

Enhanced Care Management Provider Manual

Part 3

(CCA Users)

Molina Healthcare of California

(Molina Healthcare or Molina)

2025

Capitalized words or phrases used in this ECM Provider Manual shall has the meaning set forth in your Agreement with Molina Healthcare. “Molina Healthcare” or “Molina” has the same meaning as “Health Plan” in your Agreement. The ECM Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current ECM Provider Manual at MolinaHealthcare.com.

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MOLINA® HEALTHCARE

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Care Plan

The care plan development process involves the ECM member (and their parent, caregiver, guardian, if applicable) as well as appropriate clinical input to create a comprehensive, individualized, person-centered care plan.

- The care plan will be completed within 90 days of Opt-In. As a best practice, the ECM LCM should create the care plan within 2 business days of completing the Adult or C/Y Comprehensive Assessment to encourage engagement with the member.
- The care plan is to be updated at a frequency appropriate for the member's individual progress or anytime there is a change in the member's health condition.
- Each member should only have **ONE** active care plan. Please note: if the member has an existing open ECM care plan that was created with a previous ECM provider, it does not need to be closed. The newly assigned ECM LCM can continue to work on the existing care plan but must ensure that the new ECM LCM is assigned (in the Assigned to Field within the care plan) so that updates are captured under the correct LCM.
- Problems and concerns identified in the Comprehensive Assessment should be addressed in the member's care plan, which includes areas the member is self-managing. If the member refuses to work on an identified need, the ECM LCM must clearly document via a Contact Form in CCA.
- The care plan includes but is not limited to member's identified concerns, goals, and preferences in the areas of physical health, mental health, SUD community-based LTSS, palliative care, trauma-informed care needs, social support, and housing (as appropriate for individuals experiencing homelessness), with measurable objectives and timeframes, and should evolve as the member's needs change, as indicated by the member's Comprehensive Assessment and other assessments.

Individualized Care Planning

The care plan should have customized interventions to ensure its specific to the member's needs and goals. The ECM LCM needs to develop a comprehensive, individualized, person-centered care plan that coordinates and integrates the member's clinical and non-clinical healthcare-related needs. The care plan communication must be done in a culturally relevant and linguistically appropriate manner. The ECM LCM needs to coordinate services based on risk-stratification results, comprehensive assessments, clinical data, emergency and hospital utilization, behavioral health utilization, screening tools, Long Term Services and Supports (LTSS)/Home and Community -Based Services (HCBS) assessments, and other data when provided.

Care Plan Guidelines

The following guidelines apply to the Care Plan:

- The member's main health concern identified in the Comprehensive Assessment must be clearly integrated into the care plan. This may not always be related to health (i.e. housing insecurity or other SDoH need). This can be integrated into any of the problems/milestones developed.
- Self-management activities can be listed within condition-specific interventions.
- Barriers address the condition or event that may delay or prevent reaching plan goals. All identified barriers related to each goal are member-centric, documented, and incorporated into the corresponding milestone. Each problem, goal, and intervention must have a barrier. Standard barriers are in the Library (CCA) as Barriers to Goals.
- Additional conditions/problems: choose conditions/problems identified in the assessment, conditions that put the member at risk for deterioration in health status/unstable conditions (homeless, inadequate caregiver), and conditions that need immediate attention/clinical (e.g., behavioral health, Transitions of Care (ToC), Continuity of Care (COC) needs, etc.)
    - **Clinical** (e.g., behavioral health, transition of care, continuity of care, etc.)
        - Also include ways members are self-managing their conditions, **or**
    - **Non-clinical** (e.g., homeless, inadequate caregiver support, personal goal, etc.)
- For individualized milestones, goals, and interventions, use the member's language when possible (member-directed goals)
- Measurable outcomes with *numeric values* or words *teach back* or *repeat back* to promote self-management
- A mixture of short-term and long-term goals
    - Member prioritized **long-term** goal (>60 days) – at least one (1)
    - Member prioritized **short-term** goal (≤60 days) – at least one (1)
- ECM Providers are required to confirm the assigned PCP's information with the member as part of the care plan development process and must document this confirmation via a contact form. Member's PCP information can be found in the Address Book in CCA. For members who have secondary insurance with Molina (dual members), Molina does not have the member's PCP information in the Address Book in CCA. The ECM LCM will need to confirm this information with the member as well.
- The ECM LCM should coordinate ICT meetings and document occurrences via a Contact Form in CCA. The contact form must clearly identify who attended the ICT in the notes section and information shared with those involved as part of the member's multi-disciplinary care team. Refer to the "ICT" section for more information on ICT meetings.
- The care plan should show evidence of Health Promotion activities supporting the member's learning and adopting healthy lifestyle choices, including providing the member with appropriate educational material. Refer to Healthwise Knowledge Base in CCA for education materials. Health education material must be culturally appropriate and provided in multiple formats for members with disabilities.
- The care plan should not have any overdue milestones. The care plan should consistently be updated at a frequency appropriate for the member, especially when there is a change in condition, upon reassessment, care conference and/or care plan progress updates; however, no later than six months from the last care plan update.

This includes administering a new Comprehensive Assessment to identify new problem areas.
    - Anytime the care plan is updated, the ECM LCM needs to enter a Contact Form in CCA and enter "Care Plan Development/Revision," along with "ECM" under the purpose of contact.
- ECM LCM is required to provide a copy of the completed care plan to the member and/or their representative and the member's PCP; after creating the care plan (within 90 days from opting in a member, Best Practice: within three business days from completion of the care plan) and anytime the care plan is updated (within **14 business days** of updating the care plan) in addition to mailing the ECM Care Plan Letter to the member and the ECM PCP Care Plan Letter to the member's PCP. After completing these tasks, the ECM LCM must complete a Contact Form in CCA and ensure the appropriate letters are mailed. If the member declines to receive a copy of the care plan and ECM Care Plan Letter, the ECM LCM will clearly document this via a Contact Form in CCA. If the member declines to have their care plan sent to their PCP, please document this via a Contact Form. If the member requests for their care plan to be mailed or discussed with someone else, please document this via a Contact Form.
- The ECM LCM needs to note via a Contact Form in CCA when they plan to follow up with the member on their care plan progress. It is also recommended to create a task as a reminder to follow up.
- Acuity needs to be appropriate based on members' needs and conditions and documented in the Case Properties.
- The care plan should address the member's needs and conditions, including but not limited to the following elements, as applicable:
    1. Physical and developmental health
    2. Mental health
    3. Dementia
    4. Substance Use Disorders (SUD)
    5. Oral Health
    6. Palliative care
    7. Trauma-informed care
- The care plan should have evidence of addressing all applicable community-based services, including LTSS, social services, and housing needs when applicable to the member.
- ECM LCM should support the member in their treatment, including but not limited to:
    1. Coordination for medication review and/or reconciliation
    2. Scheduling appointments
    3. Providing appointment reminders
    4. Coordinating transportation
    5. Accompaniment to critical appointments
    6. Identifying and helping to address other barriers to member engagement in treatment.

- The Contact Forms in CCA should demonstrate the ECM LCM requested a referral from the MCP for MCP-aligned community services that address social determinants of health (SDOH) needs. The ECM LCM should follow up with MCP and members to ensure that care gaps are closed and that community services were rendered as requested (i.e., "closed loop referrals"). The Contact Forms in CCA should demonstrate requesting a referral from the MCP for MCP-aligned community services, such as Community Support, which address SDOH needs.
- The care plan should ensure that the member and chosen family/support persons, including guardians and caregivers, are knowledgeable about the member's condition(s) to improve the member's care planning and follow-up, adherence to treatment, and medication management.
- The ECM LCM should use strategies to reduce avoidable emergency department visits, admissions, or readmission for the member. The ECM LCM should be documenting these care coordination services/activities via a Contact Form in CCA and provide as much detail as possible in the notes section. Examples include, but are not limited to, the following, as needed:
    1. Ensuring follow-up appointments are scheduled post-discharge.
    2. Medication adherence post hospital discharge.
    3. Home safety checks are ordered and completed as necessary.
    4. Independent living aids (e.g., stair lifts, wheelchairs, walkers, Hoyer lifts,
    1. life alerts).
    5. Home health nurse ordered.
    6. Care person ordered to assist in activities of daily living (ADLs).
- The ECM LCM must track and evaluate a member's medical care needs and coordinate any support services to facilitate safe and appropriate transitions from and among different settings, including admissions/discharges to/from:
    1. Emergency department
    2. Hospital inpatient facility
    3. Skilled nursing facility
    4. Residential/treatment facility
    5. Incarceration facility
    6. Other treatment center

Health Promotion

As established in the **PHM Policy Guide** (**Section E. Providing PHM Program Services & Supports)**, the assigned ECM LCM is responsible for ensuring that Basic Population Health Management (BPHM) is in place as part of the Members' care management. BPHM includes Health Promotion services to encourage and support Members receiving ECM to make lifestyle choices based on healthy behavior, with the goal of motivating Members to successfully monitor and manage their health. Health Promotion services can include, but are not limited to:

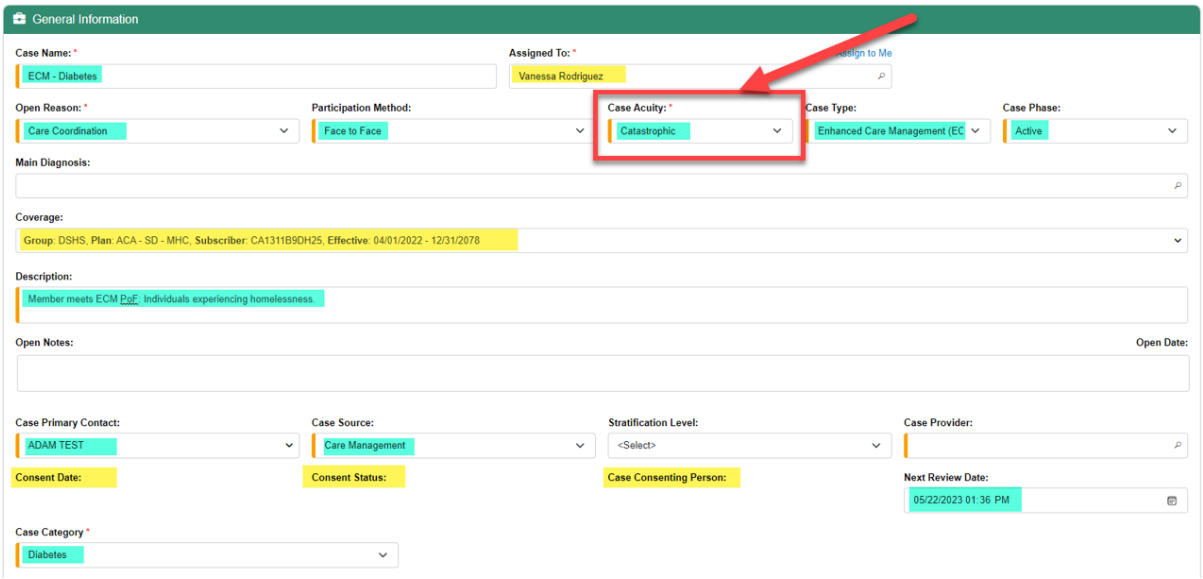
- Working with Members to identify and build on successes and potential family and/or support networks.
- Providing services, such as coaching, to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health.
- Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

The ECM LCM needs to document in CCA that Health Promotion services were provided to the member.

Case Management Acuity

ECM members must be assigned an acuity level when the ECM LCM creates the care plan in CCA (see screenshot below). The appropriate acuity level must be selected based on the member's needs and may change during the member's enrollment in ECM.

- Low acuity members should NOT be enrolled in the ECM program. Low acuity members should be re-evaluated to determine if the member requires ECM level of intensive care coordination services.
- If the member no longer needs ECM services because the member's conditions are well-managed, the member should be graduated from ECM as "All Care Plan Goals Met."
- For any members who meet an ECM Population of Focus, but do not fall under any acuity listed below, default member to Medium acuity.



Medium Acuity

If your organization's assigned ECM members fall under the following criterion, the member is considered Medium Acuity. Members of Medium Acuity should be re-evaluated every six months to determine continued eligibility for ECM. Use your clinical judgement when determining the member's acuity level.

- Maternity High Risk
- Three or four co-morbid conditions
- Targeted diagnosis with two admits within six months.
    - CVD
    - CHF
    - COPD
    - ESRD
    - Asthma
    - Diabetes
    - Sickle Cell
    - AIDS/HIV
    - Cancer
    - Behavioral Health
- Three to five avoidable Emergency Department visits within six months

High Acuity

If any of your organization's assigned ECM members fall under the following criterion, the member is considered High Acuity. Use your clinical judgement when determining the member's acuity level.

- Five or more co-morbid conditions
- Reports health as poor
- High-risk chronic illness with clinical instability as demonstrated by three or four admits within six months related to:
- CVD
    - CHF
    - COPD
    - ESRD
    - Asthma
    - Diabetes
    - Sickle Cell
    - AIDS/HIV
    - Cancer
    - Behavioral Health
- Six or more avoidable Emergency Department visits within six months

Catastrophic Acuity

If any of your organization's assigned ECM members fall under the following criterion, the member is considered Catastrophic Acuity. Use your clinical judgement when determining the member's acuity level.

- High-risk chronic illness with clinical instability as demonstrated by five or more admits in six months related to:
    - CVD
    - CHF
    - COPD
    - ESRD
    - Asthma
    - Diabetes
    - Sickle Cell
    - Aids/HIV
    - Cancer
    - Behavioral health
- Imminent risk of:
    - Inpatient admissions (psychiatric or medical) related to the inability to self-manage in the current living environment.
    - Institutionalization
- Need assistance with four or more activities of daily living, independent activities of daily living, and lacks adequate caregiver assistance.

SMART Goals

Care plan goals should be measurable and in a SMART format. Refer to the guidelines below for SMART goals:

The **SMART** acronym can help us remember these components

- **S**pecific — The goal should identify a specific action or event that will take place.

  (Who? What? Where? When? Why?)

- **M**easurable — The goal and its benefits should be quantifiable.

  (How many? How much?)

- **A**chievable — The goal should be attainable given available resources.

  (Can this really happen? Attainable with enough effort? What steps are involved?)

- **R**ealistic — The goal should require you to stretch some but allow the likelihood of success

  (What knowledge, skills, and abilities are necessary to reach this goal?)

- **T**imely — The goal should state the time period in which it will be accomplished.

  (Can I set fixed deadlines? What are the deadlines?)

Tips To Help Set Effective Goals

- **Develop a minimum of one goal for each letter of the SMART acronym.** This allows multiple channels to assist the member in care coordination over time.
- **State goals as declarations of intention, not items on a wish list.** "I want to lose weight" lacks power. "I will lose weight" is intentional and powerful.
- **Attach a date to each goal.** State what you intend to accomplish and by when. A good list should include some short-term and some long-term goals. You may want a few goals for the year and some for two- or three-month intervals.
- **Be specific.** "To improve my HbA1c" is too general; "To track my HbA1c in my smartphone daily to monitor my HbA1c" is better. Sometimes a more general goal can become the long-term aim, and you can identify some more specific goals to take you there
- **Self-Management.** Make sure interventions include a mixture of member and CM actions.
- **Share care plan goals.** Sharing the Plan's care management intentions with the PCP will help ensure success.
- **Write down your goals and put them where you will see them.** Keep the member's care plan in mind and refer to it often! The more often you read the list, the more results you get.
- **Review and revise the care plan as needed.** Experiment with different ways of stating the goals. Goal setting improves with practice, so play around with it.

