CHCF

CalAIM Experiences: Implementer Views After 18 Months of Reforms

DECEMBER 2023

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About the Authors

Goodwin Simon Strategic Research (GSSR) is an independent opinion research firm with decades of experience in polling, policy analysis, and communications strategy for clients in the public and private sectors. GSSR founding partner Amy Simon, partner John Whaley, senior research analysts Nicole Fossier and Yule Kim, and independent researcher Jill Laufer all contributed their thought leadership on this survey research in collaboration with the California Health Care Foundation.

About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy organization that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the health system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. ***Health equity is the primary lens through which we focus our work at CHCF.***

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system. For more information, visit www.chcf.org.

Introduction and Summary of Key Findings

In January 2022, the California Department of Health Care Services launched CalAIM (California Advancing and Innovating Medi-Cal), a multiyear initiative with the potential to improve outcomes for the millions of people enrolled in Medi-Cal, California's Medicaid program. It also offers an unprecedented opportunity to move to a more integrated and people-centered approach to care for people with the most complex health and social needs, including those with behavioral health conditions and people experiencing homelessness, among others.

In this still-early stage of implementation, much can be learned from people on the ground launching and running a multitude of new programs. Throughout this report, they are referred to as implementers. This report highlights both shared and differing perspectives from the staff and leaders of a broad range of health and social service providers. Encouragingly, implementers share many successes in improved access and more comprehensive care for people with complex needs. At the same time, implementers also surface significant challenges and important improvements that must be made to increase CalAIM's effectiveness in the coming years.

On behalf of the California Health Care Foundation, Goodwin Simon Strategic Research conducted qualitative and quantitative research among CalAIM implementers to gain a clearer picture of how implementation is occurring on the ground. An online survey was conducted July 21 to September 12, 2023, among 1,196 CalAIM implementers at least a little familiar with CalAIM. Also, for most respondents, 30% or more of their patient population are enrolled in Medi-Cal or are uninsured. The survey questions were shaped by six online focus groups among different types of implementers conducted March 28 to April 27, 2023.

CalAIM is still in the midst of implementation, so while reading this report, keep the survey timeline in mind. Changes that went into effect in the summer of 2023 would not yet have been felt by many survey respondents. CHCF plans to conduct another survey in the summer of 2024 to measure progress and capture the effects of additional changes to CalAIM from the point of view of implementers.

This report highlights differences among sectors, including perspectives from the staff and leaders of managed care plans, social service organizations, Federally Qualified Health Centers, and behavioral health organizations. In addition, it includes the perspectives of two linchpin roles in the complex care workforce, primary care providers and hospital discharge planners. A breakdown of who is included in each sector can be found in Appendix A under Methodology.

Key Findings

- There is a lot of room to increase familiarity with CalAIM — even among those who serve a high percentage of patients, clients, or members enrolled in Medi-Cal.
- Among those who report 75%+ of their patients are enrolled in Medi-Cal, 16% say they are not at all familiar with CalAIM, and 14% say they are only a little familiar.
- Over 90% of implementers agree with the three overarching CalAIM goals, with more than 75% *strongly agreeing*.
- Just 18 months into the program, many implementers are already starting to see improvements for the people they serve.

- A majority (52%) say that "overall access to services, including those that address health-related needs (e.g., housing navigation, medically supported food and nutrition services)" has gotten somewhat or much better as a result of CalAIM's implementation.
- A majority of implementers are already able to cite some successes with the CalAIM program. Examples cited by implementers vary considerably, with each describing different aspects of the program and its implementation.
- Despite broad agreement with the goals behind CalAIM and some initial successes, satisfaction with implementation is not especially high — at least not at this point in the process.
  - On a scale of zero to 10 where zero is "not at all satisfied" and 10 is "extremely satisfied," the average rating for implementers falls just above the midpoint at 5.9. Although satisfaction varies by sector, region, and familiarity with CalAIM, there are very few who are either extremely satisfied or extremely dissatisfied — implementers are largely clustered near the middle of the scale.
  - Encouragingly, however, respondents more familiar with CalAIM report being more satisfied with its implementation than those less familiar. The implementers who are more familiar rate CalAIM as more effective and are seeing more evidence of improvements for their organizations and the people they serve. This suggests that as more implementers become more acquainted with CalAIM, overall satisfaction may increase.
- Some implementers report that CalAIM is already improving their organization's ability to serve people, but there is considerable room for progress.
- When asked about how CalAIM has impacted their organization, a slight majority of implementers (51%) say that their ability to manage the comprehensive needs of people they serve has gotten better as a result of CalAIM, while 40% say that it has stayed about the same or that they are unsure.
- Almost half of implementers (48%) say that their ability to coordinate with other organizations serving the same people has gotten better as a result of CalAIM, while 44% say that it has stayed about the same or that they're unsure.
- The same proportion (48%) of implementers say that their ability to grow the number of new people they serve has gotten better as a result of CalAIM, while 43% say that it has stayed about the same or that they're unsure.
- There is quite a bit of variation by sector when it comes to outlook on CalAIM — managed care plans (MCPs) tend to be much more positive about CalAIM implementation so far, while behavioral health (BH) providers are more likely than those in other sectors to say that things have not yet changed for the better.
- Implementers report a number of challenges they face with implementation.
- The most significant challenge reported is that payment rates are not covering the full cost of service (32% say "very challenging," and 56% say "very or somewhat challenging").

However administrative burdens, too much time spent on documentation requirements, and ability to recruit and retain staff are also cited as major challenges.

- Social service organizations face a unique set of barriers, as they report having far less experience with contracting, data exchange, and closed-loop referrals than respondents who work in clinical settings or MCPs. This gap in experience could be leading to a much steeper learning and resource curve for these organizations.
- Aside from organizational challenges, Enhanced Care Management (ECM) providers, and to a lesser extent Community Supports (CS) providers, are reporting high levels of refusals from those offered services. The most selected reason for refusals among both ECM and CS providers is that people are not interested in the service as it is offered.
- Overall, many implementers are optimistic that CalAIM implementation will improve over time, but most say they cannot wait more than a year for significant improvement on CalAIM processes and workflows.
- Opportunities to help implementers overcome the challenges they face and improve implementation of CalAIM include providing more resources and training, providing more financial assistance to organizations, and encouraging data exchange through portals and EHRs.
- Financial resources (like more implementation funding or rates that better reflect costs of operating) top the list of resources that respondents say would be helpful — but just barely. There is appetite for all the resources tested in the poll, including clearer guidance from the California Department of Health Care Services (DHCS) and MCPs, lower administrative requirements, opportunities to learn from others doing similar work, and more.
- An overwhelming majority of implementers who have used information sharing resources like DHCS webinars or trainings from MCPs say that those resources have been at least somewhat helpful.
- Many respondents, especially those with more Medi-Cal patients, report that they are often still exchanging data outside of portals or EHRs. Notably, respondents using portals and EHRs more often report receiving more complete data more quickly — so increasing use of portals and EHRs could increase the completeness and timeliness of data exchange.
- There is also an opportunity to bring in more organizations — almost half of respondents not currently providing ECM or CS (45%) say they "definitely or probably" plan to provide ECM or CS within the next one to three years.
- The most common barrier to entry for those not currently providing ECM or CS is not being sure how to participate.

The remainder of this report presents the results in more detail.

Section 1. Implementer Views on Current State of Implementation

Familiarity with CalAIM

> *"I think it's just getting the word out there, and once somebody understands what CalAIM is and the scope of it, it's pretty shocking to them that they haven't been utilizing everything that's been at the tip of their fingers."*
>
> —Katelyn Taubman, CHCF CalAIM Advisory Group member and associate manager of client care, Illumination Foundation

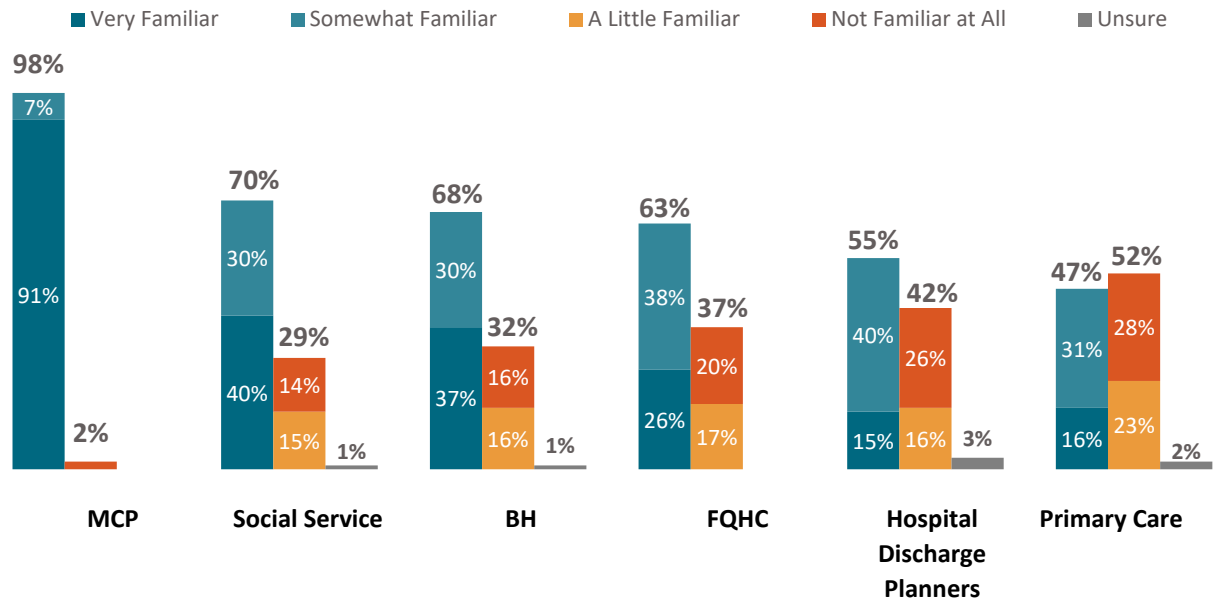
Among implementers interviewed, a slight majority (58%) say they are familiar (31% say "very familiar") with CalAIM. There is room here to increase familiarity among implementers, as a quarter (25%) say they are "not familiar at all" and 16% say they are "just a little familiar." Those not familiar at all with CalAIM were not included in the remainder of the survey.

Subgroup Findings

- Implementers at managed care plans (MCPs) are the most familiar with CalAIM, at 98% either "very familiar" or "somewhat familiar" with CalAIM.
- Less than half (47%) of primary care providers and just over half (55%) of hospital discharge planners who report that more than 30% of their patients have Medi-Cal coverage say they are "very familiar" or "somewhat familiar" with CalAIM (Figure 1).

Figure 1. Among Those Who Serve at Least 30% of People Covered by Medi-Cal, There Is Room to Increase Familiarity

Q: HOW FAMILIAR ARE YOU WITH CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL, ALSO REFERRED TO AS CALAIM? CALAIM INCLUDES MANY NEW PROGRAMS AND CHANGES, SUCH AS ENHANCED CARE MANAGEMENT, COMMUNITY SUPPORTS, CARVE-IN OF INSTITUTIONAL LONG-TERM CARE, POPULATION HEALTH MANAGEMENT, NO WRONG DOOR, BEHAVIORAL HEALTH PAYMENT REFORM, ETC.



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Those not at all familiar with CalAIM or unsure were not included in the remainder of the survey.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Agreement with CalAIM Goals

> *"CalAIM seems to be a broader health perspective and service. The old Medi-Cal was more traditional and narrower."*
>
> —Frontline provider, Central Coast

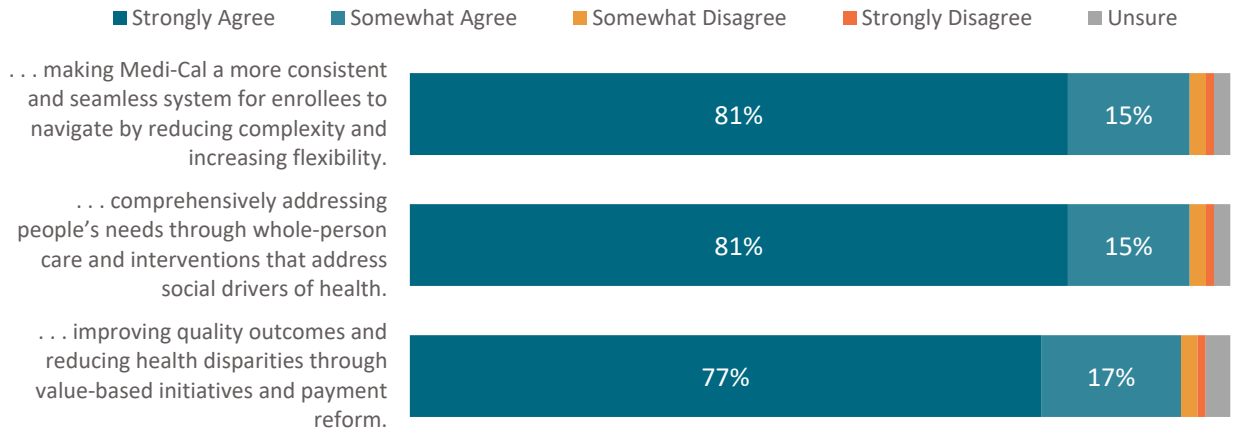
Mostly implementers agree with the core goals of CalAIM, with the vast majority saying they strongly agree with those goals. Almost all (96%) agree with CalAIM's goal of "making Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility," with 81% saying they "strongly agree" with it.

There are similar levels of agreement (96% agree, including 81% who "strongly agree") for CalAIM's goal of "comprehensively addressing people's needs through whole-person care and interventions that address social drivers of health." Close behind this selection, 94% agree

(including 77% who "strongly agree") with CalAIM's goal of "improving quality outcomes and reducing health disparities through value-based initiatives and payment reform" (Figure 2).

Figure 2. Implementers Familiar with CalAIM Are On Board with Core Goals

Q: PLEASE INDICATE HOW MUCH YOU AGREE OR DISAGREE WITH EACH OF THE FOLLOWING STATEMENTS: I SUPPORT CALAIM'S GOAL OF . . .



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Impacts on Those Served — from the Point of View of Implementers

> *"Access to care has been to date the biggest success, as we are able to start services without previous restrictions around level of care and assessment."*
>
> —Behavioral health leader, Inland Empire/Desert

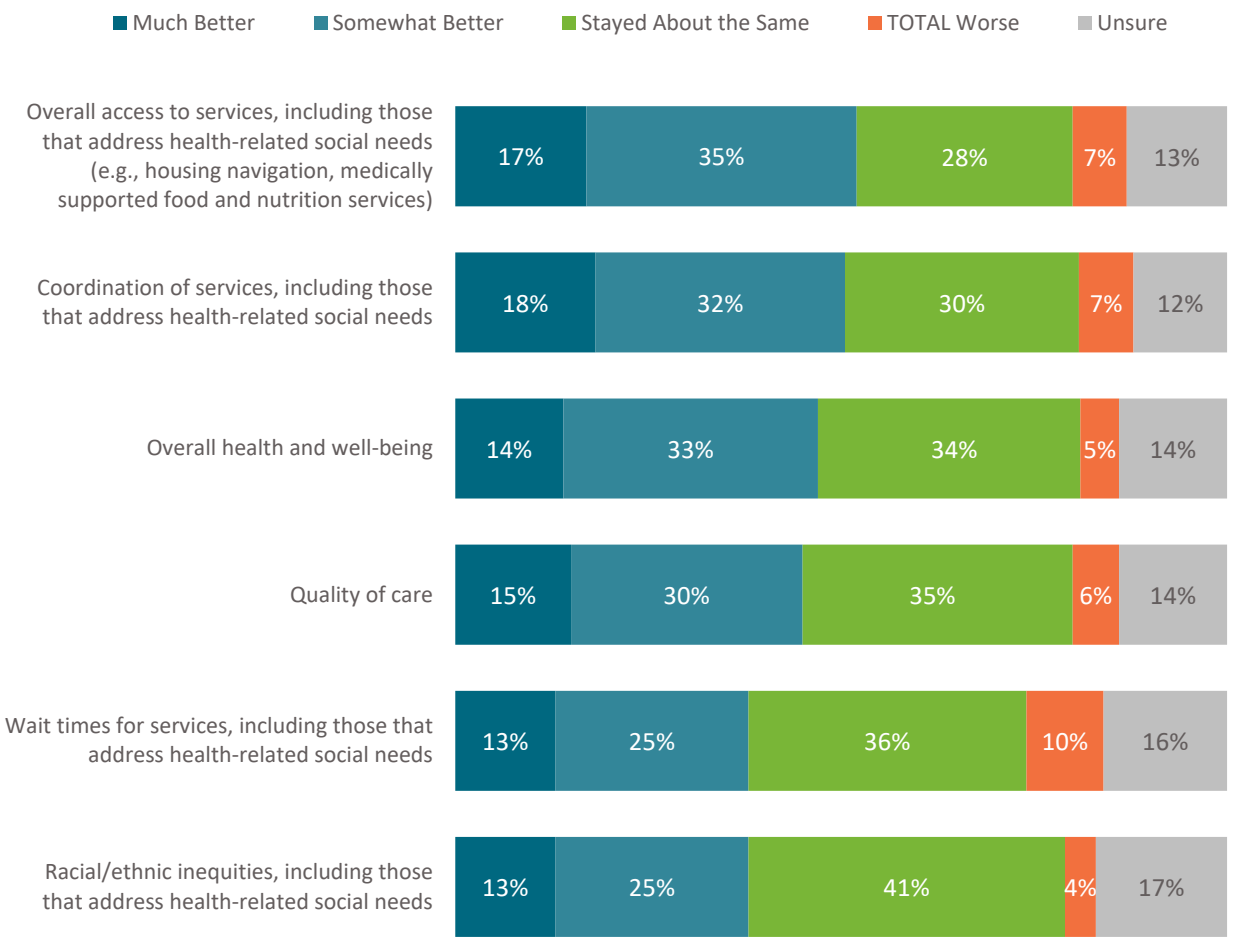
Just 18 months into the program, many implementers are already starting to see improvements in services, experiences, and outcomes for the people they serve. For example, a majority (52%) say that "overall access to services, including those that address health-related social needs (e.g., housing navigation, medically supported food and nutrition services)" has gotten "somewhat better" or "much better" as a result of CalAIM's implementation. It is encouraging to see progress at this early stage of implementation, especially considering the challenges that implementers cite in the survey (detailed insights on challenges below).

