

Process Manual



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Introduction to CalAIM and the programs that Master•Care Provides

What is CalAIM? 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.

Enhanced Care Management (ECM)

A new, statewide benefit established by the Department of Health Care Services (DHCS) to provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to populations of focus.

The following seven core services will be provided at the point of care:

Outreach and engagement:

Once a patient is assigned to Master•Care, a Care Navigator contacts them to help them enroll in ECM and begin care. If possible and in alignment with member preferences, outreach and engagement should primarily be conducted in-person.

Specific activities may include:

- Locating, contacting, and engaging members who have been identified as candidates for ECM.
- Using multiple strategies and multiple attempts to engage members, including in-person meetings, digital or telephonic communications, and/or street outreach.
- Using an active and progressive approach to outreach and engagement until members are engaged.
- Documenting outreach and engagement attempts and modalities.
- Utilizing educational materials and scripts developed for outreaching and engaging members.
- Sharing information with the health plan to ensure that it can assess members for other programs if they cannot be reached or decline ECM.
- Providing culturally and linguistically appropriate communications and information to engage members.

Comprehensive assessment and care management plan:

Once enrolled in ECM, the patient and their Care Navigator, work together to develop a comprehensive, patient-centered, and individualized care plan.

Assessment and care plan development activities may include:

- Identifying and understanding necessary clinical and non-clinical resources to appropriately assess the member's health status and gaps in care and set person-centered goals.
- Developing a comprehensive, individualized, person-centered care plan with input from the member and/or their personal support system
- Ensuring the member is reassessed at a frequency appropriate for the member's individual process or changes in needs and/or as identified in the care plan.
- Ensuring the care plan is reviewed, maintained, and updated under appropriate clinical oversight.
- The care plan is based on the member's health status, needs, preferences, and goals regarding:
 - Physical health
 - Mental health
 - Disabilities
 - Substance use
 - Oral health
- Community-based long-term services and supports
- Supports to manage serious illness (e.g., palliative care)

- Trauma-informed care needs
- Community and social services

Enhanced care coordination:

Services are provided to help the member implement their care plan and navigate and connect to needed health and community services. The member's lead care manager is a key point of contact.

Enhanced coordination of care activities may include:

- Helping the member navigate, connect to and communicate with:
 - Physical health
 - Behavioral health, and
 - Social service systems
 - including assistance with appointment and transportation scheduling, as needed.
- Sharing information with the member's care team regarding their:
 - Conditions,
 - Health status,
 - Medications, and any side effects
- Maintaining regular communication with all the member's providers and holding meetings for the care team to discuss the member's goals and needs.
- Helping the member access care and ensuring care is continuous, integrated, and accessible for members with disabilities.
- Helping the member follow their treatment plans, including managing and reconciling medications and accompanying them to appointments as needed.
- Regularly connecting with the member and their personal support system and communicating the member's needs and preferences to their providers in a timely manner.
- Monitoring referrals and needed services and supports, as well as coordination and follow-up.
- Facilitating transitions among treatment facilities, including admissions and discharges, and reducing avoidable hospital readmissions.

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

Health promotion:

The member is coached on how to better monitor and manage their health and identify and access helpful resources.

Health promotion activities may include:

- Supporting health education for the member and their family and/or personal support system.
- Providing services, such as coaching, to encourage and support the member to make choices that support healthy behavior.
- Supporting the member in strengthening skills that help them identify and access resources.
- Linking the member to resources for smoking cessation, chronic condition management, self-help recovery resources, and other services.
- Using evidence-based practices, such as motivational interviewing, to engage and help the member manage their care.

Comprehensive transitional care:

The member receives services to help them transition between treatment facilities, including admissions and discharges, and to reduce avoidable hospital admissions and readmissions. This includes transitions between the emergency department, hospital inpatient facility, residential/treatment facility, mental health facility, skilled nursing facility, correctional facility, or other treatment center, and where a member stays or lives.

Comprehensive transitional care may include:

- Developing strategies to reduce avoidable hospital stays or emergency department visits.
- Developing and regularly updating a transition plan for the member.
- Evaluating the member's medical care needs and coordinating any support services post-discharge.
- Tracking the member's admissions and discharges and communicating with their care teams.
- Coordinating medication review and reconciliation.
- Educating the member on self-management, rehabilitation, and medication management

Member and family supports:

The member, their family, and their personal support system are educated about the member's condition(s) and are connected to support to improve treatment adherence and medication management.

Member and family support activities may include:

- Documenting a member's family and/or personal support system and ensuring all required authorizations are in place so they can communicate with the care team.

