Transitions of Care for Medi-Cal Members with Long Term Services and Supports (LTSS) Needs

August 21, 2024

Webinar

Today's DHCS Presenters

- **Palav Babaria, MD, MHS**
  Chief Quality and Medical Officer
  Deputy Director, Quality and Population Health Management

- **Susan Philip, MPP**
  Deputy Director, Health Care Delivery Systems

Today's Agenda

- Welcome and Introductions
- Overview of Services and Supports available for Medi-Cal Members with LTSS Needs:
  - Transitional Care Services
  - Enhanced Care Management
  - Community Supports
- Fireside Chat Discussion
- Q&A

Today's Focus

DHCS' vision is that Medi-Cal members requiring Long-Term Services and Supports (LTSS) can remain in the least restrictive setting that meets their preferences, needs, and optimizes their quality of life.

Transitional Care Services (TCS) under Population Health Management (PHM)

Enhanced Care Management (ECM)

Community Supports

Transitional Care Services (TCS)

Care transitions are defined as a member transferring from one setting or level of care (LOC) to another.

TCS Goals:

- Members can transition to the **least restrictive level of care that meets their needs and is aligned with their preferences** in a timely manner without interruptions in care.
- Members receive timely **needed support and coordination to have a safe and secure transition** with the least burden on the Member as possible.
- Members continue to have the **needed support and connections to services that make them successful in their new environment**.

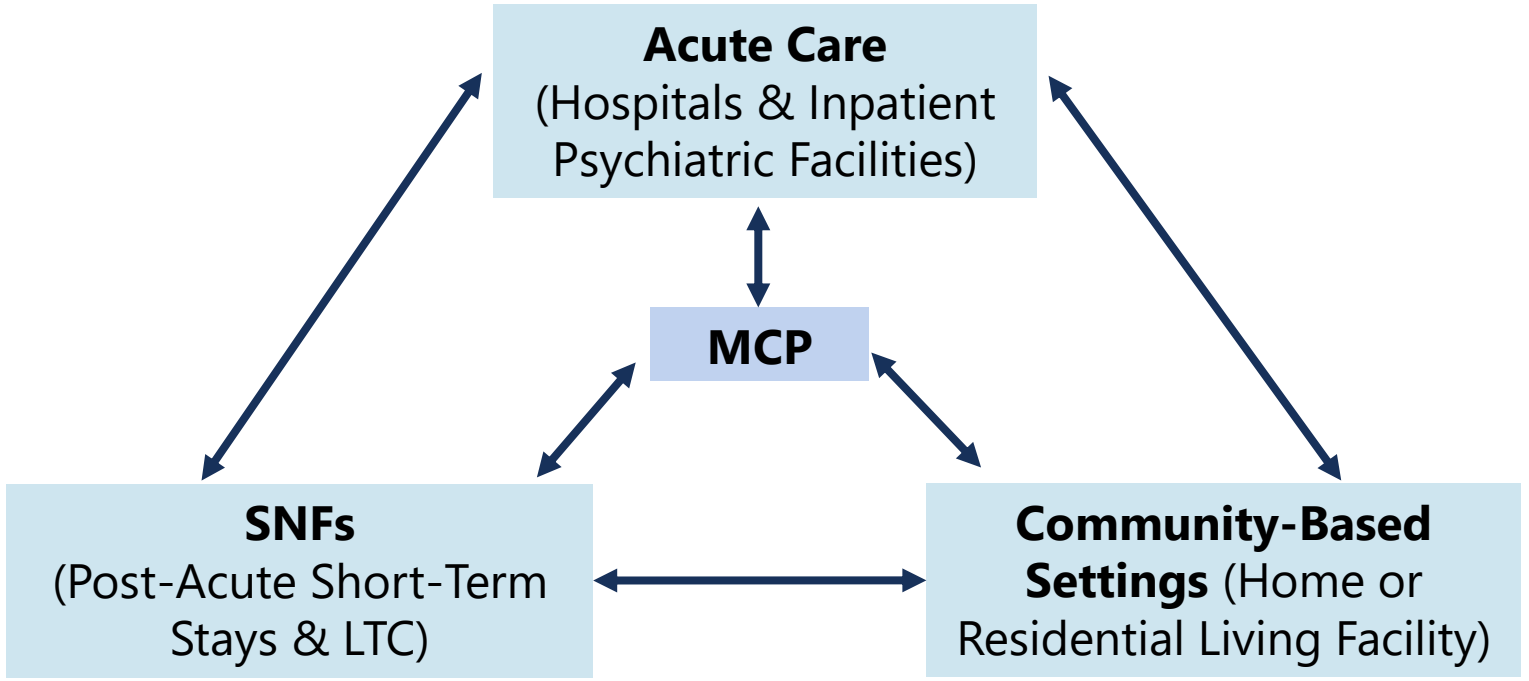
Transitional Care Services (TCS)

