



MICHELLE BAASS  
DIRECTOR

State of California—Health and Human Services Agency  
Department of Health Care Services



GAVIN NEWSOM  
GOVERNOR

Department of Health Care Services California Advancing and Innovating  
Medi-Cal (CalAIM)

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**SPEAKERS**

Lucy Pagel  
Michelle Wong  
Julia Dobbins  
Tyler Brennan  
Kamiah Thomas  
Christie Gonzales  
Dennis Hsieh

Lucy Pagel:

All right. Welcome everybody to our fourth CalAIM Community Supports spotlight webinar. We're going to begin momentarily. In the meantime, before we begin, just want to go over a few housekeeping notes. You all, as participants, will be on mute during the presentation, and we will have time for questions at the end of the webinar. Please submit any questions you have as we go through the slides via the Q&A feature on your Zoom screen.

At any point during the presentation, you can add those in, and make sure that's being done through the Q&A. The slides and all meeting materials will be posted and available soon on the DHCS website, we'll share details in the chat about how you can access those materials. Additionally, we do have captioning available for this webinar. If you would like to use this feature, please click on closed captioning at the bottom of your screen and select subtitles.

All right. Today, we'll be hearing about recuperative care and short-term post-hospitalization housing. We'll start with some introductions, hear about these two Community Supports and hear about promising practices from our presenters today. As I said, we also will have Q&A available at the end of the presentation. I'm going to turn over the mic to Shel from DHCS to introduce this webinar and our CalAIM Community Supports.

Michelle "Shel" Wong:

Thanks, Lucy. We'll begin with a brief overview of CalAIM Community Supports. Community Supports are medically-appropriate, cost-effective alternatives that Medi-Cal managed care plans may provide in lieu of services traditionally covered by Medicaid. Community Supports are designed to decrease the utilization of other Medi-Cal benefits, such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use.

Managed care plans are strongly encouraged, but not required to provide Community Supports. CalAIM currently includes a robust menu of 14 preapproved Community Supports to address the health needs of members. The list of preapproved Community Supports is informed by the work and lessons learned under previous pilot programs, including the Whole Person Care Pilot and Health Homes Programs.

Managed care plans selected Community Supports to offer when CalAIM went live on January 1st of 2022 and have the option to add new Community Supports every six months. Managed care plans in all counties are encouraged to offer at least one community support by January 1st of 2024.

Next slide, please. Community Supports are in lieu of services, which once again 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. Under regulatory requirements, in lieu of services must be authorized and identified by planned contracts and offered at plan and enrollee options. This allows for Community Supports to cover a broad range of social and support services for eligible populations.

These are financed through capitated rates to plans in the same way as state plan services and do not require 1115 waiver savings. This slide, once again, shows all of the 14 preapproved Community Supports and today's webinar, as Lucy mentioned earlier, is intended to provide information about the short-term post-hospitalization housing and recuperative care or medical respite community support and to help inform you as you consider offering these Community Supports to plan members and patients.

At this time, 55 out of 58 counties have elected to offer short-term post-hospitalization by January of 2024 and 57 counties have elected to offer recuperative care by January of 2024. Now I'll pass it over to Julia Dobbins, the director of programs and services for the National Institute for Medical Respite Care who will take us through the guidance on recuperative care.

Julia Dobbins:

Thank you so much, Shel. Hello everybody. Thank you for having me and thanks for joining us this afternoon. As Shel said, my name is Julia Dobbins and I work with the National Institute for Medical Respite Care, which is an initiative of the National Healthcare for the Homeless Council. I work as their director of medical respite. Today I'm going to be talking to you about recuperative care, also known as medical respite.

Next slide, please, Kathleen. We're going to start our conversation with just getting on the same page of how do we define this service? Recuperative care, also referred to as medical respite care, as I said, is short-term residential care for individuals who do not require hospital-level care, but do need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment.

An extended stay in a recuperative care setting allows individuals an opportunity to continue to recover and receive post-discharge treatments while obtaining access to primary care, behavioral health services, case management, and other supportive social services, such as transportation, food and housing. Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are either too ill or frail to recover from an illness or injury in their usual living environment, but who do not require hospital-level care.

This service provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the Enhanced Care Management program or ECM. Recuperative care may be utilized in conjunction with other housing Community Supports. Whenever possible, other available housing community support should be provided to members on site in the recuperative care facility.

Next slide, please, Kathleen. Recuperative care can provide a bridge between high-intensity care at hospitals or treatment centers and homeless shelters or other homeless service organizations that are not able to provide medical support. These programs provide a valuable addition to the continuum of care for people experiencing homelessness. There's a lot of diversity in what a medical respite program can look like, what recuperative care can look like.

That's a flexibility that we want to keep with medical respite and medical respite is really growing. We know of over 130 programs across the country. Just yesterday I came across our contacts list from 2017 and we had 80 programs on that list. As you can see, respite is growing, at least 50 new programs in the last five years. For more context, in the state of California, we know of at least 41 medical respite recuperative care programs.

California has always been really innovative in the field of recuperative care and it's really exciting that California is leading the way as it relates to Medicaid reimbursement for recuperative care as well. While there's a lot of diversity in programming, there are a lot of resources that the National Institute for Medical Respite Care has created and can provide around best practice. I'll share a link to those resources in the chat when I finish.

Next slide, please. In terms of offerings, at a minimum, recuperative care services must provide interim housing with a bed and meals and ongoing monitoring of the individual's medical or behavioral health condition.

Programs can also include additional services based on individual's needs such as limited or short-term assistance with activities of daily living, or ADLs, coordination of transportation to post-discharge appointments, connection to other ongoing services an individual may require including mental health and substance use disorder services, support in accessing benefits and housing, and gaining stability with case management relationships and programs.

Next slide, please. A lot of research has been conducted on the impact of medical respite programs across the country. Medical respite programs have been found to reduce the length of hospital stays for homeless individuals, as well as reduce healthcare costs. An evaluation study of a program based in Seattle, Washington, found a 28% average reduction in hospital stays for chronically homeless individuals.

That same Seattle-based program identified a \$62,000 reduction in healthcare cost per patient per

year, compared to just a \$26,000 reduction in cost for participants in a comparison group not receiving services. Another study of a medical respite program offering services that are motel-based with supplemental nursing care support, estimated savings from a referring facility of \$18,000 to \$48,000 per patient per stay.

Next slide, please. Let's talk about eligibility requirements here. Several populations are eligible for recuperative care Community Supports. The DHCS Community Supports eligibility requirements include individuals who are at risk of hospitalization or post-hospitalization, individuals who live alone with no formal supports. Like I said earlier, recuperative care and medical respite is primarily used for individuals experiencing homelessness, but the DHCS policy is a little bit more broad here in terms of eligibility.

Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification. Individuals who meet HUD's definition of homeless and are receiving ECM, or who have one or more serious chronic conditions. Additionally, individuals who are determined to be at risk of experiencing homelessness were eligible to receive recuperative care services if they have significant barriers to housing stability, and meet other conditions that are outlined in DHCS' community support policy guidance.