- Ensuring the member, their family, and/or their personal support system is knowledgeable about the member's condition.
- Helping the member and/or their family and personal support system identify and obtain needed resources to support their health goals.
- Providing education to the member, their family, and/or their personal support system about their care plan.
- Ensuring that the member has a copy of their care plan and information about how to request updates

Coordination of and referral to community and social support services:

The member receives referrals to community and social support services and follow-up to help

ensure they get the services they need.

Referral and coordination activities may include:

- Identifying community and social service needs, such as needs for food assistance or housing support.
- Determining appropriate resources to meet the member's needs, including services offered through Community Supports.
- Routinely assisting the member and following up to ensure needed services are obtained.



ECM Population of Focus- Master•Care

Although there are additional populations of focus Master•Care is serving only 5

- 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.
- High Utilizer Adults: 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.

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 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**, 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:

- 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



How we get our patients: Referrals and MIFs

MIF Also known as Member Information Files:

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:

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:

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.

Workflow ECM

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. 30-60 days to complete
 - 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
 - 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 at least one goal for care plan
 - c. Set future tasks!
 - d. Always strive towards the company mission of Highest level of Independence
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. Make referral
 - ii. Follow up on referral
 - iii. Coordinate with referral provider
 - iv. 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.
 - b. Unresponsive pt.? bi-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
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 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
 - a. Unresponsive
 - b. Unwilling to participate in anyway
 - c. Safety concern: must be documented and discussed with supervisor



Outreach 101

Outreach and 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. Five touches in the first 30 days is the goal for MIF list and 5 touches in 10 days is the goal for referred ECM and CS. Additional touches are on case by case in hopes of engaging with someone who may have missed our first attempts.

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 script ready: See script notes
4. Open SF
5. Open pt. record in SF, review patient record
6. Call directly through Sales Force/RC app
7. Document every call, assure you have complete notes, pin notes with crucial information: No activity or notes = it didn't happen
8. Add Task before closing patient record: **No task = 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.
- Be prepared to leave A LOT of voicemails
- 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:

Outreach from the MIF list:

Remember!

- **Add notes/descriptions**
- **Task your next touch**

1st attempt- within 5 days of receiving the referral/list

2nd attempt- within 12 days of receiving the referral/list

3rd attempt within 18 days of receiving the referral/list

4th attempt -within 25 days of receiving the referral/list

5th attempt- within 35 days of receiving the referral/list

*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:

Initial Contact with CS or ECM Referral

Remember!

- **Add notes/descriptions**
- **Task your next touch**

1st attempt within 1 day of referral

2nd attempt within 3 days of referral

3rd attempt within 5 days of referral

4th attempt within 7 days of referral

5th attempt within 10 days of referral



Tips and Scripts

- Call at a different time of day
- Call on a different day
- Follow each call with a text
- Always leave a message
- 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 SF.

Outreach Message Script for Outreach Member

1. Leaving a message on voicemail that is personalized as the patients
"Hi, this is (name) with MasterCare on behalf of (managed Care plan) You have been referred for a program at no cost to you. 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 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 MasterCare 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 MasterCare 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 Letters:

Sent to the outreach list by main office, they are not necessary for outreach beyond the letters being send from the corporate office. If a patient asks you to send additional information you may send the letter and/or rack card with your business card.

Expectations and Productivity Goals (KPI's)

Type	Method	Time
Attempt	Phone +Text	10-15 per hour; 4-5 mins per attempt
Attempt	Phone + VM	10-15 per hour; 4-5 mins per attempt
Attempt	Email	10-15 per hour; 4-5 mins per attempt
Attempt	In- person	16 per day: 30 mins per attempt
Connection	Phone	4 per hour: 15 mins
Connection	In- person	4-10 per day: 45 mins-2 hours per connection.



Consent and Assessment

Consent

Enrollment and Consent Requirements

1. **Task** Lisa with checking eligibility once verbal enrollment has been completed. If patient wants to do in person consent and not verbal, then task Lisa when you schedule the assessment.
2. **KPI:** 30-45 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

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)
- Thank the patient and move on to scheduling the assessment.
 - Save and upload the recording
 - Document properly

Link

You will be assigned a e-sign link, that can be send via email or text

1. Once the patient clicks on it, they can e-sign it and it comes back to you for your signature
2. Once you sign it, the fully executed consent is sent to both you and the patient
3. Upload it to patient’s file
4. Document properly

In-person

Always keep paper copies of our consent with you.