- **MCPs are required to deliver TCS** to ensure that all their members are supported throughout their transition.
- For members with **LTSS needs**, that includes that the MCP assign a single point of contact **TCS Care Manager.**
- **MCPs, hospitals, and SNFs are jointly accountable** to ensure successful transitions of care for members with LTSS needs.

Member

Supported by:

Strong relationships and shared accountability among entities at all levels of care and the MCP:



Released: Technical Assistance Resource Guide

DHCS is excited to release the **TCS Technical Assistance Resource Guide to support Medi-Cal Members with LTSS needs.**

- ✓ A summary of how PHM's TCS requirements apply to Members with LTSS needs;
- ✓ A set of promising practices from MCPs around the state that support members with LTSS needs who are experiencing transitions, including transitions in and out of SNFs;
- ✓ An overview of services and supports that can be leveraged to support transitions of care for those with LTSS needs;
- ✓ Decision tree graphics to outline when to leverage key services and supports for this population.

To learn more, please visit the Population Health Management webpage.

ECM & Community Supports

ECM & Community Supports

- Enhanced Care Management (ECM) and Community Supports are foundational parts of Medi-Cal's **extension beyond traditional hospitals and health care settings into communities**
- ECM and Community Supports are both administered by Medi-Cal Managed Care Plans to MCP members, in partnership with community-based providers

What Is Enhanced Care Management (ECM)?

ECM is a statewide Medi-Cal MCP benefit to support comprehensive care management for Members with complex needs provided primarily through in-person interactions with Members where they live, seek care, or prefer to access services.

Medi-Cal MCP Care Management Continuum

ECM is the **highest tier of care management** for MCP Members.

ECM

Complex Care Management
For MCP Members with higher- and medium-rising risk

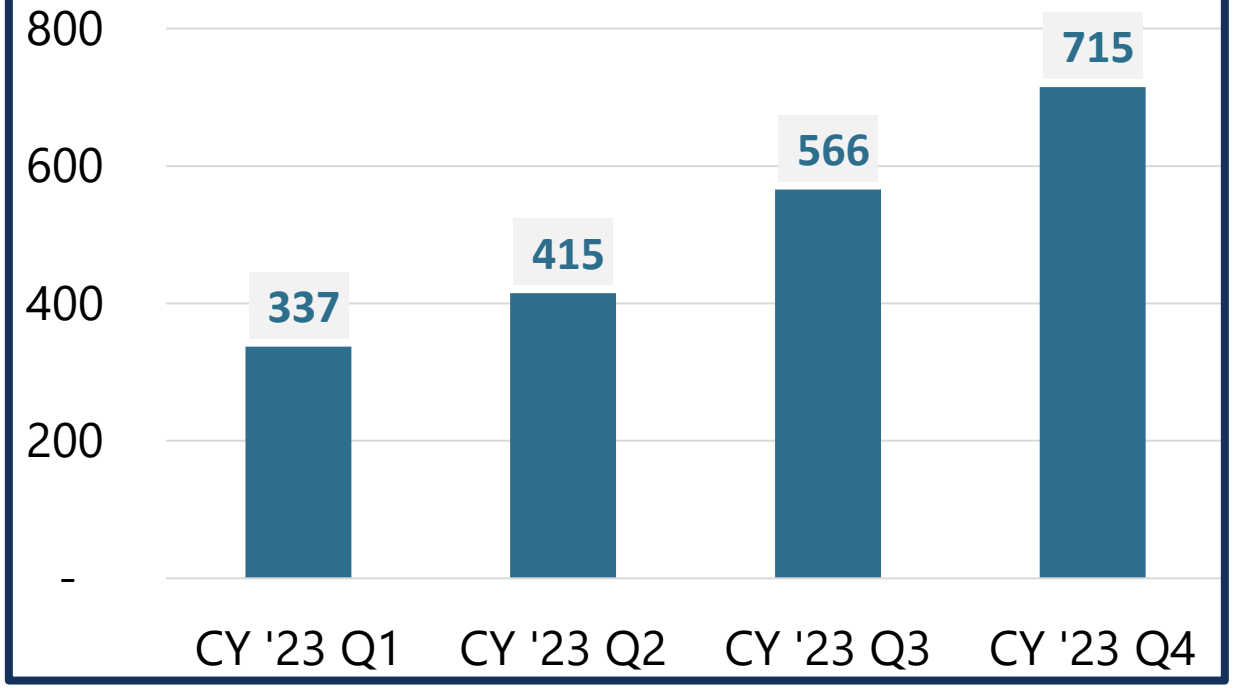
Basic Population Health Management
For all MCP Members

