CalAIM Dementia Care Learning Collaborative

Long-Term Care (LTC) Spotlight

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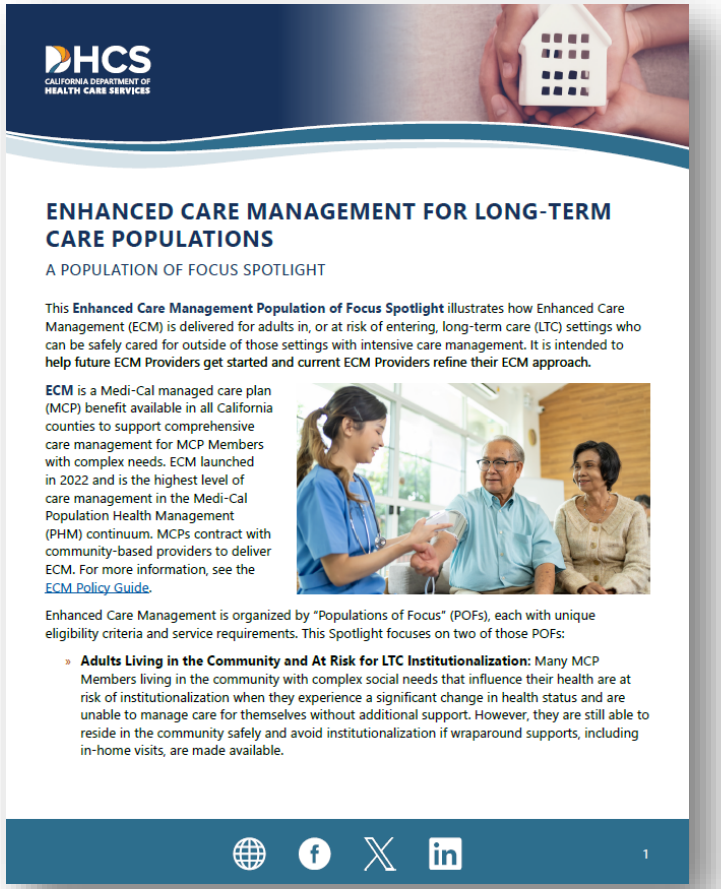
Spotlight: Enhanced Care Management (ECM) for LTC Populations

In June 2024, DHCS published the **Enhanced Care Management (ECM) for LTC Populations of Focus (POF) Spotlight**.

- ✓ Highlights key DHCS policies and resources on serving individuals in, or at risk of entering, institutional LTC in ECM settings, including a crosswalk of how members with long-term services and supports (LTSS) needs receive care management support.
- ✓ Contains member vignettes illustrating how to implement ECM for these POFs:
  - **An older adult living with Parkinson's disease who wishes to remain at home**
  - **An older adult temporarily living in a skilled nursing facility and recovering from a stroke**
- ✓ Explains how Community Supports and Transitional Care Services can be integrated to best serve members and their caregivers.

This is the third in a **series of Spotlights** showing how providers can deliver ECM models tailored to the needs of different POFs.



DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

ENHANCED CARE MANAGEMENT FOR LONG-TERM CARE POPULATIONS

A POPULATION OF FOCUS SPOTLIGHT

This **Enhanced Care Management Population of Focus Spotlight** illustrates how Enhanced Care Management (ECM) is delivered for adults in, or at risk of entering, long-term care (LTC) settings who can be safely cared for outside of those settings with intensive care management. It is intended to **help future ECM Providers get started and current ECM Providers refine their ECM approach.**

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. ECM launched in 2022 and is the highest level of care management in the Medi-Cal Population Health Management (PHM) continuum. MCPs contract with community-based providers to deliver ECM. For more information, see the ECM Policy Guide.

Enhanced Care Management is organized by "Populations of Focus" (POFs), each with unique eligibility criteria and service requirements. This Spotlight focuses on two of those POFs:

- **Adults Living in the Community and At Risk for LTC Institutionalization:** Many MCP Members living in the community with complex social needs that influence their health are at risk of institutionalization when they experience a significant change in health status and are unable to manage care for themselves without additional support. However, they are still able to reside in the community safely and avoid institutionalization if wraparound supports, including in-home visits, are made available.

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To learn more, please visit the ECM and Community Supports webpage.

Who is Eligible for ECM?

ECM is available to managed care plan (MCP) members who meet ECM POF definitions.

