DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

# ENHANCED CARE MANAGEMENT FOR INDIVIDUALS EXPERIENCING HOMELESSNESS

## A POPULATION OF FOCUS SPOTLIGHT

This **Enhanced Care Management Population of Focus Spotlight** illustrates how ECM is delivered—and Community Supports are coordinated—for **individuals and families experiencing homelessness**. It is intended to help future ECM Providers get started and current ECM Providers refine their ECM program for Medi-Cal managed care plan Members across the state experiencing homelessness.

**Enhanced Care Management (ECM)** is a Medi-Cal managed care plan (MCP) benefit available in all California counties to support comprehensive care management for MCP Members with complex needs. Launched in 2022, ECM is the highest level of care management in the Medi-Cal Population Health Management (PHM) continuum and is delivered in the community by community-based providers.

One of several "Populations of Focus" (POFs) for ECM is the **Individuals and Families Experiencing Homelessness POF**. Members in this POF are among the highest-need and most vulnerable Medi-Cal members as a result of certain social drivers of health, including inadequate access to shelter, food, and care, and tend to have extensive medical and behavioral health needs that can be difficult to address. For these members, ECM is intended to build consistent connections to medical care, behavioral health care, and housing stabilization services. This Spotlight also details how the Department of Health Care Services' (DHCS) 14 Community Supports can be integrated with ECM to meet the needs of Members.

Acknowledging that individuals experiencing homelessness are often served outside of a traditional medical office for some of their health and social needs, ECM is intended to meet enrollees wherever they are—on the street, in a shelter, in their doctor's office, or at home. Many individuals or families experiencing homelessness may be living in a shelter or an encampment or experiencing housing instability due to economic hardship—whether couch surfing or living in a motel. For families experiencing homelessness, MCPs are strongly encouraged to work with ECM Providers to serve the family unit together through one ECM team whenever possible and appropriate. Importantly, some Medi-Cal Members may also have historically experienced challenging interactions with the health care system; therefore, trust-building as part of ongoing efforts to outreach and engage Members is a critical and active part of ECM service delivery for this population.

Outside of ECM for Individuals Experiencing Homelessness, connecting individuals to ECM is an important strategy to prevent homelessness for some Medi-Cal Members, especially those who were formerly incarcerated. On January 1, 2024, DHCS launched ECM for Justice-Involved Populations. A critical component of ECM for these Members includes navigating safe and stable housing post-incarceration.

In this ECM POF Spotlight, readers will find operational guidance for the Individuals and Families Experiencing Homelessness POF, vignettes showing how ECM might support two Medi-Cal Members in this POF, and extensive resources for assessing your organization's capacity to contract with managed care plans as an ECM Provider.

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*The strategies and Member vignettes included in this Spotlight are informed in part by a series of informational interviews conducted with the following ECM Providers that serve the Individuals and Families Experiencing Homelessness POF.*

- *Illumination Foundation, a nonprofit, community-based organization (CBO) dedicated to disrupting the cycle of homelessness by providing targeted, interdisciplinary services in recuperative care centers, emergency shelters, housing services, and children's and family programs throughout Los Angeles County, Orange County, and the Inland Empire.*
- *Hill Country Community Clinic, a Federally Qualified Health Center (FQHC) providing outpatient medical, dental, mental health, intensive case management, and wellness services to residents of Shasta County, California.*
- *San Joaquin County Clinics (San Joaquin Health Centers), a designated Federally Qualified Health Center Look-Alike (FQHC-LAC) bringing health services to county residents through comprehensive health center sites as well as an expanding mobile outreach delivery system.*


*DHCS thanks these organizations for their insights and contributions to this resource.*



*Published January 2024*

## What Is ECM for Individuals and Families Experiencing Homelessness?

The Department of Health Care Services (DHCS), Medi-Cal MCPs, and providers across the state are launching ECM in phases, by "Population of Focus" (POF), from 2022 to 2024. Each POF requires a unique model, referral pipeline, and provider network to meet the needs of eligible members. The key features of ECM across POFs include:

**COMMUNITY-BASED PROVIDERS**

*Medi-Cal MCP Members are matched to community-based ECM Providers with expertise supporting their needs and experience in intensive care management. Wherever possible, the ECM Provider should have an existing, trusted relationship with the Member.*

**PERSON-CENTERED CARE**

*ECM Providers develop individualized care plans based on Members' needs and coordinate all medical care, behavioral health support, and social services across the continuum.*

**HIGH-TOUCH, IN-PERSON SUPPORT**

*ECM entails high-touch support provided by a Lead Care Manager primarily through in-person interactions with Members where they live, seek care, or prefer to access services.*

DHCS has published an ECM Policy Guide containing comprehensive details about the benefit, as well as a policy "cheat sheet." The subsequent sections highlight key aspects of ECM specific to the Individuals and Families Experiencing Homelessness POF, including how it requires:

- Its own **referral pipeline** and process for building on existing relationships with Medi-Cal Members to identify and refer eligible Members to ECM, as well as using existing datasets to identify eligible Members.
- A **provider network** that is community-based and *uniquely* experienced and expert in addressing the needs of Members in the POF.
- An **interdisciplinary team composition and high-touch model** that positions the ECM Provider as the Member's key point of contact and additional support across existing clinical and nonclinical service delivery systems for Members.

DHCS requires each MCP to have a detailed plan (Model of Care) addressing how it will implement ECM, covering each of these issues for each POF.

