Medi-Cal Managed Care
L.A. Care

Anthem BlueCross

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 member. ECM is a collaborative approach to providing intensive and comprehensive care management services to individuals.

Populations of focus

The Department of Health Care Services (DHCS) is focusing on the following populations for ECM:

- **Homeless:** Individuals and families (including children) experiencing homelessness and who have at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage
- **High utilizers — adults:** Adult high utilizers with five or more preventable emergency room visits, or three or more unplanned hospital and/or short-term skilled nursing facility (NF) stays in a six-month period
- **Serious mental illness/substance use disorder:** Adults with severe mental illness (SMI) or substance use disorder (SUD) diagnosis and experiencing one complex social factor, and are:
  - 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 pregnant.
- **Nursing facility diversion:** Adults at risk for long-term care (LTC) institutionalization who, in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient NF
- **Nursing facility transition:** Adult NF residents who want and, with support, are able to transition to the community
- **Jail transition adults:** Adults transitioning from incarceration in the past 12 months who have a chronic mental illness, chronic disease, SUD, intellectual or developmental disability, traumatic brain injury (TBI), HIV, or pregnancy
- **Children and youth:** High utilizers; complex physical, behavioral, or developmental health needs; serious emotional disturbance; California Children's Services (CCS), child welfare (including foster care); incarcerated and transitioning

ECM core service components

ECM components include:

- **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 determinants 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.

For more information

Please contact Anthem Blue Cross via email at CalAIM@anthem.com for more information or to begin the application process.

https://providers.anthem.com/ca

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