Next slide, please. In terms of service limitations, recuperative care is allowable if it is necessary to achieve or maintain medical stability or prevent hospital admission or readmission. The services are not to exceed 90 days of continuous duration and may not include funding for building modification or building rehabilitation. This community support should be supplemental and not supplant services by the Medi-Cal beneficiary.

The Community Supports policy guides states that managed care plans must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs. DHCS has released updated clarification determining that recuperative care is an inherently time-sensitive support and is subject to expedited authorization. The reason for this is that primarily referrals into recuperative care programs are coming from hospitals and so taking and so a long time to get somebody connected with a recuperative care program can be a burden on our hospitals.

Next slide, please. In terms of allowable providers, we really want to make sure that people who are coming to do this work are folks who have a history in this work, so have a history of working with people who are very vulnerable. We want providers to have experience and expertise in this unique service.

This list provided on the slide is an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services. Potential providers include interim housing facilities with additional onsite support, shelter beds with additional onsite support, converted homes, county-directly operated or contracted recuperative care facilities.

That is the piece around recuperative care. I'm going to put in the chat some resources related to best practice in medical respite. While I'm doing that, I'll pass it over to Tyler from DHCS who will share guidance on the short-term post-hospitalization housing support. Take it away, Tyler.

Tyler Brennan:

Thank you so much, Julia. We're now going to provide a summary of guidance on the short-term post-hospitalization housing community support.

Next slide. Short-term post-hospitalization housing provides members who do not have a residence and who have high medical or behavioral health needs the opportunity to continue their medical, psychiatric or substance use disorder recovery immediately after exiting an inpatient hospital, residential treatment facility, correctional facility, nursing facility, or recuperative care and avoid further preventable utilization of state plan services.

Short-term post-hospitalization housing settings must provide individuals with ongoing supports necessary for recuperation and recovery, such as gaining or regaining the ability to perform activities of daily living, or ADLs, receiving necessary medical, psychiatric, substance recovery, such as gaining or

regaining... Oh, I'm sorry, substance use disorder care, case management and beginning to access other housing support such as housing transition navigation.

Settings may include an individual or a shared interim housing setting where residents can receive these services. Members must be offered housing transition navigation supports during the period of short-term post-hospitalization housing to prepare them for the transition from this setting. The services offered as part of short-term post-hospitalization housing should include a housing assessment and the development of an individualized housing support plan to promote housing stability.

Next slide, please. In context, short-term post-hospitalization housing fits into the broader world of housing-first focused interim housing programs that provide transitional support to long-term tenancy and stable housing to support individuals with high healthcare needs. Similar programs include the Housing for Health Program founded in LA and 2012, the VA-piloted Hospital-to-Housing Program developed in 2016, and the Better Health through Housing programs piloted in Chicago and Spokane.

These programs typically build on housing-first principles through intensive care management, stabilization, and linkage to other critical medical, behavioral and social services.

Next slide, please. We'll talk about the eligibility for this community support. Eligible populations for short-term post-hospitalization housing include individuals exiting recuperative care and individuals exiting an inpatient hospital stay, either acute or psychiatric or chemical dependency and recovery hospital, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility, and who meet any of the following criteria.

Individuals who meet the Housing and Urban Development, HUD, definition of homeless as defined in section 91.5 of title 24 of the CFR, including those exiting institutions, but not including any limits on the number of days in the institution, and who are receiving ECM, Enhanced Care Management, or have suffered one or more serious chronic conditions and/or serious mental illnesses and/or is at risk of institutionalization or requiring residential services as a result of substance use disorder.

Highly encourage you to look at the actual policy for the delineation of these things. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facilities, substance use disorder residential treatment facilities, recovery residences, institution for mental disease and state hospitals, or, we're going to go down to the next bullet, individuals who meet the HUD definition of at risk of homelessness as defined in the same section of the CFR. The full criteria can be found in the Community Supports policy guide.

Let's go to the next slide, please. Talking about allowable providers, housing and shelter facilities are allowable, county and public hospital agencies, social service and homeless service organizations may all be appropriate providers for this community support. As with all Community Supports, providers must have experience and expertise in providing these services ideally located within their communities as well.

Next slide, please. Let's look at the impact that this community support can have. Looking at the research on how short-term post-hospitalization housing can impact program recipients, we see some interesting things. One program that provided homeless individuals with chronic medical conditions with post-discharge medical respite, followed by short-term post-hospitalization housing after inpatient stays demonstrated \$6,300, a little more, an average cost savings per person.

Another study on the provision of transitional housing and case management at post-hospital discharge among unhoused adults with chronic illnesses, found a 29% reduction in hospitalizations and hospital days, along with a 24% reduction in emergency department visits.

Next slide, please. Short-term post-hospitalization services are available once in an individual's lifetime and are not to exceed a duration of six months. They can be authorized for a shorter period based on individual needs however. Managed care plans are expected to make good faith effort to review information available to them to determine if the individual has previously received services.

The service is only available if an enrollee is unable to meet such an expense. Like recuperative care, the short-term post-hospitalization housing community support has been determined to be inherently

time-sensitive and all requests similarly are subject to expedited authorization.

Next slide, please. The services provided for both supports should utilize best practices for members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions, including housing-first, harm reduction, progressive engagement, motivational interviewing, and trauma-informed care. We'll provide links for more information about these modalities in the resources section of these slides.

Next slide, please. Finally, the pricing guidance. DHCS released Non-binding ILOS or Community Supports pricing guidance that outlines a high level per diem pricing approach, reflecting typical staffing ratios and service intensity. For more information, the suggested pricing guidance for the short-term post-hospitalization and recuperative care supports, please take a look at the pricing guidance document which we will drop in the chat.

With that, I'll hand it back over to Lucy to introduce our guest speakers for the day. Lucy.

Lucy Pagel:

Thank you so much, Tyler. We're going to start from hearing from Kamiah Thomas, who is the program manager of Connections Interim Housing at People Assisting The Homeless. I'll hand it over to you, Kamiah.

Kamiah Thomas:

Hi there. Thank you so much. I want to share a little bit about our program, what we offer, some of the things that we've learned while having these types of beds available in our shelter setting and then some of our best practices and takeaways.

You can go to the next slide, please. We have recuperative care and short-term post-hospitalization here at PATH. We're contracted with three different health plans for each program. One of the things that's important to us is to make sure that eligibility requirements are clear ahead of time. I'll go through what makes somebody eligible and won't make somebody ineligible.

For eligibility, the recuperative need obviously has to be there. They have to have medical needs, whether mental health or substance use, something that they're working on and need somewhere safe to do it and not be on the streets while that's happening. Another thing that's important for us is they have to be able to meet their ADLs, which is their activities of daily living. We are a shelter facility, it's a shelter setting and so we do not have nurse staff on site.

