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Graduation from ECM: When, Why, and How

Enhanced Care Management
Provider Training

Training Objectives

1. Understanding graduation
2. Identifying graduation readiness
3. Building graduation into the care plan
4. Reassessments and graduation criteria review
5. Transition planning
6. Documentation requirements
7. Audit findings and case studies

Understanding Graduation

- DHCS designed ECM as an intensive, needs-based intervention — graduation is the intended outcome
- Members graduate when goals are met and needs can be sustained through routine supports
- Graduation is distinct from loss of eligibility, member opt-out, and transition to another program
- Graduation is a success milestone, never a discharge for non-compliance

CalAIM ECM Policy Guide (page 103)

Graduation vs. Other Ways Members Exit ECM

- Members leave ECM for several reasons. Only one of them means the care plan goals were met.
- Document the exit reason accurately, because each path carries different follow-up expectations.

Graduation

Goals met, needs stable, member ready for alternative care

Member opt-out

Member declines to participate or no longer wishes to continue to ECM

* A documented choice, not a clinical determination

Exclusion

No longer meets ECM criteria, behavior or environment unsafe, or administrative closure such as unable to contact, moved out of service area, or plan change

Program transition

Member moves to another program better matched to current acuity, with or without meeting ECM goals

Common Audit Findings

Goals and Medical Necessity

- **Enrollment without active goals**
  - Members remain in ECM with no open, documented goals
- **Current support level does not warrant ECM need**
  - LCM activities do not support ongoing ECM enrollment (e.g., only scheduling transportation when member's care team has already been established, health condition stabilized, etc.)

Graduation and Transitions

- **Graduation never discussed**
  - No documented conversation with the member about readiness (e.g., ongoing review of care plan goal progress)
- **Missing reassessments and transition plans**
  - No reassessment or revised care plan goals occurring
  - No handoff documented when member has a planned graduation

Identifying Graduation Readiness

Goals and stability

- Care plan goals achieved
- Health and psychosocial needs stable
- Clinical consultation and/or case conference suggested to review step-down options

Self-management

- Member and/or member's support system able to manage physical health, behavioral health, and ADL needs
- Care team (i.e., PCP and specialist care) established and member aware of how to access services

Supports in place

- Housing, food, transportation and other SDOH needs addressed or stabilized
- Member supports such as IHSS or family supports in place
- Care management intensity already reduced

Graduation Starts at Enrollment

Design for ECM Graduation from Day One

- **Start at enrollment:**
  - Introduce graduation as the goal of ECM from the very first visit
- **Write goals toward independence:**
  - Establish expectations regarding role clarity
  - Frame every goal around member's role and lead care manager's role in ECM services
    - Ex] Educating member how to use transportation services or self-advocate through modeling when LCM attends health appointments

Sustain Graduation Discussions Through Enrollment

- **Build in sustainability:**
  - Include self-management and maintenance objectives in each care plan
    - Ex] Member will practice self-management by logging medication adherence daily for the next 30 days
      - Resource: BSC PHP Healthwise for health education articles
- **Set expectations early and often:**
  - Review member's progress toward self-sufficiency throughout the episode of care

Reassessment and Graduation Criteria Review

1

Reassess member needs

Ongoing reassessment of member's needs and care plan goals to evaluate whether ECM is still needed

2

Review member goals

Compare active goals to resolved goals and decide whether new goals justify continued enrollment

3

Clinical consultation

Bring cases to clinical consultation and/or case conferences and document the recommendations

* Please document name and discipline of the independently licensed clinical consultant (i.e., Jane Doe, RN)

Transition Planning

Clinical Resources

- Established PCP care team
- BSC PHP Medi-Cal Benefits
  - **Teladoc:** (800)835-2362 (TTY: 711)
  - **Nurse Advice Line:** 1-800-609-4166
- Behavioral health services
  - **BSC PHP Los Angeles Member Services:** (800) 605-2556
  - **BSC PHP San Diego Member Services:** (855) 699-5557

Care Management Resources

- Community Health Worker
- BSC PHP Care Management (Adults and Children)
  - **BSC PHP Los Angeles Member Services:** (800) 605-2556
  - **BSC PHP San Diego Member Services:** (855) 699-5557

Supplemental Resources

Community Supports

- A referral submission is required for a Community Supports authorization to be completed

Wellvolution

- Health and wellness programs and education for Medi-Cal members

Transportation

- BSC PHP Transportation Line (24/7): (877) 433-2178

Community Resources

- Community-based organizations (e.g., NAMI, Regional Center, Legal Aid, etc.)
  - 211 LA, 211 SD, or FindHelp for additional resources
- L.A. Care/BSC PHP Community Resource Center
- San Diego Family Resource Centers

Program Completion Questionnaire (PCQ)

- Care Plan
  - Meeting care plan goals
- Physical Health
  - Scheduling appointments, contacting PCP or Nurse Advice Line, transportation, etc.
- Mental/Emotional Health
  - Understand MH diagnosis/treatment, recognize warning signs, coping, social supports, etc.
- Housing
  - Rights in housing situation, behaviors impacting housing (e.g., hoarding), and maintaining relationship with landlord
- Daily Living
  - Activities of daily living
  - DME and supports in place
  - Food
  - Transportation
  - Identification documents and money management

Documentation Requirements

Care plan updates

Goals marked resolved and the final care plan reflects graduation readiness

Graduation rationale

Justification associated with PCQ

Member discussion

Date, participants, and the member's agreement documented

Resources provided

Contacts, referrals, and scheduled appointments given to the member

Closure notes

Required documentation completed within required timeframes

Case Studies

Appropriate graduation	Goals met, housing stable, PCP engaged; member ready for alternative care
Continued ECM enrollment	A new health need meets POF criteria to continue ECM
Step-down transition	Member moves to lower-acuity care management with a warm handoff
Goals met, new needs emerge	Reassess and adjust the plan before considering closure

Key Takeaway

ECM graduation is a successful outcome, not a discharge for non-compliance

Continuously assess member progress, promote self-sufficiency, document clinical rationale, and ensure a safe transition to ongoing supports when ECM is no longer needed. This supports appropriate use of ECM resources while keeping care member-centered.

Thank you