Nearly half say that "coordination of services, including those that address health-related social needs" (50% "somewhat better" or "much better"), "overall health and well-being" (47% "somewhat better" or "much better"), and "quality of care" (45% "somewhat better" or "much better") have gotten better as a result of CalAIM. The only category where a notable group of implementers (10%) say that things have gotten worse is "wait times for services, including those that address health-related social needs" — though far more (38%) still say wait times

have gotten better. There is no significant difference between subgroups when it comes to the proportion of respondents who report wait times have gotten worse (Figure 3).

Figure 3. A Majority or Plurality of Respondents Report Improvements in Access, Coordination, Quality of Care, and Overall Health and Well-Being for the People They Serve

Q: THINKING ABOUT THE EXPERIENCES OF THE PEOPLE YOU SERVE (E.G., PATIENTS, MEMBERS, OR CLIENTS), PLEASE INDICATE WHETHER YOU PERSONALLY THINK THE EXPERIENCES OF THE FOLLOWING HAVE GOTTEN BETTER OR WORSE AS A RESULT OF CALAIM'S IMPLEMENTATION — OR IF THEY HAVE STAYED ABOUT THE SAME. IF YOU ARE UNSURE, JUST SELECT THAT . . .



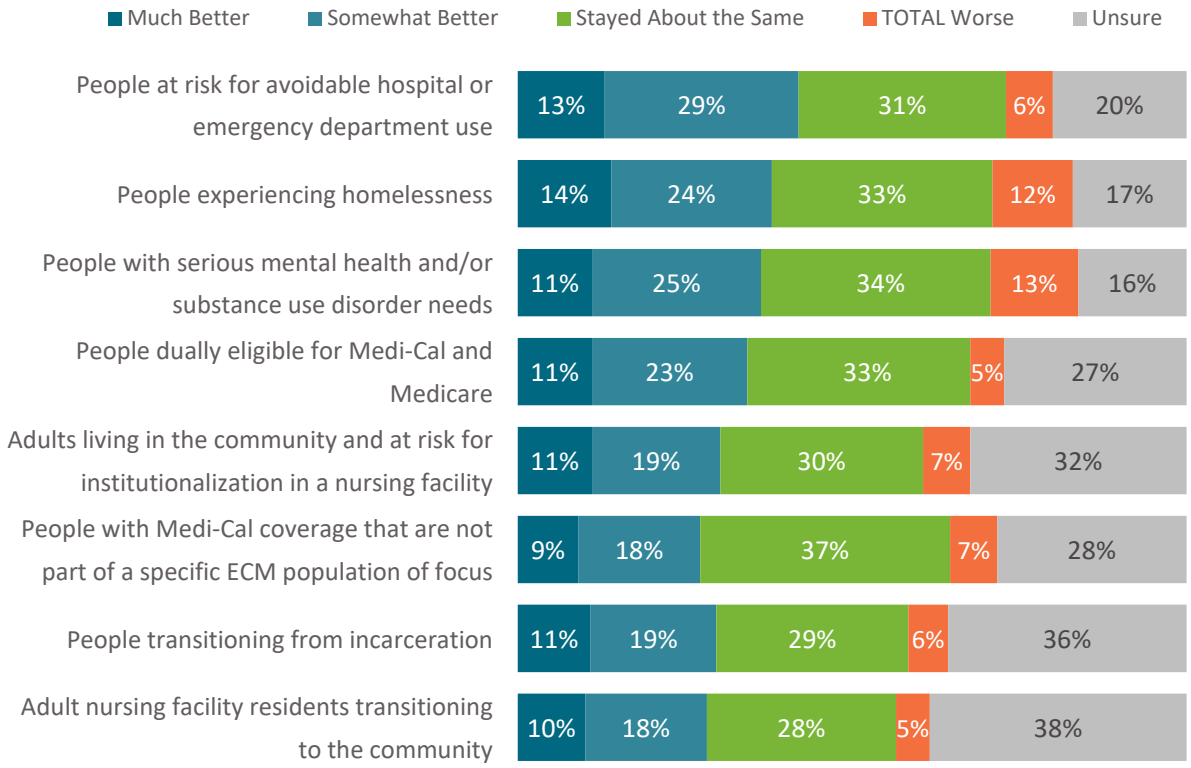
Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Ranked by Total Better; excludes those who answered "Not Applicable." TOTAL Worse is the sum of "Somewhat" and "Much" Worse responses.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Implementers are much more likely to report improvements in experience of care across populations of focus — however, they are more certain about the impacts on 2022 populations of focus than about future populations of focus. More implementers can respond about how CalAIM has affected "people at risk for avoidable hospital or emergency department use," "people experiencing homelessness," and "people with mental health and/or substance use disorder needs." When it comes to future populations of focus, implementers are more likely to say they aren't sure about how the experience of care has changed since the implementation of CalAIM (Figure 4).

Figure 4. Respondents More Certain About 2022 Populations of Focus Than About Later Populations of Focus

Q: NOW THINKING ABOUT THE EXPERIENCES OF THE PEOPLE YOU SERVE IN EACH OF THE FOLLOWING POPULATIONS, PLEASE INDICATE WHETHER YOU PERSONALLY THINK THEIR OVERALL EXPERIENCE OF CARE HAS GOTTEN BETTER OR WORSE AS A RESULT OF CALAIM'S IMPLEMENTATION OR IF IT HAS STAYED ABOUT THE SAME. IF YOU ARE UNSURE, JUST SELECT THAT . . .



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Ranked by Total Better; excludes those who answered "Not Applicable" to each population. TOTAL Worse is the sum of "Somewhat" and "Much" Worse responses.

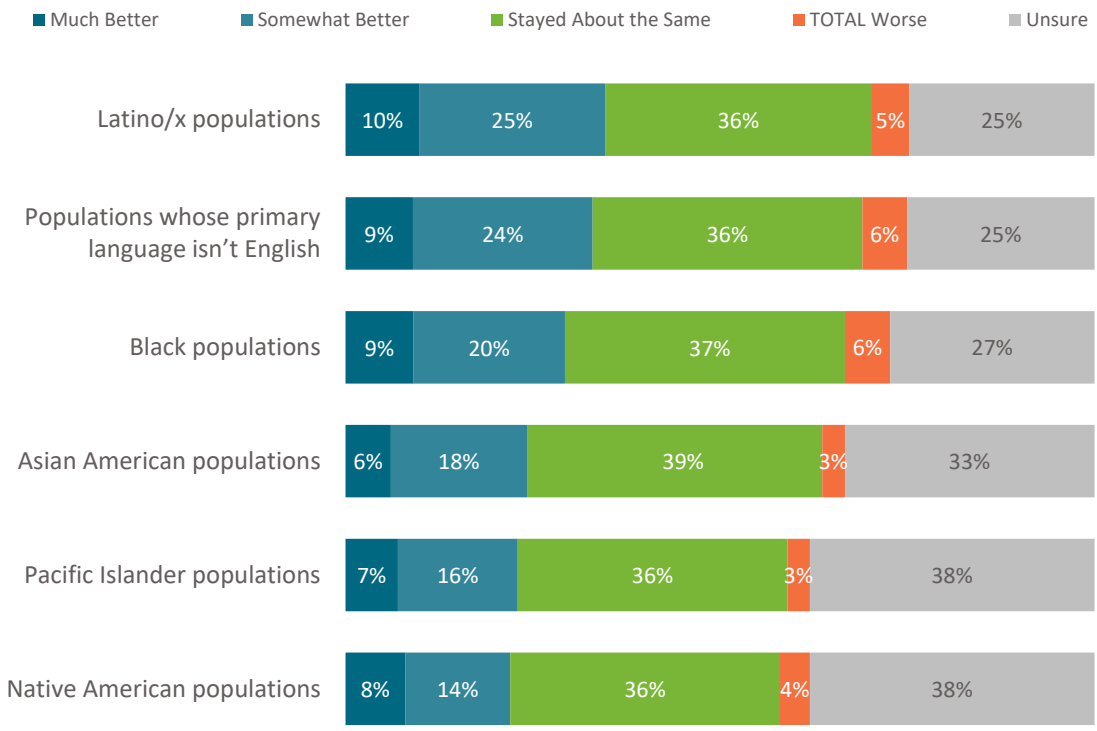
Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

When assessing the impacts of the program on the experience of care of racial and ethnic groups, respondents tend to be even less certain. Among those groups, more implementers report improvements in experience of care for Latino/x (35% “much better” or “somewhat better”) and populations whose primary language isn’t English (33% “much better” or “somewhat better”).

It's worth highlighting that across all populations, the total "Worse" numbers are relatively low, ranging from 3% to 6%, indicating that, in general, most implementers are not reporting a significant deterioration of service experiences for these groups (Figure 5).

Figure 5. Respondents Less Sure About Improvements for Racial/Ethnic Groups

Q: NOW THINKING ABOUT THE EXPERIENCES OF THE PEOPLE YOU SERVE IN EACH OF THE FOLLOWING POPULATIONS RELATED TO RACE/ETHNICITY OR LANGUAGE, PLEASE INDICATE WHETHER YOU PERSONALLY THINK THEIR OVERALL EXPERIENCE OF CARE HAS GOTTEN BETTER OR WORSE AS A RESULT OF CALAIM’S IMPLEMENTATION AS A WHOLE . . .



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Ranked by Total Better; excludes those who answered “Not Applicable” for each row. TOTAL Worse is the sum of "Somewhat" and "Much" Worse responses.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Early Successes

> *"Being able to hire more ECM case managers [CMs] is great, because I cannot address my patients' complex social needs in one 15-minute visit, and it is essential that I am to have CMs to help my patients and follow up between medical visits."*
>
> —Frontline provider, Federally Qualified Health Center (FQHC), Los Angeles County

> *"Developing a better continuum of aftercare for housing insecure and substance-dependent patients leaving the hospital, to continue their recovery."*
>
> —Hospital leader, Central Valley

Even at this early stage of implementation, the majority of implementers can cite some sort of organizational success due to CalAIM. In an open-ended question, 59% of respondents describe a success due to CalAIM, while 41% say they don't know of any successes so far or did not answer. Implementers cite a broad range of successes including being able to provide care that is more comprehensive (including case management and treatment plans) (8%), providing resources for people experiencing homelessness (7%), learning about new resources or training (5%), new partnerships and collaborations with other organizations (4%), and decreased paperwork (4%).

Organizational Impacts

> *"There needs to be onboarding support and the ability to meet the administrative requirements without changing how we do our work."*
>
> —Social service leader, Bay Area

When it comes to organizational impacts, especially those related to ability of the organization to serve people, more implementers report improvements than declines at this point in implementation. Specifically, similar proportions perceived the three areas below (also circled below in Figure 6) as being "much better" or "somewhat better" as a result of CalAIM:

- . . . ability to manage the comprehensive needs of the people you serve (51%)
- . . . ability to coordinate with other organizations serving the same people (48%)
- . . . ability to grow the number of new patients/members/clients you serve (48%)

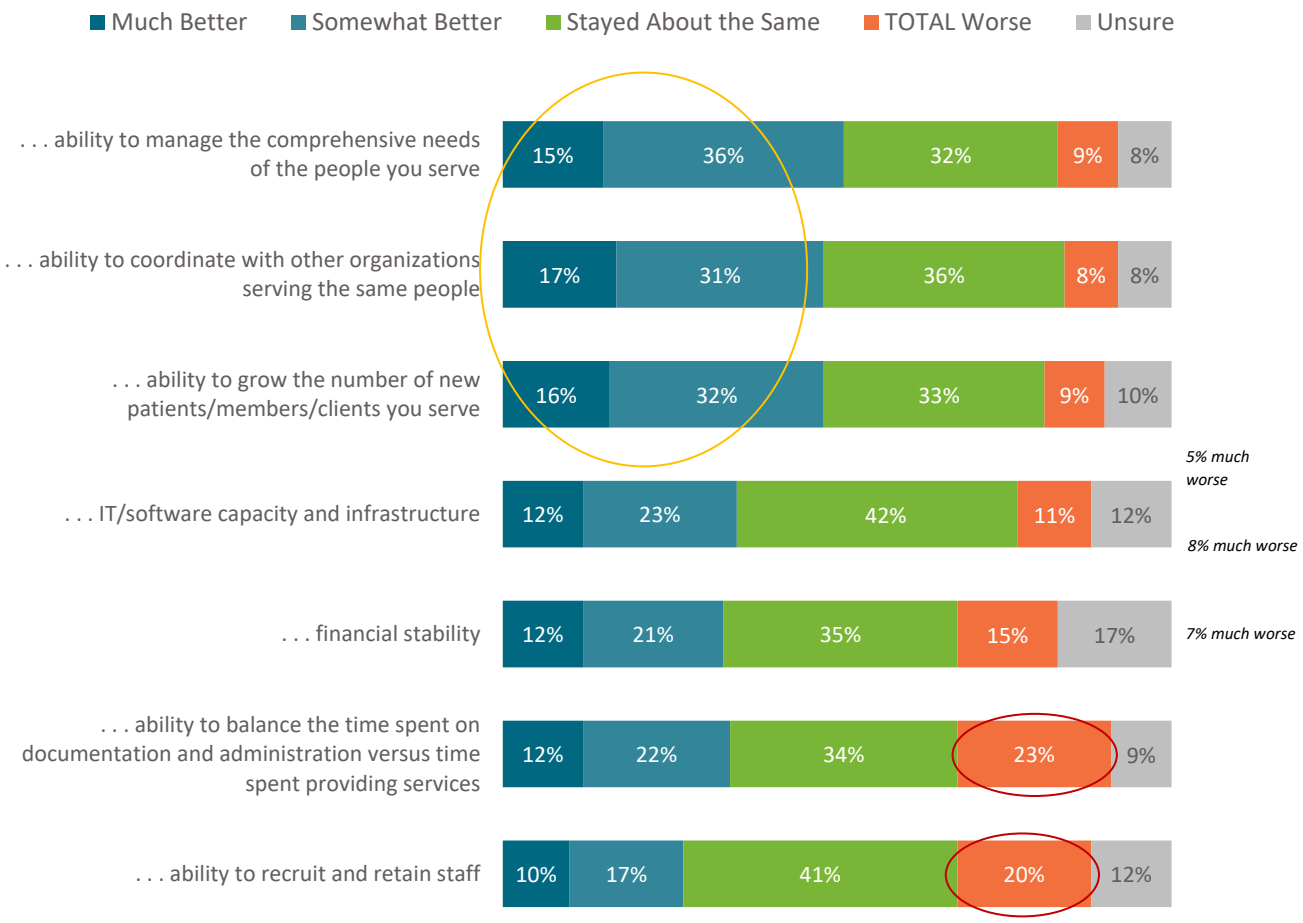
By contrast, fewer implementers report improvements for logistical and internal organizational items — and small but notable groups say things have gotten worse. For example, when it comes to "ability to balance the time spent on documentation and administration versus time spent providing services," 34% of implementers say things have gotten better while 23% say things have gotten worse. When it comes to their "ability to recruit and retain staff," 27% of implementers say things have gotten better while 20% say things have gotten worse (Figure 6).

It Is important to note that DHCS began implementing policy changes in July to decrease administrative burdens. Given that the survey was conducted soon afterward, it likely did not capture the impact of these changes.

Figure 6. Implementation Already Improving Ability to Serve

Q: NOW THINKING ABOUT YOUR OWN ORGANIZATION, PLEASE INDICATE WHETHER YOU PERSONALLY THINK EACH OF THE FOLLOWING HAS GOTTEN BETTER OR WORSE AS A RESULT OF CALAIM — OR IF IT HAS STAYED ABOUT THE SAME . . .

YOUR ORGANIZATION'S . . .



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Ranked by Total Better; excludes those who answered "Not Applicable" for each item. TOTAL Worse is the sum of "Somewhat" and "Much" Worse responses.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Subgroup Findings

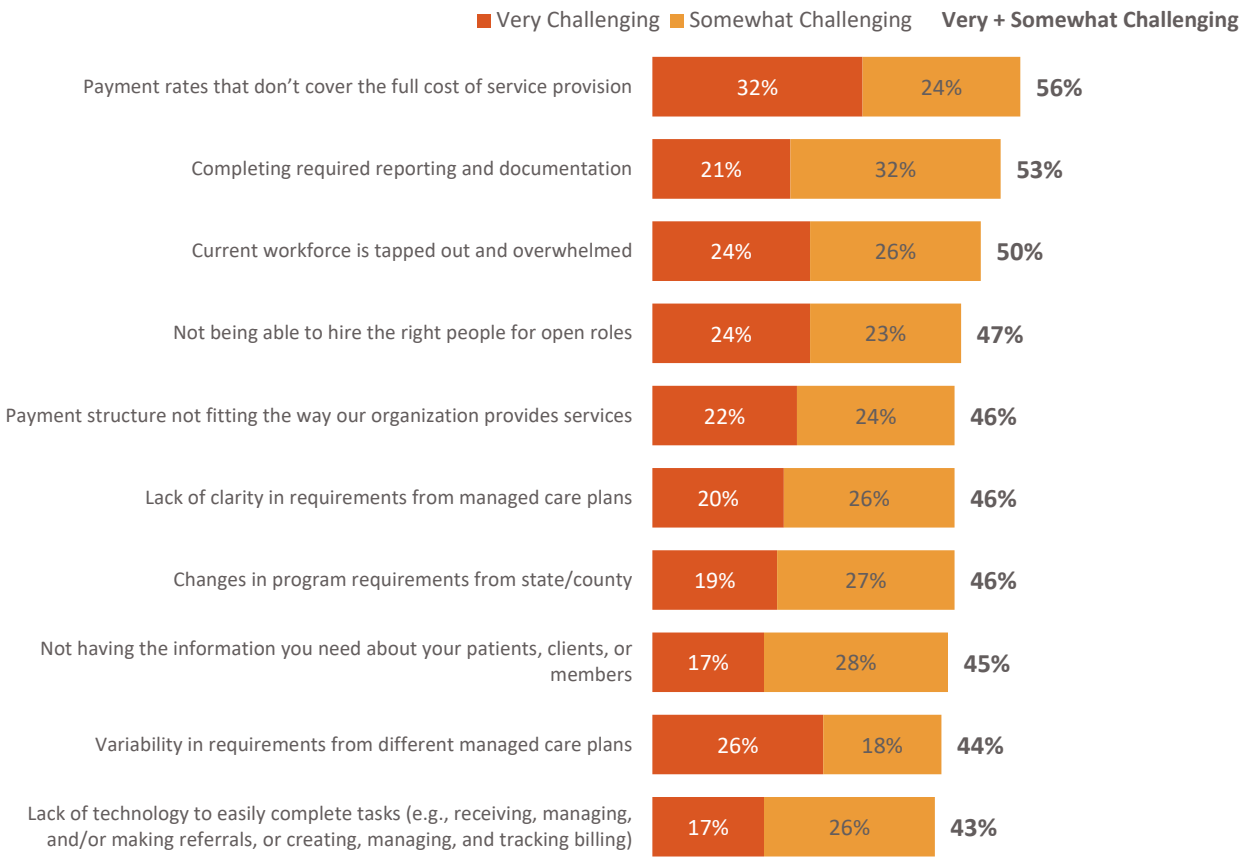
- Implementers from FQHCs (30%) and behavioral health organizations (28%) are more likely than those in other sectors to say that their "ability to balance the time spent on documentation . . ." has gotten worse.
- Implementers from behavioral health organizations (29%) and primary care providers (25%) are more likely to say that their "ability to recruit and retain staff" has gotten worse.