**ECM Provider Perspective: Preparing for ECM and Staffing**

Many potential ECM Providers may review their services based on the requirements for each ECM POF and determine their services meet the vision of ECM. In this vein, San Joaquin County Clinics (San Joaquin Health Centers) reflected on their decision to transition their existing service model to ECM and serve the Individuals and Families Experiencing Homelessness POF, saying: *"Informed by our experience with Whole Person Care, we decided to integrate social services [into our service model] in addition to medical care in order for us to be impactful. We figured that what we were doing was ECM. So, we said, 'Let's have our own ECM team that addresses needs for those individuals.' The ECM team embedded in our street medicine services is comprised of seven social workers, including a coordinator. When ECM started, the issues that we had to deal with were more about billing, coding, and understanding CPT modifiers (which we hadn't done previously). But providing the services was straightforward."*

## Who Is Eligible for the Individuals and Families Experiencing Homelessness POF?

ECM for the Individuals and Families Experiencing Homelessness POF launched in multiple phases and includes ECM provided to individuals and approaches that serve the family unit together through one ECM team:

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|---|---|
| **Jan 2022** | ECM became available for **adults and families experiencing homelessness** in 25 counties. |
| **July 2022** | ECM was launched for adults and families experiencing homelessness in the remaining 33 California counties. |
| **July 2023** | ECM was launched for **unaccompanied children and youth experiencing homelessness** in all counties. |

See the ECM Policy Guide for a detailed list of the eligibility criteria for the Individual and Families Experiencing Homelessness POF. For readers seeking specific guidance on the Children and Youth POFs, including children and youth experiencing homelessness, DHCS has also released an ECM POF Spotlight focused on the Children and Youth POFs.

## How Do Individuals and Families Experiencing Homelessness Access ECM?

Providers and patients can access ECM in multiple ways.

- **Referrals From Providers or Community-Based Organizations (CBOs)**: Eligible members can be referred to the Medi-Cal MCP by a medical or behavioral health provider, case manager, or other professional already serving them.
  - DHCS expects MCPs to source most ECM referrals in this way. Shelters, street medicine providers, homeless services providers, recuperative care providers, community partners (e.g., Homeless Coordinated Entry Systems (CESs)), FQHCs, county agencies, and other service providers with experience working with homeless individuals and families (including Community Supports Providers) are well-positioned to identify and refer individuals and families experiencing homelessness to ECM.
  - Community-based service providers are encouraged to identify and refer eligible individuals and families to their MCPs for ECM, whether or not those referring organizations are themselves serving as ECM Providers.
  - School districts may refer children and youth to MCPs for ECM, and school staff may be important members of a family's ECM care team. McKinney Vento Liaisons within schools are particularly good partners for identifying and supporting children and families experiencing homelessness. The California Department of Education maintains a list of McKinney Vento Liaisons on its website.
  - MCPs should work with their ECM Providers to receive ECM referrals from the Provider's current patients/clients who have qualifying conditions or who are already receiving other services aligned with ECM eligibility criteria.
- **Self-Referrals**: Families, caregivers, legal guardians, and adults or youth may self-refer by contacting the MCP directly.
- **Data-Driven Referrals**: MCPs must also have a process for using data to proactively identify Members who may benefit from ECM and meet POF criteria. This process should supplement, and not replace, community-based provider referral sources.
  - MCPs are specifically expected to begin utilizing data from their regional Continuum of Care (CoC) Homelessness Management Information System (HMIS) to help determine whether their Medi-Cal Members are experiencing homelessness and may be eligible for ECM.

## How Is an Individual or Family Matched With an ECM Provider?

When the Providers and CBOs listed above refer individuals experiencing homelessness to an MCP, the plan will review eligibility and authorize ECM services. MCPs must ensure that referrals are processed as soon as possible, in accordance with the required authorization times for the benefit (e.g., within five days for routine authorizations and 72 hours for expedited requests). **To speed up authorizations, DHCS encourages MCPs to use presumptive eligibility and presumptive authorization approaches where appropriate**. This is particularly critical for this POF, as individuals may be migrating from place to place and difficult to outreach. Enabling providers to enroll individuals with presumptive eligibility and authorization when they find eligible Members is essential.

The MCP must assign the Member or family to an ECM Provider in the Member's county. MCPs should prioritize assigning the individual to an ECM Provider that has an established and trusted relationship with the Member and that is contracted to provide ECM for the Individuals and Families Experiencing Homelessness POF. The list below outlines organizations that may be particularly well-positioned to serve as ECM Providers for the POF. This list is non-exhaustive and is in addition to organizations that serve multiple POFs, such as FQHCs, rural health centers, and county behavioral health programs.

**Entities Well-Positioned to Serve as ECM Providers for Individuals Experiencing Homelessness**

- **Street medicine providers** (see APL 22-023): Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. Street medicine provides an opportunity to meet individuals who are experiencing homelessness where they are in the community. Street medicine providers may be ideally suited to conduct outreach and engage with Members who are experiencing homelessness, whether serving as ECM Providers themselves or connecting Members to other ECM Providers. Individuals and families experiencing homelessness and currently being served by street medicine providers may also receive ECM services at the same time.
- **Homeless navigation centers**: Otherwise known as low barrier navigation centers (as defined in Gov. Code, Section 65660), homeless navigation centers are temporary shelters in which providers can assist individuals and families in obtaining basic needs and starting the path to permanent housing. Homeless navigation centers are well-positioned to assist MCPs and ECM Providers in making contact with Members or to serve as ECM Providers themselves.

- **Homelessness response system case management**: These organizations typically provide community- and housing-based case management to people who are experiencing homelessness or are precariously housed, including coordination with health care, behavioral health, and social services. Case managers in these entities often have experience working with navigation centers, transitional housing, and permanent housing providers.
- **Transitional housing for homeless youth**: Organizations supporting transition-age youth and youth aging out of foster care can play an important role in identifying and supporting youth in their transition to independence and stable housing by serving as a trusted ECM Provider to coordinate their care.

*Additional providers that may be well-positioned to serve individuals experiencing homelessness with unique needs or those already engaged with other statewide initiatives aimed at reducing homelessness include:*

- **Providers with expertise serving pregnant/postpartum individuals experiencing homelessness.**
- **Providers with expertise serving individuals and families affected by intimate partner violence and experiencing homelessness.**
- **Providers partnering with Project Homekey programs.**

ECM Providers will assign an ECM Lead Care Manager to each ECM Member. This individual will serve as the main point for contact for ECM, coordinate care across clinical and nonclinical systems, and provide additional support to identify and address needs.

