This ECM Certification Application distills ECM expectations as outlined by DHCS and is intended as an initial step to ensure applicants understand the core tenets of the ECM program. Applications will be reviewed and approved prior to applicants being certified as an ECM provider. **Please complete the ECM Certification Application and submit to** **CalAIMECMILOS@sfhp.org** **by June 4th 2021.** If you have any questions or concerns as you are completing the application, please email the inbox immediately.

**What is ECM?**

The intent of ECM is to partner with individuals experiencing complex medical, mental health and social barriers, and pair them with a care manager and care team who supports in addressing these barriers at the point of care, and at home/community, and connects to resources to achieve their best possible health status.

**Instruction for Evidence:**

Evidence should be collated into a single ECM Program Description where all evidence or referenced evidence (i,e, policies & procedures, screen shots, organization charts, workflows, etc) are collated, attached and labeled appropriately. Please label evidence by the corresponding required area (i.e. *ECM Program Area; Reporting*) so we can appropriately identify your evidence.

**Please indicate which target population(s) for which this application is submitted:**

[ ] Individuals experiencing homelessness: Individuals experiencing chronic homelessness, or who are at risk of experiencing homelessness, with complex health and/or behavioral health conditions

[ ] High utilizers: High utilizers are members with multiple hospital admissions, OR multiple short-term skilled nursing facility stays, OR multiple emergency room visits

[ ] Individuals at risk for institutionalization: Individuals who have a co-occurring chronic health conditions and: Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD).

**Post Application Submission:**

SFHP will review all submitted applications and will respond to each applicant with request for additional information or clarification for areas of the application that do not meet satisfaction of the ECM requirement. Both SFHP & Anthem will be available to work with you over the course of completion of this application and post submission to ensure you meet certification requirements. If evidence does not meet the requirements as outlined by SFHP & DHCS the provider will not be certified as an ECM provider.

**KEY for “Self-Assessment Effort” Column Below:**

* **No Effort**: Already meet the program area expectation
* **Low Effort**: Minimal effort to meet this area by January 2022 and we do not require assistance from the MCP
* **Medium Effort:** Will meet by January 2022 and may/may not require some assistance from the MCP
* **High Effort 1:** Will definitely require assistance from the MCP to meet by January 2022
* **High Effort 2:** Concern we cannot meet this area at all

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| **Program Area: Outreach**  | **Response**  | **Self-Assessment Effort** * *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
| ECM Provider assumes responsibility for conducting progressive outreach to each ECM eligible individual through multiple community-based modalities, prioritizing in-person outreach. ECM Provider must ensure timely outreach post retrieval of ECM eligible individuals. **Please provide your answer to the following questions in the next column.** 1. How does your program ensure in-person outreach and use of the following modalities, as appropriate, if in-person attempts are unsuccessful or to reflect a individual stated contact preferences?

▪ Mail ▪ Email ▪ Texts ▪ Telephone calls ▪ Other |  |  |  | Yes [ ]  No [ ]   |

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| **Program Area: Engagement**  | **Response**  | **Self-Assessment Effort** * *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
| Post outreach to ECM individuals the ECM Provider assumes responsibility for obtaining and documenting every individual consent into the ECM program.**Please provide your answer to the following questions in the next column.** 1. How does your program currently consent individuals in your program?
 |  |  |  | Yes [ ]  No [ ]   |

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| **Program Area: Discontinuation**  | **Response**  |  **Self-Assessment Effort** * *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
| ECM Provider must have a process to discontinue ECM when the individual;* Is no longer authorized for ECM
* Has met care plan goals
* Declines or stops participation
* Is unable to be engaged

ECM Provider must have processes for transitioning individuals into lower levels of care, when appropriate.**Please provide your answer to the following questions in the next column.** 1. How does your program/staff assess and decide when to discontinue (closed or graduated) enrolled individuals?
 |  |  |  | Yes [ ]  No [ ]   |

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| **Program Area:** **Documentation System & Reporting** | **Response** | **Self-Assessment Effort*** *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence***Provide name of document(s) you are submitting as evidence & ensure you attach to submitted email with same naming convention as indicated here.* | **Compliant****(For Internal Use Only)** |
| ECM Provider ensures a method and process to document ECM case management work with ECM eligible individuals. Preferably in a case management system or software solution. ECM provider must ensure communication flow and documentation among the entire care team.**Please provide your answer to the following questions in the next column.** 1. Where and how does your program document an individual’s case management work (i.e. outreach, discontinuation, assessment, care plan, referrals etc)?
2. How do you ensure communication flow and documentation among the entire care team?
 |  |  |  |  |
| ECM Provider ensures the technical ability to capture, track & report on data elements for each ECM individual including physical, behavioral, administrative and social determinants of health (SDOH) (e.g., Homeless Management Information System (HMIS) data); and quality measures and/or metrics, as required;**Please provide your answer to the following questions in the next column.** 1. How do use data listed above to assess and develop care plans for members enrolled in your program?
2. How does your program capture, track and report out on data metrics?
 |   |  |  | Yes [ ]  No [ ]  Yes [ ]  No [ ]  Yes [ ]  No [ ]  Yes [ ]  No [ ]   |

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| **Program Area: File Data Exchange & Encounter Submission**  | **Response**  | **Self-Assessment Effort*** *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
| ECM Provider has capability to connect to SFHP SFTP site to retrieve and deliver ECM data files in support of the ECM program.  1. On a to be determined cadence, retrieve an eligibility file that contains ECM individuals that are eligible to receive ECM services. The eligibility file will be a pipe delimited text file.
2. On a to be determined cadence, deliver the same file back to SFHP SFTP site with additional data added about each individual’s status (e.g., enrolled, excluded, homeless status etc.).

