Enhanced Care Management Target Population Descriptions

ECM Target Populations – Core Concepts

Enhanced Care Management (ECM) is designed for populations who have the highest levels of complex health care needs as well as social factors influencing their health. Candidates for ECM have an opportunity for improved health outcomes if they receive high-touch, in-person care management and are connected to a multidisciplinary team that manages all physical health, behavioral health, oral health and non-clinical needs as well as any needed long-term services and supports.

ECM will be implemented by January 1, 2021, for Medi-Cal managed care plans (MCPs) that have Whole Person Care/Health Homes Program (WPC/HHP) in their corresponding county. Plans without WPC/HHP will implement by July 1, 2021.

MCPs may propose additional populations to receive ECM, but at a minimum must provide ECM to the below list of mandatory target populations:[1]

- Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing chronic homelessness, homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization, eligible for long-term care.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD)with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

[1] Individuals transitioning from incarceration must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2021.

Settings

For all populations, the role of enhanced care management (ECM) is, through primarily face-to-face visits, coordinating all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting.

Services should be offered where the members live, seek care or prefer to access services, essentially meeting the member (and, for children and youth, their family, caretaker or circle of support) where they are within the community. This may include different settings based on the target population. For example, for individuals experiencing homelessness, ECM care managers may conduct street outreach or coordinate with shelters, homeless services providers, recuperative care providers, community partners (e.g., coordinated entry) and other services providers to connect with target individuals. For individuals with Serious Mental Illness, initial contact may be in settings such as psychiatric inpatient units, IMDs or residential settings. Children and youth may receive services in a variety of community settings, including schools, where appropriate. These are examples of how ECM settings will reflect individualized needs of the target populations.

Risk Stratification

ECM is intended for members at the highest risk level who need long-term coordination for multiple chronic conditions, social determinants of health issues, and utilization of multiple service types and delivery systems. As part of their plan submitted to DHCS, MCPs will detail the algorithms and processes they will use to identify those individuals who have the highest levels of complex health care needs and social factors influencing their health, and who present the best opportunity for improved health outcomes through ECM services.

Algorithms and data sources may vary by population. For example, some individuals may be identified using claims data and/or other health assessment information to identify multiple complex conditions or a history of utilization of high-cost services. However, for a variety of reasons, claims data may be insufficient to identify other good candidates for ECM. For some members, access to care issues and multiple social factors may limit the utility of claims data in identifying health risks.

For many populations, referrals and partnerships will be a critical method to identify ECM candidates. Entities such as health care providers, community-based organizations, social services agencies, tribal partners and local governments are important partners in identifying individuals who are at high risk of significant health care utilization and who would benefit from ECM.

Target Populations

A description of each population is outlined below. In general, for all target populations, individuals who, after multiple outreach attempts, opt not to participate in ECM services or whose assessment indicates they would not benefit from the services, would not be good candidates for ECM. The number of outreach attempts and approaches will vary based on the populations and individualized needs.

Children and Youth

Target Population:

Children or youth with complex physical, behavioral, developmental and/or oral health needs (e.g., California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis). For example:

- Children/Youth with complex health needs who are often medically fragile or have chronic conditions coupled with other behavioral, developmental and/or oral health needs. This may include children with a history of trauma and children who are engaged or have history with the child welfare system. These children often access care across multiple service delivery systems and require significant coordination to ensure their needs are being met.
- Children/Youth with significant functional limitations and multiple social factors influencing their health outcomes.
- Children/Youth who are:
    - at risk for medical compromise due to one of the following conditions/circumstances:
        (i) Failure to take advantage of necessary health care services, or
        (ii) Non-compliance with their prescribed medical regime, or
        (iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or
        (iv) An inability to understand medical directions because of comprehension barriers, or
        (v) A lack of community support system to assist in appropriate follow-up care at home, or
        (vi) Substance abuse, or
        (vii) A victim of abuse, neglect, or violence, or
        (viii) Enrolled in CCS, or
        (ix) In Foster Care, or
        (x) Have Clinical High-Risk Syndrome or the first episode of psychosis, or,
        (xi) Have a high ACE score or history of trauma, and
    - in need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

Would not include:

- Children/Youth who may benefit from less intensive interventions such as standard case management or other existing programs.
- Children/Youth that are stable and part of other care management/care coordination efforts.
- Children/Youth in foster care who are not enrolled in managed care.