**A Note About Contracting and Payments**

DHCS pays MCPs to provide ECM to Medi-Cal Members. MCPs, in turn, contract with community-based organizations to serve as ECM Providers. Payments from MCPs to ECM Providers for ECM are based on negotiated rates between MCPs and ECM Providers. Rates for ECM paid to ECM Providers are not set by DHCS. For additional information on contracting and payments, see resources in the *How Providers Can Get Started in Partnership with MCPs* section of this Spotlight.

## What Does ECM Delivery Look Like for Individuals Experiencing Homelessness?

There are **seven ECM core services**, as described in the table on the right. ECM Providers are required to offer all seven services to the Members they serve. The *"ECM in Action"* section describes examples of how these core services are offered to Members. For detailed information on each of these services, as well as other details of the ECM model, consult the **ECM Policy Guide**.

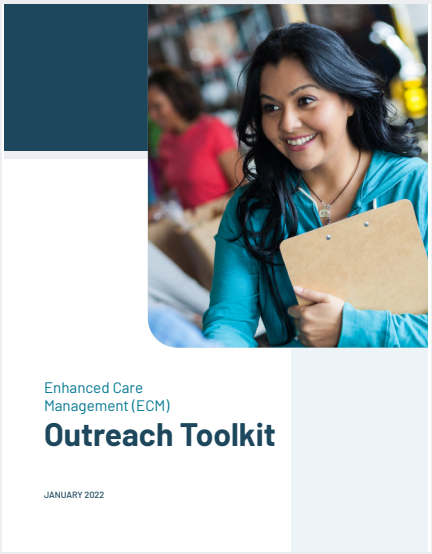
However, each of the seven ECM core services will look different for individuals with different needs and in different POFs. For the Individuals and Families Experiencing Homelessness POF, the ECM Lead Care Manager provides the needed link between physical and behavioral health care and the connection to housing and other resources associated with health-related social needs. The subsequent sections illustrate unique aspects of the POF related to outreach and engagement and to the coordination of and referral to Community Supports.

| ECM Core Services |
| --- |
| Outreach and Engagement |
| Comprehensive Assessment and Care Management Plan |
| Enhanced Coordination of Care |
| Health Promotion |
| Comprehensive Transitional Care |
| Member and Family Supports |
| Coordination of and Referral to Community and Social Support Services |

## Outreach and Engagement for Individuals Experiencing Homelessness

Outreach is an essential—and complex—part of delivering ECM for the Individuals and Families Experiencing Homelessness POF. In order to successfully engage Members in the benefit, ECM Providers must engage with Members in their communities, which can include shelters and public spaces and may be complicated by frequent relocation.

ECM outreach teams may include community health workers (CHWs) and other staff with lived experience of homelessness and/or housing instability, especially for staff supporting field-based outreach and engagement. Moreover, street medicine providers and homeless navigation centers may be well-positioned to conduct outreach and engage with Members who are experiencing homelessness, either by serving as ECM Lead Care Managers or referring Members to other ECM Providers. Other community anchors, such as faith-based organizations, may be well-suited to conduct outreach and engage certain Members who are experiencing homelessness, conduct warm handoffs to ECM Providers, and place referrals for ECM.




Of note, MCPs are expected to reimburse ECM Providers for outreach, including for unsuccessful outreach that did not result in a Member enrolling in ECM. DHCS has published an ECM Outreach Toolkit to support ECM Providers in developing their approach to outreach.

## Outreach and Engagement Tips From ECM Providers

DHCS conducted interviews with ECM Providers in July-August 2023 to gather the following tips on how to approach outreach and engagement for Members experiencing homelessness who are new to ECM. The goal of the outreach and engagement process is to build trust and ultimately give Members the opportunity to enroll in ECM.

- **Contact information provided by MCP:** The Member Information File (MIF) sent by MCPs to ECM Providers includes key contact information, including their last-known mailing and residential addresses, phone number, email address, emergency contact information, and primary care provider information.
  - The Member contact information generally provides the initial information for conducting telephone and email outreach.
  - However, frequent relocation and inconsistent phone access often mean that this information is out of date. As Illumination Foundation noted, "direct contact in the homeless population is (often) difficult and outreach through affiliates is best." In these cases, providers may try to reach the Member by contacting the emergency contact and/or primary care provider identified by the MIF or by other sources.
- **In-person outreach:** Providers can deploy an outreach team of individuals with lived experience to connect with the Member in the community, including at shelters and encampments. A core component of serving individuals experiencing homelessness, in-person outreach is often the most promising way to initiate contact when other data-driven modalities are unsuccessful.
  - At Hill Country Community Clinic, their "true outreach folks have lived experience or experienced homelessness at some point in their life. They understand camp life." Providers emphasize that an important component of in-person outreach in the community is building trust; outreach team members may bring water and show up consistently in the community to build a trusting connection with Members.
  - At San Joaquin County Clinics (San Joaquin Health Centers), outreach teams, who are typically CHWs or equivalent non-licensed staff members, meet individuals in the community during their daily routine. An outreach team member may meet an individual at the location where they do their laundry, receive social services, shower, or receive meals.
- **Contact or location information found through other data systems:** If the MIF information is not sufficient to locate and reach the Member, ECM Providers are encouraged to leverage community partners (e.g., regional homeless coordinated entry systems) to find additional contact information and identify other providers serving the Member.

## Combining ECM and Community Supports to Build More Support

ECM Providers will regularly screen and refer ECM Members to Community Supports, which are services that address Medi-Cal MCP Members' social drivers of health and help them avoid higher, costlier levels of care. DHCS has pre-approved 14 Community Supports that MCPs are strongly encouraged (but not required) to offer. Available supports vary by county and may change over time; see the **Community Supports available in each county**. View the **Community Supports Policy Guide** to learn more about eligibility and services offered through Community Supports.

Many of the 14 Community Supports would benefit an individual or family experiencing homelessness or at risk of becoming homeless, including medically tailored meals, day habilitation, and sobering centers, and six are specifically designed to provide support for people who do not have safe, stable housing. These supports are broken down into two groups: (1) support to reach long-term housing and (2) recovery-focused housing supports. The trio of Community Supports aimed at supporting Members and families to reach long-term housing should be delivered as a package when all three are available.

