CARMONA INSIGHTS

Coming Together:
Integrating Services for Older Adults Experiencing Homelessness

For the United Way of Greater Los Angeles

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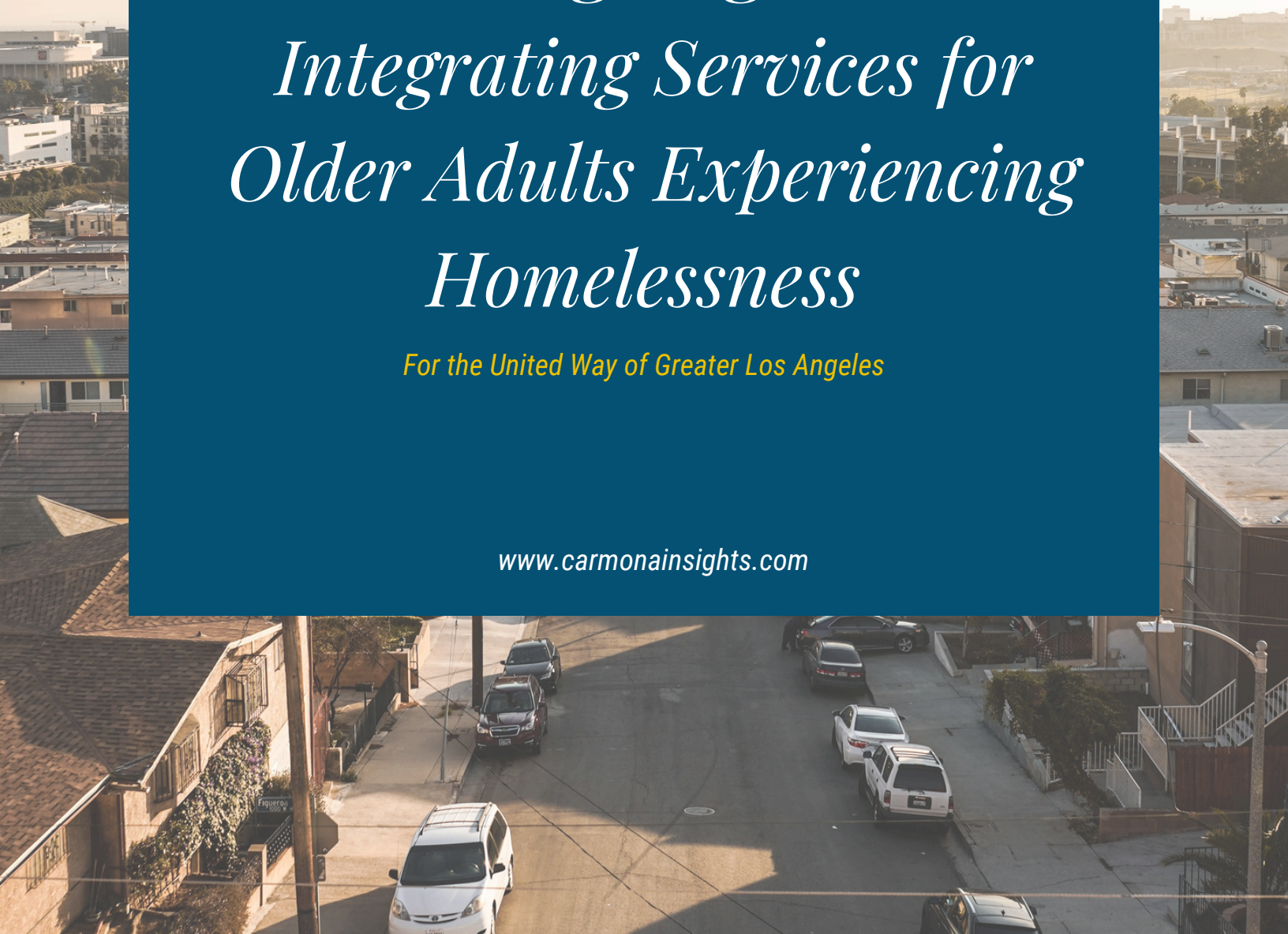


Following the release of Home for Good's report, The Older Adult Strategy: A Roadmap of Strategic System Investments to End Homelessness Among Older Adults in Los Angeles, The United Way of Greater Los Angeles (UWGLA) commissioned this report to present recommendations on the integration of CalAIM and other healthcare solutions into the strategies outlined in the Home for Good report. Current and emerging programs serving older adults were reviewed and several stakeholder community based organizations (CBOs) were interviewed to determine the recommendations outlined in this report. Report authors also took into account the ever changing healthcare landscape, including trends and learning occurring elsewhere across California.

