



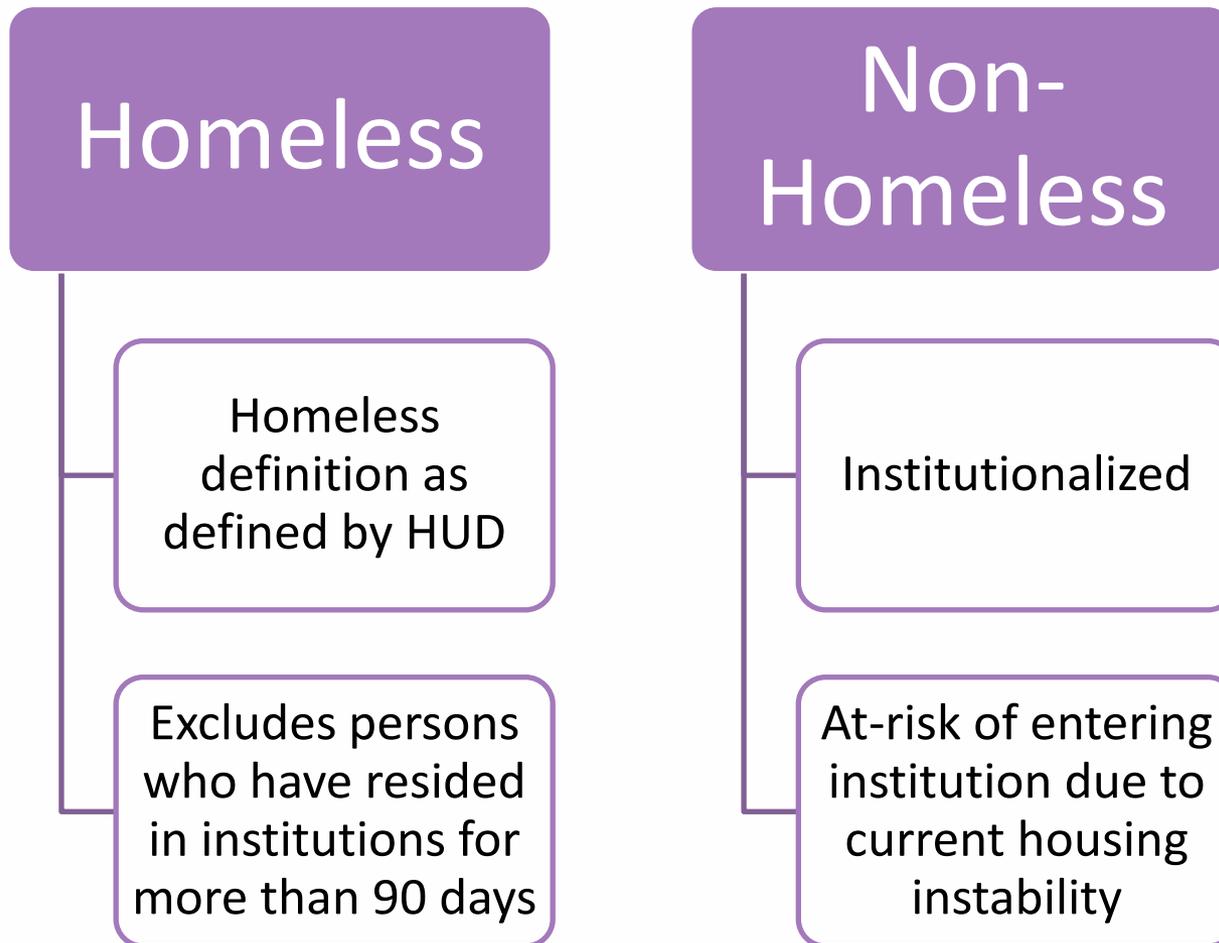
STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

SECTION 811 PRA PROGRAM ROUND II SERVICES and REFERRAL DESIGN



Section 811 PRA

Population Grouping





Non-Homeless Sub-Populations

Institutional

- Residing in an institutional setting for 90 consecutive days: SNFs, Hospitals

Developmentally Disabled

- Non-Homeless at risk of institutionalization
- Institutionalized: ICF/DDs, Developmental Centers

Mental Health

- Non-Homeless at risk of institutionalization with primary diagnosis of Mental Illness
- Institutionalized: IMDs, SNFs, Hospitals

