

Enhanced Care Management Target Population Descriptions

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)

Target Population description:

- 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. 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.

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 in COHS counties or not otherwise enrolled in managed care.
- Children/Youth who, after multiple outreach attempts, are not cooperative and do not wish to participate in ECM services or whose assessment indicates they would not benefit from the services.
- Children/Youth whose behavior or environment is unsafe for care coordination staff.

Settings:

The role of enhanced care management (ECM) is, through 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. The Care Manager will build and facilitate an interdisciplinary team as well as establish a comprehensive care plan, which will then be shared across providers.

Services should be offered where the members live, seek care or where the family prefers to access services, essentially meeting the member and family where they are within the community.

Risk Stratification:

As part of their plan submitted to DHCS, MCPs will identify the algorithms and processes they will use to identify those children/youth who have the highest levels of complex health care needs and who present the best opportunity for improved health outcomes through ECM services. Individuals could be identified using claims data and/or other health assessment information to identify children/youth with multiple conditions. In addition, MCPs could establish a process for providers who serve these children to refer them 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 social factors impacting their health.

ECM Services:

Enhanced care management will provide multiple opportunities to engage beneficiaries by stratifying risk and need, developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for non-direct care needs.

ECM could 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. This includes (but is not limited to):

- helping families access resources such as education about the child's conditions;
- 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.

The MCPs will contract with providers to perform the ECM functions, but ultimately retain responsibility for ECM activities.

CASE EXAMPLE

Joseph Smith is a 10-year old boy in foster care. His mother had been in recovery for several years but experienced a relapse and is currently incarcerated for a drug-related offense. He was living in Fresno but was recently placed in his grandmother's house in Orange County (which is a COHS county). Joseph has trauma-related behavioral health needs and was receiving behavioral health treatment in Fresno. He was substance-exposed at birth and has chronic gastro-intestinal conditions related to that exposure. He has a medically tailored diet that does not require prescribed medical foods but does contain some limitations on the types of food he can eat.

He was connected to behavioral health resources in Orange County, but during one of the first face-to-face visits with him, his ECM care manager used trauma-informed interviewing which led her to believe he may need additional services beyond those included in his current care plan. She facilitated a meeting of Joseph's Child and Family Team, which led to a reassessment of his needs. This identified a number of behavioral health needs that were not included in his existing case plan, so this plan was updated, and the care manager shared the updated plan with all providers in his team.

His grandmother asked for education about how to best support her grandson's health (including his mental health), so the care manager shared resources to help her. She also connected his grandmother with resources to address food insecurity so she can provide her grandson with the right types of food he needs to stay healthy. In addition, because the grandmother reported feeling overwhelmed by her new caregiving responsibilities, the care manager set up regular respite services to help provide her some relief. She also identified and provided her with behavioral health resources in the community that she could access if her grandson experienced a crisis associated with his behavioral health condition.

Because of his change in residence, Joseph needed a new gastroenterologist. Joseph experiences stress at the gastroenterologist and this sometimes manifests with aggressive behaviors if he is asked to wait in an unfamiliar lobby with other patients for too long. As a result, at his last two appointments, the office staff at the new doctor's office have asked his grandmother to take him home without seeing the doctor. When his grandmother explained this to the ECM care manager, the ECM care manager coordinated with Joseph's behavioral health provider to identify strategies that would help calm him in advance of his appointment. The ECM care manager also reached out to the gastroenterologist to discuss how Joseph's conditions were impacting his ability to access needed care. The physician's office agreed to minimize his wait time in the lobby and have him wait in an exam room where he could read and use his device in a quiet environment as recommended by his behavioral health provider. The ECM care manager met Joseph and his grandmother at the gastroenterologist for the next appointment to ensure he was able to successfully access his needed care.

Homeless

Target Population:

Individuals experiencing homelessness, chronic homelessness or at risk of becoming homeless.

Target Population description (what this person looks like):

- Individuals who are homeless or at imminent risk of becoming homeless without intervention but for whom coordination of services would likely result in improved health outcomes and decreased utilization of high-cost services.
- 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 the best opportunity for improved health outcomes.
- Individuals with repeated incidents of avoidable emergency department use, psychiatric emergency services or hospitalizations.

Would not include:

- Individuals who, after multiple outreach attempts, are not cooperative and do not wish to participate in ECM services or whose assessment indicates they would not benefit from the services.
- Individuals whose behavior or environment is unsafe for care coordination staff.

Settings:

The role of enhanced care management is, through 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. The Care Manager will build and facilitate an interdisciplinary team as well as establish a comprehensive shared care plan, which is then shared across providers.

