Community Supports- CS

Community Supports, previously known as In Lieu of Services or ILOS, are certain community-based services and supports 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.

There are 14 pre- approved Community Supports that Medi-Cal Plans **may** offer:

- *Housing Transition Navigation Services, which assist individuals with obtaining housing.*
- **Housing Deposits**, which 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 which aim to help individuals maintain safe and stable tenancy once housing is secured.*
- **Short-Term Post-Hospitalization Housing**, which 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)**, which 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**, which are short-term services provided to caregivers of those who require occasional temporary supervision to give relief to the caregiver.
- **Day Habilitation Programs**, which 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, which help 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, which assist 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**, which support individuals who need assistance with daily activities, such as bathing, getting dressed, personal hygiene, cooking, and eating.
- **Environmental Accessibility Adaptations (Home Modifications)**, which provide physical adaptions 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**, which help individuals achieve their nutrition goals at critical times to help them regain and maintain their health.
- **Sobering Centers**, which are 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**, which 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.

Master•Care will refer to the other CS providers as a part of ECM as appropriate and available

Social Determinants of Health -SDoH

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

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.

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)

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 Independent is a very personal goal. It encompasses many factors:

Age, Chronic Health Conditions, Education/literacy, Access to Services, Economics, along with every SDoH you can think of. 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 are 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.

Seven ways ECM works for our patients

1. Help to 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 to 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: