CalAIM Community Supports Spotlight:

Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services

September 15th, 2022

Agenda

- Welcome and Introductions
- Review of Nursing Facility Transition/Diversion to Assisted Living Facilities
- Review of Community Transition Services/Nursing Facility Transition to a Home
- Promising Practices
- Q&A

ECM and Community Supports Data Guidance Survey

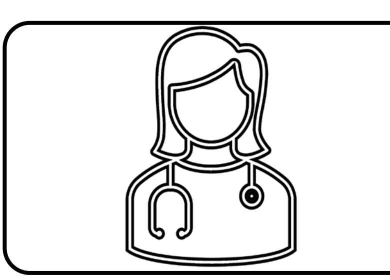
DHCS is requesting that all MCPs and launched ECM and Community Supports Providers complete this survey on ECM and Community Supports data transactions, and where persistent data exchange barriers may benefit from expanded or refined data guidance. DUE OCTOBER 7th

- Before the launch of ECM and Community Supports, **DHCS developed guidance to standardize information exchange, increase efficiency and reduce administrative burden between the state, MCPs and ECM and Community Supports Providers** (e.g., ECM Member Information File, ECM/Community Supports Billing and Invoicing Guidance, NPI application instructions).
- The survey is an opportunity for stakeholders to **provide feedback on early implementation and crucial input for DHCS** to ensure the long-term adoption and success of the ECM benefit and Community Supports.

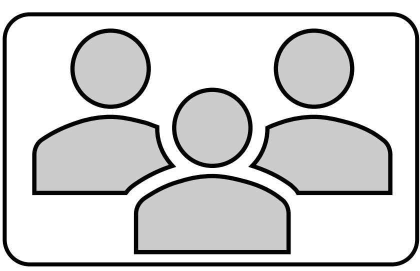
ECM and Community Supports Data Guidance Survey
The survey must be completed by all MCPs and their contracted ECM and Community Supports providers by OCTOBER 7th.

Please reach out to the CalAIM ECM and Community Supports Mailbox with any questions.
More information can be found at www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices.

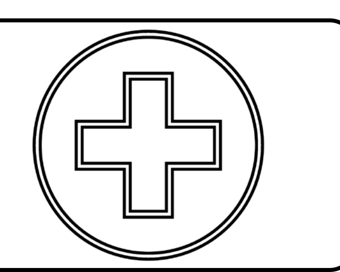
CalAIM and Community Supports



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.

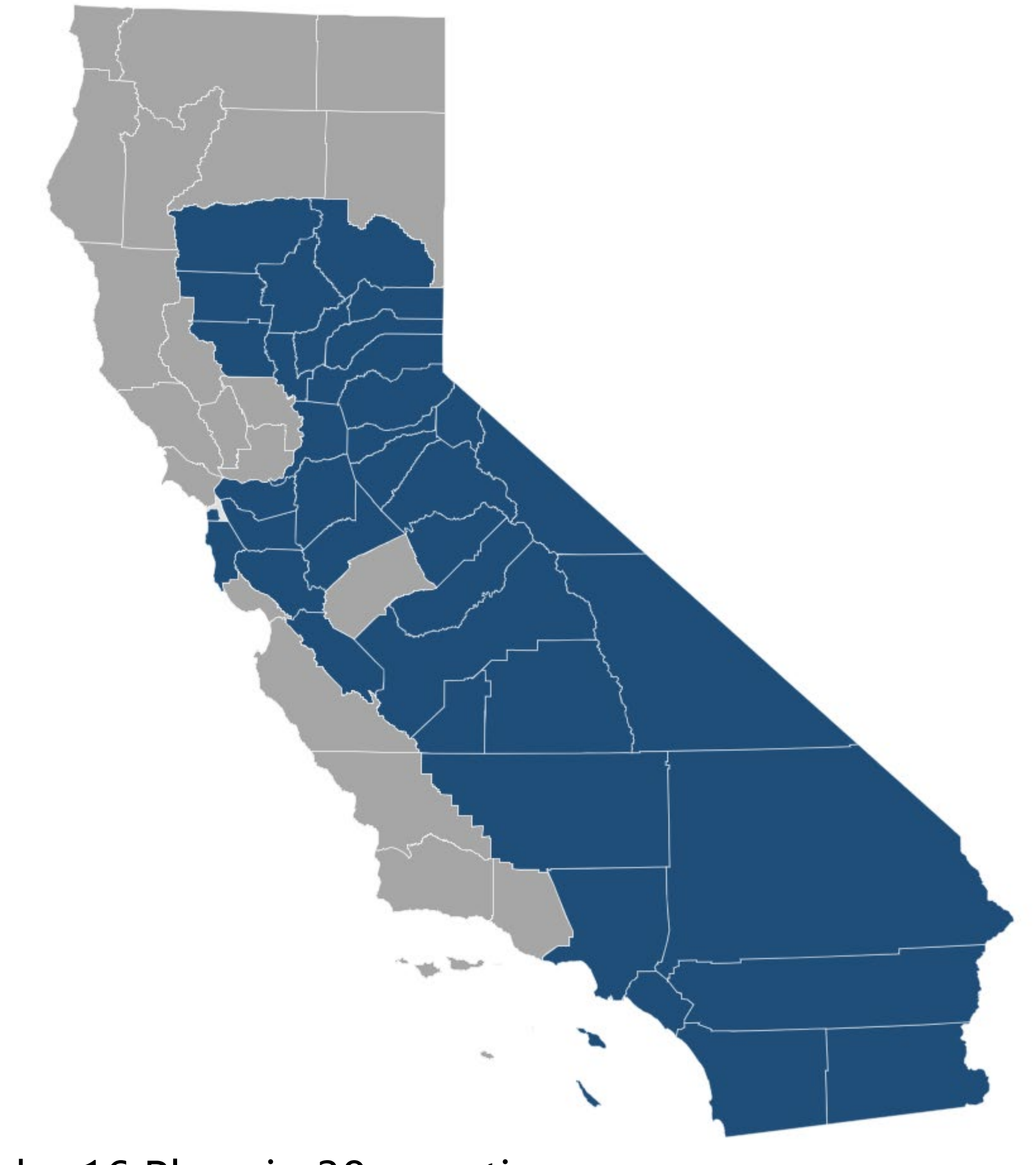
1) 42 CFR §438.3(e)(2)