ECM care managers will engage individuals experiencing homelessness or at risk of becoming homeless in the most easily accessible setting for the member. Initially, this may include street outreach or coordinating with shelters to connect with target individuals. 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.

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 (similar in intensity to the current Whole Person Care and Health Home Programs).

MCPs will identify the algorithms they will use to identify those individuals who have the highest levels of complex health care needs and who present the best opportunity for improved health outcomes through ECM services. MCPs will identify those who are 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. Members identified will be those who require multidisciplinary care to regain health and function and who present the best opportunity for improved health outcomes through ECM services. This may include individuals who have multiple medical or behavioral health conditions, or who are high utilizers of emergency department or psychiatric emergency services. While this could include utilization of claims data, it will likely include using referrals from providers and community partners (e.g., coordinated entry) who encounter the individual as they access health or social services.

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 results in high utilization of costly services such as emergency departments and inpatient settings.

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. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for non-direct care needs.

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 services 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.

The MCPs will contract with providers to perform the ECM functions but ultimately retain responsibility for ECM activities.

High Utilizer

Target Population:

High utilizers with frequent hospital or emergency room visits/admissions

Target Population description:

- Individuals with the best opportunity for improved health outcomes.
- 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 may have multiple chronic or poorly managed conditions requiring intensive coordination.

Would not include:

- Individuals 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.
- Individuals who, after multiple outreach attempts, are not cooperative and do not wish to participate in ECM services or whose assessment indicates they would not benefit from the services.
- Individuals whose behavior or environment is unsafe for care coordination staff.

Settings:

The role of enhanced care management is, through 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. Care management through a care manager, an interdisciplinary care team, and an individualized care plan that ensures access to all needed services across the spectrum of care and support.

ECM care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based settings such as a member's home or regular provider, for high utilizing members it may also initially include hospital and emergency department settings.

Risk Stratification:

As part of their plan submitted to DHCS, MCPs will identify the algorithms they will use to identify individuals who are high utilizers of medical services. 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.

Appropriate individuals may be identified from those individuals who represent the top 3-5% in expenditures or utilization and referrals from providers or internal case management for individuals who need more intensive, face-to-face coordination.

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. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for non-direct care needs.

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Risk for Institutionalization

Target Population:

Individuals at risk for institutionalization, eligible for long-term care

Target Population description:

- 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.

Would not include:

- Individuals who have complex needs but can be managed in a less intensive MCP complex case management program.
- Individuals with complex needs but who are not at risk of institutionalization.
- Individuals who, after multiple outreach attempts, are not cooperative and do not wish to participate in ECM services or whose assessment indicates they would not benefit from the services.
- Individuals whose behavior or environment is unsafe for care coordination staff.

Settings:

The role of enhanced care management is, through 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. The care manager builds and facilitates an interdisciplinary team as well as establishes a comprehensive, shared care plan, which is then shared across providers.

ECM care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based settings such as a member's home or regular provider, it may also initially include hospital settings for members recently hospitalized and ready for discharge to community settings.

Risk Stratification:

As part of their plan submitted to DHCS, MCPs will identify the algorithms they will use to identify individuals who are at risk for institutionalization or eligible for long term care. These individuals may be identified by an increasing ER and inpatient utilization, claims related to frequent falls, referrals through a provider agency, PCP, or family members.

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. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as, connections to needed community supports for non-direct care needs.

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Nursing Facility Transition to Community

Target Population:

Nursing facility (NF) residents who want to transition to the community

Target Population description:

- Individuals who are currently residing in a NF but have the desire to return to the community to live.
- Individuals able to transition safely to the community.
- Positive response to MDS Section Q. (This form is completed by NFs and assess a resident's desire to transition to the community).

Would not include:

- Individuals not interested in moving out of the institution.
- Individuals who are medically inappropriate to live in the community (high acuity).
- Individuals who, after multiple outreach attempts, are not cooperative and do not wish to participate in ECM services or whose assessment indicates they would not benefit from the services.
- Individuals whose behavior or environment is unsafe for care coordination staff.

Settings:

The role of enhanced care management is, through 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. The care team will help people move safely and easily between different care settings, such as entering or leaving a hospital or nursing facility, and returning to their own home. 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 Individuals 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.

Sample schedule: 1st visit 24-48 hours post transition, 2nd visit 2 weeks post transition, 3rd visit- 1 month post transition, then visits quarterly for one year (visit schedule is individualized dependent on participant need and situation).

Risk Stratification:

As part of their plan submitted to DHCS, MCPs will identify the algorithms they will use identify members who desire to be transitioned out of the nursing facility and into the community. Individuals may be identified by their NF address and data from Section Q on the MDS.

