CalAIM Community Supports Webinar
Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing

**♥DHCS**

August 18th, 2022

Agenda

» Welcome and Introductions

» Review of Recuperative Care (Medical Respite)

» Review of Short-Term Post-Hospitalization Housing
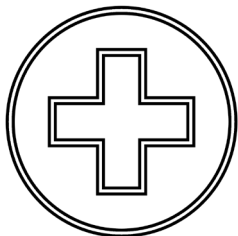
» Promising Practices

» Q&A

CalAIM and Community Supports

CalAIM Community Supports are **optional services** that health plans can opt to provide in lieu of higher-cost services traditionally covered by Medicaid.
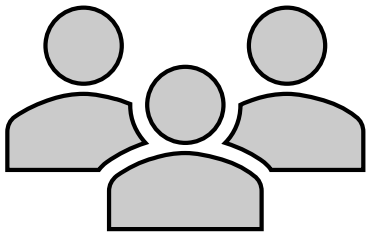
CalAIM includes **14** Community Supports.

MCPs selected Community Supports to offer when CalAIM went-live on January 1, 2022 and have the **option to add new Community Supports every six months.**

In Lieu of Services (ILOS) Authority 101

What Are "In-Lieu-Of" Services"?

ILOS are **medically appropriate** and **cost-effective services or settings** offered by a managed care plan as a **substitute** for a Medicaid state plan-covered service or setting.

States to date have covered various targeted ILOS. California's recent approval, however, establishes that ILOS authority can be used to offer a *comprehensive menu* of health-related services in Medicaid.

*Example: Offering **home asthma remediation** in lieu of **future emergency department visits.***

Regulatory requirements: ILOS are authorized through federal regulation[1] which specifies that services must be:

- Medically appropriate and cost-effective substitutes for a covered service or setting under the Medicaid State Plan
- Authorized and identified in the plan contract
- Offered at plan and enrollee option

The regulation also specifies that the cost of ILOS is taken into account in rate setting.

1) 42 CFR §438.3(e)(2)

Community Supports Services Approved in California

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Respite Services (for Caregivers)
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations
- Medically Tailored Meals/Medically-Supportive Food
- Sobering Centers

- Asthma Remediation
- **Short-Term Post-Hospitalization Housing**
- **Recuperative Care (Medical Respite)**

MCP Elections

Support	Counties with MCP election no later than 1/24
Short-Term Post-Hospitalization Housing	55
Recuperative Care	57