We do leverage healthcare support through other clinics and hospitals, but at our facility, we do not have nursing staff so we want to make sure that they're fairly independent. Additionally, they do have to be experiencing homelessness. They have to be in need of shelter and supportive services because while we're going to focus on the recuperative need, we also want to make sure we connect them to housing resources.

What makes somebody ineligible for our program? It's a pretty short list, but some of these things are non-negotiable. Again, an inability to meet activities of daily living would make somebody ineligible for our program. If they're listed on the sex offender registry, they're not eligible for our program. Our building that we are in has a very strict income limit, so everybody has to be at or under 30% AMI.

This year that's 27,000.50, but they have to be under that income limit. If they're over, we'll work with them on a transition or exit plan, but we want to make sure we check that before they come into the program.

Interim housing model and approaches. Kind of like Tyler reviewed already, housing-first is definitely a priority for us. While there's a strong recuperative need and there's need for medical support, we also want to make sure that we're focusing on housing and getting these folks into housing. That's a priority for us at all times.

Additionally, we are low barrier and we do our best when people are coming in to meet the requirements needed for documentation to be referred, but we want to make sure that we're not creating

barriers for folks to accessing housing, and so we collect the information that we need to at a minimum.

Additionally, we utilize harm reduction approaches, so nothing in our program is going to be mandatory or required. We want people to be here because they want to be here and are looking for support. We focus on minimizing harmful behaviors with folks, and we want to make sure that they're provided the support and the resources to do so.

Referral process. We have a couple of different tracks that we could go, but the general referral process is we have a referral packet that gets submitted to me directly. Once we review it, we want to make sure that they qualify on those eligibility points that I just covered. So income, that they're not listed on the registry and that they're able to meet their ADLs. Once that is approved and they do meet that, then we would submit to the health plan for approval, and once that's approved, then we would schedule an intake with the member.

Next slide, please. In doing this, we definitely have had some lessons learned, so wanted to share some of those with all of you. One of the things that's really important for us is that we realize that more than one recuperative stay may be needed and we recognize that it does not happen overnight where people wake up and suddenly feel like they're ready for housing or their medical needs have all been taken care of. It takes time.

It's very minimal, but we have seen some folks who may need additional time or may need another recuperative stay to get on track with housing and get on track with taking care of all their medical needs.

Another thing that we've learned is that achieving and maintaining stability definitely takes time. 90 days is not a lot of time, and so while they're in our program, it's a very intensive level of support that's provided, but we recognize and we want to be honest with folks that it does take time and that it's not going to happen necessarily within those first 90 days. Kind of like Tyler also mentioned, housing-first principles definitely still apply and should continue to apply.

I think a lot of our folks feel like they have to focus only on medical before they can be housed or are worried about housing or have experienced housing instability for such a long time. We want to make sure that we're reiterating that this is definitely a priority for us. Then the last thing is utilization of beds and community coordination go hand in hand.

I think for us personally, we've seen an underutilization of some of the beds that we have available and it's not because of a lack of need. I think it took a minute to get started and so in this process, we've started collaborating more, reaching out to other networks, reaching out internally, externally, letting folks know that we have these beds available and that we want to make sure they're utilized by the people who need it the most.

Next slide, please. Along with that, so best practices. Definitely, again, a lot of it was covered with Tyler, but I will add a few more things that weren't necessarily covered. One of the things that's really important to us is informed choice. We want every single participant in our program to have the ability to make a decision for themselves of what works for them, what's best for them.

We want to make sure we give them information ahead of time of what they can expect, what recuperative care looks like, what they're going to be working on while they're here, and then what support and services we're able to offer. We've had some people who decide that maybe this isn't the setting for them, or they're not interested right now. We want to make sure that they have the information ahead of time to make their own decisions.

Additionally, transparency is really important to us, so we don't have a lot of program expectations or requirements, but the ones that we do have, we want to make sure we're communicating that in advance. Additionally, this is a shelter, it's a shelter setting, and so it's not a medical or hospital facility. Some folks are more used to that or prefer that.

We want to make sure that we're clear on layout, what they can expect while they're in the program, what level of support they'll receive, and then any program guidelines or expectations that we do have so that they can make the decision again on what's best for them.

Collaboration and communication. Obviously communication is definitely key for us for successful

outcomes. We've found that it's very helpful when there's collaboration between the person who's referred and our PATH staff, between the health plan that they're working with and PATH staff, and then between the patient and healthcare providers as well. Making sure that we're closing the gaps and having collaborative conversations on planning for what's best for them is helpful for outcomes.

Then we're all on the same page and it helps the patient feel a little bit more supported. The next thing is exit planning. Exit planning for us, a best practice is we start almost immediately when they come into our program because 90 days goes by really quickly and a lot of folks have expressed feeling worried or scared about what's going to happen next. After these 90 days, do I discharge to the streets? Do I have somewhere to go?

We want to make sure we start the conversation sooner so that they feel prepared and that we can work on a housing plan with them. Additionally, for our program, it's a little bit unique in that we have a number of different programs housed within our interim shelter setting. At the end of the recuperative stay, if the person is eligible for any of our other programs and does not have a housing plan in place, we would work with them on potentially transitioning to another internal program so that they're not discharged to the streets.

Then the last best practice I think for us is defining success. We've learned that success looks very different for every single person who comes into our program. For some of them, it's focusing on physical health, for some of them, it's their mental health, for some it might be limiting substance use or stopping completely, whether it's recovering from surgery.

It's different for everybody and so as we're looking at measurable and successful outcomes, we want to make sure that we are factoring in the individual's goals and how we were able to provide support to them while they were in our program. At the end of the day, our goal is just to make sure we're supporting everybody with their specific goals.

Next slide, please. All right. Then outcomes and goals. In general, I know we did a lot of statistics earlier, so I will not share more of them, but we do make sure we're tracking our outcomes and that we are working with folks on meeting their goals. Our primary goals are to connect patients to primary care providers and make sure we're following up on their discharge plans, connecting them to community resources and ongoing support that continues once they exit from our program.

Whether that's to another program internally with PATH, to long-term housing, to permanent housing, we want to make sure that we're connecting them to the support that they'll need in order to achieve and maintain stability. Additionally, we connect patients to CES, which is our internal or external it's for the community to help refer patients to long-term or permanent support housing, some type of housing intervention.

We'll work with them, get them into the Coordinated Entry System and make sure they have an opportunity to get long-term housing. We provide support needed to make sure that they complete their 60 to 90 days' stay in recuperative care. We know 90 days is the maximum. We've had some folks move out early because they are matched to housing. We've had some folks who need to transition because maybe they're connected to housing, but not ready to move within the 90 days and they just need a little bit more time.

We make sure that we're working with them on a housing plan to know what's best for them. Then at the end of the day, our primary goal is to make sure that we're minimizing the number of emergency room stays that they have, the number of hospital visits that they have. So by connecting with Community Supports and working with hospitals or clinics or nursing staff that we leverage for support, we make sure that they're minimizing the number of emergency room visits.

Next slide, please. That is it. Questions and contact information are listed. Lucy, I'm not sure if it's just me, but I can't hear you.