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. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-

effective, quality direct care services for the individual, as well as connections to needed community supports for non-direct care needs. Individuals who have transitioned from an institution to the community are at high risk for re-institutionalization and require close monitoring to ensure safety and level of service in the community.

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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).

Target Population description (what this person looks like):

- 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 the best opportunity for improved health outcomes.
- Individuals with repeated incidents of emergency department use, psychiatric emergency services or psychiatric inpatient hospitalizations who could be served in community-based settings with supports.

Would not include:

- Individuals who, after multiple outreach attempts, are not cooperative and do not wish to participate in ECM services or whose assessment indicates they would not benefit from the services.
- Individuals whose behavior or environment is unsafe for care coordination staff.

Settings:

The role of enhanced care management is, through 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. The Care Coordinator will build and facilitate an interdisciplinary team as well as establish a comprehensive shared care plan, which is then shared across providers.

ECM care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based settings such as a member's home or regular provider, it may also initially include psychiatric inpatient units, IMDs or residential settings.

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 (may be similar in intensity to the current Whole Person Care and Health Home Programs).

MCPs will identify the algorithms they will use identify those individuals who have the highest levels of complex health care needs and who present the best opportunity for improved health outcomes through ECM services. MCPs will identify those who are at risk of institutionalization as a result of their chronic health conditions coupled with SMI,

SED or SUD, but who could be served in the community with sufficient support. This could include using claims data to identify individuals with frequent use of high-cost services such as hospitalizations, emergency department use, residential SUD treatment admissions as well as referrals from psychiatric or SUD providers who identify individuals who could benefit from ECM (accompanied with supporting claims data that documents risk).

ECM Services:

For individuals with SMI or SUD, or children with SED, enhanced care management 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 all ECM activities, but this must include coordination of all available services including medical care.

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. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for non-direct care needs.

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.
- 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.
- connecting families to resources regarding their child (or family member's) conditions to assist them with providing support for their family member's health.

The MCPs will contract with providers to perform the ECM functions but ultimately retain responsibility for ECM activities.

Individuals Transitioning from Incarceration

Target Population:

Individuals transitioning from incarceration

Target Population description (what this person looks like):

- Individuals involved with the justice system who will be transitioning from incarceration in either a jail or prison setting who have significant complex physical or behavioral health needs and may have other social factors influencing their health.
- Individuals who are involved in pre or post booking diversion behavioral health and criminogenic treatment programs and, thus, are at risk for incarceration and could, through care coordination and service placement, have a treatment plan designed to avoid incarceration through the use of community-based care and services.

Would not include:

- Individuals who, after multiple outreach attempts, are not cooperative and do not wish to participate in ECM services or whose assessment indicates they would not benefit from the services.
- Individuals whose behavior or environment is unsafe for care coordination staff.

Settings:

The role of enhanced care management is, through 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. The Care Manager will build and facilitate an interdisciplinary team as well as establish a comprehensive shared care plan, which is then shared across providers.

For justice-involved individuals, ECM requires coordination with corrections departments, including probation, courts and the local county jail system to both to identify members but also to ensure connections to care once individuals are released from incarceration. The initial ECM settings 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).¹ Post-transition, ECM care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based settings such as a member's home or regular provider, this may also include parole or probation offices if the MCP builds partnerships that allow for this setting.

In addition to the settings above, for diversion efforts, this may include meeting the member at their criminogenic treatment programs.

¹ 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.

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 (may be similar in intensity to the current Whole Person Care and Health Home Programs).

MCPs will identify the algorithms they will use to identify those individuals who have the highest levels of complex health care needs and are at risk of their health conditions deteriorating upon reentry into the community. This may include individuals with high utilization of inpatient and other services while incarcerated, or a history of emergency department and inpatient services prior to incarceration. Identified individuals will have significant health care needs and may have multiple chronic conditions, serious mental illness, substance use disorder or be pregnant. Justice and community partners will refer individuals whom they believe are good candidates for ECM to MCPs. For diversion programs, this will include behavioral health and criminogenic treatment providers, who will identify good candidates for whom ECM could help avoid high levels of health care utilization and maintain the members in the community.

ECM Services:

Many 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 involvement; diversion programs are designed to address these needs and avoid incarceration.

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. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for non-direct care needs.

For justice-involved individuals, these efforts require coordination not only with community treatment providers but also with counties, sheriffs, probation and other key stakeholders.

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.
- navigating members to other reentry support providers to address unmet needs.
- facilitating benefits reinstatement.²

The MCPs will contract with providers to perform the ECM functions but ultimately retain responsibility for ECM activities.

² 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.