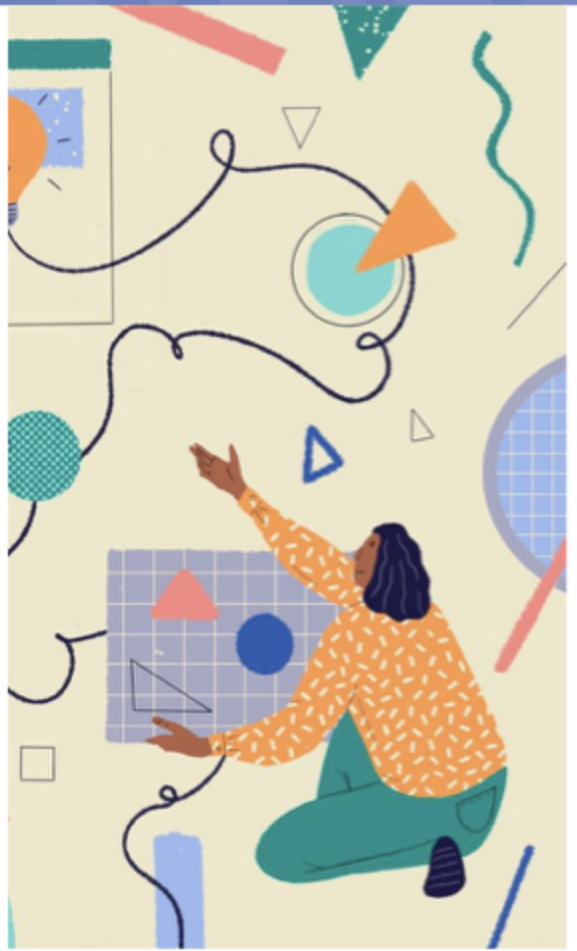
Quality Monitoring

- ✔ Data dashboards
- ✔ Routine audits
- ✔ Grievance tracking
- ✔ Corrective action process

Next Steps: Submit your interest

- If your organization is interested in working with Full Circle to provide any CalAIM services previously mentioned, the first step is to complete our online interest questionnaire.

- The questionnaire helps Full Circle learn more about your organization, specifically:
  - Where you operate
  - Types of services you deliver today
  - Whether you are a Medi-Cal provider today
  - What CalAIM services you want to operate and potential capacity



In summary …

FCHN advances health equity among vulnerable youth and families by connecting a cohesive CBO network to Medi-Cal managed care plans and other child serving systems.

1

Youth & Families

Receive trauma-informed, culturally competent services from agencies rooted in their local communities

2

Providers

Focus on their core competency of person-centered service delivery while accessing cost-effective, administrative infrastructure

3

Managed Care Plans

Get streamlined access to a cohesive CBO network implementing a high quality, standardized model of care