Recuperative care and STPHH

Recuperative care

Not elected to offer

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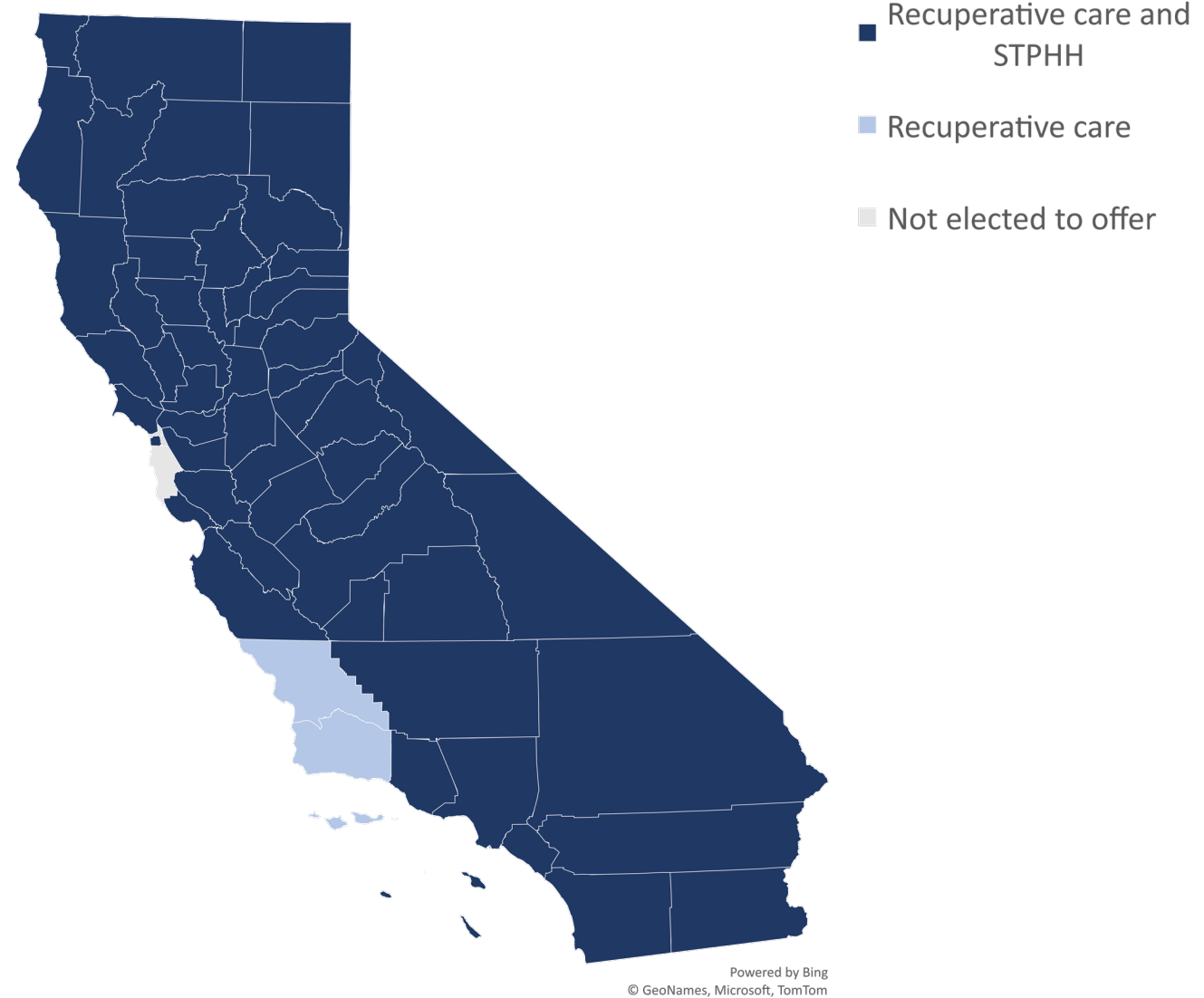
Recuperative Care (Medical Respite)

Guidance Summary

What is Recuperative Care?

» Short-term residential care for individuals who no longer require hospitalization, but still need to heal