Below are samples and templates for ECM Providers to individualize and tailor the ECM Care Plan for each member:

Diabetes:

Problem	Diabetes Program – Blood Glucose Monitoring
Goal	Member/caregiver/family will record the member's blood sugar levels daily for 30 days.
Intervention	The care manager will teach the member/caregiver/family how and why monitoring and logging blood sugar readings is vital.
Intervention	Member/caregiver/family will set reminders on their phone to track blood sugar levels.
Outcome	Member/caregiver/family recorded blood sugar levels daily for 30 days.
Barrier	Has trouble remembering to track blood sugar.

Problem	Diabetes Program – Blood Glucose Monitoring
Goal	Member/caregiver/family will provide the healthcare provider with a record of the member's daily blood sugar levels by 11/1/2025.
Intervention	The care manager will reinforce the importance of having a record of blood sugar levels for the healthcare provider.
Intervention	Member/caregiver/family will set reminders on their phone to track blood sugar levels.
Outcome	Member/caregiver/family provided healthcare provider a record of member's daily blood sugars by 11/1/2025.
Barrier	Difficulty remembering.

Problem	Diabetes Program – A1C Tracking
Goal	Member will have their A1C tested by 12/31/2025.
Intervention	The case manager will teach the member why it is essential to visit their doctor at least every three months to check their A1C level.
Intervention	The case manager will encourage the member to limit foods high in starchy carbohydrates, such as breads and pastas.
Intervention	The case manager will encourage the member to limit the intake of foods with added sugar, such as cookies, sodas, and syrup.
Intervention	Member will discuss a safe exercise plan with their doctor during the next visit.
Outcome	Member had their A1C tested within 3 months
Barrier	Health literacy: Doesn't understand how to control their A1C

Problem	Diabetes – Diet and Nutrition Monitoring
Goal	Member will meet with a diabetic educator and/or dietician to learn about healthy, nutritious, and diabetic-appropriate food choices in compliance with recommended diet within 30 days.
Intervention	The care manager will reinforce education regarding diet <*limiting sugar intake, reducing saturated/trans fats, avoiding cholesterol, reducing simple carbohydrates, increasing healthy carbohydrates, increasing fiber-rich foods, healthy heart fish, and good fats*>.
intervention	Member create a list of questions to ask the educator and/or dietician before the visit.

Outcome	Member engaged with a diabetic educator/dietician to discuss recommended diabetic-appropriate food and recommended diet within 30 days
Barrier	Health literacy: Doesn't understand dietary choices for diabetic.

Problem	Diabetes – Alcohol Use
Goal	Member/caregiver/family will identify two ways drinking alcohol can affect their diabetes in 30 days.
Intervention	The care manager will educate the member/caregiver/family on how alcohol may affect diabetes by interacting with some diabetic medications and causing severe side effects.
Intervention	The care manager will educate on how alcohol can impact blood sugar levels in the body and how the member feels throughout the day.
Intervention	The care manager will provide community resources for alcohol counseling if necessary.
Intervention	Member will consult with a healthcare provider to discuss drinking habits and how to drink in a way that is safe for diabetes management.
Outcome	Member/caregiver/family repeat back two ways alcohol consumption can affect diabetes within 30 days.
Barrier	Lack of self-control and limiting alcohol consumption.

COPD:

Problem	COPD – Knowledge of the disease process
Goal	Member/caregiver/family will identify three (3) warning signs/symptoms of worsening COPD (Chronic Obstructive Pulmonary Disease) in 30 days.
Intervention	The care manager will teach member/caregiver/family signs/symptoms of worsening COPD, such as difficulty breathing when lying flat.
Intervention	The care Manager will teach member/caregiver/family the signs/symptoms of worsening COPD, such as coughing and wheezing more than usual with productive phlegm.
Intervention	Member/caregiver/family will have all prescribed COPD medication handy at all times.
Intervention	The care Manager will teach member/caregiver/family the signs/symptoms of worsening COPD, such as increased shortness of breath when walking short distances.

Outcome	Member/caregiver/family can teach back three(3) warning signs/symptoms of worsening COPD within 30 days.
Barrier	Health Literacy: Doesn't understand warning signs and symptoms for COPD

Problem	**COPD – Knowledge of the disease process**
Goal	Within the next 30 days, the member/caregiver/family will obtain at least one educational resource (such as a brochure, online article, or pamphlet) specifically focused on managing COPD symptoms.
Intervention	The care manager will educate the member/caregiver/family on signs/symptoms of COPD exacerbation and when to report early symptoms.
Intervention	Member/caregiver/family will have all prescribed COPD medication handy at all times.
Intervention	The care manager will teach the member/caregiver/family when to contact the primary provider and/or specialist when symptoms worsen.
Outcome	The member/caregiver/family obtained at least one educational resource (such as a brochure, online article, or pamphlet) specifically focused on managing COPD symptoms within 30 days.
Barrier	Health Literacy: Doesn't understand warning signs and symptoms for COPD

Problem	**Chronic Pain**
Goal	Member will utilize 2 alternative treatments to reduce pain in 30 days.
Intervention	Care Manager will help the member develop a strategy in addition to medication adherence to reduce pain levels.
Intervention	Care Manager will help the member explore alternative pain management options with the primary care physician and or pain specialist.
Intervention	Member will try yoga exercise to help reduce the pain.
Outcome	Member has utilized 2 alternative treatments to reduce pain within 30 days.
Barrier	Physical limitation.

Depression:

Problem	**Depression – Triggers**
Goal	Member/caregiver/family will be able to teach back coping mechanisms for at least two triggers that may increase depression symptoms within 30 days.

Intervention	Care Manager will review possible triggers with the member that may have caused or triggered an alteration in depression in the past.
Intervention	Member will discuss their triggers with their provider.
Outcome	Member/caregiver/family has two coping mechanisms for at least two triggers that may increase depression symptoms within 30 days.
Barrier	Lack of energy and motivation.
Goal	Member will identify 1-3 activities that may help combat Depression in 30 days.
Intervention	Case Manager will review/explore activities that improve mood/combat depression, such as <*enter activities discussed with the member*>.
Intervention	Member will explore which activities improve mood such as <*enter activities discussed with the member*>.
Outcome	Member identified 1-3 activities that help combat depression in 30 days.
Barrier	Lack of energy and motivation.

Problem	**Depression – lifestyle**
Goal	Member will identify 1-3 activities that may help combat Depression in 30 days.
Intervention	Case Manager will review/explore activities that improve mood/combat depression, such as <*enter activities discussed with the member*>.
Intervention	Member will explore which activities improve mood such as <*enter activities discussed with the member*>.
Outcome	Member identified 1-3 activities that help combat depression in 30 days.
Barrier	Lack of energy and motivation.

SUD (Specify in member's words or use dx if the member agrees):

Problem	**SUD – Counseling**
Goal	Member will engage in a Substance use counseling program within 90 days.
Intervention	Case Manager will link the member with substance use counseling <*enter referral and resource info here*>.
Intervention	Member will call Case Manager if they have any questions/concerns regarding the Substance use counseling program.
Outcome	Member engages in substance use counseling in 90 days.

Barrier	Substance addiction interferes with daily functioning.

Problem	**SUD – Peer support**
Goal	Member will attend a support group in the next 30 days.
Intervention	Case Manager will provide the member with a list of available support groups <*enter referral resources here*>.
Intervention	Member will pick a support group near their home.
Outcome	Member attended one peer support group within 30 days.
Barrier	Lack of sober support and accountability

Problem	**SUD – Harm Reduction**
Goal	Member will have an action plan to reduce harm and risk associated with <*insert method and substance*> while not ready to abstain in 30 days.
Intervention	Case manager will encourage self-care and risk reduction while the member is not ready to abstain.
Intervention	Member will outreach to a Harm reduction program.
Outcome	Member has an action plan to reduce harm and risk associated with <*insert method and substance*> while not ready to abstain in 30 days.
Barrier	Lack of Harm Reduction information and access

Problem	**SUD – Meds/MAT**
Goal	Member will take <*Insert Medication name*> every <*insert frequency*> to treat substance use disorder within 60 days.
Intervention	Case manager will encourage adherence to Medication for Addiction Treatment (MAT).
Outcome	The member takes <insert medication dose> every <insert frequency> to treat substance use disorder within 60 days.
Barrier	Substance addiction interferes with daily functioning.

Community-Based LTSS:

Problem	**CBAS**
Goal	Member will report having 0 issues accessing Community Based Adult Services (CBAS) through <insert name of CBAS> in 30 days

Intervention	Case Manager will discuss with the member and PCP a referral to CBAS and help facilitate as appropriate.
Intervention	Member agreed to notify CBAS <insert name of CBAS> when unable to attend their scheduled <insert number days> days.
Outcome	Member reported having 0 issues accessing Community Based Adult Services (CBAS) through <insert name of CBAS> within 30 days
Barrier	Lack of community support

Problem	**IHSS – In Home Supportive Services**
Goal	Member/caregiver/family will call their local state/county In-Home Supportive Service (IHSS) agency to inquire, apply, and/or follow-up on status of IHSS application in 60 days
Intervention	Case Manager will provide member/caregiver/family with the call information for their local state/county IHSS agency to inquire on status of IHSS application.
Intervention	Member/caregiver/family will call Case Manager if questions/concerns
Outcome	Member/caregiver/family calls their local state/county In-Home Supportive Service (IHSS) agency to follow-up on status of IHSS in 60 days
Barrier	Lack of community support

Housing Insecurity/Unhoused:

Problem	**Member is currently unhoused**
Goal	Member will attain resources (income, housing vouchers, and/or benefits) sufficient to pay for adequate housing within 90 days.
Intervention	Case Manager will work with the members <Community Support> agency to help the member obtain housing.
Intervention	Member will attend necessary appointments related to housing.
Outcome	Member has attained resources (income, housing vouchers, and/or benefits) sufficient to pay for adequate housing within 90 days.
Barrier	Homeless

Problem	**Housing Insecurity**
Goal	Member will reside in a desired, stable, housing code-compliant residence adequate to house <insert number> adults and <insert number> children within 90 days.

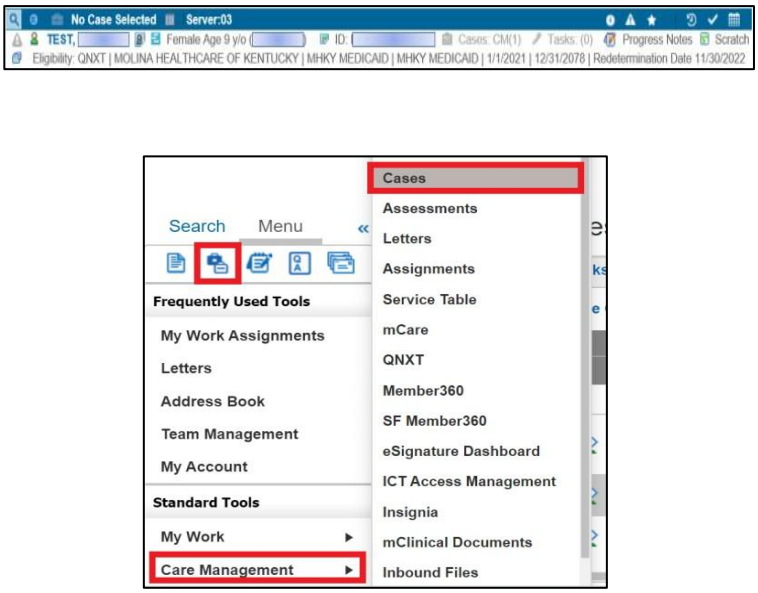
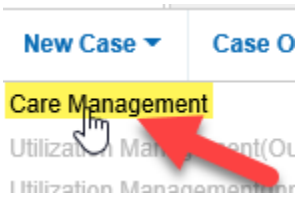
Intervention	Case Manager will work with member and member <Community Support agency> to restore or develop skills necessary to maintain housing.
Intervention	Member will attend necessary appointments related to housing.
Outcome	Member resides in a desired, stable, housing code-compliant residence adequate to house <insert number> adults and <insert number> children within 90 days.
Barrier	Housing insecurity and lack of resources.

Problem	**Overcrowded, substandard housing**
Goal	Member will reside in a desired, stable, housing code-compliant residence adequate to house <insert number> adults and <insert number> children within 90 days.
Intervention	Case Manager will work with the members <Community Support> agency to help the member obtain housing,
Intervention	Member will attend necessary appointments related to housing.
Outcome	Member resides in a desired, stable, housing code-compliant residence adequate to house <insert number> adults and <insert number> children within 90 days.
Barrier	Substandard housing and lack of resources.

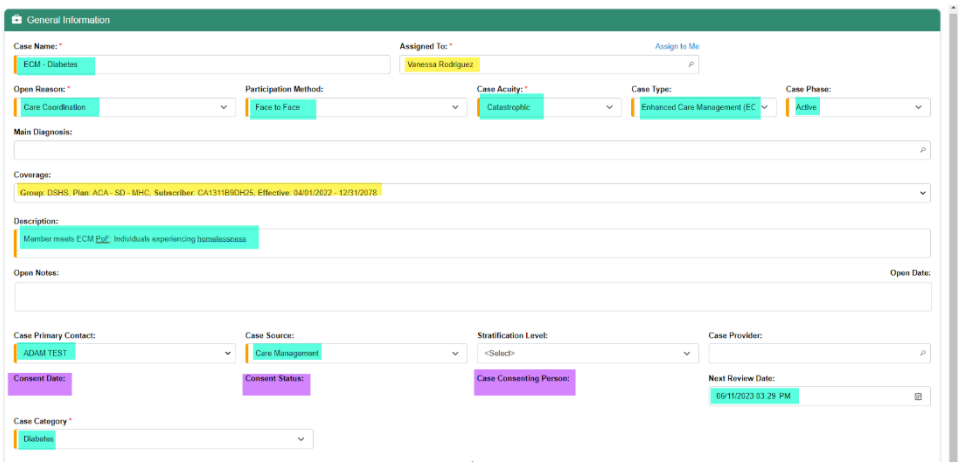
Problem	**Unhoused and not ready to access housing**
Goal	Member will access two services for basic needs (such as food, shower, and medical care) weekly for the next 30 days.
Intervention	Case Manager will link the member with (insert agencies, resources).
Outcome	Member has access to two services for basic needs (such as food, shower, and medical care) weekly for 30 days.
Barrier	Unhoused, not ready for housing and lack of resources.

Creating the Care Plan in CCA

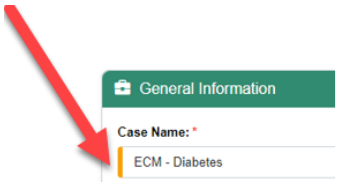
Follow the steps below to create the member's care plan in CCA. Make sure you are assigned to the member in the Assignments section of CCA before opening a care plan:

Instructions	Screenshot
Step 1: With the member in focus, click on either the: • **Cases/Tasks** icon from the Quick Tools section Or • ***Care Management*** under Standard Tools and select ***Cases***. You will be redirected to the Member Cases & Tasks landing page.	
Step 2: To create a new care plan, select "**New Case**" and "**Care Management**." **Note:** Ensure you are assigned to the member. There should **only be one** ECM Care Plan per Member. The member can have multiple problems listed under one care plan, you will continue building PGIOB sets in that care plan.	

Step 3: You will be taken to the **General Information** page. Think of this as creating a label for the member's folder where you will insert all the goals you will be working on with the member/ member's care team. The **General Information** page will appear. Complete areas highlighted in **green,** these areas need to be completed before you save the case. Areas in **yellow** will auto-populate. Areas in **purple** will auto-populate after obtaining member consent). See example below.