Despite some early successes and improvements in their ability to serve people, implementers report many challenges that hinder their ability to implement ECM or Community Supports or both. In particular, the most significant reported challenge is "payment rates that don't cover the full cost of service provision," which is rated as challenging by 56% of implementers, including 32% who rate it "very challenging."

Notably, "variability in requirements from different managed care plans" is rated "very challenging" by a quarter of implementers (26%) (Figure 7). Although this is not applicable in all areas, many implementers are managing contracts with multiple MCPs, each with its own procedures and processes. For context, among implementers who responded to this question, the majority (70%) report having contracts with more than one MCP — and on average implementers report having contracts with 3.27 MCPs.

Figure 7. Implementers Report Many Challenges, with the Most Significant Being Insufficient Payment Rates

Q: PLEASE INDICATE HOW CHALLENGING EACH OF THE FOLLOWING HAS BEEN WHEN IT COMES TO IMPLEMENTING ECM AND/OR COMMUNITY SUPPORTS: ***TOP CHALLENGES***



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Ranked by Very + Somewhat Challenging.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Current Ratings of CalAIM Implementation

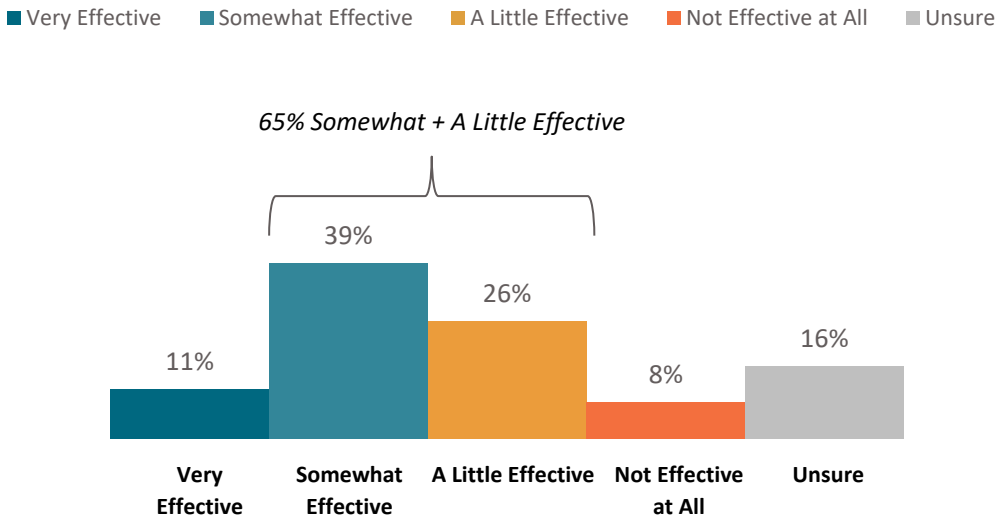
> *"It is a step in the right direction, but it is confusing and not accessible to all the people on the front line. We could use a road map; it seems like we are figuring it out slowly and on our own."*
>
> —FQHC leader, Central Coast

Implementers have mixed views of CalAIM implementation at this stage. A majority of implementers rate the effectiveness of CalAIM-related processes, protocols, and workflows as "somewhat effective" (39%) or "a little effective" (26%), together accounting for 65% of

respondents. Very few say that CalAIM-related processes, protocols, and workflows are currently "very effective" (11%), or that they are "not effective at all" (8%) (Figure 8).

Figure 8. Implementers Have Mixed Views About Effectiveness of CalAIM at This Stage

Q: AT THIS STAGE OF CALAIM'S IMPLEMENTATION, HOW WOULD YOU RATE THE EFFECTIVENESS OF CALAIM-RELATED PROCESSES, PROTOCOLS, AND WORKFLOWS OVERALL?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Subgroup Findings

- Managed care plans are much more likely than any other sector to say that CalAIM-related processes, protocols, and workflows are currently "very effective" (30%).

Similarly, satisfaction with experience with CalAIM so far is moderate, with an average satisfaction rating slightly higher than the midpoint (5.9 on a scale of zero to 10).

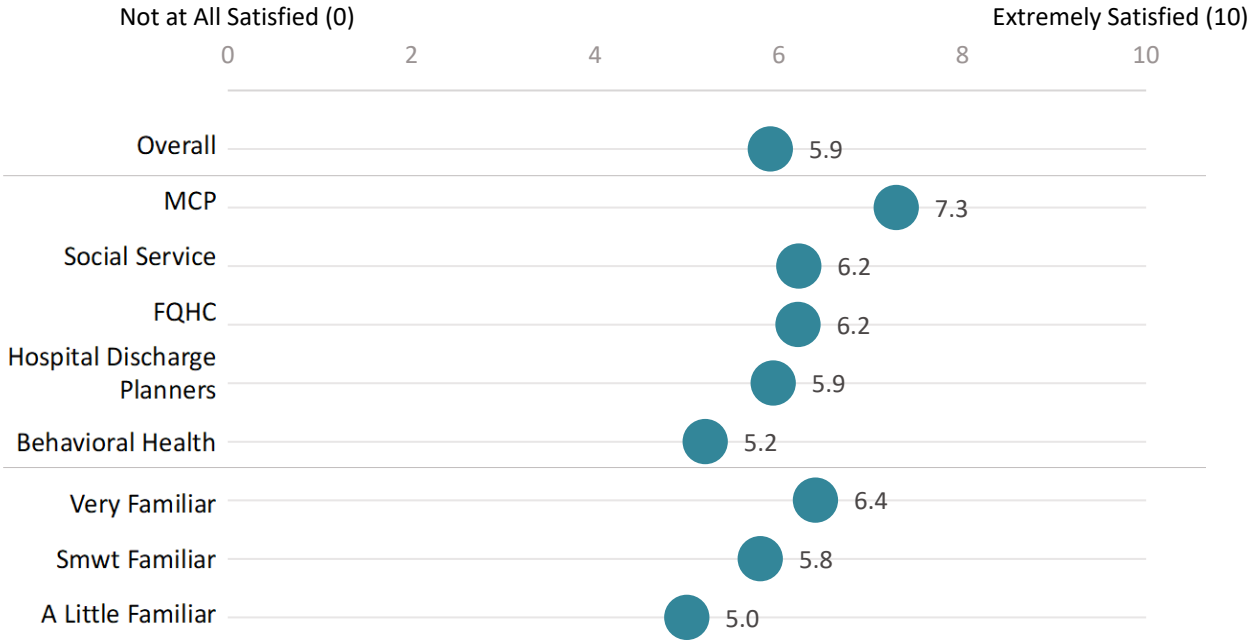
Subgroup Findings

> *"As an MCP . . . there's been flexibility for us to develop the program, especially for Community Supports. We are able to pivot the program design and implementation as needed with feedback as an iterative process with providers, other stakeholders, and DHCS. DHCS has updated their policy guide multiple times as a result of stakeholder and MCP feedback. So I think that's where we're seeing the high satisfaction among MCPs — because there's a true partnership with DHCS, providers, and our stakeholders to continuously improve the program."*
>
> —Nancy Wongvipat, CHCF CalAIM Advisory Group member and senior director of systems of care, Health Net

- MCPs stand out with the highest levels satisfaction, with an average score of 7.3 out of 10.
- On the other side of the spectrum, the behavioral health sector reports the lowest average satisfaction score at 5.2, just above the midpoint of the scale.
- Importantly, respondents who report being "very familiar" with CalAIM (average score of 6.4) express significantly higher levels of satisfaction than respondents only "a little familiar" with CalAIM (5.0), suggesting that implementers may become more satisfied with their CalAIM experience as they become more familiar with the program (Figure 9).

Figure 9. Satisfaction with CalAIM Implementation Varies by Sector and by Familiarity

Q: ON A SCALE OF ZERO TO 10, WITH ZERO MEANING NOT AT ALL SATISFIED AND 10 MEANING EXTREMELY SATISFIED, HOW SATISFIED ARE YOU WITH YOUR ORGANIZATION'S EXPERIENCE WITH CALAIM SO FAR?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Data shown are average values for each subgroup.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Additional Subgroup Findings

- Previous participation in Whole Person Care or Health Homes is correlated with higher satisfaction, as those who participated in these programs report an average score of 6.5, compared to 5.4 for those who did not.
- Respondents in County Organized Health Systems counties express higher average satisfaction (6.0) than those in Two-Plan (5.8) or Regional (5.6) counties.

Expectations for Improvement of CalAIM Processes over Time

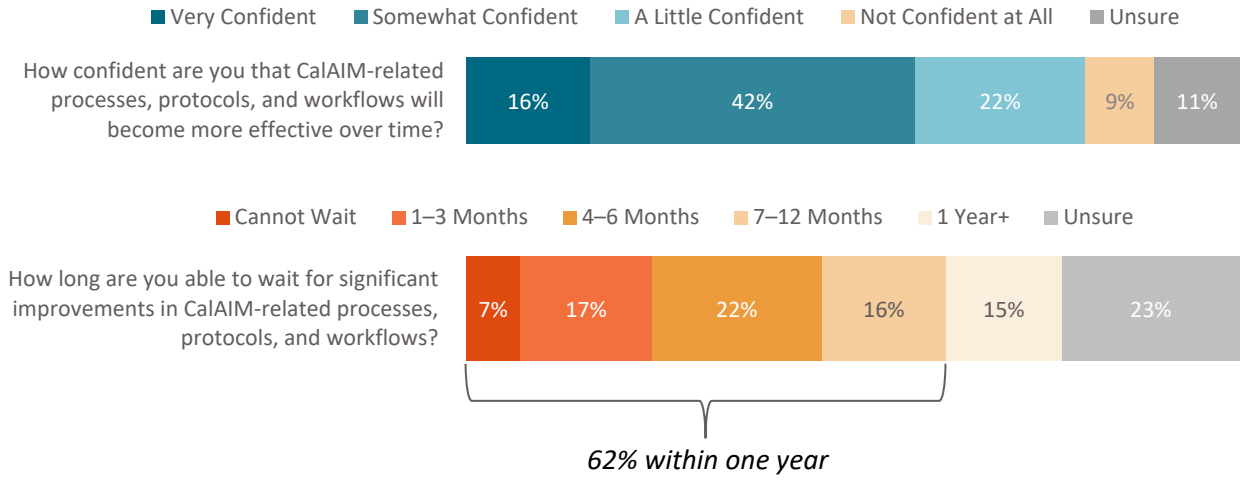
> *"We are a small nonprofit and cannot cover heavy expenditures in advance. . . . This time line is killing us. CITED and IPP funding cycles are timed awful, and payments are terribly delayed. Nobody knows what these benefits are, so they don't refer. MCPs have various billing requirements . . . and will not give guidance regarding 'time spent' and what happens when members go MIA. Does nobody understand that we don't have the up-front dollars to support this?"*
>
> —Social service leader, Rural North

Among implementers, there is a general sense of optimism about improvement, but the runway for most is less than a year. A majority of respondents (58%) who do not already rate CalAIM processes as "very effective" are "very confident" or "somewhat confident" that CalAIM-related processes, protocols, and workflows will improve over time. Less than 1 in 10 (9%) say they are "not confident at all" that processes will improve.

In terms of the expected timeline for improvement, the majority (62%) say they are willing to wait 12 months or less, with almost a quarter (24%) saying they are willing to wait 3 months or less (Figure 10). These findings collectively reflect a hopeful attitude and a desire for relatively swift progress among implementers as they look ahead to continuing CalAIM implementation.

Figure 10. There Is Optimism About Improvement, but the Runway for Most Is Less Than a Year

Q: AND HOW CONFIDENT ARE YOU THAT CALAIM-RELATED PROCESSES, PROTOCOLS, AND WORKFLOWS WILL BECOME MORE EFFECTIVE OVER TIME? / HOW LONG ARE YOU ABLE TO WAIT FOR SIGNIFICANT IMPROVEMENTS IN CALAIM-RELATED PROCESSES, PROTOCOLS, AND WORKFLOWS?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. These two questions were asked of everyone except those who answered that CalAIM-related processes, protocols, and workflows are already "very effective."

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Support for Implementers

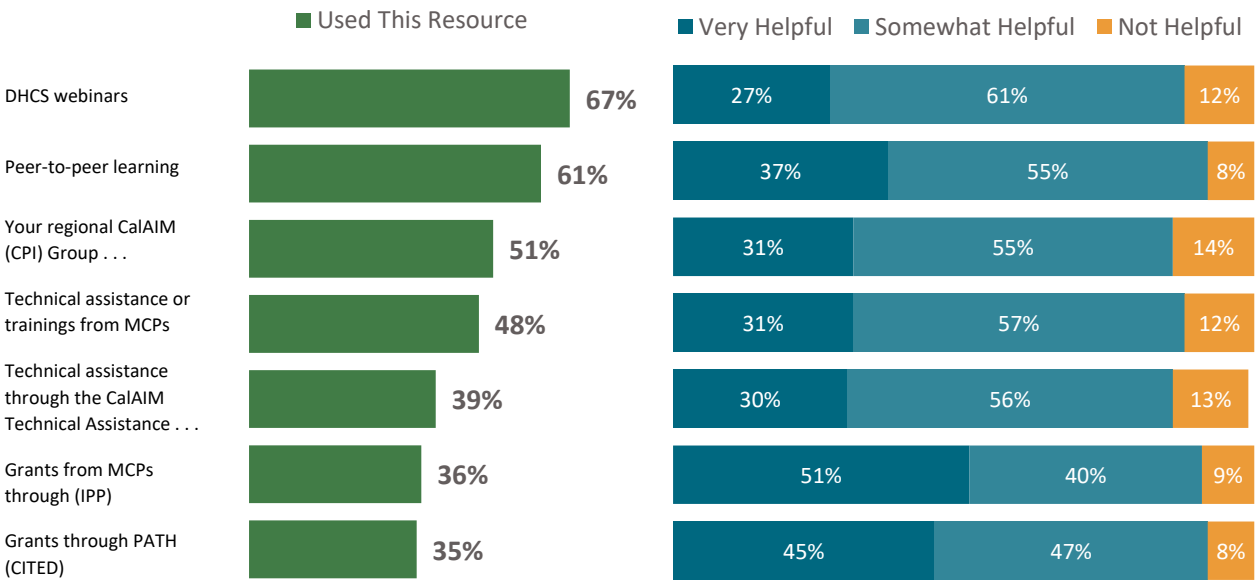
> *"Our biggest success so far is connecting participants to needed resources and being provided information on trainings and grants for application!"*
>
> —Social service leader, Central Coast

Implementers find a range of currently available resources helpful, though the resources vary widely in rate of use. In a list of resources provided to respondents, DHCS webinars and peer-to-peer learning emerged as the most frequently utilized, with 67% and 61% of respondents, respectively, reporting having used these resources. Among implementers who report having used each resource, the vast majority find them "very helpful" or "somewhat helpful."

Grants through IPP and CITED are the least utilized resource, with just a over a third of respondents using grants from "MCPs through IPP" (36%) and "grants through PATH (CITED)" (35%). Despite their lower usage, grants from "MCPs through IPP" received the highest reported rates of "very helpful" (51%), followed closely by grants through PATH (45%) (Figure 11). Grants may help bridge the funding gap for implementers who report insufficient funding streams as a challenge in implementing CalAIM.

Figure 11. Implementation Resources Vary in Rate of Use and Usefulness

Q: LISTED BELOW ARE SOME RESOURCES AVAILABLE TO HELP IMPLEMENT CALAIM. FOR EACH, PLEASE INDICATE IF YOU HAVE ALREADY TAKEN ADVANTAGE OF THAT RESOURCE AND IF SO, HOW HELPFUL IT HAS BEEN TO YOUR ORGANIZATION . . .



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

One member of CHCF's CalAIM Advisory Group explains that IPP grants are likely rated as more helpful than CITED grants because in their experience, IPP grants are less restrictive and require less time and paperwork to acquire.

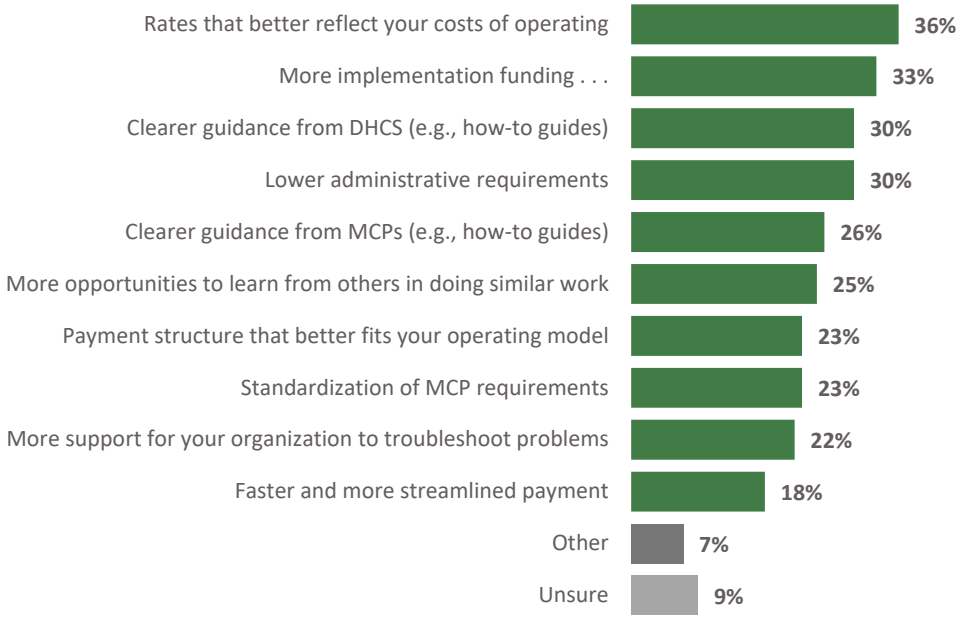
> *"I would say that the IPP was the most useful because it was a lot easier to deal with than the CITED application. With CITED, the five- to six-month wait time to get paid for what you've spent money on is a really big challenge. But the whole metrics reporting and the way that they structured that grant application is also really cumbersome and has taken us just a huge amount of time. But both have been useful in terms of the funding."*
>
> —Cathryn Couch, CHCF CalAIM Advisory Group member and CEO, Ceres Community Project

When asked what additional support implementers would find helpful, financial incentives narrowly top the list. More than a third of implementers (36%) report that "rates that better reflect your costs" would be among the most helpful support for their organization, while 33% say that "more implementation funding (e.g. for data systems, hiring/training staff)" would be among the most helpful. However, a few other types of support follow close behind, including "clearer guidance from DHCS (e.g., how-to guides)" and "lower administrative requirements,"

each chosen by 30% of implementers (Figure 12). These preferences align with some of the top challenges that implementers report, including insufficient payment rates, documentation requirements, overwhelmed workforce, and changes in program requirements.