Transitional Care Services
For all MCP Members transitioning between care settings

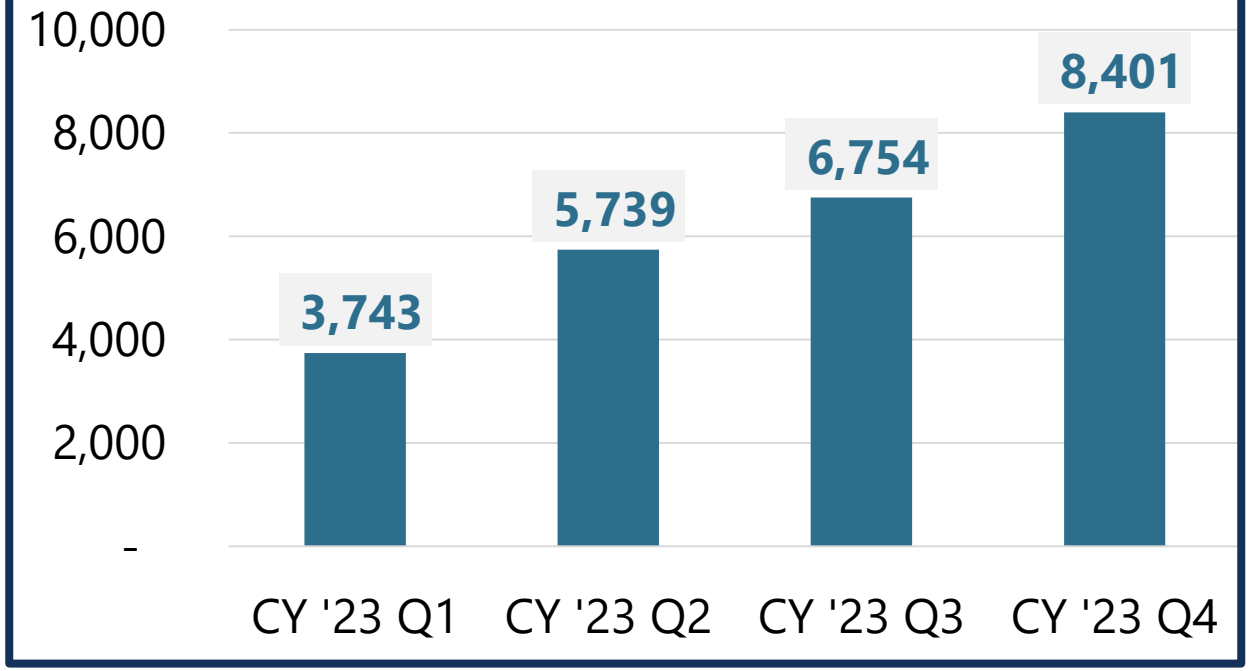
- ECM is organized by Populations of Focus (POFs), each with unique eligibility criteria and service requirements. There are two POFs for those with LTC needs:
  - **Adults Living in the Community and At Risk for LTC Institutionalization.**
  - **Adult Nursing Facility Residents Transitioning to the Community.**
- The aim of ECM for both populations is to enhance their ability to live independently and safely and remain connected to what matters most to them.