» Addresses housing instability and promotes recovery after acute care

» Allows patients to continue accessing care and social services
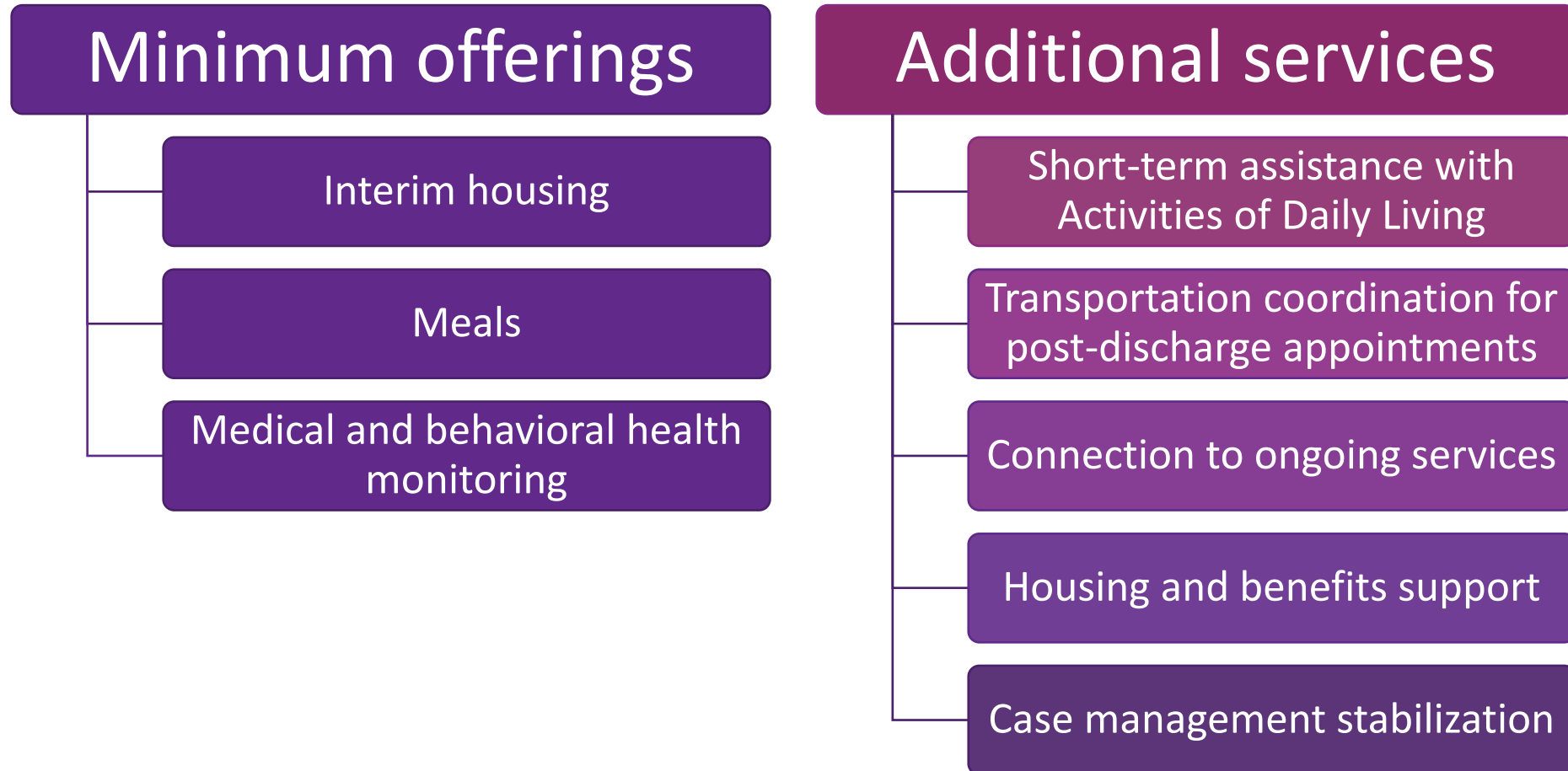
Outlined by the DHCS Community Supports Policy Guidance

Recuperative Care in Context

» Bridge program between hospital and emergency departments and homeless shelters that do not offer medical care

» Part of the continuum of care for homeless services [1]

» Broad program diversity

» Over 130 recuperative care programs in the US [2]

» 41 recuperative care programs in California [2]

Recuperative Care Service Offerings

Minimum offerings

- Interim housing
- Meals
- Medical and behavioral health monitoring

Additional services

- Short-term assistance with Activities of Daily Living
- Transportation coordination for post-discharge appointments
- Connection to ongoing services
- Housing and benefits support
- Case management stabilization

Outlined by the DHCS Community Supports Policy Guidance

Program Benefits

» 28% average reduction in hospital days for chronically homeless individuals (4.24 vs. 5.88) [3]

» Reduction in health care costs of $62,504 per person per year, versus $25,925 (a difference of $36,579) [3]

» Estimated savings of $18,000 to $48,000 per patient stay [4]

