ENHANCED CARE MANAGEMENT (ECM) REFERRAL FORM

ADULTS 21+ YEARS OF AGE

Send to **CareManagement_Referrals@sfhp.org**

SAN FRANCISCO HEALTH PLAN™
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ECM offers comprehensive case management services to individuals who are enrolled in Medi-Cal Managed Care or have Medicare with Managed Care Medi-Cal, who:

1) Have complex health and/or social needs, and

2) Meet the eligibility criteria, as outlined on this form.

ECM is an opt in benefit that is intended to serve the highest-need members and provides intensive coordination of health services.

THIS FORM IS TO REFER AN ADULT (Age 21 years and older) TO ECM SERVICES.
For children or youth, please refer to the Children and Youth referral form

ELIGIBILITY CRITERIA:

Use this form for SFHP members only. Members who qualify under **at least one** of the ECM Populations of Focus (POF) may be approved for ECM services and will then be assigned to a SFHP contracted ECM Provider.

To be eligible for ECM, a member must already be enrolled in Medi-Cal Managed Care or have Medicare with Managed Care Medi-Cal as secondary medical coverage. Members must **not** be enrolled in exclusionary programs or receiving duplicative services. Refer to exclusionary terms on page 3 for a full list.

OBJECTIVE AND GENERAL INSTRUCTIONS:

Return this completed referral form via SECURE email to SFHP at CareManagement_Referrals@sfhp.org. Allow **5 business days** for the form to be reviewed. The SFHP Care Management Intake Team will notify you of the results.

MEMBER/PATIENT INFORMATION Member must already be enrolled with SFHP for their Medi-Cal coverage	
First Name:	Last Name:
Date of Birth (MM/DD/YYYY):	SFHP ID#:
Preferred Language:	Medi-Cal Client ID (CIN):
Primary Phone Number:	Other Preferred Method of Contact:
Preferred Name/Pronoun (If applicable):	
Alternate Contact Name (If applicable):	Alternate Phone Number:

REFERRING PROVIDER OR REFERRING PERSON'S INFORMATION	
Name of Person Submitting This Referral:	
Agency or Referring Organization's Name (If applicable):	
Are You an Active SFHP ECM Provider? ☐ Yes ☐ No	
Phone Number:	Email:

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ECM QUALIFYING POPULATIONS OF FOCUS FOR ADULTS (21 YEARS AND OLDER)

Please mark the checkbox(es) next to at least **one** of the required qualifying Population of Focus (POFs) – check all that apply

☐ **Adults At Risk of Avoidable Hospital or Emergency Department Utilization** (Must meet at least one of the criteria below)

- ☐ 5 or more unplanned or avoidable emergency department visits in a 6-month period

–OR–

- ☐ 3 or more unplanned or avoidable hospital and/or short-term skilled nursing facility (SNF) stays in a 6-month period

☐ **Individuals and Families Experiencing Homeless or At Risk of Homelessness** (Must meet criteria below)

- ☐ Is/are unable to successfully self-manage due to having at least one complex physical, behavioral, or developmental health needs.

–AND– one of the following:

- ☐ Homeless/unhoused
- ☐ Chronically homeless
- ☐ At risk of homelessness

☐ **Adults with Severe Mental Illness (SMI) or Substance Use Disorder (SUD)** (Must meet each of the three criteria below)

- ☐ Must be eligible for participation in either the County Specialty Mental Health System or the Drug Medi-Cal Organization Delivery System (DMC-ODS) or the Drug Medi-Cal program (DMC) Screening and Transition of Care Tools for Medi-Cal Mental Health Services

–AND–

- ☐ Actively experiencing at least one complex social factor influencing their health (for example, lack of access to food, lack of access to stable housing, inability to work or engage in the community, history of ACEs, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms or associated behaviors)

–AND– who meet **one or more** of the following criteria:

- ☐ High risk for institutionalization, overdose, and/or suicide
- ☐ Use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care
- ☐ Two or more ED visits or two or more hospitalizations due to SMI or SUD in the past 12 months
- ☐ Pregnant and postpartum women, defined as up to 12 months after delivery

☐ **Long-Term Care OR at Risk of Institutionalization** who, in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient nursing facility. (Must meet all of the criteria below)

- ☐ Are living in the community who meet the SNF Level of Care (LOC) criteria; OR who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury.
- ☐ Are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring)
- ☐ Are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high acuity needs or conditions that are not suitable for home-based care due to safety or other concerns)

☐ **Nursing Facility / Long-Term Care Residents Transitioning to the Community** (Must meet all of the criteria below)

- ☐ Currently residing in a Skilled Nursing Facility (SNF) with desire to return home

–AND– (must meet all of the below):

- ☐ SNF stay of ≥ 90 days in duration
- ☐ Stable housing in the community (or ability to achieve stable housing within 3 months)
- ☐ Strong social support/caregiving support (or ability to achieve within 3 months)

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ECM QUALIFYING POPULATIONS OF FOCUS FOR ADULTS (21 YEARS AND OLDER) (continued)

Please mark the checkbox(es) next to at least **one** of the required qualifying Population of Focus (POFs) – check all that apply

☐ **Birth Equity** (Must meet both criteria below)

- ☐ Pregnant OR postpartum through 12 months after last day of pregnancy. Applies to live birth, termination, and pregnancy loss

–AND–

- ☐ Who self-identify as Black, American Indian, Alaska Native, or Pacific Islander

Note: This specific population is identified as experiencing disparities in care for maternal morbidity and mortality based on California public health data. Adults who are pregnant and up to 12 months after last day of pregnancy and who do not identify as one of the above racial/ethnic groups are eligible for ECM **ONLY** if they meet criteria for any of the other Populations of Focus (POF) listed on this form.

☐ **Adults Justice-Involved/Transition from Incarceration** (Must meet criteria below)

- ☐ Release from incarceration in the last 12 months

–AND– (who have at least one of the following conditions):

- ☐ Chronic mental illness
- ☐ Substance Use Disorder
- ☐ Chronic disease (for example, hepatitis C, diabetes)
- ☐ Intellectual or developmental disability
- ☐ Traumatic brain injury
- ☐ HIV
- ☐ Pregnancy

● **If you find that there is not a qualifying Population of Focus (POF), please stop here and do not submit the form. If you have questions, email CareManagement_Referrals@sfhp.org**

ECM EXCLUSIONARY TERMS

If any of these criteria apply to the member, please **do not** proceed with submitting a referral

1. A member is **not** eligible for ECM if any of the following criteria apply:
   a. Member is enrolled in D-SNP (Dual Special Needs Plan)
   b. Member is enrolled in Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPS)
   c. Member is enrolled in Program for All Inclusive Care for the Elderly (PACE)
   d. Member is enrolled in Mosaic Family Services
   e. Member is enrolled in Hospice
   f. Adults living in the community who are at risk of institutionalization into Intermediate Care Facilities (ICF) and subacute care facilities.
   g. Members residing in Intermediate Care Facilities (ICF) and subacute care facilities.
2. Please also ensure that the member is **not** enrolled in an ECM Duplicative Program. If the member is enrolled in another program, and is opting for ECM instead of the other program, please indicate the known Program(s):
   - ☐ 1915(c) Waiver Programs: Home and Community Based (HCBS)
   - ☐ HIV/AIDS
   - ☐ Assisted Living Waiver (ALW)
   - ☐ Developmentally Disabled (DD)
   - ☐ Multipurpose Senior Services Program (MSSP)
   - ☐ Complex Case Management

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ATTESTATION STATEMENT
Both checkboxes must be marked to be considered a completed referral

☐ **I, the referent, attest that to the best of my knowledge; the member is not enrolled in programs that exclude the member from ECM eligibility. If member is enrolled in an ECM duplicative program, I attest that the member is opting for ECM instead of the other program.**

☐ **I, the referent, attest that to the best of my knowledge, the member meets Population of Focus criteria as listed on this form.**

Signature:	Today's Date (MM/DD/YYYY):

For general ECM program inquiries, email **CalAIMECMILOS@sfhp.org**