1. Have the patient initial where appropriate
2. Have then chose and date the medical records portion
3. Have then sign the last page
4. Take pictures of each signed page (PDF scanner app)

5. You can leave the hard copies with the patient
6. Upload completed pdf of signed consent to patient profile
7. Document properly

ECM Assessment, Goal Setting and Care Planning

Key components include:

- In-Person Contact.
- Person-Centered.
- Comprehensive Assessment.
- Patient-Centered Care Plan.
- Patient care plan implementation- must give the patient a care plan
- Continuous and integrated care
- Treatment adherence- Health Promotion*use member website, Krames Online health library and other evidence based resources located in the Important Link Document,
- Communication
 - Fostered and on-going engagement with member
 - Timely reassessment.

Things to Remember

1. **KPI: 24-48 hours** to upload care plan and update notes and documentation regarding the assessment and goals.
2. **KPI: Minimum touches:** at minimum 1x per month more often initially and during any time where big goals are underway
3. **Goal Setting and Care Planning** happen at the assessment or can be scheduled for a later date. Try to leave with one attainable goal on the table, something you can follow up on, an open door for dialogue
4. **Add Task** before closing patient record: **No task = failure to follow through**

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- personable, approachable, conversational
- Trauma Informed Care- watch for clue of trauma triggering, be sensitive and be aware of your phrasing and use of words.

Paperwork/Documentation

1. Always completed the entire assessment
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 re-engage the patient.
6. Assessment must be uploaded to patient file within 72 hours (3 business days) You can upload the handwritten assessment or type the assessment in the fillable assessment.

Data Entry

All data entry must be completed within 72 hours of completion of assessment

1. In the patient's profile check all the boxes and completed all the fields that apply
2. Write notes where appropriate
3. Add a note with narrative from the assessment. Include observations of appearance and behaviors. In your event task put see note in the description

Always Use Current Assessment

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

We will review the ECM assessment together with the goal of finding at least one key take away to help us leave the patient with one attainable goal and maybe a little hope that someone cares.

1. Use motivational interviewing
2. Go off subject to flow with the patient but guide back to the questions at hand
3. 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!
4. Diagnosis is another key piece of information. Do they have a health diagnosis? If so explore that. Medications? Do they take them as prescribed, any side effects? Do they know what they are for?
5. Never underestimate the power of your patients support system if they have one.
6. Do they have a PCP and when did they last see them?
7. What about dental issues?

8. Look for clues, what makes them upset, or sad, 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.

Thoughts and ideas

- ⇒ You can always leave a patient with mental health crisis line, nurse advice line for their managed care plan, the telehealth app, link to member facing website for their managed care plan! This is Health Promotion!
- ⇒ Help them find a PCP and make an appointment
- ⇒ Get them a DMV appointment
- ⇒ Do coordinated entry into their county for services



Care Planning and Goal Setting

Establish SMART goals with the patient.

SMART Goals are the basis of The Master-Care Plan.

Establish Immediate, short term and long-term goals.

Sometimes goals are verbal at the assessment, but must be written out and uploaded

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.

Once you complete the Care Plan Document save it as a pdf and upload it to the patient's file

You can communicate the goals by:

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

Closed Loop Referrals: Closing the Loop

A crucial part of what we do is finishing what we started, closed loop referrals and closing the loop. What does that mean?

- We follow up with everything do (set a task to do this!)
- **We refer and coordinate all CS and other CBO referrals**
- All resources given to our patients- what was the outcome? Was it successful or not? Why?

- All communication with our patients- Do what you say you are going to do, documents the responses and outcomes of communication.

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.

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.

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.

CS- 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:

5. Finances, what can they afford?
6. Geographic region
7. Need for disability or other accommodations
8. 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.



Introduction to 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 Medi-Cal 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. For 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). Includes wrap-around services: assistance w/ ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment. Includes 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:

1. Assessing the Member's housing needs and presenting options
2. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF
3. 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)
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. 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 is our customer?

The Managed Care Plans are our customer, we are contracted with them to deliver service per our contract and DHCS guidelines.

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—Often referred to as a SNF, Skilled Nursing Facilities have varied services and some even specialize in certain types of post-acute care, such as rehabilitation from stroke or joint replacements. The SNF's 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.

TIP: Don't use the f-word- Facility. Facility feels medical and sterile, Community is welcoming, more homelike, Assisted Living Providers prefer this term as they rent their apartments primarily to private pay residents.

Types of Care: Non-Medical Care- Custodial-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. Here are some examples of ADL's

- 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 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.

Eligible AND Appropriate

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:

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

Criteria- who is eligible for this service?

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

Criteria- who is eligible for this service?

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

NF Workflow

You got a referral now what?

