2024 Mandatory Care Coordination Annual Training

Acronyms

ADL	Activities of Daily Living
APS	Adult Protective Services
CBAS	Community-Based Adult Services
CCS	California Children's Services
CIR	Critical Incident Reporting
CS	Community Supports
ECM	Enhanced Care Management
IHSS	In-Home Supportive Services
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MSSP	Multipurpose Senior Services Program
NF	Nursing Facility
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
SSP	State Supplemental Payment

Overview

- [ ] Introduction
- [ ] Eligibility
- [ ] Referral reasons
- [ ] Social Services
- [ ] Referral process
- [ ] Programs

Introduction	• Long-term services and support help seniors and adults with disabilities live independently in the community setting of their choice. • Program goals are to avoid or delay premature placement in nursing facilities and decrease the cost of health care by providing home and community-based services. • Medi-Cal traditionally funds these services, plus there are other non-Medi-Cal health plan benefits to support community living.
Eligibility	Referrals include members who: • Need social support • Need assistance with activities of daily living (personal care or household chores) • Indicate they need additional assistance/support in the home • Have a history of repeated emergency room visits or hospitalizations • Qualify for nursing home placement, but want to stay at home
Referral reasons	• Home safety concerns • Barriers to receiving treatment • Catastrophic conditions • Recurrent emergency room visits or hospital admissions • Acute or terminal phases of chronic illness • Transitioning from LTC into the community • Homelessness or at risk of homelessness
Social Services	Individualized psychosocial assessments are conducted on referrals, and members are connected to the appropriate option and/or community resources based on the care plan. Blue Shield Promise Social Services also provides: • Care coordination • Crisis intervention • Discharge planning and transition of care • Collaboration with internal and external teams • Member and family education and advocacy
Referral process	• Community-Based Adult Services **(CBAS),** In-Home Supportive Services **(IHSS),** Multipurpose Senior Service Program **(MSSP), and Promise Health Plan Social Services referrals** complete the ***Medi-Cal Social Services and Mental Health Referral form*** on the **Behavioral Health Services Program page** and fax it to **(323) 889-2109** for Los Angeles referrals or **(619) 219-3320** for San Diego referrals. • Long-Term Care referrals are made through a physician or licensed healthcare provider by contacting the Long-Term Care (**LTC**) phone referral number at **(855) 622-2755**. • Enhanced Care Management (**ECM**) referrals can be made by completing the online **ECM Member Referral** form or by emailing **ECM@blueshieldca.com**. • Community Supports (**CS**) referrals can be made by completing the online **Community Supports Request Form** or by emailing Blue Shield Promise at: **LACommunitySupports@blueshieldca.com** (for LA County) or **SDCommunitySupports@blueshieldca.com** (for San Diego County).

Programs

- CBAS
- IHSS
- MSSP
- LTC
- ECM
- CS

CBAS	**Community-Based Adult Services** is designed to help people stay mentally and physically active, reduce isolation, improve their health, and prevent decline of their abilities. People typically attend a center in their community two to five times a week, based on their individual need. CBAS programs either provide, or can assist with, transportation arrangements. **Services** Services vary from center to center but may include meals, dietary counseling, health monitoring, physical therapy, occupational therapy, speech therapy, art activities, singing, age-appropriate games, and social work. **Eligibility** CBAS may be provided to Medi-Cal dual-eligible beneficiaries over 18 years of age who: • Meet nursing facility level of care • Have organic or acquired traumatic brain injury and/or chronic mental health conditions • Have Alzheimer's disease or another dementia • Have moderate to severe cognitive impairment • Have a developmental disability **Referral process** 1. Complete the *Medi-Cal Social Services and Mental Health Referral* form located on the **Behavioral Health Services Program page**, and fax it to (323) 889-2109 for Los Angeles referrals or (619) 219-3320 for San Diego referrals to obtain pre-authorization. 2. A contracted nurse will conduct an in-person assessment to determine eligibility. 3. The CBAS center will conduct a detailed assessment and develop a care plan. Reassessments are conducted every six months.

IHSS	**In-Home Supportive Services** is a California state program that provides home care services to low-income seniors and persons with disabilities, allowing them to remain safely in their home. **Services** Services may include domestic chores (grocery shopping, house cleaning, laundry, meal preparation), personal care (bathing, dressing, feeding, grooming), paramedical assistance (administering medications, giving injections, tube feeding, wound care), and other services (accompanying to medical appointments, protective supervision). **Eligibility** IHSS may be provided to Medi-Cal dual-eligible beneficiaries who: • Are disabled or 65 years of age or older • Are California residents and U.S. citizens or legal residents • Receive, or are eligible to receive, Supplemental Security Income/State Supplemental Payments (SSI/SSP) or Medi-Cal benefits • Live in a home, apartment, or abode of their choosing not including a hospital, nursing home, assisted living, or licensed care facility • Are unable to live safely at home without care **Referral process** 1. Complete the *Medi-Cal Social Services and Mental Health Referral* form located on the **Behavioral Health Services Program page**, and fax it to (323) 889-2109 for Los Angeles referrals or (619) 219-3320 for San Diego referrals to obtain pre-authorization. 2. A *Medical Certification Form (SOC 873)* must also be submitted by a healthcare provider certifying that the member is unable to perform their activities of daily living on their own and that without IHSS, the member would be at risk for out-of-home placement. 3. An in-home needs assessment will be conducted by a county social worker noting living situation and physical and mental capacity. 4. An approval or denial notification will be submitted by the county social worker specifying the monthly hours to be provided. IHSS reassessments will be conducted annually by the county. **Who provides IHSS services?** The member may hire anyone they choose to be their home care provider, including a family member, friend, or neighbor. IHSS providers are paid by the county and must: • Complete and clear a criminal background investigation • Attend an orientation about IHSS rules and requirements

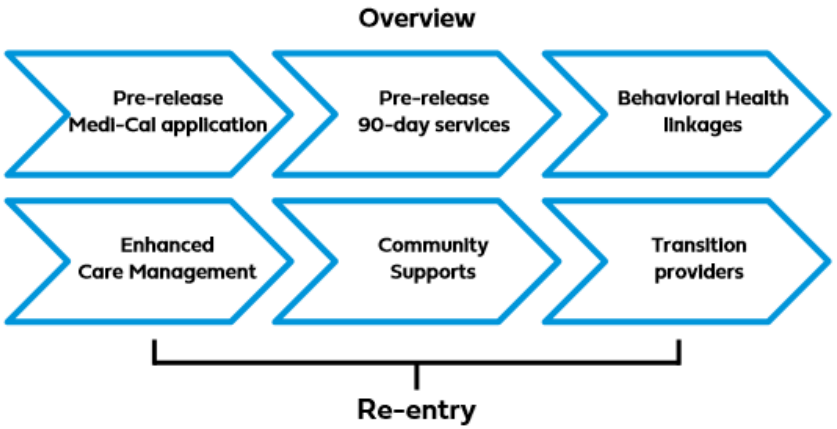
MSSP	**Multipurpose Senior Services Programs** provide social and healthcare management for frail, older adults who are certified for placement in a nursing facility, but who wish to remain living in the community. **Services** Services may include needs assessment, care plan development, monitoring of care, help accessing services, meal services, personal advocacy, supplemental personal care, respite care, personal emergency system, transportation, appliance assistance, and minor home repairs. **Eligibility** MSSP may be provided to Medi-Cal dual-eligible beneficiaries who: • Are 65 years old or older • Have an address and reside within an MSSP service area • Require nursing facility level of care **Referral process** 1. A referral is made directly to an MSSP serving the member's area (referrals may be subject to a wait list of three to six months). 2. Complete the *Medi-Cal Social Services and Mental Health Referral* form located on the **Behavioral Health Services Program page**, and fax it to (323) 889-2109 for Los Angeles referrals or (619) 219-3320 for San Diego referrals to obtain pre-authorization. 3. An MSSP nurse and social worker will conduct an in-person home assessment. 4. A care plan will be developed if all eligibility criteria are met. 5. An MSSP nurse will provide the Nursing Level of Care Certification. Reassessments and care plans are done annually. **Who provides MSSP?** Los Angeles County: Huntington Hospital • Human Services Association • Jewish Family Services • Partners in Care • Independence at Home (SCAN) San Diego County: Aging & Independence Services (AIS)

LTC	**Long-Term Care (LTC)** is the provision of medical, social, and personal care services provided in a skilled nursing facility (SNF) or subacute facility for people who cannot live safely at home but do not need to be in a hospital. **Services** Services may include mobility assistance, bathing, feeding, dressing, help using the restroom, and giving medication. **Eligibility** LTC/Custodial Care may be provided to Medi-Cal dual-eligible beneficiaries who: • Require skilled nursing level of care for more than 90 days • Are unable to complete activities of daily living (ADL) without help **Referral process** Referrals are made through a physician or licensed healthcare provider by calling the LTC referral number at **(855) 622-2755**.

ECM	**Enhanced Care Management (ECM)** provides enhanced care coordination of individualized clinical and non-clinical services based on a comprehensive needs assessment and care management plan. All services are provided at no cost to members. **Services** An ECM case manager: • Meets member wherever they are - on the street, in a shelter, in their doctor's office, or at home • Assesses individualized needs • Helps develop a care management plan • Engages several care delivery systems including primary and specialty care, dental, mental health, substance use disorder, and long-term services and support • Links member to community-based and social support services • Coordinates health promotion and transitional care services **Eligibility** ECM serves eligible Medi-Cal beneficiaries with complex medical, behavioral, and social needs. To be eligible for ECM, member must qualify for at least one of the below "Populations of Focus": • Individuals experiencing homelessness • Individuals at risk for avoidable hospital or emergency department care • Individuals with serious mental health or substance use disorder (SUD) needs • Individuals transitioning from incarceration (see below for more information) • Children and youth involved in child welfare (foster care) • Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model with additional needs beyond their CCS condition(s) • Adults living in the community and at risk for long-term care institutionalization • Nursing facility residents transitioning to the community • Black, American Indian, Alaska Native, or Pacific Islander pregnant or postpartum individuals birth equity populations of focus (racial & ethnic groups with high maternal & birth morbidity & mortality rates) Medi-Cal members may qualify for both Enhanced Care Management and Community Supports or only one of the programs. **Referrals** ECM must be pre-authorized by Blue Shield Promise prior to service and services must be provided through contracted providers. Both clinical and non-clinical providers can make referrals by completing the online **Enhanced Care Management Member Referral** form or by emailing **ECM@blueshieldca.com**. Members can refer themselves by calling Blue Shield Promise. Once a member's eligibility is confirmed, Blue Shield Promise will contact them to discuss services.

