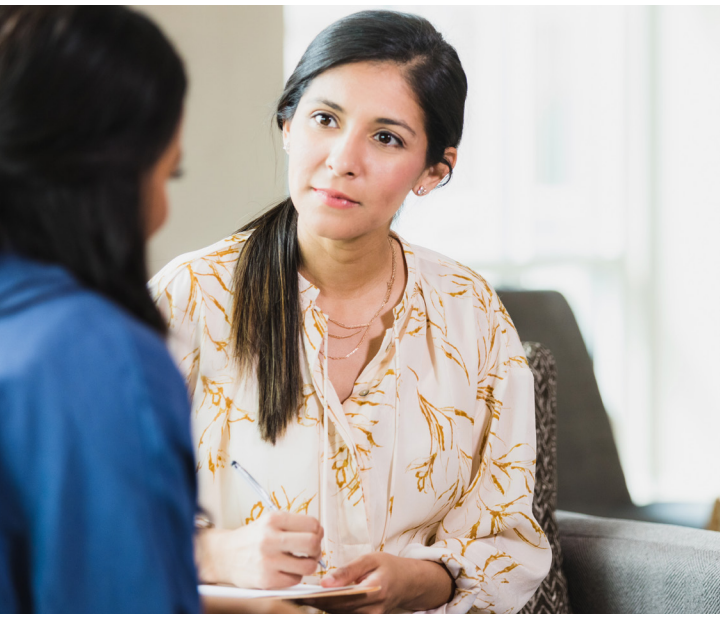
Enhanced Care Management

Enhanced Care Management (ECM) provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of a high-need Medi-Cal Managed Care (Medi-Cal) member. ECM is a collaborative approach to providing intensive and comprehensive care management services to individuals.