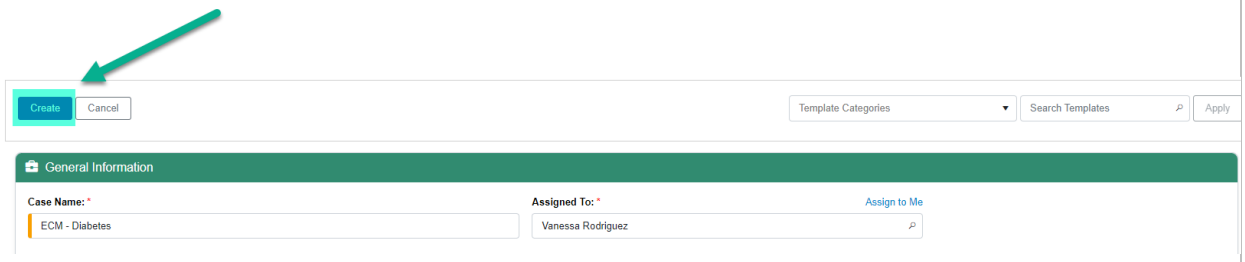


NOTE: any fields where information is entered will be flagged with an orange 'change' bar.



General Information Page	
Field Name	**Instructions**
1. Case Name ***Mandatory field****	Enter name that describes the case, typically the member's main health concern. All Case Names must start with "**ECM**-" followed by a hyphen and then the **main health concern**. Ex. ECM-Asthma This is a **mandatory** field that requires this specific naming convention.
2. Assigned To	Field will auto-populate with the name of the person creating the case. Make sure to assign yourself under "Assignments" as the primary CM before creating a care plan.
3. Open Reason ***Mandatory field****	Select **Care Coordination** as the reason from the drop-down. ***Note:** This can't be changed after saving.

General Information Page	
Field Name	**Instructions**
4. Participation Method ***Mandatory field****	Indicates how member will participate in care management: • Digital – *do not use this option* • Telephonic • Face-to-face
5. Case Acuity ***Mandatory field****	Indicate the risk level for the member (**Medium, High, Catastrophic**). Refer to the *Case Acuity* section for detailed definitions. (Members with Low acuity should not be enrolled in the Program. If any members have a "Low" acuity, they should be evaluated to determine if they are well managed or continue to meet the eligibility for Enhanced Care Management).
6. Case Type ***Mandatory field****	Select Enhanced Care Management Program (ECM) from drop-down menu.
7. Case Phase ***Mandatory field****	Select "Active" from the drop-down menu.
8. Main Diagnosis	Leave blank.
9. Coverage	Verify that the member's line of business (LOB) has auto populated in this field.
10. Description ***Mandatory field****	Enter a brief overview of the reason for why the member is enrolled in care management.
11. Open Notes	Leave blank.
12. Case Primary Contact ***Mandatory field****	Pulls list from the Address Book (new) • If member is agreeing to the care plan, choose member's name. • If a parent, legal guardian, POA, etc. will be the primary contact à must add to the address book first.
13. Case Source ***Mandatory field****	Choose **Care Management** from the drop-down menu.
14. Stratification Level	Leave blank.
15. Case Provider	Auto-populates the provider assigned.
16. Consent Date/Status/Person	Automatically populates when the care plan consent fields are completed within the care plan.
17. Next Review Date ***Mandatory field****	Enter date for next care plan review. Process is to also track this through tasks.

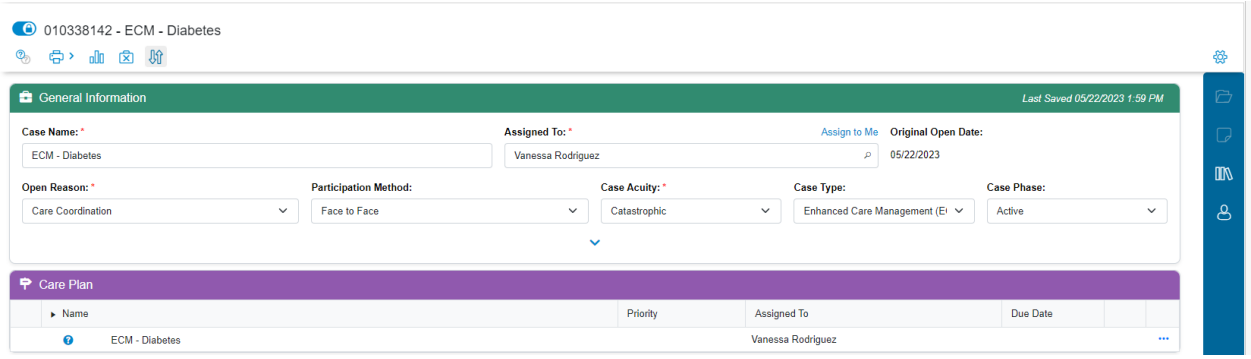
General Information Page	
Field Name	**Instructions**
20. Case Category ***Mandatory field****	Select the condition from the drown-down menu that corresponds with the case name/diagnosis. NOTE: If there isn't a category that matches the case name or diagnosis, select '*other*.'
Once you have completed the required fields in the **General Information** using the information above, click **[Create]** located in the upper left corner. 	

In edit mode, a '**Last Saved <date / time**>' message will appear in the General information green bar on the right-hand side.

NOTE: Some activities will auto-save once information is entered in the care plan while other activities require you to click the designated button to save the information.

Individualized Care Plan Development

Once opened, the system will auto-default to the layout below:



- The **General Information** (**green** banner) panel contains the basic information about the Case and its history.

- The **Care Plan** (**purple** banner) panel allows you to manage the Problems along with the associated Goals, Interventions, Outcomes, and Barriers within the member's care plan.

- The **Side Panel** (**blue** banner) lets you manage the details of the care plan.

Care Plan Tools

There are multiple tools located within the care plan module. Below is a high-level overview of each of these tools:

Tools located above the Care Plan

- **Lock/Unlock icon** – allows users to lock a care plan for editing purposes and unlock a care plan for viewing purposes only.
  - If a care plan is being edited by another user, you will not be able to edit the care plan at that time. The other user's name will display next to this icon.

EDIT MODE

OPEN MODE

- **/icon** – allows users to toggle between showing only the *Active* Problem banners within the care plan (default setting) or showing *all* of the Problem banners.
  - When viewing all of the Problem banners, the inactive ones will have a gray background at the bottom of the care plan list.

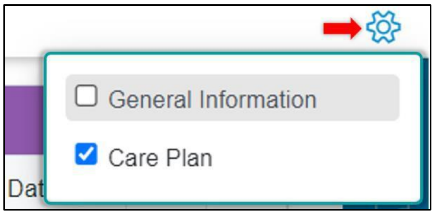
- **Print icon** – NOT currently used at Molina

- **Case Savings and Expenses icon** – *NOT currently used at Molina*

- **Close / Reopen Case icon** / – allows users to close and re-open a care plan as applicable. **ECM LCM's should not be reopening closed care plans.**

- **Reorder View icon** – allows users to move milestones within the care plan (*reorder line items*) as needed.

- **Settings icon** – located in the upper *right-hand* side; allows users to select whether to show or hide the General Information or Care Plan panels as desired.



Tools located in the Side Panel

The icons located here allow users to access the following items:

- **Details icon** – based on the milestone selected in the care plan, this icon displays the details for that item and allows users to edit as applicable; *more details below*
- **Goal Notes icon** – *only available when a goal is selected in the care plan.* Allows users to enter progress notes associated with one or more goals; *more details located below*
- **Guideline Library icon** – allows users to add milestones from the Guideline Library; *more details located* below
    - *If there are any milestones in the Libraries from a completed assessment,* these will also be available here.
- **Member Consent icon** – allows users to update member consent; *more details located* below.
- **Expansion icon** – allows users to expand the side panel to full screen. You can exit full screen by clicking the icon again.
- **Close icon** – allows users to close/minimize the Side Panel.

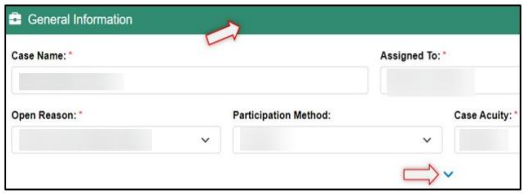
NOTE: If you begin editing a field in the Side Panel, the other fields in the page may become inactive (with the exception of custom panels); you will not be able to continue without saving or canceling your work in the Side Panel.

Viewing Options

You may determine how much information you see under the **General Information** and **Care Plan** sections based on personal preference.

General Information - Click on the heading (green bar) to fully collapse or partially expand this section.

- Click on the downward facing caret '**v**' to expand for more details.



Care Plan - Click on the heading (purple bar) to expand /collapse the information in this section

Developing a Care Plan- Adding Standard Milestones from the Library

This section outlines the procedure for adding milestones/goals using the Guidelines from the library.

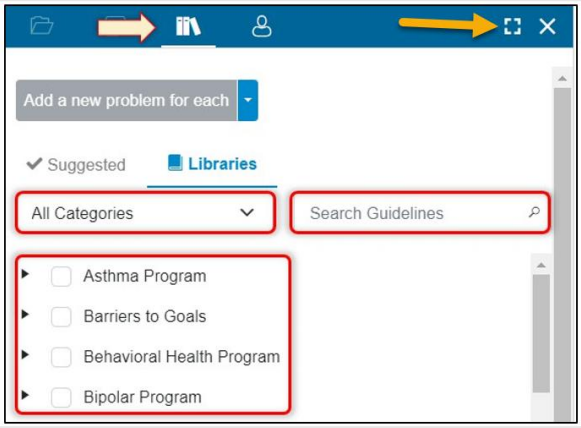
These guidelines are a standard set of *goals* and *milestones* reflecting the best practices for managing a particular *Problem* or *Diagnosis*.

From the **Side Panel** (blue banner), click on **Guideline Library Icon.**

- *You can enter full screen mode by clicking on the **square icon** in the right corner.*

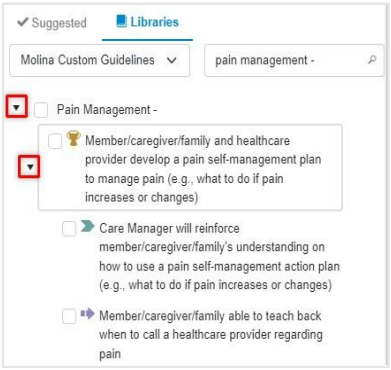
You may search for guidelines by:

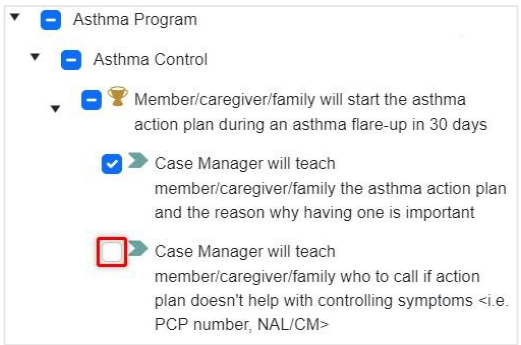
- Selecting a category from the 'All Categories' drop- down menu
- Using the 'Search Guidelines' field to find a desired guideline (i.e. pain)
- Browsing through the displayed list of categories, expanding the desired guideline(s)



Once the desired category is located, click on the triangle to the left to expand the category and view the associated goal(s).

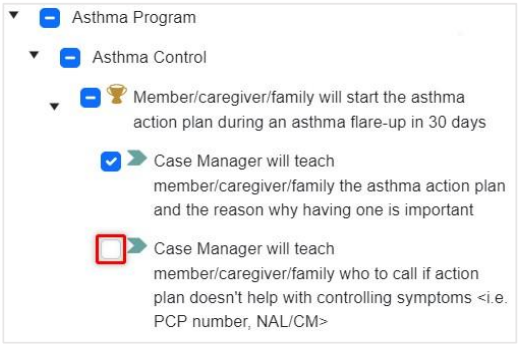
- Click the triangle to the left of the *goal* to view the associated intervention(s) and outcome(s).
- Review the milestones displayed to determine which ones are appropriate and applicable for the member's care plan.





To add the desired milestones to the care plan, click on the box next to the milestone.

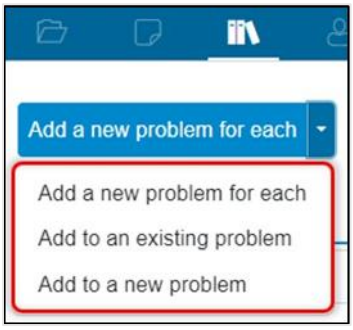
To remove any auto-selected milestones, click on the box to remove the check mark.



Problem Banner

Once the desired milestones are selected, you will need to determine which problem banner the guideline(s) should be associated with.

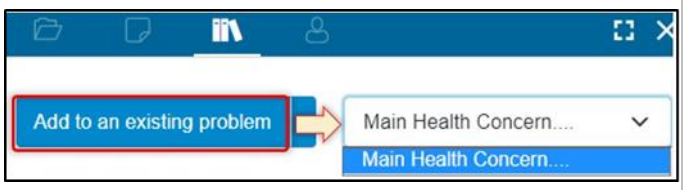
Use the drop-down menu to select the appropriate option.

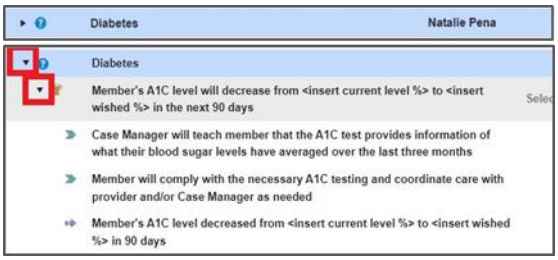


- **Add a new problem for each:** Select if creating a new problem within the care plan for each set of milestones selected, with the guideline name as the Problem name.
- **Add to an existing problem**: Select if adding milestones to an existing problem banner in the care plan; select appropriate problem from the drop-down menu.
- **Add a new problem:** Select if creating a new problem within the care plan for all guidelines.

Enter the name of the Problem banner in the text field.

Complete your selection, then click the button itself [Add…].



It may take the system a few seconds to generate the selected milestones within the care plan. Results: The new line items display in bold type in the Care Plan panel. To view the entire imported PGIO set use the arrow to expand the fields. If you need to add milestones from the library to an *existing* problem banner as well as a new problem banner, you will need to complete each set *separately*.	

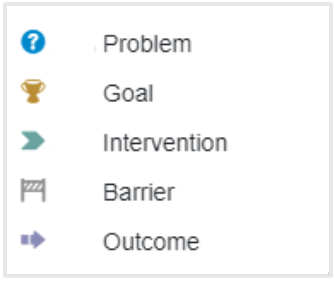
Reminder

The milestones will still need to be edited to be individualized to the member's needs or situation. *See the process* below *for instructions on how to edit the milestones.*

Every **Problem** must have at least ***1*** SMART goal that addresses it.

Every **Goal** must be in the SMART format and have at minimum ***1*** Case Manager intervention, ***1***-member specific intervention, and ***1*** outcome.