ECM re: individuals transitioning from incarceration
Justice-Involved Initiative

On January 26, 2023, California became the first state in the nation approved to offer a targeted set of Medi-Cal services to youth and eligible adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release and to ensure individuals have continuity of coverage upon their release, as well as access to key services to help them successfully return to their communities.

Overview	
Services	Support for justice-involved adults and youth transitioning to the community may include both Enhanced Care Management and Community Supports services.
Eligibility	Eligibility for justice-involved adults transitioning into the community within the past 12 months includes these medical conditions: • Confirmed or suspected mental health diagnosis • Confirmed or suspected substance use disorder • Chronic or significant non-chronic clinical condition • Traumatic brain injury • Intellectual or developmental disability • Positive test or diagnosis of human immunodeficiency virus or acquired immunodeficiency syndrome • Pregnant or within 12-months postpartum. Eligibility for youth residing in a youth correctional facility transitioning into the community within the past 12 months do not need to meet clinical criteria.
Referrals	Both clinical and non-clinical providers can make referrals by completing the online **ECM Member Referral** form or by emailing **ECM@blueshieldca.com**. Members can refer themselves by calling Blue Shield Promise. Once a member's eligibility is confirmed, Blue Shield Promise will contact them to discuss services.

CS

Community Supports are optional, non-benefit, services that enhance a member's care by focusing on the social drivers of health such as food and housing. All services are provided at no cost. Providers include social services agencies, county agencies, life skills training and education providers, home health or respite agencies, home delivered meals providers, local health departments, area agencies on aging, public hospital systems, Federally Qualified Health Centers, affordable and supportive housing providers, sobering centers, and other community-based entities.

Services

Blue Shield Promise is proud to offer all 14 available services recommended by CalAIM:

Accessibility adaptations	Arranges home modifications to ensure health and safety such as ramps and grab bars (lifetime maximum of $7,500)
Asthma remediation	Mitigates environmental asthma triggers with home modifications
Day habilitation program	Assists with developing skills necessary to reside in home-like settings. These programs may include training on use of public transportation or preparing meals
Housing tenancy and sustaining services	Helps individuals maintain stable tenancy once housing is secured and develop financial literacy
Housing transition navigation services	Assists individuals with obtaining housing
Housing deposits	Assists with funding one-time necessary services to establish a household (lifetime limit of $5,000 for members receiving housing transition navigation services)
Meals and medically tailored food	Delivers meals following hospital discharge up to 12 weeks
Nursing facility transition to assisted living facility	Offers a community-based alternative to institutionalization when possible
Nursing facility transition to home	Provides non-recurring set-up expenses for living in a private residence
Personal care and homemaker	Supports individuals who need assistance with daily activities, such as personal hygiene and eating
Post-hospitalization housing	Provides up to six months housing for recovery immediately after exiting an inpatient medical, psychiatric, or substance use disorder institutional setting
Recuperative care	Provides short-term medical respite post-hospitalization for up to 90 days
Respite services	Offers short-term relief to caregivers of members requiring intermittent supervision
Sobering centers	Encourages alternative destinations for up to 24 hours for members found to be intoxicated that would otherwise go to an emergency department or jail

CS continued	**Eligibility** • Community Supports serves eligible Medi-Cal beneficiaries with the same complex medical, behavioral, and social needs as Enhanced Care Management. • Medi-Cal members may qualify for both Enhanced Care Management and Community Supports or only one of the programs. • Members must provide written or verbal consent prior to being referred to Community Support Services. • Members cannot be enrolled in Community Supports if they are already receiving services in a similar program or are in facility-based care at the time of referral. **Referrals** • Community Supports must be pre-authorized by Blue Shield Promise prior to service and services must be provided through contracted providers. • Both clinical and non-clinical providers can make referrals, and members can refer themselves by calling Blue Shield Promise. • Once a member's eligibility is confirmed, Blue Shield Promise will contact them to discuss services. • Referrals to CS can be made by completing the online **Community Supports Request Form** or by emailing Blue Shield Promise at **LACommunitySupports@blueshieldca.com** (for Los Angeles County) or **SDCommunitySupports@blueshieldca.com** (for San Diego County).