Community Supports Services Approved in California

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Caregiver Respite Services
- 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 Supportive Food/Meals/Medically-Tailored Meals
- Sobering Centers
- Asthma Remediation
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)

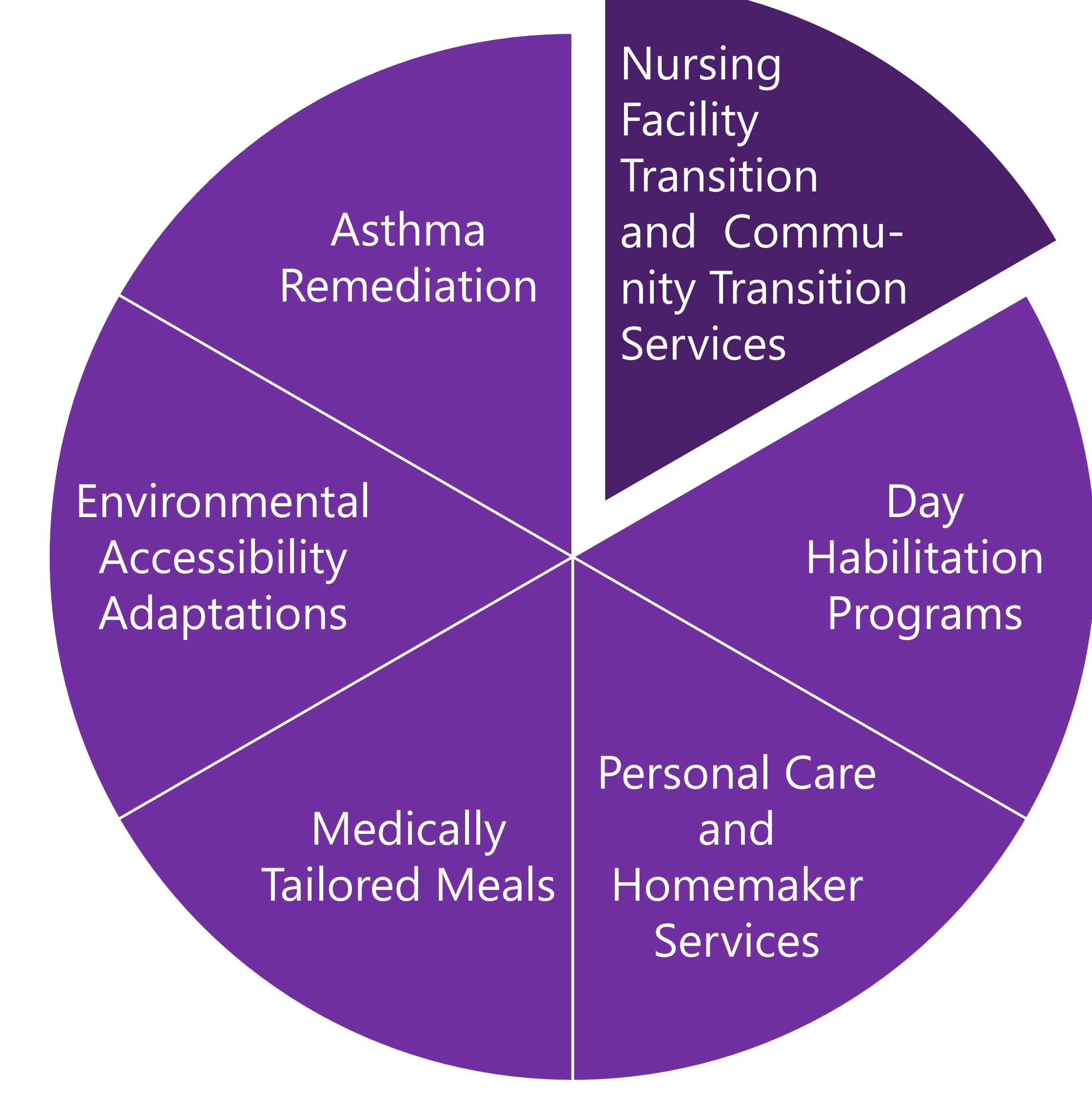
MCP Elections

Community Support	Plans-by-County* Offering Community Support by January 2024
Nursing Facility Transition/ Diversion to Assisted Living Facilities	**77**
Community Transition Services/ Nursing Facility Transition to a Home	**77**



*By January 2024, these Community Supports will be offered by 16 Plans in 38 counties.

Part of CalAIM's Independent Living-Focused Community Supports



Nursing Facility Transition/ Diversion to Assisted Living Facilities

Guidance Summary

What is Nursing Facility Transition and Diversion to Assisted Living Facilities?

Assist	Facilitate	Prevent
Assist individuals in living in their community and avoiding institutionalization	Facilitate transition from nursing facilities to community settings	Prevent skilled nursing admissions

Outlined by the DHCS Community Supports Policy Guidance

How Nursing Facility Transition and Diversion to Assisted Living Facilities Works

- Assisted living providers support individuals with Activities of Daily Living, meals, medications, and transportation
- Wrap-around services include:
  - Activities of Daily Living and Instrumental Activities of Daily Living
  - Companion services
  - Medication oversight
  - Therapeutic social and recreational programming
  - 24-hour direct care staff on-site

Outlined by the DHCS Community Supports Policy Guidance

Nursing Facility Transition/Diversion Service Offerings (1/2)

- Assess housing needs and presenting options
- Assess member service needs
- Assist in securing facility residence
- Communicate with facility administration and coordinate move-in
- Help members retain facility housing
- Coordinate with managed care plans to ensure appropriate delivery of Community Supports and Enhanced Care Management

Outlined by the DHCS Community Supports Policy Guidance

Nursing Facility Transition/Diversion Service Offerings (2/2)

- The Nursing Facility Transition/Diversion Community Supports covers ongoing expenses for Members receiving it in an assisted living facility
- For individuals who transition from a nursing facility to home, MCPs may elect to offer the "Personal Care/Homemaker" Community Supports to support ongoing ADLs/IADLs.

