

Enriched Residential Care (ERC) Program

Step-Up and Step-Out Presentation



Talking Points

Overview of the Enriched
Residential Care (ERC) Program

Understanding the Step-Up and
Step-Out processes

Criteria and workflows for client
transitions

Interdisciplinary collaboration
and partner coordination

Program impact and outcome
highlights

Next steps and opportunities for
improvement

What is ERC?

- ERC is a care model designed to enhance the well-being and quality of life for adults and elderly clients who require 24-hour assistance with daily activities but do not need the level of care provided in nursing homes.
- Facilities are licensed care settings such as adult residential facilities for individuals aged 18-59 and residential care facilities for the elderly, for clients aged 60 and above. Undocumented individuals are eligible for services.
- The goal is to create support systems around clients with complex health problems to achieve positive health outcomes and housing retention.

ERC Referral Process Overview

REFERRAL PROCESS

- Submit ERC application and required documentation in CHAMP
- Referral Assessment and Placement (RAP) team conduct a face-to-face assessment with the referred participant
- Collaborate with facility partners to identify appropriate facility match based on availability, geographic preferences (if applicable), and most importantly medical needs.
- The goal is to ensure timely transitions, reduce hospitalizations, and stabilize clients
- ERC has FAQs

ERC Financial Responsibilities

Financial Responsibilities

- All participants with income (SSI/SSDI) are responsible for paying for their rent.
- Participants keep their Personal & Incidental (P&I) rate from their SSI/SSDI income.
 - P&I for 2025 is \$179.00/month.
- Participants that are ineligible for income (undocumented) or do not have income at the start of the ERC referral will receive the full financial support from the ERC program.
 - Once a participant begins to receive income, from that day forward the participant is responsible for their rent.
- Participants eligible for income are supported with submitting a CBEST referral.

*Please note the Supplemental Security Income (SSI) rate is subject to variation each year.

Step-Up and Step-Out

- **Step-Up:** When a client's needs exceed what onsite staff or IHSS can provide, they “step up” to a higher level of care—such as ERC, ALW, or SNF—for more comprehensive support.
 - ERC collaborates with ALW and SNF to ensure the appropriate level of care placement
- **Step-Out:** When a client is ready to transition to a lower level of care or independent housing, such as PSH, or other permanent housing setting.
- Both Step-Up and Step-Out ensure appropriate client placement, improved outcomes, and efficient use of program resources.

Step-Up Example

Example:

A client currently struggling in a PSH or independent living setting with the following:

- Medication management
- Fall risks
- Decline with ADLs
- Cognitive deficits
- Wandering and/or elopement
- Frequent hospitalizations

Step-Out Process Overview

Step-Out is the result of ERC stabilization work.

Clients are identified for Step-Out through ongoing case conferencing and Interdisciplinary Team (IDT) collaboration.

- ADL function and independence.
- Stable physical and mental health.
- Ability to self-manage medications and appointments.
- Willingness to Step-Out

Step-Out Process Overview

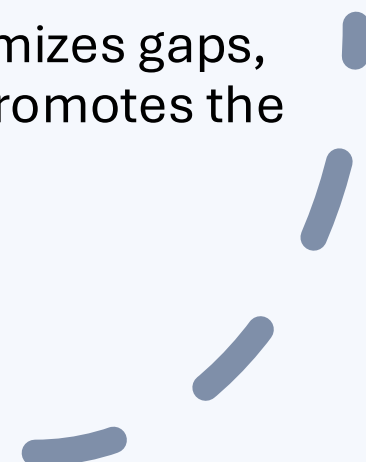
Once a referral is submitted for Step-Out:

- The Wellness PM team notifies the IDT RNs, MCWs, and OTs.
 - Each discipline then conducts their own Step-Out Assessment
- Program Managers coordinate with ICMS to secure PSH or other housing placement and may include IHCG/IHSS.
- Clients receive continued support for at least one-month post-transition to ensure stability and prevent recidivism.



Interdisciplinary Collaboration

Success of Step-Up and Step-Out depends on strong collaboration

- Weekly huddles and complex case meetings bring together IDT
 - Coordination with PSH team and Brilliant Corners-ICMS ensures alignment between medical stability and housing opportunities.
 - This collaborative model minimizes gaps, accelerates transitions, and promotes the continuum of care.
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Program Impact

Step-Up and Step-Out processes are producing clear improvements in client outcomes and more efficient use of resources.

- Step-Up reduces hospital readmissions, prevents care disruption, and increases housing retention.
- Step-Out frees up ERC capacity for higher-need clients while promoting permanent housing stability.
- Clients who successfully Step-Out demonstrate improved self-sufficiency, health stability, and reduced reliance on acute care services.
- Collaboration and data tracking have also improved program efficiency and inter-agency coordination.

Next Steps and Program Focus

- Continue to strengthen and refine collaborative workflows with housing partners and IDT.
- Enhance data integration for real-time tracking of client transitions.
- Establishing Step-Out preparation through comprehensive care planning and goal-setting at intake
- Expand clinical and wellness support for clients preparing to Step-Out.
- Maintain the use of outcome data to guide ongoing program improvements and policy recommendations.

Questions?

- All ERC referral inquiries and referral submissions should be directed to:
ERC-referrals@dhs.lacounty.gov
- The ERC RAP Team also hosts a Monthly Office Hour meeting via Teams where participants (referring parties) are encouraged to ask questions pertaining to the overall flow of the program or specific inquiries on submitted referrals. Invitation to the Monthly Office Hour can be provided upon request.
 - ERC Office Hours take place the second Wednesday of every month.