Person-centered care planning for supporting self-direction

Person-centered care is the member-controlled method of selecting and using services. It allows the person maximum control over his or her home and community-based services. The member controls the amount, duration, and scope of services, as well as choice of provider(s).

Overview	Commitment	Examples	Principles

Person-centered care planning for supporting self-direction

Person-centered care is the member-controlled method of selecting and using services. It allows the person maximum control over his or her home and community-based services. The member controls the amount, duration, and scope of services, as well as choice of provider(s).

Overview	Commitment	Examples	Principles

Overview

Person-centered care planning

- Sees the person as the expert
- Includes significant others
- Identifies hopes, interests, preferences, needs, and abilities
- Maximizes community connection

When members have diminished capacity:

- Involve them to the maximum extent possible
- Involve the legal representative, family members, or close friends
- Involve the interdisciplinary team of providers who are assessing risk to the individual

Person-centered care planning for supporting self-direction

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Overview	Commitment	Examples	Principles

Person-centered care planning for supporting self-direction

Blue Shield is committed to the provision of member care that:

Is provided in a manner that is sensitive to the member's functional and cognitive needs, language, and culture.

Member

Is offered in the least restrictive community setting, and in accordance with the member's care goals and Individualized Care Plan.

Allows for member and caregiver involvement (as permitted by the member) and accommodates and supports the member's self-direction.

Is provided in a care setting appropriate to the member's needs, with a preference for the home and community.

Person-centered care planning for supporting self-direction

Person-centered care is the member-controlled method of selecting and using services. It allows the person maximum control over his or her home and community-based services. The member controls the amount, duration, and scope of services, as well as choice of provider(s).

Overview	Commitment	Examples	Principles

Examples of self-direction in long-term services and supports

Self-direction is a consumer-controlled method of selecting and using Long-Term Services and Supports that allows a person to have maximum control over his or her home and community-based services.

Providers are employed directly.

Home and community-based services are planned, budgeted, and controlled by the consumer.

Community-supported life is individualized and self-directed.

Individualized budget determinations are accurate, fair, and flexible.

Person-centered care planning for supporting self-direction

Person-centered care is the member-controlled method of selecting and using services. It allows the person maximum control over his or her home and community-based services. The member controls the amount, duration, and scope of services, as well as choice of provider(s).

Overview	Commitment	Examples	Principles

Principles of self-direction

Recognition of the contribution that individuals with disabilities can make in their communities

Freedom to decide how a person wants to live his or her life

Responsibility for the wise use of public dollars and authority over a targeted amount of dollars

Support to organize resources in ways that are life enhancing and meaningful to the individual

The interdisciplinary care team (ICT) is person-centered.

The interdisciplinary care team facilitates care assessment, planning, and management, as well as authorization of services and care transition. Members and caregivers are encouraged to participate. The team typically includes a case manager, social worker, pharmacist, medical director, and treating physician. Others are included based on member needs.

The ICT is built on the member's specific needs and preferences and is based on the Health Risk Assessment and Individualized Care Plan.

Member

The member can choose to limit or remove in-home support services providers, family members, and other caregivers on the team.

The ICT delivers services with dignity, transparency, individualization, and linguistic and cultural competence.

Blue Shield requires individualized care teams to comprise knowledgeable team members on these key competencies*:

- Cultural competence
- ADA accessibility and accommodations
- Independent living
- Wellness principles