Program Benefits

- 50% of participants stayed in the community after one year[1]
- 14% increase in discharges from skilled nursing facilities to homes within six months of admission[1]
- Among nursing home residents who relocated from nursing facilities, 25% – 35% transitioned to assisted living[2]

Eligible Populations

Nursing Facility Transition

- Resided 60+ days in a nursing facility
- Willing to live in an assisted living facility
- Able to safely reside in an assisted living facility

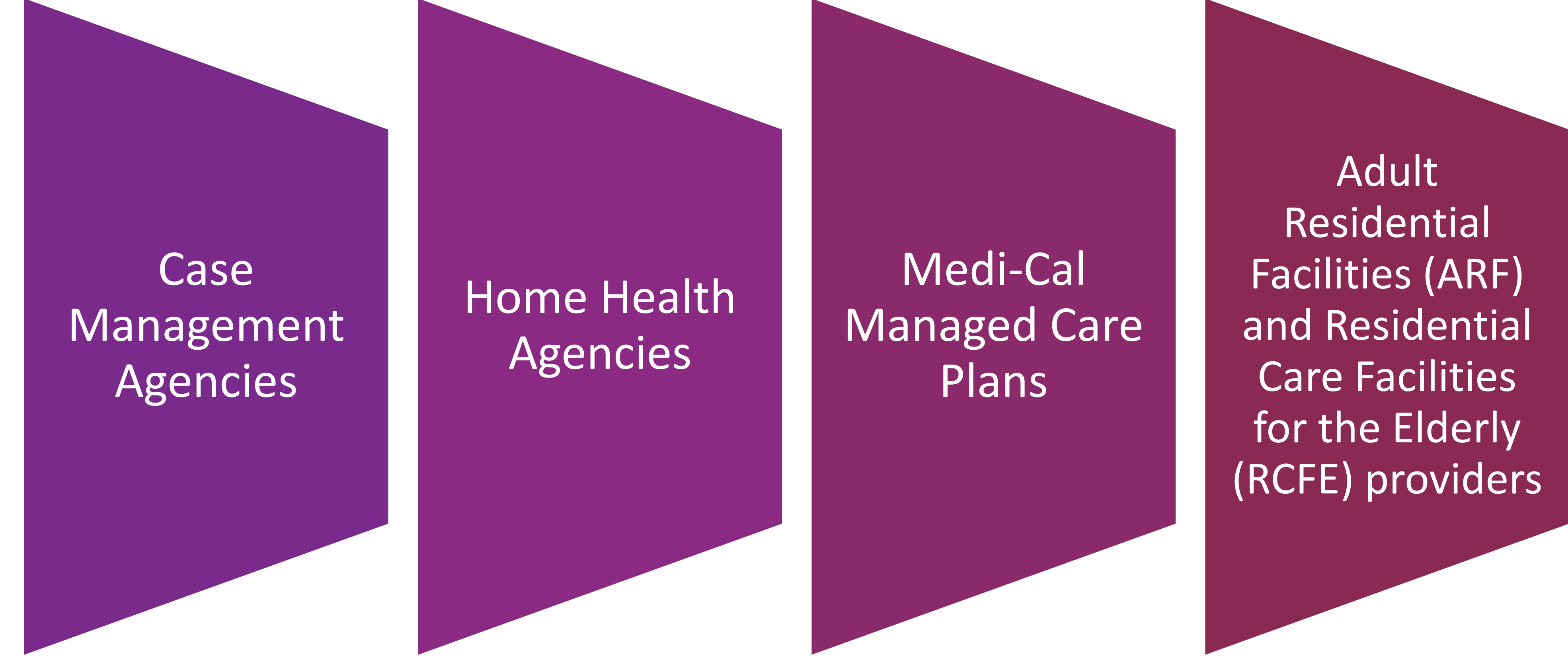
Nursing Facility Diversion

- Interested in remaining in the community
- Willing and able to safely reside in an assisted living facility
- Receiving medically necessary nursing facility level of care or meet minimum criteria to receive nursing facility services

Outlined by the DHCS Community Supports Policy Guidance

Allowable Providers

Including but not limited to:



Outlined by the DHCS Community Supports Policy Guidance

Service Limitations

- Individuals are directly responsible for paying their own living expenses.
- This Community Support supplements (and does not supplant) services received through other State, local or federally-funded programs.

Community Transition Services/ Nursing Facility Transition to a Home

Guidance Summary

What Are Community Transition Services?

Non-recurring set-up expenses for transition from licensed facility to private residence

Help members live in the community and avoid further institutionalization

Outlined by the DHCS Community Supports Policy Guidance

What Are Community Transition Services?

- Assessing member housing needs and presenting options
- Assisting in searching for and securing housing
- Communicating with landlord and coordinating the move
- Establishing procedures and contacts to retain housing
- Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility
- Identifying the need for and coordinating funding for environmental accessibility modifications

Outlined by the [DHCS Community Supports Policy Guidance]

Community Transition Covered Services

- Security deposits
- Set-up fees for utilities or service access
- First-month coverage of utilities
- Services necessary for the individual’s health and safety, such as pest eradication and one-time cleaning prior to occupancy
- Home modifications, such as an air conditioner or heater
- Medically-necessary services, such as hospital beds to ensure access and reasonable accommodations

Outlined by the DHCS Community Supports Policy Guidance

Eligible Populations

- Currently receiving medically necessary level of care (LOC) services and choosing to transition from a nursing facility or Medical Respite
- Lived 60+ days in a nursing home or medical respite setting
- Interested in moving back to the community
- Able to reside safely in the community

Outlined by the DHCS Community Supports Policy Guidance

Allowable Providers

Including but not limited to:

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- County mental health providers
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

Outlined by the DHCS Community Supports Policy Guidance

Impact of Community Transition Services

- Care transition is associated with a decrease in 12-month readmission rates from 17% to 12%[3]
- 20% increase in global life satisfaction among individuals who transitioned to community living[4]
- Care transition services produced savings of up to 50%[5]