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|  <br>**Housing "Trio" to support reaching long-term housing** | **Housing Transition Navigation Services**: Help finding, applying for, and securing housing for Members experiencing homelessness or at risk of homelessness.<br>**Housing Deposits**: Once housing is found, assistance with housing security deposits, utilities setup fees, first and last month's rent, and first month of utilities.<br>» Housing deposits may also include funding for goods such as air conditioners, heaters, and hospital beds to ensure their new homes are safe for move-in.<br>**Housing Tenancy and Sustaining Services**: Once housing is secured, assistance with maintaining safe and stable tenancy such as coordination with landlords to address issues, assistance with the annual housing recertification process, and linkage to community resources to prevent eviction. |
| **Recovery-Focused Housing Supports** | **Recuperative Care (Medical Respite)**: Short-term residential care to Members who no longer require hospitalization but still need support to heal from an injury or illness.<br>**Short-Term Post-Hospitalization Housing**: Short-term housing for Members who do not have a residence and who have high medical or behavioral health needs while continuing their medical/psychiatric/substance use disorder (SUD) recovery.<br>**Day Habilitation**: Programs provided in a Member's home or an out-of-home, non-facility setting designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in their natural environment. |

For ECM Members, the ECM Lead Care Manager may serve as the key individual who identifies the need for Community Supports, places referrals, and coordinates services, all while coordinating the Member's broader clinical and nonclinical care. The visual on the following page illustrates how an ECM Member experiencing homelessness who was hospitalized from an injury may experience the housing-focused Community Supports, highlighting the role of the ECM Provider and Community Supports Providers in coordinating with the Member to support their care.

**ECM Provider Perspective: Coordinating Community Supports**

In an interview with DHCS to inform this Spotlight, Illumination Foundation, an ECM Provider, shares reflections on how the ECM Lead Care Manager and Housing Supports Navigator work together to serve Members: "*The Housing Navigator would be the one to submit an application for housing deposits, but once the client is in transit to being housed and connected to tenancy, we have weekly interdisciplinary staff meetings with their [ECM Lead Care Manager]. So, if the client is connected to a Housing Navigator and an ECM Lead Care Manager, presumably they are talking on a weekly basis. The Lead Care Manager would know all the Member's activities and would intervene as necessary and continue with follow-up. The impact of ECM is to ensure fluidity and longevity and connectedness of services.*"

Illumination Foundation offers recuperative care (medical respite), day habilitation programs, housing transition navigation services, housing tenancy and sustaining services, and housing deposits.

This visual is intended to illustrate how ECM and six housing-focused Community Supports can work in concert to support a Member experiencing homelessness. Members' specific needs will vary, and the availability of specific Community Supports services varies by MCP and county.

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| **ECM Member …** | *Begins to receive ECM* | *Is referred by ECM Provider for recovery-focused, short-term housing* | *Is referred by ECM Provider to Community Supports Providers who will help them find, secure, and maintain long-term housing* |
| **ECM Provider …** | **Overall role in supporting Member**: Serves as the key point of contact and coordinator across all the Member's clinical and nonclinical support needs, including (but not limited to) the Member's need for secure, safe, stable housing.<br><br>**To support housing needs specifically**: Identifies need and eligibility for services over time, places referrals for Community Supports that provide specialized housing services, and coordinates with Community Supports Providers to ensure seamless delivery of services. | | |
| **Community Supports Provider …** | | **Recuperative Care**<br>Provides interim housing, bed, meals, and ongoing monitoring of medical or behavioral health conditions.<br><br>**Day Habilitation**<br>Provides programmatic support to assist with socialization and adaptive skills. | **Short-Term Post Hospitalization Housing**<br>Provides interim housing and ongoing supports needed to support recovery and recuperation. |

**"Housing Trio"**

**Housing Transition Navigation Services**
Conducts a housing assessment and develops an individualized housing support plan for the Member. Presents housing options to the Member and helps coordinate financial support for security deposits and modifications.

**Housing Deposits**
Provides funds to establish household and assistance in spending those funds (e.g., deposits, utilities, air conditioner).

**Housing Tenancy and Sustaining Services**
Provides support with maintaining housing once secured (e.g., identifying and addressing hoarding and other lease violations, education, dispute resolution).

# ECM in Action

## Eddie, a LGBTQ Youth Experiencing Homelessness

*The following vignette describes how a fictional Member named Eddie might be supported by ECM from a fictional nonprofit—Starbright Foundation—that provides shelter and navigation, medical respite, health care, and housing for individuals experiencing homelessness. This vignette was developed based on interviews with current ECM Providers; see page 3 for additional information.*

**Eddie is a 19-year-old LGBTQ man experiencing homelessness in Southern California and a Medi-Cal MCP Member.**

After a traumatic experience coming out to his parents, Eddie left home in San Diego two years ago, moved to Orange County, and has since used methamphetamines. In between couch surfing with distant friends on and off for temporary shelter, he often stays in a tent near a downtown area. Over time, Eddie's substance use escalated, and he began experiencing severe episodes of paranoia and depression.

Becoming more desperate, he reached out to his aunt, Ana, who lives across the country but maintained a close relationship with him in recent months after Eddie became estranged from his parents. Ana researches local services that can help Eddie and contacts Orange County Homeless Services, the county Continuum of Care (CoC) program, which connects Eddie to a local shelter where he stays for several weeks.

### Accessing ECM

Tina, a case manager from the shelter, recognizes that Eddie would benefit from more intensive services like those offered by a local nonprofit, Starbright Foundation, a designated access point for the Coordinated Entry System (CES) that provides case management, housing services, medical coordination, and behavioral health and substance use counseling. After discussing with Eddie, Tina contacts Eddie's MCP and places a referral for ECM. In recognition that Members and families may also place referrals for ECM, at this stage, Ana might also have contacted Eddie's MCP and placed the referral. Eddie's MCP reviews the referral and authorizes him for the standard 12 months of ECM because he meets the POF criteria for:

- Unaccompanied Children/ Youth Experiencing Homelessness
- Children and Youth With Serious Mental Health and/or Substance Use Disorder Needs

## Assigning an ECM Provider

At Tina's recommendation, Eddie's MCP assigns Starbright's Multi-Service Center in Orange County to serve as Eddie's ECM Provider.