Recuperative Care: Eligible Populations

» Individuals who are at risk of hospitalization or are post-hospitalization

» Individuals who live alone with no formal supports

» Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification

» Individuals who meet the HUD definitions of "homeless" or "at risk of homelessness" and who are receiving ECM or who have one or more serious chronic condition(s) and/or serious mental illness and/or is at risk of institutionalization as a result of a substance use disorder

Outlined by the DHCS Community Supports Policy Guidance

Service Limitations

» Must be necessary to achieve or maintain medical stability and prevent hospital admission or re-admission

» 90-day limitation on continuous duration

» Must not include funding for building modification or building rehabilitation

» Recuperative care has been determined inherently time sensitive and is subject to expedited authorization

Allowable Providers

Interim housing facilities with additional on-site support

Shelter beds with additional on-site support

Converted homes with additional on-site support

County directly operated or contracted recuperative care facilities

Outlined by the DHCS Community Supports Policy Guidance

Short-Term Post-Hospitalization Housing

Guidance Summary

What is Short-Term Post-Hospitalization Housing?

Site for patients to continue medical, psychiatric, or substance use disorder recovery

For patients exiting inpatient and residential treatment facilities

Individual or shared housing setting

Supports recuperation, recovery, and transitions to other housing

Outlined by the DHCS Community Supports Policy Guidance

In context: Interim Housing Services

» Builds on housing-first model

» Provides case management and stabilization for medically vulnerable individuals

» Links patients to long-term supports

Short-Term Post-Hospitalization Housing: Eligible Populations

» Individuals exiting recuperative care

» Individuals exiting an inpatient treatment stay who satisfy any of the following:

   » Meet the HUD definition of homeless and receive ECM, have one or more serious chronic conditions, or are at risk of institutionalization for substance use disorder

   » Meet the HUD definition of at risk of homelessness and receive ECM, have one or more serious chronic conditions, serious mental illness, or are at risk of institutionalization, or are transition-age youth facing housing instability

» Individuals must have medical/behavioral health needs that would likely result in hospitalization, re-hospitalization, or institutional readmission after experiencing homelessness upon discharge from care.

Outlined by the DHCS Community Supports Policy Guidance

Allowable Providers

Interim housing facilities with additional on-site support	Shelter beds with additional on-site support	Converted homes with additional on-site support	County directly operated or contracted recuperative care facilities
Supportive Housing providers	County agencies	Public Hospital Systems	Social service agencies

Providers of services for individuals experiencing homelessness

Outlined by the DHCS Community Supports Policy Guidance

Impact of Short-Term Post-Hospitalization Programs

» $6,307 cost savings per patient per year [6]

» 29% reduction in hospitalizations and hospital days [7]

» 24% reduction in emergency department visits [7]

Service Limitations and Restrictions

» Available once in an individual's lifetime

» Are not to exceed a duration of 6 months (but may be authorized for a shorter period based on individual needs)

» The service is only available if enrollee is unable to meet such an expense

» Short-Term Post-Hospitalization Housing has been determined inherently time sensitive and is subject to expedited authorization

Best Practices for Short-Term Post-Hospitalization Housing and Recuperative Care

» Many members may be experiencing homelessness and complex health conditions

» Best practice frameworks include:
  » Housing First
  » Harm Reduction
  » Progressive Engagement
  » Motivational Interviewing
  » Trauma-Informed Care

Pricing Guidance

» The Non-Binding ILOS Pricing Guidance outlines a high-level per-diem pricing approach reflecting typical staffing ratios, caseloads, and service intensity.

Short-Term Post-Hospitalization Housing and Recuperative Care Provider Promising Practices

Kamiah Thomas, Program Manager of Connections Interim Housing, People Assisting the Homeless (PATH)

PATH : Recuperative Care + Short Term Post Hospitalization Housing (STPHH)

Recuperative Care and STPHH at PATH

» Health Plans
  » Contracted with 3 different health plans for each program

» Eligibility Requirements
  » What makes someone eligible?
  » What makes someone ineligible?