Service Limitations and Restrictions

- Does not include monthly rental or mortgage expenses, food, regular utility charges, or diversionary or recreational household appliances or items
- Lifetime maximum of $7,500
  - Except if a member is compelled to move from a provider-operated living arrangement to a private residence through circumstances beyond the member's control
- Services must be necessary for member's health, welfare, and safety
- This Community Support supplements (and does not supplant) services received through other State, local or federally-funded programs

Outlined by the DHCS Community Supports Policy Guidance

Pricing Guidance

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

Nursing Facility Transition and Community Transition Services Provider Promising Practices

Serene Health
Jeannine Nash – Director of Operations
Jorge Medina – Director of Business Development

Nursing Facility Transition and Community Transition Services
Provider Promising Practices

Serene Health
Jeannine Nash – Director of Operations
Jorge Medina – Director of Business Development

A Positive Choice/Serene Health

Our Mission is to assist our members with obtaining the resources and referrals necessary to live an independent lifestyle within their community with respect, integrity, and dignity. Making a difference within our communities to help one person at a time and changing their lives.

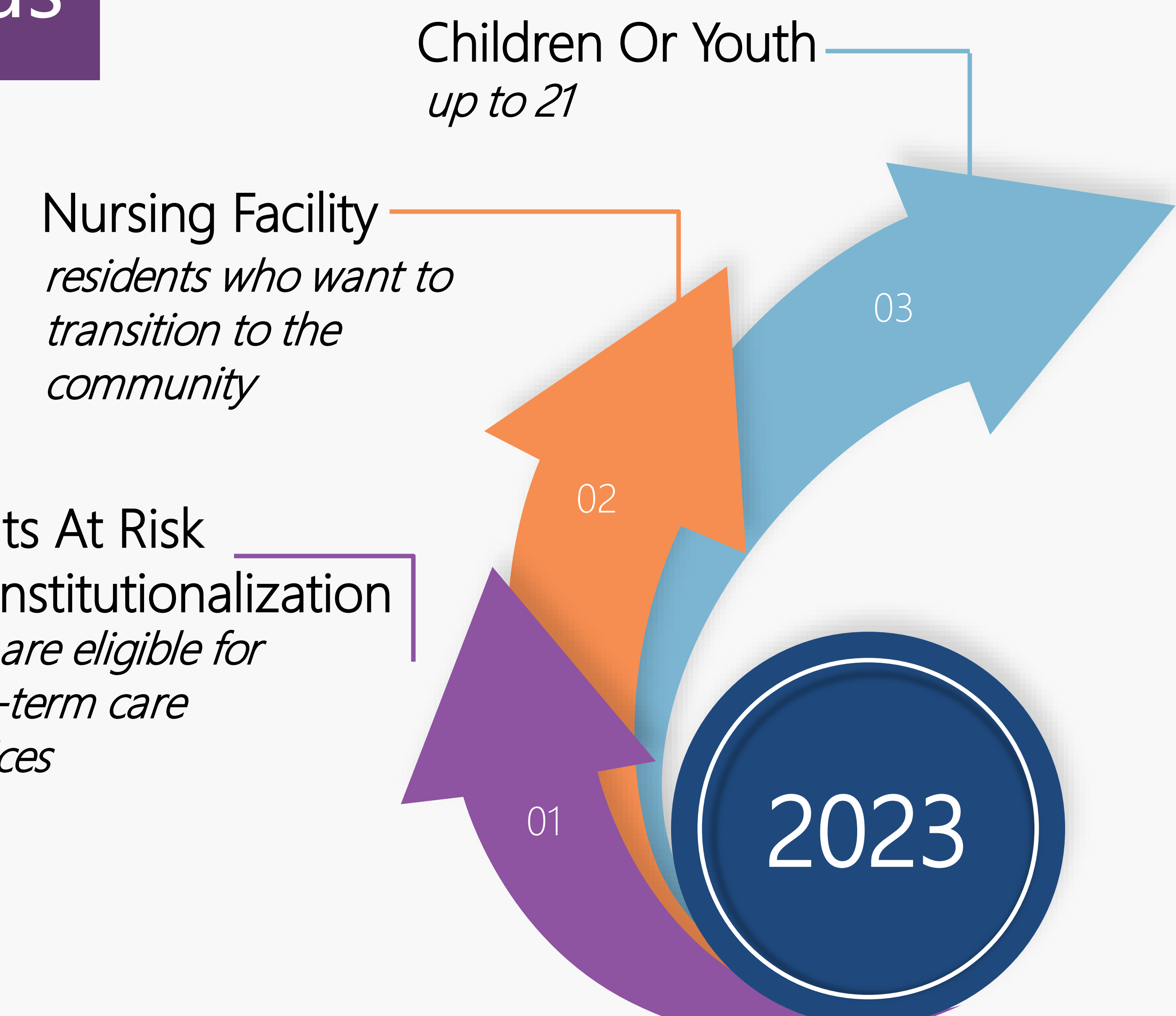
Based out of San Diego, CA, we provide **COMMUNITY SUPPORT SERVICES** for over **22 COUNTIES** in California and are growing. We have been in the community since 2014.

San Diego	Contra Costa
Los Angeles	Madera
Sacramento	Marin
Riverside	Mendocino
San Bernardino	Napa
San Francisco	Shasta
Imperial	Sonoma
Alameda	Solano
Fresno	Placer
King	Kern
Santa Clara	Tulare
Humboldt	Yolo

Populations of Focus

2022

- ✓ Individuals And Families Experiencing Homelessness
- ✓ High Utilizer Adults
- ✓ Adults With Serious Mental Illness (SMI) Or Substance Use Disorder (SUD)
- ✓ Adults & Children/Youth Transitioning From Incarceration



Nursing Facilities Transition/Diversion to Assisted Living Facilities

Comprehensive Discharge Planning

Organize follow-up services and address patients' financial and psychosocial barriers to receiving needed care.

Collaborating critical member information with outpatient providers

Essential information includes diagnoses, test and procedure results, pending tests, medication lists, rationale for medication changes, advance directives, caregiver status, contact information for the discharging physician, and recommended follow-up care.