ECM Services:

ECM can be used to assess gaps in both health care and social support needs and develop a care plan that addresses the whole health needs of the child. While MCPs may use claims data to identify good candidates, referrals will be an important mechanism to identify children and youth who would benefit from ECM. Health care providers, the child welfare system, schools, community-based organizations and social services agencies are examples of other important potential referral partners for children/youth. MCPs should establish a process for providers to refer for ECM based on a needs assessment and/or Adverse Childhood Experience (ACE) score which includes consideration of the community supports available for the children and their families and caretakers, as well as social factors impacting their health.

Services should be offered where the members live, seek care or where the family, caretaker, or circle of support prefers to access services, essentially meeting the member and family/caretaker/support where they are within the community. Activities may include coordination in school-based settings if permitted by the schools.

For this population, ECM services include (but are not limited to):

- helping families, caretakers, and circles of support access resources such as education about the child's conditions.
- identifying and coordinating services that will help families, caretakers, and circles of support with the health needs of their children, which may include referrals for services those individuals need to enable them to support their children's health (e.g., referral to behavioral health or substance use disorder services for a parent, or housing-related services for households experiencing homelessness, either of which could be critical to ensure the parent can support the health needs of the child).
- coordination of services across various providers including facilitating cross-provider data sharing and member advocacy to ensure the child's whole person needs are met and needed services are accessible.
- assistance with accessing respite care as needed.
- referral to community and social services to address food insecurity and other social factors that may impact the child's health.

Homeless

Target Population:

Individuals experiencing homelessness or chronic homelessness, or who are at risk of experiencing homelessness, for whom coordination of services would likely result in improved health outcomes and decreased utilization of high-cost services. For example:

- Individuals at the highest levels of complex health care needs as a result of medical, psychiatric or substance use disorder-related conditions, who may also experience access to care issues and multiple social factors influencing their health outcomes.
- Individuals with repeated incidents of avoidable emergency department use, psychiatric emergency services or hospitalizations.

ECM Services:

Individuals experiencing or at risk of homelessness are among the highest-need individuals in Medi-Cal. They often lack access to necessities such as food and shelter that are critical to attaining health. Individuals often have high medical needs that are difficult to manage due to the social factors that influence the individual's health. This often results in high utilization of costly services such as emergency departments and inpatient settings.

Engagement for this population may include street outreach or coordinating with shelters, homeless services providers, recuperative care providers, community partners (e.g., coordinated entry) and other service providers to connect with target individuals.[2] As individuals are connected to resources, the ECM care coordinator will meet the member at their preferred location in the community or at provider locations.

ECM can be used to link individuals with a variety of services to meet their complex needs. This includes (but is not limited to):

- utilizing ILOS housing services to identify housing and prepare individuals for maintaining stable housing.
- coordinating short-term post-hospitalization housing and recuperative care services as appropriate.
- regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to ensure progress towards regaining health and function continues.
- coordinating and collaborating with various health and social services providers including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, identifying barriers to adherence and accompanying members to appointments as needed.

[2] These same entities will be important referral partners to identify potential ECM candidates.

High Utilizers

Target Population:

High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits that could be avoided with appropriate outpatient care or improved treatment adherence. For example:

- Individuals that have impactable conditions or opportunities for interventions that have the potential to decrease inappropriate utilization or can be performed at an alternative location.
- Individuals with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement.
  Individuals with multiple chronic or poorly managed conditions requiring intensive coordination, beyond telephonic intervention.

Would not include:

- Individuals currently receiving End of Life Care.
- Individuals who have a chronic disease and have unavoidable or expected admissions due to the condition.
- Individuals who refuse to engage in any telephonic or face to face case management.
- Individuals who are benefiting from complex case management or less intensive interventions, such as disease management or other existing programs.

ECM Services:

Enhanced care management will provide multiple opportunities to engage individuals by stratifying risk and need, developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Managed Care Plans will identify the algorithms they will use identify individuals who are high utilizers of medical services.