» Interim Housing Model and Approaches

» Referral Process

Submit Referral Packet to PATH Interim *(kamiaht@epath.org)*	Submit Request to Health Plan	Intake
Approved →	**Approved** →	

Lessons Learned

» More than one recuperative care stay may be needed.

» Achieving and maintaining stability takes time.

» Housing-first principles still apply and should continue to apply to recuperative care and STPHH care.

» Utilization of beds and community coordination go hand in hand.

Best Practices

» Informed Choice
  » Provide detailed information to referred patients about what recuperative care/STPHH is, and what they can expect

» Transparency
  » Organizational practices and program expectations

» Collaboration and communication
  » Between referred patient and PATH staff
  » Between health plan and PATH staff
  » Between patient and healthcare providers

» Exit Planning

» Defining Success

Outcomes and Goals

» Connect patients to PCPs and follow up on post-discharge plans.

» Connect patients to community resources and ongoing support that will continue after program exit.

» Connect patients to CES, resulting in housing stability.

» Provide support needed to ensure patients complete their 60-90 day stay in recuperative care.

» Minimize return to ER/hospitals within patient's recuperative stay.

Questions and Contact Information

» Questions

» Contact Information:
  » Kamiah Thomas – Interim Housing Program Manager
  » (619) 775-7486
  » Kamiaht@epath.org

Recuperative Care Provider Promising Practices

Christie Gonzales, Chief Programs Officer, WellSpace Health

WellSpace Health

Christie Gonzales, MPA

Chief Programs Officer

- Founded in 1953

- Non-profit 501(c)(3)

- Federally Qualified Health Center

- Behavioral Health System

Mission

Achieving regional health through high quality comprehensive care.

WELLSPACE **HEALTH**

We see You.

Everybody deserves to be seen, no matter who you are, where you come from, where you work or what place you call home.

WELLSPACE HEALTH

We see YOU.

People Served (2021)