ECM LTC Members Who Received ECM Each Quarter: CY 2023 Data

Total Number of Unique Members in the Adult Nursing Facility Residents Transitioning to the Community POF Who Received ECM Each Quarter: CY 2023 Q1 – CY 2023 Q4



Total Number of Unique Members in the Adults Living in the Community and At Risk for LTC POF Who Received ECM Each Quarter: CY 2023 Q1 – CY 2023 Q4



Source: ECM and Community Supports Quarterly Implementation Report for Q4 2023

Released: Spotlight on ECM for LTC Populations

In June, DHCS released the [Enhanced Care Management (ECM) for Long-Term Care Populations of Focus Spotlight].

- ✓ **Lifts up key DHCS policies and resources on serving individuals in, or at risk of entering institutional Long-Term Care in ECM settings.**
- ✓ **Contains Member vignettes to illustrate ECM for these POF:**

Older adult living with Parkinson's disease who wishes to remain at home	Older adult temporarily residing in a SNF & recovering from a stroke

- ✓ **Explains how Community Supports and TCS can be integrated to best serve Members and their caregivers.**

This is part of a series of *Spotlights* on how Providers can deliver ECM models tailored to the needs of different Populations of Focus.

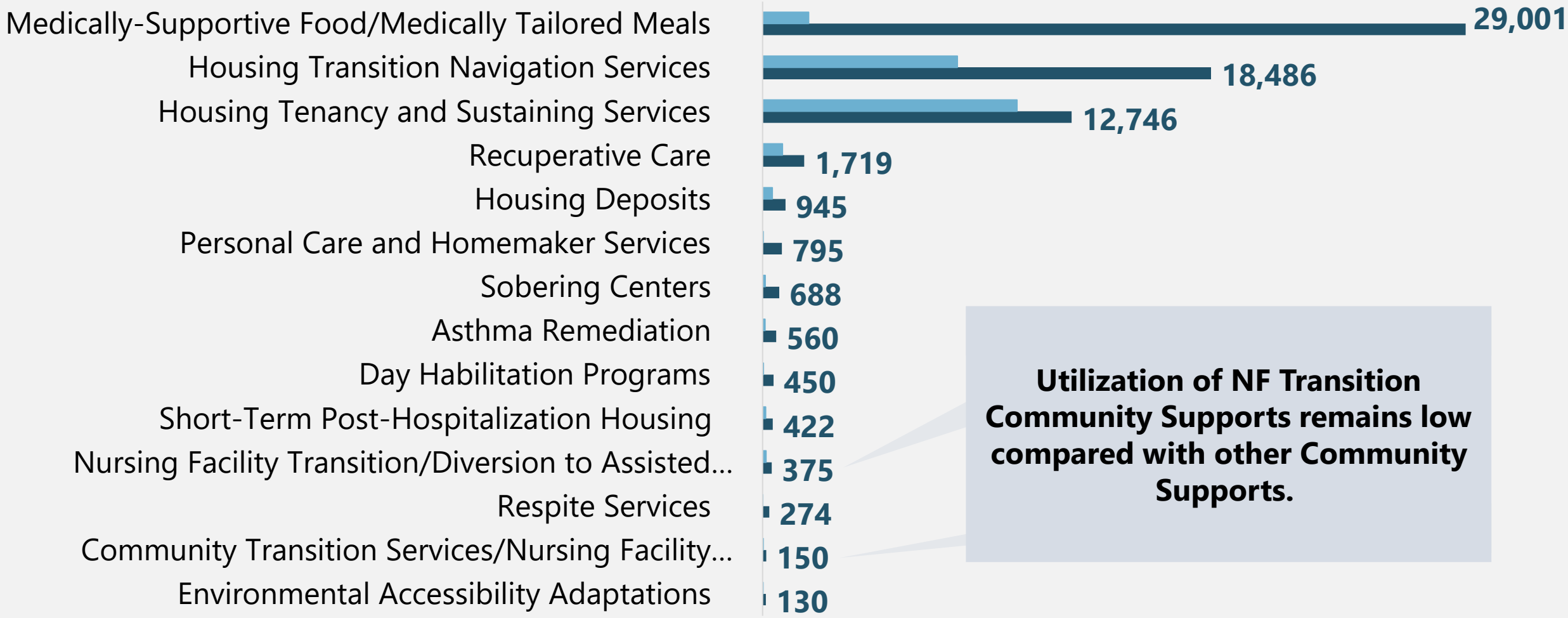
To learn more, please visit the ECM and Community Supports webpage.