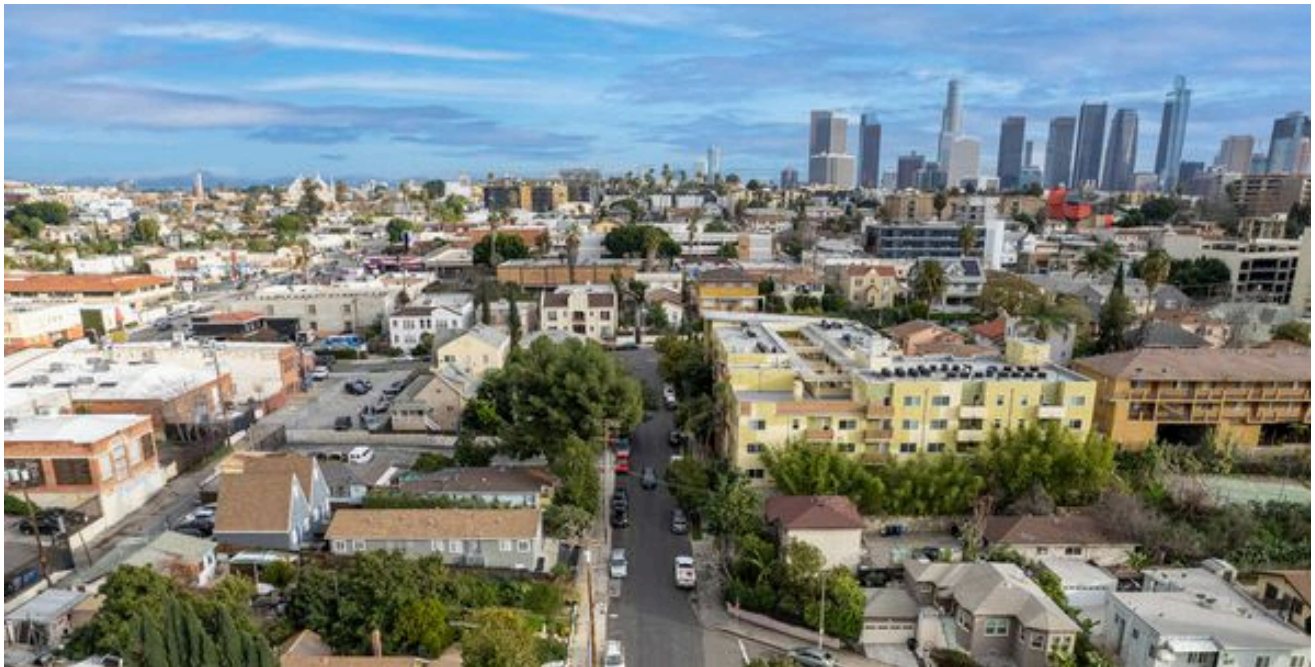
This report recommends activities that address several key recommendations from the Home for Good report:

Help the state save money over the long term by ensuring Medi-Cal finally helps its older adults maintain their housing stability through smart CalAIM reforms, In Lieu of Services (ILOS) Provisions, Waiver Programs, and the Home and Community Based Services Spending Plan.	Case-management should be provided for every older adult as soon as they are identified. This case-manager should stay connected to them throughout their services, even after they have been housed to support stabilization.
Fund creative team-building activities, work retreats, and networking events to fuel teamwork across the aging and homeless sectors.	Optimize Project Homekey sites to create facilities and environments that are beautiful, comfortable, accessible, trauma informed, and therapeutic for older adults.
The homelessness response system needs to be more closely tied to other systems, such as behavioral health and older adult services where people can access supportive services and housing.	Whenever possible clients should be able to stay in their existing housing and access different services as needed.