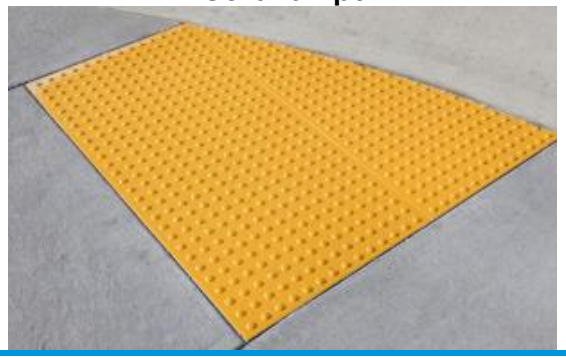
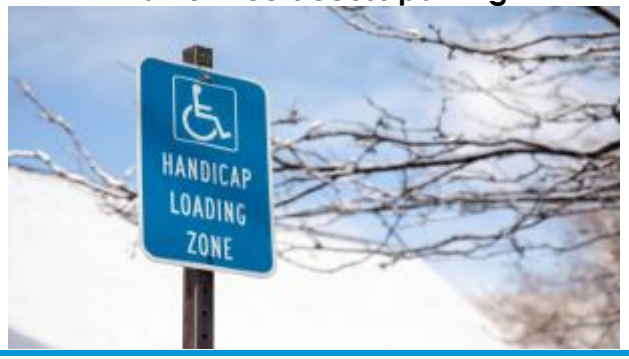
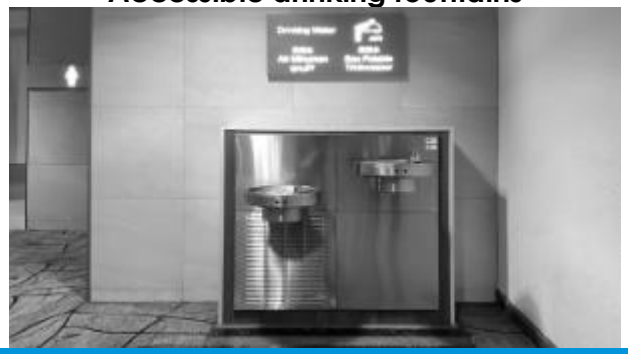
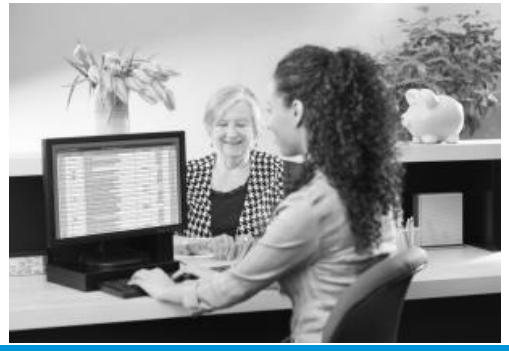
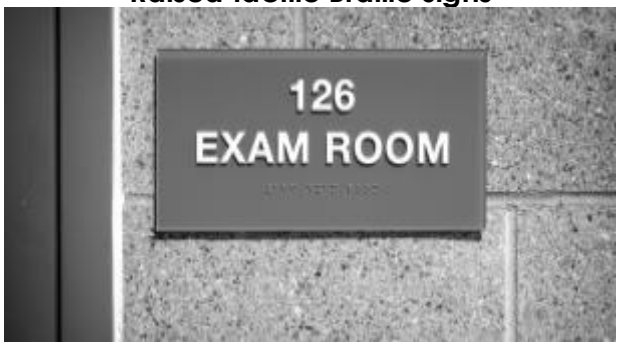
* minimum - not limited to


Cultural competence
Cultural competence is the ability to effectively interact with people across cultures. Cultural competence encompasses:
• Developing positive attitudes towards cultural differences
• Gaining knowledge of different cultural practices and world views
• Developing skills for communication and interaction across cultures
Underlying cultural competence are the principles of trust, respect for diversity, equity, fairness, and social justice.

Accessibility and accommodations

The Americans with Disabilities Act and Section 504 of the Rehabilitation Act require that health care providers provide individuals with disabilities full and equal access to their health care services and facilities.

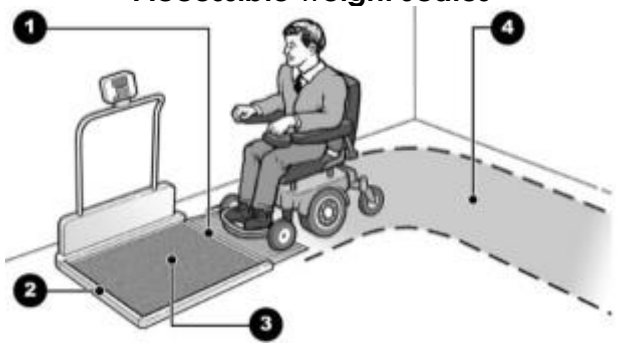
- Parking spaces
- Curb ramps
- Barrier-free access from parking
- Wide doorways
- Accessibility in public spaces
- Ample, accessible restrooms
- Accessible drinking fountains
- Accessible service counters
- Raised tactile Braille signs
- Accessible exam rooms
- Accessible exam tables
- Accessible weight scales
- Transfer equipment
- Communication & auxiliary aids

Parking spaces 	**Curb ramps** 	**Barrier-free access parking** 
Wide doorways 	**Accessibility in public spaces** 	**Ample, accessible restrooms** 
Accessible drinking fountains 	**Accessible service counters** 	**Raised tactile Braille signs** 

Accessible exam rooms

Accessible exam tables

Accessible weight scales



1. Sloped surface provides access to scale platform – no abrupt level changes at floor or platform.
2. Edge protection at drop-off.
3. Large platform to accommodate various wheelchair sizes.
4. Provide maneuvering space to pull onto and off scale.

Transfer equipment

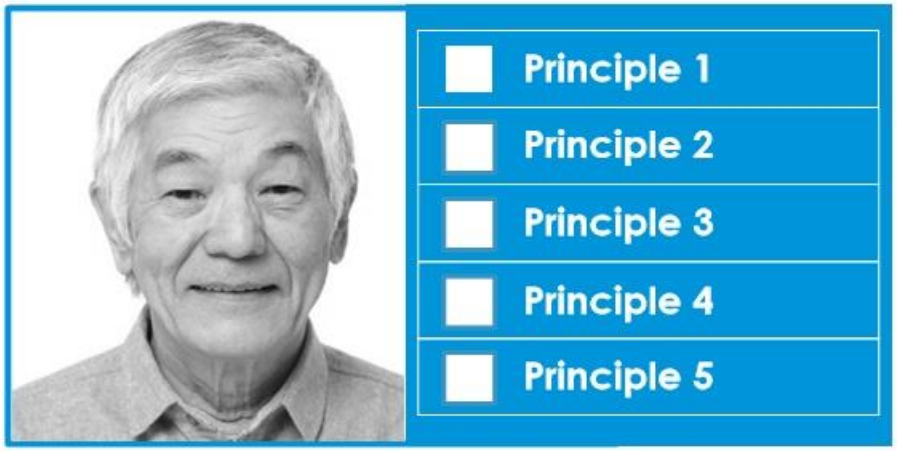
Communication & auxiliary aids

Communication and auxiliary aids

https://www.ada.gov/effective-comm.htm

Independent living

The independent living philosophy emphasizes that people:



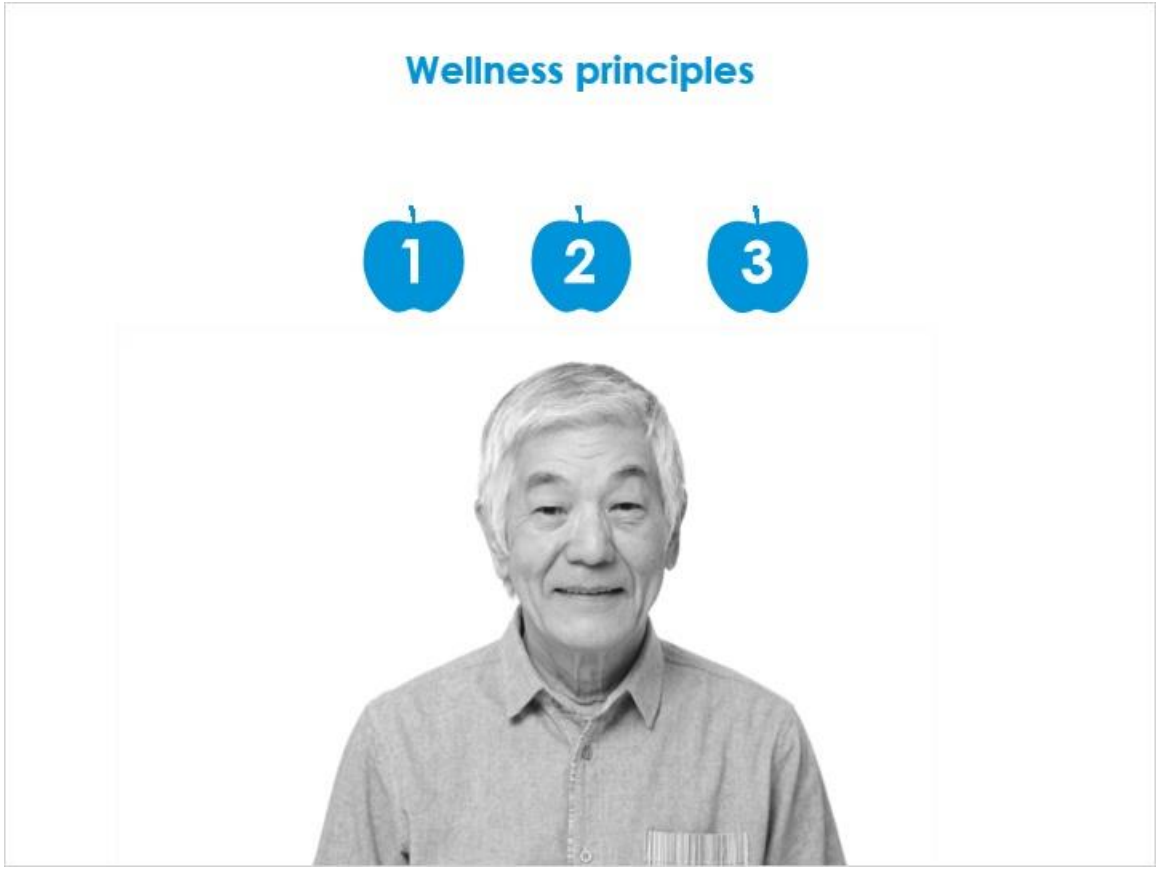
Principle 1	Deserve equal opportunities
Principle 2	Are the best experts of their own needs
Principle 3	Have crucial and valuable perspectives to contribute
Principle 4	Have consumer control
Principle 5	Should decide how to live and take part in the community

Olmstead Act

Olmstead is the name of the most important civil rights decision for people with disabilities in our country's history. This 1999 United States Supreme Court decision was based on the Americans with Disabilities Act (ADA). The Supreme Court held that people with disabilities have a qualified right to receive state-funded support and services in the community when the following are met:

- The person's treatment professionals determine that community supports are appropriate;
- The person does not object to living in the community; and
- The provision of services in the community would be a reasonable accommodation for other similarly situated individuals with disabilities.

Courts quickly made clear that Olmstead applied to all state- and Medicaid-funded institutions, including nursing facilities.