For this population ECM may include, but is not limited to:

- Frequent follow up visits, education and care coordination activities to ensure the member's and families' needs are being met where they are.
- Connection to appropriate community-based organizations, programs and resources that will meet the member's needs.
- Reinforcing the importance of adherence to the member's treatment plan, including education and tools on how to increase adherence.
- Medication review, reconciliation, assistance obtaining medications, and reinforcement with medication adherence.

Risk for Institutionalization –Long Term Care

Target Population:

Individuals at risk for institutionalization, eligible for long-term care services. Medi-Cal beneficiaries who, in the absence of services and supports would otherwise require care for 90 consecutive days or greater in an inpatient nursing facility (NF) would qualify. Individuals must meet Nursing Facility level of care criteria AND be able continue to live safely in the community with wrap around supports.

Examples include, but are not limited to:

- Seniors and persons with disabilities who reside in the community, but are at risk of being institutionalized.
- Individuals in need of increasing assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- Possibly, individuals with changes to family or caregiver status.
- Possibly, individuals with medical or surgical setbacks resulting in a decrease in functional, cognitive, or psychological status.
- Possibly, individuals showing early signs of dementia with little or no natural supports.
- Possibly, individuals who are noncompliant with their prescribed medical regime.
- Possibly, individuals who fail to take advantage of necessary health care services.
- Possibly, individuals who lack a community support system to assist in appropriate follow-up care at home.

***Would not include*:**

- Individuals who have complex needs but can be managed through a less intensive MCP complex case management program.
- Individuals with complex needs but who are not at risk of institutionalization.
- Individuals whose assessment indicates they would not benefit from the services.

ECM Services:

Services include preventing skilled nursing admissions for individuals with an imminent need for nursing facility placement. For this population ECM may include, but is not limited to:

- Face-to-Face assessment to determine natural supports available, risk factors, social determinants of health, and other factors to determine safety and feasibility of continued stay in the community.
- Connection to needed supportive services, including “in-lieu of services” such as meals, environmental accessibility adaptations (home modifications), and personal care.
- Frequent follow up visits (including regular home visits), education and care coordination activities to ensure the member and families’ needs are being met where they are.
- Connection to appropriate community-based organizations, programs and resources that will meet the member’s needs.

- Placement of wrap-around services to maintain the member in their current, community setting.

Nursing Facility Transition to Community

Target Population:

Individuals who are currently residing in a Nursing Facility (NF) but have the desire to return to the community to live. Transition from the NF to community is strictly voluntary. Individuals have the option to transition to the community, when that can be done in a cost-effective manner. Individuals must be able to transition safely to the community.

Individuals must have an identified support network system available to them. The support network system may consist of care providers, community-based organizations, family members, primary care physicians, home health agencies, members of the individual's medical team, licensed foster parent, or any other individual who is part of the individual's circle of support. The individual's circle of support may consist of family members, legal representative/legally responsible adult, and any other person named by the individual.

Would not include:

- Individuals not interested in moving out of the institution.
- Individuals who are not medically appropriate to live in the community (high acuity).
- Individuals whose total projected costs outside the institution are greater than the cost of institutionalization.
- Individuals who do not have the supports to reside safely in the community.
- Individuals who would be at a high risk of re-institutionalization.

ECM Services:

The care team will help individuals move safely between different care settings, such as entering or leaving a hospital or nursing facility, and returning to their own home. Services include facilitating nursing facility transition back into a homelike and community setting with the necessary wrap-around services, community supports, and natural supports when available.

Care manager visits will occur face to face at the facility throughout the transition process. An in-person home visit will occur prior to the individual's move to ensure the health and safety of the new residence. Post-transition individuals will then be visited in person at a determined schedule at their home or community placement.

SMI, SED and SUD Individuals at Risk for Institutionalization

Target Population:

Individuals who are at risk for institutionalization who have co-occurring chronic health conditions and:

- Serious Mental Illness (SMI, adults);
- Serious Emotional Disturbance (SED, children); or
- Substance Use Disorder (SUD).

Potential candidates include:

- Individuals who have the highest levels of complex health care needs as a result of psychiatric or substance use disorder-related conditions with co-occurring chronic health conditions, who may also experience access to care issues and have multiple social factors influencing their health outcomes and as a result of these factors are at risk for institutionalization.
- Individuals with repeated incidents of emergency department use, psychiatric emergency services, psychiatric inpatient hospitalizations, or short-term skilled nursing facility stays who could be served in community-based settings with supports.