In order to maximize services available for older adults experiencing homelessness, strategic actions to further advance initial recommendations from the Home for Good report are recommended:

- ***Advance a model of care for older adults experiencing homelessness that can be used as a resource for providers across Los Angeles County.***
- ***Promote cross sector engagement to promote a foundational understanding of the environment and strengthen service coordination.***
- ***Support early implementation activities, training and technical assistance to promote successful steady growth in services available to older adults experiencing homelessness.***

The health care needs of homeless older adults represent a significant public health concern, highlighting the intersection of age, poverty, and social exclusion. As this population faces unique challenges—including higher rates of chronic illnesses, cognitive decline, and mental health issues—they often encounter barriers to accessing adequate health care, such as lack of transportation, insufficient insurance coverage, and the stigma associated with homelessness. This report aims to understand how CalAIM has changed the service landscape for older adults experiencing homelessness and identify how to integrate these changes into existing housing support infrastructure. By understanding the complexities of their health challenges and the systemic barriers they face, we can develop more effective strategies to build on existing programs and initiatives, improve health outcomes, and enhance the quality of life for homeless older adults.



Health Program *Opportunities*

CalAIM, or the California Advancing and Innovating Medi-Cal initiative, is a comprehensive reform program designed by the California Department of Health Care Services (DHCS) to transform California's Medi-Cal system and improve health outcomes for its beneficiaries. Launched in January 2022, CalAIM seeks to address the diverse and complex needs of Medi-Cal members by integrating services, promoting whole-person care, and enhancing access to preventive and behavioral health services.

The initiative focuses on several key components, including the expansion of managed care, the implementation of health-related social needs programs, and the creation of a more coordinated care delivery system. By prioritizing population health management and supporting community-based organizations, CalAIM seeks to reduce health disparities, improve health equity, and ultimately create a more efficient and effective health care system for California's most vulnerable populations.

Key components of CalAIM, relevant for older adults experiencing homelessness include:

Enhanced Care Management (ECM): ECM is meant for those Medi-Cal beneficiaries with the most complex health and social needs. Lead care managers are meant to coordinate all of the person's care and needed services by collaborating with medical providers, social workers and other CBOs to reach care plan goals. This includes understanding all services and support that might benefit the individual, assisting them with accessing those services and ensuring that the services were delivered. ECM may not be available to certain individuals eligible for both Medi-Cal and Medicare.

Adults experiencing homelessness are eligible for the ECM benefit if they also have at least one complex physical, behavioral, or developmental need, with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high- cost services. Also eligible for ECM are adults eligible for Long Term Care and at risk of institutionalization as well as nursing home residents transitioning to the community.

Community Supports (CS): Community Supports consists of fifteen (15) medically appropriate and cost-effective substitute services provided by Medi-Cal managed care plans to help members address their health-related social needs, such as having access to safe housing or healthy meals to aid in their recovery from illness, living healthier lives, and avoiding higher, costlier levels of care.

Housing Navigation: Housing service providers screen and assess individuals, develop a housing support plan, identify options, secure housing and ensure the individuals successfully move in.

Housing Deposits: Providers identify, coordinate, secure or fund one-time services and modifications necessary to enable an individual to establish a basic household (does not include room and board costs).

Housing Tenancy and Sustaining Services: Providers assist individuals with maintaining safe and stable tenancy once housing is secured through education, coaching, coordination, advocacy and linkage to other community resources.

Transitional Rent (Live 2025): This coming service will provide up to six months of transitional rent services as homeless or at risk of homelessness and transitioning out of institutional levels of care, congregate residential settings, correctional facilities, the child welfare system, recuperative care facilities, short-term post-hospitalization housing, transitional housing, homeless shelters or interim housing, as well as those who meet the criteria for unsheltered homelessness or for a Full Service Partnership (FSP) program.

Day Habilitation: Providers assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment.

Recuperative Care: The service includes short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.

Short-term Post Hospitalization Housing: This service is for individuals who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital, residential substance use disorder treatment facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.

Sobering Centers: This service provides alternative destinations for individuals who are found to be publicly intoxicated and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Nursing Facility Transition/Diversion to Assisted Living Facilities: This service facilitates nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC).