Figure 12. Financial Incentives Top the List of Resources Implementers Would Find Helpful, but Narrowly

Q: WHICH OF THE FOLLOWING DO YOU THINK WOULD BE THE MOST HELPFUL FOR YOUR ORGANIZATION IN IMPLEMENTING CALAIM? PLEASE SELECT THE TOP THREE.



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

The support that implementers report would be most helpful varies by sector, reflecting the different challenges each sector faces and the different experiences they have had so far in CalAIM implementation.

- Managed care plans (MCPs) prioritize "support for troubleshooting problems" (45%), "clearer guidance from DHCS" (43%), and "more opportunities to learn from others in doing similar work" (42%). These preferences underscore the desire for more information and guidance that was surfaced by MCP participants in the focus groups.
- Hospital discharge planners have a similar need for more information and guidance in implementation. They seek clearer guidance from both MCPs (39%) and DHCS (34%), as well as "opportunities to learn from others engaged in similar work" (34%).

- Federally Qualified Health Center (FQHC) implementers emphasize securing "more implementation funding" (41%), and "rates that better reflect [their] costs of operating" (38%), both of which point to a need for more financial resources.
- Similarly, social service organizations prioritize obtaining more implementation funding (40%) and rates that better align with their operating costs (35%).
- The top most helpful support for behavioral health implementers is "rates that accurately reflect [their] costs of operating," (47%), and "lower administrative requirements" (37%), which would help address their concerns about administration and documentation requirements that some report having increased instead of decreased as a result of CalAIM. In the focus groups, some participants express frustration that payments do not cover the amount of time it takes to complete documentation requirements.
- Primary care providers want "lower administrative requirements" (37%) and "clearer guidance from MCPs (e.g., how-to guides)" (32%), highlighting a need for direction and more streamlined processes in navigating the complexities of CalAIM implementation and managed care plan relationships (Figure 13).

Figure 13. Most Helpful Resources Vary by Sector

Q: WHICH OF THE FOLLOWING DO YOU THINK WOULD BE THE MOST HELPFUL FOR YOUR ORGANIZATION IN IMPLEMENTING CALAIM? PLEASE SELECT THE TOP THREE.

% Who Selected Each Statement	Overall	MCP	FQHC	BH	Social Service	Hospital Discharge Planners	Primary Care
Rates that better reflect your costs of operating	36%	25%	38%	47%	35%	30%	28%
More implementation funding . . .	33%	34%	41%	29%	40%	24%	28%
Clearer guidance from DHCS (e.g., how-to guides)	30%	43%	28%	33%	26%	34%	28%
Lower administrative requirements	30%	25%	35%	37%	25%	22%	37%
Clearer guidance from MCPs (e.g., how-to guides)	26%	30%	36%	23%	20%	39%	32%
More opportunities to learn from others in doing similar work	25%	42%	20%	24%	26%	34%	24%
Payment structure that better fits your operating model	23%	9%	20%	28%	20%	19%	28%
Standardization of MCP requirements	23%	22%	24%	19%	23%	28%	18%
More support for your organization to troubleshoot problems	22%	45%	21%	18%	19%	31%	30%
Faster and more streamlined payment	18%	19%	16%	14%	18%	18%	22%

Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Section 2. Organizational Partnerships

> *"CalAIM has joined together a lot of different stakeholders across the health system that I think previously worked in silos."*
>
> —Primary care provider, leader, Bay Area

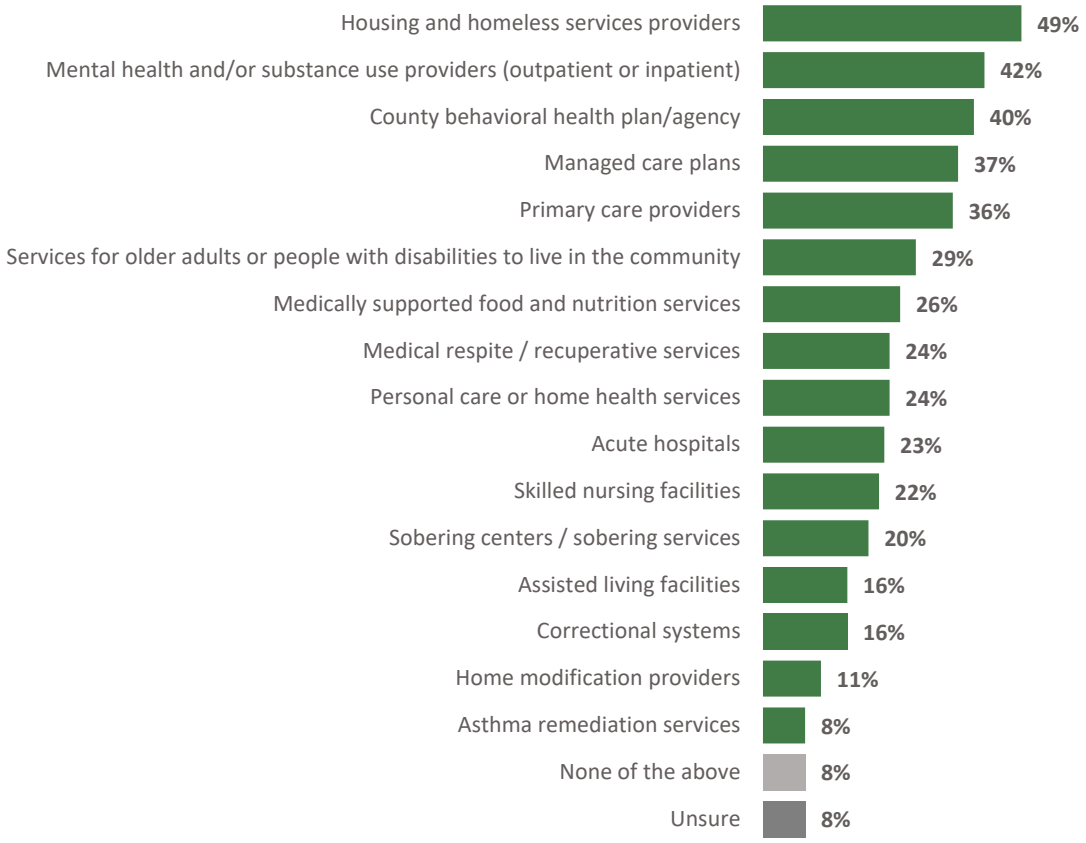
Most organizations report partnerships in other sectors, but there is still room to increase cross-sector collaboration. The survey findings reveal that 62% of organizations report partnerships in three or more sectors. Although 10% report partnerships in two sectors, and 12% maintain a partnership in just one sector, this distribution demonstrates a substantial level of collaboration that spans multiple areas of the health care landscape.

However, those partnerships are not evenly distributed across sectors, with only about 1 in 10 implementers reporting partnerships with home modification (11%) or asthma remediation service providers (8%).

Additionally, 8% of implementers say they do not have partnerships in any of these sectors, which suggests an opportunity for these entities to expand their collaborative efforts and establish formalized agreements with other organizations in various sectors. Overall, the data suggest a positive starting point for partnerships, with room to grow through CalAIM implementation (Figure 14).

Figure 14. Most Orgs Report Partnerships, Though Still Room to Increase Collaboration

Q: DO YOU CURRENTLY HAVE PARTNERSHIPS IN ANY OF THE FOLLOWING SECTORS — WHETHER OR NOT YOU DEVELOPED THEM THROUGH CALAIM? BY "PARTNERSHIPS" WE MEAN A FORMALIZED, THOUGH NOT NECESSARILY FINANCIAL, AGREEMENT (E.G., AN MOU, COLLABORATION AGREEMENT, OR CHARTER WOULD SUFFICE). PLEASE INDICATE THE SECTORS IN WHICH YOU HAVE AT LEAST ONE PARTNERSHIP.



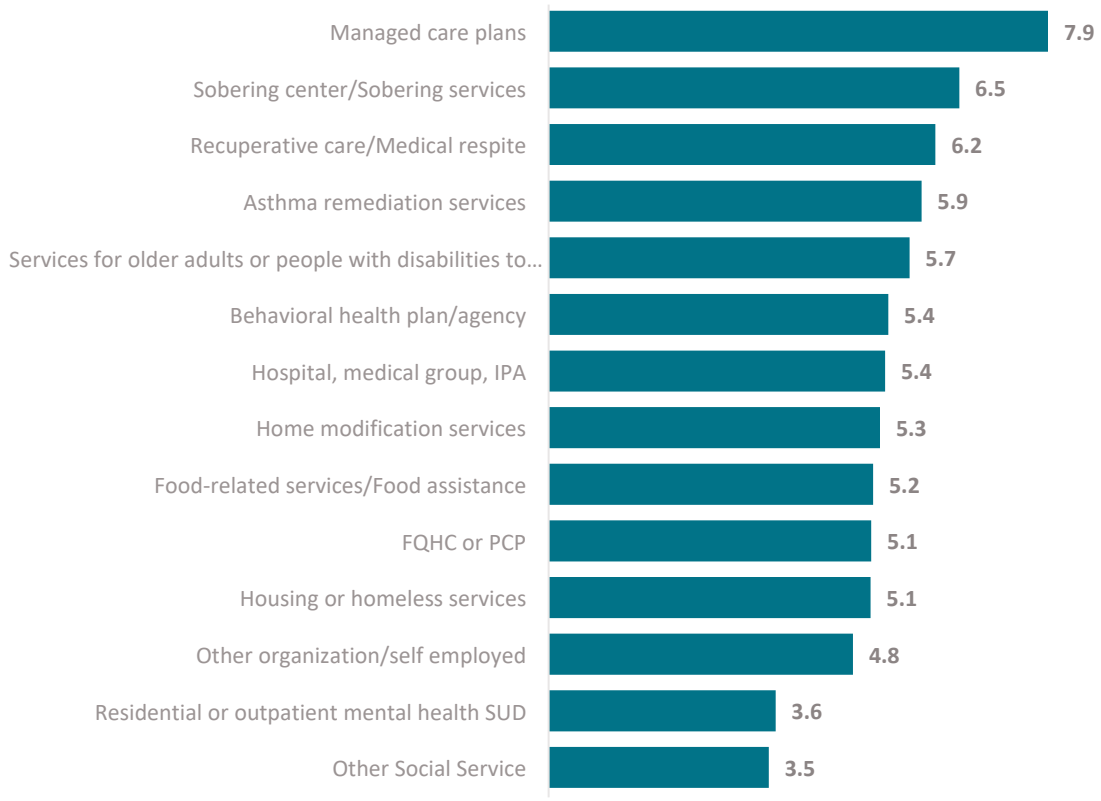
Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Breaking down the partnerships by each respondent's organization type shows that partnerships are not evenly distributed across sectors. On average, respondents from managed care plans report partnerships across 7.9 different sectors, whereas residential or outpatient mental health and substance use disorder providers report partnerships across 3.5 sectors. Figure 15. shows in how many different sectors each respondent type reports having at least one partnership. See Appendix B for a heatmap with additional detail.

Figure 15. Some Respondent Types Report More Cross-Sector Collaboration

Q: DO YOU CURRENTLY HAVE PARTNERSHIPS IN ANY OF THE FOLLOWING SECTORS — WHETHER OR NOT YOU DEVELOPED THEM THROUGH CALAIM? BY "PARTNERSHIPS" WE MEAN A FORMALIZED, THOUGH NOT NECESSARILY FINANCIAL, AGREEMENT (E.G., AN MOU, COLLABORATION AGREEMENT, OR CHARTER WOULD SUFFICE). PLEASE INDICATE THE SECTORS IN WHICH YOU HAVE AT LEAST ONE PARTNERSHIP.



Notes: See detailed topline document for full question wording and response options.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Partnership Perceptions

> *"[Community-based organizations] are at a large disadvantage in negotiating with plans. I know a lot about CalAIM, and several times the plans made statements about what they are able / not able to do that were not correct. If I hadn't known as much, I would not have been able to challenge them."*
>
> —Social service leader, Bay Area

When implementers rate their partnerships with other organizations, they tend to be more positive about superficial aspects of working together, and a little less positive about deeper dimensions of partnership, like trust and compromise. When thinking about their best partnership in another sector, implementers are more likely to say they "communicate about shared clients/patients, when needed" and "work together to identify unmet needs and decide how gaps will be filled" but less likely to say they "speak the same language (literally and figuratively)," "approach our partnership with a spirit of give and take," and "trust one another."

Health Care Organizations

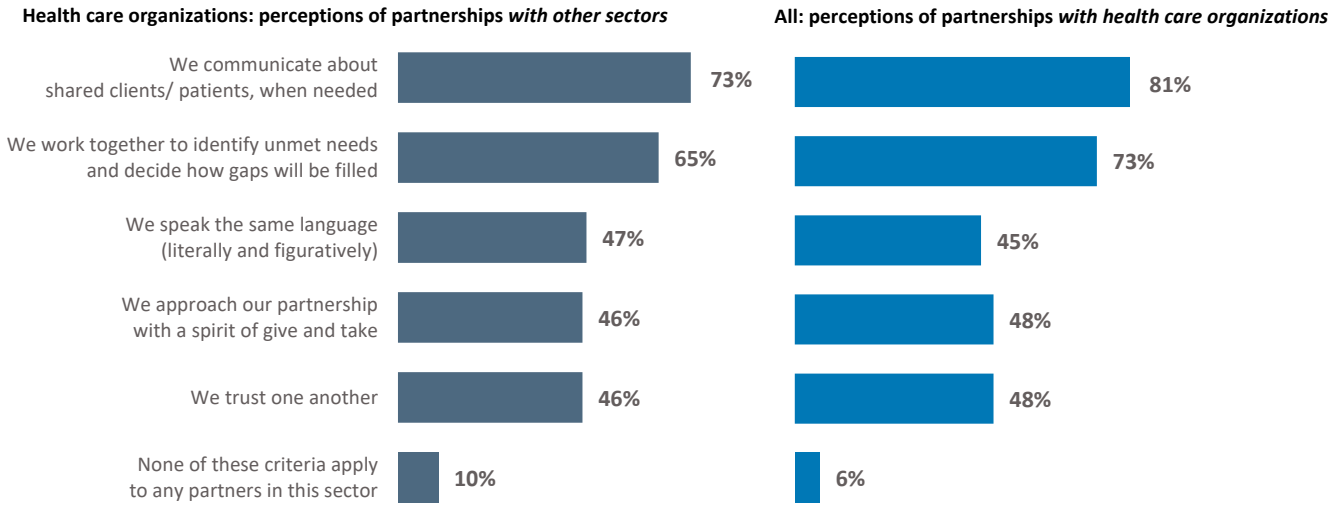
Implementers outside health care organizations[1] rate their partnerships with health care organizations more highly than health care organizations rate their own partnerships with other organizations when it comes to communication and working together to identify unmet needs. Overall, health care organizations are positive about their partnerships, and other organizations are positive about their partnerships with health care organizations — even though there is room to increase trust and partnership approach from both sides.

- When implementers are asked about their partnerships with health care organizations, 81% say they "communicate about shared clients/patients, when needed," compared to 73% of health care organizations who say the same about their own partnerships with other organizations.
- When implementers are asked about their partnerships with health care organizations, 73% say they "work together to identify unmet needs and decide how gaps will be filled," compared to 65% of health care organizations who say the same about their own partnerships with other organizations (Figure 16).

[1] This reference to health care organizations includes acute hospitals, primary care providers, skilled nursing and assisted living facilities, home health agencies, and correctional systems.

Figure 16. Partnership Perceptions: Health Care Organizations

Q: THINKING ABOUT YOUR BEST PARTNERSHIP WITH [SECTOR], WHICH OF THE FOLLOWING WOULD YOU SAY ACCURATELY DESCRIBES YOUR PARTNERSHIP?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

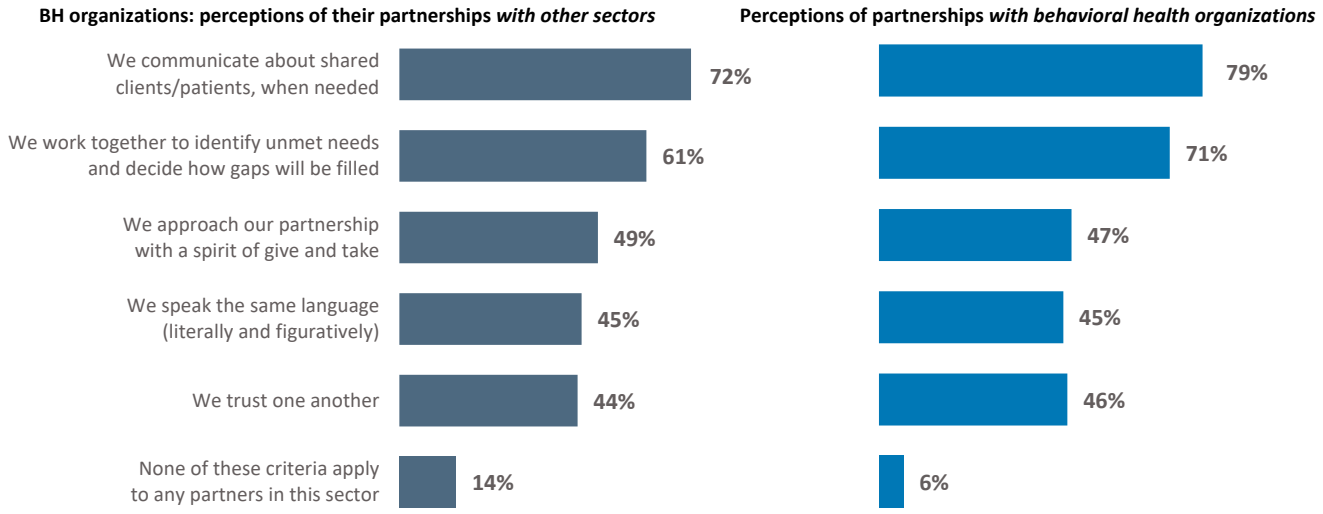
Behavioral Health Organizations

Behavioral health partnerships show a similar pattern to health care organization partnerships. Implementers rate their partnerships with behavioral health organizations more highly than behavioral health organizations rate their own partnerships with other organizations when it comes to communication and working together to identify unmet needs. Overall, behavioral health organizations are positive about their partnerships, and other organizations are positive about their partnerships with behavioral health organizations — even though there is room to increase trust and partnership approach from both sides.