Assessing Financial Barriers To Filling Member Needs For Long-term Care Plan Goals

Lead Case Managers also assess financial barriers to filling prescriptions and provide medication lists to outpatient providers.

Using a "teach back" method to ensure patient understanding

Patients are asked to restate instructions or concepts in their own words. Education can be supplemented by illustrations and written materials at appropriate reading levels.

Nursing Facilities Transition/Diversion to Assisted Living Facilities

Open Communication and Continual Communication with outpatient providers to ensure a high level of care for our member(s) are being met

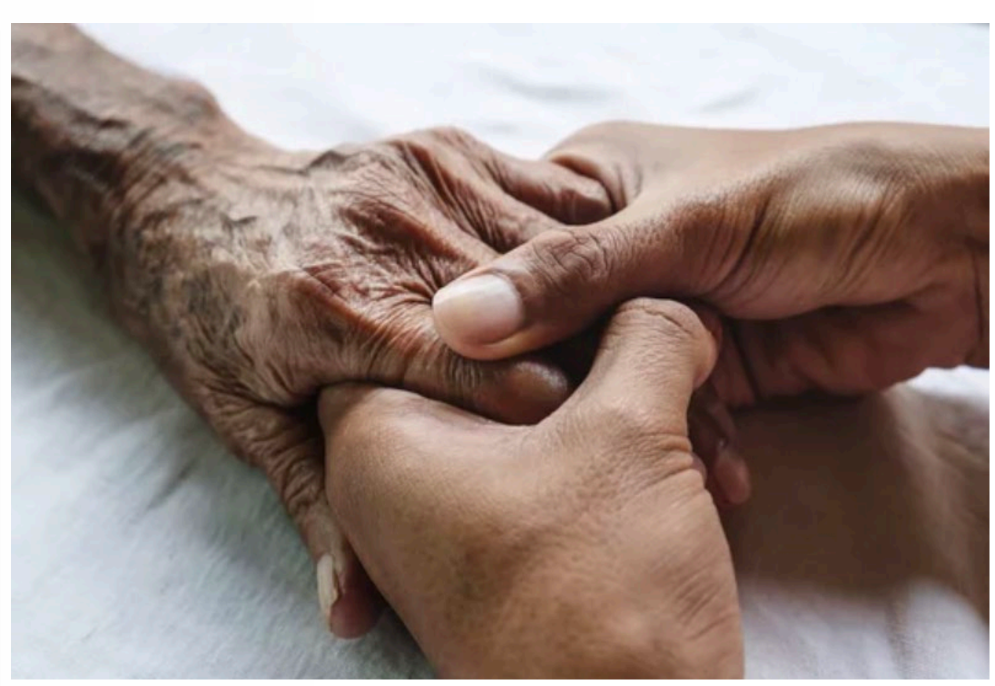
Responsibilities are clearly defined for the discharging provider and the subsequent provider.

Prompt Follow-Up Visit with an outpatient/community provider after discharge

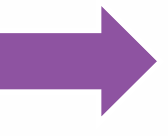
Schedule follow-up visits prior to discharge, recommended within seven days of discharge.

*Research strongly suggests that these best practices create a strong foundation for high-quality, cost-saving care transitions.

Referral Process



Submit Referral
apcinfo@apositivechoice.org
(619) 872-2485 (Fax)



Submit Request to Health Plan
Approval Process

Member Intake
Community Support Intake Process begins

Successful Placement

Jeannine & Tawnya.

Thank-You, Thank you, Thank You! If There Is A Heaven on Earth, We Found It, Linen Table Clothes, Beautiful Clean Silverware, A Real menu. We Can order Two meals A day, I Ate Shrimp Lunch & Dinner The First Day, And All The Ice Cream I Want.

My eyes Dont Burn, my Face Has Healed and I Can Breath, And I Sleep solid every Night, or until The Sun Comes up From The East and Blinds me.

Today I Went In The Shuttle Bus With other Residents To Walmart (4 miles) When we Came Back There Was Grocery Bags And people every Where, I Stumbled over The Yellow Dots (sped Bumps?) In Front of Walmart, Luck I Was Hanging onto The Basket, I Sprain my Right ankle, But If your Having Fun, The pain Isnt To Bad.

Wednesday I Have, Finally, A Beauty Shop Appointment To get my Hair Cut, I Dont Have To Cut & Style my Hair ever again, And I Just Sit In The Walk in Shower and Feel So Clean, After Five months (may 31) My Feet Are Clean.

Some of The Ladies Are pointing out The Single guys, Retired officers, Money, Etc, But I Not Ready For That, IM So Excited To Be In Heaven on Earth. Thank you

Questions and Contact Information

Contact Information:
Jeannine Nash – Director of Operations
(619) 436-4715
Jeannine@serenehealth.com

Nursing Facility Transition and Community Transition Services Provider Promising Practices

Institute on Aging
Danielle Vincer, Vice President of Community Living Services

AgeOn.®
Institute on Aging
DANIELLE VINCER, RN, MHI,
VP OF COMMUNITY LIVING SERVICES

Institute on Aging's Four Key

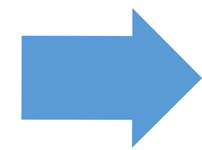
PRIORITY IMPACT AREAS

Dementia	Caregiving	Social Isolation & Loneliness	Alternatives to Long-term Care
Adult Day Services	Non-Medical Homecare	Friendship Line	PACE
Companioa Ecosystem	Support @ Home	Elder Abuse Prevention	**Community Living Solutions**

Intensive Care Management with IOA

Community Living Fund

- 2007
- San Francisco
- DAS



Community Care Settings Program

- 2014
- San Mateo
- WPC and HPSM

Whole Person Care

- 2017
- Santa Clara
- WPC and Santa Clara County

CalAIM

Current
CalAIM Offerings

Enhanced Care Management: POF

- Homelessness
- SMI/SUD
- High Utilizer
- Nursing Facility transitioning to Community

Community Supports

- Housing Navigation Services
- Housing Deposits
- Nursing Facility Transition/Diversion
- Community Transition
- Housing Tenancy & Sustaining Services
- Environmental Accessibility

Institute on Aging

Best Practices

Patient Centered Care

- 1 ECM/CS Provider
- Submit waiver applications
- Provide RCFE Options

What is working??

Multidisciplinary team approach

Specialized Community Supports Care Manager

Claims, reporting, and authorizations – Standardize? Dedicated Staff?

Plan Promising Practices: Nursing Facility Transitions and Diversion to Community and Residential Care Facilities for the Elderly

Santa Clara Family Health Plan
Lori Andersen, Director of Long-Term Services and Supports
Nicole Bell, Community Supports Program Manager

Who is Santa Clara Family Health Plan?

Local, community-based health plan dedicated to creating opportunities for better health and wellness for all.

- Public agency acting on behalf of and accountable to the people of our community.
- In partnership with providers and community organizations since 1997, we serve more than 280,000 residents of Santa Clara County through our Medi-Cal and Cal MediConnect (Medicare-Medicaid) health insurance plans.
- Santa Clara Family Health Plan (SCFHP) is the not-for-profit Medi-Cal and Cal MediConnect alternative in the county.

Mission

To improve the well-being of our members by addressing their health and social needs in a culturally competent manner, and partnering with providers and organizations in our shared commitment to the health of our community

Vision

Health for all – a fair and just community where everyone has access to opportunities to be healthy

Community Supports Offerings

Community Support	Launch Date
Housing Transition Navigation Services	1/1/2022
Housing Deposits	1/1/2022
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities	1/1/2022
Community Transition Services/Nursing Facility Transition to a Home	1/1/2022
Medically Supportive Food/Meals/Medically Tailored Meals	1/1/2022
Housing Tenancy and Sustaining Services	7/1/2022
Recuperative Care (Medical Respite)	7/1/2022
Sobering Center	7/1/2022
Personal Care and Homemaker Services	1/1/2023
Respite Services	1/1/2023
Environmental Accessibility Adaptations (Home Modifications)	1/1/2023
Asthma Remediation	1/1/2023
Short-term Post-Hospitalization Housing	7/1/2023
Day Habilitation Programs	7/1/2023

Current offerings

Coming 1/1/2023

Why offer Nursing Facility Transition - Diversion Community Supports in Santa Clara County?

Community and MCP Expertise, Experience, and Integration

- MCP experience serving LTC population via Coordinated Care Initiative since 2014
- CBO network experience serving LTC population: Health Homes Program, Whole Person Care, Community Care Transitions (CCT) and other programs
- Collaboration with the County Continuum of Care (CoC)
  - Updating county definition of "homelessness" to include LTC residents transitioning from SNF to community
  - Advocacy for modification to the VI-SPDAT to reflect LTSS population needs
- MCP participation in County LTSS Integration Committee
  - Key stakeholder for the inclusion of LTC transitions into Whole Per Care Pilot program

Long Term Care Population

Partnerships and best practices provided a foundation

Coordinated Care Initiative	Development of Infrastructure	Partnerships
2014 MLTSS and Long Term Care carve-in for Medi-Cal benefit package Nursing facility (SNF) Network Development - 40+ contracted SNFs Designated Provider Network Associate staff	Cross functional team – Utilization Management, LTSS case management & Pharmacy to determine potential for LTC transition and LTSS referrals Identification of common member characteristics and conditions that indicate appropriateness for community transition Staff - designated Case Manager to assist and coordinate member transitions back to the community	CBOs with experience transitioning LTC members to the community Silicon Valley Independent Living Center (SVILC): California Community Transitions (CCT) Peer Support, Housing Search Assistance, information and referral services Institute on Aging (IOA) - Whole Person Care (WPC) agency: Community case management services, Assisted Living Waiver (ALW) Administrative agency

Program Model Development

Process

- **Step 1:** Drafted program model outline from DHCS Community Supports Policy Guidance and MCP experience/best practices
- **Step 2:** Engaged interested CBOs for review and input:
  - Staffing models and needs – clinical, direct care vs oversight & supervision
  - Service components and time needed to complete
  - Pricing and cost assumptions
- **Step 3:** Detailed program models finalized
  - Set of tasks and services and 'Service Bundles'
  - Prevention of Skilled Nursing Facility Admissions
  - Post Transition to RCFE
  - RCFE Enhanced Services

Finalized Program Models

Community Support	Service Bundle	Billable Months
NF Transition/Diversion to Community	A: Transition Services	2
	B: Prevention of SNF Admissions	2
	C: RCFE Support	Interval of 6
	D: RCFE Direct Support	Interval of 6
Community/NF Transition to Home	A: Housing Assessment, Search, & Resources	2-4
	B: Move-in & Retention	1

Program Model Pricing Development

Assumptions

Services split into 2 categories & priced separately

1. Transition services – needed to move member into RCFE
   - Provided by non-clinical staff via face-to-face in the community case load - 1:25
   - Clinical oversite or supervision of non-clinical staff case load - 1:10
2. Ongoing services in RCFE - Enhanced Services
   - Activities of Daily Living (ADLs)
   - Instrumental ADLs (IADLs) as needed
   - Companion services
   - medication oversight
   - Therapeutic social and recreational programming provided in a home-like environment

Multiple Sources

- Provider Feedback from engagement meetings
- Local salary ranges - equivalent or higher than Santa Clara County employee salaries
- The Bureau of Labor Statistics Data
- Key Pricing recommendations form DHCS
- Variation of a PMPM Payment Model was selected

Provider Network Development

- **Landscape analysis of potential providers**
  - Existing CCT providers, Complex Case Management Providers, Primary Care Clinics with linkages to SNFs
- **Compared experience and capacity for transitions**
  - Primary Care Clinics did not have direct experience in transitioning members
- **Shared draft program models with potential providers**
  - Gathered feedback and interest on delivering NF transition/diversion to Community service
- **Readiness Assessment**
  - Compared to DHCS Guidance, program materials, and staffing capacity and skill
  - Noted limited RCFE network with capability to accepting population
- **Contracting**
  - 3 providers
  - 15 placements available at one time

Provider Engagement

Gathered input on program models

ECM alignment and coordination – Population of Focus (POF) #3

- Development of ECM POF criteria and referral mechanisms
- Training requested and provided for ECM providers on best practices working with SNFs