Community Transition Services/Nursing Facility Transition to a Home: This covers non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board.

Medically Tailored Meals and Supportive Food: Meals provided to the individuals home tailored to meet the dietary needs of those with chronic disease or to prevent hospital readmission.

Personal Care and Homemaker Services: This service is provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. This is sometimes seen as a program that can extend services provided by In Home Supportive Services (IHSS).

Respite Services: Respite is provided for caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Environmental Accessibility Adaptations (Home Modifications): This includes physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization.

Asthma Remediation: physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Integrated Managed Long Term Services and Supports (MLTSS): As part of CalAIM, DHCS is working to strengthen infrastructure and better integrate care for seniors and persons with disabilities. Part of this effort includes the completion of a gap analysis and multi-year roadmap of Medi-Cal home and community based services (HCBS) and MLTSS programs. The effort also includes carving Long Term Care (LTC) into managed care statewide, utilization of the newly established Community Supports, and unified MCP enrollment for dual eligibles into Dual Special Needs Plans.

Other Limitations: One clear barrier to success is the fact that all of the available wrap-around services do not provide resources for the additional housing that may be needed. More important for the older adult population, most housing options do not provide the kind of supports that many older adults require. The L.A. County CEO's Housing Initiative (CEO HI) has began an Activities of Daily Living (ADL) project with this in mind, partnering with the MCPs. The MCPs provided significant funding to CEO HI to:

- establish 4 multidisciplinary field-based Enhanced Care Assessment teams to assess the ADL needs of people experiencing homelessness and refer them to appropriate services;
- create about 100 slots of personal caregiving services in interim housing to stabilize individuals while seeking to transition them to IHSS or Community Supports; and
- create 80 slots to place people experiencing homelessness in licensed residential care facilities (ARF) and Residential Care Facilities for the Elderly (RCFE).

While these are promising initial steps, expanding these kinds of services will be critical to meet demand for older adults experiencing homelessness.

WHAT IS A DUAL SPECIAL NEEDS PLAN (D-SNP)?

D-SNPs are Medicare Advantage plans providing specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medicaid). Under CalAIM, DHCS transitioned the prior Cal MediConnect program to the D-SNP program. These plans meet certain care coordination requirements and have integrated member materials. CalAIM changes ensure that members can received both their Medicare and Medi-Cal services from the same plan and are expected to additionally improve care through the Medi-Cal managed care carve-in of Skilled Nursing Facility care, launch of ECM for populations needing Long Term Services and Supports, and the introduction of Community Supports. Keep in mind that individuals under age 65 may qualify for Medicare if they are living with a qualifying disability. D-SNPs are offered by both prime MCPs in Los Angeles County.

What is not covered under CalAIM?

Several factors may exist that make an individual ineligible to receive certain ECM services. This can often occur because the person is already receiving a service that is considered duplicative. This is well demonstrated in the case of ECM. Some of ECM exclusions are:

- ***1915(c) Waiver Programs:*** Adults, children and youth can be enrolled in ECM or in a 1915(c) waiver program but not both at the same time. These programs include the Multipurpose Senior Services Program (MSSP), Assisted Living Waiver (ALW), Home and Community-Based Alternatives (HCBA) Waiver, HIV/AIDS Waiver, HCBS Waiver for I/DD, and the Self-Determination Program for Individuals with I/DD.

- ***County-based Targeted Case Management (TCM):*** Beginning July 1, 2024, Members who meet ECM POF criteria should be enrolled in ECM and may no longer be enrolled in ECM and County-based TCM programs at the same time except for a one-year exception from July 1, 2024 to June 30, 2025 for limited specified cases. For those found to be eligible for both ECM and TCM, ECM should be the first option for comprehensive care management. All Members who meet ECM Population of Focus criteria should be referred to the Member's MCP for ECM authorization. It should be noted that individuals receiving Specialty Mental Health Services TCM from counties may be eligible for and receive ECM services. MCPs are required to work with counties to identify Members receiving SMHS TCM and ensure non-duplication of services.

- ***Complex Care Management (CCM):*** MCPs are required to provide CCM program and services under DHCS' Population Health Management (PHM) Program. CCM is a service for higher- and medium-rising-risk MCP Members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. An individual cannot be enrolled in ECM and CCM at the same time; rather, CCM is on a care management continuum with ECM.

