Name: Dennis Hsieh, MD, JD

Professional Title, Organization: Chief Medical Officer, Central California Alliance for Health (at time of work Chief Medical Officer, Contra Costa Health Plan)

CHIP Title: Implementing CalAIM Community Supports to Create a System of Safe Discharge Options for Challenging Patients from Acute Care Facilities to Decrease Administrative and Denied Days

Project Description:
Medicaid patients remain in acute care settings (acute hospitals, long term acute care hospitals, skilled nursing facilities) because there are no safe, clinically appropriate discharge options. This results in an increased number of administrative or denied days because the patients are no longer clinically acute and are just awaiting placement. Patients who could be in an inpatient bed or in a skilled nursing facility are instead stuck boarding in the emergency department or an inpatient bed. This leads to crowding both in the emergency department and the inpatient setting, which is both bad for the patient and costly for the health care system.

Enhanced Care Management (ECM) and Community Supports (CS), as offered through California Advancing and Innovating Medicaid (CalAIM), can address this problem by increasing the number of safe, clinically appropriate discharge options. The challenge is weaving the discrete benefits and funding streams offered under CalAIM into a system of care that augments the existing discharge options.

This project focuses on the implementation of CalAIM Community Supports by translating CalAIM's vision into a concrete approach through nontraditional partnerships. The project expands the capacity of existing service providers (personal care services providers, shelters, recuperative care/medical respite, transitional housing, sober living environments, board and cares, assisted living facilities, residential care facilities for the elderly (RCFEs), etc.) through using CalAIM CS to pay for these services and makes them directly accessible to acute care facilities as Medicaid funded discharge options.

Key Findings and Lessons Learned:

- Created discharge analytical approach and playbook for Contra Costa Health Plan and hospital partners.
- Implemented robust referral process and network of Community Support Providers resulting in high utilization of community support services.
- In May and June 2023, successful placement of 4 long stay patients at Contra Costa Regional Medical Center (CCRMC) who had each been in the hospital over 100 days each awaiting placement at board and care facilities through leveraging Community Supports.
- Successful collaboration between Contra Costa Health Plan (CCHP) (Medicaid Insurance), Contra Costa Health, Housing and Homeless Services (H3), and the Contra Costa County Continuum of Care to support 22 new FTEs in the homeless system of care.
- 50 new rooms at Motel 6 in Pinole as bridge housing starting early 2024. A second motel is in process. Expansion of both shelter beds and medical respite in process.

Next Steps:

- Quantify cost savings, decreased number of administrative days, and reduced crowding and boarding.
- Replicate this across Santa Cruz, Monterey, Merced, San Benito, and Mariposa counties.
- Partner with CHCF to create playbook for all plans and acute care facilities for approaching difficult discharges
- Ensure ongoing support for board and cares, assisted living facilities, and RCFEs through Medicaid
- Work with advocates and partners to remove the Medicaid bar on paying for housing when clinically indicated.