- When implementers are asked about their partnerships with behavioral health organizations, 79% say they "communicate about shared clients/patients, when needed," compared to 72% of behavioral health organizations who say the same about their own partnerships with other organizations.
- When implementers are asked about their partnerships with behavioral health organizations, 71% say they "work together to identify unmet needs and decide how gaps will be filled," compared to 61% of behavioral health organizations who say the same about their own partnerships with other organizations (Figure 17).

Figure 17. Partnership Perceptions: Behavioral Health Organizations

Q: THINKING ABOUT YOUR BEST PARTNERSHIP WITH [SECTOR], WHICH OF THE FOLLOWING WOULD YOU SAY ACCURATELY DESCRIBES YOUR PARTNERSHIP?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Hospital discharge planners aren't shown because their base size is low (fewer have partnerships with BH organizations).

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

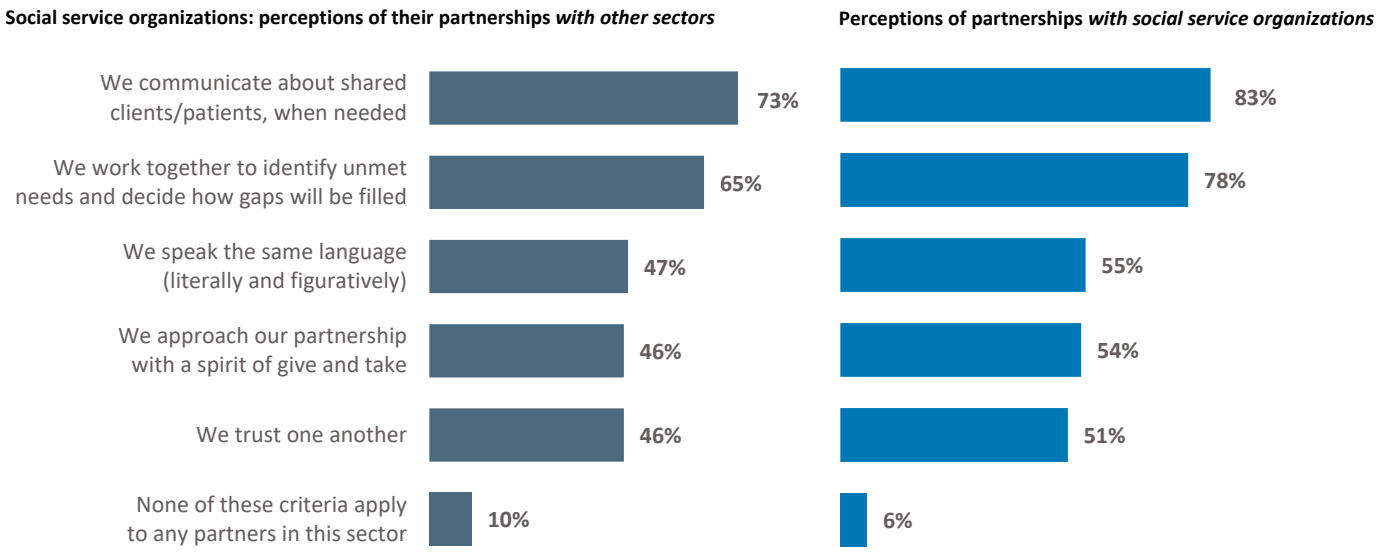
Social Service Organizations

Social service partnerships show a similar pattern to social service organization partnerships. Implementers rate their partnerships with social service organizations more highly than social service organizations rate their own partnerships with other organizations when it comes to communication and working together to identify unmet needs. Overall, social service organizations are positive about their partnerships, and other organizations are positive about their partnerships with social service organizations — even though there is room to increase trust and partnership approach from both sides.

- When implementers are asked about their partnerships with social service organizations, 83% say they "communicate about shared clients/patients, when needed," compared to 73% of social service organizations who say the same about their own partnerships with other organizations.
- When implementers are asked about their partnerships with social service organizations, 78% say they "work together to identify unmet needs and decide how gaps will be filled," compared to 65% of social service organizations who say the same about their own partnerships with other organizations (Figure 18).

Figure 18. Partnership Perceptions: Social Service Organizations

Q: THINKING ABOUT YOUR BEST PARTNERSHIP WITH [SECTOR], WHICH OF THE FOLLOWING WOULD YOU SAY ACCURATELY DESCRIBES YOUR PARTNERSHIP?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Managed Care Plans

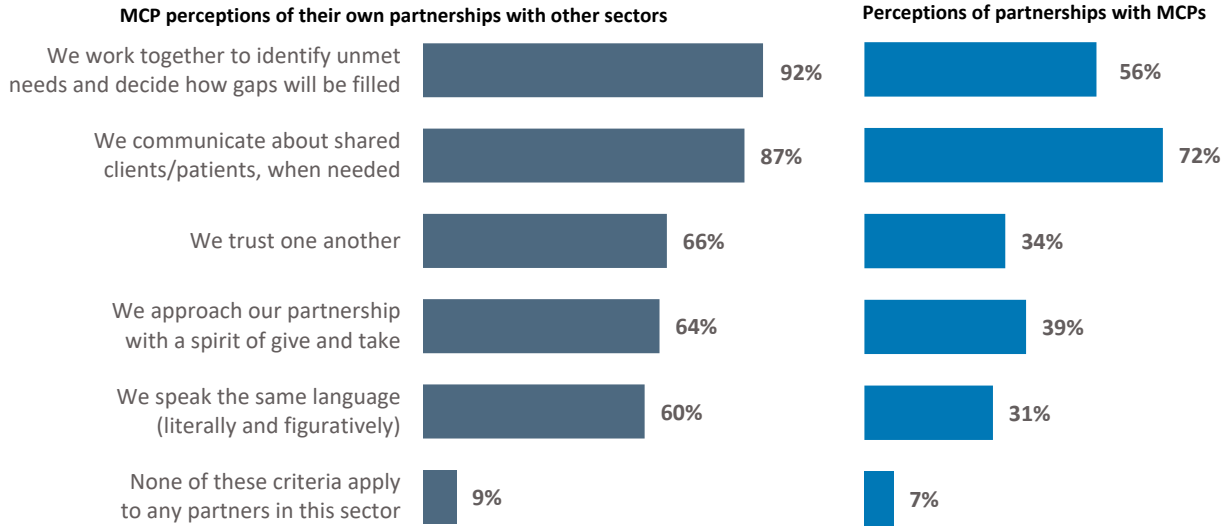
Managed care plan partnerships follow a different trend than the other sectors — MCPs rate their own partnerships more positively than other partners rate them on every aspect.

- When implementers are asked about their partnerships with MCPs, 56% say they "communicate about shared clients/patients, when needed," compared to 92% of MCPs who say the same about their own partnerships with other organizations.
- When implementers are asked about their partnerships with MCPs, 72% say they "work together to identify unmet needs and decide how gaps will be filled," compared to 87% of MCPs who say the same about their own partnerships with other organizations (Figure 19).

For this sector the lowest-ranking category from both sides is "we speak the same language (literally and figuratively)" — highlighting the need for more *effective* communication between MCPs and the organizations they contract with.

Figure 19. Partnership Perceptions: MCPs

Q: THINKING ABOUT YOUR BEST PARTNERSHIP WITH [SECTOR], WHICH OF THE FOLLOWING WOULD YOU SAY ACCURATELY DESCRIBES YOUR PARTNERSHIP?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Social Service Organizations: Experience Working with Health Care Partners

> *"One significant challenge we faced was understanding how health administrative processes work. Since receiving referrals and filing claims are new to us, it was difficult to understand how we as a CBO [community-based organization] implement those processes as a part of our programming."*
>
> —Social service leader, Bay Area

For social service organizations, some foundational aspects of CalAIM are novel and may be contributing to a steeper learning and resource curve than for organizations already working in the health care space. Many social service organizations have limited prior experience in areas central to CalAIM's implementation.

These organizations frequently have experience contracting with other social service providers, with 60% indicating they have "a fair amount" or "a lot" of experience in this regard. However, only about a third have "a fair amount" or "a lot" of experience contracting with health care organizations (33%) or MCPs (34%) — and over a third report having no prior experience in these areas (35% and 36%, respectively). This discrepancy in experience underscores the

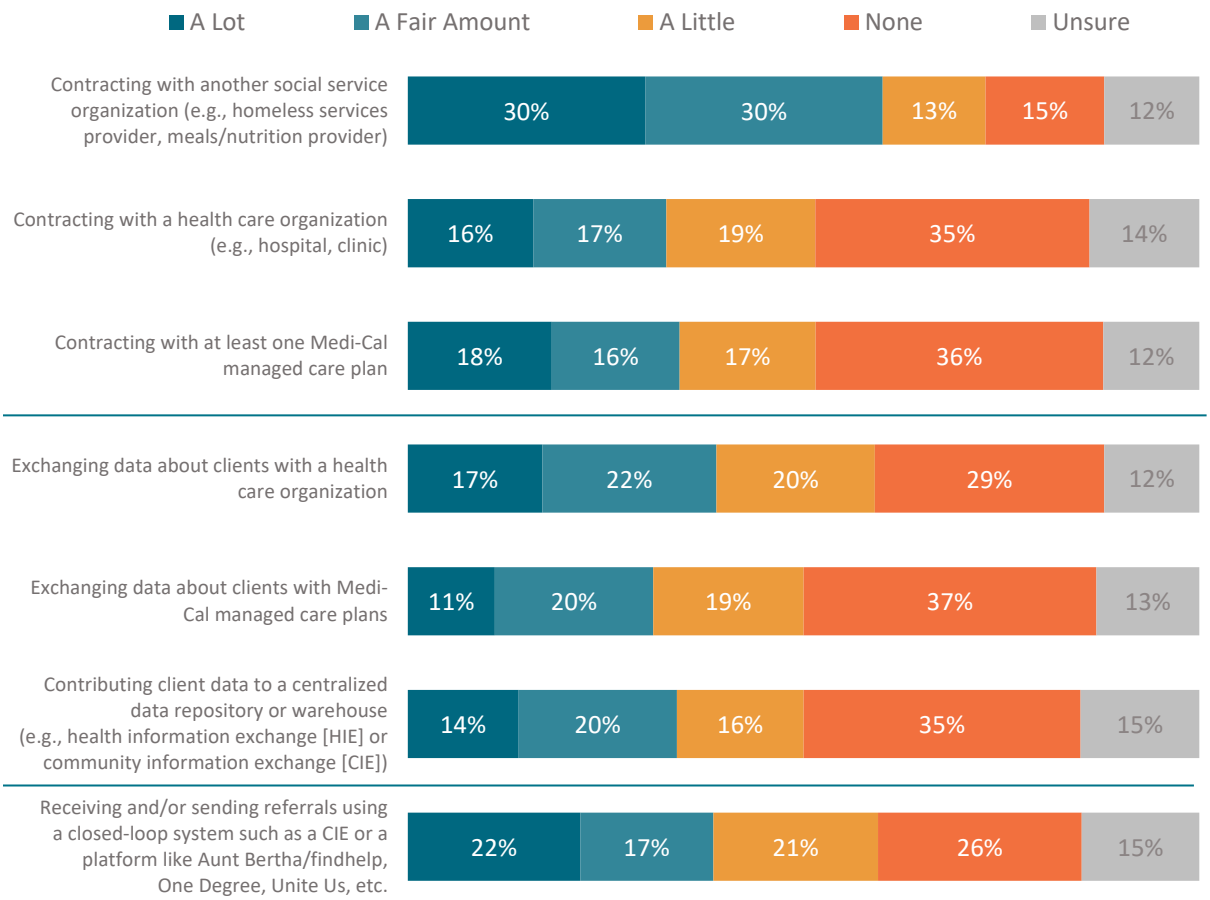
challenges associated with implementing a program that necessitates collaboration between entities with distinct backgrounds and practices.

When it comes to data exchange with health care organizations or MCPs, or contributing data to a centralized repository, social service organizations report fairly uniform yet relatively low levels of experience, with around one-third having "a fair amount" or more experience, and about another third having no prior experience.

When it comes to referrals, less than half (39%) report having "a fair amount" or "a lot" of experience with referrals using a closed-loop system, emphasizing the need for training and support in these aspects of the program (Figure 20).

Figure 20. Foundational Aspects of CalAIM Are Novel for Social Service Organizations

*Q: PRIOR TO CALAIM'S LAUNCH (JANUARY 2022), HOW MUCH EXPERIENCE DID YOUR ORGANIZATION HAVE WITH THE FOLLOWING:**



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. *Asked of social service organizations only

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Section 3. Data Exchange

Accuracy, Amount, and Timeliness of Information Received

> *"When it comes to those hiccups and knowing if that member is obtaining services elsewhere, we are not getting that in a timely manner. That means that we start providing those services without knowing that they're already getting those services. By the time we've already done it for a few months, we come to find out that client was already getting those services or has an authorization. We then have to go back with billing and ask, 'Are you going to provide the money for this because we were not made aware. . . .' It affects the clients, it affects our billing, it affects what my workflow is for my housing navigator. So they're not sure — do we provide the service, do we not? Do we wait for the authorization? My housing navigation team is kind of just up in the air right now."*
>
> —Katelyn Taubman, CHCF CalAIM Advisory Group member and manager of case management, Illumination Foundation

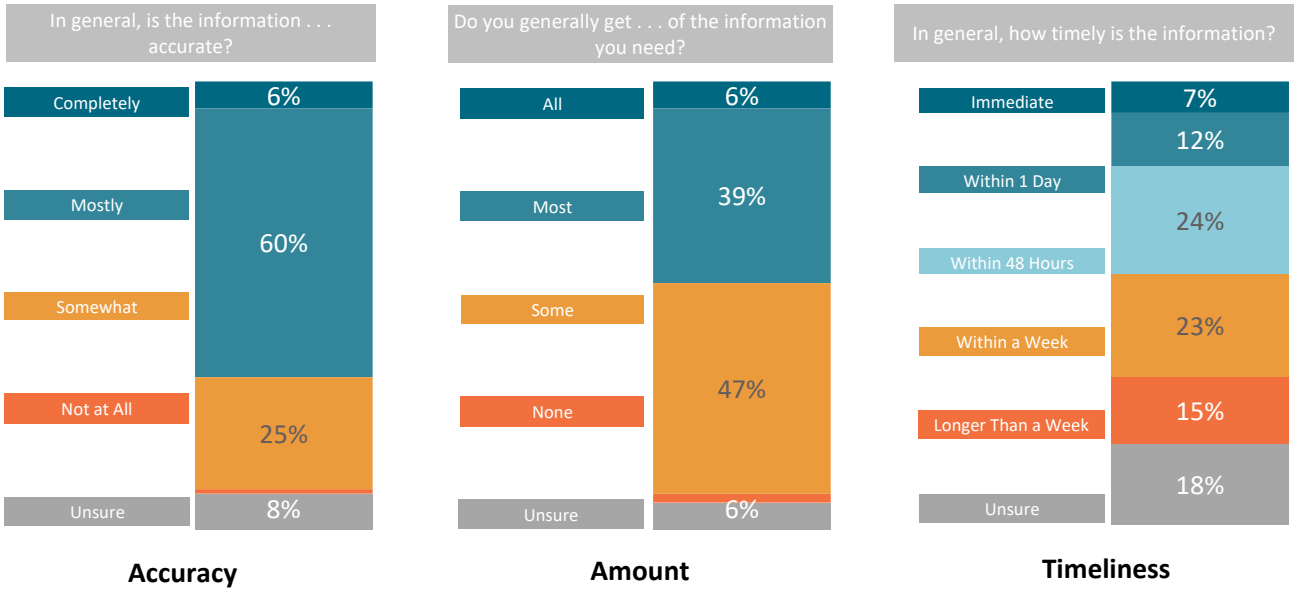
Data exchange is currently far from the goal of complete, accurate, and real-time information to implementers. Although two-thirds of implementers (66%) say the information they get about the people they serve is "mostly" or "completely" accurate, a quarter (25%) say the information they get is only somewhat accurate.

Less than half (45%) say they get at least most of the information they need, with only 6% saying they get all of the information they need.

Less than half (43%) say they get information about the people they serve within 48 hours, with 19% saying they get information within one day, and only 7% saying they get immediate information (Figure 21).

Figure 21. Information About Patients/Clients/Members Could Be More Complete and Timelier

Q: STILL THINKING ABOUT THE INFORMATION ABOUT OTHER CARE THAT THE PEOPLE YOU SERVE ARE GETTING . . .