- ***Dual Eligibles:*** Those eligible for both Medicare and Medi-Cal may be eligible for ECM through their Medi-Cal MCP if they meet the applicable ECM Population of Focus criteria, and if they are not enrolled in any of the plans/programs listed below, as these plans/programs offer comprehensive care management that is duplicative of ECM services:
    - Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs);
    - D-SNPs;
    - Program for All-Inclusive Care for the Elderly (PACE); and
    - California Community Transition (CCT) Project

Lessons from *the Field*

To better understand on-the-ground experiences with CalAIM services, successes, and ongoing opportunities, we interviewed a cohort of 6 local community organizations: Housing Works, L.A. Family Housing, Pacific Clinics, The People Concern, San Fernando Valley Community Mental Health Center, and Sycamores. While all organizations support individuals experiencing homelessness, the organizations also offered a range of expertise across scope of service delivery, priority populations, and involvement as CalAIM service providers. Successes include the ability to expand service offerings and key challenges include overarching concern about ongoing insufficiency of funding to support client needs.

Identified Success Strategies

Two primary success strategies arose in discussions with the organization cohort: ability to blend and diversify funding streams through a variety of contracts, and expanded scope of services beyond their traditional footprint.

Diversified Funding Streams

All organizations in the cohort acknowledged having multiple contracts comprised of a blend of direct and subcontractor arrangements. Direct contracts are most often held with Los Angeles County entities, with almost all organizations affiliated with the Department of Mental Health, many contracted with the Los Angeles Homeless Services Authority (LAHSA), and a subset of organizations also contract with the Department of Public Health. Several organizations also hold direct contracts with one or more of the Los Angeles Managed Care Plans (MCPs) for CalAIM services. Subcontractor arrangements are almost exclusively with the County of Los Angeles Department of Health Services (DHS), for the Housing for Health Intensive Case Management Services (ICMS) program.

Diversified streams have benefitted the organizations through increased visibility and expanded relationships with entities across Los Angeles County and beyond, and access to additional resources, such as staff training opportunities and start-up funding. At the service delivery level, the organizations shared that these diversified funding streams helped them expand services and serve a broader client base.

Expanded Scope of Services

Through funding streams intended for different service areas – housing development, housing navigation, care management, and specialty mental health – the organizations in our cohort shared that they have been able to expand service offerings. For example, half of the organizations interviewed have historically provided specialty mental health services. Contracts through DHS and MCPs for additional CalAIM services have allowed them to broaden their scope to include programs such as Enhanced Care Management (ECM) and an array of homeless and housing support services.

Expanded services benefit not only the clients but also the organizations, by allowing the organization to build a broader one-stop shop under their roof, thereby offering a wider array of benefits to clients with the same known organization. The result is a "win-win" for both client and organization.

Key Challenges

Organizations we interviewed noted that the successes of diversified funding and ability to increase scope of services are not without ongoing challenges. Namely, organizations identified difficulties with administrative burden of multiple contracts with different requirements, insufficient funding to support the scope of services at the intensity required, and a need for more specialized care models for specific populations, primarily older adults.

Administrative Burden

As frequently noted in other analyses of CalAIM programs, community providers have often identified administrative burden as an impediment to expanding service provision. For many organizations – including those we interviewed – working with CalAIM programs requires new methods of documentation, data tracking and reporting, and billing and revenue cycle management. The level of responsibility varies depending on role as direct contractor versus subcontractor, with direct contractors holding most responsibility for reporting and claims submission to the MCPs.

Specific complexities related to inaccurate data received from MCPs, different reporting requirements by MCP, and more robust documentation requirements than pre-CalAIM. While organizations have received training and often work directly with MCPs, the administrative components of the contracts require significant staff time and investment and can detract from funding available to support direct service provision.

Insufficient Funding

Despite receiving funding from varied sources, organizations noted that incoming funding was insufficient in a variety of ways. Reimbursement rates offered through contracts for CalAIM services including ECM and housing services are insufficient to cover the array of services and staff required to meet client needs, including clinically trained staff when indicated.