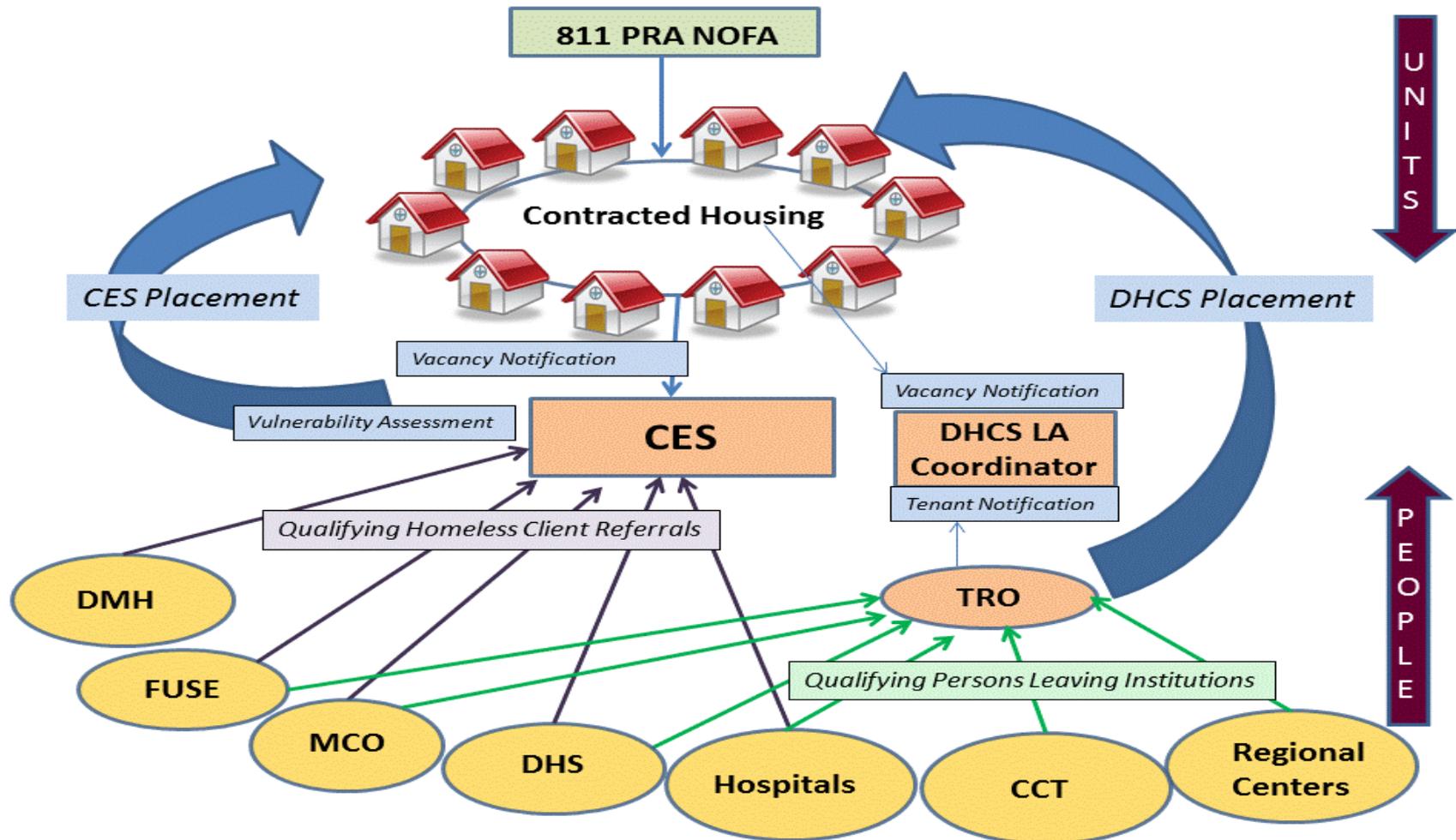


SHAPING THE MODEL:

REFERRAL PROCESS / DESIGN



Referral / Intake Process





Referral / Intake Process

- TROs will submit tenant referral packet to DHCS Housing Coordinator which must include all documentation required to meet criteria for placement in coordinated housing entry system.
- If Medi-Cal member packet is complete and all criteria is met they are eligible for coordinated housing entry.
- When an 811 unit referral is submitted to DHCS Housing Coordinator from Developer/Management company, the TRO(s) for the top 3 eligible tenants in the coordinated housing entry system will be contacted and instructed to submit rental application and schedule site visit for potential tenants.
- Units will be allocated on a, “first come, first served basis.”
- Priority in the coordinated housing entry system is given to persons currently residing in an institution over persons who are, “At Risk of losing housing.”



Role of DHCS

DHCS LA Housing Coordinator

- Develop / maintain coordinated housing entry system (Global and project-specific as necessary)
- Ensures tenant selection in required timeframe
- Single point contact for Developers and TROs
- Ongoing TA and Case Management meetings with TRO and Waiver Service Provider

Coordinated Housing Entry Criteria

- Verification of Medi-Cal eligibility
- Verification of age (18 – 61 at time of lease-up)
- Valid Identification
- Documentation of SSN and SSI/SSDI income
- Other (???)



Compare/Contrast

Non - Homeless

- Tenant/Unit referrals routed through DHCS 811 Coordinator
- Units split across eligible non-homeless populations
- Only prioritization is institutional transitions over at-risk
- Developers have flexibility to work with certain subpopulations and/or service delivery systems

Homeless

- CES is facilitator between 811 unit referrals and tenant referrals
- Eligible units and tenants are pooled and filled based upon prioritization
- Prioritization based upon VI-SPDAT score



SHAPING THE MODEL:

WHO/WHAT ARE THE TENANT REFERRAL ORGANIZATIONS (TRO)?