Lucy Pagel:

All right. Can you hear me now?



Kamiah Thomas:

Yes.

Lucy Pagel:

All right. I'm so sorry about that, everyone. Thank you so much for your presentation, Kamiah. I think we'll save Q&A until the end, but appreciate you sharing your experience with being a short-term post-hospitalization and recuperative care provider with our audience today. With that being said, we're now going to hear from Christie Gonzales who's the chief programs officer at WellSpace Health. I'll hand it over to you, Christie.

Christie Gonzales:

Good afternoon. Christie Gonzalez with WellSpace Health. Next slide. WellSpace Health is a federally qualified health system here in the Sacramento area, and so coming from a perspective of running recuperative care from a more health-centric organization today.

Next slide. Our mission is of course, that we're achieving regional health through high quality comprehensive care and we really feel that these Community Supports and recuperative care services are adding to that mission of comprehensive care. Thinking about going outside those four walls of a traditional community health center.

Next. Next. In our health center, we have 125,000 patients that are assigned to us, but we are contracting with our managed care plans to not just see the patients that are assigned to us as a healthcare system. We are working with our managed care plans to do Community Supports that really do support the patients of the entire community and in the greater Sacramento area, that's quite a few folks who are experiencing homelessness or at risk of homelessness, who benefit from this recuperative care service.

Next. We are in the greater Sacramento area. We are contracted with managed care plans in three different counties. In Placer County, Amador County and Sacramento County. While the recuperative care services and post-hospitalization services that I'm going to describe today are located in one facility in Sacramento, because we're working with the managed care plans from the different counties, we're able to ensure that we're using a regional approach to making sure that patients have access to these services.

Next. Next. Now, we'll go ahead and skip this. Next. One of the things that as a health center, we're very proud of our different quality metrics that we hold ourselves to. When it comes to recuperative care, we work really closely with Julia and her team at the National Institute for Medical Respite Care. They have really great guidance around national standards for medical respite care and we really try to make sure that we're aligning to those standards as well too.

Aligning to DHCS' standards for what's required with CalAIM, aligning to the National Institute for Medical Respite Care, really making sure that the services that we're offering are evidence-based and that those outcomes are being measured.

Next. All right. Going to be talking about our center, where we are hosting our recuperative care services in Sacramento. We call it our Gregory Bunker Care Transitions Center. We started offering a medical respite service back in 2006, so we have been providing this service for a while now. We were really excited when we knew that CalAIM was coming. We were really excited when we saw that recuperative care was going to be coming as one of those Community Supports.

Running a program for that many years, where we've already seen the benefits of a medical respite care program and of a recuperative care program, really let us know what to expect as far as volume in our community. When we started in 2006, we started with 18 beds, and at the beginning of CalAIM and on January 1st of this year, we had 59 beds. In 2006 to 2022, growing from 18 to 59 beds, and knowing that there was still room for more.

Luckily, we had been working with our hospital partners and with our county for a really long time on medical respite care in those interim years before CalAIM. Because of that, we were able to express

what some of our challenges were being co-located at a shelter. Until 2022, we were co-located with shelters where it was our medical staff and our case management staff who would go into the shelter and provide specifically that medical respite oversight with nursing and case management.

Our shelter partners were the ones who were helping us with the housing, keeping the roof over their heads, with the laundry, with the food services. We were able to open a new building in 2022, and you'll see a couple of photos of that today too.

Next. Here are some of those photos of that building that I mentioned that we had started to open in 2022. It took us about four years to finalize construction. So we have been really anticipating CalAIM and recuperative care coming into our community for a long time now.

Next. Next. We opened up our Gregory Bunker Care Transitions Center in April of 2022, and we were able to move our existing 59 beds that we had co-located shelters into the new center. There's the address there of where it's located. We're happy to have you out for a tour if you're ever interesting.

Next. Our grand opening, some photos here from our grand opening. We named it the Gregory Bunker Care Transitions Center after a gentleman in our community who has passed away. He dedicated his life to serving those who are experiencing homelessness. These are some of his family members who were able to be there for our grand opening.

We really just wanted to tie in the legacy of recuperative care in our community and name it after him in his honor. Because of course his name is Gregory Bunker, we affectionately call our recuperative care center, The Bunker, in honor of him.

Next. These are some photos of our facilities here. We have different beds that you'll see as I go through my slides. We have some single-level beds and we do have some hospital beds. One of the things that we found about medical respite care is that a good number of those folks that you're going to be welcoming in to recuperative care, do need a hospital bed. They're going to need to be able to sit up and be elevated. They're going to need different elevations that they can get in and out of easily.

I would recommend investing in some hospital beds if you're looking at opening a recuperative care center. However, not all patients need a hospital bed. Some folks are able to get away with more traditional wire frame single bed so it's good to have a variety of different types of beds that you offer, including bariatric beds, if needed as well too.

Next. We also wanted to make sure that the center felt really warm and welcoming, so one of the really beautiful things about being able to move into our own center is that we were able to create an environment that was a little bit more homelike. Even though it is congregate living still, we wanted it to really feel like this was their home for the next 10 days, 20 days, 30, 60, 90 days. We have a variety of day rooms. We have a variety of areas for recreation, indoors and outdoors.

We also have a business center that you can see here. This is really helpful when our Enhanced Care Management staff are working with those patients who are staying in our recuperative care, making sure that they're applying for benefits, helping to coordinate their care, helping to communicate on patient portals with their specialists, whatever it may be. Knowing that they have access to those computers is a really important part of that care coordination that we try to do as part of ECM and recuperative care.

Next. By being co-located with shelters, WellSpace Health, the operators of the medical respite care, didn't used to have to worry about things like laundry services or food services, and now that we have our own center, that is now something that we operate. You can see here our dining room. We're having a little bit of a learning curve as we learn what it is like to provide hot meals for our patients three times a day, really to make sure that our patients have access to healthy fruits and snacks throughout the day.

We all know that persons experiencing homelessness deal with a lot of food insecurity, so we wanted to make sure that when they were staying with us at that recuperative care center, that there was a feeling of being welcome to have those snacks when needed and when wanted.

If you are thinking of opening a recuperative care center in your own areas, I would really encourage you to look at what does co-location look like with your local shelters? What does co-location

not look like? Then what are those services then that your own organization may have to take on to provide, to ensure that they have that full range of dignified services while they're staying.

Next. With CalAIM coming, we had used to call our recuperative program, our interim care program. That was the name that it was locally known by. With CalAIM coming into the lexicon, we started referring to it more as recuperative care, really wanting to align the community's expectations with what we know was coming down from DHCS. We also know that we had been working with hospitals now for well over 15 years on what a referral system looked like into those services.

We were really lucky to be able to communicate really clearly with our local hospital systems and really clearly with our managed care plans and talk about, we didn't want that authorization for services to delay services to that patient. We know how important it is to get that patient out of that hospital bed and into recuperative care.