**Please provide your answer to the following questions in the next column.** 1. Does your program has current ability to connect to SFHP Secure File Transfer Protocol (SFTP) site and retrieve and submit data files.
2. If currently trading with SFHP, please specify which data exchanges are being traded.
3. If not currently trading with SFHP please assess effort to do so in effort columns
 | ***NOTE:*** If not currently trading with SFHP then participation and successful completion of SFHP’s file testing process is required to be certified as a ECM provider.  |  |  | Yes [ ]  No [ ]   |
| ECM Provider has capability to generate and submit encounters in a HIPAA 837 format to SFHP (at minimum monthly).**Please provide your answer to the following questions in the next column.** 1. Does your program have current ability to exchange encounter data with SFHP?
* Please specify if generating and submitting encounters directly, through a clearinghouse or via another method (ie Portal).
 | ***NOTE:*** All ECM Providers will be required to submit documentation that outlines how you will meet this requirement and have to pass encounter testing. |  |  |  |

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| **Program Area: Multi-Disciplinary Care Team**  | **Response**  | **Self-Assessment Effort*** *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
| ECM Provider must maintain a multi-disciplinary care team. Care Team will include a primary lead to whom the individual is assigned/associated and that data must be submitted to the plan regularly. **Please provide your answer to the following questions in the next column.** 1. Describe your current program care team model.
 |  |  |  | Yes [ ]  No [ ]  Yes [ ]  No [ ] Yes [ ]  No [ ]  |

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| **Program Area: Capacity**  | **Response** | **Self-Assessment Effort*** *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
|  **Please provide your answer to the following questions in the next column.** (Please answer by program and number of FTEs if possible).1. What is your current staffing and capacity for your program(s)?
2. What would staffing and capacity be to outreach and engage ECM eligible members?

Looking for staff to member ratio and average number of indiv served in a year.  |  |  |  | Yes [ ]  No [ ]  Yes [ ]  No [ ] Yes [ ]  No [ ]  |

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| **Program Area: Assessment & Care Planning**  | **Response** | **Self-Assessment Effort*** *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
| **Please provide your answer to the following questions in the next column.** 1. What is your current assessment and care planning process?
2. What domain areas does the assessment cover?
3. Is the care plan developed by working with the individual to assess risks, needs, goals and preferences?
4. Does the care plan coordinates and integrates clinical and non-clinical health care related needs?
5. Is there a process to set acuity and an reassessment cadence?
 |  |  |  | Yes [ ]  No [ ]  Yes [ ]  No [ ]  Yes [ ]  No [ ]   |
| **Program Area: Health Promotion**  | **Response** | **Self-Assessment Effort*** *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
| **Please provide your answer to the following questions in the next column.** 1. How does your program encourage and support the individual to make lifestyle choices based on healthy behavior, with the goal of motivating individual to successfully monitor and manage their health?
2. How does your program support the individual in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions?
 |  |  |  | Yes [ ]  No [ ]   |
| **Program Area: Individual and Family Supports**  | **Response** | **Self-Assessment Effort*** *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
| **Please provide your answer to the following questions in the next column.** 1. How does your program ensure that the individual and chosen family/support persons, including guardians and caregivers, are knowledgeable about the individual ’s condition(s) with the overall goal of improving the Individual ’s care planning and follow-up, adherence to treatment, and medication management?
2. How does your program document a individual ’s chosen caregiver(s) or family/support person?
 |  | **Notes** | **Submitted Evidence** | Yes [ ]  No [ ]   |
| **Program Area: Enhanced Care Coordination**  | **Response**  | **Self-Assessment Effort*** *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
| **Please provide your answer to the following questions in the next column.** 1. How does your program ensure care is continuous and integrated among all service providers outside of where your org sits including primary care/physical and developmental health, mental health, SUD treatment, community services, oral health, palliative care, and social services, ILOS, and housing, as needed?
2. How does your program provide support for treatment adherence including coordination for medication review/reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to adherence?
3. How does your program ensure individuals needs and preferences timely to all of the individuals care team in a manner that ensures safe, appropriate and effective person-centered care.
 |   |  |  |  |
| **Program Area: Transitional Care**  | **Response**  | **Self-Assessment Effort*** *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
| **Please provide your answer to the following questions in the next column.** ECM providers must support and provide evidence-based transition planning for individual and families who are experiencing or are likely to experience a care transition. 1. How does your program track each admission or discharge to/from an emergency department, hospital in individual facility, skilled nursing facility, residential/treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members?
2. How does your program develop and regularly update a transition plan for the individual?
3. How does your program evaluate medical care needs and coordinate any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges?
 |  |  |  | Yes [ ]  No [ ]  Yes [ ]  No [ ]   |
| **Program Area: Referrals Requirements**  | **Response** | **Self-Assessment Effort*** *No Effort*
* *Low Effort*
* *Medium Effort*
* *High Effort 1*
* *High Effort 2*
 | **Submitted Evidence** | **Compliant****(For Internal Use Only)** |
| **Please provide your answer to the following questions in the next column.** 1. How does your program manage referrals, coordination, and follow-up to needed services and supports; actively maintain a process ensuring appropriate referrals and follow-up to ensure services were rendered?
2. How does your program determine appropriate services to meet the needs of individuals, including services that address social determinants of health needs, including housing?
 |  |  |  | Yes [ ]  No [ ]  Yes [ ]  No [ ] Yes [ ]  No [ ]  |

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| **Completed By:** |  | **Date:**  |  |
| **Title:** |  |
| **Phone Number:** |  | **Email Address:** |  |