CHCF Patient Vignettes

Playbook for Complex Discharges:
Patient Vignettes

Making It Real

These four patient vignettes accompany the *Playbook for Complex Discharges*, a resource that describes promising practices for people at organizations supporting planning and coordination for complex discharges. The vignettes were inspired by interviews and feedback sessions with informants but do not reflect the actual experience of any specific individual. They are intended to offer insight on how different settings and services can facilitate complex discharge planning, how the roles on a care team can work in reality and also change over time for multistep discharges, and how alternatives should be considered, especially as they align with the patient's goals and wishes.

- **Sky's Story:** Wound Care Recovery in Recuperative Care as a Bridge to Independent Housing
- **Elliott's Story:** Transitioning Home from Skilled Nursing After a Stroke
- **Luis's Story:** Transitioning Home After a Traumatic Brain Injury with End-Stage Renal Disease
- **Jesse's Story:** Skilled Nursing Facility to Residential Treatment Facility to Board and Care After a Spinal Cord Injury

Sky's Story: Wound Care Recovery in Recuperative Care as a Bridge to Independent Housing

Sky, a 35-year-old nonbinary individual who uses methamphetamine and fentanyl, was recently hospitalized for worsening wounds they developed as a complication of their substance use disorder. A year ago, Sky was living in an apartment and going to art school, but their rent increased to a level they could no longer afford, and they were evicted by their landlord. Sky has been living in an encampment with their dog, a Chihuahua named Banjo, since being evicted.

The hospital social worker is working with Sky to develop a discharge plan for when they are ready to leave the hospital and has identified these complex needs for Sky:

CATEGORY	CONDITION OR NEED
Physical health	This is Sky's third hospital stay related to wound infections in the past six months. Past attempts at discharge back to their encampment to self-manage their wounds with follow-up by the Street Medicine nursing team were unsuccessful.
Behavioral health	Sky restarted on methadone during this hospital stay. They are ambivalent about abstinence but would like to cut back drug use to help their wounds heal.
Cognitive impairment	No cognitive impairment was identified at the time of discharge.

CATEGORY	CONDITION OR NEED
Functional needs	Sky has struggled with attending outpatient medical appointments and regularly taking the medications, dosed twice daily, prescribed by their doctors.
Social needs	Sky has been living in an encampment with their dog, Banjo. They have struggled in placements that are structured and have many "house rules." Sky has been resistant to leaving the encampment because they feel cared for in the community and do not want to be separated from their pet. Sky is well known to the hospital social work discharge team, who feel like Sky has sabotaged past housing placement opportunities out of frustration. Sky is not receiving Supplemental Security Income or Social Security Disability Insurance.

What are Sky's goals?

Sky's goal is to have their own apartment again, where they can bring Banjo and make art. They are ambivalent about abstinence but would like to reduce drug use to help their wounds heal. Sky has many friends in the encampment and is scared to move away from them, but is willing to if it means they can meet their goal.

Who is on Sky's care team at the time of discharge?

- Inpatient discharge planner (quarterback))
- Street Medicine team
- Utilization management nurse at the managed care plan (MCP)
- Primary care team
- Substance use disorder (SUD) treatment team

What discharge options does the team come up with?

- A prolonged hospital stay while wounds heal enough that Sky can be discharged to their encampment
- A skilled nursing facility (SNF)
- Recuperative care

What is the discharge plan?

STEP	SETTING AND SERVICES	CARE TEAM
Recuperative care	Recuperative care (through Community Supports) coupled with Enhanced Care Management (ECM) is the best option for Sky, as there is a facility contracted with the MCP that provides wound care, accommodates pets, partners with a local methadone clinic, and has a gender-inclusive policy that allows Sky to choose their preferred dorm or bed. This allows Sky to receive transitional support and clinical care at a lower level of care than the hospital or a SNF, but with SUD and medical supports they need before they are ready to live on their own. It also helps buy some time for Sky to build a relationship with an ECM Lead Care Manager and get connected to housing navigation services in order to help them find a pet-friendly unit. Sky can also get connected to primary care and consider a switch from methadone to buprenorphine and enrollment in recovery incentives (contingency management).* Finally, day habilitation services could help Sky find employment in order to have income to qualify for housing. If Sky is not able to get connected to independent housing while in recuperative care, short-term posthospitalization housing can help bridge the gap for up to six months.	▸ ECM Lead Care Manager affiliated with the recuperative care organization (quarterback) ▸ Recuperative care clinical staff ▸ Housing navigation provider ▸ Day habilitation provider ▸ Primary care team ▸ SUD treatment team ▸ Short-term posthospitalization housing provider (if needed)