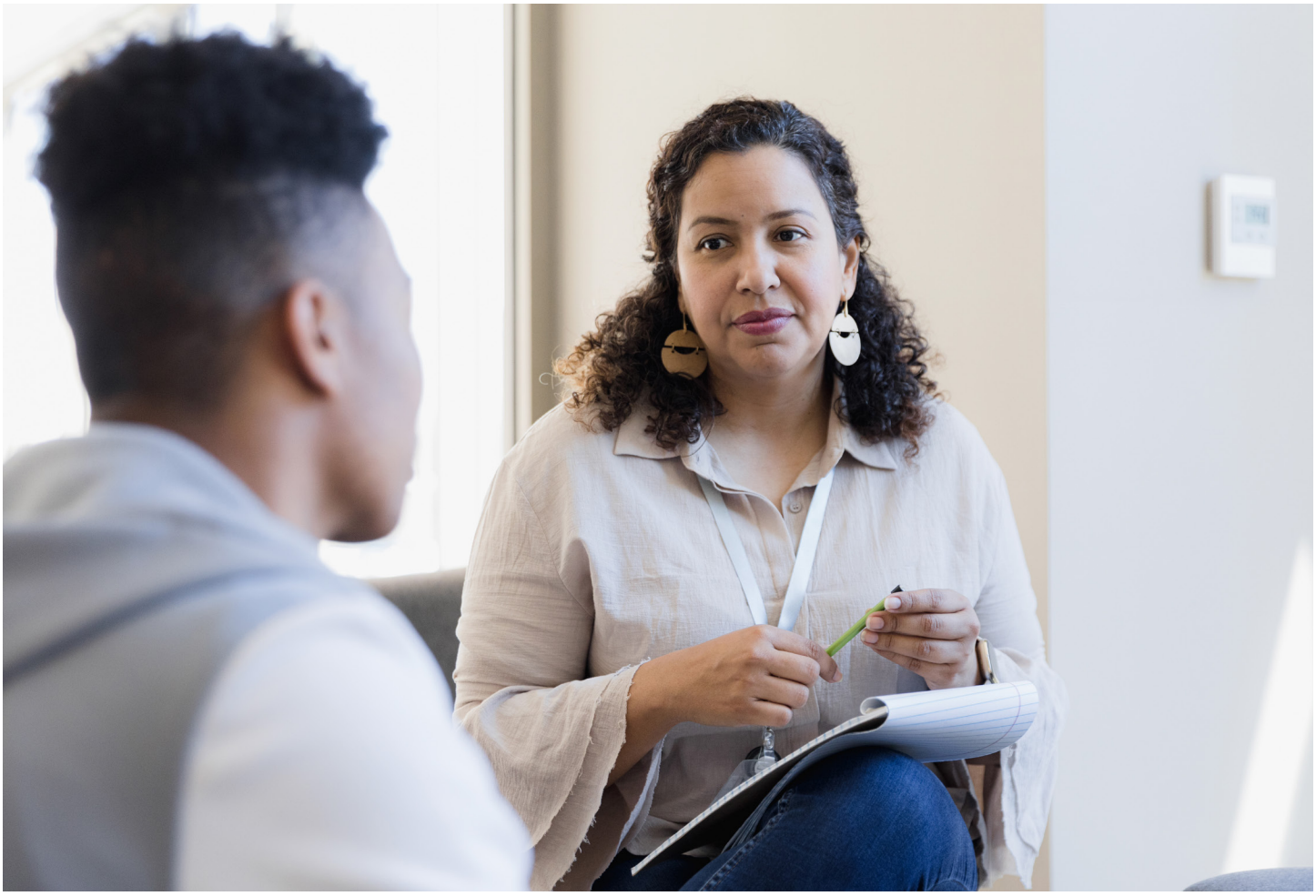
Populations of focus

The Department of Healthcare Services (DHCS) has defined the following populations of focus (PoFs) for ECM:[1]

- **Individuals experiencing homelessness:**
  - Adults without dependent children/youth living with them who are experiencing homelessness and have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage
  - Homeless families or unaccompanied children and youth experiencing homelessness who are experiencing homelessness or are sharing the housing of other persons[2]



- **Individuals at risk for avoidable hospitalization or emergency department (ED) utilization (formerly called high utilizers):**
  - Adults who have five or more preventable emergency room visits; or three or more unplanned hospital, or short-term skilled nursing facility (SNF) stays, in a six-month period within the last 12 months
  - Children and youth who have three or more emergency room visits or two or more unplanned hospital or short-term SNF stays within the last 12 months
- **Individuals with serious mental health and/or substance use disorder (SUD) needs:**
  - Adults who meet the eligibility criteria for participation in, or obtaining services through, Specialty Mental Health Services (SMHS), The Drug Medi-Cal Organization Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program, are actively experiencing at least one complex social factor, and are experiencing one or more of the following:
    - High risk for institutionalization
    - User of crisis services
    - Two or more emergency department visits or inpatient in past 12 months due to SMI/SUD-related hospitalizations, or pregnancy
  - Children and youth who meet the eligibility criteria for participation in or obtaining services through SMHS and DMC-ODS or DMC program[3]