Ongoing Training

- Deep dive series highlighting specific Community Supports for both ECM and CS providers
  - Eligibility Requirements
  - Services Provided in Program Model
  - Coordination with Referring and Other Providers (Closed Loop)

Impact

Program Model and Provider Network

- Program models and pricing reflect MCP and provider experience
- Ensures all contracted providers complete applicable required task/services
- Service bundles allow providers to bill for each set of services prior to completing all
- Reflected alignment with ECM role for Population of Focus (POF)

Community Education

Provider User Guide includes

- Overview of CalAIM and Community Supports
- Election and launch dates
- Program Models for each launched service
- Eligibility criteria
- Pricing Guides and definitions

Provider and Community Education

- Development of materials that simply explain the programs offered and how member can be referred or access

COMMUNITY SUPPORTS
Provider User Guide
July 2022

40721

Santa Clara Family Health Plan

Community Supports

What are Community Supports?

Community Supports, are special care options for Santa Clara Family Health Plan (SCFHP) Medi-Cal members. These may be offered to qualified members at medium to high levels of health risk.

Community Supports can help members remain healthy, reduce complications from illnesses, and avoid unnecessary stays in the hospital, nursing facilities, and emergency departments.

Are Community Supports Medi-Cal benefits?

No, Community Supports are not Medi-Cal benefits. Community Supports are extra services paid by SCFHP. They are typically delivered by a different provider or in a different setting than traditional Medi-Cal benefits.

How do eligible Medi-Cal members get Community Supports Services?

- **A provider submits a referral form for a member.** Providers can submit a referral form to SCFHP for Community Supports through the Provider Portal. They can also download a referral form and send the complete form to SCFHP.
- **A member asks to join.** Individuals can contact SCFHP Customer Service and ask if they qualify for Community Supports. If the member is currently enrolled in Enhanced Care Management, they may also request a referral from their Care Manager.

For more information visit: www.scfhp.com/communitysupports/

50511E

Outcomes

Implementation – Launched 1/1/2022

- 1 provider with existing RCFE contracts and experience
- 3 providers experienced with nursing home transition/diversion services
- 12 members approved for RCFE "Enhanced" Services at launch - Prior WPC
- 2 members approved for all services transition through RCFE placement and "Enhanced" Services
- Identified need for more capacity in RCFE

RCFE Network Development

- IPP funding used to contract with Institute on Aging (IOA)
- Inventory RCFE providers and expand contracting for Community Supports
- Promote Assisted Living Waiver (ALW) program with RCFE providers as mechanism for long term sustainability for members needing RCFE placement

Lessons Learned

Variations in provider operation may affect service delivery and pricing

- Early discussions related to workflows, service delivery, staffing models, SNF roles and communication are very important
- Continued learning may result in program model modifications

Data sharing issues & lack of appropriate documentation

- Need clear guidance and follow up with providers to ensure documentation for timely authorizations
- Training and ongoing provider support required for appropriate referrals

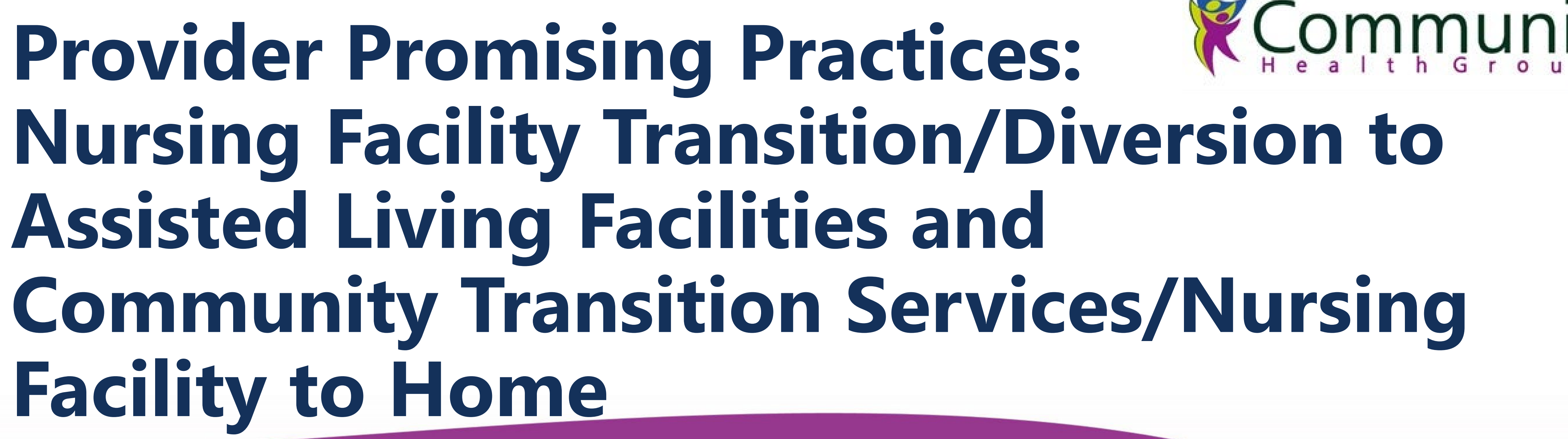
Lack of housing limits transitions & requires MCP engagement

- MCP joins CoC efforts to expand and invest in permanent supportive housing (e.g. HHIP)
- Explore alternative housing options such as set-aside units for members

High costs for RCFE placements

- Determine MCP role with RCFE provider network
- Alignment with ALW program and payment structure
- Network expanded to 18 RCFEs
- Agreed to higher CS rate once provider is ALW enrolled

Provider Promising Practices: Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services/Nursing Facility to Home



Community Health Group
Yousaf Farook IMG, CCM, MBA
Senior Director of Healthcare Services

WHO WE ARE

- San Diego's largest and oldest local non-profit health plan with 40 years of history
- Serving 317,000 members
- 24/7/365 Live member services with MAGIC
- Office located just 8mi from the US/MX border

MISSION STATEMENT

Community Health Group is dedicated to maintaining and improving the health of our members by providing access to quality care and offering exceptional service to diverse populations.