STEP	SETTING AND SERVICES	CARE TEAM
Ongoing	Independent housing with an ECM Lead Care Manager who works at the same agency that provides SUD treatment.	▸ ECM Lead Care Manager (quarterback) ▸ Primary care team ▸ SUD treatment team ▸ Tenancy and sustaining services

* For more on this treatment option, see "Recovery Incentives Program: California's Contingency Management Benefit," California Department of Health Care Services (DHCS), accessed June 30, 2024.

Who pays for what?

Sky is enrolled in Medi-Cal, so most of their postdischarge care will be paid by the managed care plan. County SUD will authorize and pay for SUD treatment services. In addition, Sky's MCP authorizes and pays for recuperative care and ECM, as well as other housing-related Community Supports linked to their transition to independent permanent housing (e.g., housing navigation, housing deposits, tenancy and sustaining services, day habilitation).

What are alternatives?

Without recuperative care that embraces a harm reduction approach to substance use and/or allows pets, Sky may choose to return to their encampment. If they do so, it may make more sense for Sky's ECM Lead Care Manager to be connected to or part of the Street Medicine team, which is more likely to remain connected to Sky and can offer a trusted bridge to services like wound care, recovery incentives, a substance use navigator, or housing navigation.

How did it all work in practice?

✔ Because the MCP was looped into the care team and the plan for Sky's discharge, they were connected to an ECM Lead Care Manager before leaving the hospital. The Lead Care Manager was able to build rapport with Sky before they were discharged and also got looped into the strategy and approach for Sky and Banjo. The MCP supported the care team by expediting the authorization approval for recuperative care, and also provided the parameters and requirements for short-term posthospitalization housing as Sky's next step after recuperative care.

✔ Having a recuperative care facility in the MCP's network that could accommodate a pet and that employed a harm reduction approach to substance use was key to helping Sky get discharged from the hospital and begin a transition to independent housing. The MCP recognized the value of this flexibility for complex discharges and began engaging with other recuperative care facilities in its network on adopting these flexibilities.

✔ Sky's ECM Lead Care Manager (who is also their substance use navigator) identified that Sky is eligible for the local Recovery Incentives Program (contingency management benefit), and accompanied Sky to their PCP appointment to discuss their interest in switching from methadone to buprenorphine.

✔ The ECM Lead Care Manager connected Sky with housing-focused Community Supports, such as housing transition navigation, where a housing navigator can start the housing assessment process and facilitate connection with a local housing support services Coordinated Entry unit. The ECM Lead Care Manager also helped Sky apply for CalFresh and CalWORKs benefits and connected Sky to an organization providing day habilitation to help with the process of finding a job. The two of them also visited the encampment to check in on Banjo, who was being cared for by Sky's friends while they were hospitalized.

- ✔ When Sky was able to get a housing unit, the ECM Lead Care Manager and the housing navigator supported them in their move through housing deposits, which help pay for move-in costs such as furniture, and connection to tenancy and sustaining supports to help Sky keep the apartment and not get evicted again.

Elliott's Story: Transitioning Home from Skilled Nursing After a Stroke

Elliott, a 75-year-old man who was previously living independently, has been recovering at a skilled nursing facility (SNF) for the past four months since he had a stroke that resulted in right-sided weakness and inability to speak. He has met his SNF rehabilitation goals and continues to have residual right upper- and lower-extremity weakness and difficulty finding words. He is ready to be discharged from the SNF with additional services to support him but has some complex needs, making discharge more challenging.

The social worker at the SNF has been working with Elliott on his discharge plan and has identified these complex needs:

CATEGORY	CONDITION OR NEED
Physical health	Elliott has diabetes and requires insulin. Since the stroke, Elliott now takes over 10 medications and needs help keeping his doses and schedule straight, managing side effects, and making sure he gets his prescriptions refilled.
Behavioral health	When Elliott arrived at the SNF, he was overwhelmed with his loss of independence and the changes in his lifestyle resulting from the stroke. He has been receiving treatment for mild depression while at the SNF, but is stable and motivated to transition home, knowing the challenges and support he will need to manage his condition.
Cognitive impairment	Elliott's care team is concerned about his cognitive capacity, with neurocognitive testing showing results consistent with mild to moderate cognitive impairment.
Functional needs	Elliott will need support with ADLs and IADLs, including showering, housekeeping, and shopping. Elliott will also need home modifications, such as the addition of grab bars, to prevent falls related to his residual weakness. After the stroke, Elliott is no longer able to hold a syringe, so he can't administer insulin himself. The team is also concerned about his ability to track his blood glucose levels.
Social needs	Elliott has an apartment but is at risk for eviction as he was unable to pay rent while he was hospitalized and at the SNF. Elliott is originally from the Midwest and moved to California to be closer to his sister almost 15 years ago. He does not have any children, and lost contact with his sister's family a decade ago.

Notes: *ADLs* are activities of daily living. *IADLs* are instrumental activities of daily living.

What are Elliott's goals?

As part of the planning for his discharge from the SNF, Elliott agreed to and is receiving Enhanced Care Management (ECM) to help him transition back to his home. The ECM Lead Care Manager centers care planning on Elliott's goals — primarily, that he is motivated to go home. He understands there's a lot he can't do anymore but is very interested in taking care of his personal needs himself, including being able to use the toilet and dress himself with minimal help. Elliott loves cooking and wants to make some of his own meals — mostly home-cooked meals from the recipes his grandmother taught him. He also loves reading and has missed going to the library to check out new books since he was hospitalized for his stroke.

Who is on Elliott's care team at the time of discharge?

- SNF case manager/discharge planner (quarterback)
- ECM Lead Care Manager (same agency as the one providing nursing facility transition services as a Community Support)
- Utilization management nurse at the managed care plan (MCP)
- Primary care provider
- Specialists (neurologist; endocrinologist; physical therapist; occupational therapist; speech therapist)
- Personal care and homemaker services/nursing facility transition to a home services agency (same agency provides both Community Supports services and ECM)
- Medically tailored meals provider

What discharge options does the team come up with?

- Stay in SNF as a long-term care/custodial resident.
- Move to and receive assisted living services in a residential care facility for the elderly (RCFE) through the nursing facility transition to assisted living facility Community Support.
- Transition home with supports: ECM, nursing facility transition to a home, medically tailored meals, personal care and homemaker services, paramedical In-Home Supportive Services (IHSS), and Community-Based Adult Services (CBAS; formerly known as Adult Day Health Care).

What is the discharge plan?

STEP	SETTING AND SERVICES	CARE TEAM
Home with supports	Elliott is discharged to his home with continued physical, occupational, and speech therapy; ECM; and three Community Supports (nursing facility transition to a home services, personal care and homemaker services, and medically tailored meals) paid for and arranged by his MCP, while he applies and is approved for IHSS and finds and hires a caregiver who can provide paramedical services.* (Elliott's PCP suggested the team look into paramedical services through IHSS, which allows a trained caregiver to administer insulin and help check Elliott's glucose levels.) The nursing facility transition services provider also helps Elliott get his apartment in order — including turning his utilities back on and working with his landlord to get caught up on rent and prevent eviction. The MCP also coordinates the delivery to Elliott's home of medically tailored meals that meet his diabetic dietary needs. To make sure his home environment is set up to reduce fall risk and address other safety risks, the primary care team works with the MCP to makes sure there is a home safety evaluation scheduled for a few weeks after his discharge.	▸ ECM Lead Care Manager (quarterback) ▸ Personal care and nursing facility transition services agency (same agency as ECM) ▸ Medically tailored meals provider ▸ Primary care team ▸ Neurologist ▸ Endocrinologist ▸ Physical, occupational, and speech therapy team

STEP	SETTING AND SERVICES	CARE TEAM
Ongoing	Elliott qualifies for IHSS, and the team is able to line up paramedical services for Elliott's insulin and an occupational therapist to work with him on hand dexterity. His IHSS caregiver also helps him cook delicious and healthy food, including some of the recipes from his grandmother. Elliott also starts going to the CBAS center twice per week for social interaction and other supports, which the team hopes will slow his cognitive decline.† A couple of months later, there is an incident where Elliott leaves the stove on without realizing it, so the MCP authorizes environmental accessibility adaptations (home modifications) so that he can't use the stove without his caregiver there. The care team is also concerned about progression of his cognitive deficits, so they work with the MCP to identify options, should they be needed, for him to transition to an RCFE.	▸ ECM Lead Care Manager (quarterback) ▸ IHSS case manager ▸ IHSS provider ▸ Home modification vendor ▸ CBAS center team ▸ Primary care team ▸ Neurologist ▸ Endocrinologist ▸ Physical, occupational, and speech therapy team

* For more on this support, see "Paramedical Services Through the IHSS Program," Disability Rights California, October 1, 2014.

† For more on this support, see "Community-Based Adult Services," California Department of Health Care Services (DHCS), accessed June 30, 2024.

Who pays for what?

Elliott is enrolled in both Medicare and Medi-Cal for health insurance: "traditional" fee-for-service Medicare (not a Medicare Advantage Plan or Dual Eligible Special Needs Plan, or D-SNP) and Medi-Cal managed care. Most of his physical health services (e.g., physical and occupational therapy, primary care, neurology, prescription drugs) are covered by Medicare. The MCP pays Medicare copayments as allowable under state law, pays for CBAS, and pays for ECM and the relevant Community Supports (nursing facility transition to a home, medically tailored meals, personal care and homemaker services as a bridge to IHSS, and environmental accessibility adaptations/home modifications). IHSS is a Medi-Cal benefit that is carved out of managed care, with costs split between the county, the state, and the federal government.

What are alternatives?

If Elliott's cognitive impairment declined quickly, such that he was unable to hire and manage a caregiver through IHSS, he could move to an RCFE, either funded by the MCP as a Community Support (nursing facility transition/diversion to assisted living facility) or through the Assisted Living Waiver, if available in his county. If Elliot moves to an RCFE, he will pay his room and board, and either the MCP or the Assisted Living Waiver will pay for the ongoing caregiving services and supervision provided by the RCFE.

Elliott's PCP recommended paramedical services to support Elliott in administering his insulin but could also weigh other options for managing his diabetes, such as switching from insulin to a weekly injectable antidiabetic agent, which could be delivered by the CBAS center.

How did it all work in practice?

✔ As soon as Elliott arrived at the SNF, the SNF case manager/discharge planner began exploring options for Elliott's discharge with his MCP. The MCP authorized and assigned Elliott to an ECM provider that focused on nursing home transitions, knew the local non-MCP resources well, and also offered relevant Community Supports.

✔ Elliott's ECM Lead Care Manager followed best practices for motivational interviewing and started conversations with Elliott about goals of care, including talking about what's most important to him in his day-to-day life, his priorities for his health and health care, and his worries and concerns. As part of developing his care plan, clinical staff on the care team engaged with Elliott about his decisionmaking preferences and helped make sure he

had an advance health care directive in his medical record that documented his wishes.

✔ Collaborating with the MCP early in the care-planning process helped identify additional resources available and covered by the plan:

- **Enhanced Care Management** to support Elliott in his transition home, helping to develop his care plan and coordinate various supports and services set up for him during and after his discharge.
- **Nursing facility transition to a home services** for people who need support securing and retaining their housing when transitioning home from a nursing facility. In Elliott's case, these services helped him get his rent payments sorted out to avoid eviction and figure out if he needed any modifications to his home for accessibility.
- **Personal care and homemaker services** to bridge any gaps in Elliott's IHSS eligibility and availability of services as soon as he transitioned home.
- **Medically tailored meals** to support Elliott with medically supportive food tailored to his chronic conditions as well as nutrition counseling and education.
- **Environmental accessibility adaptations (home modifications)** to install grab bars in Elliott's apartment to help reduce his fall risk.
- **Community-Based Adult Services (CBAS)** as an option for Elliott to receive nursing services (if there are challenges with paramedical services through IHSS); physical, occupational, and speech therapy; mental health services; and meals and nutritional counseling. The MCP and CBAS center can also arrange transportation for Elliott to/from his home.

Luis's Story: Transitioning Home After a Traumatic Brain Injury with End-Stage Renal Disease

Luis, a 50-year-old man, was admitted to the hospital three weeks ago following a severe car accident. His hospitalization has been complicated by a traumatic brain injury (TBI), a broken arm, and kidney damage, resulting in end-stage renal disease (ESRD) and the initiation of hemodialysis. Luis is a monolingual Spanish speaker from Honduras but has been in California over a decade. Prior to his accident, Luis was living with his wife, Maria, his adult son, and his son's family in a two-bedroom house in a rural area.

The inpatient planner at the hospital is working with Luis to develop a discharge plan and has identified these complex needs for him:

CATEGORY	CONDITION OR NEED
Physical health	The car accident left Luis with ESRD, and he now requires hemodialysis at least three times per week.
Behavioral health	Luis has no mental health or substance use disorder needs.
Cognitive impairment	Due to the TBI, Luis frequently gets confused and argumentative, often struggling during his thrice-weekly hemodialysis sessions. He does much better when his wife is with him, but she has been working part-time and can't accompany him three times per week to a lengthy dialysis session.
Functional impairment	Luis injured his right arm in the accident, with multiple fractures that required casting, and will need rehab once the cast is removed. Luis is right-handed and needs assistance with dressing and bathing without his dominant hand.

CATEGORY	CONDITION OR NEED
Social needs	Luis's wife, Maria, is concerned about her ability to support him as a caregiver and ensure everyone's safety at home, especially if she is working part-time. Luis lives in a rural area, where outpatient and In-Home Supportive Services are limited. Luis and Maria's two adult children help to support them financially by paying their rent and living expenses. Luis used to work on a local farm that paid him in cash until about two years ago, and Maria has been working part-time at a grocery store. Although both he and Maria have legal immigration status, they are not eligible for Social Security benefits.

What are Luis's goals?

Luis's primary goal is to be able to live at home with his family. He misses his family and friends, and getting together with them to watch soccer and play cards. Although he dislikes the difficulty of his physical therapy sessions, Luis is more engaged and responsive with reminders of his goal to be able to do things on his own. Luis is aware that the TBI has impacted his emotions and that this has been challenging for Maria and his family. He has started some counseling sessions to learn coping strategies and is open to continuing to learn more about how to manage his emotions more effectively.

Who is on Luis's care team at the time of discharge?

- Inpatient discharge planner
- Utilization management nurse lead at the managed care plan (MCP) until an Enhanced Care Management (ECM) Lead Care Manager is assigned
- Primary care team
- Specialists (nephrologist; neurologist; psychologist; physical therapist; occupational therapist)

What discharge options does the team come up with?

- Skilled nursing facility (SNF) with dialysis on-site
- SNF and a dialysis facility
- Home with supports and home dialysis
- Home with supports and a dialysis facility

What is the discharge plan?

STEP	SETTING AND SERVICES	CARE TEAM
Home with personal care services	The team was unable to find a SNF with on-site dialysis, but the MCP is contracted with a home hemodialysis provider that can come to his home three times per week. Luis is eligible for IHSS but is not able to hire a caregiver before he is discharged home. The MCP authorizes personal care and homemaker services as a Community Support through its contracted provider, while Luis and Maria determine if she could or would want to be his IHSS worker. The MCP does not identify a Spanish-speaking ECM Lead Care Manager before Luis's discharge, but does locate one within a few days of his returning home.	▸ MCP nurse lead handing off to ▸ ECM Lead Care Manager (quarterback) ▸ Primary care team ▸ Nephrologist with home hemodialysis provider ▸ Neurologist ▸ Psychologist ▸ Physical and occupational therapists ▸ Personal care services caregiver

STEP	SETTING AND SERVICES	CARE TEAM
Home with IHSS	Luis and his family, along with his care team, plan for him to continue his recovery and rehabilitation at home. As Luis continues to stabilize and improve, Maria gains more confidence that she could be Luis's IHSS caregiver. This allows her to quit her part-time job and accompany Luis to his appointments. Luis's Spanish-speaking ECM Lead Care Manager helps him schedule medical and therapy appointments. They also keep in frequent communication with Maria, coordinating with the MCP to authorize caregiver respite hours when Maria gets overwhelmed and needs a break.	▸ ECM Lead Care Manager (quarterback) ▸ IHSS provider ▸ Primary care team ▸ Nephrologist ▸ Neurologist ▸ Psychologist ▸ Physical and occupational therapy therapists ▸ Respite services caregiver

Note: *IHSS* is In-Home Supportive Services.

Who pays for what?

Luis's primary diagnoses are related to his physical health (with no co-occurring behavioral health diagnoses), so his MCP is responsible for paying for his postdischarge care once the funds from his motor vehicle insurance settlement are depleted.

What are alternatives?

If home hemodialysis is not available and transportation to a dialysis facility is not feasible, Luis may need to be admitted back to the hospital or a SNF. Depending on which county Luis resides in, there may also be other options, such as an adult residential facility (ARF) through the Assisted Living Waiver (with a higher reimbursement rate since Luis has a TBI) or a specialized TBI program that could help him with his recovery.

How did it all work in practice?

- ✔ Because the inpatient discharge planner connected with Luis's MCP as part of his discharge planning, he was able to get a Spanish-speaking ECM Lead Care Manager assigned within a few days of leaving the hospital. Ensuring Luis had an ECM Lead Care Manager as soon as possible helped support both Luis and his family, giving them the security of knowing he had a main point of contact for scheduling and coordinating the services he would be receiving at home as well as his medical appointments.
- ✔ Transitioning Luis back home not only aligns with his and his family's goals, but will be less costly for the MCP than admitting him to a SNF. Home hemodialysis will be difficult to arrange in a rural area, but the MCP locates a home hemodialysis provider that will send a nurse to his home three times per week. As Luis gains more mobility and continues to recover from the TBI, his care team will reevaluate if transportation with his caregiver to a dialysis facility is a better option.
- ✔ The inpatient discharge planner sent in the referral for IHSS during his hospitalization, and Luis was approved before his discharge. IHSS services were set up as part of his transition of care plan, and the MCP was able to provide, through Community Supports, personal care services as a bridge until he was able to hire his wife as his IHSS worker.

Jesse's Story: Skilled Nursing Facility to Residential Treatment Facility to Board and Care After a Spinal Cord Injury

Jesse, a 27-year-old man, was admitted two weeks ago for emergency stabilization with a gunshot wound to his abdomen after an altercation on the street. The bullet lodged in his spine, resulting in a spinal cord injury and paraplegia below the waist. Jesse is already known to the inpatient team as he has been

hospitalized several times for psychosis and methamphetamine use. He is enrolled in a Full Service Partnership (FSP) program with county behavioral health, although when the hospital connects with his FSP case manager and psychiatrist, they share that he was well linked for services up until six weeks ago, when he left the board-and-care facility where he was living and disconnected from care. Postoperatively, Jesse displays extreme anxiety and paranoia and confirms that he stopped taking his medications. With his consent, his doctors reintroduce antipsychotic medications for the management of his psychosis.

Over the last 10 days, Jesse has stabilized on psychiatric medications and has actively engaged with various therapy team members to learn how to adapt to his paraplegia. His health plan's utilization management (UM) nurse, his FSP case manager, and the hospital discharge planner work with Jesse to figure out the next best steps for his recovery. They have identified the following complex needs for Jesse:

CATEGORY	CONDITION OR NEED
Physical health	Jesse's surgical site wounds have healed, but he will need a broad range of rehabilitative services to retrain in his ADLs and prevent secondary complications of his spinal cord injury. Jesse will need to adjust to a new toileting process, including using a catheter for urination. He also needs durable medical equipment and other assistive devices to support his return to the community.
Behavioral health	Jesse displayed symptoms of schizophrenia, including paranoia and anxiety; he is currently well controlled on a medication regimen and expresses willingness to continue his medications after discharge. In the community, Jesse used methamphetamine multiple times a day "to keep me on alert" while sleeping outdoors.
Cognitive impairment	No cognitive impairment was identified at the time of Jesse's discharge.
Functional impairment	Jesse needs assistance with many ADLs as a result of his paraplegia, including transferring, dressing, showering, and toileting. He also needs assistance with some IADLs due to his schizophrenia, including navigating transportation and shopping.
Social needs	Jesse is currently unhoused and does not have family or friends he can live with during his rehabilitation and recovery. His mother is supportive and wants to be involved in his life, but she is not willing to have Jesse live with her if he is not medicated or is using methamphetamines. Jesse is afraid for his safety after the assault and is not open to living in a congregate setting.

Notes: *ADLs* are activities of daily living. *IADLs* are instrumental activities of daily living.

What are Jesse's goals?

Jesse knows he won't be able to live on his own without help learning how to use his wheelchair and other adaptive devices. He is considering whether he wants to start on a long-acting injectable antipsychotic for his schizophrenia and thinks that if he had a safe place to live, he'd be interested in not using methamphetamine. He may be interested in an addiction treatment program that can accommodate his new disability. Jesse likes playing music and writing songs. He used to have a guitar and would like to take guitar lessons to meet other people interested in songwriting.

Who is on Jesse's care team at the time of discharge?

- Inpatient discharge planner (quarterback)
- FSP case manager
- UM nurse at the managed care plan (MCP)
- Substance use navigator
- Psychiatrist/therapist
- Primary care team
- Physical and occupational therapy team

What discharge options does the team come up with?

- Acute rehabilitation facility
- Skilled nursing facility (SNF) or Special Treatment Program (STP)/psychiatric SNF
- Recuperative care or psych respite/recuperative care
- Residential treatment facility and outpatient spinal cord injury rehab

What is the discharge plan?

STEP	SETTING AND SERVICES	CARE TEAM
SNF	The team is unable to find an acute rehabilitation program for Jesse based on his psychiatric history, but given that he is stable on medications and not actively using methamphetamine, he is accepted by a SNF for short-term rehabilitation. While he is there, he is enrolled in ECM with a provider that focuses on integrated care for people with SMI and SUD. The county disenrolls him from FSP as they reserve limited spots in that program for people who are not eligible for ECM. He is also connected to a Community Supports provider that has experience with housing navigation for people living with disabilities and coordinates his application for SSI. While at the SNF and abstaining from substance use, Jesse reconnects with his mother. Jesse is grateful for her support and presence in his life, and is motivated to do what it takes to stay in recovery and on his medication.	▸ ECM Lead Care Manager ▸ SNF case manager (quarterback) ▸ SNF medical director ▸ SNF occupational and physical therapy team ▸ Psychiatrist/therapist ▸ Primary care team ▸ SUD navigator ▸ Housing navigation team member
Residential treatment facility (RTF)	At the SNF, Jesse expresses concerns to the team about relapsing and having meth cravings, similar to what he has experienced in past periods of sobriety after his other hospitalizations. Jesse and his team agree that he needs more recovery support than he can get in an outpatient setting, so he enrolls in an RTF for a 90-day dual diagnosis program. There isn't a program in his county that can accommodate a wheelchair user, so his ECM Lead Care Manager works with the MHP to find him a place out of county. Jesse still needs assistance with ADLs, so the MCP helps secure personal care services while he is in the program. Jesse does well in the program, and the housing navigation provider takes him on several tours of adult residential facilities as well as a permanent supportive housing option.	▸ ECM Lead Care Manager (quarter-back) ▸ RTF medical director ▸ RTF social worker ▸ UM nurse at the MCP ▸ Primary care team ▸ Psychiatrist/therapist ▸ Personal care services provider ▸ SUD navigator

STEP	SETTING AND SERVICES	CARE TEAM
Adult residential facility (ARF)	Jesse decides on an ARF, or board and care, as it feels safer than the permanent supportive housing and provides more support with ADLs. His SSI has been approved, and that pays for his room and board in the ARF, with the MCP paying the ARF through the nursing facility transition/diversion to assisted living facility as a Community Support for additional wraparound services (e.g., help with ADLs and IADLs). The ECM Lead Care Manager supports Jesse in his transition to the ARF, and also refers him for day habilitation services as a Community Support through the MCP, which can support Jesse with a long-term plan to find work opportunities that enable him to play music.	➤ ECM Lead Care Manager (quarterback) ➤ Psychiatrist ➤ SUD navigator ➤ Primary care team ➤ Nursing facility transition/diversion to assisted living facility Community Supports provider ➤ Day habilitation Community Supports provider (if different from the ARF)

Notes: *ECM* is Enhanced Care Management. *MHP* is mental health plan. *SMI* is serious mental illness. *SSI* is Social Security Income. *SUD* is substance use disorder.

