



Process Manual



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Introduction to CalAIM and the programs that Master•Care Provides

What is CalAIM?

In 2022, DHCS (Department of Healthcare Services) launched the CalAIM program to improve the quality of life and health outcomes of the Medi-Cal population by addressing clinical and non-clinical needs of individuals.

CalAIM stands for California Advancing and Innovating Medi-Cal.

CalAIM has three primary goals:

- Identify and manage comprehensive needs through **whole person care** approaches and **social determinants of health**.
- Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.
- Make Medi-Cal a more consistent and seamless system for enrollees to **navigate by reducing complexity and increasing flexibility**.

DHCS developed CalAIM in response to the challenges facing California's most vulnerable populations such as:

- Homelessness
- Insufficient behavioral health and substance abuse care access
- Children with complex medical conditions
- Incarcerated individuals with complex medical conditions
- The growing number of older adults

This program recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that target social determinants of health and reduce health disparities and inequities.

These services are integrated with current Medi-Cal health plan coordination activities, but ECM provides a more intensive level of support.



Master•Care and the Delivery of ECM and CS Services

We always strive to help our patients achieve **their** Highest Level of Independence.

Highest Level of Independence is a very personal goal. It encompasses many factors:

Age, Chronic Health Conditions, Education/literacy, Access to Services, Economics, along with all social determinants of health (SDoH). It also involves willingness, engagement, and an excellent support system. The Highest Level of Independence can change and grow depending on the person.

Master•Care's goal is to get to the root cause and help our patients through support, resources, accountability, caring and encouragement.

We cannot build infrastructure that is not there, but we can be honest, creative, encouraging, caring and resilient.

Enhanced Care Management (ECM) offers extra services at no cost to Medi-Cal members who have complex needs and challenges that make it hard to improve their health. This could include outside challenges, such as not having a place to live. ECM provides extra services offered as part of their current Medi-Cal plan. The Medi-Cal services they get now **will not be taken away**. They can still see your same doctors, but now they can get extra help navigating their care.

Community Supports (CS) offer specialized services at no cost to the Medi-Cal Members who have complex needs and challenges that make it extra hard to improve and manage their health. CS services compliment the needs of the ECM patient but are not always coupled with ECM services and can be offered as a stand-alone service.



ECM Population of Focus (PoF)

The term “populations of focus” refers to populations that are the central focus of attention and efforts to address their unique needs. In the context of Enhanced Care Management (ECM), it refers to groups with specific health conditions, socioeconomic challenges, or other characteristics that require tailored support. In the Enhanced Care Management (ECM) program, the populations of focus are listed in the table below.

Although there are multiple Populations of Focus, Master•Care is only serving 5:

Populations of Focus	Master•Care Populations of Focus
Individuals Experiencing Homelessness	✓*
Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly “High Utilizers”)	✓
Individuals with Serious Mental Health and/or SUD Needs	✓*
Adults Living in the Community and At Risk for LTC Institutionalization	✓
Adult Nursing Facility Residents Transitioning to the Community	✓
Individuals Transitioning from Incarceration	
Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition	
Children and Youth Involved in Child Welfare	
Birth Equity	

*Anthem Only



Definitions and Criteria for the 5 MasterCare Populations of Focus (PoF)

- **Individuals and families experiencing homelessness:** Individuals and families experiencing homelessness AND have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage for whom coordination of services would likely result in improved health outcomes AND/OR decreased utilization of high-cost services.
- **Individuals At Risk for Avoidable Hospital or ED Utilization:** High Utilizer Adults are members with five or more emergency room visits AND/OR three or more unplanned hospital admissions and/or multiple short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.
- **Adults with Serious Mental Illness (SMI) or substance Use Disorder (SUD):** Adults with Serious Mental Illness (SMI) or Substance Use Disorder (SUD) who meet the eligibility criteria for participation in or obtaining services through the County Specialty Mental Health (SMH) System AND/OR the Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) program AND are actively experiencing one complex social factor influencing their health e.g., food, housing, employment insecurities, history of ACES, history of recent contacts with law enforcement related to SMI/SUD, former foster youth. etc. AND meet one or more of the following criteria: high risk for institutionalism, overdose and/or suicide, use crisis services, ERs, urgent care or inpatient stays as the sole source of care, two+ ED visits or two+ hospitalizations due to SMI or SUD in the past 12 months, pregnant and post-partum (12 months from delivery).
- **Adults at risk for institutionalization:** Adults who are eligible for long-term care services who, in the absence of services and supports would otherwise require care for 90 consecutive days or more in an inpatient nursing facility.
- **Nursing facility residents:** Adults who want to transition to the community, who are strong candidates for successful transition back to the community and have a desire to do so.

Social Determinants of Health (SDoH)



The CalAIM program emphasizes the importance to address a person's non-clinical needs by managing comprehensive needs through whole person care approaches. Whole person care identifies social determinants of health.

Social determinants of health are the conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to healthcare, education access and quality.

SDoH can be grouped into 5 domains:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

Examples and Codes for SDoH

- Z55.0 Illiteracy and low-level literacy
- Z59.0 Homelessness
- Z59.1 Inadequate housing (lack of heating/space, unsatisfactory surroundings)
- Z59.3 Problems related to living in residential institution
- Z59.4 Lack of adequate food and safe drinking water
- Z59.7 Insufficient social insurance and welfare support
- Z59.8 Other problems related to housing and economic circumstances (foreclosure, isolated dwelling, problems with creditors)
- Z60.2 Problems related to living alone
- Z60.4 Social exclusion and rejection (physical appearance, illness or behavior)
- Z62.819 Personal history of unspecified abuse in childhood
- Z63.0 Problems in relationship with spouse or partner
- Z63.4 Disappearance & death of family member (assumed death, bereavement)
- Z63.5 Disruption of family by separation and divorce (marital estrangement)
- Z63.6 Dependent relative needing care at home
- Z63.72 Alcoholism and drug addiction in family
- Z65.1 Imprisonment and other incarceration
- Z65.2 Problems related to release from prison
- Z65.8 Other specified problems related to psychosocial circumstances (religious or spiritual problem)



Enhanced Care Management

Seven ways ECM works for our patients

1. Help your patient stay engaged in their care
The ECM lead care manager and care team help our patients focus on their health and make sure they receive the services and support they need. We meet our patients where they live or where they receive services.
2. Help patients craft a plan
Together, our patients and care team will make a personalized care plan. The plan covers:
 - Doctors they see
 - Health goals they set
 - Services they get
 - Care they need
 - Their physical and behavioral health needs
 - Their oral health needs
 - Their substance use treatment needs
 - In-home services (e.g. help with bathing, dressing, cleaning, cooking, etc.)
 - Neighborhood and social services (e.g. food and housing services)
3. Help your patient to connect with and update their doctors
The care team includes a lead care manager. The Lead Care Manager keeps all of their patients doctors up to date on the health and the services they receive. They can also help patients find:
 - Figure out your patient's health needs, goals and wishes
 - Help patients learn to make appointments and check on prescriptions and refills
 - Help patients find the right doctors
 - Help patients arrange transportation to doctor visits
 - Help patients apply for services to help you live on your own— services include meal delivery, housing and personal care
4. Help Your Patient Learn the Best Ways to Better Support Their Health
Help your patients, their caregivers and other people who support them, learn about the best ways for your patient to take care of their health issues.
5. Help to move your patient safely from one care setting to another.
Your care team will help you move safely and easily if you need to enter or leave:
 - A hospital
 - A nursing facility



- Another care setting
 - They can help you with challenges like:
 - Learning how to take care of yourself after a hospital stay
 - Making follow-up doctor visits
 - Filling prescriptions
 - Getting transportation to appointments
6. Help your patient to work with their support people
- The care team can make sure the patient's family, caregivers and others who support them, know about their health issues. These people can also work with the care team to learn how to best help the patient.
7. Help to connect your patient to community and social services
- ECM can help patients get linked to other non-health services, too. The care team can help them find community and social programs that they need. These may include:
- Food
 - Job training
 - Childcare
 - Disability-related services
 - Resources to help you stay in your home



Community Supports (CS)

Community Supports are certain community-based services that address health-related social needs. Medi-Cal managed care health plans may offer these alternative services to their members to avoid hospital care, nursing facility care, visits to the emergency department, or other costly services. Members do not need to be enrolled in ECM services to receive Community Supports.

Some Managed Care Plans may not offer certain Community Supports in their counties. Refer to specific MCP referral guides for more information.

Community Supports under CalAIM

There are 14 Community Supports under CalAIM.

Master-Care provides 4 Community Supports in some counties with select MCPs. Refer to MCP Counties roster.

Community Support Name	Community Support Description	Master-Care provides this service in <i>select</i> counties:
Housing Transition Navigation Services	Assist individuals with obtaining housing.	✓
Housing Deposits	Assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board	
Housing Tenancy and Sustaining Services	Aims to help individuals maintain safe and stable tenancy once housing is secured.	✓
Short-Term Post-Hospitalization Housing	Provides those 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 recovery immediately after exiting an inpatient institutional setting	
Recuperative Care (Medical Respite)	Provides short-term integrated and clinical care for individuals who no longer require hospitalization but still need to heal from an	

	injury or illness (including behavioral health conditions).	
Respite Services	are Short-term services provided to caregivers of those who require occasional temporary supervision to give relief to the caregiver	
Day Habilitation Programs,	Provide services in or out of a person's home to assist them in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the community	
Nursing Facility Transition/Diversion to Assisted Living Facilities	Helps individuals live in the community by facilitating transitions from a nursing facility back into a home-like, community setting, or preventing nursing facility admissions for those with imminent need	✓
Community Transition Services/Nursing Facility Transition to a Home	Assists individuals to live in the community to avoid further institutionalization by providing non-recurring set-up expenses for individuals transitioning from a licensed facility to a living arrangement in a private residence	✓
Personal Care and Homemaker Services	Supports individuals who need assistance with daily activities, such as bathing, getting dressed, personal hygiene, cooking, and eating.	
Environmental Accessibility Adaptations (Home Modifications),	Provides physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home	
Meals/Medically Tailored Meals/Medically Supportive Foods	Helps individuals achieve their nutrition goals at critical times to help them regain and maintain their health	
Sobering Centers	Used as alternative destinations for individuals who are found to be publicly intoxicated and would otherwise be transported to the emergency department or jail	



Asthma Remediation	Provides physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.	
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Master•Care will refer to the other CS providers as a part of ECM as appropriate and available.

ECM and CS Counties and Services

For an updated roster of Managed Care Plans, Services, and Counties, refer to MCP Counties and Teams Roster found in the Salesforce library.



How We Get Our Patients

MasterCare receives our patients through Member Information Files (MIFs) or Referrals.

MIF Also known as Member Information Files

Only Applies to Enhanced Care Management (ECM)

This is the list of patients generated by the Managed Care Plans. We are paid for outreach to these patients. We have a responsibility to the Managed Care Plans to make at least 5 attempts to reach these patients in 90 days. Attempts include in person or door knocks. We also need to verify eligibility for these patients if they are interested in our services and enroll them.

Referrals from Managed Care Plans

Applies to BOTH Enhanced Care Management (ECM) and Community Supports (CS)

When we receive a referral from a Managed Care plan it will be assigned to you, but the difference is they are already eligible and have been referred to the Managed Care Plan by another provider such as a PCP, Case Manager or Discharge Planner. We use different language reaching out to these patients. We may still have to explain our services, but we can tell them they are already enrolled, and we just need their consent and to schedule an assessment. These patients are pre-qualified for this program and are usually good candidates for this program.

Referrals Generated by Our Own Efforts

Applies to BOTH Enhanced Care Management (ECM) and Community Supports (CS)

These patients come to us both organically and because of relationships we have made with PCP, Case Managers, Discharge Planners, SNFs, CBOs and other community resources. While working with different providers and resources we always need to ask for referrals, let them know we are happy to assist them in referring their patients or members of the community they serve. These patients require we qualify them thoroughly and refer them in directly to the Managed Care Plans.

Refer to page 17 for Referral process and guidelines.

Who Qualifies for ECM?

To qualify for with MasterCare you must be enrolled in Medi-Cal Managed Care with one of the Managed Care Plans we work with AND meet one of the following criteria:

1. Adults who are at risk for hospital or emergency stays that could be avoided.
2. Adults at risk of going to a long-term care facility such as skilled nursing or nursing home
3. Adults who are moving/discharging from a nursing home to the community or back home.



Master-Care Universal Procedures

Referrals of New Patients to Master-Care

If you receive a referral by email, phone or when out in the community you must follow this protocol to ensure all referrals are processed promptly.

Managing New Patient Referrals Checklist

- ☐ Email all referral information to Notification@mastercareplan.com AND cc the Referrer
- ☐ Follow up with referrer to let them know to reach out to our referral team
 - Notification@MasterCarePlan.com
 - 855.836.6355 Office
 - 877.924.7010 Secure Fax
- ☐ If any additional documentation is needed, our referral team will reach out directly to the referrer.

Best Practice Tips

- Gather all documents! Include all contact information for the referrer in your email to notification@mastercareplan.com
- Give your referral sources the tools to directly refer! Email your connections with how to refer to Master-Care and include forms and other program information.
- Only send referral forms for services in your area! Know what we do in your area and which care plans we work with!