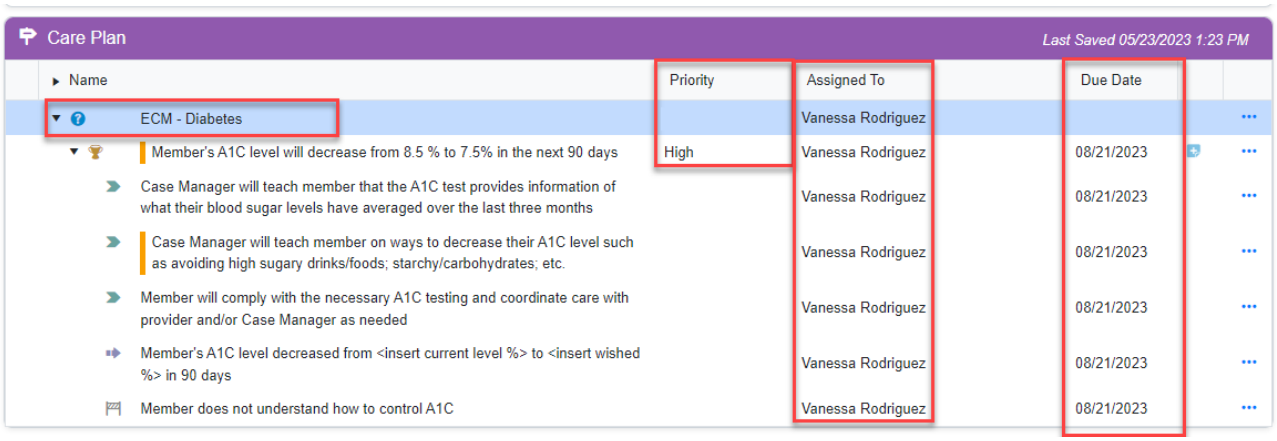
- Any applicable barriers should also be added to the goal with an intervention to address *how the barrier will be resolved.*
- See the legend for the Problem and Milestones:



Care Plan Columns

The columns within the Care Plan panel provide the following information:

- **Name –** the milestone within the care plan (Problems, Goals, Interventions, Outcomes and Barriers)
- **Priority –** level of importance of the goal *to the member; goal level only. Select from drop-down menu.*
- **Assigned to –** who is responsible (ECM LCM) for that particular milestone in the care plan
- **Due Date –** date the associated milestone is projected to be completed by. *Select from calendar or enter date (should have a mixture of short term and long-term goals).*



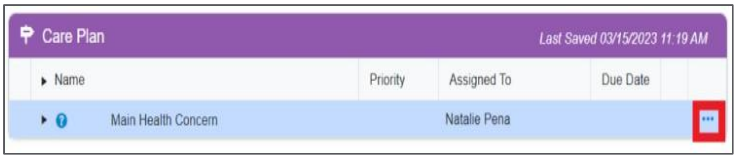
Adding Customized Milestones to the Care Plan

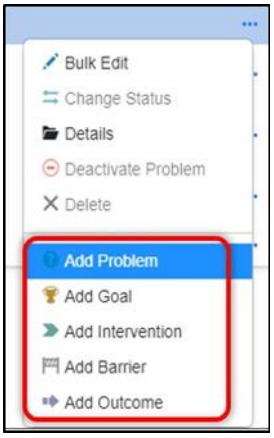
Problems and milestones that are *not* listed in the Library Guidelines can be created independently.

- Non-clinical milestones are typically added to the care plan using this process.

To add PGIOs *not* found in the library

- Click on the ellipsis (•••) located to the far right of each milestone.
- From the pop-up menu, select the *type* of PGIO you would like to add to the care plan.
    - **Add Problem –** *this option is only available if you select the ellipsis icon next to <u>another</u> problem banner.*
    - **Additional features –** *information provided for:*
        - *Details*, *Deactivate* & *Delete* options located below
        - *Bulk Edit* located below





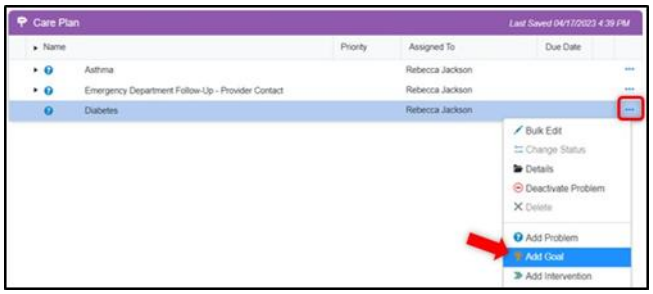
Problem	
If the desired **Problem** banner does not yet exist in the care plan, begin by selecting this option from the pop-up menu. A new line item will populate; enter the problem name. Click the green √ to save or the red **X** to leave the section without saving. The new problem banner will display in the care plan.	

Goal

To add a **Goal** to the Problem banner, click on the *ellipsis* on that problem banner and selecting '**Add Goal'** from the pop-up menu.

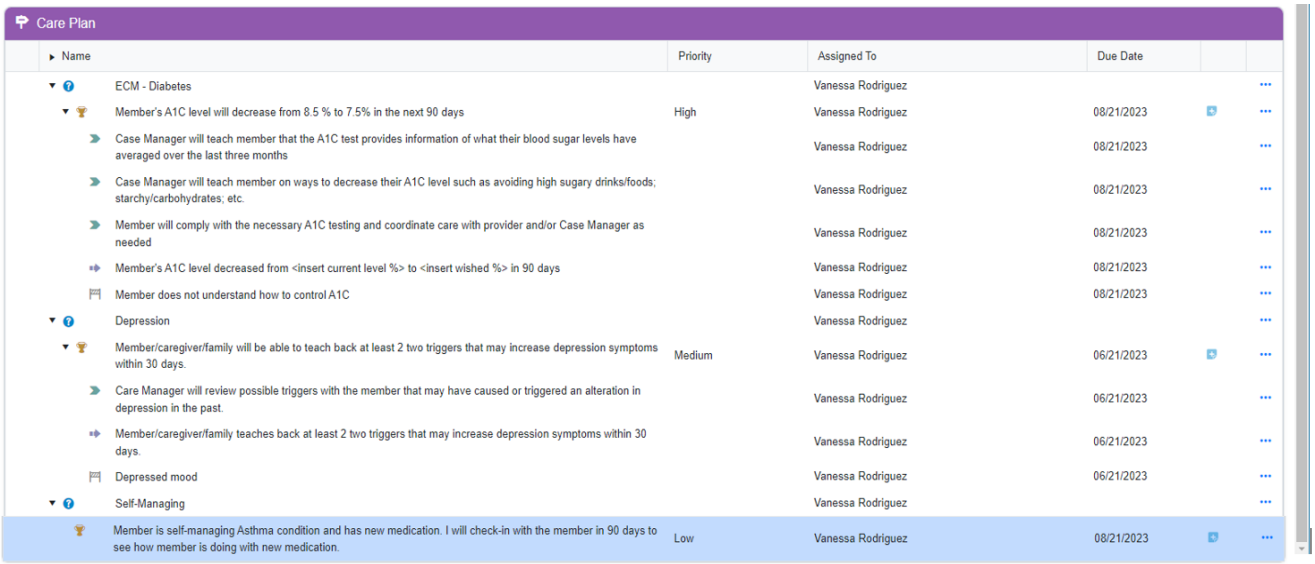
Another new line will appear. Fill in the fields and click the green √ to save or the red X to leave the section without saving.

- **Name:** enter SMART goal
- **Priority:** select from drop-down menu (low, medium, or high)
  Applies to the goal only
- **Assigned To**: leave as default
- **Due Date**: enter date goal will be met.



Follow these same steps to add customized *Interventions*, *Outcomes*, and *Barriers* to the goal by clicking on the ellipsis (•••) on that goal line.

See example below of a care plan. The ECM LCM will also need to add problems the member reports to be **self-managing** by creating a problem and naming it "**Self-Managing**," and adding a goal for each problem the member is self-managing. Self-managing problems/concerns should demonstrate health promotion activities, support with medication review, and communication/care coordination between all of the member's treating providers.



Name	Priority	Assigned To	Due Date
ECM - Diabetes		Vanessa Rodriguez	
Member's A1C level will decrease from 8.5 % to 7.5% in the next 90 days	High	Vanessa Rodriguez	08/21/2023
Case Manager will teach member that the A1C test provides information of what their blood sugar levels have averaged over the last three months		Vanessa Rodriguez	08/21/2023
Case Manager will teach member on ways to decrease their A1C level such as avoiding high sugary drinks/foods; starchy/carbohydrates; etc.		Vanessa Rodriguez	08/21/2023
Member will comply with the necessary A1C testing and coordinate care with provider and/or Case Manager as needed		Vanessa Rodriguez	08/21/2023
Member's A1C level decreased from <insert current level %> to <insert wished %> in 90 days		Vanessa Rodriguez	08/21/2023
Member does not understand how to control A1C		Vanessa Rodriguez	08/21/2023
Depression		Vanessa Rodriguez	
Member/caregiver/family will be able to teach back at least 2 two triggers that may increase depression symptoms within 30 days.	Medium	Vanessa Rodriguez	06/21/2023
Care Manager will review possible triggers with the member that may have caused or triggered an alteration in depression in the past.		Vanessa Rodriguez	06/21/2023
Member/caregiver/family teaches back at least 2 two triggers that may increase depression symptoms within 30 days.		Vanessa Rodriguez	06/21/2023
Depressed mood		Vanessa Rodriguez	06/21/2023
Self-Managing		Vanessa Rodriguez	
Member is self-managing Asthma condition and has new medication. I will check-in with the member in 90 days to see how member is doing with new medication.	Low	Vanessa Rodriguez	08/21/2023

Reminders

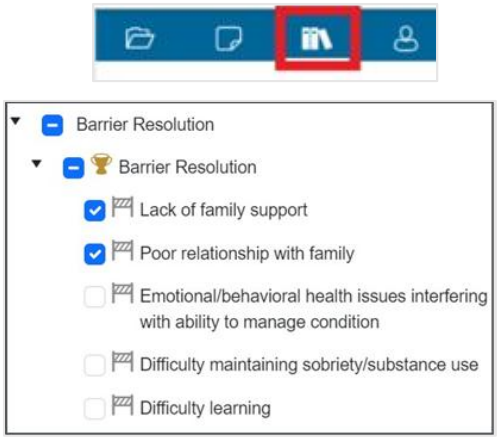
- Any imported milestone(s) will still need to be *edited* to be specific to the member's needs.
- Any other identified concerns that did *not* auto-generate associated milestones still need to be addressed in the member's care plan.

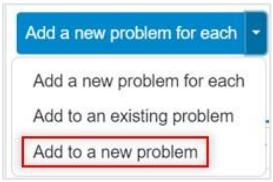
Adding Barriers to the Care Plan

Barriers may be added as a stand-alone item within the care plan, if the barrier applies to all of the goals, or attached to the specific goal it applies to.

To add a barrier as a *stand-alone* item in the care plan:

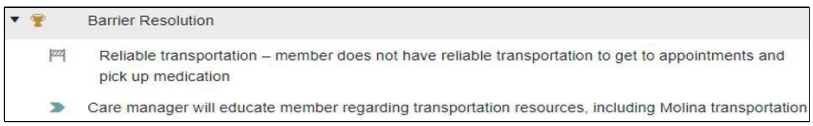
1. From the **side panel** (blue banner), click on **Guideline Library Icon**
2. Under the **Barriers to Goals** category, click on the arrows to expand the corresponding guidelines.
3. Select the appropriate barrier(s) to be added by clicking on the box next to the individual barrier(s).
4. Once the barrier(s) is selected, choose **[Add to a new problem]** from the drop-down menu at the top and then click on the selection again to import the barrier(s) into the care plan.





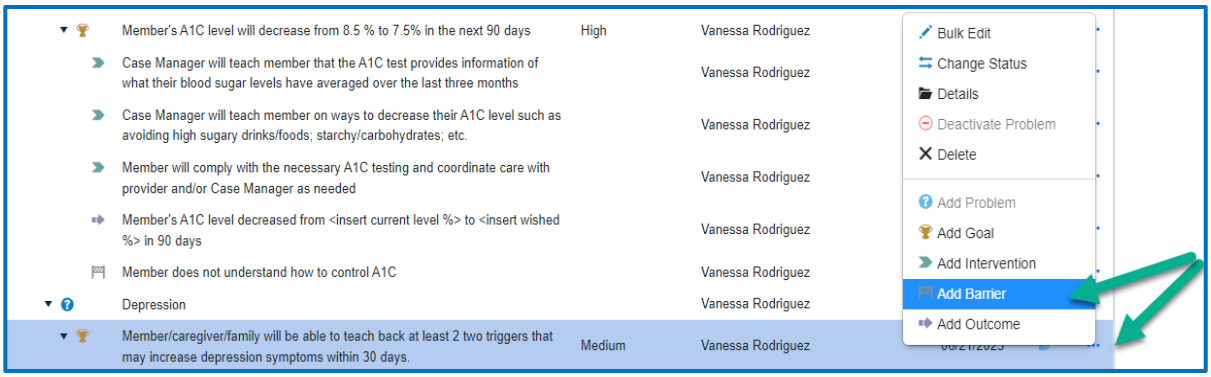
The care plan will display the Barrier(s) selected as a new Problem banner.

Best Practice: edit the barrier to be *individualized* to the member and add an intervention to address the barrier.



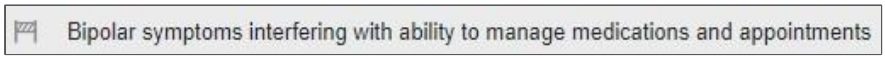
Attach barrier to a specific goal: follow the steps above for adding Customized Milestones.

- Be sure to select 'Add Barrier' from the pop-up menu at the goal level:



In the new line that is generated, enter the details of the barrier:

Remember: Barriers should be *individualized* to identify member specific problems



Editing Care Plan Milestones (PGIOBs)

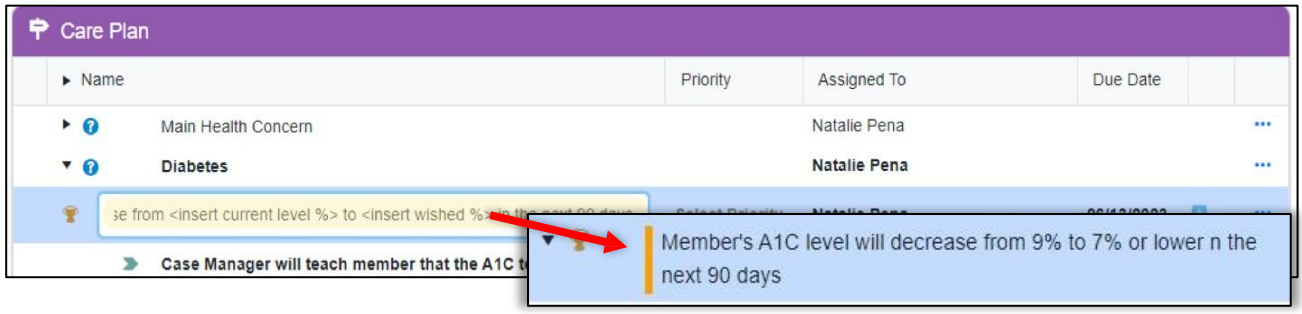
All of the milestones within the care plan must be edited to be individualized to the member's needs as appropriate.

The following fields may be edited directly within the **Care Plan** panel (purple banner):

- Milestone Name
- Priority Level, *for goals only*
- Assigned To
- Due Date

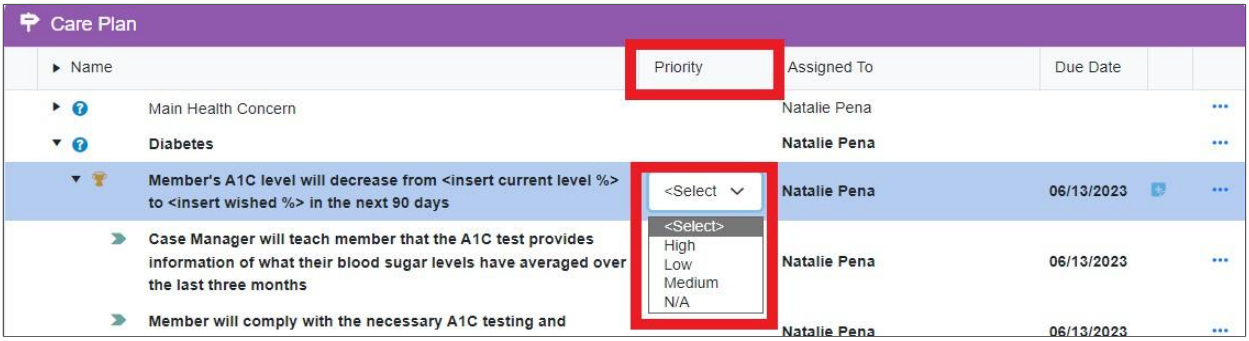
To **edit** a field, click on the field to change to edit mode.