1. Tell the truth no elaboration needed!
2. We are selling nothing This is a great program but does have criteria!
3. Manage referrers expectations!
4. Never promise anything
5. Let them know you will review and check eligibility
6. Ask for all the documentation you are going to need to qualify this referral
 1. Facesheet
 2. Current Nursing Notes, MD notes, PT/OT notes
7. Enter Patient in Salesforce
8. Required Fields:
9. Name
 1. CIN (Medicaid/Medi-Cal number) 8 numbers ending with a letter sometime has 3 leading letter and 4 numbers on the end. 98765432A (XDJ98765432A or XDJ98765432A1234)
 2. DOB
 3. Name of SNF
 4. Upload all documents
 5. Status 2-pending
10. Task Lisa with Eligibility Check
11. Task Kathy with Review
12. Task yourself with follow up
13. Review the patient are they:
 1. Appropriate for this program?
 2. What are the obvious obstacles? Injections, complex med protocol, bed bound, dementia without POA or family, etc.
14. Once confirmed eligible:
 1. Get **consent** and explain the program to patient and if any family or support system
 2. Confirm income of the patient and understanding that 90% of SSI (only of SSI) must be paid for Rent (room and board) patient must agree to this.
 3. Explain that you will refer them into the program and if authorized you will follow up for an assessment.
15. IF pt. is eligible but needs help organizing finances, getting payer, applying for SSI- they need ECM first so we can get paid to assist the patient with these things. Task Lisa with ECM referral.

16. Task Lisa with referral- assure all documents necessary are uploaded and legible.
17. Let the referrer know where you are at in the process

If Ineligible

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

Patient is Eligible and Authorized- Transition to AL (see transition to home)

1. Connect with referrer and patient to schedule an assessment
2. Confirm willingness and ability to pay 90% of income.
3. Complete appropriate assessment- document well with narrative
4. Complete Discharge Plan-Care Plan
5. Get 602 completed
6. Task Kathy with 602 review
7. Task Patience with initial RCFE search for your patient
8. Once RCFE's have been identified-present possible options
9. Task Patience with scheduling assessments- coordinate together

Assessed and Accepted by RCFE

1. Confirm rates and get admissions agreement
2. Task Debra with review of rate and agreement
3. Confirm choice with patient- explain that we will be submitting for authorization
4. Task Debra with submitting for authorization

Authorized for Wrap Around!

1. Refer in for ECM- if not already in ECM
2. Coordinate Discharge date with SNF, Patient and RCFE
3. Gather all crucial items for discharge:
 - a. Medications- 30 day supply
 - b. Supplies- what do they need? Personal hygiene items etc.
 - c. Clothes
 - d. Personal items

- e. Paperwork
4. Arrange transportation
5. Be present at discharge to assure all goes well
6. Follow transportation to RCFE
7. Remain with patient throughout the admission process
8. Assist patient with settling into new home
9. DOCUMENT!
10. TASK FOLLOW UP
11. CELEBRATE SUCCESS!

Follow up

Create tasks to assure you follow up with the patient and the RCFE or other providers

Week 1:

- Check in with patient and RCFE or other provider to see how they are settling in
- Assure coordination between ECM and the RCFE or other providers is in place
- Assure patient's person support system is introduced to the RCFE so they can visit and support the patient.
- Work with patient and/or patient representative to request SSI increase if below the Non-Medical Out-of-Home Care (NMOHC) Payment Standard for Individuals-Licensed Facility or Without In-Kind Room and Board

First 30 days after discharge to RCFE:

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

Patient is Eligible and Authorized- Transition to Home

1. Connect with referrer and patient to schedule an assessment
2. Complete appropriate assessment- document well with narrative
3. Complete Discharge Plan-Care Plan
4. Home inspection to assure pt. can move home safely
 - a. Is home safe? If not can it be made safe with reasonable wrap around services
 - b. Coordinate all services necessary for safe discharge, this varies by patient and patient's housing situation.
5. Who is providing care? Coordinate schedule and assure coverage is in place as part of the care plan

- a. Who is providing medication management? Assure there is a way to have medication delivered and managed to assure pt is taking them appropriately
- b. 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.
6. Refer in for ECM
7. Coordinate Discharge date with patient support and care
8. Gather all crucial items for discharge:
 - a. Medications- 30 day supply
 - b. Supplies- what do they need? Personal hygiene items etc.
 - c. Clothes
 - d. Personal items
 - e. Paperwork
9. Arrange transportation
10. Be present at discharge to assure all goes well
11. Follow transportation to Home
12. Remain with patient to assure all supports are in place and patient understand the care plan and what to expect such as appointments etc.
13. Assist patient with settling into new home
14. DOCUMENT!
15. TASK FOLLOW UP
16. CELEBRATE SUCCESS!