3 Types

DD

- Regional Centers

MI

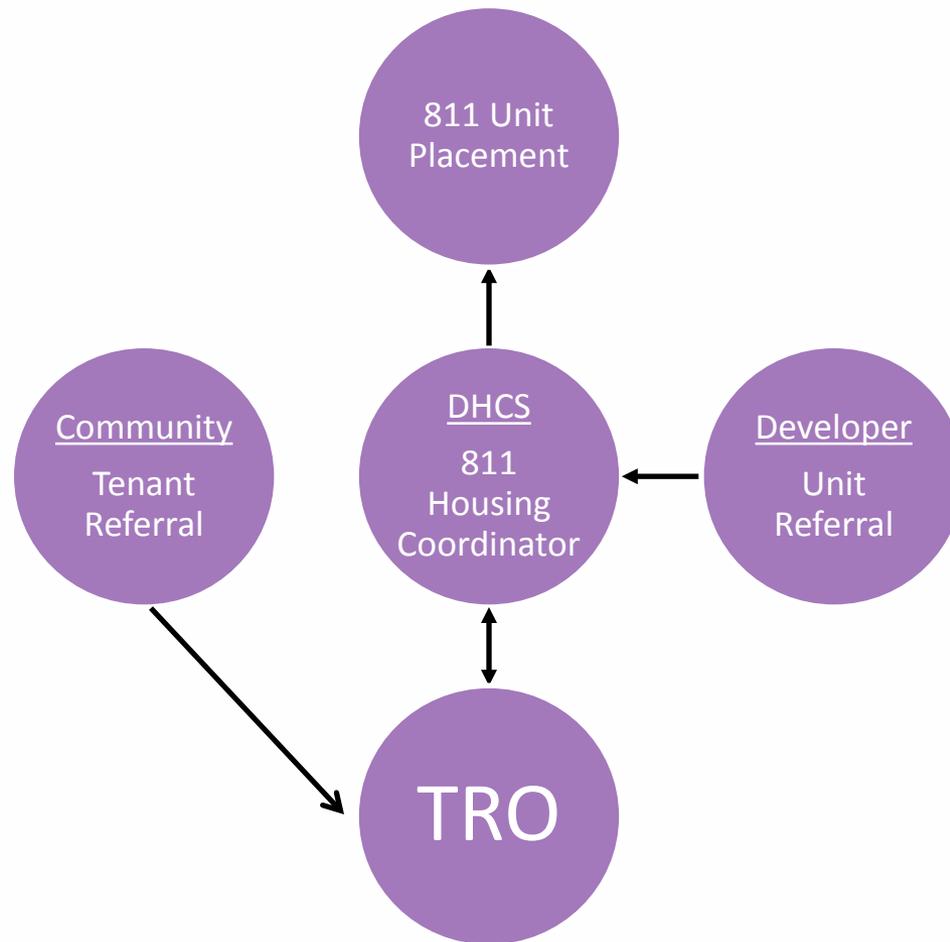
- Los Angeles Dept Mental Health

Institutionalized

- California Community Transitions (CCT) Lead Organizations (LOs)



Direct Relationship

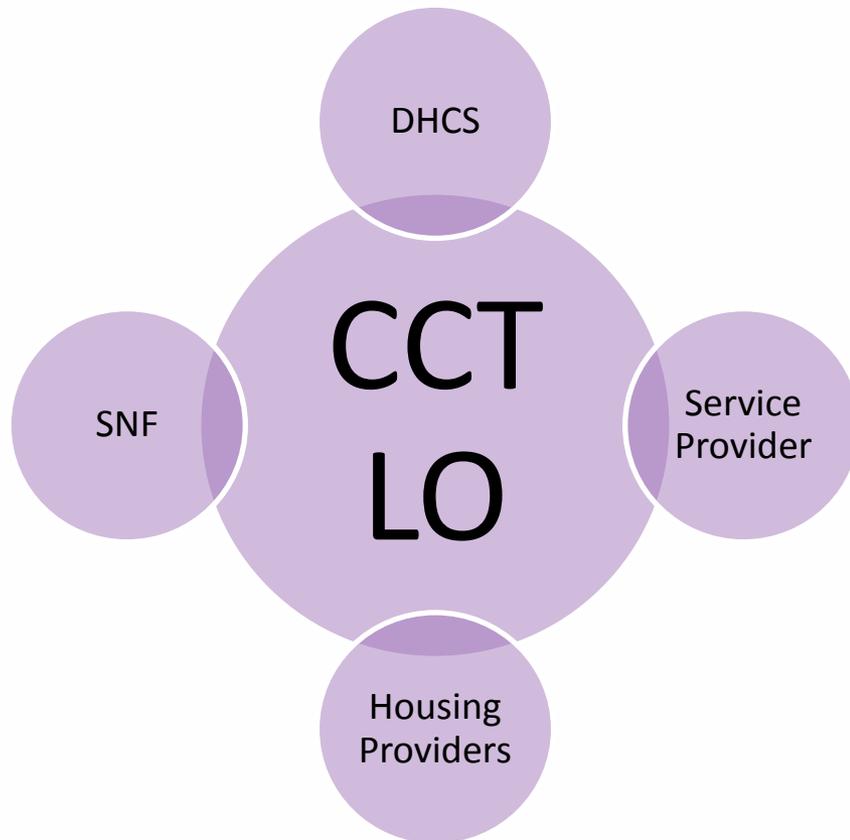




Why CCT?