Begin typing the changes or select the appropriate option as applicable. An orange change bar indicates fields you have edited but have not yet saved. The information will be saved as soon as you click into a *new* field.



Prioritizing Goals

All goals added to the Care Plan must be prioritized *based on the member's preference.* To select or change the priority level, click on the **Priority** column corresponding to the goal and select the appropriate item from the drop-down box.



Again, and orange change bar will display, indicating the field has been edited but not yet saved. The priority level will be saved as soon as you click into a new field.

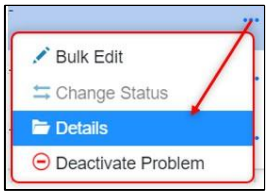
*Repeat this same process to change information under the Assigned To and Due Date columns for individual milestone.

Details

This option allows you to edit the *Details (a.k.a. Milestone Properties)* of a particular milestone. The type of information that you may edit will be based on the type of *milestone* selected within the Care Plan panel.

The **Details** option is available:

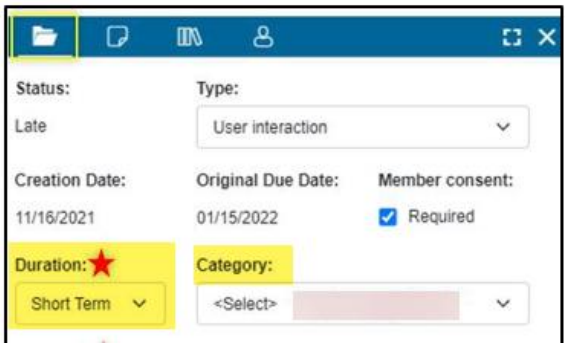
- In the Side Panel by clicking on the folder icon
- from the ellipsis drop-down menu; select the Details option.



Goal

When a goal is selected in the Care Plan, you will be able to edit the following fields:

- Duration (long term, *61 days or longer*, vs. short term, 60 days or less). Select Short Term or Long Term.
    - Reminder, care plan needs to have a mixture of short term and long term goals.
- Category, *process to 'Silence' milestones* see below for more information



For any milestones added from the Guideline Library, there may be educational information from Healthwise Knowledgebase under the *Content* section.

NOTE: Do ***not*** edit any of the other fields.

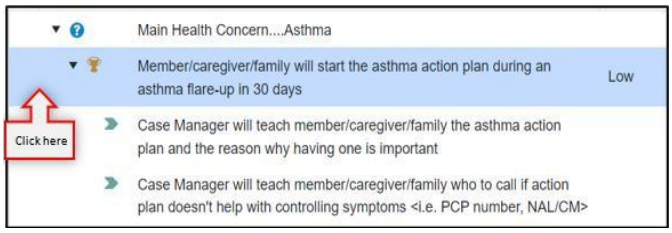
Interventions, Outcomes, and Barriers: Will display similar fields as found for goals except the Duration and Category fields.

NOTE: Any fields where you are currently editing the information will display an orange bar. Once you click out of the field or make a selection, the information will *automatically save*.

Silencing Milestones

Members have the right to ask for milestones within the care plan to be 'silenced' and not shared with their Primary Care Physician and other ICT members. Milestones silenced through the Care Plan tab will *not* be printed on the ECM ICP report that is sent to member's Primary care physician and other ICT members.

- This is ONLY per member request.
- Milestones can only be silenced at the *goal* level; all associated milestones will be silenced along with the goal.
- Click to the *left* of the goal to be silenced to highlight it.

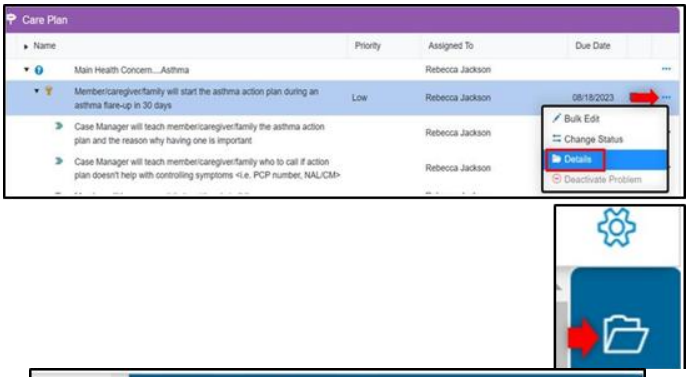


You may either:

- Click on the ellipsis at the goal level and select 'Details' from the drop-down menu

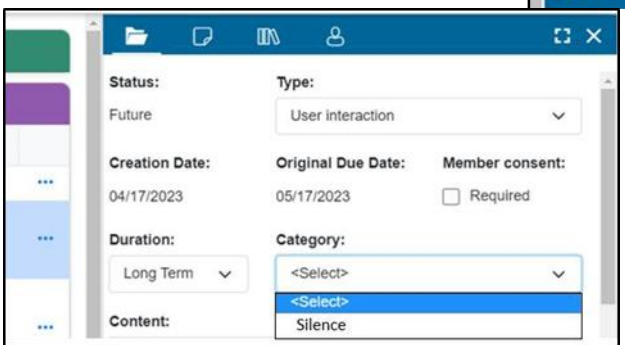
OR

- Click on the 'Details' icon in the side panel.



The side panel will expand.

Under the ***Category*** section, select 'Silence' from the drop-down menu.



Result

A silence icon will appear at the goal level only, but all associated milestones will be 'silenced' / hidden when the *CCA ECM ICP* report is generated.

Reorder Milestones

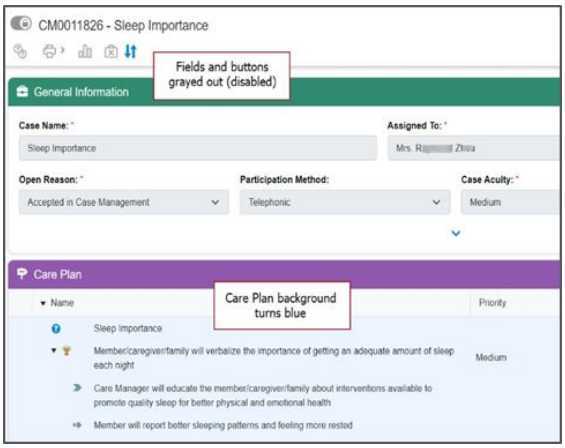
This option allows you to move, or reorder, the milestones within the Care Plan as needed.

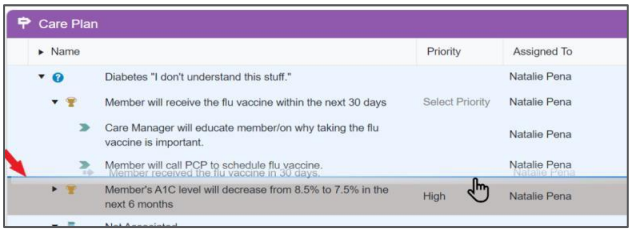
To rearrange the order of the milestones, select the **Reorder** icon located at the top, left-hand side.

The button and page are put into Reorder mode: the Care Plan line items are highlighted in blue, and all other fields are disabled.

You may do any of the following activities:

- Move a milestone to a different goal
- Move a milestone to a different position under the same goal
- Move a goal (along with the associated milestones) to a different problem banner
- Move a goal (along with the associated milestones) to a different position under the same problem banner
- Move a problem banner to a different position in the list of problems.

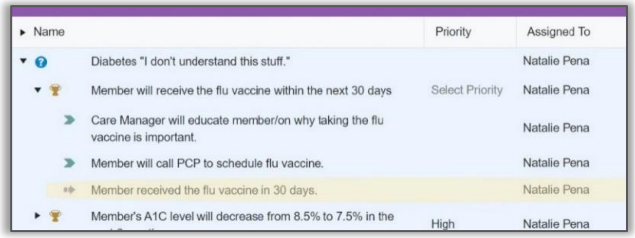




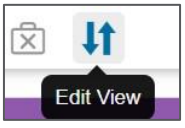
To move a milestone or goal, click to the left of the item and hold the mouse button down as you drag the item to the desired location. Release the mouse button.

NOTE: The line will turn blue only if you are allowed to move the milestone to that spot.

Result



When all items have been reordered as desired, click the **Reorder** icon to return to the standard edit mode.



Documenting Member Consent

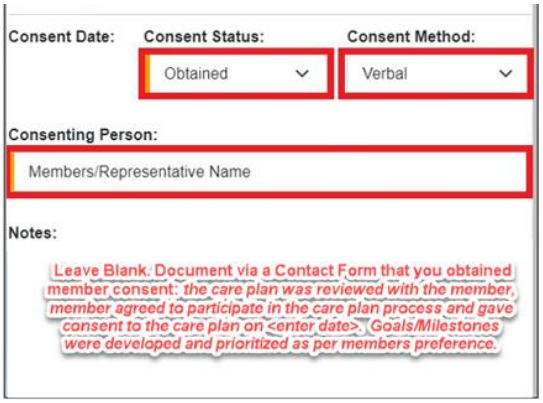
Once the care plan has been developed with the member (or member's representative), consent must be obtained. Member consent means the ECM LCM discussed the care plan with the member (or member's representative) and agreed with the care goals and any care plan updates. If "Obtained" is not selected within 90 days of enrollment, the Care Plan is considered non-compliant, even if it was created on-time. If "Obtained" is not selected after updating the care plan, the Care Plan is considered non-compliant. In addition, always document via a Contact Form when member consent is obtained, refer to Contact Form Scenarios section above.

Below is a detailed description on how to be sure to accurately capture member consent within CCA.

From the **Side Panel** (blue banner), click on **Member Consent icon** to open the *Member Consent* panel.

Consent Status - Select 'Obtained' from the drop-down menu

- Obtained



Consent Method - Select the method by which the consent was obtained.

- Verbal
- Written
- Other

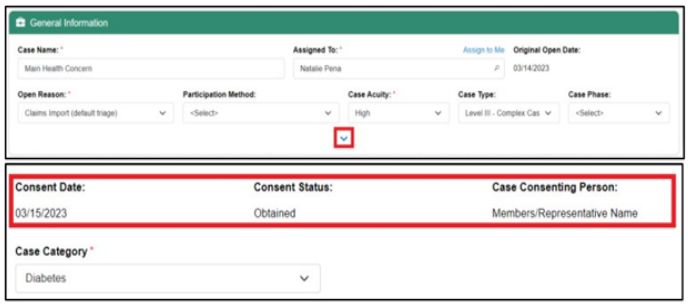
Consenting Person - Enter "Member" if member consented to care plan. If the member's representative consented to care plan, enter full name of individual, along with relationship to the member (e.g., Hilda Chavez, member's sister).

Notes - Do not enter anything in this Notes section. Instead, enter notes pertaining to the member consent via a Contact Form under the Progress Notes.

Click **Apply** to save the information.

Result:

The **Consent Status** and **Consent Date** fields on the *General Information* panel change to reflect the new information. You can expand the field using the arrow at the bottom of the panel.

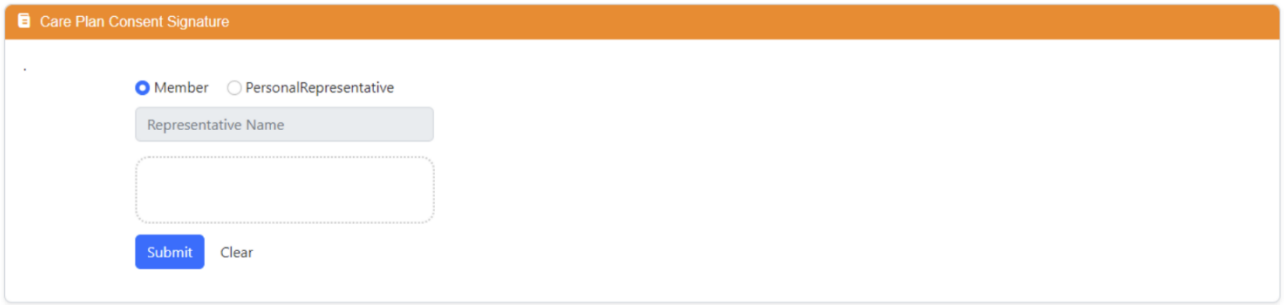


Reminder

The care plan should be updated after speaking with the member/representative/guardian/ POA, as appropriate, and member consent captured/obtained ***every*** time.

Be sure to make all changes to the care plan before updating member consent. Changes made to the Care Plan after the member consent was captured will reverse the status of the consent to "In Process" status!

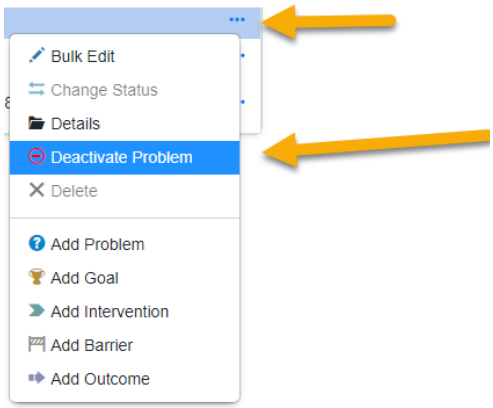
Please note: CCA displays the following section for Care Plan Signature Consent. Disregard this section – this feature is for Molina internal CM use only. Continue to use the procedures above to obtain member consent.



How to Deactivate a Problem and Delete Milestones

Deactivate Problem

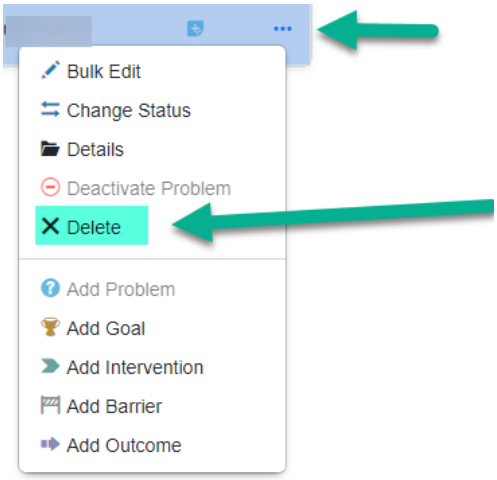
This option under the ellipsis ••• drop-down menu allows you to deactivate a problem banner, *if applicable*.



Reminder: You can choose to view or hide deactivated problem banners by clicking on this icon located above the *General Information* panel.

Delete

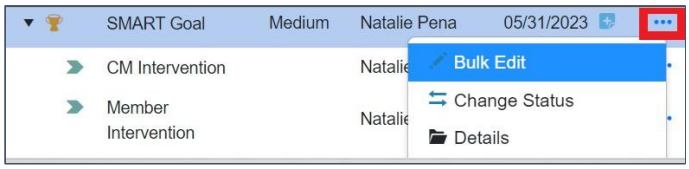
This option under the ellipsis ••• drop-down menu allows you to delete a milestone added in error:



Bulk Edit

The **Bulk Edit** option from the ellipsis ••• menu allows you to edit the *Due Dates* and *Assigned To* details for multiple milestones at one time.