Here in the Sacramento area, we were able to work out a system again, after a lot of clear communication with the hospitals and the managed care plans, where there would actually be no change to that referral process from the hospitals where it was going to be WellSpace Health as the operators of the recuperative care, who would seek authorization from the health plan so as to streamline that discharge process from the hospitals.

Next. At WellSpace Health, we have a really strong nursing component as part of our recuperative care services. While every patient requires a different level of need, some of our patients are able to fully ambulate, are able to fully shower and clean themselves and dress their wounds.

We know it's really important to have that nursing oversight and that nursing education as part of medical respite and so we do employ registered nurses, licensed vocational nurses, as well as certified nursing assistants in case there is a patient who maybe does need a little bit of help ambulating, a little bit of help feeding themselves.

We really want to make sure that that assistance is available to them. Even though of course, the requirements to go into recuperative care are different than those who need to go into a SNF facility, we want to make sure that we have a nursing oversight and a staffing dynamic, where we can make sure that someone has a successful stay, even if they just need that little bit of extra help.

Next. We are able to expand our hours of intake and the days of admission by opening up our own center. And so if you are thinking of being co-located with another center, or you're currently a shelter system that is thinking of operating a recuperative care, really be thinking about the hours you are accepting referrals, really think about the hours you're accepting admissions.

We know that our hospitals are constantly looking for discharges. It doesn't only happen Monday morning at 8:00 AM, so where our weekend hours or extended evening hours, where there might be able to jump in and say, "Yes, I can still meet that need of that day."

Next. With the movement towards post-hospitalization, we know that there are going to be some patients who are able to move into a bunk. You saw earlier the hospital bed and the single-level bed. This is a photo of some of our bunk beds that we have in the facility as well too.

Thinking about how many folks you can fit into your footprint, thinking about those who are a little more medically frail, and may not, of course, be able to get up onto a bunk, but perhaps there is a population that can, and where we're finding a lot of that population is in our post-hospitalization population.

Next. As I mentioned, really working closely with our Enhanced Care Management services, we utilize this center as a major hub for these services. Housed in that one center is our recuperative care and our post-hospitalization, but we have our ECM case managers in and out of that center all the time.

And because we control the whole center, we're able again, to have extended hours into the evening and hours into the weekend, so that there are times when our ECM case managers are there off of a more traditional banking hours' time but sometimes it's easier to catch that patient's attention and have a conversation with them over dinner than it may be to have a conversation say on a Tuesday morning at 9:00 AM.

We also have some onsite primary care services. Again, as WellSpace Health is a primary care provider, making sure that they're connected with their primary care provider, whether it be WellSpace Health or someone else, making sure that health home orders are being coordinated, oxygen orders, durable medical equipment orders. We know that when they are in recuperative care, sometimes we find those things out as we're interacting with that patient, and so that onsite primary care is really helpful and beneficial to streamlining access to services for those patients.

Next. Phase two, near future. I mentioned we moved our current 59 beds into our new facility. We are going to be able to add more beds to our facility. What we're going to be able to do is we're going to be able to take advantage of that expanded population that folks were talking about earlier. From 2006 to 2022, it had purely been a post-hospitalization for persons experiencing homelessness.

As you heard, the new CalAIM guidance has given a little bit more variation to that. Is it someone who might need services to stay out of the hospital? Maybe now there's a pre-admission area where we can accept a patient in to recuperative care services. Or is it a patient who maybe isn't necessarily experiencing homelessness, but is not safe at their own home in managing that condition and would be better served in recuperative care?

This new phase two expansion of our building and of the CalAIM allowances for who is eligible for recuperative care, we anticipate that in our greater Sacramento area, we're going to be able to adapt and enhance the kinds of services that we can offer at recuperative care to now take advantage of these folks who are at risk of hospitalization, whereas before we wouldn't have been able to have that ability to welcome them into the door.

We're also really working deeper with our coordination, with physical therapy, occupational therapy, some of those more specialty services that our patients may be involved with, where previously being co-located with a shelter we were a little prohibited in who we could welcome in to work with the patient. Now that we have our own center, we're able to expand those restrictions. We're able to welcome more folks onto site to work with those patients.

Again, I encourage you that if you're going to be operating a recuperative care out of your own center, where you have full operational control, really think about how we can open up more services for the patients on site, instead of being more restrictive and instead of putting those hurdles in place.

Next. We are always looking for feedback from our partners, and we're always looking at expansion of intake and referral criteria. One of the things that WellSpace Health really believes in when it comes to recuperative care is a try to get to yes model. So we're working with our managed care plans, with our hospital partners to say, "Tell me more about the patient. I recognize they may have a behavioral health component, but I'm still going to need them to be able to be successful in a dorm-like setting. Let's have a conversation about what his or her distress tolerance has been able to be."

I really encourage you to be communicative with your referral partners, to make sure that we're trying to get to a successful place. We want this to be a successful placement and so how can we remove those barriers? How can we remove those hurdles? I also encourage you to really work with your counties, work with your cities, work with your local continuum of care entities, because all of these areas are going to be additional referral sources, if possible.

Work with your local community health centers, work with your local doctors who take Medi-Cal. They're out there. They know who these patients are and the more that you can help communicate what your admission criteria is and what you're willing to work with them on to meet them somewhere in the middle, the more successful that stay is going to be for that patient.

Next slide. That has been my time. Again, I'm Christie Gonzales with WellSpace Health, and very happy to always answer any questions you may have by reaching out by email or phone at any time.

Lucy Pagel:

Thank you so much, Christie. We do have one question for you that I think is specific to you, so we can answer now, but I am not seeing where it went actually. One second. Oh, okay. I see that it was answered

by Holly. Beautiful facility. I'm curious to know what was done to make it all come together and where the funding came from. It looks like Holly answered that you work with regional hospital systems and counties to build the system and that they are big supporters. Thank you for answering that, Holly.

All right. We are going to move on to our final speaker. Now we're going to hear from Dennis Hsieh who is the chief medical officer at Contra Costa Health Plan and Services. I'll hand it off to you, Dennis.

Dennis Hsieh:

Great. Thank you so much, Lucy. Could I get the next slide please? A little bit of background on Contra Costa Health Plan. We're a county-owned and operated health plan. I'm a county employee. We serve a majority of Medi-Cal managed care patients and a small line of commercial or county employee and IHSS workers.

Slide, please. Before I jump into the slide, I think I just wanted to talk a little bit about our approach to Community Supports. I think this comes from my background as a clinician. I'm an ER doc by training. I still practice. I work both in the Bay Area as well as I continue to work in LA. I came to Contra Costa County for the purpose of CalAIM Enhanced Care Management and Community Supports to help play a role in this.

I think our approach has been that countywide also part of the reason I joined the county was we do have a firm belief that the social determinants of health play an important role in health and there's been long partnerships in place between county agencies and CBOs, including Contra Costa County's Health, Housing & Homeless, and the public health agency that have allowed us to really, I think, leverage the Community Supports and really try to set a systems approach to making this work.

As a health plan, we obviously believe in a robust network and working with both of our county and community-based agencies, and we operate it like any other benefit. We understand this is not technically a benefit, but we also understand that DHCS intends to make this a benefit within a few years, if all the cards align. We see no reason to make life more difficult for providers or anybody else, given we already have a system in place for authorizations and things along those lines.

We really, from an implementation standpoint, try to keep that in mind of not trying to add one other system everybody needs to learn, but really let's use what we have in place and make this easiest so that the most people can get access to the service. I think one key element there is our philosophy has always been, we allow for retro referrals and authorizations. I saw a question in the chat earlier about, well, timeliness of authorizations.

I know working as an ED doc having spent plenty of time on the inpatient wards in residency, that when you want to get someone out, you want to get them out now. You don't want to wait two days for a health plan authorization or a bed for that matter. So we really do encourage with our providers that if they feel like someone meets, they can always accept them, submit the retro and generally our criteria are aligned with their criteria.

So if they do meet that retro criteria, we will approve it and they don't need to hold up to wait for prior authorization before accepting the member. I think our goal is really trying to make the process operationally smooth, understanding that [inaudible 00:53:19] that come in place from the provider side, both on the hospital and ED side or SNF side, as well as the respite or the shelter.

Slide, please. In terms of workflows and processes, like I said, alluded to earlier, we're really trying to keep patient and provider-centered and working within existing processes to make life easier. We've really emphasized the no wrong door approach in terms of anyone can request a service. Doesn't have to be a licensed professional as with an EMT. We know there's strict guidance on that.

But really open to anybody calling in and using a system that we already have in place. For certain providers, our Epic system directly links in. For others, there's the Epic Provider Portal, our cclink Provider Portal, and then also for members and friends and family to be able to [inaudible 00:54:23]. Really trying to have a very clear, very standard way of doing business and building on top of that for all of our Community Supports, not just these two so that again, we're really allowing people to just think like

anything else and not have to learn something new.

Then we've taken the approach that we review these like any other prior auth request and utilization management, not using a special separate team, separate group of people to do this, and like I said, retrospective reviews is also okay. I think for this, I'd really want to emphasize this. I think a lot of people think Community Supports they think a whole new process, a whole new thing.

For us, it's really saying, "Okay. Look, yes, this is super special on one side. This is something that has never been traditionally covered and we all believe this is super important. But on the other side, I'm sorry, it's not that special. We don't need to have a special process, a special login, a special password that everyone's going to forget. Just continue on as you normally do business and instead of referring to a cardiologist, you're now referring to respite or you're referring to post-hospital stabilization."

In my opinion, being special in terms of processes is usually bad. Really want to emphasize that approach because I think when there's been non-standard processes put in place, that's really been a pain point, especially for providers who rail against using any new system, especially when it's only for one community support or two Community Supports. Just basically not adding complexity to the system.

Slide, please. In terms of successes, I think for us, because of how integrated we were with the county and with our providers, we've been able to build upon our already existing relationship and partners with different providers and to message like, this is going to be the same workflow. This is going to be a new thing within the same workflow, troubleshoot things with them, and really have people focus on remembering to refer for our service as opposed to remembering a new login in order to refer for a new service.

Then in terms of having regular check-ins with all of our providers, that's one thing we've really been focused on because I think there's many people in any new program that have a fear of being overwhelmed. I'm a former legal services attorney. I've seen every medical-legal partnership that's been started. The big concern is I'm going to be overwhelmed with referrals. There's so much need. Then they open up and the first day, basically they get no referrals. The second week they might get one referral and everyone's confused.

I think people forget that even if there's a huge need clinically, and even if everybody agrees, this is a good idea, clinicians and providers are so busy that anything new, there's a huge barrier to entry, even if it's much needed in terms of that culture change, that thought process change. Just remembering to refer for something, even if it's really needed, that there's a huge barrier that needs to be overcome there.

I think for us really keeping those lines of communication open, both with our providers in terms of medical providers, hospitals, SNFs, as well as with our community support providers and making sure everybody is lockstep, checking in, troubleshooting any problems that come up regularly and making sure that those lines of communication are open so that people are not discouraged after one challenge.

As we know, with any new process, there's often challenges, and really making sure that the end result is the patient gets the service so that people will continue to refer has been one of our true focuses or foci. Then our last big thing in terms of success, we started small and agreed to scale.

I think in part, because of that fear of being overwhelmed by referrals, which hasn't happened, but also just to make sure those meetings are manageable, that we're talking, we're really troubleshooting and making sure things work, even though we're taking advantage of existing processes as new partners, trying to make sure those relationships are built and that they can directly troubleshoot as needed.

Slide, please. In terms of implementation considerations, I think I didn't want to call this slide necessarily opportunities for improvement, because I think these are things that are real-world limitations that we have to think of and take into account with any new program, but especially around these programs.

Yes, theoretically, they are opportunities for improvement, some of them, or all of them potentially, but a lot of them are potentially areas that are structural and not necessarily in my opinion, something realistic that is as simple as changing your workflow. It's about building more capacity and infrastructure, which yes, in a technical sense is an opportunity for improvement, but realistically is probably something

you have to live with and work through and take into consideration when you are starting or continuing one of these programs.

I think one of the big things is limited capacity. Our respite system of care has limited capacity. Our shelter system of care that we're using for post-hospital stabilization has limited capacity. When we said, "Okay. Well, we're not necessarily in the position to build new shelters or new respite as much as we want, how about we look locally?" We looked to San Francisco, we looked to Alameda, we looked to Sacramento. The only place that had capacity was our previous provider, WellSpace.

They agreed to work with us to take overflow from Contra Costa if needed, which we very much appreciate. But Alameda and San Francisco, the providers there, we may have reached out to the wrong people, but overall, we didn't even get a call back because it sounded like there wasn't capacity, there was so much demand locally there wasn't extra beds lying around saying, "yes, we can take overflow from the county." I think with the Community Supports, especially like with food, it's much easier.

I think with the Community Supports around housing, especially infrastructure, which is respite and post-hospitalization, those are true challenges. I know for the other Community Supports we're not talking about, right? I can navigate people all I want. I can approve people for navigation, but if there's no housing to navigate them to that's a challenge. I think the physical infrastructure is something that you must take into consideration and do your best to address, but there are realistic limits.

I saw another question earlier, how do we prevent the health plans from slowing down the process? My experience has been, it's not so much the health plans not authorizing things in the timely manners that we would like to authorize, but the facilities can't find an open bed to get people into. Then I think it's hard to predict the overall need and volume is part of the challenge.

I think what we realized after doing some modeling and then with some experience is the fourth bullet point, is that are hospital's necessarily the right setting to be focused on? I think initially we very much focused on hospitals, but as we've rolled this program out, we realize that a lot of patients are first more SNF-appropriate, but really that discharge from a skilled nursing facility is where the post-hospitalization and respite are really useful, because we see a lot of SNFs locally, and I think this is true across the state, having some hesitancy taking an individual who is experiencing homelessness, because they're worried about what do they do once that patient becomes not acute and they become a discharge challenge?