## Outreach and Engagement

Starbright reviews Eddie's Member Information File containing critical information about his pressing health needs and contact information—like the phone number of Eddie's aunt, Ana. Based on Eddie's location and health profile, Starbright taps one of its outreach team members, Jake, a nonclinical care team member who was formerly homeless, to begin the process of locating and establishing contact with Eddie. Jake contacts Eddie's aunt, Ana. Ana has not heard from Eddie since the CoC program connected him to the shelter, and the number Eddie used to call her weeks ago is disconnected. Jake proceeds to contact the shelter where Eddie was last seen, but staff confirm that Eddie hasn't been seen at the shelter in two days. However, Jake, who has lived experience and knows the surrounding areas well, eventually locates Eddie at a nearby park. As part of the outreach team, Jake is adept at communicating with young men like Eddie navigating young adulthood, homelessness, and substance use.

After sitting with Eddie for an hour, Jake and Eddie decide to return to the shelter to have a snack and continue their conversation, where he conducts an initial screening and gets Eddie's perspective to help identify who on Starbright's ECM team would be the best fit to serve as his ECM Lead Care Manager. Eddie is eager to leave again, but before he does, Jake lets him know more about what services can support him through ECM and asks him if he can follow up more and connect him with a Lead Care Manager to help coordinate his care.

After an initial screening, Jake notifies Starbright's administrative team that Tim, another nonclinical staff member, would be a good fit for Eddie based on his experience working with young men around Eddie's age struggling with substance use. The administrative team assigns Eddie to Tim as his ECM Lead Care Manager. Understanding the importance of timely follow-up for cases like Eddie's, Tim contacts Tina, and together with Jake and Eddie, they make a plan to conduct a more robust assessment.

## Comprehensive Assessment and Care Management Plan

The next morning, Tina and Jake identify the food pantry next to the shelter as the most likely option for finding Eddie around lunchtime and conducting a comprehensive health risk assessment. Completed via a template provided by the MCP, the assessment specifically addresses housing needs in addition to Eddie's medical, behavioral health, and social needs. Given that Eddie has a pre-existing relationship with the staff at the shelter and has built trust with the shelter staff after staying at the shelter on and off for over a month, Tina joins Tim and Eddie for this meeting over lunch. Jake is adept at facilitating a connection between Eddie and Tim without overwhelming him with information. Tim and Eddie begin to establish common ground, learning that they are both from

the San Diego area and used to frequent many of the same music venues. In the assessment, Eddie shares that he would like immediate help to stabilize his environment, is willing to pursue behavioral health treatment to address his substance use disorder and has a clear need to be quickly connected to short-term housing. The information from the assessment informs Eddie's care management plan and outlines how Tim and the rest of the care team who will be involved—including substance use counselors, nurses, behavioral health specialists, and housing navigators—will work with Eddie to set and meet goals.

## Enhanced Coordination of Care

The care team focuses on first addressing Eddie's expressed priorities, which include stabilizing Eddie's living situation to ensure he can access secure and safe substance use treatment services, along with mental health services for depression and anxiety. Leveraging a presumptive authorization agreement that Starbright has with the MCP, Tim immediately connects Eddie with two Community Supports that Starbright offers at their flagship site in Fullerton: Recuperative Care, which will provide interim housing and meals and monitor his substance use recovery, and Day Habilitation program services, through which he will receive training on how to cook, clean, and shop for himself.

Tim works with Eddie to arrange transportation to the Fullerton site and, once onsite, introduces Eddie to Starbright's clinical team involved in ECM, including substance use counselors, behavioral health specialists, and nurses. Knowing that recuperative care cannot extend beyond 90 days, Tim initiates the process to get Eddie approved for another housing-related Community Support: Short-Term Post-Hospitalization Housing, which is also offered at the Fullerton site and through which Eddie could receive up to six months of additional interim housing. Understanding that Eddie wishes to build more relationships with the LGBTQ community in Orange County as part of his recovery, Tim connects Eddie with a health center that offers individual and group counseling and support services tailored specifically for members of the LGBTQ community struggling with substance use.

## Comprehensive Transitional Care

Several weeks later, Eddie has a relapse and a brief stay in the psychiatric unit of the hospital. Tim is alerted to Eddie's admission via a community-based resource that leverages a platform called the Emergency Department Information Exchange (EDIE) to track real-time admissions into clinical institutions. This alert prompts Tim to connect with Eddie and the clinical team at the inpatient psychiatric unit managing Eddie's care, who were unaware that Eddie was enrolled in ECM. Prior to discharge, Tim connects the hospital team with a registered nurse from Starbright Foundation who conducts discharge planning for Eddie and works with Tim and the team at the Fullerton site to facilitate a safe transition back to short-term housing. Tim works closely with the nurse to ensure the discharge plan is followed. In alignment with DHCS' Transitional Care Policies, Tim is required, as Eddie's Lead Care Manager, to coordinate all of Eddie's transitional care needs following a hospital stay.

### Health Promotion

While supporting Eddie's recovery, Tim connects Eddie with an intensive outpatient program to help with treatment adherence and works with him to help identify and build on other support networks. Prior to his methamphetamine use, Eddie enjoyed playing guitar with his friends from high school. Tim helps Eddie identify local music therapy and recovery groups to join.

### Member and Family Supports

With Eddie's consent, Tim remains connected with Ana throughout Eddie's ECM journey, as she has a long-established, trusting rapport with Eddie. Eddie, Ana, and Tim connect on ways that Ana can support Eddie's recovery and remain invested. Tim keeps her updated on the progress of Eddie's care plan and housing journey. Also with Eddie's permission, Ana begins to re-establish contact with his parents on his behalf.