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Data Exchange Methods

> *"Our team has spent a lot of time trying to understand where is this data exchange piece going? What are we actually going to be mandated to do? And how does that intersect with the ways that we're already sharing this kind of information? And we're spending a lot of time on it, and it still doesn't feel like there's clarity about it. This is a really important thing in terms of how do we support nontraditional health care partners in effectively engaging in traditional health care data exchange systems."*
>
> —Cathryn Couch, CHCF CalAIM Advisory Group member and CEO, Ceres Community Project

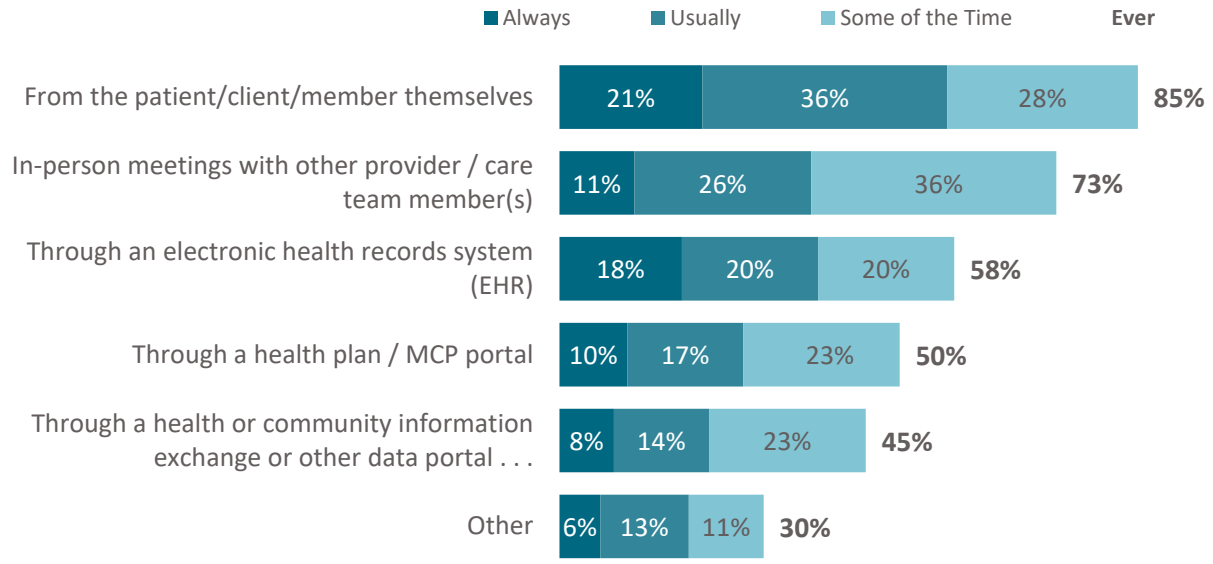
In the context of CalAIM, implementers are getting information about the people they serve primarily from personal contact (either with the patient, member, or client themselves, or from in-person meetings with other providers). A majority (57%) report that they "always" or "usually" get information directly from patients, clients, or members. "In-person meetings with other care team members" is identified as the second most common method for obtaining information (37% "always" or "usually").

Implementers are less likely to say they get information through IT solutions like electronic health record systems (EHRs), health plan / MCP portals, or health or community information exchanges (HIE/CIE).

Also, 19% of implementers report "always" or "usually" getting information from "other" sources, and open-ended responses reveal that this largely involves informal communication channels with other providers, such as virtual meetings, phone calls, emails, and fax (Figure 22).

Figure 22. Information Largely Coming from Personal Contact over IT Solutions

Q: SWITCHING TOPICS SOMEWHAT, HOW DO YOU CURRENTLY GET INFORMATION ABOUT THE OTHER CARE THAT THE PEOPLE YOU SERVE ARE GETTING IN THE CONTEXT OF CALAIM (E.G., ECM, COMMUNITY SUPPORTS)? PLEASE CHOOSE AN ANSWER FOR EACH ROW.



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Implementers who report using IT solutions for data exchange also report getting more data and getting them faster — suggesting that leveraging IT solutions like HIE/CIE information exchange and MCP portals, as well as EHRs, can improve data exchange between providers. Seven in 10 implementers who use HIE/CIE portals (71%) or MCP portals (70%) say they get all or most of the information they need, compared with only 53% of implementers who get information directly from the patient, client, or member. Just under two-thirds of implementers who use EHRs (64%) or MCP portals (65%) and even more implementers who use HIE/CIE portals (72%) say they get information within 48 hours, compared with 47% of implementers who get information directly from the patient, client, or member (Figure 23).

Figure 23. Implementers That Report Using IT Solutions Also Report Getting More Accurate and More Timely Data

Q: STILL THINKING ABOUT THE INFORMATION ABOUT OTHER CARE THAT THE PEOPLE YOU SERVE ARE GETTING . . .

Respondents Who Get Information Through Each Source	*EHR* (*n* = 460)	*CIE/Portal* (*n* = 267)	*MCP Portal* (*n* = 321)	*Care Team in Person* (*n* = 452)	*Patient* (*n* = 686)
Get all or most of the information needed	66%	71%	70%	64%	53%
Information is completely or mostly accurate	80%	81%	82%	81%	73%
Get information within 48 hours or faster	64%	72%	65%	57%	47%

Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

MCPs and hospital discharge planners are much more likely to be using IT solutions for data exchange in the context of CalAIM, and social service organizations are much less likely to be using them (Figure 24). These findings underline the uneven landscape of IT utilization and adoption.

Figure 24. Use of IT Solutions for Data Exchange Varies by Sector

Q: SWITCHING TOPICS SOMEWHAT, HOW DO YOU CURRENTLY GET INFORMATION ABOUT THE OTHER CARE THAT THE PEOPLE YOU SERVE ARE GETTING IN THE CONTEXT OF CALAIM (E.G., ECM, COMMUNITY SUPPORTS)? PLEASE CHOOSE AN ANSWER FOR EACH ROW.

Showing the % Responding "Always" or "Usually"	Overall	MCP (*n* = 53)	FQHC (*n* = 140)	*BH* (*n* = 292)	Social Service (*n* = 412)	Hospital Discharge Planners (*n* = 67)
From the patient/client/member themselves	57%	57%	53%	67%	59%	63%
In-person meetings with other provider / care team member(s)	38%	64%	33%	44%	33%	46%
Through an electronic health records system (EHR)	38%	62%	51%	36%	24%	63%
Through a health plan / MCP portal	27%	66%	28%	18%	25%	33%
Through a health or community information exchange (HIE/CIE) or other data portal . . .	22%	58%	20%	16%	20%	37%

Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Also, those serving higher percentages of patients covered by Medi-Cal report less frequent usage of information technology (IT) solutions for data exchange (Figure 25). This trend suggests that health care providers with a significant Medi-Cal patient population may face unique challenges or a resource gap in adopting IT solutions for data exchange.

Figure 25. Those with More Medi-Cal Patients Using IT Data Solutions for Data Exchange Less Frequently

Q: SWITCHING TOPICS SOMEWHAT, HOW DO YOU CURRENTLY GET INFORMATION ABOUT THE OTHER CARE THAT THE PEOPLE YOU SERVE ARE GETTING IN THE CONTEXT OF CALAIM (E.G., ECM, COMMUNITY SUPPORTS)? PLEASE CHOOSE AN ANSWER FOR EACH ROW.

		% of Medi-Cal Patients		
Showing the % Responding "Always" or "Usually" with Each Statement	**Overall**	***0%–50%* (*n* = 271)**	***51%–75%* (*n* = 304)**	***75%+* (*n* = 595)**
From the patient/client/member themselves	*57%*	*55%*	*57%*	*59%*
In-person meetings with other provider / care team member(s)	*38%*	*35%*	*40%*	*39%*
Through an electronic health records system (EHR)	*38%*	*45%*	*45%*	*33%*
Through a health plan / MCP portal	*27%*	*33%*	*30%*	*23%*
Through a health or community information exchange (HIE/CIE) or other data portal . . .	*22%*	*29%*	*29%*	*17%*

Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

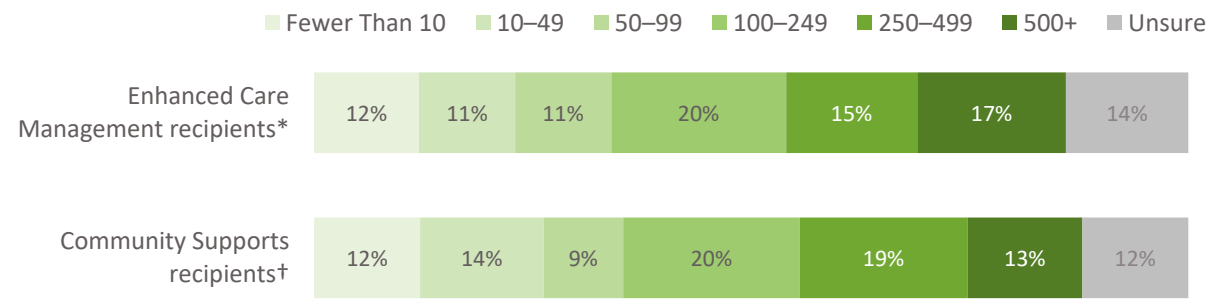
Section 4. Deep Dive on ECM and Community Supports

> *"We do not get enough referrals for Community Supports and/or many interested clients are not eligible. Regarding ECM: A large percentage of the referrals that we receive do not turn into ECM clients. . . . So we do not get enough referrals to fill caseloads, but we also have a huge burden of outreach to eligible members. . . . But this time does not translate into billable client services."*
>
> —Frontline social service, San Diego/Orange

A majority of implementers (54%) have served fewer than 250 clients under ECM, and about the same proportion have served fewer than 250 clients under Community Supports (Figure 26).

Figure 26. More Implementers Report Serving <250 Clients Than Serving 250+ Since ECM and CS Launched

Q: HOW MANY PATIENTS, CLIENTS, OR MEMBERS HAS YOUR ORGANIZATION SERVED SINCE JANUARY 2022 UNDER ECM AND/OR COMMUNITY SUPPORTS? PLEASE MAKE YOUR BEST ESTIMATE.



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. *ECM providers only (*n* = 286), †CS providers only (*n* = 315).

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Subgroup Findings

- Larger organizations — with 50 or more FTEs — are serving a greater number of people through ECM and Community Supports than their smaller counterparts.

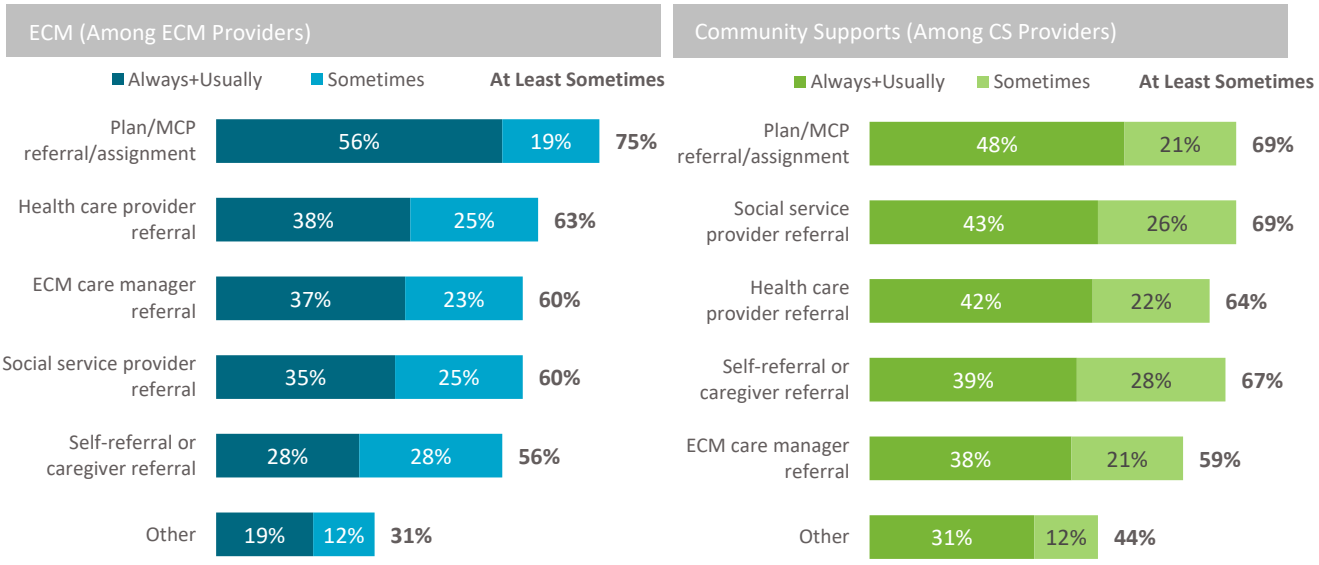
Referral Sources

> *"We know that our network is effective if our providers are local and embedded in our communities as trusted partners. With the recent DHCS guidance that a majority of referrals for ECM and CS services should come from the community and not just data mining through the health plans, it's critical that the network is comprised of those local CBOs or providers, some of whom may not have the initial capability or infrastructure to enter into a contract with the health plan. Building the right network that is culturally responsive and trusted in the community plays into how well we do on engaging our diverse populations."*
>
> —Nancy Wongvipat, CHCF CalAIM Advisory Group member and senior director of systems of care, Health Net

Referrals are coming from a range of sources — though MCPs are referring the plurality for both ECM and Community Supports. Referrals come from MCPs more often for ECM (56% saying those they serve get referred through MCPs "always" or "usually") than for Community Supports (48% saying those they serve get referred through MCPs "always" or "usually"). Implementers report Community Supports referrals being more distributed from different sources (Figure 27).

Figure 27. Referrals Come from Range of Sources, Although MCPs Referring Plurality for Both ECM and CS

Q: HOW ARE THOSE YOU SERVE TYPICALLY GETTING REFERRED TO YOUR ORGANIZATION FOR [ECM/COMMUNITY SUPPORTS]?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Ranked by Always + Usually.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Decline Rates

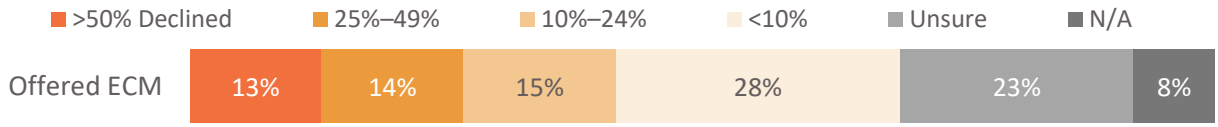
> *"What we have been finding out in the community is that community members don't know about the services in depth. . . . So if you call and ask if you want a case manager, they say, 'What is a case manager? What I'm getting into it, what is this? What is my commitment?' I think especially the Latino community, there's a factor of denying services that they have access to because they have experienced abuse, they have been taken advantage of, and they have not received sincere services, and in many cases they believe you are going to be selling something."*
>
> —Alex Fajardo, CHCF CalAIM Advisory Group member and director, El Sol Neighborhood Educational Center

The decline rates for ECM services are relatively high — and the most common reason implementers report is that those they serve are just not interested in the benefit. More than 1 in 4 (27%) say that 25% or more of the people they serve who are offered ECM decline it. More than 1 in 10 (13%) say that at least half of the people they serve who are offered ECM decline it.

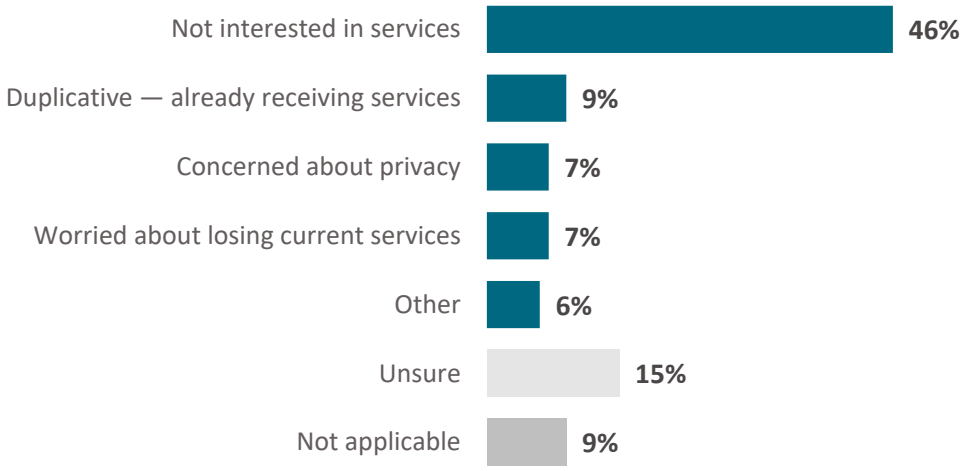
The most frequently cited reason for people declining ECM services is the lack of interest from the people they serve in the offered services, with 46% of implementers indicating this as the primary cause. Other reasons for decline have much lower rates, with "duplicative" being the second top reason at 9% (Figure 28).

Figure 28. Decline Rates for ECM Are High, with "Not Interested" Most Common Reason

Q: APPROXIMATELY WHAT PERCENTAGE OF THE PEOPLE YOU SERVE WHO ARE OFFERED ECM DECLINE SERVICES?



Q: WHAT IS THE MOST COMMON REASON WHY PEOPLE DECLINE SERVICES?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. *ECM providers only (*n* = 286)

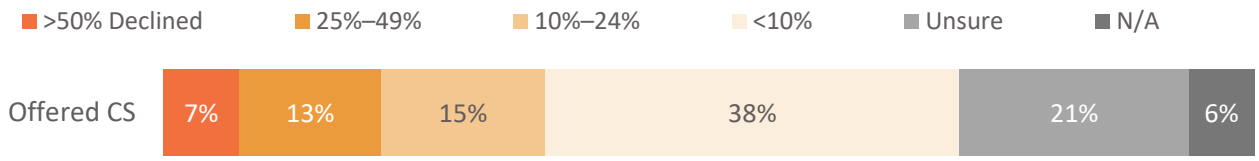
Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Decline rates for Community Supports are lower than for ECM — but with implementers reporting similar reasons for declines. One in 5 (20%) say that 25% or more of the people they serve who are offered Community Supports decline it. Under 1 in 10 (7%) say that at least half of the people they serve who are offered Community Supports decline it.

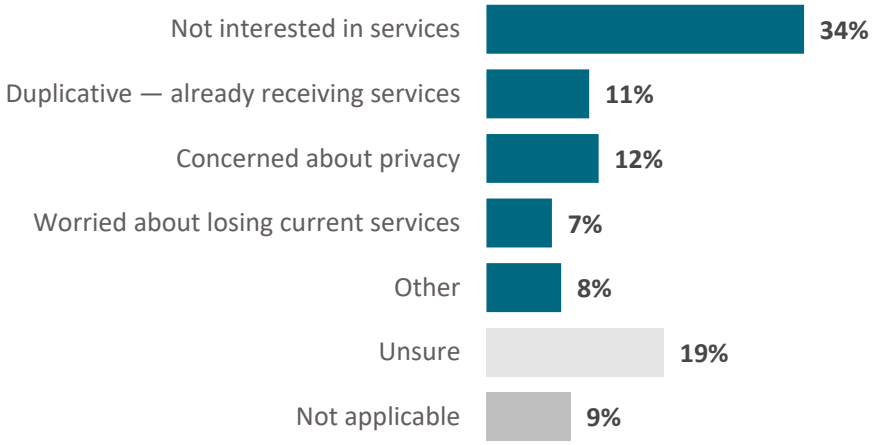
The most common reason reported for people declining Community Supports is their lack of interest in the offered services, accounting for 34% of the responses (Figure 29).

Figure 29. Decline Rates for CS Are Lower, with Similar Reasons for Declines as ECM

Q: APPROXIMATELY WHAT PERCENTAGE OF THE PEOPLE YOU SERVE WHO ARE OFFERED COMMUNITY SUPPORTS DECLINE SERVICES?