IMPORTANT! We do not assess or begin care for patients who have not been authorized! We must check eligibility and refer them for services first- no exceptions. Please manage expectations accordingly. We can certainly explain services to a new referral, as long as we are careful to explain that we must first ensure they are eligible, I wouldn't want to promise something we cannot do.

Email Script

Sample Email:

We appreciate your referrals and want to make sure you have what you need to refer to Master-Care.



Our referral team does a great job taking care of your referral. Referrals can be submitted in three ways.

Email: Notification@MasterCarePlan.com

Call: 855.836.6355 Office

Fax: 877.924.7010 Secure Fax

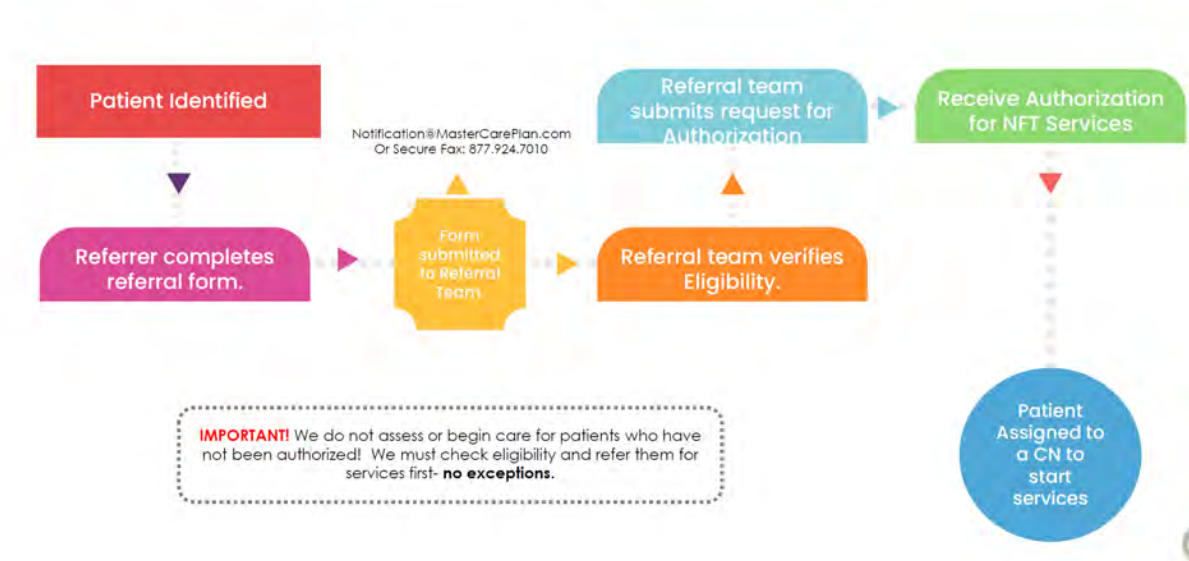
I have attached referral forms for the following services:

- ECM
- CS Nursing Facility Transition/Diversion
- CS Housing Navigation

If you are not sure which form to complete, you may call or send the ECM form with any patient information and we can help ensure your patient is referred to the most appropriate program. We look forward to working with you!

Direct Referrals

Direct referrals are referrals generated by our own efforts through Community Relations, word of mouth, personal referrals, etc.



Outreach

Initial Contact

Immediate response to outreach candidates and newly referred CS and ECM patients is a priority.

Review your calendar immediately to schedule your initial contact and outreach touches.



GOAL: Making contact to explain services, get consent, schedule an assessment, or get a decline of service.

Outreach Process Steps

1. Make sure you are in a space that has no distractions
2. Have a note pad and pen ready
3. Have your scripts and talking points ready
4. Open Salesforce
5. Open patient record and patient record
6. Call directly through Sales Force using Ring Central integration
7. Documents details of the call
8. If successful with scheduling an assessment, create a Salesforce Calendar Event "Initial Assessment"
9. Add Follow Up Tasks before closing patient record. (No task will result in failure to follow through.)

Tips:

- Pace yourself but be efficient! Hit your KPI's (see chart below)
- Give yourself enough time for your ESL or possible non-English speaking patients.
- Use Google translate to send a follow up text if non-English speaking, explain that you are using a translation tool and ask if they have anyone that can translate for them before requesting translation services from the Managed Care Plan. *Write the text in Google translate and copy and paste into your Ring Central in Salesforce.
- Always leave a voicemail.
- Follow up with a text message.
- Do not discount a disconnected number. No outreach patient is considered unreachable until we have done all forms of outreach.
- Set your next outreach task for a different day and time.

KPI's of Outreach (MIF)

Outreach from the MIF List

5 attempts minimum:

- 1st attempt- within 24 hours of assignment
- 5th attempt- Door Knock within 30 days
- Attempts beyond 5 are on a case-by-case basis, if there is a good reason to continue pursuing the patient.

KPI's of Initial Contact (Referrals)

Initial Contact with CS or ECM Referral



8 attempts minimum:

- 1st attempt- within 24 hours of assignment
- 8th attempt- Door Knock within 30 days
- Attempts beyond 8 are on a case-by-case basis, if there is a good reason to continue pursuing the patient.

Unresponsive Patient

If a patient is not responsive, you must try multiple times and ways to connect with your patients within 60 days. (Min. 5 Attempts for MIF, 8 Attempts for Enrolled/Referrals from MCPs)

If patient is not responding:

- Multiple attempts within the month must be made. At minimum, once a week.
- If no successful attempts at 30 days, attempt a Door Knock.
- If no successful attempts at 45 days, leave a voicemail and/or text message informing of possible disenrollment at 60 days.
- If no successful attempts at 60 days, disenroll patient.

Document all attempts. Do not leave patient chart without creating a task.

Outreach Scripts

Outreach Message Script for Outreach Member

1. Leaving a message on voicemail that is personalized as the patients
"Hi, this is (name) with Master•Care on behalf of (managed Care plan) You have been referred to participate in a new care management program to assist with navigating your healthcare benefits. My number is (your number) I look forward to hearing back from you."
2. Leaving a message on a generic voicemail (does not identify the person you are calling)
"This message is for (name) this is (your name) with Master•Care, can you please give (name) a message to call me back or let me know if this is the right number to reach (name) My number is (your number)"
3. Leaving a message with someone who is not the patient
"May I leave (name) am message? This is (your name) with Master•Care My number is (your number) this is regarding his/her healthcare benefits."

Initial Contact Message Script for Referred CS or ECM Member

1. Leaving a message on voicemail that is personalized as the patients
"Hi, this is (name) with Master•Care on behalf of (managed Care plan) You have been referred for Enhanced Care Management. My number is (your number) I look forward to hearing back from you." OR "Hi, this is (name) with Master•Care on behalf of (managed Care



- plan) You have been referred for [Name of Community Supports]. My number is (your number) I look forward to hearing back from you.”
2. Leaving a message on a generic voicemail (does not identify the person you are calling)
“This message is for (name) this is (your name) with Master•Care, can you please give (name) a message to call me back or let me know if this is the right number to reach (name) My number is (your number)
 3. Leaving a message with someone who is not the patient
“May I leave (name) am message? This is (your name) with Master•Care My number is (your number) This is regarding his/her assessment.

Outreach Text Message Script for MIF list

Hello, this is (your name) with Master-Care on behalf of your health plan (name of managed care plan). I am trying to reach (patients name). Master-Care has been assigned as your Enhance Care Management provider. If you could give me a text or call back, I would like to explain the program and see if you’re interested in enrolling in this free program.

Outreach Reporting

Master-Care document and submit a report of the members who have declined/opted out of ECM services or remain unable to reach for each month according to contractual expectations according to each Managed Care Plan partner.



Consent

Enrollment and Consent Requirements

It is required to obtain consent from each patient for services and data sharing. There are various methods available to you to obtain and upload consents into patient charts.

1. **Task** RCN to check eligibility once verbal enrollment has been completed. If the patient wants to do in person consent and not verbal, then task RCN when you schedule the assessment.
2. **KPI:** 30 Days to complete assessment after verbal enrollment (sooner is better). At 60 days we are considered out of compliance and will have to dis-enroll the patient.

Verbal Enrollment Consent

1. Tell the outreach candidate that you are going to read a quick enrollment statement. Read the following script:
 - “This is [your name, “Care Navigator”] with Master•Care, I am verbally enrolling [patient’s name] into Enhanced Care Management and/or Community Supports.
 - [Patient name], Do you authorize Master•Care to initiate services on your behalf, which includes scheduling an assessment with you at a location of your choosing? (Patient response)
 - Do you further authorize the authorized Master•Care, to communicate with you in writing, electronically, or by telephone, as may be necessary for the purpose of your healthcare coordination and management? (Patient response)
 - Do you authorize Master•Care to share data regarding your Healthcare service with other authorized providers in coordination with the services we provide? (Patient response)
 - Do you understand that you may, AT ANY TIME and without consequence, withdraw your participation from the program at any time? (Patient response)
3. Thank the patient and move on to scheduling the assessment.
4. Save recording to desktop and upload the recording into Salesforce
5. CN to document properly and ensure Consent Date is accurate in Quality tab.

Electronically Signed (E-Signed) Enrollment Consent

You will be provided an e-sign link, that can be sent via email or text.

1. Once the patient clicks on it, they can review the document sign in appropriate areas.
2. Once signed, the fully executed consent is sent to both the patient and Master•Care admin.
3. Master•Care admin will upload consent into Salesforce and notify CN via task.
4. CN to document properly and ensure Consent Date is accurate in Quality tab.

Paper Enrollment Consent

Always keep paper copies of our consent with you.

1. Have patient sign and initial where needed
2. Take pictures of each signed page (PDF scanner app)
3. You can leave the hard copies with the patient



4. Upload completed PDF of signed consent to patient profile
5. CN to document properly and ensure Consent Date is accurate in Quality tab.

Termination and Graduation

Extending authorization

If a patient is coming to the end of their authorization period, they must be evaluated for graduation or extended authorization.

If graduation is appropriate- follow graduation process

If extended authorization is appropriate:

1. Complete the graduation questionnaire (must show continued need) or other required paperwork
2. Submit it to Tisha 30 days prior to the end of authorization.
3. Always upload all documentation to patient files

Graduation and Termination from ECM or CS

Common Reasons for graduation/termination, but not limited to:

Reason	Status:
Verbally declined services	Declined
Unresponsive	Discharged/Termed
Refuses to Cooperate	Discharged/Termed
Unsafe Behavior	Discharged/Termed
Enrolled in Duplicative Program (i.e. Hospice, Cal Medi-Connect)	Discharged/Termed
Medi-Cal Termination	Discharged/Termed
Moved Out of Service Area	Discharged/Termed
Met All Care Plan Goals	Graduation
Independently Managing their Care	Graduation

Process Checklist

- ☐ Change Patient Status
 - Declined
 - Discharged/Termed
 - Graduated
- ☐ Add Discontinuation Date and Narrative
 1. Select ECM or CS
 2. Scroll to “Administrative Only”
 3. Update “Discontinuation Date” field.
 4. Update “Discontinuation Narrative” field.
 5. Click Save.



- ☐ Add a note in “Notes” section stating reason for disenrollment.
- ☐ Share the note with your direct supervisor.

Assuring Excellent Care Management & Providing Ongoing ECM and CS

Communication Requirements

The number of monthly engagements with patients is based upon the care plan and overall needs of your patient.

We require no less than one engagement per month, and this is only appropriate if patients needs/desires minimal interaction. Most patients require more than one engagement per month.

Please note, attempts do not count as patient engagement. If a patient is not responsive, you must try multiple times and ways to connect with your patients within 60 days. (Min. 5 Attempts for MIF, 8 Attempts for Enrolled/Referrals from MCPs)

Professional communication is required both written and verbally.
Always maintain your sense of professionalism even when a patient is being difficult.

If patient is not responding:

- Multiple attempts within the month must be made. At minimum, once a week.
- If no successful attempts at 30 days, attempt a Door Knock.
- If no successful attempts at 45 days, leave a voicemail and/or text message informing of possible disenrollment at 60 days.
- If no successful attempts at 60 days, disenroll patient.

KPIs for Engagement

- **KPI:** Patient MUST be engaged 1 time per month MINIMUM.
- **KPI:** All Enrolled patients are required to have at least 1 task pending.

MDT: Multidisciplinary Team Communication

What is MDT? The multidisciplinary team may include Doctors, Nurses, and other clinical professionals. It may also include county and community professionals working with the patient, clinical and paraprofessionals. Care Conferences are also MDT.

Multidisciplinary Team Communication is requirement. Communicating with other clinical and care professionals involved with our patients is a crucial part of delivery of care. In some cases where there is little involvement of care professionals, we must still assure that as we connect



our patients to clinical and care professionals that we include communicating the care plan, goals, for review and to show their part in the goals.

Ways to engage with MDT

1. Go to appointment with your patient
2. Do a conference call
3. Send an email including patient and others that are a part of their MDT
4. When the MDT does not want to engage: Mail initial care plan, include all ways to communicate with you and your patient and your request for their involvement in the patients Care Plan.
5. Collaborate with:
 - i) Area hospitals;
 - ii) Primary Care Providers;
 - iii) behavioral health Providers, Specialists;
 - iv) dental Providers;
 - v) Providers of services for LTSS, and other associated entities, such as;
 - vi) Other CalAIM Providers, as appropriate, coordinate member care.