From the **Care Plan** panel, click the ellipsis ••• for one of the milestones that needs editing.



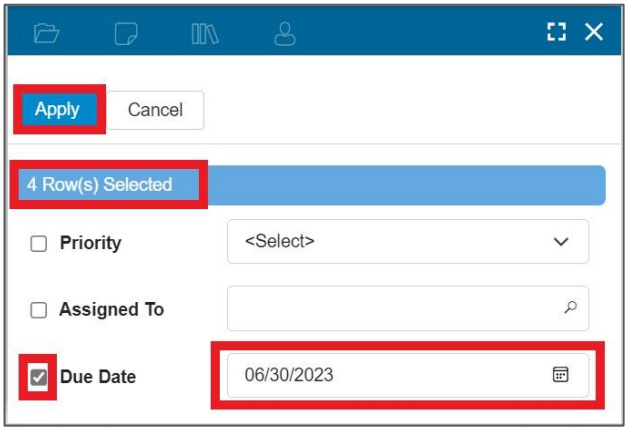
Click on the **Bulk Edit** option from the drop- down menu.

To select multiple milestones to edit, highlight them by either:

- Holding down the Ctrl button down and select multiple line items.
- Clicking and holding the left button on the mouse while drawing a box around the items you want to edit (edge of field, far left hand side)

The number of line items you selected is noted at the top of the Side Panel.

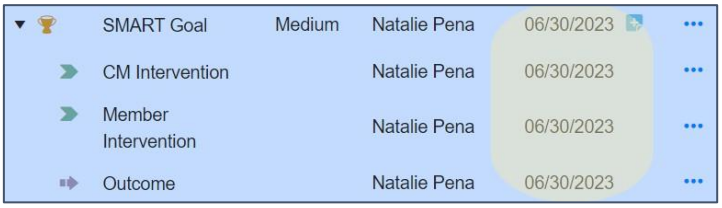
Select the box next to the field(s) you want to change and enter the new value.



**Priority does not function at this time.*

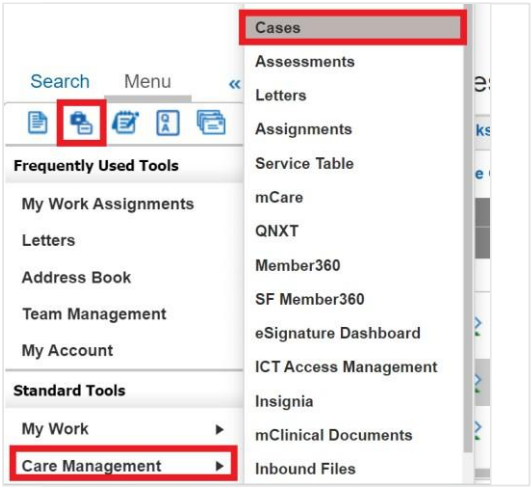
Click **Apply**.

Result: The selected milestones and fields will reflect the new data entered.



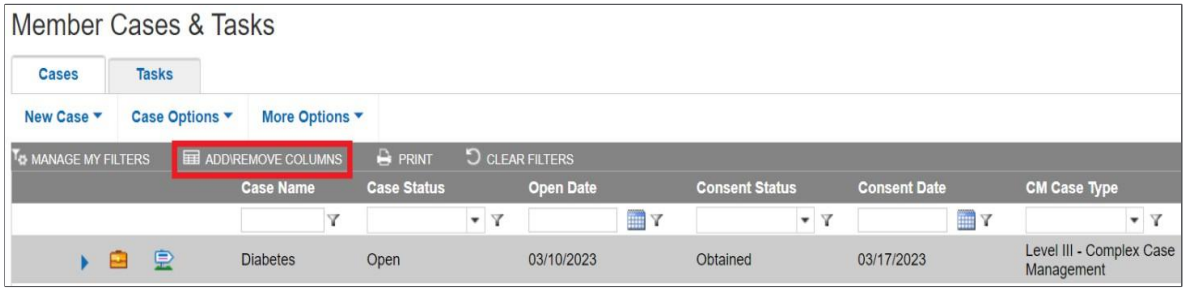
Accessing a Member's Care Plan

There are two routes you can take to access a member's care plan.

Instructions	Screenshot
Route 1: With the member in focus, click on the **Case ID#** located in the dark blue banner at the top. You will be automatically redirected to the member's care plan (open mode). Click on the lock icon to switch to '*edit* mode'	
Route 2: • **Cases/Tasks** icon from the Quick Tools section Or • Click on ***Care Management*** under Standard Tools, and select **Cases** You will be redirected to the **Member Cases & Tasks** landing page.	 

Member Cases & Tasks

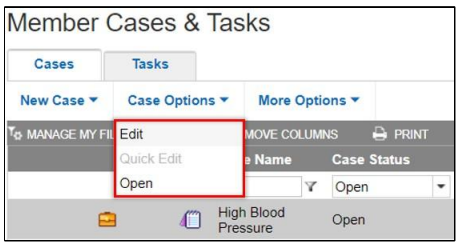
You may determine the information displayed by adding or removing columns based on personal preference. Recommended columns: ***Case Name, Case Status, Open Date, Consent Status, Consent Date, CM Case Type***



Click on the active care plan (**Case Status** *Open*) to highlight it.

From **Case Options** menu, select:

- **Edit** – to edit the case. This will lock the case so no other user can edit the care plan while you are in it.
- **Open** – allows users to view the care plan but not edit it.



Updating the Care Plan

As you work on the care plan with the member / member representative, the care plan should be updated accordingly and as applicable.

This may include:

- Changing the status of milestones
- Documenting a Progress Note
- Adding milestones or editing existing milestones (i.e. adding ICT recommendations as applicable).

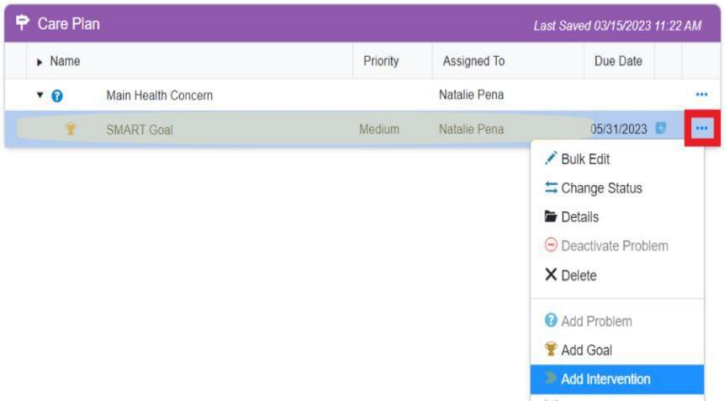
ICT Documentation

After an ICT meeting, the care plan should be updated to incorporate the ICT recommendations. Best Practice suggests that the care plan be updated with the ICT recommendations and action items within ***3*** days of completing the ICT meeting. If member did not attend the ICT meeting, the ECM LCM must call the member to discuss the meeting outcome and ICT recommendations and document member's acceptance in care plan.

ICT Recommendations

To update the care plan with ICT recommendations, go into the member's care plan.

- Click the ellipsis ••• in the last column of the PGIO set the ICT recommendation is to be associated with.
- Select the appropriate type of milestone to be added (**Goal and/or Intervention**).
- In the new line item that populates, complete the required fields.



Milestone Name

Always include the words **"Per ICT recommendations"** when adding ICT Recommendations to the care plan.

Click the green √ to save or the red **X** to leave the section without saving.

The added **ICT recommendation** milestone will now appear within the care plan.

Repeat the above steps if additional ICT recommendations need to be added to care plan. Reference the process above for additional information on *how to add customized milestones.*

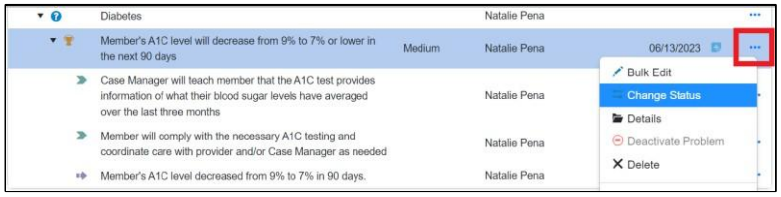
ICT Progress Note

Any changes made to the care plan after a formal ICT meeting must be accompanied by a member outreach as evidenced by a completed Contact Form, refer to ICT Meetings section below for more information.

Change Milestone Status

As interventions are completed and goals are met or not met, the status must be changed to accurately reflect care plan progress.

From the **Care Plan** panel, click the ellipsis ••• in the last column of the milestone you need to change status.



Click on the **Change Status** option from the drop- down menu.

In the *Change Status* panel, select the appropriate options from the drop-down choices.

Change status to:

- Met
- Not Met
- Redefined
- *N/A, do NOT use this option*

Reason:

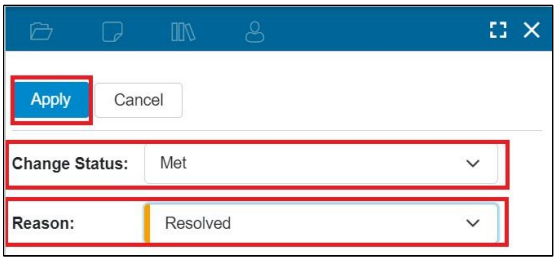
- Member refused to participate
- No longer applicable
- Not Resolved
- Resolved
- Unable to contact

If applicable, check the "*Update the status of all incomplete milestones associated to this goal*".

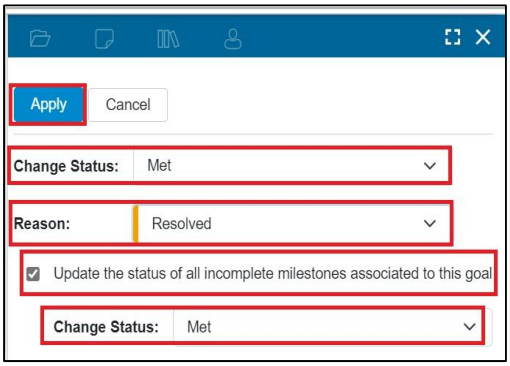
This is auto populating the drop-down field below.

Click **Apply.**

Goal ***not*** selected as one of the milestones:



Goal ***is*** selected as one of the milestones:

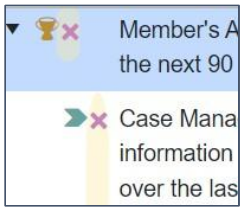


Result:

Milestone icon will indicate a green check mark for milestones that have been met or a purple X for milestones that are not met.

Met:

Not Met:



NOTE: Once a status has been applied, it can be changed following this process but not *removed.*

Closing the Care Plan

The ECM LCM will need to close the care plan prior to disenrolling a member from the ECM Program.

Before closing a case, make sure to:

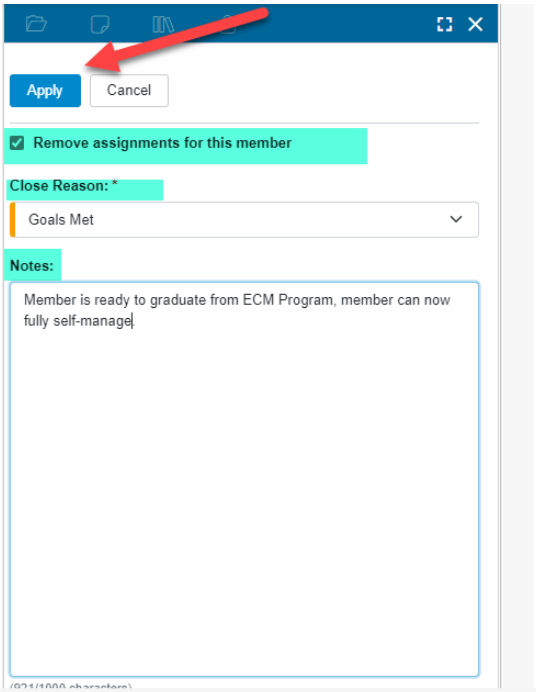
- Complete any open tasks
- Close out any pending milestones

(refer to changing Milestone Status above)

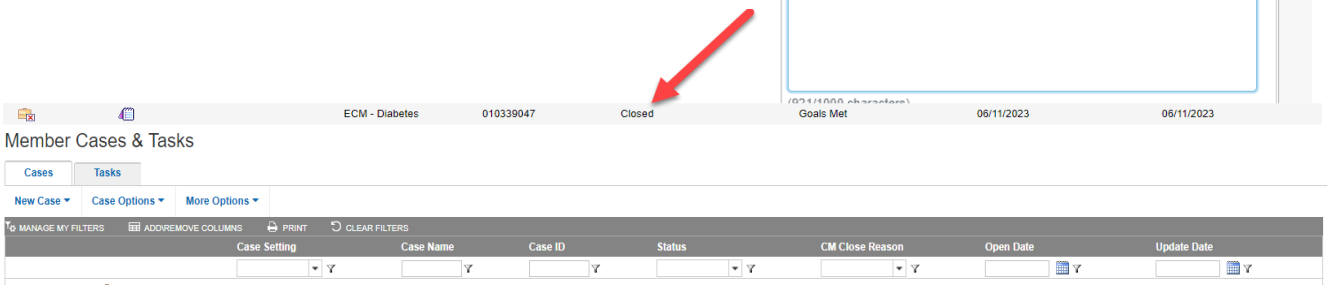
Close a Care Plan

To close a care plan, open the care plan in 'edit mode'.

1. Click on the [**Close Case**] icon located above the Care Plan (and General Information) panel.
2. The Side Panel will open up.
3. Select "Remove assignments for this member"
4. Select the appropriate **Close Reason** from the drop-down menu.
5. Enter a brief **note** supporting the reason for closing the case.
6. Click [**Apply**]



The care plan will reflect "**Closed**" under the Status:

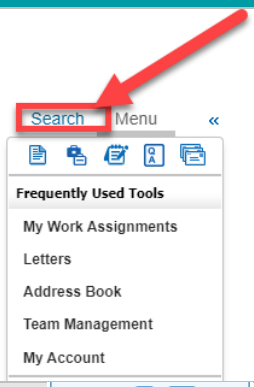
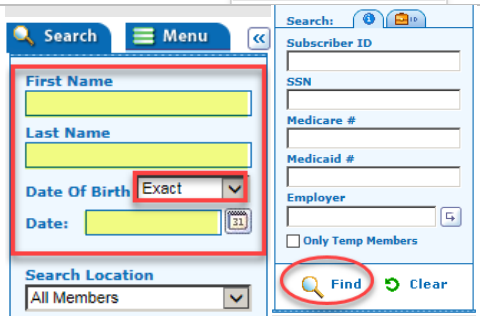
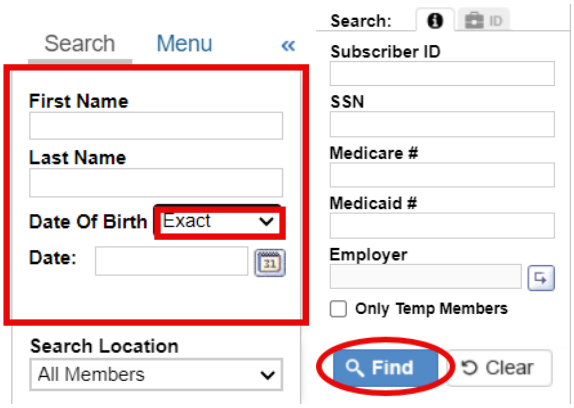


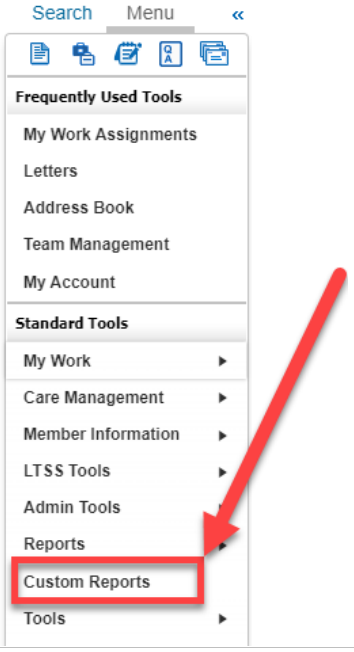
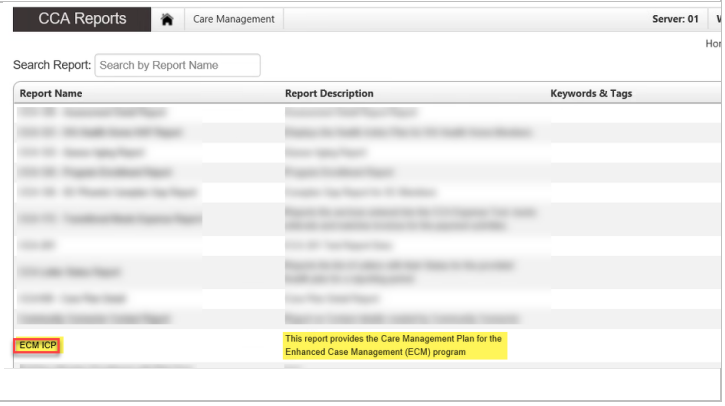
If there are any goals in the care plan that were added by the member's assigned Community Supports (CS) Provider and you need to close the care plan because you are disenrolling the member from ECM, inform the member's Community Supports (CS) Provider and Molina's CS Team: MHC_CS@MolinaHealthcare.com . The CS Provider will need to open a new non-ECM care plan to continue documenting care plan activities in CCA.