Q: WHAT IS THE MOST COMMON REASON WHY PEOPLE DECLINE SERVICES?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. *CS providers only (*n* = 315)

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Implementers Not Currently Providing Enhanced Care Management or Community Supports

> *"I confess that despite my attendance at a few PATH meetings, I find CalAIM very confusing and I truthfully do not even really know how to move forward."*
>
> —Social service leader, Bay Area

The primary reason cited by implementers for not providing ECM or Community Supports or both is their uncertainty about how to participate, with 36% identifying this as a "major" or "one of the most important" reasons. Also, a quarter of respondents (25%) report that they are currently in the process of deciding whether they will participate in these services, and 19% say they are in the process of signing up. Some implementers (22%) say lack of capacity is a "major" or "one of the most important" reasons they don't provide ECM or Community Supports. Very few respondents (6%) attribute their decision not to provide ECM or Community Supports to

the belief that these services are not helpful, giving an indication of the recognition of the value of these programs, even among those not currently participating (Figure 30).

Figure 30. Lack of Info Top Reason ECM or Community Supports Not Provided

Q: BELOW ARE SOME REASONS WHY AN ORGANIZATION MIGHT NOT BE PROVIDING ECM OR COMMUNITY SUPPORTS. FOR EACH REASON, PLEASE INDICATE HOW BIG A REASON IT IS IN YOUR ORGANIZATION FOR NOT PROVIDING ECM OR COMMUNITY SUPPORTS.

Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Ranked by Total Reason. Asked of FQHC leaders, behavioral health leaders, or social service leaders not providing ECM or Community Supports (*n* = 162).

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Subgroup Findings

- Lack of information (uncertainty of how to participate) is a particularly big reason for social service organizations, with 42% identifying this as a "major" or "one of the most important" reasons they don't provide ECM or Community Supports.
- Behavioral health organizations are more likely to be already in the process of deciding to participate (30%). These data suggest that within the behavioral health sector, there is an increased readiness to explore participation in ECM and Community Supports, possibly driven by a better understanding of the processes involved.

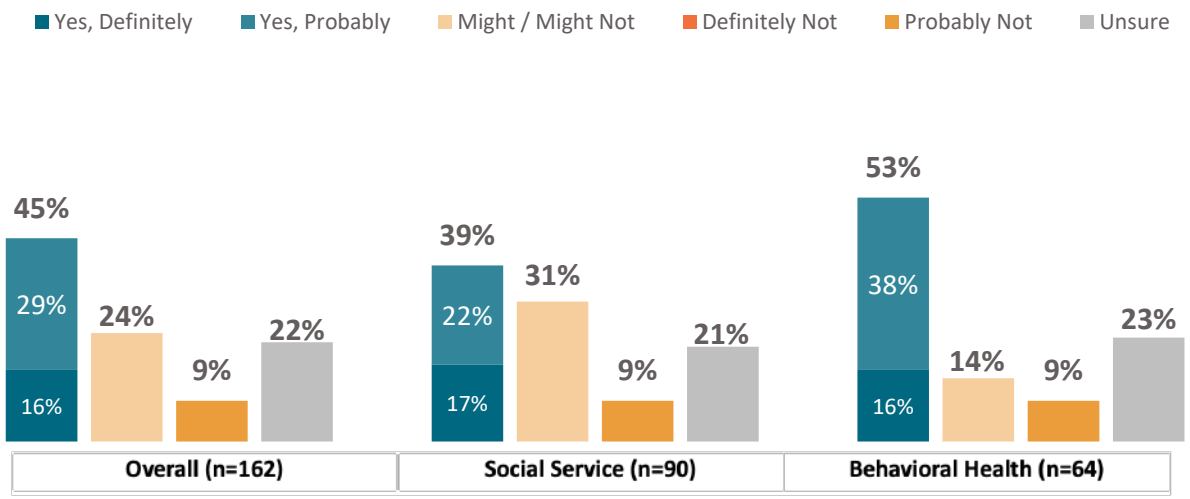
Despite encountering barriers, nearly half of implementers (45%) not currently providing ECM or Community Supports report that they will definitely or probably provide ECM or Community Supports in the next one to three years. Notably, none of the respondents outright rejected the idea, as no respondent answered that they would "definitely not."

Subgroup Findings

- Behavioral health organizations are more likely to say they will provide ECM or Community Supports in the next one to three years (53%).
- Social service organizations are more likely to say they might or might not provide ECM or Community Supports in the next one to three years (31%) (Figure 31).

Figure 31. Despite Barriers, Almost Half of Implementers Intend to Start Providing ECM/CS

Q: DO YOU THINK YOUR ORGANIZATION MIGHT PROVIDE ECM OR COMMUNITY SUPPORTS WITHIN THE NEXT ONE TO THREE YEARS?



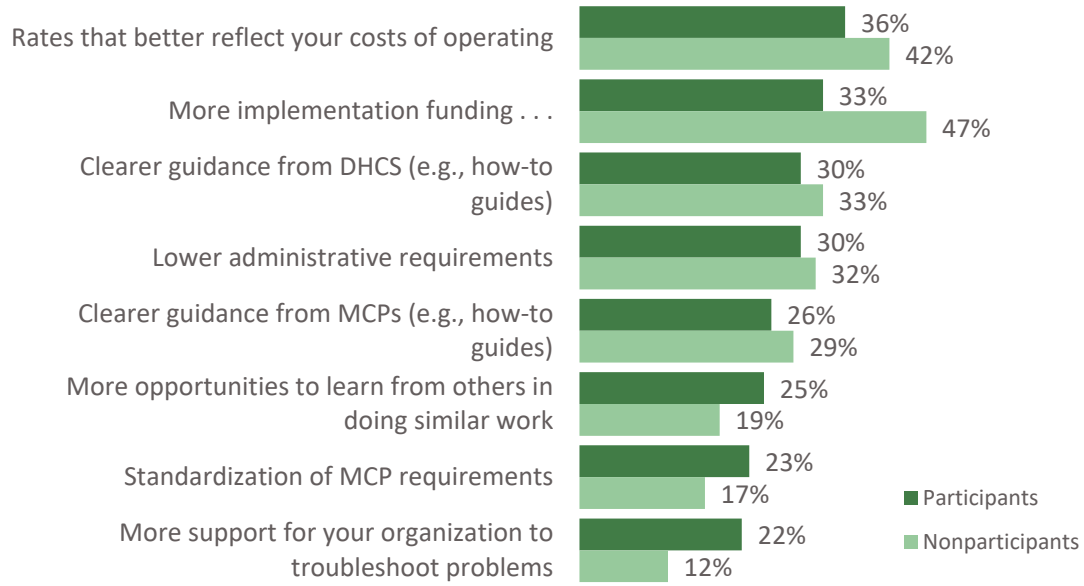
Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Asked of FQHC, BH, and social service leaders not currently providing ECM or CS (*n* = 162).

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Levers to increase participation for those not currently participating are similar to the levers for those already participating in ECM or Community Supports. Of note, the top two items rated as most helpful by both current participants and nonparticipants are "rates that better reflect operating costs" and "more implementation funding." "Clearer guidance" from both DHCS and MCPs, along with "lower administrative requirements," follow financial incentives for both current participants and nonparticipants (Figure 32). These findings emphasize the shared priorities in addressing challenges and enhancing participation in ECM and CS, regardless of an organization's current participation status in these services.

Figure 32. Most Helpful Levers Similar for Nonparticipating and Participating

Q: WHICH OF THE FOLLOWING DO YOU THINK WOULD INCREASE YOUR ORGANIZATION'S LIKELIHOOD OF PROVIDING ECM OR COMMUNITY SUPPORTS? / WHICH OF THE FOLLOWING DO YOU THINK WOULD BE THE MOST HELPFUL FOR YOUR ORGANIZATION IN IMPLEMENTING CALAIM? PLEASE SELECT THE TOP THREE.



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Asked of FQHC, BH, and social service leaders not currently providing ECM or CS (*n* = 162).

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Section 5. Deep Dive on Other CalAIM Programs

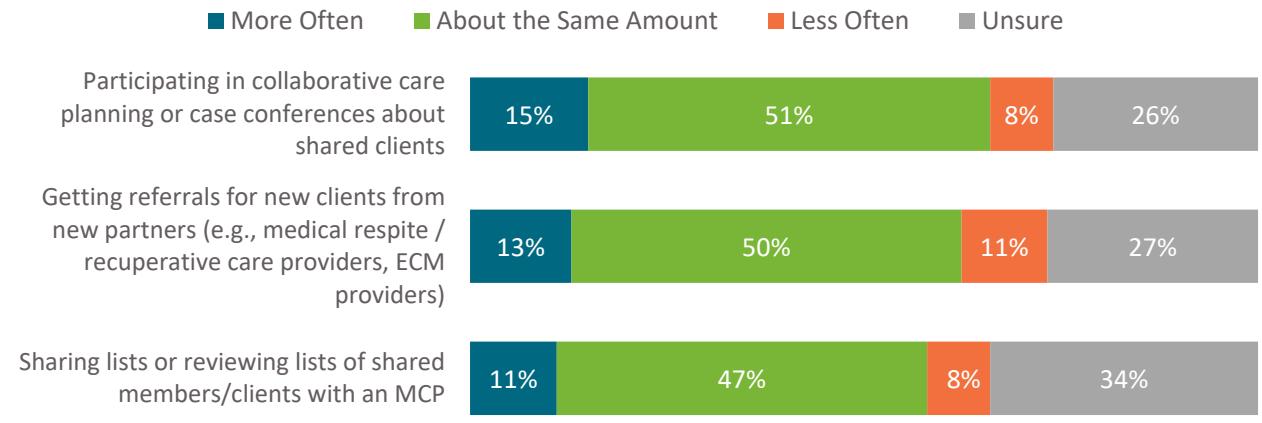
Perspectives on Behavioral Health

> *"There is still a lot of confusion with the screening tool 'No Wrong Door,' etc. I thought CalAIM was supposed to reduce the amount of administrative oversight, but in most cases I am seeing more."*
>
> —Behavioral health leader, Rural North

Most behavioral health leaders have not seen improvements in volume or workflows since the implementation of ECM and CalAIM. About half report no change in "participating in collaborative care planning or case conferences about shared clients" (51%), "getting referrals for new clients from new partners (e.g., medical respite / recuperative care providers, ECM providers)" (50%), or "sharing lists or reviewing lists of shared members/clients with an MCP" (47%). The next highest response for all three items is "unsure," at 26%, 27%, and 34%, respectively. Very few say any of the three are happening more often, or happening less often (Figure 33).

Figure 33. Most BH Leaders Do Not Report Volume or Workflows Changing Much Due to ECM

Q: BELOW ARE VARIOUS PROCESSES TO IDENTIFY CLIENTS WITH SERIOUS MENTAL ILLNESS OR A SUBSTANCE USE DISORDER WHO ARE ELIGIBLE FOR ENHANCED CARE MANAGEMENT. FOR EACH, PLEASE INDICATE WHETHER YOU ARE DOING THAT PROCESS MORE OR LESS OFTEN SINCE THE LAUNCH OF CALAIM.



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Ranked by More Often. Asked of BH leaders only (*n* = 119).

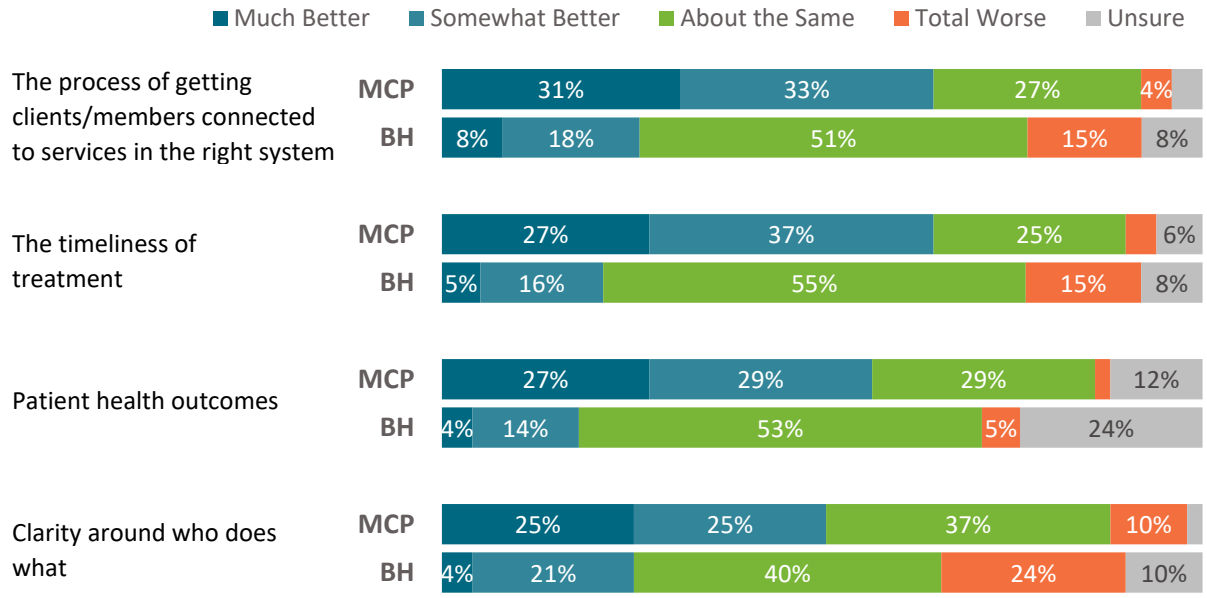
Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

When it comes to the perspectives on the impact of "No Wrong Door" policies so far, MCPs report significantly more improvement compared to behavioral health organizations, who largely think things have not yet changed. Over half of MCPs have seen improvement in the process of getting members connected to services in the right system (64%), the timeliness of treatment (64%), and patient health outcomes (56%). On the other hand, over half of BH leaders express that they perceive little to no change in the process of getting clients/members connected to services in the right system (51%), timeliness of treatment (55%), and patient outcomes (53%) as a result of "No Wrong Door" policies.

Notably, around a quarter of behavioral health leaders find that clarity around who does what has gotten worse with the implementation of "No Wrong Door" policies (24%) (Figure 34).

Figure 34. MCPs See More Improvement Than BH, Who Largely Think Things Have Not Yet Changed

Q: PLEASE INDICATE IF EACH OF THE FOLLOWING HAS GOTTEN BETTER OR WORSE OR IF IT HAS STAYED ABOUT THE SAME AS A RESULT OF THE "NO WRONG DOOR" POLICIES . . .



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Ranked by Much Better, MCP; MCP=managed care plan leaders (*n* = 51), BH=behavioral health leaders (*n = 119)*

Source: CHCF/GSSR Survey of CalAIM implementers (July 21, 2023, to September 12, 2023).

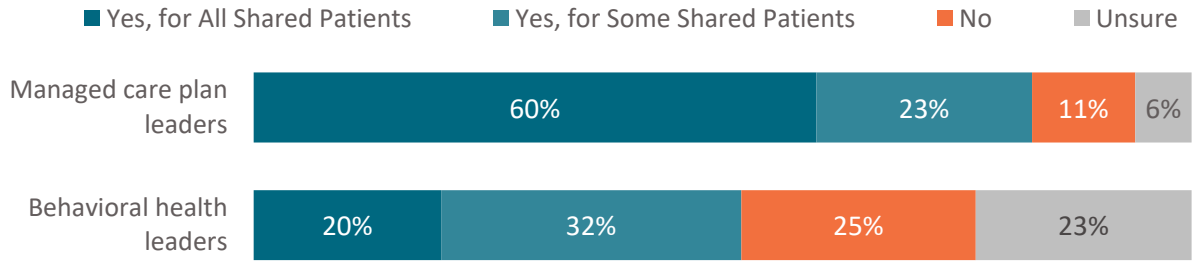
When it comes to having a point of contact to assist in challenging transfers or cases, MCPs and behavioral health organizations show a similar divergence in reporting. The majority of MCPs indicate that they have a designated point of contact for all shared patients (60%) while only 20% of behavioral health organizations say they have a point of contact for all shared patients.

A quarter of behavioral health organizations (25%) report that they do not have a point of contact for any shared patients (Figure 35).

This suggests there is work to be done to improve collaborative workflows between MCPs and county mental health plans (MHPs) in the context of CalAIM's "No Wrong Door" policy.

Figure 35. Behavioral Health Much Less Likely Than MCP to Have Point of Contact for Challenging Cases

Q: DO YOU HAVE A POINT OF CONTACT IN THE OTHER MH SYSTEM (MCP OR MHP) THAT CAN ASSIST YOU WITH CHALLENGING TRANSFERS OR CASES?



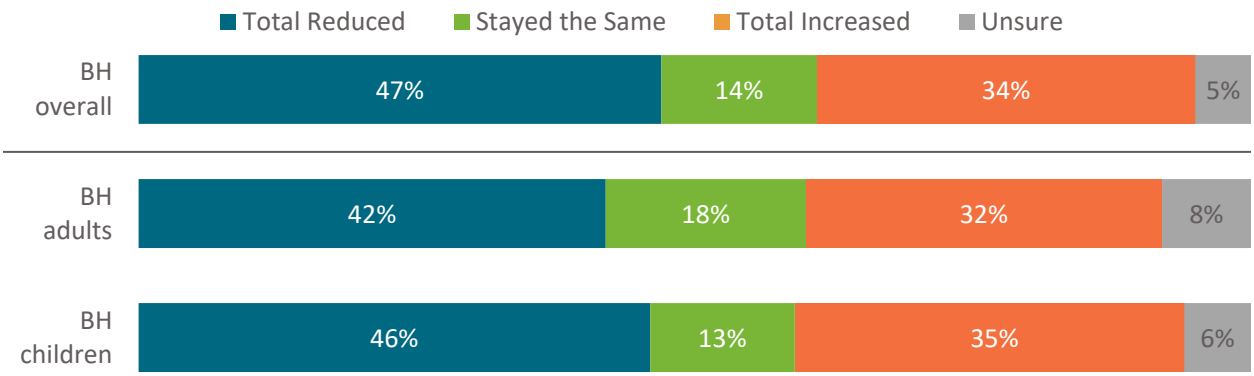
Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Managed care plan leaders (*n* = 51), behavioral health leaders (*n* = 119).

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Behavioral health leaders hold mixed views regarding the documentation burden associated with reforms introduced through CalAIM. Although a plurality (47%) report that documentation burden has decreased, over a third (34%) report that the burden has increased. A smaller percentage (14%) reports that the documentation requirements have remained consistent, and 5% are unsure (Figure 36).