Most organizations noted a dependence on philanthropy and other fundraising as the means to close funding gaps. Dependence on philanthropy to close funding gaps also translates into less available funding to support new projects and innovations. Some organizations also noted that such unrestricted funding has also become harder to come by since the advent of CalAIM, given expectations that more services are covered under the state programs.

Finally, organizations also noted time-limited services, and associated reimbursements, further limit service provision. For example, housing tenancy support services under CalAIM Community Supports services are intended to be a once-in-a-lifetime service and time-limited to a duration specified by the MCP. Upon the end of the authorized service period, organizations may be faced with a need to either discontinue services, utilize alternate funding if additional services are required, or provide unreimbursed extended services.

Special Considerations for Older Adults

Our interviews highlighted the unique needs of unhoused older adults, and the challenges faced by organizations supporting this population. Time-limited services are of greatest consequence with older adults served by organizations we interviewed. Housing services under CalAIM are generally geared toward support of unhoused individuals with a goal of stabilization and independence with support of these programs. For older adults facing a different point in their life trajectory, optimism for future independence is limited.

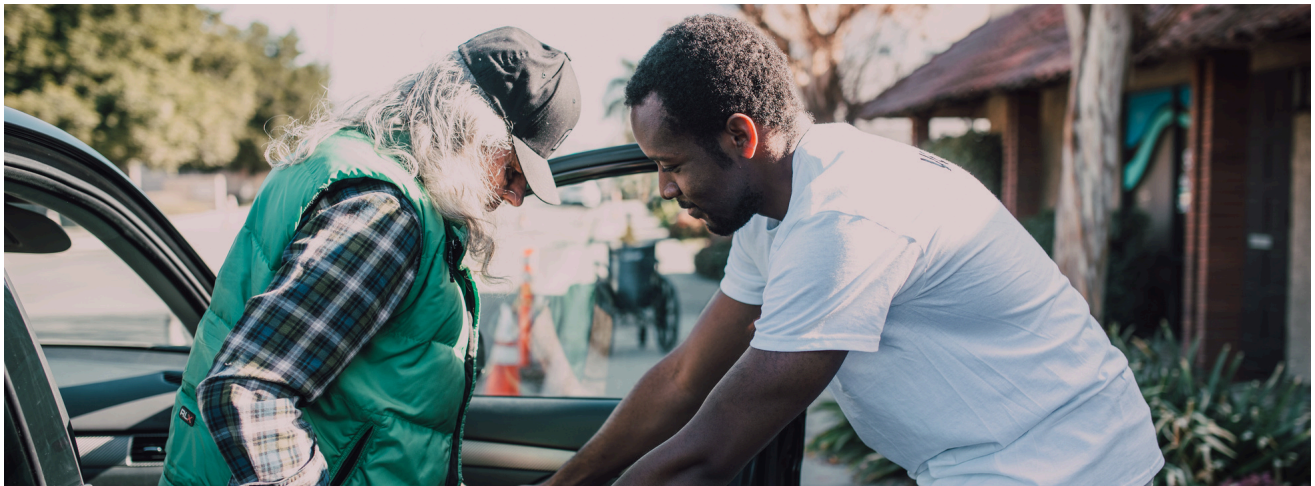
For example, when time-limited funding to support housing stability ends, the organizations noted this can be especially difficult for older adults, as social security payments are severely insufficient to cover rent and other living expenses, including caregiving. Instead, organizations stated they struggle to bring together multiple forms of support to aid older adults experiencing homelessness, including hospice services, In Home Support Services (IHSS), other Community Supports services, the Assisted Living Waiver, and Enriched Residential Care.

A Tailored Model of Care

A key theme arising from our interviews is the need to develop a specialized model of care and support for older adults who are unhoused or at risk of losing their housing. Several considerations, including many mentioned above, coalesce into this recommendation. Service providers and funders must acknowledge the phase of life in which older adults find themselves. Services must be tailored in a way that does not depend on a future state of independence and self-sufficiency, with anticipation that an older adult will have less income to dedicate to housing and other care-related expenses over time instead of more. Additionally, care models for older adults must inherently include the expectation that more services, rather than less, will be needed in the future.