1	Physical exercise, good nutrition, stress-management, and social support are important for everyone, and health promotion activities are critical for people who are prone to a more sedentary lifestyle.
2	Health includes a dynamic balance of physical, social, emotional, spiritual, and intellectual factors.
3	Providers can be of tremendous assistance in helping people select and practice tailored health promotion behaviors to increase their level of well-being.

Interdisciplinary care team participants

Required

- Member or authorized representative (whenever possible)
- County IHSS social worker (if receiving IHSS)
- Medical expert (PCP or specialist)
- Care coordinator (case manager, social worker, or behavioral health specialist)

Optional*

- Pharmacist
- Health Educator
- Public Program Coordinator
- Specialized Providers (PT, OT)
- Long-Term Care Provider
- Disease Management Specialist
- LTSS Service Provider (CBAS, MSSP, etc.)
- County Behavioral Health Providers

Interdisciplinary care team communication

Blue Shield facilitates information flow between members, interdisciplinary care team participants, and physicians with:

- Documentation in the care management system and member's Individualized Care Plan
- Regular telephonic communication with member/caregiver and provider
- Written interdisciplinary care team meeting minutes
- A member data dashboard that includes utilization and pharmacy data

*As needed or approved by member

Facilitates	Facilitates care management and coordination
Conducts	Conducts individualized care team meetings periodically and at the member's request
Takes into account	Takes member's communication needs into account (cognitive, communicative, or other barriers)
Maintains	Maintains a call line or other mechanism for the member's inquiries and input
Analyzes	Analyzes and incorporates health risk assessment results into the Individualized Care Plan
Authorizes	Authorizes services and transitional care
Refers	Refers members to other agencies when needed (e.g., long-term supports and services or behavioral health services)
Manages	Manages information flow for care delivered outside the primary care site

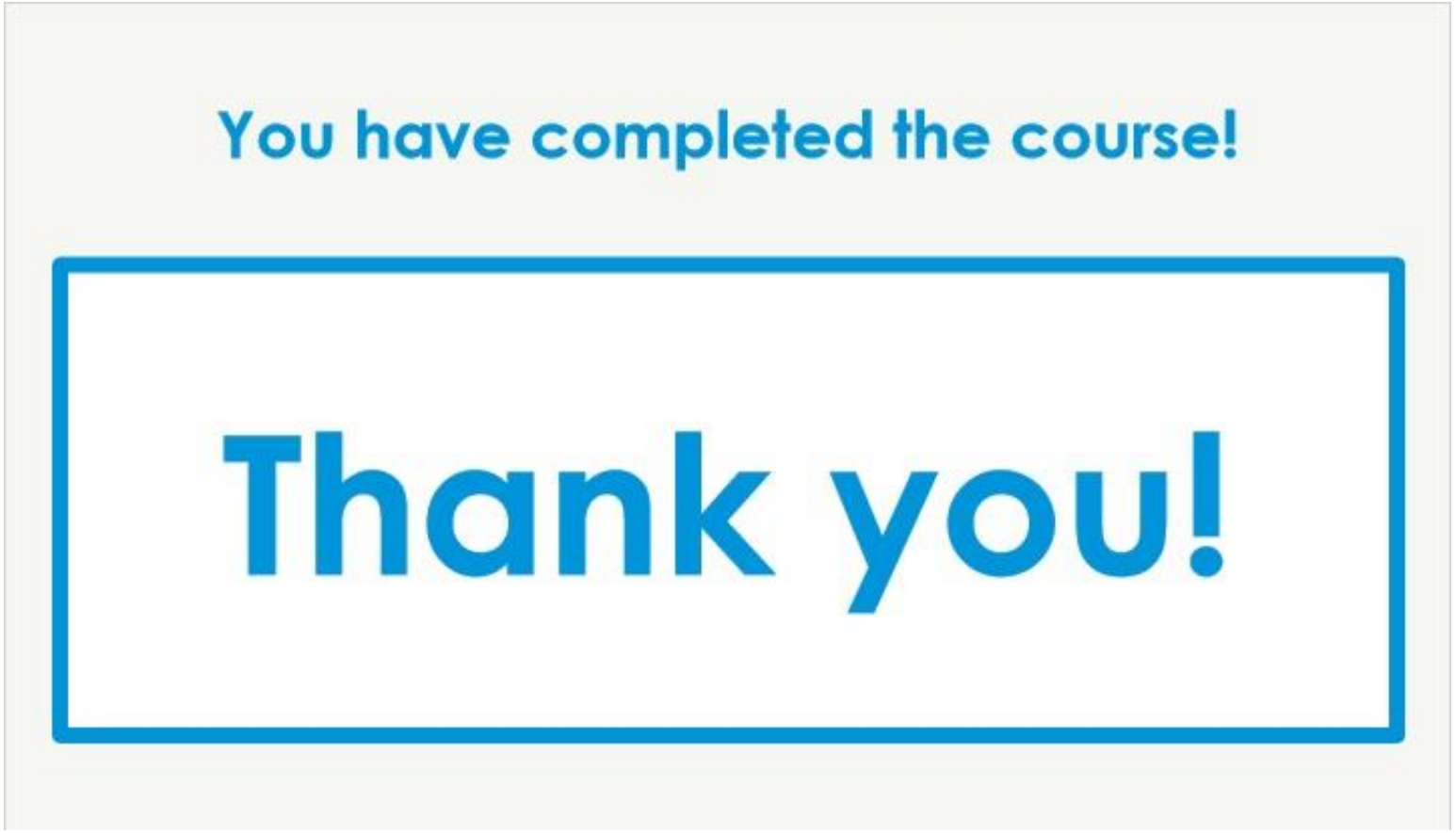
Overview	• The Individualized Care Plan is developed specifically for each member. • The member, or their authorized representative, must be given the opportunity to review and sign the Individualized Care Plan or any amendments. • The Individualized Care Plan must be at a sixth grade reading level, in alternative formats, and in the member's preferred written or spoken language.
Components	• Name and contact information for the member's primary care physician and any specialists • Member goals and preferences • Measurable objectives and timetables for medical and behavioral health services and long-term services and supports • Time frames for reassessment: at minimum, annually or per current state or federal requirements
IHSS	For members receiving In-Home Support Services, the Individualized Care Plan must include: • Contact information for the county social worker who has responsibility for authorizing and overseeing the member's in-home support services hours • Contact information for the member's In-Home Support Services worker