Follow up

Create tasks to assure you follow up with the patient and the RCFE or other providers

Week 1:

- Check in with patient and other provider to see how they are settling in
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First 30 days after discharge to RCFE:

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



How to help when we can't

If ineligible

Let the referrer know why (wrong insurance) Let them know that the patient may choose a different Managed Care Plan. **BUT!** Still not guarantee as the person must also be appropriate.

If not appropriate

Let the referrer know why:

- Age + conditions: Solution have them refer the patient into ECM for their managed care plan.
- Conditions or care needs too high/complex: Solution Will the conditions improve or can they be improved with a different treatment plan and if the patient willing to participate in the treatment plan. If so once they have completed treatment and conditions have improved, we can work reevaluate.
- No pathway to income to pay room and board: Solution Have SW or other staff work with the patient to apply for SSI
- Unwilling to pay room and board: Solution No options unless the patient is willing. The program is voluntary, and this is a requirement.

Community Relations: Educating Providers about the populations we service

How we receive referrals:

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. The 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: SNF's 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, its 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.



Community Relations and 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.

Ask for 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.

CS-NF Transition 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,

Care Planning for NF transition Patients

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 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 CS-NF Transition

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



Assuring Excellent Care Management & Providing Ongoing ECM and CS

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

Setting your patient up for success

- Managing 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- realistic goals are key
- Reminders and follow up to assure proper level of support for success
- Education & Health promotion- encouraging better health and health decisions
- Accessible Mental Health Resources
- Telehealth
- Make a list of questions for the PCP
- 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

Communication requirements

If a patient does not communicate and participate it is crucial that you give them notice that you will be terminating them from the program. Their participation is required.

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

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

What Is a Care Conference?

Group Care Conference and individual 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 follow in 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**

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:

- Unresponsive
- Has completed all care plan goals and is independently managing their care
- Step down to lower level of care: The Member is ready to transition to a lower level of care.
- Decline to participate (member choice)
- Refuses to cooperate
- Unsafe behavior Is aggressive, abusive, or otherwise unsafe to continue
- Enrolled in a duplicative program
- Enrolled in hospice
- Enrolled in Cal Medi-Connect
- Medi-Cal termination
- Switch to another health plan
- Moved out of the service area

Graduation/Termination Process

Each Managed Care Plan has different forms for graduation

1. Completed graduation form
2. Upload to patient's file
3. Close out the patient: disposition, documentation, notes etc.
4. Add Task or multiple tasks before closing patient record: **No task = failure to follow through**

Referral Process

When you identify someone who may benefit from our services.

Gather information- this person **MUST** qualify for ECM, or we do not refer them in, screen appropriately

1. Name
2. DOB
3. Medi-Cal Number
4. Name of Care Plan
5. Population of Focus – you will identify this while screening- please see attached Enhanced Care Management Screening Check List (it is HealthNet but works universally for your screening) You do not need to fill this out but you must make sure they qualify.
6. Complete referral form for appropriate Managed Care Plan
7. Add new referred patient to SF
8. Upload referral form
9. Task ECM Director (or designated referral person) with submitting the referral
10. Do not engage with this person for ECM until we have approval. You can let them know the process is approximately 5 business days

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 Master-Care, an MCP or other providers. In all cases we must document and address these complaints.

Tasks

Subject to change

Task Lisa

- Eligibility- as soon as enrolled or assessment scheduled
- Authorizations- When the patient is 30 days from end of authorization for services.

Task Kathy (Ops/ECM Director):

- Care Plan Review
- Care Conference Needed
- Complaints
- Issues and/or that need to be reviewed
- Graduation – disenrollment
- ECM and CS Referrals

Task Jennifer (RN):

- Care plan uploaded and ready for review
- Care Conference Needed

Task Patience (Remote Care Navigator and Resource Specialist)

- Need help finding a resource

Ongoing Education and Training Requirements:

- Stay up to date on training and education.
- Always participate in offered training and suggest additional training topics.
- Make suggestions for trainings
- Ask for additional training if unclear on policy or process

Documentation: Naming Conventions, Clear Documentation

Naming Conventions, Activities and Tasks

Assessments and Care Plans:

Patient's Initial_date of assesement_Type of document

Examples:

KI_92622_AssesmentCarePlan

KI_92622_Assesment

KI_92622_CarePlan

KI_12623_AssesmentCarePlanUpdated

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

Communication

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.

Key Documentation Language

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 Carol's 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.

Time Management

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.

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

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.

Let's talk about what that means:

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

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

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

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!

