



East Bay Innovations - TCCM Department

Strengthening Prevention, Care, and Long-Term Stability

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eastbayinnovations.org

Overview of EBI Services



East Bay Innovations

All departments at EBI serve clients with ID/DD dx who are connected to the Regional Center of the East Bay (Except the TCCM department!)



TCCM - Transitional Care Case Management

- Case management for MediCal and AAH enrolled adults
- Searching for affordable housing
- Coordinating transitions from SNFs to proper placements
- Helping individuals to access IHSS and other community supports
- Ensure access to all resources needed (food, social supports, income, DME, etc).
- Identifying needed healthcare professionals in the community

Target population groups for the TCCM:

- Elderly persons with one or more medical, functional, or cognitive disability.
- Persons with one or more physical and/or mental health disabilities/dx.
- Unhoused persons
- Residing in SNF
- High utilizer of ER/Hospitals



Effective Strategies for Prevention and Supportive Services



Person Centered Care Planning

Meeting with the client and understanding their preferences for support and what goals they have for themselves. Review risks and interventions with client and determine what is important to them.



LTSS

Connecting with long term services and supports in the community as an alternative to living in a nursing home. Connecting clients to IHSS and finding providers, MOW/CalFresh, low-income utility programs, affordable and accessible housing, etc.



Addressing Health Related Social Needs

Addressing clients immediate needs such as food insecurity, transportation, income or other factors that are impacting overall health. TCCM has RNs that conduct assessments to understand client's health hx and create a plan of care for medical/health needs.



Case Studies

Sharing case studies to provide an overview of how transition services and case management strengthens client's health, housing, and long term stability. Collaboration on successes and troubleshooting barriers as a team.



Person Centered Care Planning

Evaluating the clients needs and helping them develop a plan that is meaningful to them.



01

Integrated Medical & Clinical Support

Engaging the client with appropriate healthcare linkages to promote health and wellness.

02

Functional & In-Home Assistance

Bringing supports to the home to enable them to live as independently as possible for as long as possible.

Case management strengthened through ongoing training:

Harm Reduction, Cultural Humility, Motivational Interviewing, Suicide Risk Assessment, Social Determinants of Health, De-Escalation & Conflict Management, Promoting Autonomy.

03

Housing Retention

Addressing housing needs to prevent eviction or re-institutionalization.

04

Psychosocial & Mental Health Support

Developing short term and long term goals to promote overall wellness and stability.



Transition from Skilled Nursing Facility

Key phases throughout the transition process



Long Term Services & Supports



Health Care Services

- Plan of Treatment
- Nursing Care Services
- Nutrition Services
- PT/OT, Other therapies
- Durable Medical Equipment & Supplies



Financial services

- Medi-Cal coverage
- Financial Education
- SSI/SSP payments



Environmental Services

- Home Modifications
- Assistive Technology
- Household set-up
- Safe Housing



Social Services

- Peer Support
- Recreation, Cultural, & Spiritual Connections



Supporting Services

- Family & Friends
- Caregivers/Personal Attendants
- Emergency Backup
- Transportation



Education/training Services

- Independent living skills & life skills development
- Caregiver coordination & management
- Emergency planning



Other Services

- Waivers
- Employment Services
- Supplemental services



CalAIM & Waivers

Programs and services offered as an alternative to nursing homes and are primarily Medi-Cal funded.



Home and Community Based Alternatives Waiver (HCBA)

Comprehensive menu of services provided in the home like nursing, personal care, case management, and emergency response systems. No age requirement.



Medi-Cal Waiver Program (MCWP)

Direct care services to persons living with HIV as an alternative to nursing home. Comprehensive services include, case management, long term home health, meals, personal care.



CalAIM

Enhanced Care Management & Community Supports provided to most vulnerable populations experiencing homelessness, chronic illness and disabilities.



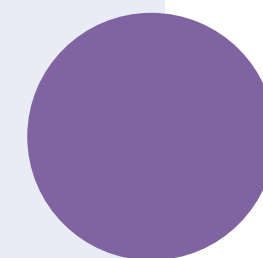
PACE

Comprehensive menu of services for adults 55+ where participants can receive medical care, personal care, meals, rehab therapies, and social services.



Other Waivers

MSSP, CBAS, ALW, CCT



We serve clients under different programs that best suit their needs/eligibility: ECM, HCS, HCBA Waiver, CCT, etc.



Case Study: EBI support to long term HOPWA client

The Journey of a 78 year old client living with HIV



2017

- Signs lease for HOPWA unit in senior building
- Client living with HIV; History of CVA; uses a cane; early signs of dementia
- Connected to primary care, CalFresh, East Bay Paratransit
- Weekly EBI check ins and tenancy support



2021

- Report of bed bugs and hoarding behavior
- IHSS caregiving put in place
- Support to treat bed bugs and condition of unit to improve quality of life and preserve tenancy
- Referral to behavioral health and alzheimer's services



2022

- Client hit by a car; 2 month hospital and rehab stay
- Increased mobility issues and lowered activity tolerance
- More support needed to manage diabetes and hypertension
- Enrollment in HCBA waiver to access more support



2026

- The client continues to live in same unit independently
- Receives required amount of personal care support
- EBI case management work closely with client, caregiver and property manager



EBI Services: Case Study

Supporting a client exiting from homelessness to HOPWA



Situation

- Client referred by street health team.
- Currently unhoused and living on the street.
- Deterioration in health.
- Admitted to a Skilled Nursing Facility.



Background

- 82 year old gentleman living with HIV and COPD.
- Housing lost after death of wife; struggled to manage.
- Long history of housing instability throughout life.



Assessment

- EBI collaborates with street team to locate client.
- Comprehensive assessment completed.
- Enrollment in transition program.
- Active search for suitable housing.



Outcome

- Successfully housed in HOPWA unit.
- Connected to primary care services.
- Has caregiver through IHSS.
- Collaborative support from EBI, caregiver, and property manager.



HOPWA Units

- Friendship Senior (3 vacancies left, 1 bedroom)
- 808A Street (EBI Partnership, no current vacancies)
- Any others?

Thank You!

Any Questions?

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