Who is the CCT-LO?



- **DHCS** – Contractual oversight and administration of CCT in partnership with CCT LOs to perform institutional transitions
- **SNF** – CCT LOs are responsible for maintaining direct relationships with various facility types
- **Housing Providers** – CCT LOs partner with housing providers to locate affordable and accessible housing
- **Service Providers** – CCT LOs identify need for and facilitate delivery of IHSS, waiver services, and enrollment into managed care plans



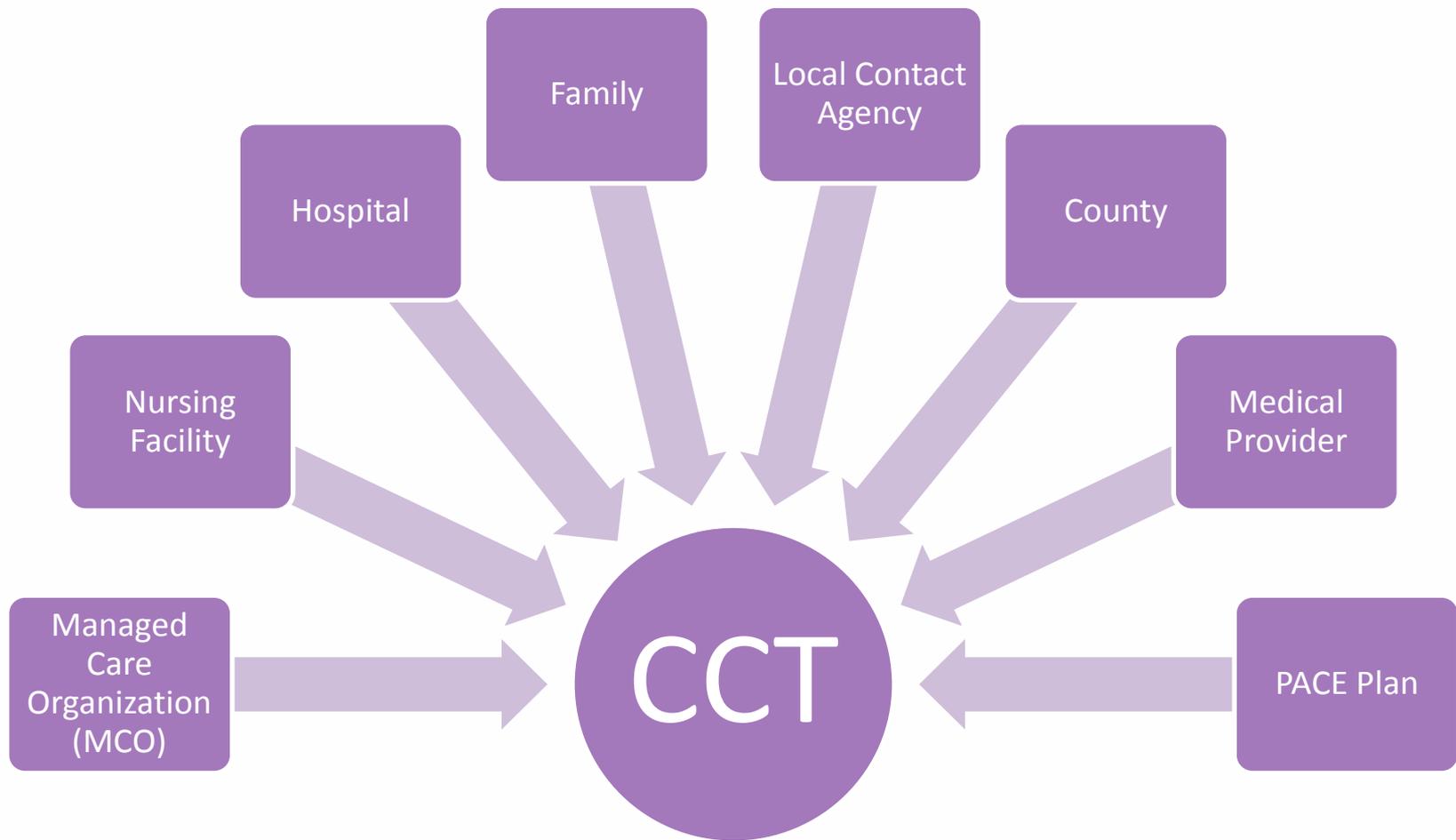
CCT Eligibility Criteria

- Persons of all ages.
- Continuous residence in an inpatient nursing facility for at least 90 days-- Medicare or short-term rehab days not included.
- Medi-Cal Eligibility for at least one day.
- Continue to require the same “level of care” provided in a health care facility.