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

Sales Force: 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

Sales Force Activities and Documentation:

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 Force 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

Activities happen 5 ways:

1. Call (through RingCentral)
2. Text (through RingCentral)
3. Email (through outlook)
4. In person (SalesForce Event)
5. Research (use the timed activity tool or a task)

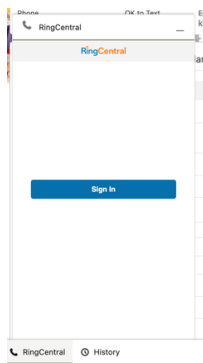
How should you document your activity?

Telephonic activities

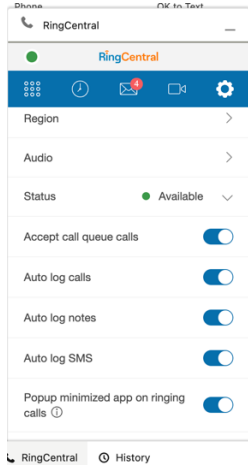
must be done through RingCentral. Those calls and text must be logged in SF.

This is the activity we will edit to add information – not the task

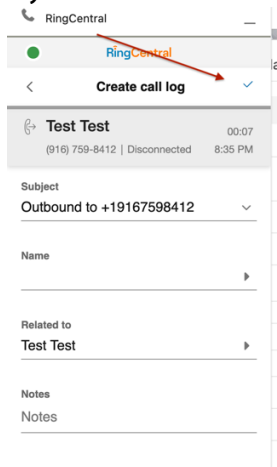
When you log into SF make sure you are also logged into RC, sometimes you have to re log into RC in SF, this is part of HIPPA



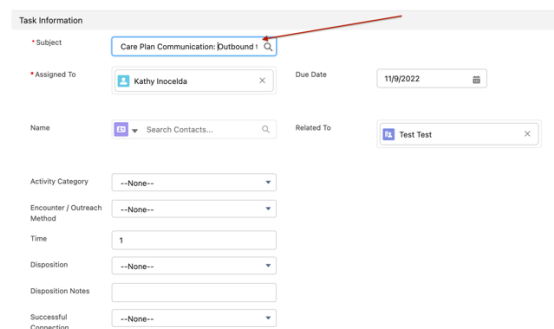
If your calls and texts are not logging check your settings, they should look like this:



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.



Disposition Notes

Successful Connection

Follow Up Date

Place of Service (POS)

Place of Service Other Notes

Comments

Additional Information

Priority

Status

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 one of the many 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

New Task New Event Email

Subject

Description

Start

Date

Time

End

Date

Time

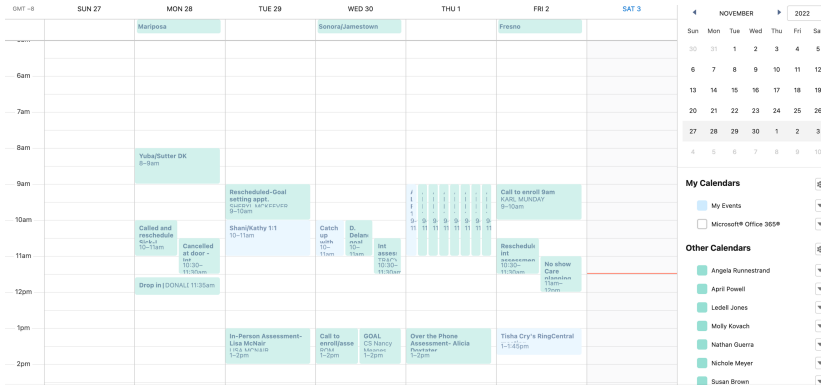
Location

Name

Related To

Save

MASTER•CARE PROCESS MANUAL



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.

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Activity

New Task New Event Email

*From k.inocelda@mastercareplan.com

To Test Test X Cc Bcc

Subject Enter Subject...

Font Size B I U A -

Kathy Inocelda
COO
K.Inocelda@MasterCarePlan.com
916.398.4999 Office
877-924-7010 Fax
916.333.7768 Direct
MasterCarePlan.com
Master•Care, Inc. takes confidentiality seriously.