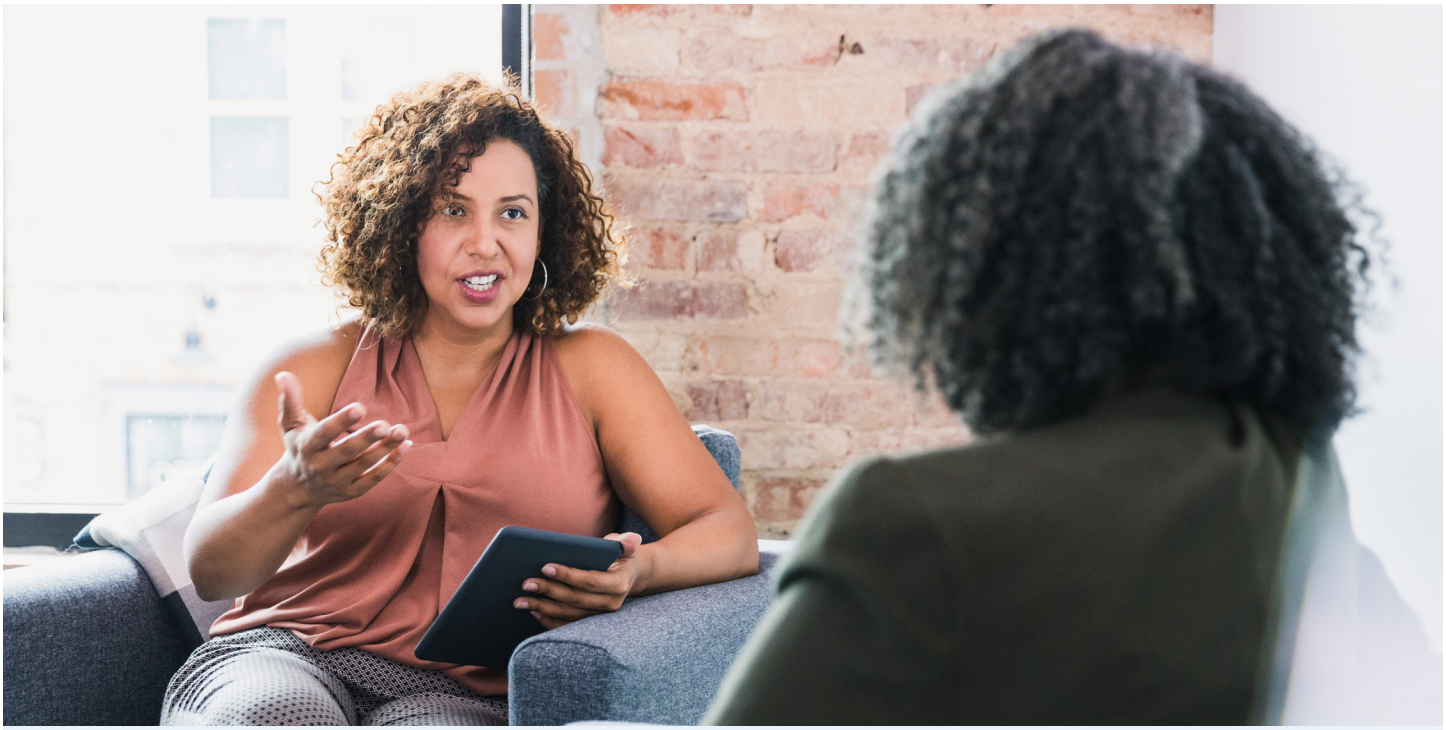


Populations of focus (cont.):

- **Adults living in the community and at risk for LTC institutionalization:**
  - Adults who are at risk for long-term care (LTC) institutionalization and in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient NF.
- **Adult nursing facility (NF) residents transitioning to the community:**
  - Adults who are NF residents who want and, with support, are able to transition to the community.
- **Individuals transitioning from incarceration:**[4]
  - Adults who are transitioning or have transitioned from a correctional setting within the last 12 months and have a mental illness, chronic condition, SUD, intellectual or developmental disability, traumatic brain injury (TBI), HIV/AIDS, or pregnancy
  - Children and youth who are transitioning or transitioned from a youth correctional facility within the past 12 months[5]
- **Children and youth enrolled in California Children's Services (CCS):**
  - Children and youth who are enrolled in CCS and are experiencing at least one complex social factor influencing their health:[6]
    - Children and youth involved in child welfare
  - Children and youth who are:
    - Under age 21 and are receiving foster care in California;
    - Under age 21 and previously received foster care in California or another state within the last 12 months;
    - Have aged out of foster care up to age 26 (having been in foster care on their 18 birthday or later) in California or another state;
    - Under age 18 and are eligible for or in California's Adoption Assistance Program;
    - Are under age 18 and are receiving or have received services from California's Family Maintenance program within the last 12 months.

ECM core service components:

- **Comprehensive assessment and care management plan:** A comprehensive, individualized and person-centered care plan developed by working with the member to assess risks, needs, goals, and preferences, and collaborating for input with the member, care team members, support networks, and caregivers, as appropriate. This plan addresses physical and developmental health, mental health, dementia, SUD, community-based long-term services and supports (LTSS), oral health, palliative care, trauma-informed care, necessary community-based and social services, and housing.
- **Enhanced coordination of care:** Organizing patient care activities, as laid out in the care plan, sharing information with the member's key care team, and implementing the member's care plan. It is ensuring care is continuous and integrated among all service providers as well as providing support for member treatment adherence with medication reconciliation, scheduling appointments, coordinating transportation, accompaniment to critical appointments, and helping to address barriers to adherence.
- **Health promotion:** Working with members to identify and build on resiliencies and potential family or community supports and providing services to encourage and support members to make lifestyle choices based on healthy behavior, with the goal of supporting members' ability to successfully monitor and manage their health.
- **Comprehensive transitional care:** Developing and regularly updating a transition plan for the member that includes evaluating a member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges.
- **Member and family supports:** Includes activities that ensure that the member and chosen family/support persons, including guardians and caregivers, are knowledgeable about the member's condition(s) with the overall goal of improving the member's care planning and follow-up, adherence to treatment, and medication management.
- **Coordination of and referral to community and social support services:** Determining the appropriate services to meet the needs of members, including services that address social drivers of health needs, and following that up with closed loop referrals, in which the member is referred to available community resources and confirmation that services were rendered.



More information:

1. For more information about becoming an ECM provider, email CalAIMReferrals@anthem.com.
2. To refer a member for ECM services, call the Medi-Cal Customer Care Center at **800-407-4627** (**TTY 711**) or **888-825-7801** (**TTY 711**) for members in Los Angeles County.
3. For more resources, visit the link: **http://tinyurl.com/mscktjm4**

Learn more about Anthem programs **https://providers.anthem.com/ca**

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References:

1. Children and youth PoFs go live July 2023.
2. Children, youth, and families do not need to meet the additional "complex, physical, behavioral, or developmental need" criteria for adults.
3. Children and youth are not required to be enrolled in or have accessed services through SMHS, DMC-ODS, or DMC to be eligible for ECM.
4. Live in Los Angeles County only. Go live statewide as early as January 2024.
5. Children and youth do not need to meet the additional health need criteria noted for adults.
6. The presence of a complex social factor is not necessary for children in CCS to be eligible for ECM if they meet the criteria of any other ECM PoF.

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