Care models must also facilitate the addition of and transition between services as indicated by client level of need. For example, a client in a Permanent Supportive Housing may be able to reside successfully for a number of months or years with assistance from In Home Supportive Services and/or other caregiving support. However, when additional caregiving is required, considerations for assisted living or other services will be needed. Current funding levels for the Assisted Living Waiver (ALW), for example, and the time-bound nature of other current services do not support the increasing needs of this population. Advocating for greater funding to valuable supportive programs, such as the ALW, and/or extended service provision timelines for older adults receiving time-bound services could be of benefit.

Finally, care models for unhoused and at-risk older adults need to further integrate physical health, behavioral health, and social needs. Our interviewees noted that few Permanent Supportive Housing buildings are currently dedicated to older adults. More of this type of model are needed, with a high level of integration of care between physical health, to address mobility and chronic need; behavioral health, to address diagnosed needs and coping skills; and social needs, to support access to social services and supports. Establishing a system comprised of more PSH buildings dedicated to older adults with full wraparound assistance that expands based on client level of need will allow for greater overall support for this growing population.



Integration *in Practice*

KAREN, 69

ABOUT KAREN

After being hit by a car, Karen recently had a hospital stay where hospital staff also discovered she was suffering from diabetes and her cardiovascular complications. Because the hospital and housing provider had an established relationship, the hospital connected with the provider to help her access services.

Because Karen is eligible for both Medicare and Medi-Cal, staff assisted Karen with enrolling in a D-SNP plan to help coordinate all her necessary services.

KAREN'S CARE PLAN

As a **D-SNP** member, Karen's care manager began assessing her needs and connected her with a housing provider who could assist with placement. Her **Housing Navigation** provider worked with a housing facility who was a part of the plan's Short-term **Post Hospitalization Housing** as they continued to search for a permanent placement that was appropriate for her needs.Karen was able to receive **2 meals a day** delivered to her new residence as she adjusted. During this time, she benefitted from **Personal Care and Homemaker Services** while awaiting approval for **IHSS**. Her housing facility also provided **Housing Tenancy** services while her D-SNP care manager continued to assist with transportation to medical appointments. Her Tenancy provider and D-SNP care manager continue to communicate on Karen's future placement needs.

Integration *in Practice*

DENNIS, 61

ABOUT DENNIS

Dennis has recently found his way to a local Housing Navigation provider after living on the street for 6 years. He has a history of substance use and is known as outgoing with many friends in the community.

DENNIS' CARE PLAN

After being enrolled in **Medi-Cal**, Dennis' **Housing Navigation** provider links him to an **Enhanced Care Management** provider at the local clinic. The ECM and Housing Navigation provider ensure that he is able to see a doctor to begin discussing any medications or therapies he may be open to for addressing his substance use. While seeing his doctor, Dennis is made aware that he has some cardiovascular risks that may require medication. Dennis is finally able to secure a housing placement with the **Housing Deposits** service and while the facility is not a **Housing Tenancy** provider, his existing Housing Navigation provider is able to link him to a tenancy provider within her organization. Dennis is also linked with a **Day Habilitation** program and is very successful, enabling him to graduate from ECM. He is so successful that he is eventually brought on as a **peer support specialist** at one of the organizations that supported him in his own journey.

CalAIM: *The "Hub" Model*

EXPLORING THE CONCEPT OF "HUBS"

Many organizations have been exploring the idea of contracting with, or becoming, a "Hub" provider. While an agreed-upon definition of "Hubs" does not currently exist, the notion is one of an organization performing certain administrative functions for a sub-network of service providers. This Hub would hold the MCP contract, as well as contracts with all of the sub-contracted providers, and be responsible for elements such as documentation, data sharing, claims submission and provider oversight. In deciding whether to establish a Hub entity, organizations should consider the following:

- Is there demand for a Hub entity among providers in the area? Many smaller housing service providers are already effectively part of a Hub through their contract with L.A. County Department of Health Services (DHS). Is that working for them? How many providers would take advantage of this option - is the volume worth it?
- Is our organziation in the position to dedicate the time and resources for initial start-up activities (e.g. MCP contracting, developing Policies & Procedures, setting up systems) as well as ongoing activities (e.g. claims & billing, MCP data exchange, provider oversight)? Many providers (including Hubs) are surprised by the kinds of requirements MCP contracts include. (e.g. 24-hour member calls, translation services, etc.).
- Does the estimated revenue make this model successful? Understanding the MCP reimbursement rates will help in developing the administrative fees that will support the Hub's operations. Is it possible to develop a fee structure that sustains both the "Hub" and its contracted providers?
- Is this the best use of our financial resources, influence and reach? Are there additional ways to create value that don't involve direct service provision or administration? Are there other Hubs that we could recommend to providers? Many organizations call themselves Hubs but are actually providing technical assistance, advocacy and training services to providers without administering a service.