Engaging the MDT can be a challenge at times but opening lines of communication with clinical and care professionals is required even if they do not engage with you.

Important: Document all encounters with MDT even if they do not engage with you or respond.

Care Conferences

Care conferences are held for every person receiving services from Master•Care. They help the Care Team involved in the patient's care, share information, and work together to meet the patient's needs.

Individual care conferences can be done via the review process with our RN and/or ECM manager.

Once your assessment has been completed and uploaded task our RN (Jennifer) and Our ECM manager (me) with review.

Group Care conferences are scheduled monthly, as a group.

Care Conferences allow us to review and make decisions about each patient's Care Plan both initially and as updates/changes are needed. A care plan tells us:

- what the patient's needs are



- what the goals are for meeting those needs
- what steps are planned to meet those goals

The initial care conference is usually held immediately following the initial assessment. This is a chance to share information and talk about concerns. At the initial care conference:

- Assessment findings are presented. This is used to help plan care and acts as a baseline for care decisions and to measure progress or regression as time goes by.
- Important facts about the patient are discussed
 - Family, work, social background
 - Medical diagnosis- corresponding care needs and information about current care
 - Social Determinates of Health
 - Attitude, interests, likes and dislikes
 - Financial needs and budget
- A plan is worked out and assignments made. Each team member knows their part, and understands the overall goals of the care plan

After the initial conference, more care conferences are held as changes take place, or after a set amount of time has passed. These new conferences are used to keep the assessment, facts, and plan up to date.

What's Your Role?

As part of the Care Team, you are there to communicate and collaborate: Explain findings, ask questions, and gather information, so an effective person-centered plan can be put into motion with goals and assignments.

How Can You Get Ready?

We have a limited amount of time for care conferences. Being prepared is key to productive care conferences.

- Lead Care Navigators should have a list of patients to be discussed at group care conferences. For individual care conferences Lead Care Manager should have patient file accessible for review.
- Beforehand, flag and write down questions or concerns you have. And make a note of any facts you think the care team should know about. For individual care conferences you can add notes to the patient file.
- During the meeting or after the review notes are submitted, speak up. If you don't understand a point, ask to go over it again. If you don't agree with something, say so. The purpose is to collaborate in the best interest of the patient.

Care Conferences are crucial to success!

- They help make sure there is a team approach to care.



- They help make sure everyone involved has the facts they need.
- They help make sure everyone understands three key things: the patient's needs; the goals set up to meet those needs; and the plan for reaching the goals.

Care Conference Requirements

1. Care plan updates and conferences: as needed or once a quarter. (every 3 months)
2. Always update notes and activities after a care conference even if RN or ECM Director are adding notes. Your notes are equally important and will have an action behind them.
3. Add Task or multiple tasks before closing patient record: **No task = failure to follow through**

Emergency Situations

Safety is a priority, if at any time a situation becomes dangerous call 911 and move yourself and if appropriate your patient to a safe location.

Hotlines and Call Centers

Assure you have hotline numbers at the ready:

- Suicide
- Mental health
- Dementia
- Veterans
- Warm lines

Complaints

1. Document all patient complaints, task and message your supervisor with details
2. Actions should always be taken when a complaint is made even if the complaint is unfounded
3. Investigation into the complaint will take place and all parties will be notified of the outcome.
4. Documentation of all encounters is a crucial part of investigation into complaints. Always documents all encounters.
5. Complaints can be made against MasterCare, an MCP or other providers. In all cases we must document and address these complaints.



Enhanced Care Management (ECM) Program

ECM Assessment

Key Components

- In-Person Contact
- Person-Centered
- Comprehensive and complete
- Patient-Centered Care Plan
- Care plan implementation
- Continuous and integrated care
- Treatment adherence and Health Promotion
 - Get a PCP and make an appointment
 - Use member website such as Krames Online health library and other evidence-based resources located in the Important Links Document
 - Encourage Journaling, tracking
- Communication
 - Fostered on-going engagement with patient
 - Timely reassessment.

Reassessment Protocol

- Minimum of 1x per year
- After Admission, Discharge or Transition
 - Response to ADT within **72 hours** of notification
 - Reassessment
 - Updated care plan – new goals
 - Exception to updated assessment and care plan: minor illness without a change in condition such as cold and flu.
- Any event that causes a change in condition, housing, or SDoH

KPIs for Assessments

1. **KPI: 24-48 hours** to upload assessment and care plan. Update notes and documentation regarding the goals and next steps.
2. **KPI: 24-48 hours** to task Clinical Team (RN) with Assessment and Care Plan Review

Completing the Assessment

A complete assessment is not only required by the Managed Care Plans but is how we create goals and The Master Care Plan



Remember your training:

- Motivational Interviewing- remain personable, approachable, conversational.
 - Trauma Informed Care- watch for clues of trauma triggering, be sensitive, and be aware of your phrasing and use of words.
1. Always complete the entire assessment. Leave no blank fields.
 2. Allow the patient to decline to answer- document decline to answer.
 3. Put N/A in the places that do not apply to your patient.
 4. Do not make the patient uncomfortable but take notes and make observations that you can later document.
 5. Always try to leave with at least 1 goal with next steps. Having a goal makes it easier to re-engage the patient.

Data Entry

All data entry must be completed on Salesforce within 48 hours of completion of assessment.

1. In the patient's profile check all the boxes and complete all the fields that apply.
 - a. Required Fields
 - i. Population of Focus
 - ii. Social Determinants of Health
 - iii. Date of Consent
 - iv. Date of Assessment
 - v. Date of Care Plan
2. Add a note with narrative from the assessment. Include observations of appearance and behaviors. In your event task put see note in the description.

Best Practice Tips

Successfully completing an assessment includes looking for key information to form an Initial Care Plan and set at least one immediate and attainable goal.

2. Use motivational interviewing
3. Go off subject to flow with the patient but guide back to the questions at hand
4. Pay close attention to the mental health portion of the assessment. We have a serious mental health crisis in CA. Many people who have no diagnosis may still struggle from time to time, especially when they are having other crisis in their life. It doesn't mean they have a diagnosable mental health issue, but they may be having a temporary mental health crisis. It more common than most people admit!
5. Diagnosis is another key piece of information. Do they have a health diagnosis? If so, explore that. Do they take medications as prescribed, any side effects? Do they know what they are for?



6. Never underestimate the power of your patient's support system if they have one.
7. Do they have a PCP and when did they last see them?
8. Do they have dental issues and when was their last dental exam?
9. Look for clues on what makes them upset or reactive in anyway. That may be a pain point in their life. Tread carefully but it may be exactly what you need to focus on helping them with.

Set your patient up for success with these ideas and examples:

- Manage expectations. What are their expectations? Setting appropriate expectations is key to building trust and having success.
- Assuring your patient has the tools they need to achieve their goals.
- Reminders and follow up to assure proper level of support for success.
- Health Promotion: Leave patient with important information such as mental health crisis line, nurse advice line for their managed care plan, a telehealth app, link to member facing website for their managed care plan, etc.
- Don't overlook medications- Assure your patient can access and understand their medications AND takes them appropriately. If in doubt their PCP should do a med review.
- Vision and Dental
- Start process for scheduling a PCP appointment.

Care Planning and Goal Setting

SMART Goals

A SMART goal is used to help guide goal setting. SMART is an acronym that stands for **S**pecific, **M**easurable, **A**chievable, **R**ealistic, and **T**imely.

SMART goals are:

- **Specific:** Well-defined, clear, and unambiguous
- **Measurable:** Specific criteria that measure progress toward the goal
- **Achievable:** Attainable and not impossible to achieve
- **Realistic/Relevant:** Within reach, realistic, and relevant.
- **Timely:** With a clearly defined timeline, including a starting date and a target date. The purpose is to create urgency.

SMART Goals are the basis of The MasterCare Plan.
Establish Immediate, short term and long-term goals.



Completing the Care Plan

Sometimes goals are verbal at the assessment but must be written out on the MasterCare plan and uploaded into the patient's file.

- Always document the communication of the goals/care plan
- Do not forget to add tasks to follow up on the tasks/responsibilities
- Encourage the patient to do their part as Highest Level of Independence is the Goal

Always identify:

- The patient's responsibility to the goal
- Any barriers- plans to overcome these barriers
- Time to accomplish the task/responsibilities
- Desired outcome and date to accomplish the goal

Communicating the Care Plan

Communicating the goals and tasks/responsibilities is a requirement.
Documentation of this communication is a requirement.

You can communicate the care plan and goals by:

- Mailing the sheet to the patient
- Emailing the sheet to the patient
- Verbal communication via text or phone

KPIs for Care Planning

- **KPI:** Upload Care Plan into patient's chart within 30 days of assessment. Once you complete the Care Plan Document save it as a PDF and upload it to the patient's file.

Closed Loop Referrals

A crucial part of what we do is finishing what we started. Closed loop referrals means:

- We follow up with everything do (set a task to do this!)
- We refer and coordinate all CS and other CBO referrals.
- We document all resources given to our patients- what was the outcome? Was it successful or not? Why?
- We communicate with our patients- Do what you say you are going to do, document the responses and outcomes of communication.



How To Refer to Community Supports

If you identify that your patient may benefit from Community Supports, your Remote Care Navigator assists you with the process of submitting the referral.

1. Review your patient's Eligibility Criteria
2. Gather supporting documents
3. Document notes and/or upload documentation according to requirements. Each Community Support will have varying requirements.
4. Task Remote Care Navigator on Salesforce with Referral Submission
5. Coordinate all communication. Follow up and close the loop.
6. Set Follow Up Tasks on Salesforce
7. Document all activity on Salesforce

How To Refer to Community Based Organizations (CBO) or Other

If you identify a need during assessment or care planning, you will coordinate the referral for your patient.

1. Identify CBO, or other community entity, that can assist in meeting the needs of your patient.
2. If referring on behalf of the patient, ensure the patient is aware and consents to the referral.
 - Make a referral based on a timeline agreed to with the patient.
 - Follow up or do a warm introduction to ensure services are being provided.
 - Document interactions and outcomes.
3. If giving patient information for self-referral:
 - Inform the patient of the referral process.
 - Follow up with the patient based on an agreed timeline.
 - Document interactions and outcomes.

Requirements and Documentation for Community Support Referrals

Community Support	Requirements	Documents
Housing Transition Navigation Services	Are they exiting any of the following: <input type="checkbox"/> Recuperative care <input type="checkbox"/> inpatient hospital stay <input type="checkbox"/> Residential alcohol or drug abuse recovery or treatment facility <input type="checkbox"/> Residential mental health treatment facility <input type="checkbox"/> Correctional facility	Documentation: It's recommended you upload one or more of the following documents with this request: <ul style="list-style-type: none">• Documentation of homelessness or at risk for homelessness by service providers, PCPs, specialists, or outreach providers

	<p>What is the member's housing status?</p> <p><input type="checkbox"/> Homeless</p> <p><input type="checkbox"/> Chronically homeless</p> <p><input type="checkbox"/> At risk of homelessness</p> <p>Is the member currently receiving housing navigation services? <input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>What is the member's housing status?</p> <p><input type="checkbox"/> Homeless</p> <p><input type="checkbox"/> Chronically homeless</p> <p><input type="checkbox"/> At risk of homelessness</p>	<p>Documentation of entries/exits from shelters</p> <ul style="list-style-type: none"> • Notices from current landlord • Financial Statements
Housing Deposits	<p>Identification, coordinating, securing, or funding one-time services and modifications necessary to enable the member to establish a basic household. Funding to support security deposits, set-up fees/deposits for utilities, first months and deposit, services necessary for member's health and safety, and goods/medically necessary adaptive aides to preserve the member's health and safety in the home. Does not include provisions beyond first and last month's rent. Lifetime maximum of \$6500</p> <p>What is the member's housing status?</p> <p><input type="checkbox"/> Homeless</p> <p><input type="checkbox"/> Chronically homeless</p> <p><input type="checkbox"/> At risk of homelessness</p> <p><input type="checkbox"/> Prioritized for a permanent supportive housing unit or rental subsidy resource through the local CES</p>	<ul style="list-style-type: none"> • Lease agreement • W9 from the landlord matching the lease • Statement from patient stating that they can sustain housing • Housing Plan • If landlord wishes to have DD banking info and voided check. Must match W9
Housing Tenancy and Sustaining Services	<p>Services to maintain a safe and stable tenancy once housing secured. Services can include the identification and intervention of behaviors that jeopardize housing, education on role/rights/ responsibilities of tenant</p>	<p>Documentation: It's recommended you upload one or more of the following documents with this request:</p> <ul style="list-style-type: none"> • Housing support plan • Lease agreements