Research and other non-patient contact such as care conferences

Simply add the activity using the time clock activity panel

00:09:42
Stop Reset

* Subject

Documentation Date
Nov 10, 2022

* Activity Category
Select Type

Encounter Outreach Method
Select Encounter Outreach Method

Disposition
Select Disposition

Related To
Test Test

Description

Successful Connection
Select Type of Connection Made

Time (minutes)
10

Save



Other Important Salesforce Tools for Productivity:

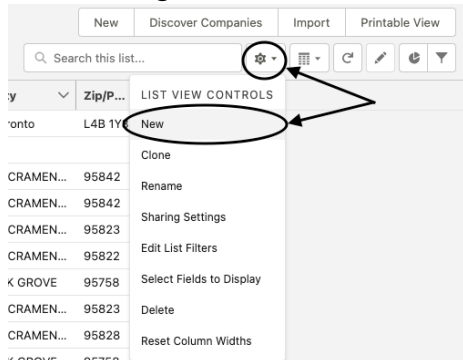
- Patient Lists
- List View
- Tasks

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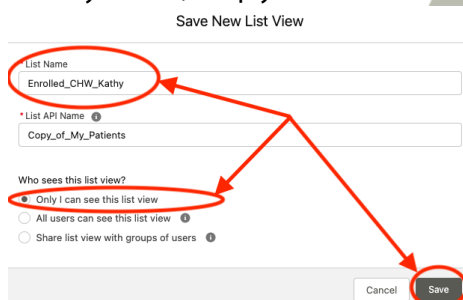
Creating a Custom list

Making filtered lists is a must for organization and productivity. Especially when working a list for outreach or organizing your calendar for an extra busy week.

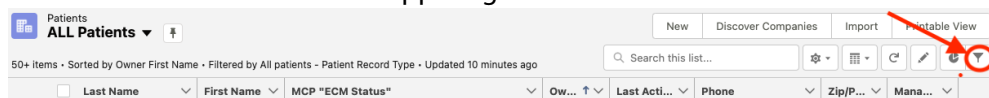
1. Go to Patients tab- Choose My Patients or All Patients
2. Click on the gear and choose New



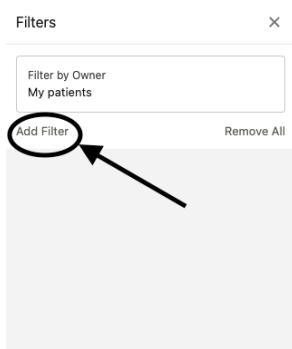
3. Name your list, keep your list. Private – Only you can see this list. Click Save



4. Click on the filter button in the upper right-hand corner above the list



5. Click add filter



6. From here the field, operator, and value open. This is where you can choose what you want to see on this list.

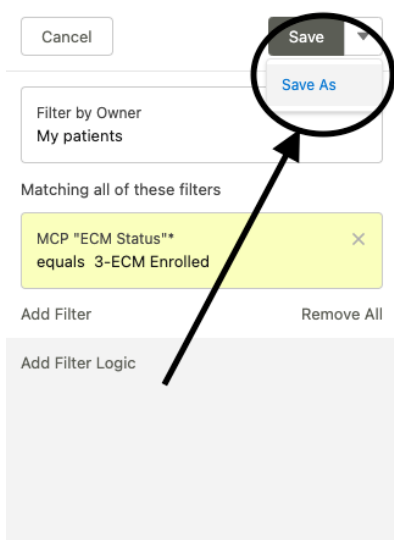
For a specific MCP

- a. Field: Managed Care Plan
- b. Operator: Starts with
- c. Value: name of MCP
- d. Click Done

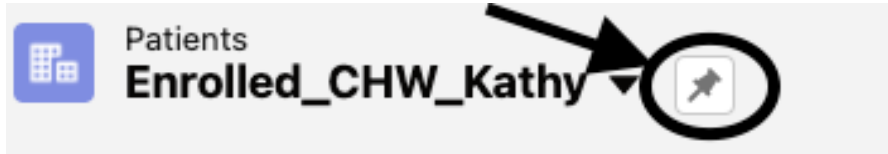
For a specific Patient Status

- a. Field: MCP "ECM Status"
- b. Operator: Equals
- c. Value: Chose option from drop down
- d. Click done

7. Choose how you want your list saved by clicking on save or the arrow next to save and choosing Save as



8. Pin your list by clicking on the push pin on your new list. You can only pin one list at a time but your other lists are available in the drop down.