Community Supports at CHG

HISTORY OF CS-LIKE SERVICES
Skilled Nursing Facility (SNF) to Assisted Living Facility (ALF)
SNF to Home
Home Adaptations/Modifications
Medically Tailored Meals
Asthma Remediation
Respite Services

Currently Offering All 14 Community Supports Services

Community Support	Effective Date
Housing Transition Navigation Services	1/1/2022
Housing Tenancy & Sustaining Services	1/1/2022
Recuperative Care (Medical Respite)	1/1/2022
Nursing Facility Transition/Diversion to ALF and RCF	1/1/2022
Environmental Accessibility Adaptations (Home Modifications)	1/1/2022
Medically Tailored Meals	1/1/2022
Sobering Centers	1/1/2022
Asthma Remediation	1/1/2022
Housing Deposits	7/1/2022
Short-Term Post-Hospitalization	7/1/2022
Respite Services	7/1/2022
Day Habilitation	7/1/2022
Community Transition Services/Nursing Facility Transition to a Home	7/1/2022
Personal Care and Homemaker Services	7/1/2022

Lessons Learned

IMPORTANCE OF:
Dedicated Staff
Multi-disciplinary approach
Whole person-centered approach
Ongoing trainings
Open lines of communication
Simplifying access to services

DEVELOPMENT OF ECM/CS PORTAL
Enhanced existing web-based portal
Centralized workflows & communications
Improve data sharing
Online referrals for quicker turnarounds
Open lines of communication
Simplifying access to services

New & Improved

Nursing Facility Transition/ Diversion to Assisted Living Facilities (ALF)

Community Health Group

1. Member Identified by Inpatient Case Manager (IPCM)
2. IPCM pulls in support from Transition of Care Coordinator (TOC)
3. TOC assesses for & refers to Care Coordination Agency (CCA) for help w/Assisted Living Waiver (ALW)
4. Collaboration between SNF, CHG, CCA, and family if involved
5. ALW is approved

   Multidisciplinary team finds ALF vacancies
6. Placement into ALF

Community Transition Services/ Nursing Facility to Home

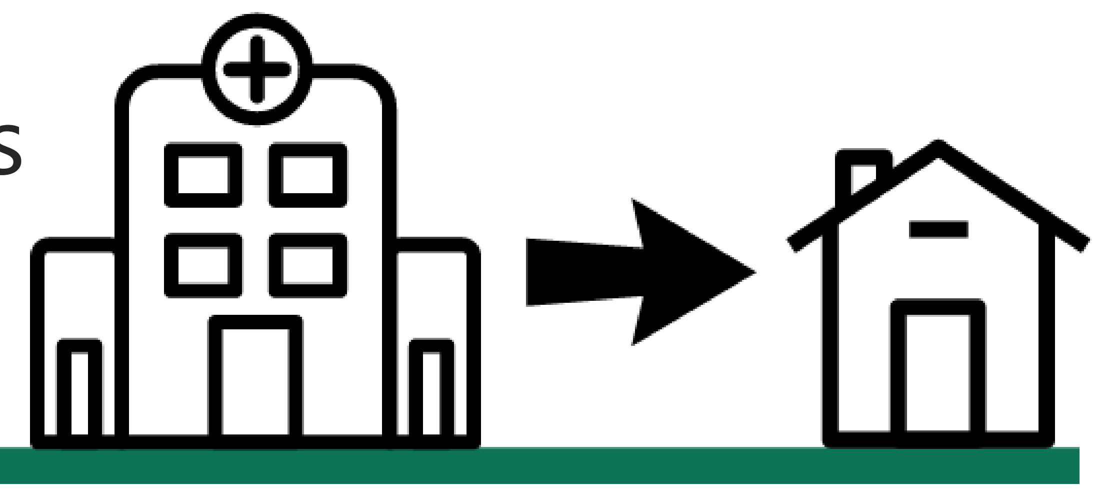
Community Health Group

- Member Identified by Inpatient Case Manager (IPCM)
- IPCM pulls in support from Transition of Care Coordinator (TOC)
- TOC evaluates needs and existing resources
- TOC presents affordable housing options to Member
- TOC coordinates/ advocates to prepare for successful transition
- Safe discharge to home

Nursing Facility Transition/ Diversion to Assisted Living Facilities (ALF) & Community Transition Services/ Nursing Facility to Home

*Over 400 Members served

*63 Members served as of 1/1/22 ECM/CS rollout



Adaptation to Barriers

CHALLENGE −	TOC WORKAROUND +
NF to ALF Member hesitation due to unknowns. E.g. Fear of "losing" SSI or fear of moving into new environment.	Rapport building. Take the time to educate Members about the benefits of the opportunity.
Difficulty reaching SNF staff. E.g. Short staffed. Limited access to communications due to direct patient services.	Continuous follow up. Involving more team members. Field visits to the facility
SNF unfamiliar or unaware of resources and processes to access resources.	Take the time to educate SNF staff and discharge planners.
Shortage of ALFs that accept the waiver.	Frequent research of vacancies. Maintain healthy relationships with ALFs that do accept.

Future Plans- Proactive Approach

Early identification of populations at risk of institutionalization

Community → Institution → ALF/Home

Member Successes

Thanks to our team's collaborative efforts, we are able to safely transition Members into appropriate levels of care using a whole-person centered approach.

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:
  - Housing Navigation, Tenancy Supports, and Deposits
  - October 15th at 1pm PT.
- Please send questions to: CalAIMECMILOS@dhcs.ca.gov.

Citations

1. State Strategies to Reduce the Risk of Long-Term Nursing Care After Hospitalization
2. Diversion, Transition Programs Target Nursing Homes' Status Quo
3. Improving Patient Outcomes with Better Care Transitions: The Role for Home Health
4. Connecticut's Money Follows the Person Yields Positive Results for Transitioning People Out of Institutions
5. Impact of Cal MediConnect on Transitions from Institutional to Community-Based Settings

Resources

» DHCS Community Supports Policy Guidance

» DHCS Community Supports Executive Summary

» Non-Binding ILOS Pricing Guidance