I think for us, we've really brought SNFs into the conversation to say, "Look, we will guarantee placement in a respite or a post-hospital stabilization setting if clinically appropriate after the SNF stay." So the SNFs can then open up their capacity and be willing to take the patients out of the hospital. Because from my perspective, not only is this doing the right thing for the patient, but it's also about opening up the capacity at the right level of care.

I think one of the big things is once again there's been slow uptake, to my previous point, not because I don't think this is not needed, but I think once again, because it's a new thing. There's a culture change that has to happen. I think with that, I'd like to give an example. This comes from my work as a medical-legal partnership attorney. I was working at a clinic in South LA advertising my services of helping with housing, with eviction defense, with benefits appeals.

This was a few months in. I was sitting in the provider room and I heard one doctor say to another doctor, "I'm so frustrated. I have a patient who's getting evicted. It seems like their landlord is really causing them a problem. I wish I could have someone to help me with that problem." I had just done a presentation the last week and I was actually sitting literally right in front of them in their room and I think the providers... I mean, I think that's the cultural barrier.

It's not really an opportunity for improvement, but it's an implementation consideration I think that we need to address. Like whether it's the social workers, whether it's the doctors, whether it's the nurses. Just thinking to use this is going to take time and ongoing communication, discussions, presentations are all good, but at the end of the day, it's still going to take time for people to take advantage of this.

A lot of these services, I think in some senses have been in place for years. Respite is not new,

shelter system of care is not new. People do already somewhat know how to use them, thinking to refer, thinking to refer to help get prioritization or other funding is an extra step that people may not think to use. Then I think in terms of I think the last challenge or place is that the shelters and respite already getting these individuals, they don't necessarily think to do retro referrals to bring in more funding.

They already have some funding. I think there is cultural change all around. There's some administrative wraparound to this that is required. I think those are some considerations from my perspective in terms of implementing.

Slide, please. I think in terms of next steps for us, what we're thinking about given our experience so far eight months in, I think really thinking about how to... We're changing our respite referral within our system to really try to capture our members and make sure that that administrative piece is minimized and thinking about overall limits and capacity and how do we prioritize and get people into care if they are identified as a health plan member?

We're really going forward to educate SNFs about they can use this community support. We also developed with our hospitals a guarantee letter they can give for one of our members to the SNF saying, "If you take this individual experiencing homelessness, we will guarantee placement afterwards." We're doing ongoing education reminders with our hospitals, our emergency departments. We're expanding to additional hospitals in the county [inaudible 01:07:20] that we started with.

I think, yes, we're a small county relatively to many other counties, but I think we're also relatively understaffed compared to some other counties. The fact that I'm doing this presentation as opposed to a director of Community Supports or director of housing, neither of which we have at the health plan, I think gives some insight into that. I think size, yes, it's easier to do some things in a smaller county, but I don't think necessarily given.

I think we're staffed in a way that we may be understaffed compared to some of the larger counties. I think it is doable, but I think it's about the relationships. It's about a personal touch. It's about really working with your partners to make sure that there's true buy-in, true use, because you could set up the perfect system and then be shocked in some senses that nobody uses it, but you really shouldn't be.

Slide, please. I think in terms of the question around metrics, I know this came up from Michelle, I think. From our perspective, we're looking at a few different metrics. We're looking at process metrics on implementation, really thinking about how our daily operations are going, number of referrals, how timely are people getting in, are people able to get in?

Then there's obviously outcome metrics, which I think the previous presenters at the beginning of the session have discussed, I don't need to belabor, in terms of all the benefits of community support such as these two.

Slide, please. I think in summary my perspective from the plan, and I think as a provider, as much as a plan, I think best practices and lessons, it is a work in progress, but communication is key, with the hospital, with the EDs, with the SNFs, with the plan, with our community support providers. It's really about not adding complexity to the system.

It's about replicating existing workflows and really not adding barriers to a already challenging environment, the healthcare environment in which to implement. About repeat touches, repeat looping back, regular communication, not just talking once in the beginning, once a year. It's about really repeated touches, troubleshooting in real time. It's about partnering with the SNFs, which I think is a point that I thought was underemphasized for both of these benefits.

It's about thinking long term about capacity. We know we would love more of these spaces. Congratulations to WellSpace for the good work and the funding that they did, but that needs to be replicated a hundred times across the state and especially in terms of the other half of this. Even if we can navigate people out of hospitals, out of SNFs to post-hospital, to respite, we still do need more housing capacity to navigate people out of respite, out of shelters, into permanent housing of some sort.

I know that's not a conversation for today, but I think it is something that we do need to think about and work on together. With that, thank you. There's my contact information. Happy to chat at any point, if



we can be helpful.

Lucy Pagel:

Thank you so much, Dennis, and thank you for answering questions as they've come up in the Q&A box. We will have some time for Q&A in just a bit. I just wanted to review that DHCS has provided the non-binding pricing guidance for all Community Supports, including those that we're talking about today. That can be found in the Non-Binding ILOS Pricing Guidance resource.

Ultimately though, despite this guidance, managed care plans and service providers negotiate the final rates. Again, this is just guidance that DHCS has put out. If you are interested in becoming a Community Supports provider, it's best to reach out to your local health plans to determine what the application process is. It is going to depend from health plan to health plan.

Patients can be referred to Community Supports through many different sources. Please reach out to the client's managed care plan to determine the preferred referral process. Again, it's going to differ from plan to plan. Eligibility for Community Supports are outlined in the DHCS Community Supports policy guidance. Billing rates, how to become a provider, who can refer patients and eligibility are the most frequent questions we have.

So DHCS has prepared guidance on all of that that is available. I think now we're going to jump into the Q&A portion of our time today. Let me see. Let me look in the box and see what we have here. Okay. One question we keep getting is, what happens if a member needs more than 90 days in medical respite? I'm going to pass that off to DHCS.

Tyler Brennan:

Sure. That's a great question. I'll take this one. This is Tyler again. Let's go back to the limitation slide for recuperative care actually real quick if we could. All right. As you can see here, there is a 90-day limit on continuous duration for the recuperative care medical respite support. However, many individuals exiting medical respite may be eligible for enrollment in the short-term post-hospitalization housing support to continue receiving care.

As we covered in the guidance on the support, the short-term post-hospitalization housing support is really a site for patients to continue medical, psychiatric, or substance use disorder recovery, so these sites can be a good option to continue recovery for many patients. There may also be other services available through different local programs.

Lucy Pagel:

Great. Somewhat related question that we've gotten a few times now is about short-term post-hospitalization housing lifetime limit. What happens if a member needs that service more than one time in their lifetime? How should providers and plans prioritize and manage the utilization of that community support and lifetime limit?

Michelle "Shel" Wong:

Yeah. Lucy, I can take this question. It is a great question and currently this is a once-in-a-lifetime service. However, managed care plans and providers are encouraged to explore other coverage options in instances where the member has already used this community support.