### Community and Social Support Services

Since Eddie is only in short-term housing, Eddie's MCP approves the Housing Transition Navigation Services Community Support to help Eddie identify a longer-term housing solution. Victor—a Starbright Community Supports Provider specialized in housing navigation—is assigned to Eddie's team and works with him closely to develop a tailored housing plan as part of this process. As Eddie's ECM Lead Care Manager, Tim serves as the key individual who identifies the need for Community Supports, places referrals, and coordinates services, all while ensuring the fluidity and connectedness of the totality of services Eddie receives. Victor's primary role as the Community Supports lead is to help Eddie through the initial setup and technical processes as part of accessing Community Supports. For example, over the course of several months, Victor works with Eddie to complete documents and navigate the process of securing rent subsidies. Together, they look for housing options, and—after several months of searching—Victor helps Eddie complete the paperwork for his new rental unit. Throughout this process, Tim and Victor sync on the progression of Eddie's Community Supports needs on a regular basis.

Tim, who has been closely tracking Eddie's housing search, works with the MCP to authorize the Housing Deposits Community Support and secure funds to cover Eddie's security deposit and the setup fees for all his utilities. Tim also works with the MCP to authorize Eddie for Housing Tenancy and Sustaining Services, through which Victor provides continued support to make sure Eddie is able to stay in his new home, including bimonthly check-ins to determine whether there are any lease violations that may jeopardize his housing and must be addressed.

## Helen, an Older Adult Experiencing Homelessness in the Rural North

*The following vignette describes how a fictional Member named Helen might experience ECM from a fictional nonprofit—Mountain Home Services—located in a rural northern county, that provides medical services, dental care, behavioral health/counseling services, addiction services, chronic disease management, family planning, chiropractic services, and care management to individuals experiencing homelessness. This vignette was developed based on interviews with current ECM Providers; see page 3 for additional information.*

**Helen is a 61-year-old experiencing homelessness in a rural county in Northern California. She has bipolar disorder and is a Medi-Cal MCP Member.**

Recently, Helen's husband, George, passed away, and without George's income, Helen could no longer afford to remain in their apartment in Redding. After temporarily moving in with her cousin, Jen, she began experiencing severe depression and mood swings as a result of her grief, financial stress, and inconsistent use of medication needed to manage her bipolar disorder.

Helen's friend could not handle living with Helen and arranged for Helen to live in another friend's pop-up camper an hour north in rural Shasta County. Shortly after the move, Helen accidentally hurt herself and needs nonemergent care. A couple camping nearby notices her distress and drives her 30 minutes to the nearest walk-in clinic.

The staff at the clinic are able to make Helen comfortable enough to share about her situation. The clinic determines she is eligible for Specialty Mental Health Services (SMHS) and refills her medication.

### Accessing ECM

Helen begins receiving SMHS through Shasta County's Mental Health Plan. During an outpatient counseling session, a county caseworker recognizes that Helen would benefit from a more intensive set of coordinated housing and social services and help with medication management. The caseworker reaches out to a local ECM Provider, Mountain Home Services, to see if they might have the capacity to help Helen.

After a briefing from the caseworker about her needs and a discussion with Helen after an outpatient visit, Mountain Home determines that she is eligible for ECM and places a referral for ECM. Mountain Home has a strong partnership with Helen's MCP, with which they have a presumptive ECM authorization agreement for cases like Helen's. They are able to immediately begin outreach for ECM because she clearly meets the criteria for the following two POFs:

- Adult Experiencing Homelessness
- Adult with Serious Mental Health and/or Substance Use Disorder Needs

## Assigning an ECM Provider

In accordance with the presumptive authorization agreement, Helen's MCP assigns her to receive ECM from Mountain Home, a full-service health center, which offers medical, counseling, and integrative health and dental services.

## Outreach and Engagement

Mountain Home has a dedicated outreach team and attempts to reach Helen immediately upon referral over the phone, but the call does not go through. The outreach team's primary role is to go out into the community and connect with individuals in person when telephonic contact is unsuccessful and to start to build trust. Eventually, the team makes contact with Helen at an encampment near the pop-up camper where she had previously been seen. There, the team also learns about the local food pantry that Helen visits for lunch on a weekly basis and meets her at the food pantry twice over the next few weeks, where the team learns that she has misplaced the bipolar medication she is supposed to take daily. After their second visit with Helen at the food pantry, Helen expresses her openness to receiving ECM services. The outreach coordinator identifies an ECM Lead Care Manager, Janet, a community health worker who has experience working with older adults. The outreach team asks if Helen would be receptive to meeting Janet for an initial needs assessment at Mountain Home's clinic, and Helen agrees.

## Comprehensive Assessment and Care Management Plan

Mountain Home coordinates a ride for Helen to come to her comprehensive assessment appointment in person, where she meets Janet. Janet walks Helen through her onboarding paperwork. Janet asks specific questions to better understand Helen's medical and social needs to inform her care plan. Helen shares several different needs, including a lack of reliable transportation and social connection, as well as financial and food insecurity. Helen also begins to open up about her struggles with medication adherence and depression. Janet brings in a nurse, TJ, to conduct an assessment of her behavioral and physical health needs. TJ uses a tool called the PHQ-9 to screen for the severity of her depressive symptoms. Noticing Helen's increasing agitation and distress, Janet and TJ recognize an urgent need to begin evaluating her medications.

## Enhanced Coordination of Care

Janet connects Helen with a behavioral health specialist at Mountain Home who conducts a psychiatric evaluation, including assessing her bipolar medications and reconciling her medication. Janet joins Helen at the evaluation and plays an advocacy role during the visit in helping Helen voice her symptoms. With Helen's consent, Janet also joins a morning huddle with the behavioral health specialists of the clinic to discuss the best ways to remain coordinated on Helen's care.

## Community and Social Support Services

Through the comprehensive assessment, Janet identifies a significant number of social needs that need to be addressed to keep Helen healthy and safe. She begins by helping Helen put together documents and apply for CalFresh, Supplemental Security Income, and Meals on Wheels.

Housing is one of Helen's most pressing needs, so Janet turns there next. She submits a referral to the MCP for Helen to receive Recuperative Care, through which she would receive interim housing and meals. Mountain Home does not offer Recuperative Care, but Helen's MCP assigns Helen to a local shelter that does.