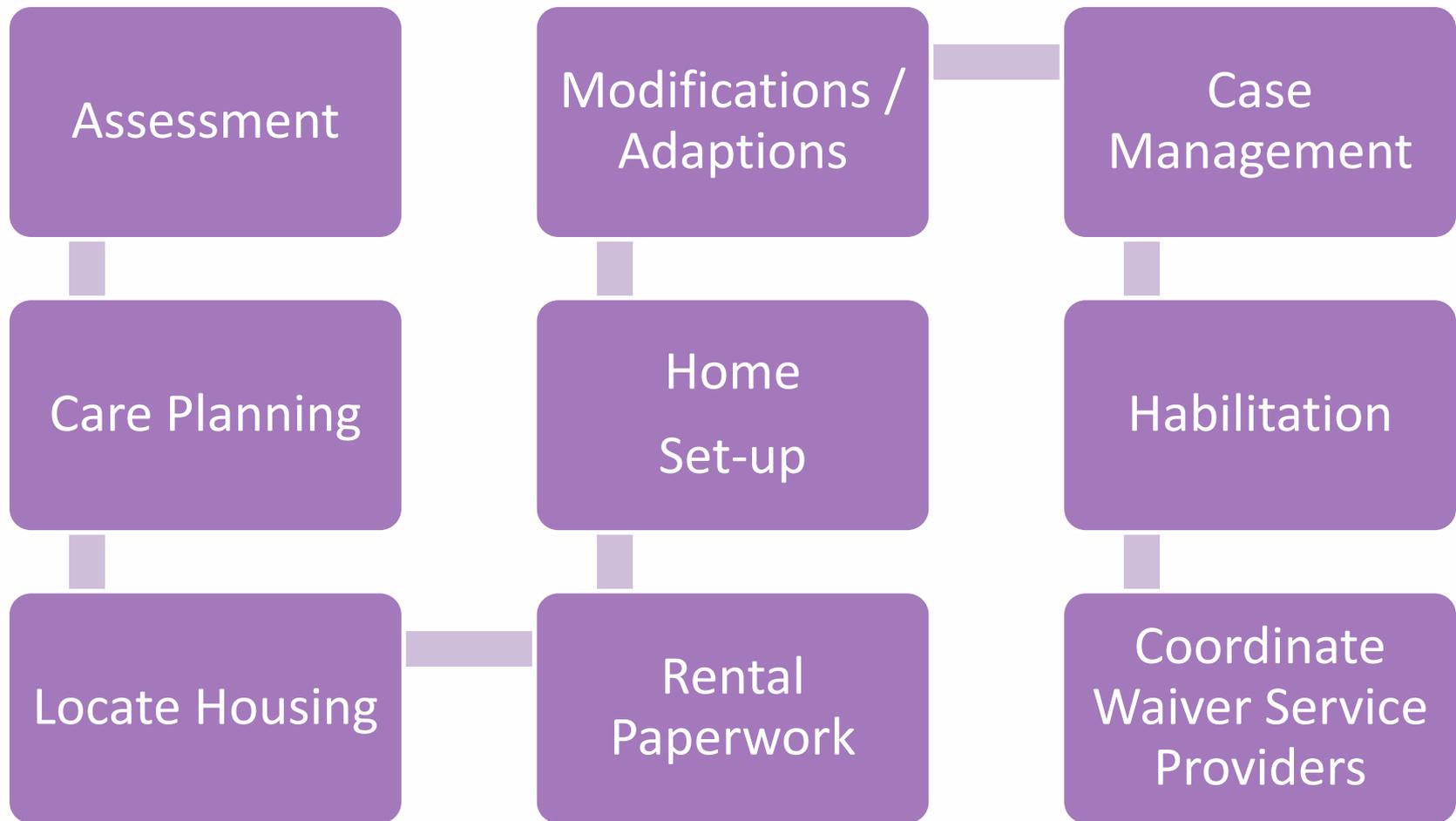


CCT Referral Sources



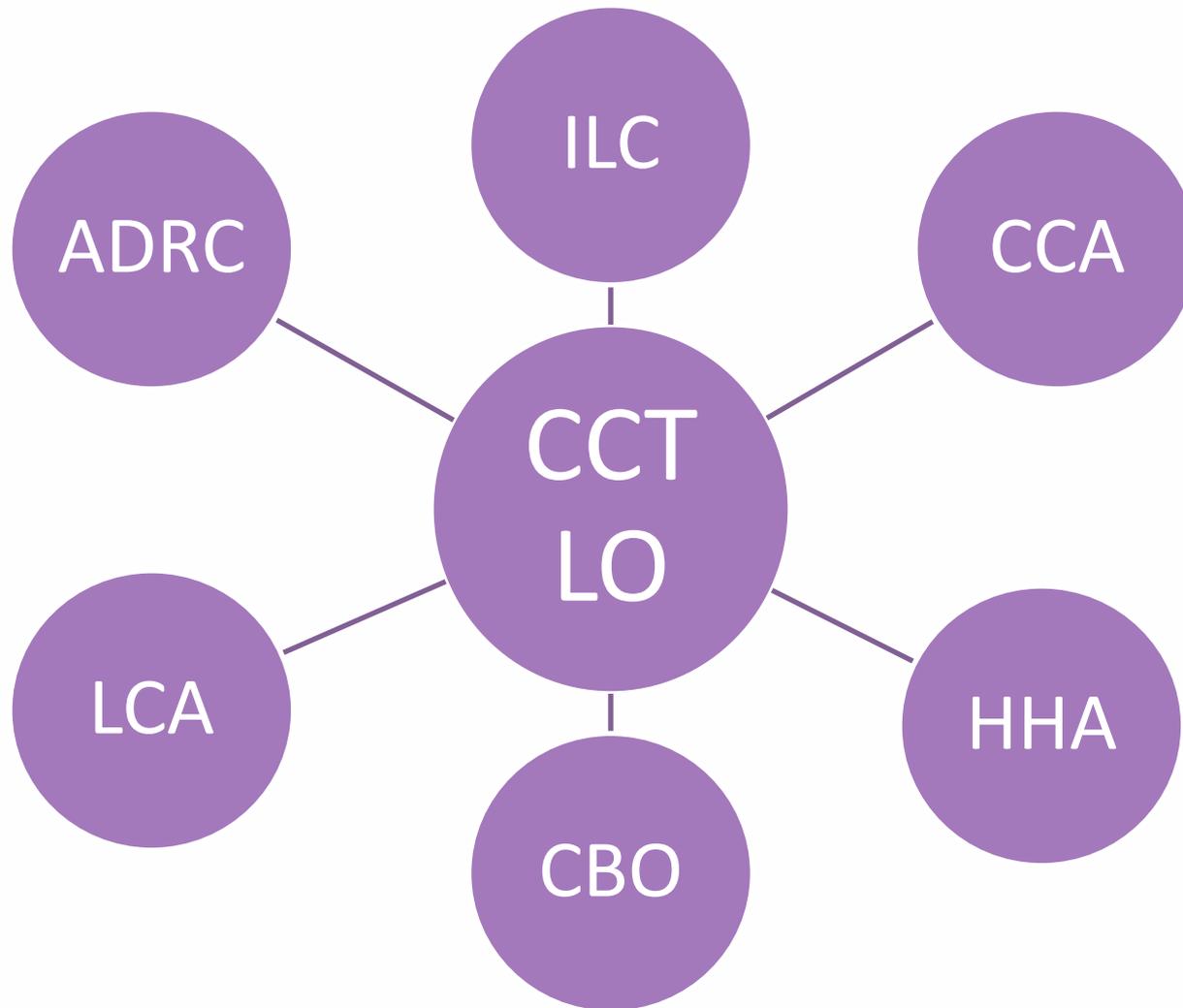


CCT Process and Services





Who can be a CCT LO?



Los Angeles County CCT LOs



- Alzheimer's Family Services Center (AFSC)
- Communities Actively Living Independent and Free (CALIF)
- Independent Living Center of Southern California (ILC-SC)
- InnerJoy Home Health Service
- Libertana
- SCAN / Independence at Home
- Services Center for Independent Life (SCIL)
- The Caring Connection (TCC)



SHAPING THE MODEL:

SERVICE DELIVERY

Service Options – High Level



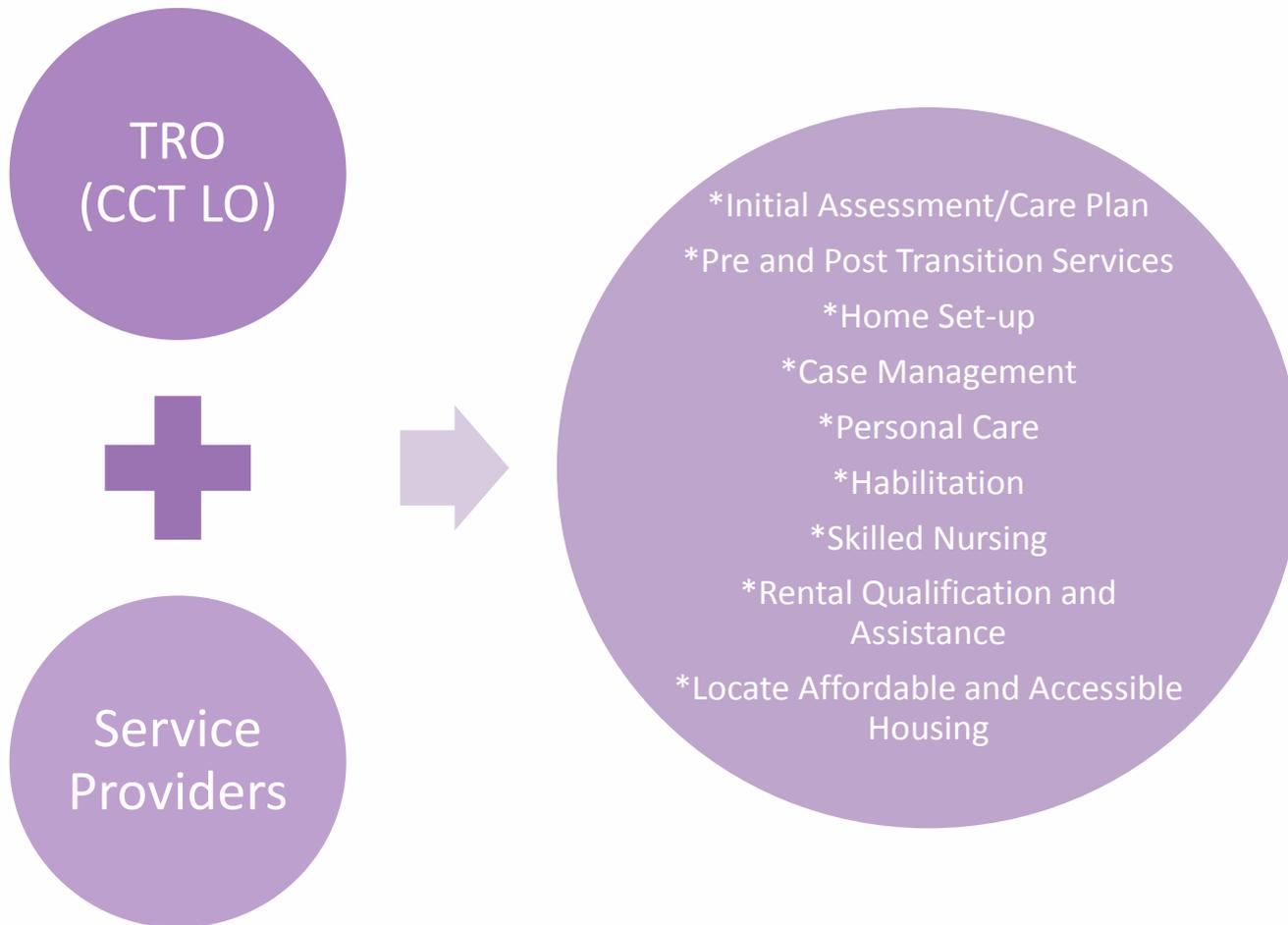
Populations

- Institutionalized
- Developmentally Disabled
- Mental Illness

Services

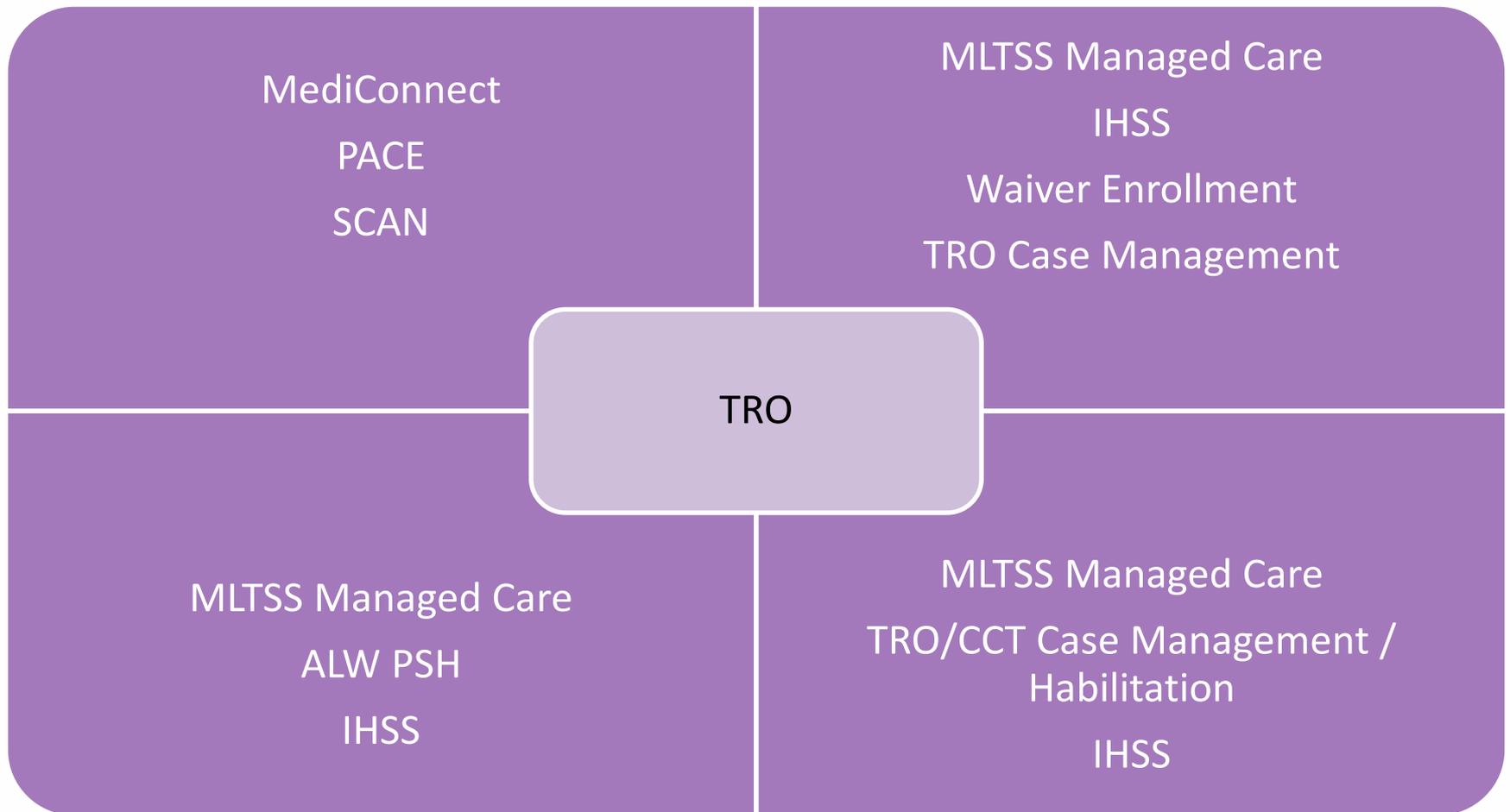
- Case Management
- Managed Care Enrollment
 - MediConnect/MLTSS/PACE/SCAN
- Medi-Cal HCBS Waivers
 - 1915(i) or 1915(c)
- Regional Center Services
- Specialty Mental Health Services
 - Rehab Option
- Other State Plan Services
 - i.e. IHSS
- Tenancy Support Services