Recommended *Strategic Actions*

Several strategies exist to further UWGLA's work to promote access to comprehensive services for older adults experiencing homelessness:

Advance a model of care for older adults experiencing or at-risk of homelessness.
Many stakeholders in California have established that various populations require tailored models of care in order to be successful. Population-specific stakeholders have already begun work in partnership with DHCS to establish these models. While much of this work is in progress, the DHCS Community Supports Spotlight Series has highlighted models other providers have used to implement CalAIM[2]. Prior work in developing pilots, plans and engaging in gap analysis for older adults experiencing homelessness[1] can be leveraged and refined with new health program information and discussion with additional stakeholders like managed care plans and DHCS. Initial activities to further this work would include:

- Beginning with the prior work by Home for Good and the L.A. County CEO's office, evaluate the status of those efforts and understand where to build from;
- Incorporating information about health programs into earlier work resulting in a comprehensive picture of what is available for older adults experiencing homelessness; and
- Engaging housing and health stakeholders, including DHCS, for discussions and potential socialization of the model.

Promote cross sector engagement
While many organizations providing housing and health care services work diligently to serve as many individuals as possible, one noticeable area for progress across the state is coordination across sectors to provide the comprehensive bundle of services needed. In this regard, regular engagement among these providers is critical for success and highlights the importance of care coordination. This enables awareness of resources and partner contacts, makes joint workflow development possible and socializes roles across the continuum of service provision.

[1] DHCS Community Supports Spotlight Series, Housing Suite: ***https://www.dhcs.ca.gov/Documents/MCQMD/2022-10-20-CS-Housing-Supports-Slides.pdf***
[2] Earlier work referenced in Home for Good's The Older Adult Strategy includes Dennis Culhane, Andy Perry, Max Stevens, Dan Treglia, Randall Kuhn, ***A Roadmap for Phased Implementation of an Older Adult Housing Pilot in Los Angeles County***, September 21, 2020 and County of Los Angeles, Chief Executive Office. (2020) ***Creating a Comprehensive Plan and Recommendations to Address the Needs of Homeless Older Adults in Los Angeles County***.

Activities to initiate engagement and collaboration across sectors could begin with:

- Hosting a regular convening of cross sector partners (housing service providers, developers, managed care plans, etc.) with forethought regarding intention and focused objectives such as development of workflows; and
- Leading a summit with key partners not usually convened together to further participants' foundational understanding of all the services available, potential model of care and organization roles moving forward;
- Partnering with local organizations (e.g. LA County Medical Association, Hospital Association of Souther California, or MCPs) to provide educational resources on the work of homeless services providers to create a framework and foundational understanding for partnership.

Support early implementation activities, training and technical assistance.

During interviews with key stakeholders, a clear cohort emerged of organizations who not only were not providing CalAIM services, but also had limited understanding of what they were or how their clients could access them. Organizations often need initial support to even make a decision about whether to begin offering additional services that may benefit the individuals they serve. Once a decision has been made to implement new services, there is often insufficient training and technical assistance offered by agencies, managed care plans and other payors. Significant value can be provided by offering the following:

- Initial working sessions with small CBOs to decide whether to begin offering new health programs in addition to their current service suite. These sessions would include a briefing on what is required, potential revenue expectations, and braiding funding. If participants decide not to move forward, additional training on how to connect their clients with these services could be provided;
- Deep dive training on health programs for CBOs deciding to move forward with offering these additional services. Development of this series could include service requirements, in-depth model of care exploration, workflow development and billing; and
- Initial grants to fund startup costs for systems and staff until sufficient volume is reached for sustaining levels of revenue.