Critical Incident Reporting

Definition	A critical incident is defined as any actual or alleged incident that created a significant risk of substantial or serious harm to the physical or mental well-being or safety of a Blue Shield Promise member receiving Long-Term Services and Supports (LTSS).
Scope	The Critical Incident Reporting (CIR) procedures covered in this module pertain to members enrolled in Long-Term Services and Supports (LTSS) such as: • In-Home Supportive Services (IHSS) • Community-Based Adult Services (CBAS) • Multipurpose Senior Services Program (MSSP) • Long-Term Care (LTC)
Identification	**Critical incidents include:** • Abuse (physical, sexual, financial) • Neglect • Exploitation • Rights violation • Serious injury • Missing person • Death • Emergency situation • Medical emergency • Psychiatric emergency (suicidal and/or homicidal) • Medication error • Restraints (personal, mechanical, chemical, seclusion, isolation)
Purpose	CIR is intended as a safeguard to prevent abuse, neglect, and exploitation. It is used to track and trend quality improvement efforts for the delivery of LTSS for members.
Policy	It is the policy of Blue Shield of California Promise Health Plan (Blue Shield Promise) that internal employees and external providers must report critical incidents for members receiving LTSS services. Reports must be made when the employee or provider becomes aware of the incident. Local and state agencies are responsible for any subsequent investigation that may result from a critical incident.

Reporting sources	**Critical Incident Reporting sources include:** • Family members or caregivers • Community-Based Adult Services (CBAS) • Long-term care and skilled nursing facilities • Multipurpose Senior Services Programs (MSSP) • Provider networks **And the following Blue Shield of California Promise Health Plan departments:** • Case Management • Claims • Customer Care • Long-Term Services and Supports • Member Appeals and Grievances • Medical Care Solutions • Pharmacy • Quality Management • Social Services
Mandated reporting	Elderly and dependent adult reports are based on witnessing an event or receiving information or evidence. Events are reported to Adult Protective Services (APS). **Mandated reporters include:** • Healthcare professionals • All Blue Shield Promise employees • Any person who has assumed full or partial responsibility for the needs or care of an elder or dependent adult Mandated reporters are required by California law to report known or suspected abuse, neglect, or self-neglect. **Failure to report is a misdemeanor and punishable by jail or fine.**
Contact these agencies	**Contact these agencies to report elder or dependent adult abuse:** **Adult Protective Services** LA County: **(877) 477-3646 / Online Report** San Diego County: **(800) 510-2020 / Online Report** **Long-Term Care Ombudsman Program: (800) 231-4024** **Call 911 if an elder or dependent adult is in immediate danger or needs medical care.** All the above services are open 24 hours a day and seven days a week.

How to report	**What to do when you learn of a critical incident** Verify that the Blue Shield Promise member receives one or more LTSS services (IHSS, CBAS, MSSP, or LTC.) If the incident requires mandated reporting, report the incident to the appropriate community agency. AND Fax a Blue Shield Promise Critical Incident Report Form to the Blue Shield Promise Social Services Department at **(323) 889-2109**. You can find the form by clicking the "*Policies, guidelines, standards and forms*" tab in the Promise provider resource's section of Blue Shield's Provider Connection website. If you are uncertain whether an incident qualifies as CIR, call the Blue Shield Promise Social Services Department at **(877) 221-0208**, Monday through Friday, 9 a.m. to 5 p.m.
After reporting	**What happens when a critical incident is reported to Blue Shield Promise?** Reports are stored in the Blue Shield Promise Social Services Department. A quarterly report is submitted to the state with the number of critical incident reports received and the type of LTSS service members are receiving.


You have completed the course!
Thank you!