Total Patients: 125,000

Total Encounters: 400,000

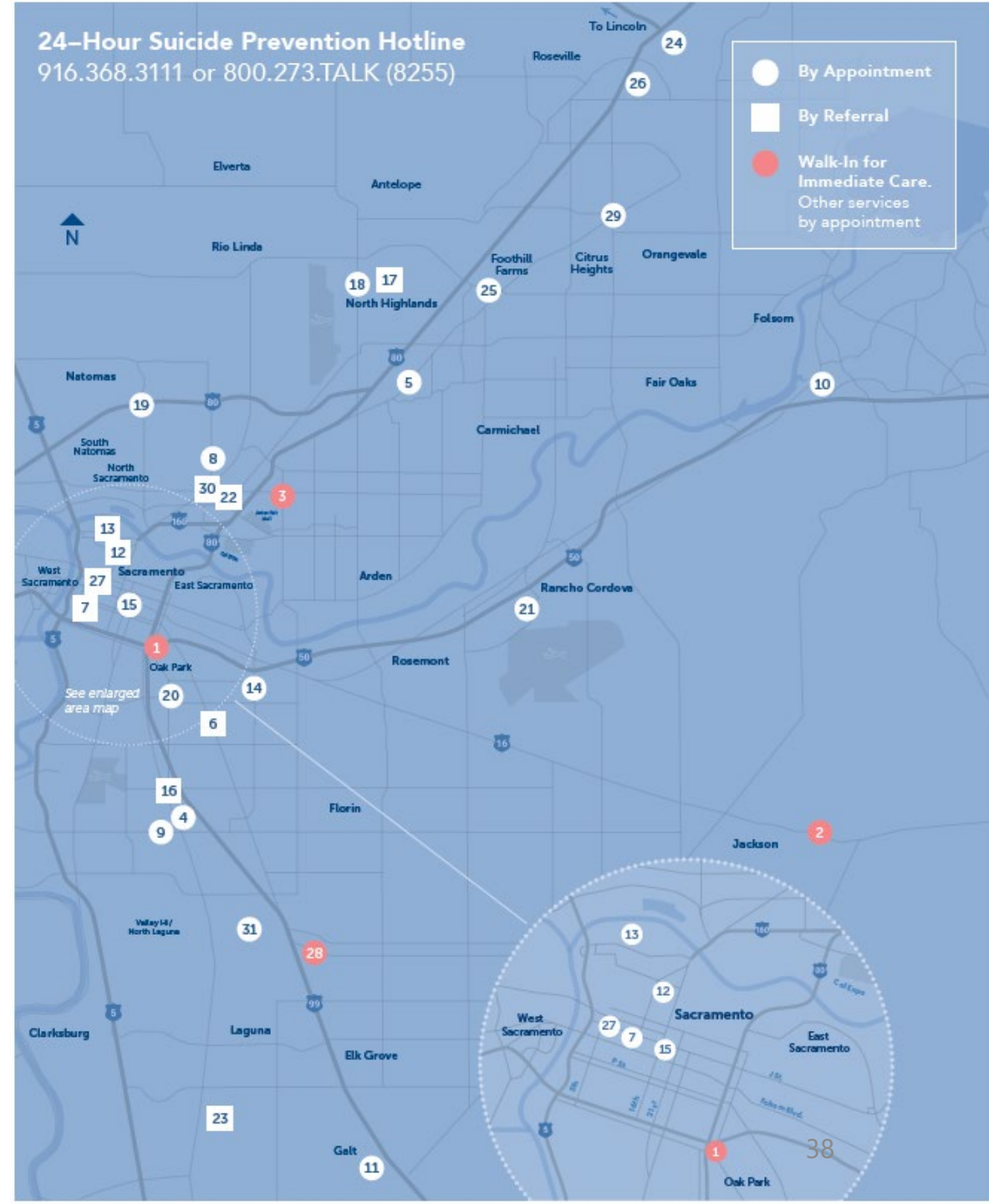Encounters Per Day: 1,400

Patients Served

Low Income: 92%

Uninsured: 15%

Homeless: 5%

30+ Locations

Sacramento, Placer, & Amador counties

- Community Health Centers

- Immediate Care Centers

- Dental Centers

- Behavioral Health Centers

- Supportive Service Centers

- Partnership Sites

Programs & Services *(partial list)*

- Primary Care
- Immediate Care
- Pediatrics
- Dental Care
- Behavioral Health
- Women's Health
- Health Education
- Sweet Success

- Suicide Prevention & Crisis Line
- Interim Care Program
- Sacramento Violence Intervention Program
- Substance Use Disorder Treatment
- Birth and Beyond Family Resource Center
- Intensive Case Management
- Housing Tenancy and Sustaining Services
- Criminal Justice – Involved Programs