ECM POFs		Adults	Children & Youth
1	Individuals Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or Emergency Department Utilization	✓	
3	Individuals with Serious Mental Health and/or Substance Use Disorder Needs	✓	✓
4	Individuals Transitioning from Incarceration	✓	
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity	✓	✓

ECM is available for adults with intellectual or developmental disabilities (I/DD) and pregnant and postpartum individuals if they meet the eligibility criteria for any existing POF. In July 2023, children and youth with I/DD or who are pregnant/postpartum-became eligible for ECM if they met the eligibility criteria for any existing POF.

What are the ECM Core Services?

Members in ECM receive seven core services tailored to their POF and individual needs.

Outreach and Engagement

Comprehensive Assessment and Care Management Plan

Enhanced Coordination of Care

Coordination of and Referral to Community and Social Support Services

Member and Family Supports

Health Promotion

Comprehensive Transitional Care

Entities Positioned to Serve as ECM Providers for The LTC POFs

Adults Living in the Community and At Risk of LTC Institutionalization	Adult Nursing Facility Residents Transitioning to the Community
» CBAS Centers » Area Agencies on Aging » Home Health Agencies » Centers for Independent Living » Memory Care, Assisted Living, and Independent Living Organizations » Alzheimer's Association » HCBS Providers	» CCT Lead Organizations » Affordable Housing Communities » Memory Care, Assisted Living and Independent Living Organizations » Alzheimer's Association » HCBS Providers

Sonja is a 62-year-old with Parkinson's disease (PD) and recently diagnosed with possible Parkinson's disease dementia (PDD). Sonja values her neighborhood community but is facing challenges living alone.

Sonja is a Medi-Cal MCP member enrolled in Fee-For-Service Medicare in San Bernadino County living alone in a studio apartment, where she has lived for 14 years. The unit is in need of updates and repairs, and, while on the first floor, has not been updated with accessibility features.

ECM Core Services for Sonja

Outreach and Engagement	Connected to ECM via her primary care provider. The ECM provider is Community Partners, and the Lead Care Manager (LCM) is Miguel.
Comprehensive Assessment and Care Management Plan	Her friend Arlene helps, mobility challenges are noted, and medication reconciliation completed.
Enhanced Coordination of Care	Connected to specialty care for PD, Miguel works to get her In-Home Supportive Services (IHSS) caregivers.
Comprehensive Transitional Care	Sonja develops a urinary tract infection and requires a short-term stay at a skilled nursing facility (SNF) with additional supports.
Coordination of and Referral to Community and Social Support Services	Apartment unit needs grab bars; installment is arranged through Community Supports (CS). Sonja is connected to a CBAS center.
Health Promotion	Medication reminders set up.
Member and Family Supports	Arlene is integral; Sonja socializes at the CBAS center, and IHSS workers help her see old friends at the park.

Felix is a 72-year old living with multiple chronic conditions who has a stroke. Upon discharge from the hospital, he spends several months recovering in a SNF. Felix and his wife are looking for support as he prepares to transition back home.

Felix is a Medi-Cal MCP member enrolled in Fee-for-Service Medicare living in Sacramento County. He and his wife, Teresa, have lived in Sacramento over 40 years and raised their children there. Felix has been living with Type 2 diabetes, and high cholesterol for two decades.

After suffering a major stroke, he is admitted to the hospital for 12 days. He experiences partial paralysis on the right side of his body as a result and has limited ability to speak or swallow. His condition does not improve during his hospital stay, and he is admitted a SNF. He requires a feeding tube into his stomach and significant therapies for speech, swallowing and his right-sided paralysis.

ECM Core Services for Felix

Comprehensive Transitional Care	Stroke, feeding tube, right-sided paralysis -- SNF -- MDS (Minimum Data Set) review – Felix wants to go home. ECM/CS provider Vida is contacted.
Outreach and Engagement	Vida worker Jolana reaches out by phone.
Comprehensive Assessment and Care Management Plan	A plan is arranged for his transition to home, including his wife's needs; physical and occupational therapy needs are assessed.
Enhanced Coordination of Care	ECM works with SNF discharge planner; durable medical equipment (DME) is ordered.
Coordination of and Referral to Community and Social Support Services	Multiple CS services used: Nursing Home Transition, Medically Tailored Meals, Personal Care and Homemaker Services, Respite Services.
Health Promotion	Diabetes and cholesterol management help, online movement class offered.
Member and Family Supports	Support for wife Teresa is key. Respite Services delivered and connected to a Caregiver Resource Center.

Questions

- What are key concerns and current challenges in implementing ECM for the LTC POFs?
- What are bright spots in the implementation?
- What provider partnerships are most effective and why?
- What are bright spots and challenges in coordinating with Community Supports?

Thank you

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