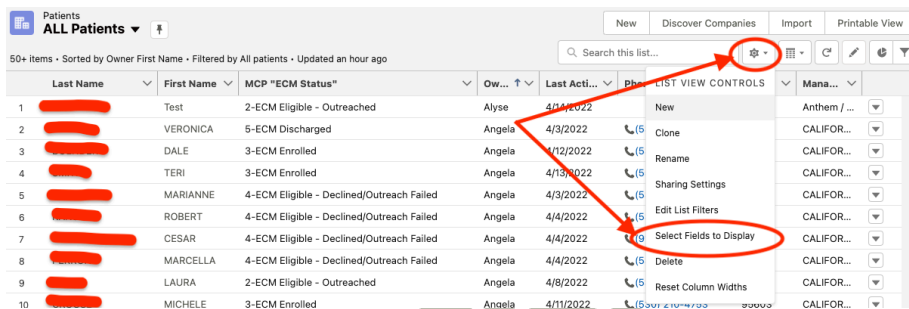


List Views

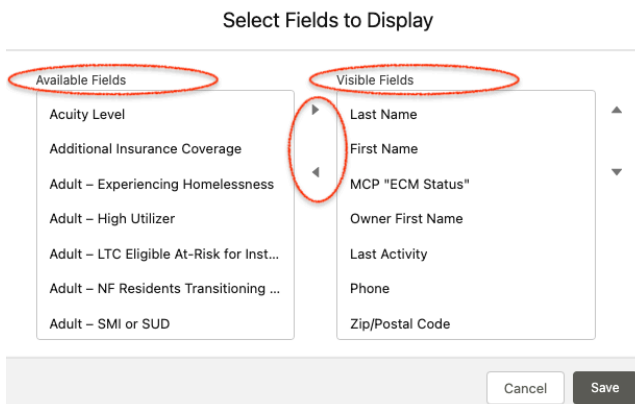
The way you see your list and the information displayed depends on your personal preference and the use of the list.

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



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



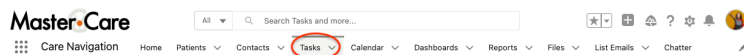
3. Put them in the order you want to see them on your list by highlighting and using the arrows on the right to move the field.

Select Fields to Display

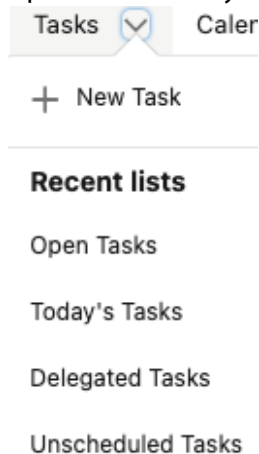
Available Fields	Visible Fields
<ul style="list-style-type: none"> Acuity Level Additional Insurance Coverage Adult – Experiencing Homelessness Adult – High Utilizer Adult – LTC Eligible At-Risk for Inst... Adult – NF Residents Transitioning ... Adult – SMI or SUD 	<ul style="list-style-type: none"> Last Name First Name MCP "ECM Status" Owner First Name Last Activity Phone Zip/Postal Code

Tasks

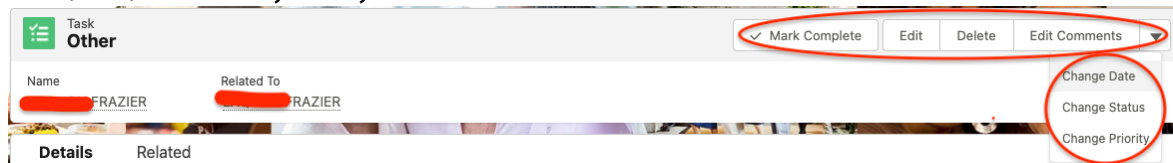
1. Choose Tasks from the tool bar



2. Open the task list you want to view



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

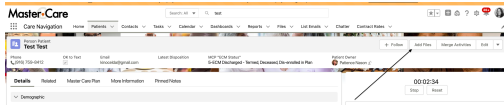


All Activity must be documented
All Activity must be documented correctly

Adding Files to Patient Profile

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

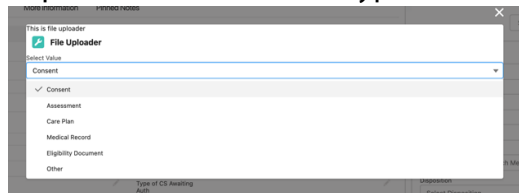
Step 1- in the top section of the patient file look for the Add Files button.



Step 2- the file uploader will pop up



Step 3- choose document type from the drop down



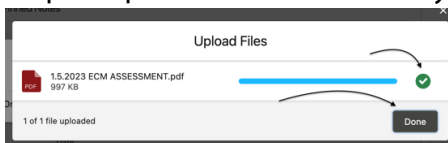
Step 4- choose next



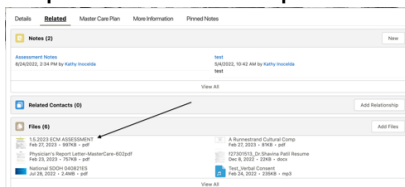
Step 5- Upload file



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



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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

UMU



Find Help

HR Assigned:

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