	<p>and landlord, coaching on maintaining and developing landlord/property managers, assistance with landlord/neighbor disputes, advocacy/linkage to community resources, benefits advocacy, assistance with annual housing recertification, review/update/modify housing support and crisis plan, assistance with lease compliance, health and safety visits, and independent living and life skills.</p> <p>Is the member receiving housing navigation services? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What is the member's housing status?</p> <p><input type="checkbox"/> Homeless</p> <p><input type="checkbox"/> Chronically homeless</p> <p><input type="checkbox"/> At risk of homelessness</p>	
Short-Term Post-Hospitalization Housing	<p>This service provides housing for members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical, psychiatric, or substance use disorder recovery immediately after exiting one of the following:</p> <ul style="list-style-type: none"> • Inpatient hospital • Residential alcohol or drug abuse recovery or treatment facility • Residential mental health treatment facility • Correctional facility • Nursing facility • Recuperative care <p>The member must also be receiving housing navigation services. May request urgent/expedited review. Lifetime benefit one-time and not to exceed duration of six months</p>	<p>Documentation: It's recommended you upload one or more of the following documents with this request:</p> <ul style="list-style-type: none"> • _ED or inpatient discharge paperwork • _Documentation of homelessness by service providers, PCP, specialists, or outreach providers • _Documentation of member participating in housing transition navigation services

	<p>Are they exiting any of the following:</p> <p><input type="checkbox"/> Recuperative care</p> <p><input type="checkbox"/> Inpatient hospital stay</p> <p><input type="checkbox"/> Residential alcohol or drug abuse recovery or treatment facility</p> <p><input type="checkbox"/> Residential mental health treatment facility</p> <p><input type="checkbox"/> Correctional facility</p> <p>What is the member's housing status?</p> <p><input type="checkbox"/> Homeless</p> <p><input type="checkbox"/> Chronically homeless</p> <p><input type="checkbox"/> At risk of homelessness</p> <p>Is the member currently receiving housing navigation services? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
Recuperative Care (Medical Respite)	<p>Short-term residential care for members who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. At a minimum, includes interim housing with bed and meals and ongoing monitoring of the members medical or behavioral health condition. Limited to continuous 90 day stay. The member:</p> <p><input type="checkbox"/> Is at risk of hospitalization</p> <p><input type="checkbox"/> Is post-hospitalization and needs to heal from injury or illness</p> <p><input type="checkbox"/> Lives alone with no formal support</p> <p><input type="checkbox"/> Faces housing insecurity or has housing that would jeopardize his or her health and safety without modification</p>	<p>Documentation: It's recommended you upload one or more of the following documents with this request:</p> <ul style="list-style-type: none"> • Emergency department, inpatient, or skilled nursing discharge paperwork • Documentation of homelessness by service providers, PCPs, specialists, or outreach providers • Documentation of entries/exits from shelters • Documentation from any support agency indicating services/supports member needs • Documentation/office visit notes with

		<p>diagnosis and identification of frailty</p> <ul style="list-style-type: none"> • Assessment determining limitations in ADLs • Medication/treatment orders
Respite Services	<p>Respite services for non-paid caregivers of members only. Provided on a short-term basis due to the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. Services can be provided in the home or a facility. May request urgent/expedited review.</p> <p>The member (<i>check all that apply</i>):</p> <p><input type="checkbox"/> Resides in the community</p> <p><input type="checkbox"/> Requires assistance with activities of daily living</p> <p><input type="checkbox"/> Is dependent on non-paid caregivers</p> <p>Does the caregiver require relief to avoid institutional placement of member? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is member willing to receive respite care in home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is member willing to receive respite care in a facility? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Documentation: It's recommended you upload one or more of the following documents with this request:</p> <ul style="list-style-type: none"> • Documentation/office visit notes with diagnosis and identification of frailty • Documentation from support agencies indicating services/supports member needs or receives • Attestation from unpaid caregiver(s) requesting services
Day Habilitation Programs,	<p>Provided in home or out-of-home, non-facility setting. Programs designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills to remain in their natural environment.</p> <p>What is the member's housing status?</p> <p><input type="checkbox"/> Homeless</p> <p><input type="checkbox"/> Chronically homeless</p> <p><input type="checkbox"/> At risk of homelessness</p>	<p>Documentation: It's recommended you upload one or more of the following documents with this request:</p> <ul style="list-style-type: none"> • _Documentation of housing status by service providers, PCP, specialists, or outreach providers • _Documentation of participation in housing navigation or housing tenancy and sustaining services

	<p><input type="checkbox"/> Entered housing in the last 24 months</p> <p>The member is participating in <i>(check one or both)</i>:</p> <p><input type="checkbox"/> _Housing navigation</p> <p><input type="checkbox"/> _Housing tenancy and sustaining services</p> <p>The member would benefit from the following training:</p> <p><input type="checkbox"/> Use of public transportation</p> <p><input type="checkbox"/> Personal skills development in conflict resolution</p> <p><input type="checkbox"/> Community participation</p> <p><input type="checkbox"/> Developing and maintaining interpersonal relationships</p> <p><input type="checkbox"/> Daily living skills (cooking, cleaning, shopping, money management)</p> <p><input type="checkbox"/> Community resources awareness such as police, fire, or local services to support independence</p> <p><input type="checkbox"/> Selecting and moving into a home</p> <p><input type="checkbox"/> Locating and choosing suitable housemates</p> <p><input type="checkbox"/> Locating household furnishings</p> <p><input type="checkbox"/> Managing personal financial affairs</p> <p><input type="checkbox"/> Recruiting, screening, hiring, training, supervising, and dismissing personal attendants</p> <p><input type="checkbox"/> Dealing with and responding appropriately to governmental agencies and personnel</p> <p><input type="checkbox"/> Asserting civil and statutory rights through self-advocacy</p> <p><input type="checkbox"/> Building and maintaining interpersonal relationships, including circle of support</p> <p><input type="checkbox"/> Other</p>	
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<p>Nursing Facility Transition/Diversion to Assisted Living Facilities</p>	<p>This service is for members residing in the community, who are at risk of imminent need for nursing facility level of care and are willing to reside in an assisted living facility as an alternative to long term placement in a nursing facility. Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board.</p> <ol style="list-style-type: none"> 1. Is the member interested in remaining in the community? 2. Are they willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services? 3. Do they meet minimum criteria for nursing facility level of care (unable to complete ADLs without assistance)? _No 4. Are they able to pay for own living expenses? 	<ul style="list-style-type: none"> • Documentation from support agencies indicating services/supports member needs or receives • Documentation/office visit notes with diagnosis and identification of frailty • Medication/treatment orders
<p>Community Transition Services/Nursing Facility Transition to a Home</p>	<p>Non-recurring set up expenses for members who are transitioning from a licensed facility to a living arrangement in a private residence or assisted living facility where the member is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable the member to establish a basic household that does not include room and board.</p> <ol style="list-style-type: none"> 1. Is the member currently residing in a nursing facility and receiving medically necessary nursing facility services? 2. Have they lived 60 or more days in a nursing facility? 	<ul style="list-style-type: none"> • Skilled nursing discharge plan/paperwork • Documentation from support agencies indicating services/supports member needs or receives • Documentation/office visit notes with diagnosis and identification of frailty • Documentation of home modifications/services completed

	<ol style="list-style-type: none"> 3. Are they interested in moving back into the community 4. Are they willing and able to reside safely in a home? 5. Are they willing to live in an assisted living facility with appropriate and cost-effective supports and services? 6. Are they willing and able to pay for own living expenses? 	<ul style="list-style-type: none"> • Medication/treatment orders
Personal Care and Homemaker Services	<p>Assistance with activities of daily living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Can include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Homemaker or chore services include help with tasks such as cleaning, shopping, and laundry. Services aid members who could not remain in their homes. May request urgent/expedited review.</p> <p>The member is:</p> <p><input type="checkbox"/> At risk for hospitalization or institutionalization in a nursing facility</p> <p><input type="checkbox"/> Has functional deficits with no other support system</p> <p><input type="checkbox"/> Is approved for In-Home Supportive Services (IHSS), but needs additional support</p> <p>Is the member willing to be referred to In-Home Supportive Services if applicable? <input type="checkbox"/> _Yes <input type="checkbox"/> _No</p> <p>The member:</p> <p><input type="checkbox"/> Requires additional In-Home Supportive Services hours beyond the 283-hour maximum per month</p>	<p>Documentation: It's recommended you upload one or more of the following documents with this request:</p> <ul style="list-style-type: none"> • Documentation/office visit notes with diagnosis and identification of frailty • Assessments identifying members physical needs • Documentation from support agencies indicating services/supports member needs or receives • Physical therapy/durable medical equipment evaluation documenting safety needs • Medication/treatment orders

	<input type="checkbox"/> Is in a waiting period for In-Home Supportive Services review including prior to and up through IHSS application date <input type="checkbox"/> Not eligible for IHSS, but require services to avoid a short-term stay in a skilled nursing facility (not to exceed 60 days)	
Environmental Accessibility Adaptations (Home Modifications),	<p>Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of a member, or enable the member to function with greater independence in the home, without which the member would require institutionalization. Lifetime cap is \$7500</p> <ol style="list-style-type: none"> 1. Is the member at risk for institutionalization in a nursing facility? 2. Is the home owned, leased, rented, or occupied by the member? 3. This request is for (<i>check all that apply</i>): <ul style="list-style-type: none"> <input type="checkbox"/> Equipment <input type="checkbox"/> Home modification <input type="checkbox"/> Personal emergency response system (PERS) 	<p>Documentation: It's recommended you upload one or more of the following documents with this request:</p> <ul style="list-style-type: none"> • _Physical therapy/durable medical equipment evaluation documenting safety needs • _Documentation/office visit notes with diagnosis and identification of frailty
Meals/Medically Tailored Meals/Medically Supportive Foods	<p>Chronic condition in the following categories and the need for supportive meal temporarily</p> <ul style="list-style-type: none"> • Diabetes • Congestive heart failure • Stroke • Chronic lung disorders • Human Immunodeficiency Virus (HIV) • Cancer • Gestational diabetes, or other high risk perinatal conditions 	<p>Documentation: recommended:</p> <ul style="list-style-type: none"> • Documentation/office visit notes with diagnosis or identification of chronic illness requiring special diet • Skilled nursing discharge plan • Documentation from support agencies indicating services/supports

	<ul style="list-style-type: none"> • Chronic or disabling mental/behavioral health disorders • Other _____ 	<p>member needs or receives</p> <ul style="list-style-type: none"> • ED, Inpatient, Skilled Nursing discharge paperwork • Medication/treatment orders
Sobering Centers		
Asthma Remediation	<p>Physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the member or enable the member to function in the home while reducing acute asthma episodes that could result in the need for emergency services and hospitalization. Lifetime cap is \$7500. The member has poorly controlled asthma documented by:</p> <p><input type="checkbox"/> Emergency department visit</p> <p><input type="checkbox"/> Hospitalization</p> <p><input type="checkbox"/> Two sick/urgent care visits in past 12 months</p> <p><input type="checkbox"/> Score of ≤ 19 asthma control tests</p> <p>Is the home owned, leased, rented, or occupied by the member? <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No</p> <p>This request is for (<i>check all that apply</i>):</p> <p><input type="checkbox"/> Equipment</p> <p><input type="checkbox"/> Home modification</p>	<p>Documentation: It's recommended you upload one or more of the following documents with this request:</p> <ul style="list-style-type: none"> • Documentation of asthma diagnosis from service provider, PCP, or specialists • Pulmonary function tests • Prescriptions • Asthma treatment plan • List of asthma medications

ECM Workflow Checklist

1. Outreach- Initial engagement and introduction to ECM or CS service
 - a. Initial attempt to be made within 5 days of receiving pt. name



- b. 30-90 days to complete if MIF 30-60 days for Referred
- c. 5 attempts minimum for MIF, 8 attempts minimum for Referred
 - i. Exceptions:
 - 1. if pt. declines service outreach ends
 - 2. If contact information is not good and no other way to find pt. outreach ends
- 2. Consent to services and data sharing
 - a. Upload proof of consent within 24-48 hours
- 3. Assessment:
 - a. Must be completed within 30 days of obtaining consent
 - b. Must leave with at least one goal for care plan
 - c. Set future tasks!
 - d. Always strive towards the company mission of Highest level of Independence
 - e. Task Clinical Team (RN) with Assessment and Care Plan Review
- 4. Initial Care Planning and Goal setting
 - a. Can be done in coordination with assessment
 - b. May be done in separate session
 - c. Written Care Plan must always be given to patient. (in-person, mail or email)
- 5. Referrals to CS or other CBOs: Close Looped referrals
 - a. When identified during assessment and if pt. desires referral
 - i. Task Remote Care Navigator with submitting referral to MCP
 - ii. Create Follow Up Tasks
 - iii. Follow up on referral
 - iv. Coordinate with referral provider
 - v. Document progress and outcomes
- 6. Minimum encounters per month: Minimum encounters are based upon the care plan and overall needs of your pt.
 - a. No less than one encounter per month- this is only appropriate if your pt needs or desires minimal interaction. * One encounter does not mean one attempted phone call; you must try multiple times and ways to connect with your patients.
 - b. If patient is unresponsive, continue with weekly calls/texts, encouragement regarding initial goal. Document all attempts thoroughly.
 - c. Person-centered: how often and how much engagement are based upon goals, needs and desires of the pt. Set expectations early and set tasks accordingly
- 7. Reassessment
 - a. Every 6 months minimum- adjust goals accordingly
 - i. Use Program Progress Questionnaire to determine new goals or possible graduation *use managed care plan specific if required by managed care plan
 - ii. Focus on positives- goals met and positive progress in their lives

- iii. Encourage and set new goals or move on to short term and long-term goals. Make a game plan for movement towards graduation.
- iv. Always work towards our company mission: Highest level of independence.
- b. Change in condition
 - i. ER visit or hospitalization/SNF
 - ii. New conditions identified
 - iii. New immediate or short-term goals needed to meet long-term goals
- 8. Graduation: only appropriate for pt. who has completed program met goals and/or feels satisfied with outcome.
- 9. Dis-enrollment if patient is:
 - a. Unresponsive
 - b. Unwilling to participate in anyway
 - c. Safety concern: must be documented and discussed with supervisor

Community Supports: Housing Navigation

Assessment and Care Planning

The objective of this assessment is assistance with finding housing, it is much less than involved and particular to finding housing such as:

- 1. Finances, what can they afford?
- 2. Geographic region
- 3. Need for disability or other accommodations
- 4. Who are they working with, what resources have they applied for
- 5. Reality check, what may be temporary and the next steps to permanent housing

Developing a Housing Plan is exactly like doing any other care plan only the focus is housing.