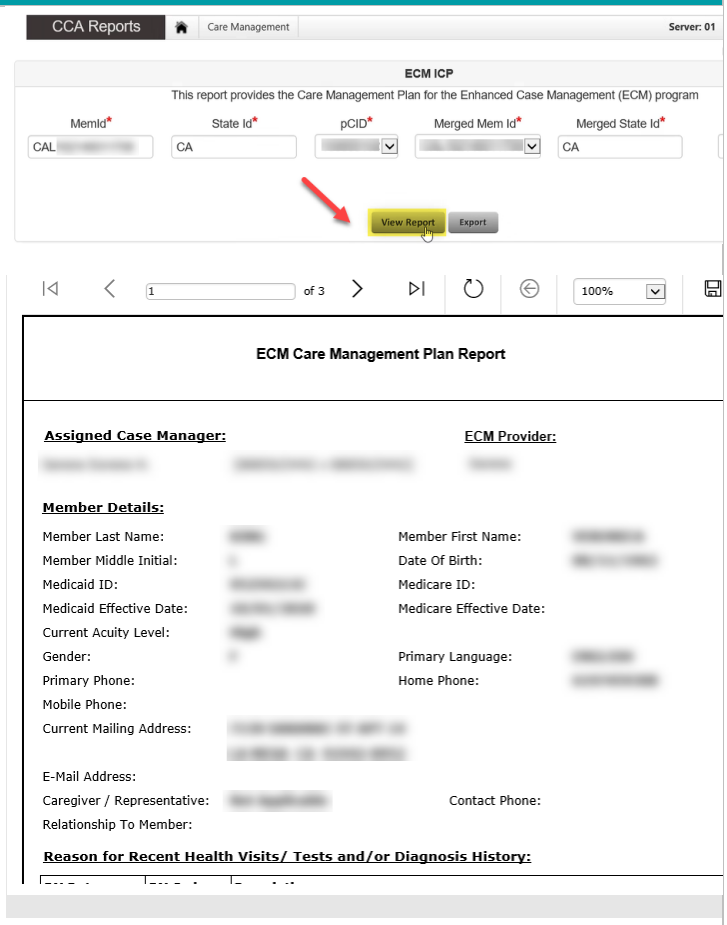
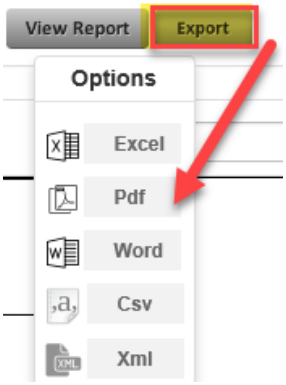
CCA Custom Report- ICP Report

If the ECM LCM is unable to attach the care plan to the care plan letter (see steps **Generating Letters in CCA and Attaching ECM Care Plan Letter to the ECM Care Plan below**) and gets an error message: The system is not able to pull care plan report, please attach manually, the ECM LCM will need to pull the care plan manually, also known as the ICP Report. Member consent must be obtained in the care plan to access and pull the ICP Report. The ECM LCM must provide a copy of the care plan to the member and the member's PCP after developing it and when it gets revised.

Follow the steps below to pull the ICP Report from CCA:

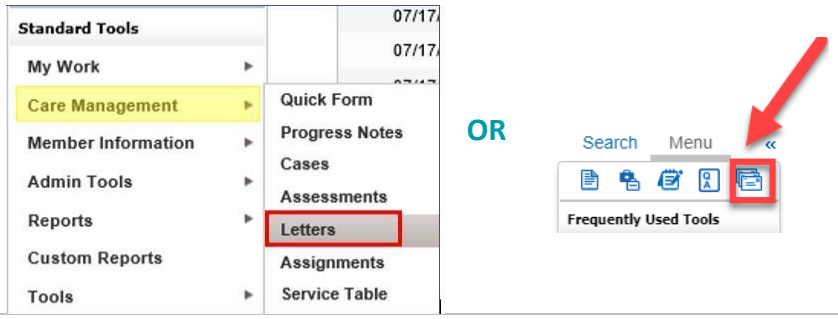
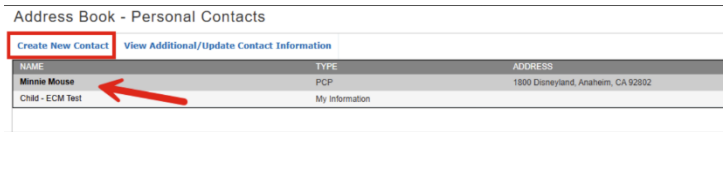
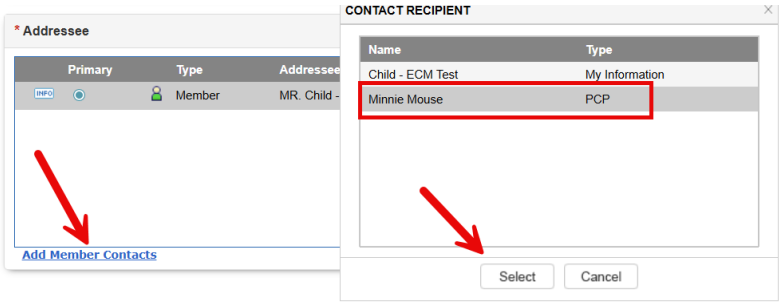
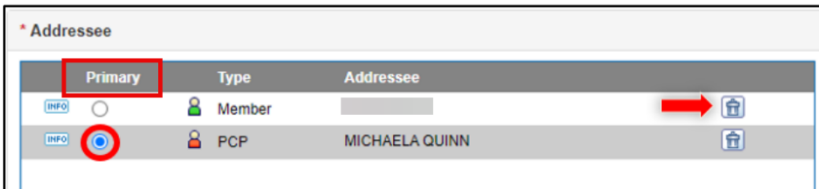
Instructions	Screenshot
Access CCA and click on the **SEARCH** tab to enter the member's full name.	
Type in the member's **FIRST NAME**, **LAST NAME**, and **DATE OF BIRTH** (selecting **EXACT** DOB from the drop-down box), then select **FIND** Alternate Search Criteria are available using the following: • Medicaid # • Employer = CA	 

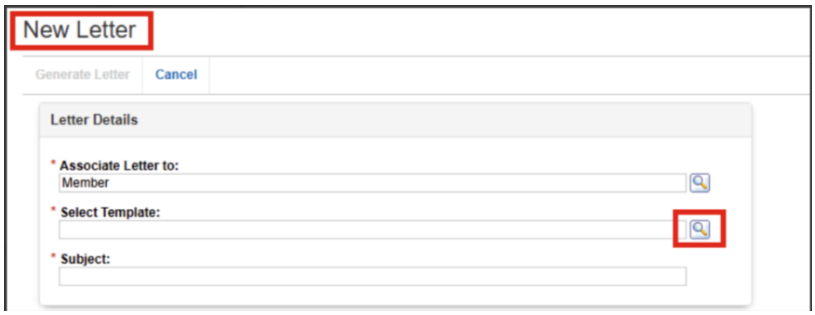
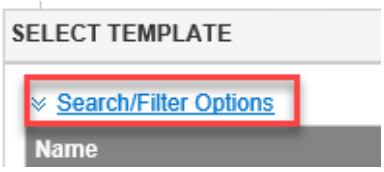
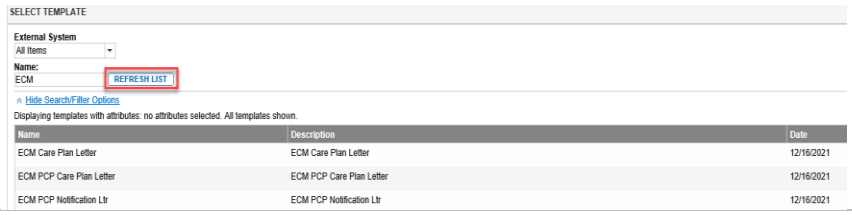
Instructions	Screenshot
Search Results will populate members' information. Select the member by clicking on the member's name. This will bring the member "into focus."	
Select the **Custom Reports** module:	
Select **ECM ICP**:	

Instructions	Screenshot
Select ***View Report,*** and the report will appear:	
Click **Export** and **PDF**. Mail this copy of the care plan to the member and the member's PCP, along with the appropriate care plan letter.	

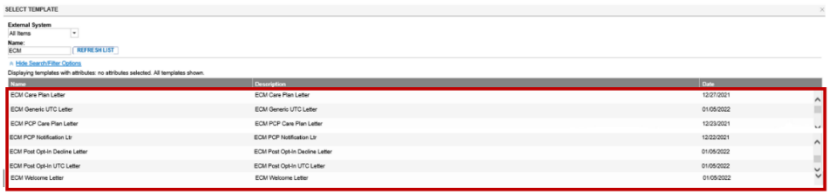
Generating Letters in CCA and Attaching ECM Care Plan Letter to the ECM Care Plan

The steps below demonstrate how to generate letters in CCA and how to attach the ECM Care Plan to the Care Plan Letters.

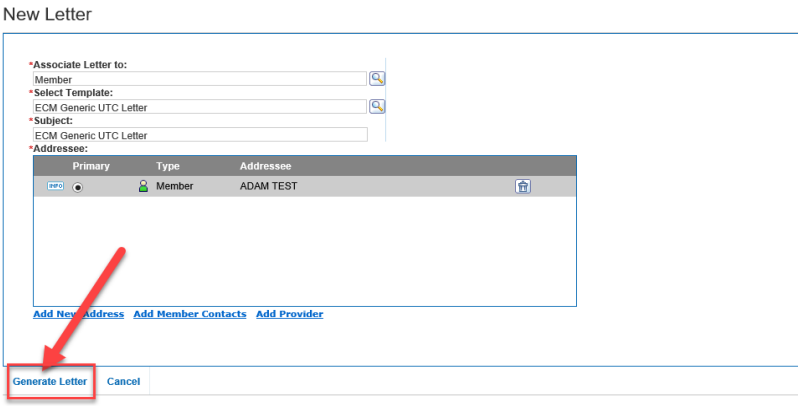
Instructions	Screenshot
Step 1: With the Member in Focus, go to the [**Letters]** Module in CCA.	
Step 2: Click on [**New]** on Top Banner.	
Step 3: Address If sending the letter to an address other than the member's assigned mailing address, the correct address must be updated in this field. Click on the Add Member Contacts hyperlink. In the pop-up menu, click on the correct contact highlight and then click on **[Select].** Primary Column: Select the radio button next to the correct contact Other Entries: Delete all other addresses listed by clicking on the trash icon.	  

○ If *not* removed, the system reads the letter as a 'carbon copy' and will not send the letter; showing up as 'failed' on the CM Letter Report. Only ***1*** contact should be displayed in this field when the letter is generated.	
Step 4: To the right of the ***Select Template** field, click on the magnifying glass to search for the desired letter template. Below is a list of all our ECM Letter Templates found in CCA: • ECM Generic UTC Letter • ECM Welcome Letter • ECM Care Plan Letter (initial and updates) • ECM PCP Care Plan Letter • ECM Post Opt-In UTC Letter • ECM Post Opt-In Decline Letter	
Step 5: Click on the **Search/Filter Options** to expand. In the **Name** field, enter the Letter Name *(Full or partial name can be used).* Click [**Refresh List**]. Scroll to select the letter.	 

Step 6: Select the Letter (a gray highlight banner will mark the letter).



After selecting the letter template, click [**Generate Letter**] on the bottom to generate a letter template for the member.

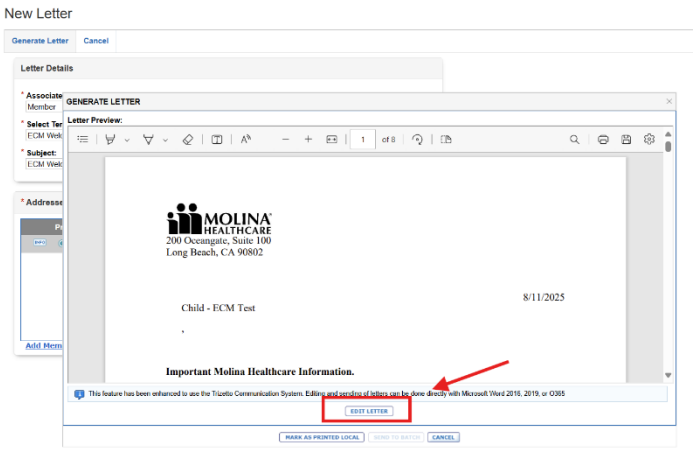


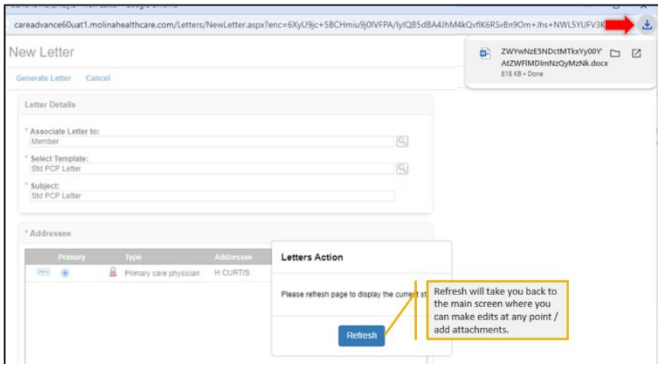
Step 7: Click [Edit Letter] in PDF Viewer to edit the letter.

Edits required in the letter:
If there are approved edits to the letter that needs to be made, click on the downloaded document from the pop-down menu in the upper right corner.

If one does not appear, click the download icon to display the menu

No edits required at this time:
Click on **[Refresh]** to return to the main landing page of the Letters module.