KEY ACTIVITIES





Delivery Options



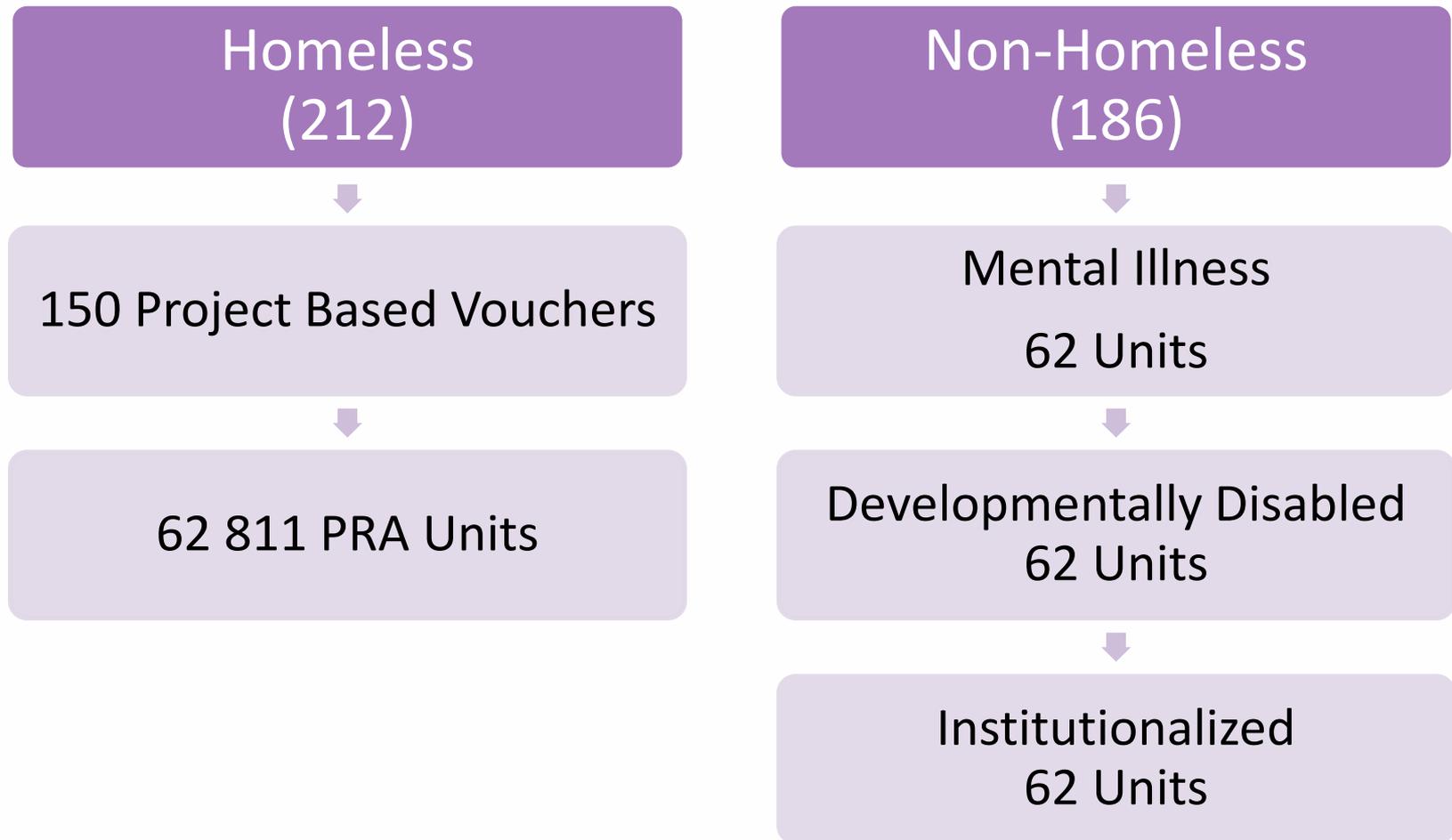


DISCUSSION POINT:

811 PRA RESOURCE ALLOCATION



Unit Allocations





Stakeholder Input

- Using PBV resource for Homeless population to incentivize Developer commitment of units for Non-Homeless population in same or separate project/award.
- Innovative ideas for service delivery partnerships?
- Best options for engaging tenancy based support services?



Questions / Contacts

- Long-Term Services and Supports Operation Branch,
Acting Chief:

Joseph.Billingsley@dhcs.ca.gov

(916) 322-4766

- Tenant Referral or MediCal Supportive Services:

Urshella.Starr@dhcs.ca.gov

(916) 445-0381

<http://www.calhfa.ca.gov/multifamily/section811/index.htm>