You will use the Housing Plan, and the goals, tasks and objective will be based upon housing.

Housing Navigation Workflow Checklist

- 1. Outreach- Initial engagement and introduction to Housing Navigation
 - a. Initial attempt to be made within 5 days of receiving pt. name
 - b. 30-60 days to connect
 - c. 5 attempts minimum
 - i. Exceptions:



1. if pt. declines service outreach ends
 2. If contact information is not good and no other way to find pt. outreach ends
2. Consent to services and data sharing
 - a. Verbal: must upload recording
 - b. E-sign link: upload completed form
 - c. In-person: upload completed form
3. Assessment:
 - a. Within 30 days of consent
 - b. Must leave with housing assessment and plan completed
 - c. Set future tasks!
 - d. Always strive towards the company mission of Highest level of Independence
 - e. Written Housing Plan must always be given to patient. (in-person, mail or email)
4. Referrals to other CBOs or ECM: Close Looped referrals
 - a. When identified during assessment and if pt. desires referral to ECM
 - i. Task Remote Care Navigator with submitting referral
 - ii. Follow up on referral
 - iii. Coordinate with referral provider
 - iv. Document progress and outcomes
5. Minimum encounters per month: Minimum encounters are based upon the care plan and overall needs of your pt.
 - a. No less than one encounter per month- this is only appropriate if your pt needs or desires minimal interaction. * One encounter does not mean one attempted phone call; you must try multiple times and ways to connect with your patients.
 - b. Unresponsive pt.? Weekly calls/texts, encouragement regarding initial goal
 - c. Person-centered: how often and how much engagement are based upon goals, needs and desires of the pt. Set expectations early and set tasks accordingly
6. Graduation: only appropriate for pt. who has completed program met goals and/or feels satisfied with outcome.
7. Dis-enrollment
 - a. Unresponsive
 - b. Unwilling to participate in anyway
 - c. Safety concern: must be documented and discussed with supervisor



Community Supports: Nursing Facility Transition and Diversion

Transition to RCFE

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Medical Patients with an imminent need for nursing facility level of care (LOC).

Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

Wrap Around Services

Individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF) are eligible for wrap-around services.

Wrap Around Services include:

- Assistance w/ ADLs and IADLs as needed.
- Companion services
- Medication oversight
- Therapeutic social and recreational programming
- 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

Allowable expenses are those necessary to enable a person to establish a community facility residence (**except room and board**), including, but not limited to:

- Assessing the Member's housing needs and presenting options
- Assessing the service needs of the Member to determine if the Member needs enhanced onsite service
- Assisting in securing a facility residence, including the completion of facility applications, and securing required documentation (e.g., Social Security card, birth certificate, prior rental history)



- Communicating with facility administration and coordinating the move.
- Establishing procedures and contacts to retain facility housing.
- Coordinating with the Medi-Cal managed care plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.

Transition to Home

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization. Community Transition Services/Nursing Facility Transition to a Home are **non-recurring set-up expenses** for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the Member's housing needs and presenting options.
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord (if applicable) and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.

Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; 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; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations



Who are the Providers?

Hospitals

Hospitals are not a main target for referrals nor are they where most of our referral will come from. However, in some cases, especially at critical access Hospitals or small rural hospitals with limited access to SNF beds, we may use the diversion aspect of this CS service to help discharge a patient who is unable to discharge safely, or the hospital is unable to find a SNF bed.

Skilled Nursing/Post-Acute/Rehab

Our Main Target for referrals, Skilled Nursing Facilities (SNF), have varied services and some even specialize in certain types of post-acute care, such as rehabilitation from stroke or joint replacements. The SNFs we will be dealing with must accept Medi-Cal and have long term custodial patients.

Below are some tasks or specialized care that can only be provided by a licensed medical provider, such as a Nurse, and is prescribed as part of the medical care plan:

- Wound Care
- Injections
- Physical or Occupational Therapy (exercises may be prescribed to be done without therapist but actually PT/OT sessions must be done by licensed PT, OT etc.)
- Care of Gastronomy Tubes or Naso-Gastric tubes
- Tracheotomy Care such as suctioning
- Oxygen monitoring

Sometime these medical needs can be met in an assisted living situation with the use of a “Home Health” agency that sends medical professionals to the assisted living community to provide this type of care or the assisted living may offer these services via an exception (*see restricted and prohibited conditions). Often individuals who require this type of care on-going will move to a skilled nursing facility based upon a physician’s assessment and recommendation or when family cannot provide care at home.

Physicians and Clinics

Often clinics will have concerns regarding their elderly patients. Educating them on this CS service is another way to get help to those who may need it.

Assisted Living/RCFE’s

Residential Care Facility for the Elderly is the licensed term for non-medical assisted living facilities. They vary from the very large CCRC to the micro 4 residential home.



Types of Care

The three types of care are:

- Non-Medical Care
- Custodial Care
- Memory Care

All three can fall into a similar category that can be broken down by levels of care or level of assistance needed. This covers ADL's or activities of daily living, activities that are required to live daily, things we usually do for ourselves but after illness or with age become hard to do or even impossible without assistance.

Examples of ADLs:

- Bathing, dressing, grooming, hygiene
- Toileting or incontinence care
- Meals- preparation and/or eating
- Medication reminders and management
- Transfer assistance- help getting in and out of bed, a chair or car etc.
- Housekeeping and laundry
- Transportation
- Making appointments
- Shopping

How much assistance you need with some, or all of these comes into play with the cost of care. This is often referred to as Level of Care.

Non "care" activities that are important for the social, emotional, and spiritual well-being are often included by senior living and senior care providers. Activities such as:

- Crafts
- Games
- Social gatherings
- Exercise class
- Movie Nights
- Outings
- Gardening
- Worship/religious services

Memory Care Only or as a Separate Area in the Assisted Living

The care of persons with a diagnosis of memory impairment due to dementia, Alzheimer's or other similar illness. This category goes hand in hand with Non-Medical Care as often times those who are memory impaired need help with ADL's even if it is simply to be reminded when



and how to do these things. Additionally, memory impaired individuals need extra care to assure safety in a secured environment. Memory Care specific communities or Caregivers who are specifically trained in Memory Care are usually the best option for memory impaired individuals. Some of the special needs of memory care impaired individuals are:

- Secured environment such as locked exterior/exit doors
- Memory care specific environment such easy to navigate spaces, soothing colors and familiar reminders of where they are to help keep the resident oriented
- Specialized activities to help improve brain function and memory
- Caregivers specially trained in dealing with behaviors through redirection

IHSS, CBOs, County Supports and other CS providers

When transferring back to home and not at an RCFE we will use a different set of providers. These include IHSS, Community Based Organizations, such as, senior centers, meals on wheels, religious organizations etc. Use of county programs that are free, and the referral to CS providers for things such as Environmental Accessibility Adaptations (EAA) Medically Tailored Meals (MTM). It also includes assisting in the coordination of the patients' personal supports, as they will be providing care.

Expectations and Roles

Care Navigator

Your priority is patient care. The patient is your responsibility

All Patient (and patient support system) communication is through you.

Set that standard early- "call me with any questions or concerns, I am here to support you throughout this process as your community support provider."

Managing expectations: What we can and cannot do & reality vs. expectations sometimes set by others. Protect the process and the patient, there are often barriers that we need to manage and work around, all involved need to follow your lead and discharge plan

Follow Workflows and Direct the Discharge/Care Plan to RCFE/ALF

- ⇒ Gathering documentation needed
- ⇒ Tasking referrals and review to appropriate team member
- ⇒ Communication with other team members involved
- ⇒ Assessment and crafting the discharge/care plan based on the best interest of the patient. Always Person Centered



- ⇒ Scheduling assessments with other providers- assuring that the patient, family, referrer, and anyone else involved is aware and expectations are managed
- ⇒ Assuring other provider relationships are well managed. *The ALF representative does not need to communicate with the patient or family outside of the assessment unless they are chosen for move in.
- ⇒ Presenting options (if more than one) AFTER we have assured, they are cost affective and appropriate.
- ⇒ Tours (only if necessary) after the appropriate ALF is presented
- ⇒ Assuring rent payments to ALF has been arranged or there is a plan in place
- ⇒ Arranging and coordinating discharge -all necessary items **should be listed and tasked on the discharge plan*, including any paperwork that needs to be signed.
- ⇒ Be present at the discharge and move-in (unless other arrangements have been made)
- ⇒ Assuring ECM has been referred
- ⇒ Assuring SSI increase has been requested
- ⇒ Assuring PCP has been assigned and appointment has been made
- ⇒ Assuring clear communication between the patient (and patient support) and ALF- warm hand off!

Management and Administrative Roles

Oversight, Review, Barrier and Challenge Assistance, Billing, Authorizations, Eligibility

COO/Supervisor:

- ⇒ General oversight and guidance
- ⇒ Barrier and challenge assistance

CEO

- ⇒ Barrier and challenge assistance
- ⇒ PR

Nursing Facility Program Director

- ⇒ Review and submission of Wrap-Around to MCP
- ⇒ NFT Assessment/602 Review
- ⇒ Barrier and challenge assistance

Regional Manager

- ⇒ Barrier and challenge assistance

Remote Care Navigator:

- ⇒ Referral coordination



- ⇒ Eligibility check
- ⇒ Referral for Services to MCP
- ⇒ General assistance with calls, tasks as needed to coordinate the move

Quality Assurance Coordinator:

- ⇒ External referral coordination

Provider Relations Coordinator

RCFE/ALF Relationships, Searches and Documentation

- ⇒ Identifying appropriate RCFE/ALFs
- ⇒ Assuring the RCFE/ALFs understand and are willing to participate in the program
- ⇒ Communicating needs and requests of RCFE/ALF providers to the Care Navigator
- ⇒ Presenting options to Care Navigator- so they may present to the patient when appropriate
- ⇒ Warm hand off and/or introduction to Care Navigator
- ⇒ Follow up to assure RCFE/ALF that not chosen are informed*always wait until we are certain-changes happen!
- ⇒ Communicating any concerns to the Care Navigator and others Master•Care team members involved.
- ⇒ Updating data base to reflect participating RCFE/ALF providers
- ⇒ Documentation

Determining Eligibility and Appropriateness for NFT-D

During initial contact and review we must determine if the patient is appropriate for the program. There are key factors we must pay close attention to:

NFT Populations of Focus

For this program our patients may fall into several PoFs but the primary focus PoFs will be:

1. Nursing facility residents who want to transition to the community
2. Adults at risk for institutionalization who are eligible for long-term care services

Must be appropriate:



- Our patients will also be older adults or those who have similar conditions and care needs of older adults.
- Our patients will fit in and be fulfilled living in an Assisted Living Environment
- Our patients will not be disruptive to the lives of other residents at the Assisted Living
- Our patients MUST need ADL and/or ADL/IADL assistance
- Our patients must not be drug or alcohol seeking if former SUD
- Our patients may have SMI but it must be well controlled without excessive or disruptive behaviors
- Our patients must not be violent or put other residents at risk
- Our patient must not need excessive (read that expensive) medical services as ongoing support

NFT Criteria

Nursing Facility Diversion services to an Assisted Living Facility

- Is the member interested in remaining in the community?
- Are they willing and able to reside safely in an Assisted Living Facility with appropriate and cost-effective supports and services?
- Do they meet minimum criteria for Nursing Facility level of care (unable to complete ADLs without assistance)
- Are they able to pay for own living expenses?

Community Transition Services to a Home or Assisted Living Facility

- Is the member currently residing in a Nursing Facility and receiving medically necessary Nursing Facility services? (Unable to complete ADLs without assistance)
- Have they lived 60+ days in a Nursing Facility?
- Are they interested in moving back into the community?
- Are they willing and able to reside safely in a home?
- Are they willing to live in an Assisted Living Facility with appropriate and cost-effective supports and services?
- Are they willing and able to pay for own living expenses? (Room and board- has SSI or other income)
- If going home-Has appropriate housing and can afford to sustain this housing

For Nursing Facility Transition to RCFE:

1. Has resided 60+ days in a nursing facility.



2. Willing to live in an assisted living setting as an alternative to a Nursing Facility.
3. Able to reside safely in an assisted living facility with appropriate and cost- effective supports.
4. Has ADL and or ADL/IADL support needs
5. **Is cost effective**
6. Has ability and is willing to pay room and board

For Nursing Facility Diversion to RCFE:

1. Interested in remaining in the community.
2. Willing and able to reside safely in an assisted living facility with **appropriate and cost-effective supports and services.**
3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility. *(hint: they must need ADLs and/or a combo of ADLs and IADLs)*
4. Has ability and is willing to pay room and board

For Nursing Facility Transition to Home:

1. Currently receiving medically necessary nursing facility Level of Care (LOC)
2. Has lived 60+ days in a nursing home and/or Medical Respite setting
3. Interested in moving back to the community
4. Able to reside safely in the community with appropriate and cost-effective supports and services.
5. Has appropriate housing and can afford to sustain this housing



NFT to RCFE Workflow Checklist

Referral/Quality Team assigned when referral is received

- ☐ Verify Patient Requirements
 - ☐ Consent- confirm they understand the program and would like us to submit a referral if possible.
 - ☐ “Some” Income- verify they have some income or a pathway to income such as applying for SSI.
 - ☐ Willingness & ability to contribute 90% of Income to Assisted Living
 - ☐ Appropriate for program: Has ADL needs
 - ☐ Eligibility Check
- ☐ Retrieve Required Documents
 - ☐ H&P/Face Sheet OR
 - ☐ Current Nursing, MD, or PT/OT notes OR
 - ☐ Accurate and Complete 602 Assessment
- ☐ Enter Patient in Salesforce
 - Required Fields:
 - ☐ Name
 - ☐ CIN (Medicaid/Medi-Cal number)
 - ☐ DOB
 - ☐ Name and address of SNF.
 - ☐ Upload documents.
 - ☐ Select appropriate Status.
 - ☐ Set Follow- Up Tasks

Confirmed Eligible for NFT Services

- ☐ NFT Referral- assure all documents necessary are uploaded and legible.
- ☐ Explain to referral source or patient that you will refer them into the program and will follow up as soon as authorization is received.
- ☐ Set Follow Up Tasks

If Ineligible for NFT Services

- ☐ Let the referrer know why (wrong insurance, inactive insurance, etc.) and look for solutions or alternative resources to assist.
- ☐ Set Follow Up Tasks



Authorized for NFT Services

Field Care Navigator is assigned to begin services.

- ☐ Get consent and explain the program to the patient and family or support system, if any. Upload consent.
- ☐ Confirm income and understanding that 90% of total monthly income will go towards Rent (Room and Board). Patient must agree to this. Document in Salesforce.
 - ☐ If the patient is eligible but needs help organizing finances, getting payer, applying for SSI, etc. please assist and if appropriate/necessary please task RCN with ECM referral.
 - ☐ Explain that we will help them request an increase to the NMOHC rate of \$1492.82 once they move. No guarantee but we will assist in the process.
- ☐ Complete NFT Assessment
- ☐ Confirm necessary documents have been received:
 - ☐ Accurate and Complete 602 Assessment
 - ☐ Medication List
- ☐ Review Patient
 - ☐ Is the patient appropriate for this program? (Consider age, care needs, diagnosis, etc.)
 - ☐ What are the obvious obstacles? (Consider injections, complex medication protocol, mobility status, dementia without POA or family, smoker, etc.)
 - ☐ Does the patient have Prohibited Conditions? (Stage 3 and 4 Pressure Injuries, Gastrostomy tubes, Naso-gastric tubes, Staphylococcus aureus ("staph") infections or other serious infections, Tracheotomies)
- ☐ Complete Pre-Transition Care Plan
- ☐ Upload all documents into Salesforce.
- ☐ Task **Nursing Facility Program Director** with 602A and NFT assessment review
- ☐ Task **Provider Relations Coordinator (PRC)** with initial ALF search for your patient-
- ☐ Work with **Provider Relations Coordinator (PRC)** to Schedule ALF assessments-using list presented by **Provider Relations Coordinator (PRC)** or **supervisor**. Be present to manage expectations, if possible. We do not require a tour. Not all ALF's are appropriate or will accept just because they did the assessment.
- ☐ Once ALF's have accepted the patient and are appropriate for the program, offer options to the patient.

Patient Has Chosen and Been Accepted by ALF

- ☐ Confirm rates- must have documentation and rate breakdown of Care Costs
- ☐ Obtain an admissions agreement from ALF.
 - ☐ If you haven't placed there before, please request a Blank Admissions Agreement



- ☐ Obtain Appraisal/Assessment by the Assisted Living (603)
- ☐ Assure income, willingness, and ability to pay 90% are documented in Salesforce.
- ☐ Task **Nursing Facility Program Director** with review of rate and agreement
- ☐ Confirm choice of RCFE with patient/family/conservator. Explain that in the next step we will be submitting for Wrap Around authorization.
- ☐ Confirm the amount they will be paying for room and board.
- ☐ Task **Nursing Facility Program Director** with submitting for Wrap Around authorization.

When you set a task for **Nursing Facility Program Director** in the Comments Section of the Task itself, add:

- ☐ Patient's Income
- ☐ Add name of supporting document - Income Verification
- ☐ The name of the A.L. Community (RCFE) patient is moving to.
- ☐ Add name of Pre-Admissions Appraisal
- ☐ Add name of the Care Cost Breakdown document
- ☐ The "Total Monthly Rate"
- ☐ Add name of DPOA/conservator/responsible party

If URGENT - Please mark "URGENT" in Subject line of Task and add the reason.

- ☐ Task **Remote Care Navigator** with ECM Referral if not already referred in for ECM.

Authorized for Wrap Around Services

- ☐ Coordinate Tentative Discharge date with SNF, Patient, and ALF
- ☐ Create Calendar Event on Salesforce for "Tentative Move-In Day"
- ☐ When date is confirmed, update Calendar Event to "Confirmed Move-In Day"
- ☐ Gather and assure all crucial items are ready for discharge:
 - ☐ Medications- 30-day Supply
 - ☐ Supplies
 - ✓ DME (Hospital bed, walker, wheelchair, shower chair, etc.)
 - ✓ Clothes
 - ✓ Personal Hygiene Items
 - ✓ Furniture
 - ☐ Paperwork
 - ☐ Payments (know how, when and how much)
- ☐ Arrange transportation.
- ☐ Discharge and Move-In
 - ☐ Be present at discharge to assure all goes well.
 - ☐ Follow transportation to ALF.
 - ☐ Remain with patient throughout the admission process.
 - ☐ Assist patient with settling into new home.



- ☐ Call SSI with Patient or RP/POA to request an increase to the NMOHC rate of \$1575.07
- ☐ Salesforce: Document activity.
- ☐ Salesforce: Update patient demographics (address).
- ☐ Salesforce: Upload/update Care Plan
- ☐ Introduce **ECM- Field Care Navigator**
- ☐ Assure coordination between ECM and the ALF or other providers is in place.
- ☐ Assure patient's personal support system is introduced to the ALF so they can visit and support the patient.
- ☐ Present Master-Care blanket!

NFT-ECM Transition

Week 1:

- ☐ **ECM Field Care Navigator** conducts ECM Assessment and completes NFT to ECM Post Transition Care Plan
- ☐ Make PCP appointment.
- ☐ Check in with patient and ALF or other providers to see how they are settling in.
- ☐ Arrange transportation and accompany to PCP appointment as necessary.
 - Assure medications are managed properly, any medication changes are sent to the ALF.
 - All medications need to be delivered- PCP can be prescribed this way.
 - If incontinence supplies are needed Medi-Cal pays, assure you advocate for this.
 - If labs are needed be certain to arrange transportation or mobile if available.
 - Any changes in clinical care must be written and signed by PCP and delivered to the ALF.
- ☐ Establish Monthly MDT Meeting

Resubmission of Wrap Around Authorization- "Re-Wrap"

Re-wrap definition: Enrolled patient who has been wrapped and is moved into an RCFE and has had; a change in conditions, increase or decrease in income, or needs to be moved to a new RCFE.

Re-wrap process:

- ☐ Document encounter that triggered the re-wrap. If complex, send to **Nursing Facility Program Director** and **Regional Manager** for review.
- ☐ Gather documentation necessary to justify any changes in existing wrap authorization.
- ☐ Task "Re-wrap Review and Process" to **Nursing Facility Program Director**
- ☐ Follow up with all involved and document the follow-up.



- ☐ Once approved and authorized, communicate with RCFE and patient/RP the changes in payments, location, and overall process.
- ☐ Document changes and update Salesforce fields where necessary.
- ☐ Get supplemental billing agreements and ensure all are signed. Obtain a copy for our records and upload into patient files.
- ☐ If moving to new RCFE, coordinate discharge date.
- ☐ Create Calendar Event on Salesforce for “Tentative Move-In Day”
- ☐ When date is confirmed, update Calendar Event to “Confirmed Move-In Day”
- ☐ Arrange transportation.
- ☐ Discharge and Move-In
 - ☐ Be present at discharge to assure all goes well.
 - ☐ Follow transportation to ALF.
 - ☐ Remain with patient throughout the admission process.
 - ☐ Assist patient with settling into new home.

NFT to Home Workflow Checklist

Patient is Eligible and Authorized for Transition to Home

- ☐ Connect with referrer and patient to schedule an assessment.
- ☐ Complete appropriate assessment- document well with narrative
- ☐ Complete Discharge Plan-Care Plan
- ☐ Home inspection to assure patient can move home safely.
 - ✓ Is home safe? If not, can it be made safe with reasonable wrap around services.
 - ✓ Coordinate all services necessary for safe discharge, this varies by patient and patient’s housing situation.
- ☐ Who is providing care? Coordinate schedule and assure coverage is in place as part of the care plan.
 - ☐ Who is providing medication management? Assure there is a way to have medication delivered and managed to assure the patient is taking them appropriately.
 - ☐ What other services are necessary?
 - i. Make Necessary Referrals
 - ii. Assure all are authorized or if they cannot be authorized find solutions.
 - iii. Coordinate timing for all referred and necessary services.
- ☐ Task *Remote Care Navigator* with Referral for ECM
- ☐ Coordinate Discharge date with patient support and care.
- ☐ Create Calendar Event on Salesforce for Move-In Day
- ☐ Gather all crucial items for discharge:
 - ☐ Medications- 30-day supply



- ☐ Personal hygiene items
- ☐ Clothes
- ☐ Paperwork
- ☐ Arrange transportation.
- ☐ Be present at discharge to assure all goes well.
- ☐ Follow transportation to Home.
- ☐ Remain with the patient to assure all supports are in place and patient understand the care plan and what to expect such as appointments, medications, emergency phone numbers, etc.
- ☐ Assist patient with settling into new home.
- ☐ Document in Salesforce and assign follow up tasks.
- ☐ Update and Upload Care Plan
- ☐ CELEBRATE SUCCESS AND PROVIDE MASTERCARE BLANKET!

Transition to Home Follow Up

- ☐ Create tasks to assure you follow up with the patient, family, caregivers and/or other providers.

Week 1:

- ☐ Check in with patient and other provider to see how they are settling in.
- ☐ Ensure coordination between ECM and other providers is in place.
- ☐ Assure patient's person support system understand the care plan.

First 30 days after discharge to home:

- ☐ Check in with the patient.
- ☐ Inquire about supplies and needs, assure everything is going smoothly.
- ☐ Engage with the patient and update a care plan to reflect current goals and needs.

How to Help When We Can't

If Patient is Ineligible

Let the referrer know why (wrong insurance, etc.) and look for solutions or alternative resources to assist.

If Patient Is Not Appropriate

Let the referrer know reasons and explain possible solutions:

- Age and conditions
 - Solution: We can refer the patient into ECM to create a master care plan.
- Conditions or care needs too high/complex.



- **Solution** Consider if the conditions will improve. Can current conditions improve with a different treatment plan? If so, is the patient willing to participate in the treatment plan? We can re-evaluate its appropriateness once conditions have improved.
- No pathway to income to pay room and board
 - **Solution** Have social worker or other staff work with the patient to apply for SSI.
- Unwilling to pay 90% of total income for room and board.
 - **Solution** There are no options unless the patient is willing. The program is voluntary, and this is a requirement.
 -

Community Relations

NFT Referrals

These are the ways in which we receive referrals for NFT-D Services:

Directly from the MCPs

In this case we will receive the referral in the same way we receive our ECM referrals. Patients are identified by the MCP, authorized, and assigned to Master•Care. Then we assign the patient to the Care Navigator.

From Providers

Skilled Nursing Facilities will refer patients directly to us. We then vet the patient based upon eligibility criteria, we check eligibility with the MCP and submit the referral to the MCP. We usually have an answer in 5 business days.

Community Relations are crucial to the success of this program. Your understanding the different types of providers and program needs to be clear so we can promote the services without over promising and under delivering.

Identifying the challenges these the different types of providers face is crucial; how can we offer a solution if we do not understand the problem? Know your audience and build relationship accordingly.