Lucy Pagel:

Great. Thanks, Shel. Let's see. Along the same lines, if a member's stay at a short-term post-hospitalization facility is interrupted due to a change in their condition that results in readmission, does that affect their ability to return to the short-term facility?

Michelle "Shel" Wong:

Yeah. I can take that one also. We've gotten some questions about this in the past and for situations where a member's stay in a short-term post-hospitalization setting is unexpectedly cut short or interrupted and the MCP does make the determination that this alternative setting would continue to be both medically-appropriate for the member and cost-effective for the plan, the continuation of the service may be offered to the member so long as the overall duration does not exceed six months.

Lucy Pagel:

Thanks, Shel. All right. We have a question about authorizations. Is there standard policy in place to ensure that authorizations happen quickly since placement in recuperative care in short-term post-hospitalization housing can be time-sensitive for members' health needs? Can you offer any guidance about timelines for authorizations?

Tyler Brennan:

Sure. Shel, I'll take this one. DHCS recently updated our policy on this topic. For certain Community Supports that require a rapid turnaround, managed care plans are required to establish policy and procedures to provide expedited authorization determinations in 72 hours from the receipt of that request. This policy applies to recuperative care and short-term post-hospitalization housing as well as to sobering centers and medically-tailored meals that are offered after acute care.

The requirement is effective now and managed care plans are currently working on updating their policies to meet this requirement.

Lucy Pagel:

All right. I think it'd be helpful just to hear a little bit more about what it means to expedite the authorization, just given some questions that we're seeing.

Tyler Brennan:

Sure. Since some of the Community Supports are designed to meet urgent member needs, some supports should be authorized on an expedited basis. To meet this goal, managed care plans... or DHCS is requiring managed care plans to have policies and procedures in place to expedite this authorization process of the four Community Supports that we mentioned for urgent needs.

For example, if a hospital identifies a member who would be a good fit for medical respite post-discharge, the health plan will need to turn around their authorizations faster than usual within 72 hours, as opposed to the standard authorization turnaround times.

Lucy Pagel:

All right. Let's see. There's a broader question about referring patients for these supports. Does somebody have to be a Community Supports provider to refer a client to any of the Community Supports? If not, and they have a client who might be eligible for recuperative care or short-term post-hospitalization stay, who would they reach out to to make that referral? I think Shel, I think you should-

Michelle "Shel" Wong:

Yeah. I can take this one. For referring members to community support, so the referral process is... Oh my gosh, I'm totally blanking out right now. Basically the referral process it's no wrong door policy. Members can refer themselves and any provider can submit a referral for any community support. So contacting the managed care plan would be the best way to submit a referral and that's either for a member calling the member services or for any provider, regardless if they're there are Community Supports provider or not, submitting a referral through the plan.

Lucy Pagel:

The referral always goes through the health plan?

Michelle "Shel" Wong:

It can. I believe in other situations, as mentioned I believe earlier, that the referral can go directly to the provider and the provider can submit the authorizations of the plan.

Lucy Pagel:

Great. Thank you, Shel. All right. Switching gears about provider contracting. For organizations that already offer respite services or post-hospitalization housing, but who aren't currently contracted with any of the MCPs as a CS provider, Community Supports provider, how can they join the Community Supports program as a provider?

Michelle "Shel" Wong:

Yeah. I can take this one again. Anyone who is interested in becoming a Community Supports provider should reach out to their local managed care plans to determine the provider application process. You can also review the managed care plan final election segment, which is publicly available on our website to see which plans in the county offer the Community Supports that you would like to provide.

I believe earlier, Lucy, you also mentioned all of the different referral... Or not referral pathways, but the different resources that providers can also look at if they're interested in becoming a provider.

Lucy Pagel:

Great, thank you. For providers interested in providing Community Supports that don't have a state level enrollment pathway, what are the requirements for managed care plans that potential providers would have to meet?

Tyler Brennan:

Sure. Shel, I'll jump in on this one. That's a great question. In situations where there is not a state-level enrollment pathway, which can be the case for many community support providers being these are pretty novel services in Medi-Cal, the providers still have to be vetted by the managed care plan. We can also drop a link in the chat to the ECM and Community Supports FAQ document, which goes into more detail on this. Essentially, yeah, there is a process for vetting if there is no state-level enrollment pathway for the provider.

Lucy Pagel:

All right. Thank you, Tyler. Okay. I think we touched on this a little bit, but just to clarify, are reimbursement rates for Community Supports set by DHCS?

Michelle "Shel" Wong:

Yeah. Tyler, I could take this one. The reimbursement rates are not set by DHCS, but DHCS has provided the non-binding pricing guidance for all Community Supports and it's really up to the MCPs and the providers to negotiate their final rates. Maybe someone from the team can drop the link into the chat and it has also supplemental information on the non-binding guidance.

Lucy Pagel:

Great. Thank you. Regarding eligibility, can you clarify how DHCS defines at risk for hospitalization?

Michelle "Shel" Wong:

Yeah. Can we please go back to the eligibility slide for recuperative care? All right. This bit of eligibility criteria is part of the policy guidance that we covered earlier in the overview on recuperative care.

However, it is our expectation that MCPs should use their own definitions and analytics to determine if a member meets this specific criteria.

Once again, individuals who are at risk of hospitalization, post-hospitalization, who live alone with no formal supports, face housing insecurity, or have housing that would jeopardize their health and safety without modification, individuals who meet the HUD definition of homeless or at risk of homelessness, and who are receiving ECM or who have one or more serious chronic conditions and/or serious mental illness, or is at risk of institutionalization as a result of substance use disorder.

Lucy Pagel:

Great. Thank you so much, Shel. I'm seeing that as the majority of the questions we received multiple times from folks on the line. There are a few specific questions that I don't think we'll be able to provide answers to today, but I want to provide a few moments now to get any last questions in before we move on to finish out our presentation today. I know our speakers have been great about answering some of these questions in text live today, so hopefully you all are seeing those answers as well.

Was there a link that was to be shared, RE: pathways to community providers? Let's see. All the links I believe have been shared. There's materials on the DHCS website that are helpful to understand what you need to do to become a provider and it really is talking to your health plan. I don't know if DHCS has any other comments on that.

Michelle "Shel" Wong:

Yeah. I'd say the FAQ, which was dropped into the chat as well as the Community Supports explainer would be two good resources to start with also.

Lucy Pagel:

Great. Thank you, Shel. All right. Looks like the questions have slowed down so let's go ahead and move onto the next slide. All right. Thank you all for joining today. I do want to emphasize that the slides will be available on the DHCS website following the webinar. This is a series, so our next Community Supports webinar is going to be on September 15th at 12:00 PM. This is Pacific Time. We'll be talking about housing navigation, tenancy supports, and deposits. The whole suite of housing Community Supports. We hope you all will join us then.

That will be it for today. Have a wonderful rest of your week and thank you to all of our speakers and the DHCS team for taking time today. All right. Thank you.

Tyler Brennan:

Thank you.