ECM Services:

For individuals with SMI or SUD, or children with SED, ECM will coordinate and collaborate across the systems through which members access care. For these particular individuals, MCPs may contract with county behavioral health systems to perform ECM activities, but this must include coordination of all available services including medical care and long-term services and supports. Initial engagement may be in treatment settings such as psychiatric inpatient units, IMDs or residential settings. For children with SED, activities may include coordination in school-based settings if permitted by the schools.

ECM can be used to link individuals with a variety of services to meet their complex needs. This includes (but is not limited to):

- Provide post-hospitalization or post-residential treatment care planning to connect individuals with the supports they need to avoid rehospitalization including identifying appropriate community placements.
- Regular contact with members to ensure there are not gaps in the activities designed to avoid institutionalization and swiftly addressing those gaps to ensure the individual can remain in the community placement.
- Utilizing ILOS housing services to identify housing and prepare individuals for maintaining stable housing if needed and connecting to other social services to address social factors that influence the individual's health outcomes.
- Connecting with supports to assist members with recovery including peer supports as well as social services.
- Connecting families, caretakers and circles of support to resources regarding the member's conditions to assist them with providing support for the member's health.
- Coordinating and collaborating with various health and social services providers including sharing data (as appropriate).

- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, identifying barriers to adherence and accompanying members to appointments as needed.

Individuals Transitioning from Incarceration[3]

Target Population:

Individuals transitioning from incarceration or justice-involved juveniles who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

In addition, this population includes individuals who are involved in pre or post booking diversion behavioral health and criminogenic treatment programs and therefore are at risk for incarceration and who could, through care coordination and service placement, have a treatment plan designed to avoid incarceration through the use of community-based care and services.

ECM Services:

Some individuals transitioning from incarceration have significant health care needs that require ongoing treatment in the community post-release. Individuals often also experience significant social factors that impact their ability to successfully manage their health conditions, such as lack of safe and stable housing and unemployment. Upon transition back to the community, individuals are required to coordinate a significant number of basic life needs and as a result often experience care disruptions, which result in deterioration of their conditions and increased use of emergency departments and inpatient settings (as well as returning to incarceration). For some individuals, unmet health care needs can increase their likelihood of justice-system re-involvement; diversion programs are designed to address these needs and avoid incarceration.

For justice-involved individuals, ECM requires coordination with corrections departments, including probation, courts and the local county jail system to both to identify/refer members and also to ensure connections to care once individuals are released from incarceration. All individuals receiving ongoing behavioral health treatment (including treatment for substance use disorder) should be referred to county behavioral health programs upon release. Therefore, the ECM care managers will need to coordinate and collaborate with county behavioral health departments for those individuals.

The initial ECM engagement locations will depend on the collaborations that MCPs are able to build with local justice partners. At first, ECM staff will begin work with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting), or in criminogenic treatment programs.[4] Post-transition, ECM care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based engagement such as a member's home or regular provider office, this may also include parole or probation offices if the MCP builds partnerships that allow for engagement in those offices.

[3] This target population must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2021.

[4] DHCS is looking to leverage H.R. 6 SUPPORT Act to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release.

ECM can be used to link individuals transitioning from incarceration (or in diversion programs) with a variety of services to meet their complex needs. This includes (but is not limited to):

- Coordination of an initial risk assessment to evaluate medical, psychiatric and social needs for which the individual requires assistance.
- Direct connections with community providers to ensure continuity of care for their conditions (especially for medications) and to address any health care needs not treated while they were incarcerated. This will also include peer mentorship to help provide positive social support.
- Utilizing ILOS housing services to identify housing and prepare individuals for maintaining stable housing.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social services needs, and swiftly addressing those gaps to prevent reincarceration and ensure progress towards regaining health and function continues.
- Coordinating and collaborating with various health and social services providers as well as parole/probation including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, identifying barriers to adherence and accompanying members to appointments as needed.
- Helping members set and monitor health goals to maintain or improve their health.
- Education of families, caretakers and circles of support regarding the member's health care needs and available supports.
- Navigating members to other reentry support providers to address unmet needs.
- Facilitating benefits reinstatement.[5]

[5] To complement these efforts, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2022. The ECM care manager would also help facilitate accessing other benefits as needed by the member.