With Helen secure in temporary housing, Janet works with the MCP to authorize Helen for the Housing Transition Navigation Services Community Support and begin finding a long-term housing solution. Janet also closely tracks the number of days Helen has been in recuperative care, since she knows how critical it is to find long-term housing before the 90-day limit is reached. Mountain Home is assigned as the Community Supports Provider, and Janet—who is also trained to provide the specialized housing navigation required for this Community Support—begins to work with Helen on finding a home. While permanent supportive housing is in short supply in the area, Janet helps Helen apply for a HUD-assisted housing voucher with the help of the county housing authority. Through this process, a Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) screening is conducted to help determine the most appropriate housing intervention for Helen.

## Comprehensive Transitional Care

One evening, Helen leaves the recuperative care setting against the advice of clinic staff and makes her way back to the campsite, but she gets lost on her way. Becoming disoriented, she eventually makes her way into a local late-night diner. She grows increasingly distressed and diner staff call law enforcement, who determine that Helen's behavior poses a danger to herself. The officer escorts her to the regional medical center, where she is placed on a temporary psychiatric hold. Understanding that Helen is unhoused, a social worker at the psychiatric unit learns from Helen that she recently left a local clinic that was providing her with temporary shelter. Based on the description, the social worker contacts the shelter where Helen was receiving recuperative care and reaches out to the staff, who connect them with Janet. Janet works with the team at the regional medical center and the clinical team at Mountain Home to develop a discharge plan to ensure Helen's successful return to the recuperative care center.

## Member and Family Supports

To help Helen get back on track financially, Janet connects Helen to another Mountain Home employee who runs the Representative Payee Program (RPP), whereby recipients receive help with money management assistance to ensure that their food, clothing, shelter, and daily living needs are met. Janet has been trained on how to help individuals like Helen access RPP, understanding

that enrollment in such a program can help build the foundation for Helen's ability to maintain independence.

At the same time, Janet works with Helen on her relationship-building skills because she lacks a meaningful social support system. Janet makes an introduction to a connected living facility run by a health system partner that offers meals and opportunities for Helen to socialize with other women her age, in addition to a psychiatric day rehabilitation center that provides group wellness activities. Regaining her confidence, Helen soon reaches out to Jen, her cousin, and makes plans to meet for lunch.

### Health Promotion

Janet works with Helen on strategies to improve her adherence to her bipolar treatment with tools like medication reminders. In addition, Helen is connected with a behavioral health specialist to learn self-management strategies to assist in managing symptoms and improving overall wellness. Now that Helen has access to a phone with the help of the California LifeLine Program, she is learning to use the reminder functions and enjoys reporting back to Janet on her progress.

# How Providers Can Get Started in Partnership With MCPs

To diversify and expand ECM Providers and build ECM capacity for MCP Members, DHCS has created a broad set of resources to support ECM development and planning. DHCS encourages new Providers to access the documents below, starting with the ECM Policy Guide and ECM Provider Toolkit, and to request access to the ECM Technical Assistance (TA) Marketplace as they refine their capacity to provide ECM.

## 1. Determine If ECM Is Right for Your Organization

Determine whether your organization has the relevant experience, capacity, and infrastructure to become an ECM Provider. Here are some elements to consider:

- ☐ **Do you have the expertise and experience to provide ECM?**

  Providers of ECM must have the capacity to provide intensive, in-person, timely care management; person-centered care coordination; and services to the specific POFs they would serve, in a culturally and linguistically competent manner.

  - Consult the **ECM Policy Guide** to learn the experience requirements for ECM Providers.

- ☐ **Do you have the necessary infrastructure to provide ECM—or could you create it?**

  Providers of ECM must be able to either submit claims to MCPs or use a DHCS invoicing template to bill MCPs, and they must have a documentation system for care management. They also must bidirectionally share data with their MCP partners about Members.

**DHCS Resources for Prospective and Contracted ECM Providers**

DHCS is committed to supporting prospective and contracted ECM Providers through a broad range of resources. Please click the links below to learn more.

The **Providing Access and Transforming Health (PATH)** Initiative supports providers interested in building capacity and infrastructure and obtaining technical assistance to build and scale ECM and Community Supports. It includes the following resources:

- ☐ **Technical Assistance (TA) Marketplace** offers providers, CBOs, counties, tribal partners, and others access to a range of off-the-shelf and hands-on technical assistance (TA) resources needed to implement ECM. Providers can view potential TA offerings through the "Shop" tab on the Marketplace. DHCS encourages organizations hoping to learn more about TA offerings to create an account and request access from DHCS by sending an email to the TA Marketplace Team at ta-marketplace@ca-path.com. For more details visit the *'Am I eligible'* section of the TA Marketplace.

- Review the DHCS **data guidance documents**.
- Watch **DHCS webinars** that provide an overview of the **data sharing and billing requirements** and showcase **how ECM Providers have implemented those requirements**.
- Apply for **Capacity and Infrastructure Transition, Expansion, and Development (CITED) grants** to build the data and billing infrastructure needed for ECM.

☐ **Does ECM make financial sense for your organization?**

Organizations are encouraged to consider the financial impact of participating in ECM.

- The **TA Marketplace** provides both off-the-shelf and hands-on resources to help Providers implement ECM.
- The **ECM Provider Toolkit** offers guidance on how to talk with an MCP about ECM Provider payment rates, which are not set by DHCS.

Providers are encouraged to explore funding sources, such as **IPP** and **CITED grants**, which might enhance capacity for launch.

☐ **Capacity and Infrastructure Transition, Expansion, and Development (CITED) grants** provide funding to ECM and Community Supports Providers to build capacity in areas such as limited staffing support, care management or billing capabilities, or other technology infrastructure such as data exchange with contracted MCPs or providers in network.

☐ Regional **Collaborative Planning and Implementation (CPI)** groups that support local information sharing and collaborative implementation among MCPs, providers, counties, and other local stakeholders.