We see, YOU.
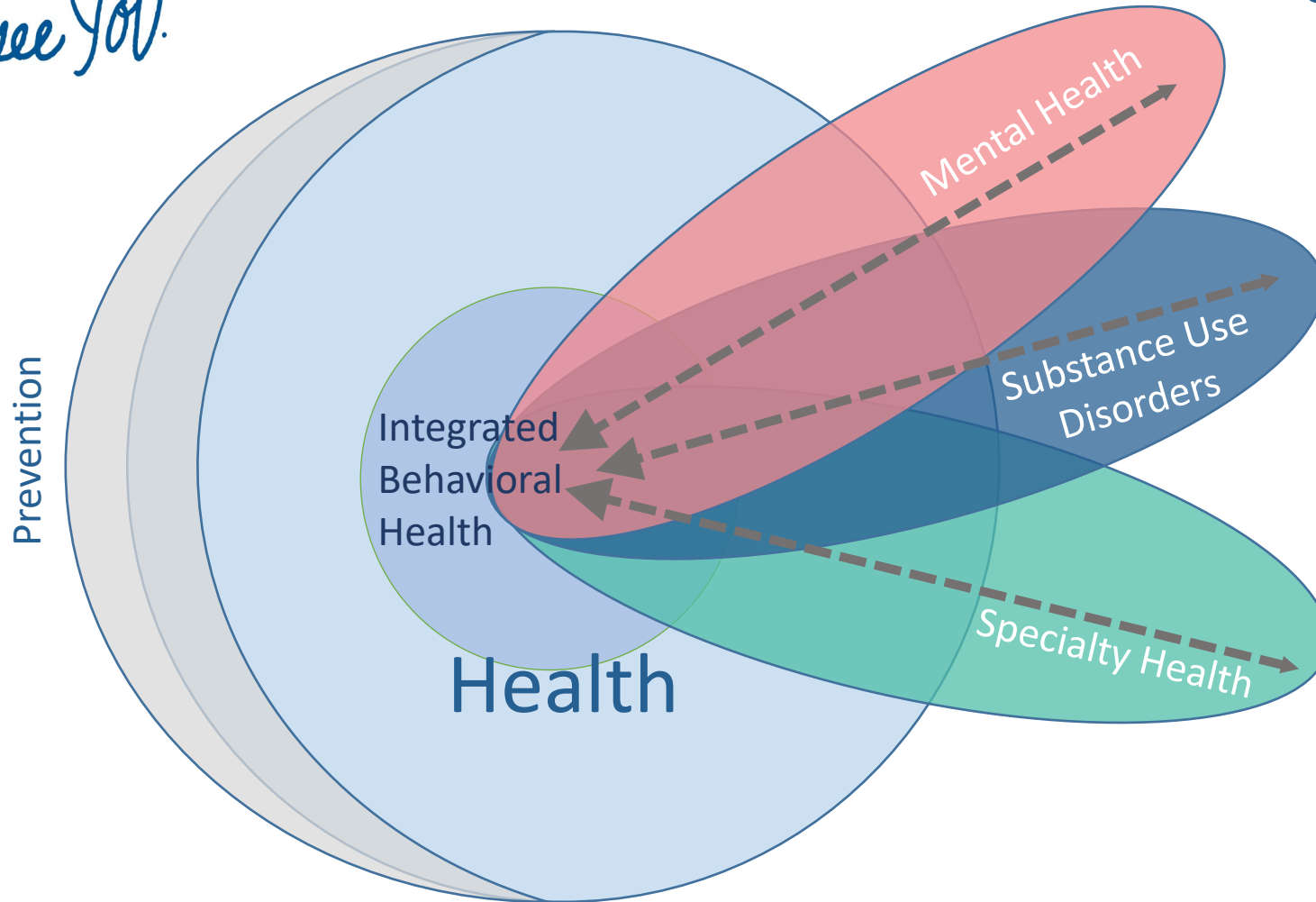
The Joint Commission
Ambulatory Care Accreditation
Behavioral Health Accreditation
Patient Centered Health Home Certification
Behavioral Health Home Certification

HRSA Quality Improvement Awards
Improving Quality of Care Award
Advancing Health Info Tech for Quality
Patient Centered Medical Home Recognition

American Association of Suicidology
Crisis Center Accreditation

Recuperative Care

Gregory Bunker Care Transitions Center

WELLSPACE HEALTH

Interim Care Program (ICP)

- Medical Respite Care model
- 2006
- 18 beds
- Co-located
- ICP+
- Pathways to Heath + Home
- New building

Facility

Facility

Phase 1 Open

- Gregory Bunker Care Transitions Center

- 4990 Stockton Blvd
- Sacramento CA 95820

- 59 current beds

Gregory Bunker Care Transitions Center

Facility

Facility

We see, YOU.

Facility

We see YOU.

CalAIM

- Recuperative Care

- Hospitals- No change to referral process

- WellSpace Health- authorization from Health Plan

Facility

Updated Protocols

- Referral hours:
  - **8am**-4pm, Monday-Friday
- Admission hours:
  - 10am-**6pm** Monday-**Saturday**
- Greater ability to flex beds:
  - gender
  - disease state
  - distress tolerance

Facility

We see YOU.