NF Transition Community Supports

Community Support Service	Brief Service Description
Nursing Facility Transition/Diversion to Assisted Living Facilities (ALFs)	Facilitates a Member's transition into an ALF, RCFE or ARF for Members who are currently receiving nursing facility level of care (LOC) or who meet the criteria to receive nursing facility LOC. Services include: 1. Time-limited **transitional coordination** that enables a Member to establish residence in an ALF, RCFE or ARF. 2. Ongoing assisted living expenses (except room and board) that include **wrap-around care** (e.g., assistance with Activities of Daily Living).
Community Transition Services/Nursing Facility Transition to a Home	Facilitates a Member's transition from a licensed facility **to a private residence** where the Member is directly responsible for his or her own living expenses. Services include: 1. Time-limited **transitional coordination** that enables a Member to transition into a private residence **2. Non-recurring set up expenses** (e.g., security deposits, set-up fees for utilities, pest eradication)

DHCS anticipates releasing refined service definitions for both Community Supports in Fall 2024 to clarify allowable settings and services and support uptake of the services.

Total Members Utilizing Community Supports by Service in CY 2022 Q3, compared with in CY 2023 Q3



Utilization of NF Transition Community Supports remains low compared with other Community Supports.

***Source**: ECM-CS ArcGIS Quarterly Implementation*

Bringing it all Together

Felix's Patient Story Vignette

Felix's Member Story Vignette

Felix is a 72-year old living with multiple chronic conditions who has a stroke. Upon discharge from the hospital, he spends several months recovering in a SNF. Felix and his wife are looking for support as he prepares to transition home.

Felix is...

Admitted to a hospital for a stroke & is identified as high-risk for TCS.	***Referred to ECM by his TCS Care Manager. He meets ECM POF eligibility for Adult Nursing Facility Residents Transitioning to the Community.***	***Served by the ECM and Community Supports Providers, Felix successfully transitions home.***
The TCS Care Manager assigned to Felix by the MCP supports his transition from hospital to SNF.	Felix's is assigned an ECM Provider assesses services, supports, and needs to support Felix in transitioning from the SNF back to his home.	Felix is successful remaining at home because of ongoing support from his ECM and Community Supports Providers.

Fireside Chat

Today's Fireside Chat Features:

Guest Speakers:

Chris Esguerra, MD
Chief Medical Officer
Health Plan of San Mateo

Anwar Zoueihid
Vice President, Long Term Services & Supports
Partners in Care Foundation

Key Themes for Discussion:

Building relationships between MCPs and SNFs

Ensuring Appropriate Member Placement

MCP Coordination of Programs and Services

Building Relationships between MCPs and SNFs

Robust relationships between MCPs and providers at all levels, particularly SNFs, are critical to supporting effective transitions of care from hospitals into SNFs and from the SNFs back into the community.

Ensuring Appropriate Member Placement

Given the current capacity challenges faced by California's SNFs, MCPs must work to distinguish between members in need of SNF-level care from those who can successfully be supported in alternative settings.

MCP Coordination of Programs and Services

MCPs must engage in system-level coordination to meet all of members' needs during transitions of care. MCPs must integrate and coordinate various services and supports to be available at the time of discharge so members can successfully transition from hospitals or SNFs to home- or community-based settings

Thank You

Please send any questions and comments on today's webinar to the DHCS PHM Section at: PHMSection@dhcs.ca.gov