Community Relations with SNFs and Medical Providers

Our expectation is that our Care Navigators will promote our services with medical providers. We will not receive a MIF/TEL for these patients for this service, we will need to educate and build relationships with SNF's to get referrals. This is not sales and marketing, it's community relations.



What are some of the key issues SNF and even hospitals face when it comes to these patients?

1. Low reimbursement rates from Medi-Cal for long term patients
2. Patients with no safe discharge plan or nowhere to discharge to
3. Patients living in skilled nursing with no skilled nursing care needs

Community relations includes:

- Building a relationship with important referral sources
- Communicating and educating appropriate contacts at the SNF or other Medical Providers
 - Discharge planners
 - DONs
 - Social Workers
 - Admissions
 - Administrator
- Cooperation! Making it easy for them to work with us
 - What works for them? Faxing, emailing, texting, a quick phone call?
 - Know what information you need, have it memorized!
- Managing expectations- never over promise
 - Tell the truth
 - Never promise- this is a new service with all sorts of confusion around it, the last thing we want to do is promise something and not deliver.
 - Know the service we are providing and be able to answer professionally
 - If you do not have an answer, be honest and let them know you will get back to them
 - Communicate- don't go dark, check in let them know you are working on things.
 -

Provider Education

We are not selling anything!

We are introducing a new Medi-Cal program/benefit for long term skilled nursing patients.

We are a Medi-Cal Provider working with Anthem (HealthNet, CHW and others coming soon) to assist in the safe discharge of patients to and Assisted Living or back to a home with wraparound services

Use the rack card and your business card to get started. Other flyers can be used if requested or you think they will be useful in getting referrals.

Obtaining Referrals

Social Services and Discharge Planners are the go-to for referrals. Although they may come from other sources these are your main targets.



Remember to never over promise and under deliver!
Tell them you will check eligibility, then we can go from there.

NFT-D Assessment

The objective of this section is to understand the assessment process and how it differs for NF transition patients.

- Use the current NF Assessment
- Prefill as much as possible from the information you have received
- Confirm that these are still relevant diagnosis, conditions or treatments-often patients improve and the reason for admission may not be relevant anymore

Like any other assessment you need to:

- Use motivational interviewing techniques
- Be trauma aware
- Make notes of important information the patient may mention or questions that trigger
- emotions of any kind.

Unlike other assessments:

- This assessment is always done in person.
- The patient may have family that is involved due to cognitive decline

Consent

Sometimes a verbal response to the questions will be all you can collect from a patient for many different reasons such as dementia or difficulty with motor skills due to arthritis or other chronic condition.

If the patient has a POA they do not have to sign unless the patient has declared capacity issues and the POA is responsible for the person.

Note: POA is not replacing the rights and decisions of a patient with capacity, it is only when the patient can no longer speak or act for themselves

This does not mean you do not involve family; it means you do not need their consent to move forward. Involving family and supports is a different matter,



NFT Care Planning and Goal Setting

Discussing Finances

Finances can be a tricky and touchy subject. Most of our patients will not have assets, some may not have income, but most will have some form of SSI.

It is important that you do financial discovery early in the process. It can hold up the whole process.

The patient is responsible for Room and Board, Room and Board is 90% of SSI or if transitioning home must be able to pay expenses necessary to return home.

If the patient has SSI:

1. How much per month?
2. Who controls your income? Self, family, professional
3. Would you consider a payer service?

If No income:

1. Patient must apply for SSI
2. Follow up closely to assure everything is submitted and communicated properly

Payer Services

- Payer services are a way to assure the patient's room and board are paid. It also helps safeguard the patient from fraud.
- The patient can have the remaining 10% of their SSI transferred to their personal banking account for use.
- This is not required for patients with responsible parties, or who have full mental capacity but is highly recommended.
- If a patient has any cognitive impairment and no responsible party, we must assign payer services.

Matching Patient with an RCFE

What type of RCFE /Senior Living should I consider for my patient? What type of environment do they prefer? What is the preferred geographic area?



Our patients will be limited in their choices for multiple reasons, the biggest being cost the second being provider participation. We will be working with a variety of providers who will fall into one of the following descriptions:

Always ask about services, amenities, additional costs and types of care provided as these vary by community.

Large Assisted Living Community:

- Larger apartment like community
- Licensed by the state to provide care
- Often have programs/departments dedicated to activities and recreation
- May have a more “resort” type atmosphere
- May have memory care wing/building designed especially for residents with memory diagnosis
- May include independent and assisted living in the same community

Small Assisted Living- Care Home

- 2-15 Residents
- Licensed to provide care by the state
- Usually, a home that has been converted into a care home
- Home/family like atmosphere
- Often can provide a higher care level- more one on one, lower caregiver to resident ratio. Services vary quite a bit by community always ask!
- Can provide memory care- *always ask! You don’t want an alert older adult in a community that has only memory care residents and vice versa

Memory Care Only Community

- Vary in size and number of residents
- Licensed by the state to provide care
- Entire community is designed and developed to cater to the needs of residents who have memory/cognitive issues such as dementia



Glossary for NFT-D

LOC: Level of Care

SNF: Skilled Nursing Facility

Acute care: a level of health care in which a patient is treated for a brief but severe episode of illness, for conditions that are the result of disease or trauma, and during recovery from surgery

Post-Acute: Services to patients to regain their strength and return home. Patients receive these services after hospitalization for surgery, injury, or illness. This acts as a bridge between the hospital and the next steps to recovery.

RCFE: Residential Care Facility for the Elderly

ARF: Adult Residential Facility

AL: Assisted Living

MC: Memory Care

ADL: Activities of Daily Living

IADL: Instrumental Activities of Daily Living

H&P: Health and Physical

MDS: Minimum Data Set for nursing home

Med List: List of all Medications including OTC, dosage and schedule

MD Notes: Physician Notes

Therapy Evaluation or Notes: PT/OT observations, evaluation and notes

602: Physicians Report for Residential Care Facilities for the Elderly



Tools

A crucial part of delivering our service is using the tools provided. This not only allows for seamless and consistent communication it protects our patients and keeps us in compliance with HIPAA.

We require the use the following tools for all Master•Care related business:

- Outlook 365: Email with Trustfi
- Ring Central: Phone, Text, Fax, Messaging
- Salesforce: Documentation and Patient Records System, Ring Central and Outlook integrated

Outlook 365

Outlook 365 includes outlook email as well as the entire Microsoft Office suite

1. Log in on your Desktop
2. Download the Outlook app to your phone (optional but recommended)

Trustfi is a secure email service that is an add-in as part of your Outlook- Use this when sending secure patient information outside of our organization- emails including patient name, CIN and DOB

Ring Central

1. Activating your account via email: You will receive a link via email, click the link, set your password and you are ready to go. Username is your email.
2. Download the Cell phone App: Log in using your credentials
3. Download the Desktop App: log in using your credentials
4. Integration into Sales Force: Log in using your credentials



Sales Force

Salesforce is the tool we use to document everything we do without patients. It's how we bill the managed care plans for services we provide and it's how the managed care plans audit our work to assure we are delivering quality. Consistent and clear documentation is crucial.

Notepads are great for jotting down things in a pinch and when it is not appropriate to have your laptop open. However, all documentation must be added to Salesforce DAILY, No exceptions.

Tasks

Tasks are your To Do list and are a requirement on every active patient you are managing. Outreach and Enrolled until they are declined, terminated, or graduated. You will not remember all you have to do and tasks are a list of things you need to do.

Activities are what we do and they happen 5 ways:

1. Call (through RingCentral)
2. Text (through RingCentral)
3. Email (through outlook)
4. In person (SalesForce Event)
5. Research

Documenting Activities in Salesforce

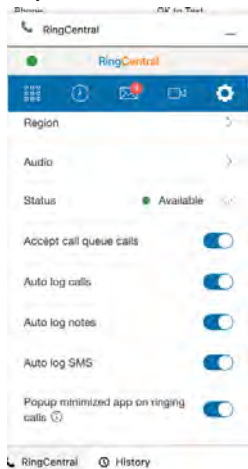
Telephonic Activities

Calls must be done through RingCentral. Those calls and text must be logged in Salesforce.

When you log into Salesforce make sure you are also logged in to Ring Central.



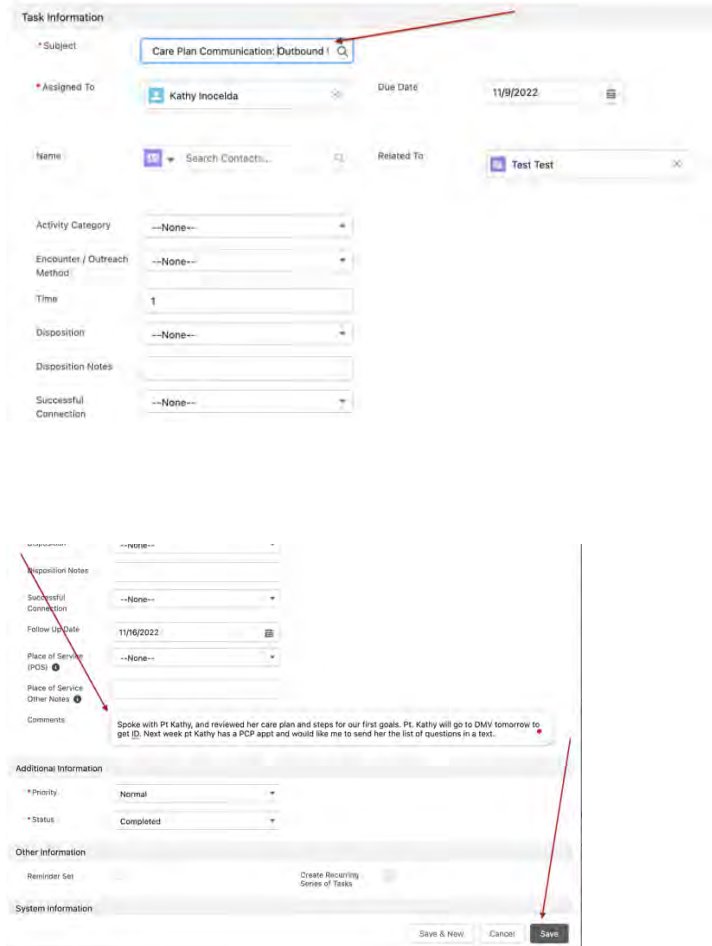
If your calls and texts are not logging check your settings, they should look like this:



If your call or text did not log go back and try to log it



Your call or text should show up in the activities panel. This is the activity you should edit and add details to.



Task Information

* Subject: Care Plan Communication: Outbound

* Assigned To: Kathy Inocelda Due Date: 11/9/2022

Name: Search Contacts... Related To: Test Test

Activity Category: --None--

Encounter / Outreach Method: --None--

Time: 1

Disposition: --None--

Disposition Notes:

Successful Connection: --None--

Follow Up Date: 11/16/2022

Place of Service (POS): --None--

Place of Service Other Notes:

Comments: Spoke with Pt Kathy, and reviewed her care plan and steps for our first goals. Pt. Kathy will go to DMV tomorrow to get ID. Next week pt Kathy has a PCP appt and would like me to send her the list of questions in a text.

Additional Information

* Priority: Normal

* Status: Completed

Other Information

Reminder Set: Create Recurring Series of Tasks

System Information

Save & New Cancel Save

Texts are documentation but they need to have the subject edited with the appropriate Naming Conventions.

Events

Events are in person meetings with the patient or any meeting on behalf the patient that happens in person.

You schedule events and edit them after the event occurs. Use Naming conventions and add details- all the details, especially if this is an assessment.

Events will show up in your calendar in both Salesforce and Outlook



Activity

Description:

Start

Dec 3, 2022

12:00 PM

⌚

End

Dec 3, 2022

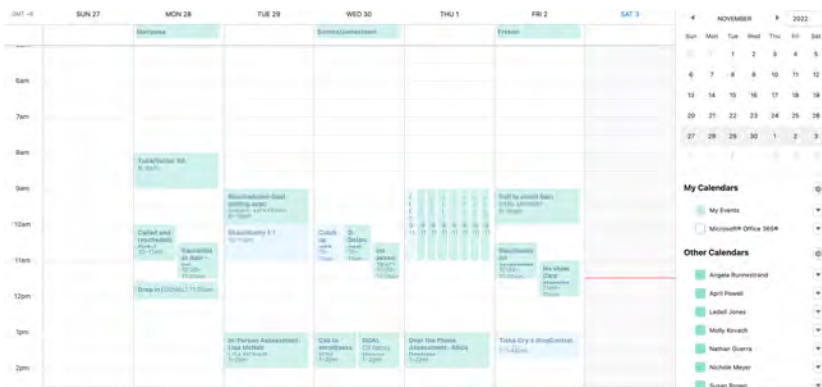
1:00 PM

⌚

Location:

Name:

Related To:



Emails

These need no editing like texts but be sure to use naming conventions or descriptive subject line so its easily identified for what the activity is.