Who pays for what?

Jesse's complex needs span mental health, SUD, and physical health, and though his coverage is all through Medi-Cal, there are multiple payers that are responsible for coordinating and funding Jesse's care. The MCP is responsible for coordinating and paying for his physical health care needs and needs related to his spinal cord injury. The MHP is the payer for Jesse's care related to his specialty mental health needs — this includes the psychiatric treatment and care coordination. And the county's Drug Medi-Cal Organized Delivery System (DMC-ODS) plan is responsible for Jesse's substance use treatment. While Jesse was not Medicare-eligible at the time of discharge planning, he will likely become eligible in the future as a result of his physical and mental health disabilities.

What are alternatives?

An acute rehabilitation facility would be a good option for Jesse after he is discharged from the hospital but may not be able to support his psychiatric needs. A Special Treatment Program, or psychiatric SNF, may also be an option if it is able to accommodate Jesse's physical rehabilitation needs. If there are challenges finding a SNF placement, Jesse could also continue to receive rehabilitative support at a recuperative care facility or psychiatric respite.

Although Jesse and his team agree that an ARF is the best place for him after his 90-day residential treatment program, the care team continues to leave open the possibility that Jesse may be interested in independent living at some point, and that sober living could also be a good option if he is ready and open to it.

If Jesse experiences any setbacks (e.g., he discharges himself from drug rehab or relapses with stimulant use), the care team can take additional steps to ensure continuity with his psychiatrist and ECM Lead Care Manager between levels of care to help get him back on track with his recovery.

How did it all work in practice?

✔ Flexibility, relationships, and alignment on Jesse's goals were key in helping him transition to lower levels of care that could meet his needs and support his rehabilitation and recovery. The SNF was willing to accept a patient with schizophrenia because of their rapport and relationship with the MCP, as well as the engagement and commitment from the MHP and FSP provider on a care plan with next steps. The RTF was willing to accept Jesse for treatment due to the MCP's commitment to coordinate and pay for personal care services to assist with ADLs while Jesse completed the program.

- ✔ Coordination and clarity on payer responsibility between the county MHP, DMC-ODS, and the MCP allowed the care team to focus on a holistic approach, driven by Jesse's goals and wishes to be independent. All three payer partners had a long history of working together through challenging cases, so they were more willing to "do whatever it takes" to help facilitate the best options for Jesse.

- ✔ Transitioning Jesse from FSP to ECM allowed the MHP to optimize limited resources and open a slot for a new FSP client, while still ensuring that Jesse received critical care management support through ECM.

- ✔ Having a long-term and multistep plan that reflected Jesse's goals helped keep him motivated and committed to his recovery.

- ✔ For Jesse's transition to the adult residential facility, the MHP and MCP coordinated to ensure the ARF was equipped to support him:

  - ➤ **Enhanced Care Management** continued to provide important care coordination between Jesse's behavioral health treatment providers (psychiatrist, SUD navigator) and physical health providers (physical and occupational therapists). With Jesse's permission, the ECM Lead Care Manager helped ensure that Jesse's mother could stay connected and be involved in his care planning. They also helped refer Jesse for additional day habilitation services through the MCP to help him with IADLs once he transitioned to the ARF.

  - ➤ **Nursing facility transition/diversion to assisted living facility** services allowed the MCP to provide additional reimbursement to the ARF for enhanced services to support Jesse's ongoing needs.

  - ➤ **Day habilitation** services helped Jesse find employment, learn how to use public transportation in a wheelchair, and continue developing skills for daily living like shopping and managing his finances.

About the Authors

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About the Foundation

The **California Health Care Foundation** (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.