Updated Protocols

- Enhanced Care Management (ECM)

- Housing Navigation

- Specialty diets

- Transportation

- On-site Primary Care services

Phase 2-
Near Future

- Expand bed capacity

- Expand to "at risk of hospitalization"

- On-site Behavioral Health services

- Bariatric patients

- Deeper coordination with Health Home, physical therapy, occupational therapy

Next Steps

- Referrals from the Emergency Department

- Continued feedback from partners

- Continued expansion of intake & referral criteria

We see YOU.

We see you.

Short-Term Post-Hospitalization Housing and Recuperative Care Plan Promising Practices

Dennis Hsieh, Chief Medical Officer, Contra Costa Health Plan
Nicolas Barcelo, Medical Director, Contra Costa Health Plan

Short-Term Post-Hospitalization Housing and Recuperative Care

August 18, 2022

Dennis Hsieh, MD, JD, Chief Medical Officer

Nicolás Barceló, MD, Medical Director

Contra Costa Health Plan

» County owned and operated health plan

» Serve majority Medi-Cal Managed Care

» Small line of Commercial (county employees) and IHSS workers

Approach to Community Supports

» Firm belief that social determinants of health play an important role

» Long-standing partnership: County Agencies + CBOs

  » CC Health, Housing & Homelessness + CC Public Health

» Believe in a robust network

» Operate like any other benefit

» Allow for retro referrals

Workflow/Process

Patient and Provider Centered Perspective

Receive requests similar to any other Prior Auth Request (No Wrong Door)
o ccLink (EPIC) vs ccLink Provider Portal (formerly fax) vs member services

Review in UM as any other Prior Auth Request

Implementation Successes

» Great communication/partnership with providers as to process & workflows

» Regular check-ins as to progress & capacity

» Fear of being overwhelmed
  » Close coordination on cases

» Great relationships with hospitals

» Start small and scale

Implementation Considerations

» Limited overall capacity (local & regional)

» Hard to predict need/volume

» Slow uptake by hospitals

» Hospitals right setting (vs SNF)

» CS providers already doing the work

Next Steps

Revamp of respite referral to capture CCHP members
- Capacity/ Prioritization to be explored

Education of SNFs
- Guarantee letter in place

Ongoing Education/ Working with Hospitals

Expansion to additional hospitals

Metrics

» Process (During Implementation + Judge of Reach/Daily Operations)
  » Number of referrals
  » Timeliness

» Outcomes
  » Utilization (ED/Inpatient)
  » Adherence to Treatment (PCP/specialist/meds)
  » Successfully Housed
  » Health Outcomes (Self Rated + Disease Based)
  » Other SDOH Successfully Addressed

Best Practices & Lessons (A Work in Progress)

» Communication

» Replicate existing workflows

» Repeated touches

» Partnership with SNFs

» Capacity

Thank You!

Dennis Hsieh dhsieh@cchealth.org

Nicolás Barceló nbarcelo@cchealth.org

FAQs

» Billing and rates

» How to become a provider

» Who can refer patients and how to make a referral

» How eligibility is determined

Questions?

Closing

» Next Community Supports Webinar:

  » Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities and Community Transition Services/Nursing Facility Transition to a Home.

  » September 15th at 12pm PT.

» Please send questions to: CalAIMECMILOS@dhcs.ca.gov.

Citations

1. NIMRC Defining Characteristics of Medical Respite

2. NIMRC State of Medical Respite Care

3. A Pilot Study of the Impact of Housing First–Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services

4. Program evaluation of a recuperative care pilot project

5. Medical Respite Care Bridges Critical Gap for Californians Without Housing

6. Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care

7. Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults

Resources

» [DHCS Community Supports Policy Guidance](#)

» [Non-Binding ILOS Pricing Guidance](#)

» [National Institute for Medical Respite Care Medical Respite Tool Kit](#)