Activity

New Task New Event Email

*From: k.inocelda@mastercareplan.com

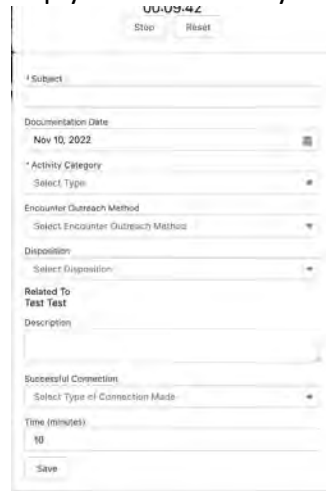
To: Test Test

Subject: Enter Subject...

916.398.4999 Office
877.924.7010 Fax
916.333.7768 Direct
MasterCarePlan.com

MasterCare, Inc. takes confidentiality seriously.

Research and other non-patient contact such as care conferences
 Simply add the activity using the time clock activity panel



Other Important Salesforce Tools for Productivity:

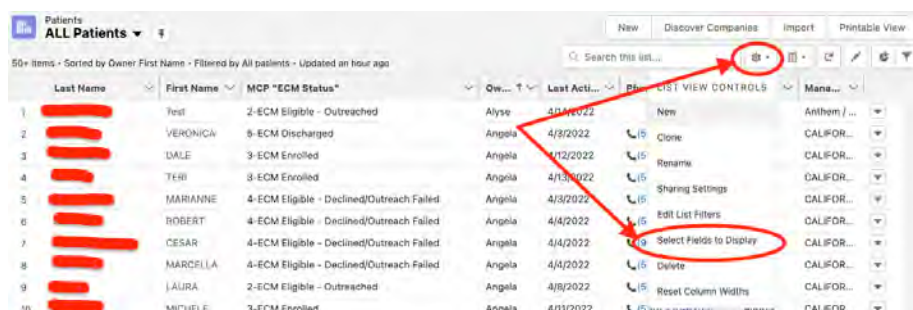
- Patient Lists
- List View
- Tasks

List Views

The way you see your list and the information displayed depends on your personal preference and the use of the list.

For example, if you want a list that helps you organize door knocks you will want city and zip code in easy view for sorting and planning.

1. Using gear on your patient list, click fields to display



	Last Name	First Name	MCP *ECM Status	Ow...	Last Act...	Manage
1	[REDACTED]	Test	2-ECM Eligible - Outreached	Alyse	4/1/2022	New
2	[REDACTED]	VERONICA	5-ECM Discharged	Angela	4/3/2022	Clone
3	[REDACTED]	DALE	3-ECM Enrolled	Angela	4/12/2022	Rename
4	[REDACTED]	TEH	3-ECM Enrolled	Angela	4/13/2022	Sharing Settings
5	[REDACTED]	MARIANNE	4-ECM Eligible - Declined/Outreach Failed	Angela	4/3/2022	Edit List Filters
6	[REDACTED]	ROBERT	4-ECM Eligible - Declined/Outreach Failed	Angela	4/4/2022	Select Fields to Display
7	[REDACTED]	CESAR	4-ECM Eligible - Declined/Outreach Failed	Angela	4/4/2022	Delete
8	[REDACTED]	MARCELLA	4-ECM Eligible - Declined/Outreach Failed	Angela	4/4/2022	Reset Column Widths
9	[REDACTED]	LAURA	2-ECM Eligible - Outreached	Angela	4/8/2022	Share with others
10	[REDACTED]	MICHELE	3-ECM Enrolled	Angela	4/11/2022	

- Choose the fields you want displayed on your list by moving from available fields to visible fields using the arrows

Select Fields to Display

Available Fields	Visible Fields
Acuity Level	Last Name
Additional Insurance Coverage	First Name
Adult – Experiencing Homelessness	MCP "ECM Status"
Adult – High Utilizer	Owner First Name
Adult – LTC Eligible At-Risk for Inst...	Last Activity
Adult – NF Residents Transitioning ...	Phone
Adult – SMI or SUD	Zip/Postal Code

Cancel Save

- Put them in the order you want to see them on your list by highlighting and using the arrows on the right to move the field.

Select Fields to Display

Available Fields	Visible Fields
Acuity Level	Last Name
Additional Insurance Coverage	First Name
Adult – Experiencing Homelessness	MCP "ECM Status"
Adult – High Utilizer	Owner First Name
Adult – LTC Eligible At-Risk for Inst...	Last Activity
Adult – NF Residents Transitioning ...	Phone
Adult – SMI or SUD	Zip/Postal Code

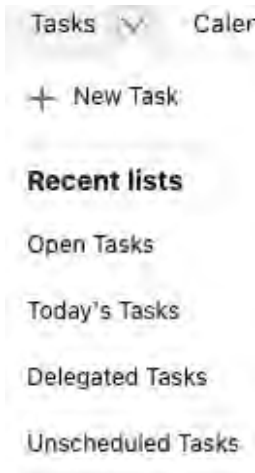
Cancel Save

Tasks

- Choose Tasks from the tool bar



- Open the task list you want to view



3. Work, edit, add directly from your task list



All Activity must be documented

All Activity must be documented correctly

Adding Files to Patient Profile

This feature captures what type of file AND automatically records important dates.

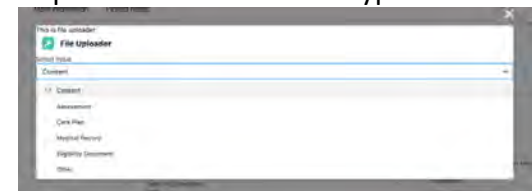
Step 1- in the top section of the patient file look for the Add Files button.



Step 2- the file uploader will pop up



Step 3- choose document type from the drop down



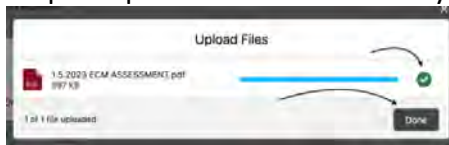
Step 4- choose next



Step 5- Upload file



Step 6- Upload done! Make sure you have the green check mark, then choose done



Step 7- Confirm it's uploaded before you delete it from your computer files



Documentation

Naming Conventions, Activities and Tasks

Assessments and Care Plans:

Patient's Initial_date of assesement_Type of document

Examples:

KI_92622_AsessmentCarePlan

KI_92622_Assesment

KI_92622_CarePlan

KI_12623_AsessmentCarePlanUpdated

Medical Records or other documents:

Patient's Intitals_date document was received_Type of document

Examples:

KI_92622_medicationlist



KI_92622_housingapplication
KI_92622_medicalrecords
KI_92622_602

Activities and Tasks

Outreach 1, Outreach 2, Outreach 3 etc.
Pt Verbally Consented to ECM services and data sharing
Assessment
Cancelled Assessment
No Show Assessment
Care Plan Follow up
Care Plan Communication
Care Planning and Goal Setting
Patient Check in
Patient Check in Final
Goals or Graduation Check-in
Graduation
Dis-Enrollment
RN Care Plan Review
RN Care Plan Recommendations
Care Plan Review- Management
Managed Care Plan Communication
Research
Documentation
Resource Communication
Medical Provider Communication
ECM Referral
CS Referral
Door Knock, in-person outreach

Key Documentation Language

Proper documentation is key to all processes and protocol. To service our clients, patients, and other providers we must always adhere to quality standards not only in what we do and say but in how we document every interaction.

Always Identify the individual throughout documentation. Not everyone is familiar with your case, dynamics, care plan or the individuals and organizations involved. Be thorough, note detail and completion of task, add a task (all actions should end with a task)

Examples

Incorrect: Went to pt. Joe's house with Kathy. We discussed his living arrangements with Julie



Correct: Went to pt. Joe's house with CN Kathy. We discussed his living arrangements with his sister Julie. Pt. Joe and sister Cindy agree that moving in with her is the best option. Pt, Joe will move in 5 days. Have referred pt. Joe for CS services: EAA & Medically tailored Meals.

Action: Add task- Follow up with pt. and sister day before moving; Add 2nd task follow up on referrals and assure pt. and sister are aware of start dates and are connected with the CS providers and other resources.

Incorrect: Spoke to Tami regarding Carols medications, made appointment.

Correct: Called with pt. Carol: Spoke to RN Tami at Healthy Medical Group regarding pt. Carol's medication concerns, she will have the PCP review medications with pt. Carol in a telehealth visit. Telehealth is scheduled for Wednesday 4/12/22.

Action: add task for 4/12/22- call to remind pt. Carol about appt.; add 2nd Task: follow up with Carol after the appointment

Incorrect: Debra called and wanted to know if James had a ride to PT today.

Correct: IHSS CG Debra called and wanted to know if pt. James had a ride to his PT appointment at 1:00 today. I confirmed with Mobile-Rides and called IHSS CG Debra back with the pick-up time of 12:30.

Action: Add task (if not already scheduled) to check in on PT appointment

Incorrect: Nick's brother wants to know how much it cost to get a wheelchair. He's been having trouble getting around.

Correct: Pt. Nick's brother Sam called and wanted to know how much it cost to get a wheelchair for pt. Nick. Brother Sam is having difficulty helping pt. Nick getting around when they have appointments, errands etc. out of the house. I have put in a request with MD Johnson's office to see if they can get a referral for a wheelchair for pt. Nick. Will follow up tomorrow if I do not hear back.

Action: Add follow up task

Incorrect: Did research

Correct: Outreach pt. Kim asked about finding a new doctor and getting on SSI. I explained that to help her I would need a consent and to set an appointment for and assessment. Did verbal consent and schedule assessment. I did research on new PCP in her area and gathered SSI information to bring to the scheduled assessment.

Action: Add Event- Assessment Day and time, Add Task-remind pt. of assessment appointment.

Service Standards

Time Management

So much to do in a day. Can I do it all?

Making a schedule, using your calendar, setting goals, managing expectations, and setting boundaries are the only way to have success in the position of Field Care Navigator.



Juggling expectations and demands can take its toll on a person. Managing your schedule, excepting what you cannot change and communicating any challenges are key to successfully meeting goals and expectations of your position.

Creating an efficient schedule and monitoring your use of time will help you develop good habits that are productive and stress reducing.

Respecting your work hours and set boundaries both personally and professionally is a win for true work life balance.

Protect your office time, set boundaries, and schedule time to complete documentation and tasks.

Managing your commute and assuring you are in position to work at 8:30 and quit at 5:00 is paramount to work life balance.

Your commute is personal time, so unless you are working from home for the day you should be at the office or near your first assessment or door knock area by 8:30. Also assuring your last appointment for the day will completed close to 5:00 and if possible and reasonable- close to home!

Schedule Examples

Start at home office, main office or a place near your first assessment or door knock (except in remote area)

Day Example 1

8:30-9:00:

Clock in

Check emails

Review Calendar

Review Tasks

9:00 -12:30:

In person Outreach (10-12 patients)

12:30-1:00: Lunch Break

1:00-3:00:

Assessment or Community Resource visits or

Charting and updating in SF or care plan research



4:00-5:00:

Calendar review, adjust for scheduled assessments etc.

Charting: Update/review patient profiles in SF

Check tasks in SF to assure you completed all or rescheduled if appropriate.

Add tasks to SF from notes if missing

Day Example 2

8:30-9:00:

Clock in

Check emails

Review Calendar

Review Tasks

9:00 -12:30:

Charting

Outreach calls

Making referrals and working care plans

12:30-1:00: Lunch Break

1:00-5:00:

Patients follow up calls

Charting

Resource research for care plan

Day Example 3

8:30-9:00:

Clock in

Check emails

Review Calendar

Review Tasks

9:00 -12:30:

Outreach calls

12:30-1:00: Lunch Break

1:00-3:00:

Assessment or Community Resource visits or

Care planning or current patient calls and communication

4:00-5:00:

Calendar review, adjust for scheduled assessments etc.

Charting: Update/review patient profiles in SF

Check tasks in SF to assure you completed

Add tasks to SF from notes if missing



The best laid plans...

Your assessment took 3 hours instead of 2 **and** You got lost for 30 minutes **and** You still need to call 3 new patients back **and** You need to do research for one of your existing patients by tomorrow **and** Your child has an appointment at 5:30

Ask for help!

If something needs to be done that day and cannot be rescheduled ask for help. Your Remote Care Navigator can do research and follow up calls. Your supervisor can jump in and so on. We will find a solution; you are not alone in this!

Required Self-Paced Training List

Elsevier

1. CalAim ECM Mandatory Trainings: 1,2 &3
2. CDS:Cultural Competence: The Culture of Support Services
3. The Basics of Motivational Interviewing Lessons 1 & 2
4. CDS: Introduction to Mental Health and Mental Illness: Lessons 1, 2, 3, 4, (not 5), 6
5. CDS: Person-Centered Care Planning – Introduction and Lessons 1-4
6. CRCI Introduction to Mental Health Recovery and Wellness: Lessons1, 2, (not 3 or 4), 5, 6, 7, 8, (not 9)
7. CRCI Trauma Matters: Lessons 1, 2, 3, (not 4), 5, 6, (not 7), 8, (not 9), 10, (not 11 or 12)
8. Trauma Informed Care 101
9. Trauma Informed Care Comprehension

HR Assigned:

1. Mandated Reporter

Rippling

1. Sexual Harassment
2. HIPAA
3. Compliance Anti-Corruption
4. Bloodborne Pathogens
5. Unconscious Bias
6. Information Security
7. Code of Conduct