☐ The **Incentive Payment Program (IPP)** supports the implementation and expansion of ECM by providing incentives to MCPs. Ask your local MCPs if IPP funds are available to help build capacity and infrastructure for ECM.

DHCS-hosted ECM and Community Supports **webinar series** also provides policy guidance, spotlights provider models for ECM, and lifts up other critical technical assistance to promote ECM program success.

## 2. Determine Which POFs To Serve

For organizations that are a good fit for ECM, there are several steps to consider in determining which POF to serve, including:

☐ **Identify where you have specific expertise and experience within the communities your organization serves.**

Members in each POF have distinct needs, and the providers who serve them must have expertise and experience addressing those needs to ensure trust and engagement with these populations. Prospective providers are encouraged to review this Spotlight and the **ECM Policy Guide** and compare these elements to determine which POFs they are equipped to serve.

Hill Country Community Clinic operates in rural Shasta County and opted to contract for the Individuals and Families Experiencing Homelessness POF because of extensive history of working with Members experiencing homelessness in their community. In an interview with DHCS, the team shared that, to best care for Members, they worked with their MCP to create more reliable transportation services, and that they regularly navigate poor cell and internet service in their care with Members. "Understand what's in your community; that's how you provide the best services," they reflected.

San Joaquin County Clinics (San Joaquin Health Centers) had experience serving individuals experiencing homelessness. While considering ECM, the team reflected that "In addition to medical care, we added social services and expanded to provide street medicine and figured that what we are doing is ECM, so let's have our own ECM team that addresses needs for the most vulnerable, most-resource-challenged individuals."

- ☐ **Talk with your local MCP(s) to understand potential referral volumes and what they are looking for in their network.**

  While reflecting on their journey to launching ECM, Illumination Foundation shared, "We were already doing ECM on our own in our own ways, but it wasn't a benefit. We had different grant programs with university health centers and other programs. One of the big things we did is get out and talk to Plans ahead of time to understand what they were looking for. We went to meetings and focus groups with [the MCP] and had a voice at the table."

- ☐ **If you have capacity constraints, determine whether it may be more feasible for your organization to launch with one or a small subset of POFs.**

## 3. Become an ECM Provider

For organizations that decide to become an ECM Provider, there are several steps to implementation.

- ☐ **Connect with local partners working on ECM implementation.**
  - Joining your regional **CPI groups** will connect you with local partners—including MCPs, county departments, and local TA providers—who can facilitate your entry into ECM.
- ☐ **Reach out to your local MCP(s) to discuss contracting for ECM.**
  - The **ECM Provider Toolkit** offers guidance on how to approach contracting with MCPs.
  - The **TA Marketplace** provides both off-the-shelf and hands-on resources to help providers with becoming Medi-Cal providers and contracting for ECM.
- ☐ **Determine the ECM model of care for each POF you'll serve.**

  Providers for the Individuals and Families Experiencing Homelessness POF are encouraged to work closely with other providers in their county to design their model and establish roles, data sharing, and referral systems with other care management and social service programs. Because of the limited resources in their more rural environment, Hill Country Health & Wellness has built strong partnerships to deliver Community Supports to their ECM Members. They noted,

"Community Health is our sister organization, and they are bigger than us. They are offering more Community Supports than we offer and so our collaboration has been invaluable. Often, we are sharing patients between us to enhance the Community Supports we aren't offering."

- **DHCS webinars spotlight various ECM models of care across the state and provide guidance on how housing supports can be integrated into ECM.**
- The **TA Marketplace** has resources that help providers build models of care for specific POFs.

☐ **Build the capacity and infrastructure—including data sharing and billing workflows—needed to launch.**

While assessing their infrastructure, San Joaquin County Clinics (San Joaquin Health Centers) found that they "had to staff with new people. We were excited that [MCPs] were willing to work with us with their IPP funding to support the initial staffing, and then we could expand even more through CITED. In addition, we were able to expand our street medicine program with the help of Housing and Homelessness Inventive Program (HHIP) funds, which enabled us to build in an ECM component to our service delivery."

- The **TA Marketplace** provides resources to support staff training, billing/coding, data sharing, and more.
- Applying for a **CITED grant** could help you build capacity and infrastructure to provide ECM.
- Your MCP may offer **IPP** funding opportunities to ECM Providers.

**Your patients may be ready for ECM today.**

All providers—prospective, contracted, or those serving individuals facing housing insecurity who need ECM—are strongly encouraged to reach out to their local MCP to learn how to refer eligible Members to the ECM benefit.

# Key ECM Resources

- **ECM and Community Supports Policy Materials**
  - ECM Policy Guide
  - Community Supports Policy Guide
  - ECM and Community Supports Policy Cheat Sheet
  - Street Medicine APL
- **ECM Technical Assistance**
  - ECM Provider Toolkits
  - ECM Member Toolkit
  - ECM Outreach Toolkit
  - ECM & Community Supports Webinar Series
  - TA Marketplace
  - Collaborative Planning and Implementation (CPI)
- **ECM Billing and Data Guidance**
  - ECM Member-Level Information Sharing Guidance
  - ECM & Community Supports Coding Options
  - Billing & Invoicing Guidance
  - National Provider Identifier (NPI) Application Guidance
  - Social Determinants of Health (SDOH) Coding Guidance
  - CalAIM Data Sharing Authorization Guidance
  - Quarterly Implementation Monitoring Report

- **ECM Model of Care Template**
  - ECM and Community Supports Model of Care Legacy Template
  - ECM Model of Care Template Addendum I for Long-Term Care POFs
  - ECM Model of Care Template Addendum II for Children & Youth Populations of Focus and Birth Equity POFs
- **Funding Opportunities**
  - Funding Opportunities Cheat Sheet
  - Incentive Payment Program (IPP)
  - Providing Access and Transforming Health (PATH)
  - PATH Capacity and Infrastructure Transition, Expansion, and Development (CITED) grants
  - Housing and Homelessness Inventive Program (HHIP)
  - Behavioral Health Continuum Infrastructure Program (BHCIP) and the Behavioral Health Bridge Housing Program (BHBH)