Figure 36. Although a Plurality Report Reduction, a Third Report Documentation Burden Has Increased

Q: TO WHAT DEGREE HAS DOCUMENTATION BURDEN IN SPECIALTY MENTAL HEALTH SERVICES (SMHS) AND/OR DRUG MEDI-CAL (DMC, DMC-ODS) CHANGED SINCE THE START OF CALAIM?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Asked only of BH leaders (*n* = 119).

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

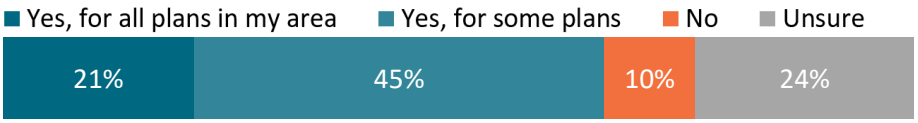
Population Health Management Initiative: Discharge Planners' Perspectives

> *"The challenge for direct providers like us is getting the current information regarding the plans: ECM, CS, other services, and how to access them."*
>
> —Hospital discharge planner, Central Valley

Most hospital discharge planners lack a point of contact at each MCP they work with to assist with challenging transfers or cases. Only 21% have a point of contact for all plans they work with, while almost half (45%) have a point of contact for some, but not all, MCPs. One in 10 say they don't have a point of contact for any of the MCPs they work with, and 24% are not sure (Figure 37).

Figure 37. Most Discharge Planners Do Not Have a Point of Contact for All Plans in Their Area

Q: DO YOU HAVE A POINT OF CONTACT AT EACH MEDI-CAL MANAGED CARE PLAN THAT YOU WORK WITH THAT CAN ASSIST YOU WITH CHALLENGING TRANSFERS OR CASES?



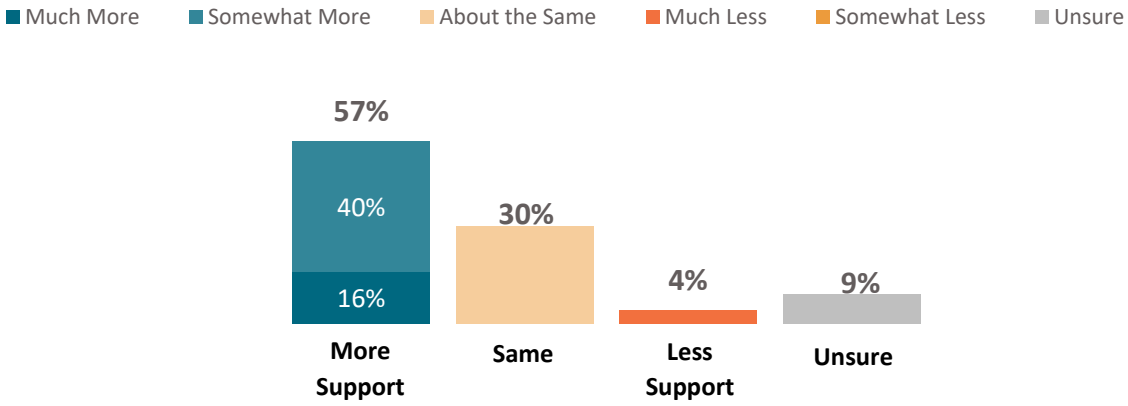
Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Shown for hospital discharge planners (*n* = 67).

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Encouragingly, hospital discharge planners report that CalAIM has increased support for high-risk Medi-Cal patients postdischarge. A majority of hospital discharge planners (57%) report that high-risk Medi-Cal patients are receiving more support accessing needed services postdischarge since the start of CalAIM, with 30% saying they're receiving about the same amount of support, and only 4% saying they're receiving less support than before CalAIM. This finding suggests that CalAIM has been effective in enhancing the care and support provided to Medi-Cal patients during their transition from hospital settings to postdischarge environments (Figure 38).

Figure 38. More Than Half Say Medi-Cal Patients Receive More Support After Hospital Discharge Than Before CalAIM

Q: WOULD YOU SAY THAT HIGH-RISK MEDI-CAL PATIENTS ARE RECEIVING MORE SUPPORT ACCESSING NEEDED SERVICES POSTDISCHARGE SINCE JANUARY 2023 — OR ABOUT THE SAME AS BEFORE?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Shown for hospital discharge planners (*n* = 67).

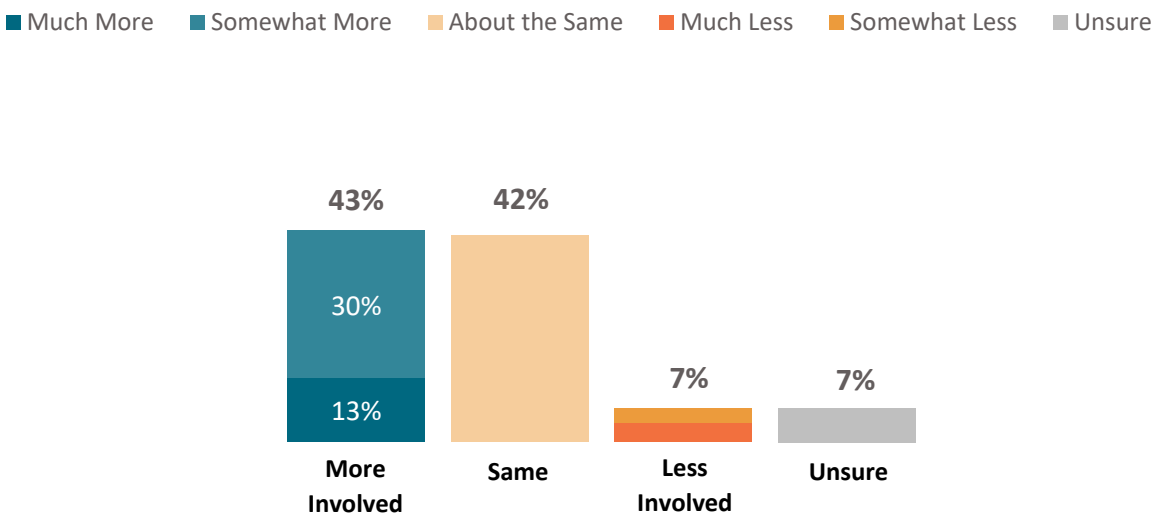
Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Also, a plurality of hospital discharge planners (43%) report increased involvement from MCPs for Medi-Cal patients related to CalAIM's Population Health Management Initiative. An almost equal percentage, 42%, perceives that MCP involvement has remained at the same level. Only 7% report seeing less involvement. This suggests a somewhat positive trend in MCP collaboration and assistance in the management and transition of Medi-Cal patients (Figure 39).

Figure 39. Some Discharge Planners Report Increase in MCP Involvement

Q: AS PART OF CALAIM'S POPULATION HEALTH MANAGEMENT INITIATIVE, PLANS ARE REQUIRED TO PROVIDE TRANSITIONAL CARE SERVICES FOR HIGH-RISK PATIENTS, WHICH INCLUDES IDENTIFYING A TRANSITIONAL CARE MANAGER WHO ENGAGES IN DISCHARGE PLANNING WITH FACILITY STAFF. THESE REQUIREMENTS EXPAND TO ALL PATIENTS TRANSITIONING BETWEEN SETTINGS OF CARE IN JANUARY 2024.

WOULD YOU SAY THAT MEDI-CAL MANAGED CARE PLANS (OR THEIR DELEGATES) HAVE BEEN MORE OR LESS INVOLVED IN DISCHARGE PLANNING FOR YOUR MEDI-CAL PATIENTS SINCE JANUARY 2023 — OR ABOUT THE SAME AS BEFORE?



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Shown for hospital discharge planners (*n* = 67).

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Appendix A. Methodology and Sample Profiles

Qualitative: Focus Groups

To inform the design and interpretation of the survey, six focus groups were conducted from March 28 to April 27, 2023, among 37 CalAIM implementers who said they were at least a little familiar with CalAIM. Participants were divided into the following categories, and one focus group was conducted with each category:

- Enhanced Care managers working in primary care at FQHCs
- Homeless service providers and Medical Respite / Recuperative Care providers
- Community-based organizations providing other Community Supports
- Acute hospital discharge planners
- Managed care plans
- Behavioral health leaders, including a mix of county and county-contracted providers

Quantitative: Survey Methodology

The survey was administered online July 21 to September 12, 2023, among 1,196 CalAIM implementers in California. All survey respondents were offered an incentive for completing the survey. Throughout this report, the survey respondents are referred to as *implementers*. The survey sample was designed to ensure it captured a broad swath of implementers across sectors and regions in California and was composed of several nonprobability sources, including:

- Outreach conducted by CHCF; the Social Interventions Research and Evaluation Network at University of California, San Francisco; and Eviset (*n* = 801)
- WebMD's Medscape panel of health care professionals (*n* = 395)

The survey was intentionally designed to focus on implementers who serve at least some patients covered by Medi-Cal, and who are also at least a little familiar with CalAIM. In addition to the 1,196 completed interviews, 981 respondents were terminated because they report having less than 30% of their patients/clients/members enrolled in Medi-Cal, and 420 respondents were terminated because they were not familiar with CalAIM. Some cases were also excluded due to nonsensical responses and/or insufficient attentiveness.

The report references the following sectors (please note that some implementers may qualify in more than one sector):

- Staff and leadership at managed care plans (*n* = 53)
- Staff and leadership at Federally Qualified Health Centers (FQHCs) (*n* = 140)
- Behavioral health, which includes a mix of staff and leadership at county and county-contracted organizations (*n* = 292):

- Works for a county behavioral health plan/agency
- Works for an outpatient mental health and/or substance use center/practice/clinic
- Works for a residential mental health and/or substance use treatment facility
- Medical specialty is psychiatry, or
- Has a PhD, PsyD, EdD, LMFT, LPCC, LCSW, Trainee (AMFT, APCC, or ACSW), or is a behavioral health peer support specialist

➢ Staff and leadership at social service organizations (*n* = 412)

➢ Hospital discharge planners (*n* = 67)

➢ Primary care providers (PCPs) (*n* = 162):

- Has an NP, PA, or MD/DO and medical specialty is primary care, or
- Is frontline staff and primarily works in outpatient primary care

Note that there is some overlap between the PCP category and the FQHC category, with 27% of PCP respondents working at FQHCs.

Table A1 shows the proportion of implementers who completed the survey by the sectors described above.

Table A1. Sector Categories Described in the Report

Sector	%
Managed care plans	4%
Federally Qualified Health Centers	4%
Behavioral health	24%
Social service organizations	34%
Hospital discharge planners	6%
Primary care providers	14%

Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Sample Profile: Characteristics of Respondents' Organization

Table A2 shows the proportion of respondents who work at each type of organization.

Table A2. Types of Organizations Respondents Work At

Type of Organization	%
A social service provider (e.g., housing and homeless services, food and nutrition services, asthma remediation, services for independent living, vocational rehabilitation, child and youth services, reentry services, etc.)	34%
A Federally Qualified Health Center or other type of community clinic	12%
A hospital or health system	16%
Kaiser Permanente or one of the Permanente medical groups	2%
A medical group other than those that are part of Kaiser Permanente	4%
An independent practice association	3%
A Medi-Cal managed care plan	4%
A county behavioral health plan/agency	4%
An outpatient mental health and/or substance use center/practice/clinic	8%
A skilled nursing facility or nursing home	2%
Assisted living provider	1%
A residential mental health and/or substance use treatment facility	3%
A correctional facility	1%
An advocacy organization or member association	2%
Self-employed	2%

Notes: Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Table A3 shows the proportion of social service organization respondents working at various types of social service organizations. Respondents were allowed to select multiple categories.

Table A3. Types of Social Service Organizations

Type of Social Service Organization	%
Housing or homeless services	65%
Food-related services / food assistance	48%
Information and referral services	48%
General social services assistance	47%
Benefits navigation	38%
Services for older adults or people with disabilities to live in the community	34%
Recuperative care / medical respite	20%
Reentry services following incarceration	18%
Child welfare services	17%
Home modification services	13%
Sobering center / sobering services	11%
Legal services	10%
Asthma remediation services	7%
Other	14%

Notes: Totals may not add to 100% due to rounding or multiple responses. This table is shown only for respondents who report working at social service organizations.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Sample Profile: Characteristics of Sectors

Table A4 shows the organization characteristics among respondents who work in each of the sectors shown throughout the report.

Table A4. Organization Characteristics by Sector

Organization Characteristics	Total (%)	MCP (%)	FQHC (%)	BH (%)	Social Service (%)	Hosp. Discharge Planner (%)	PCP (%)
Number of FTEs (Full-Time Equivalents) in Organization							
<10	9%	2%	4%	10%	12%	0%	2%
10–24	10%	8%	5%	9%	14%	1%	14%
25–49	10%	6%	7%	7%	15%	6%	12%
50–99	13%	23%	9%	11%	16%	16%	12%
100–249	20%	21%	24%	18%	21%	21%	21%
250+	30%	42%	42%	33%	17%	43%	29%
Type of Organization							
Private entity	23%	38%	8%	24%	13%	33%	32%
Nonprofit	65%	51%	81%	61%	80%	48%	50%
Government agency	14%	11%	14%	20%	8%	15%	21%
Organization Also Operates in States Outside of California							
Yes	7%	2%	2%	7%	6%	7%	4%
No	93%	98%	97%	93%	93%	93%	94%
Role of Respondent							
Frontline staff or provider	41%	9%	50%	37%	26%	94%	84%
Leader	54%	85%	47%	56%	70%	0%	13%
Other	5%	6%	3%	7%	4%	6%	3%

Notes: Totals may not add to 100% due to rounding, or respondents marking “unsure.”

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Sample Profile: Demographics

The sample represents a diverse population of CalAIM implementers. Table A5 shows the demographic profile of the sample overall.

Table A5. Demographics of Respondents

Demographic Characteristic	%
Gender	
Female	63%
Male	27%
Race and Ethnicity	
White	49%
Hispanic / Latino/x	21%
Asian / Asian American	12%
Black / African American	9%
American Indian / Alaska Native / Indigenous	2%
Native Hawaiian / Pacific Islander	1%

Notes: Totals may not add to 100% due to rounding and multiple or missed responses.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Table A6 shows the proportion of respondents whose organizations operate in each region of the state and the counties included in those regions. Some respondents report working in multiple regions and therefore may appear in more than one category. In addition, 5% of respondents say their organization operates statewide; those organizations are not included in the table below.

Table A6. Regional Breakdown of Respondents

Regions	%
Bay Area: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma	23%
Rural North: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba	8%
Greater Sacramento: El Dorado, Placer, Sacramento, Yolo	6%
Central Coast: Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura	8%
Central Valley: Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare	9%
Los Angeles County: Los Angeles	19%
San Diego/Orange: Orange, San Diego	18%
Inland Empire/Desert: Imperial, Inyo, Mono, Riverside, San Bernardino	7%

Notes: Totals may not add to 100% due to rounding.

Source: CHCF/GSSR Survey of CalAIM implementers (July 21–September 12, 2023).

Appendix B. Cross-Sector Collaboration in Detail

Table B1 is a heat map that shows which types of organizations have partnerships with other types of organizations. The rows indicate the survey respondent's organization type. The columns indicate the types of organizations that the respondent reports having partnerships with. For example, the darker cells and higher numbers in the row of respondents who work in managed care plans indicate they are more likely than other types of organizations to report having partnerships with primary care providers, housing and homeless service providers, and county behavioral health plans and agencies.

Table B1. Organizational Partnerships with Other Types of Organizations

*Sector of Respondent	Avg. number of sectors with ≥ 1 partnership	Housing/homeless service providers	Med. respite/ recup. services	Food/nutrition services	Asthma remediation services	Services for older adults/ people with disabilities	Sobering centers/services	Home modification providers	Personal care / home health services	Assisted living facilities	Skilled nursing facilities	Acute hospitals	Primary care providers	Managed Care Plans	County behavioral health plan/agency	Mental health/substance use providers	Correctional systems
Managed care plans	**7.94**	**72%**	**53%**	**62%**	**25%**	**49%**	**25%**	**40%**	**58%**	**34%**	**55%**	**42%**	**75%**	**53%**	**66%**	**57%**	**15%**
Sobering centers / sobering services	6.53	82%	50%	48%	11%	50%	66%	16%	36%	23%	30%	27%	43%	27%	48%	52%	30%
Medical respite / recuperative services	6.15	78%	65%	51%	19%	51%	31%	18%	42%	23%	28%	22%	33%	38%	24%	36%	14%
Asthma remediation services	5.93	64%	61%	64%	64%	61%	32%	39%	54%	32%	29%	7%	21%	21%	7%	14%	0%

*Limited to sectors with at least 30 respondents

	Avg. number of sectors with ≥ 1 partnership	Housing/homeless service providers	Med. respite/ recup. services	Food/nutrition services	Asthma remediation services	Services for older adults/ people with disabilities	Sobering centers/services	Home modification providers	Personal care / home health services	Assisted living facilities	Skilled nursing facilities	Acute hospitals	Primary care providers	Managed Care Plans	County behavioral health plan /agency	Mental health/substance use providers	Correctional systems
Services for older adults / people with disabilities	5.74	71%	34%	42%	12%	68%	18%	32%	43%	24%	23%	19%	24%	37%	38%	35%	12%
County behavioral health plan/agency	5.40	64%	19%	17%	0%	32%	19%	4%	26%	9%	23%	32%	38%	51%	60%	62%	38%
Hospital, medical group, IPA	5.35	33%	29%	23%	6%	24%	19%	9%	34%	24%	38%	38%	46%	36%	25%	33%	10%
Home modification providers	5.27	61%	20%	39%	8%	69%	8%	57%	49%	24%	20%	24%	20%	37%	31%	24%	8%
Food/nutrition services	5.16	66%	32%	36%	10%	48%	24%	18%	28%	18%	15%	15%	23%	31%	38%	37%	13%
FQHC or Primary care providers	5.13	37%	21%	30%	11%	22%	19%	11%	25%	17%	25%	32%	51%	44%	35%	41%	12%
Housing/homeless service providers	5.12	79%	31%	28%	8%	42%	29%	15%	24%	16%	16%	12%	25%	33%	44%	49%	18%
Mental health / substance use providers	4.84	43%	24%	19%	8%	32%	18%	6%	20%	18%	27%	24%	32%	39%	38%	37%	17%
Other Social Service	3.61	35%	7%	10%	3%	11%	20%	2%	5%	3%	2%	9%	23%	24%	58%	56%	22%
Managed care plans	3.50	35%	9%	20%	5%	14%	9%	6%	5%	5%	2%	3%	17%	22%	34%	37%	15%