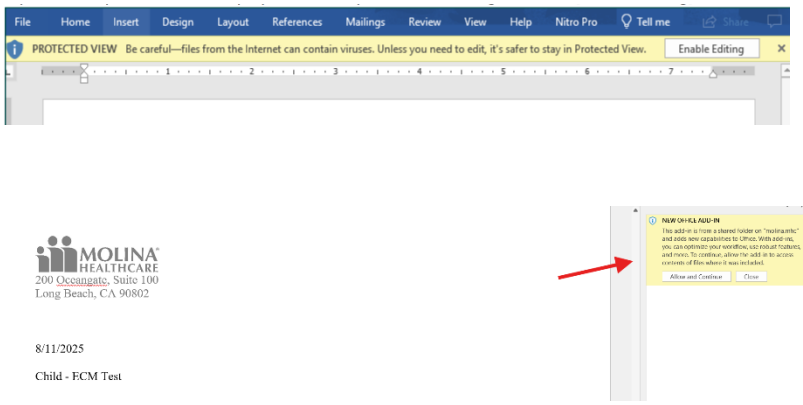


In MS Word:

- Click on [**Enable Editing**] in the yellow banner at the top.
- Edit the carrot areas <XXXX> in the letter and any other areas as applicable.

First time editing a CCA letter in MS Word:

- ***NOTE:** *If this is the first time Editing a CCA letter in MS Word,* you may be asked to [**Trust this add-in**]. This is the *communication link* from CCA, the CAE Letter Editor.
- Click on [**Trust this add-in**].



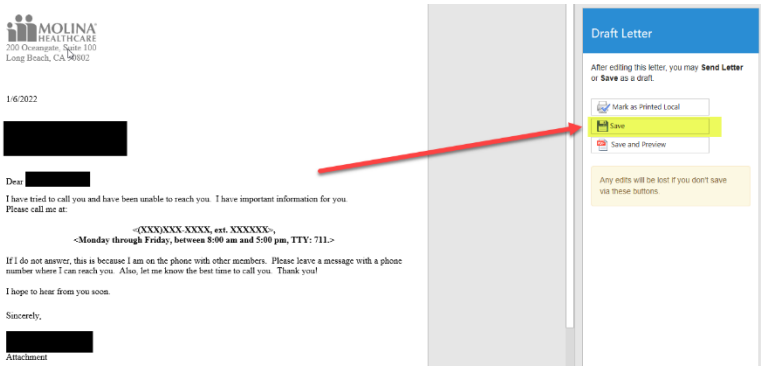
For the following letters only, follow Steps 8-9. The process ends in Step 9:

- ECM Generic UTC Letter
- ECM Welcome Letter
- ECM Post Opt-In UTC Letter
- ECM Post Opt-In Decline Letter

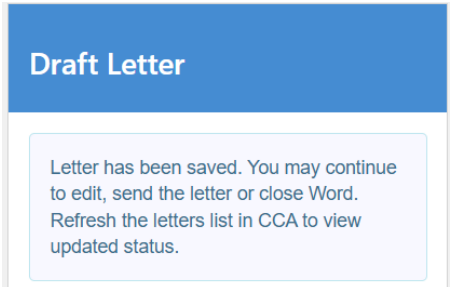
Step 8: CAE Letter Editor

Do not close this window!

Once all edits to the letter are made, click on [**Save**]. If you are unable to save this letter, please see additional instructions below.



Once the modifications have been saved, the following message will appear.

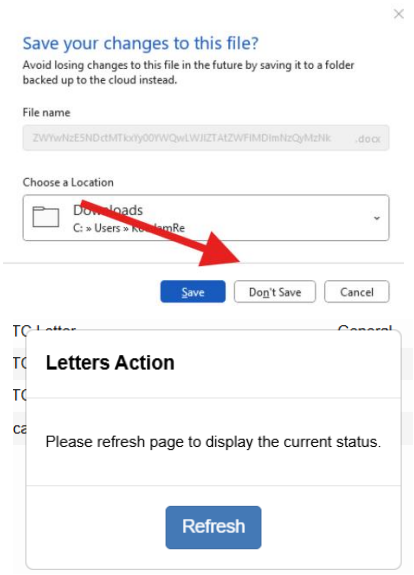


Click on the **X** in the upper right corner to close/exit out of MS Word.

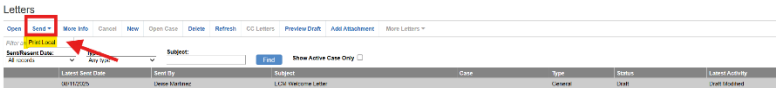
A pop-up window will ask if you want to save changes – this is asking if you want to save a copy to your computer.

Click on [Do *Not* Save] the letter locally (to your computer).

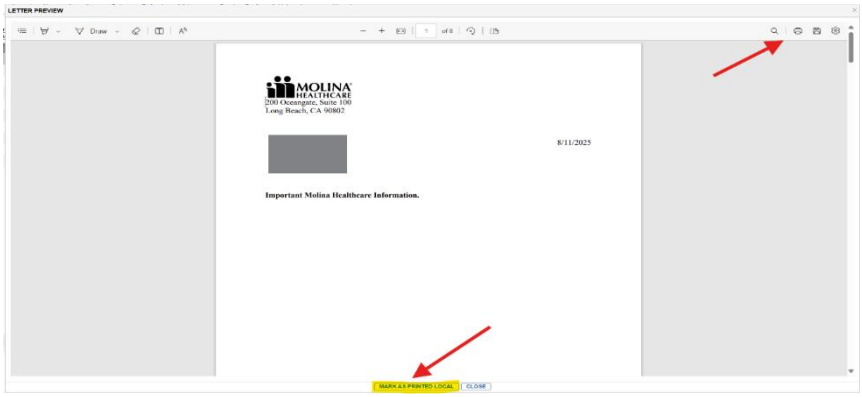
Click on [**Refresh**] in CCA.



Step 9: You will be taken back to the main screen of the Letters module. Click on **Send** and then [**Print Local**]



The letter will preview. Click on the printer icon to print the letter. After the letter has been printed, click on **[MARK AS PRINTED LOCAL]**



The status will reflect **Sent.**

Congratulations, you've printed one of the following letters:

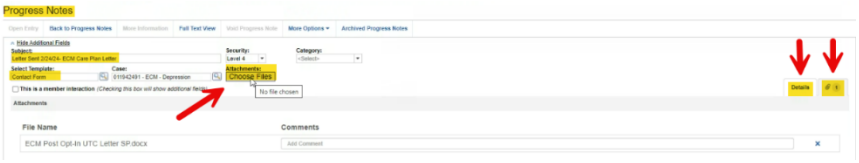
- ECM Generic UTC Letter
- ECM Welcome Letter
- ECM Post Opt-In UTC Letter
- ECM Post Opt-In Decline Letter

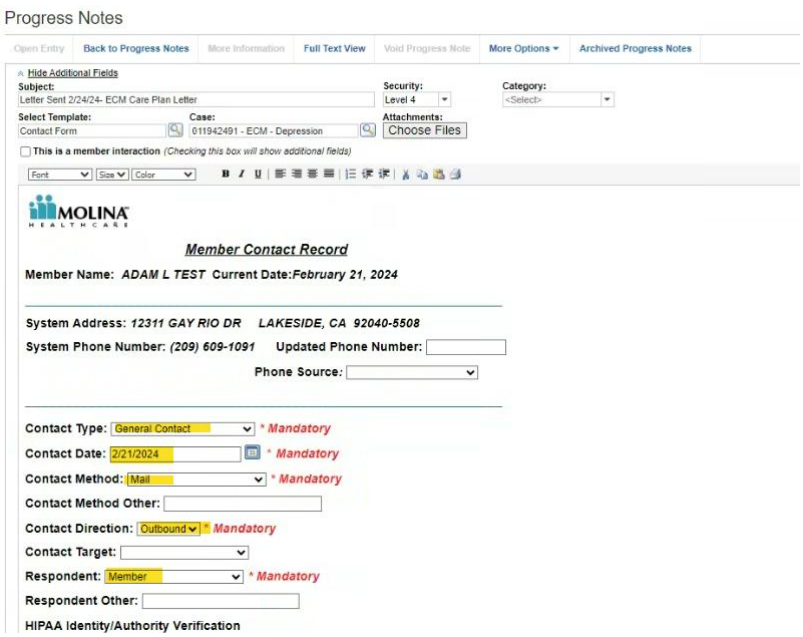
Please see latest update as of 2/25/2024:

If you are unable to generate a letter in CCA, please use the letter templates attached to the Provider Manual and follow instructions below. Molina can provide letter templates in word when requested.

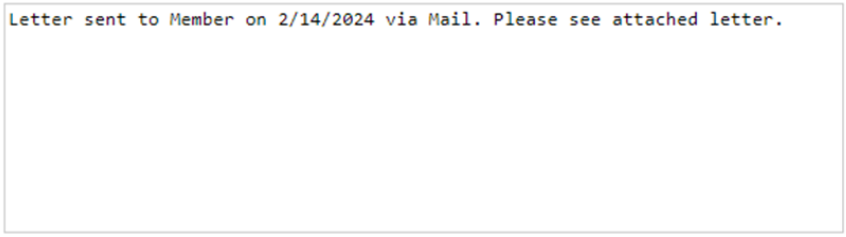
First, save the letter to your desktop then create a contact form to attach the letter. Proceed by following the progress note process (see screenshots for reference). Make sure to include "**Letter Sent <today's date> - Letter Name**" to the subject line of the Progress Note. Please note, when selecting Purpose of Contact select ECM, other, and additional services (Care Plan, Welcome contact, etc.)

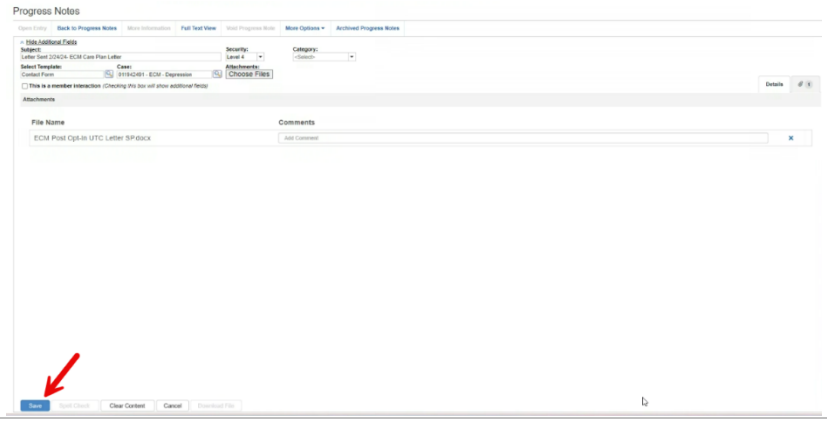
- To add the letter as an attachment on the Progress Note, select Choose file and upload the letter as an attachment.





Notes:





For the following letters only, follow Steps 10-14. The process ends at Step 14:

- ECM Care Plan Letter (initial and updates)
- ECM PCP Care Plan Letter

Step 10: CAE Letter Editor

Do not close this window!

Once all edits to the letter are made, click on [**Save**].

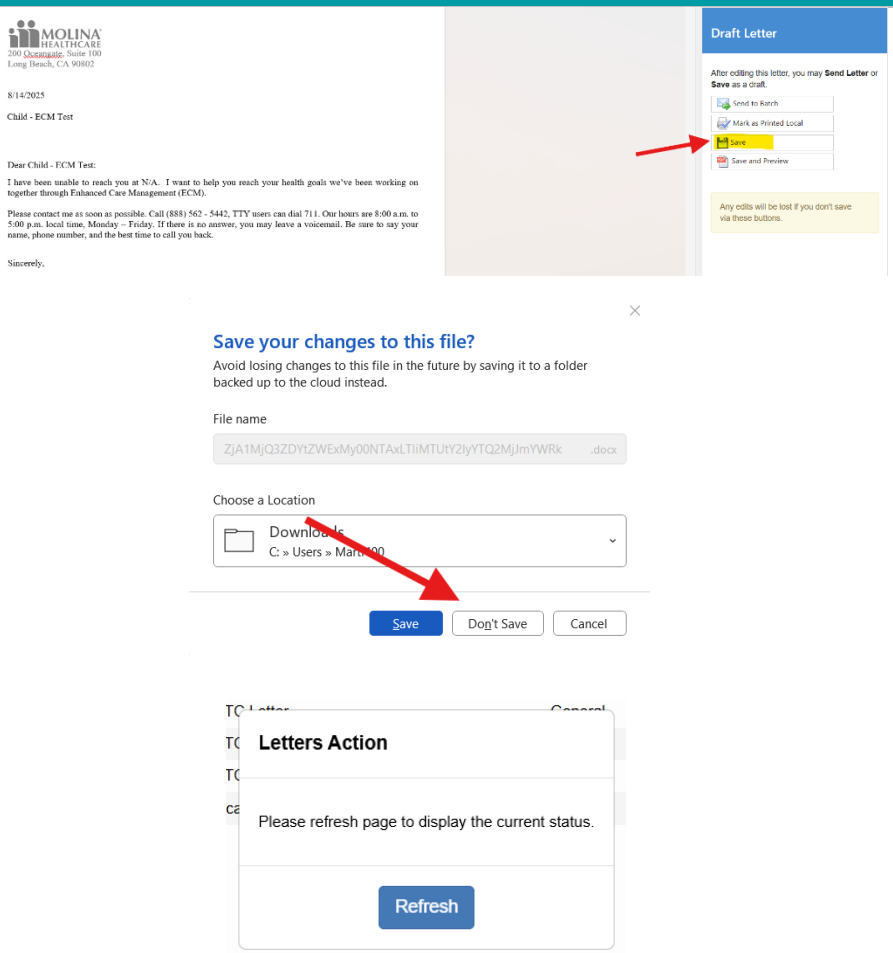
Do Not click Mark as Printed Local.

To attach documents in CCA, the letter needs to be a Draft.

Once the edits have been saved, the following message will appear.

Exit out of MS Word; do *not* save the letter locally (to your computer).

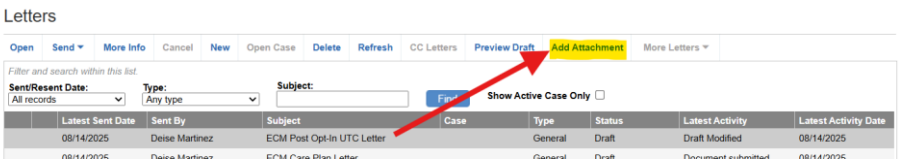
Click on [**Refresh**] in CCA.



Step 11: To attach **ECM Care Plan to the letter**:

- Select the Draft letter to highlight it.

In the Top Banner Options, click [**Add Attachment**].

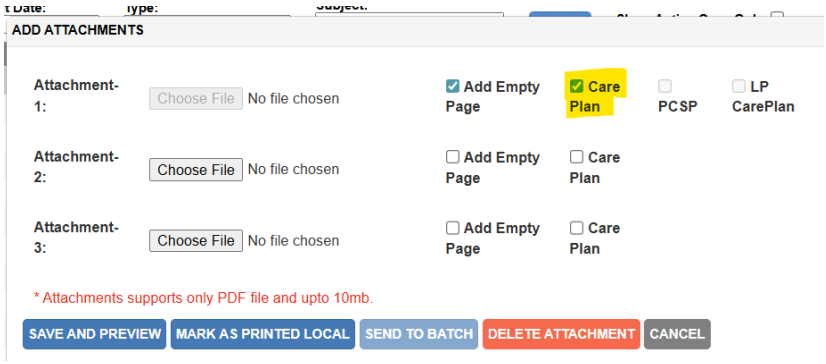


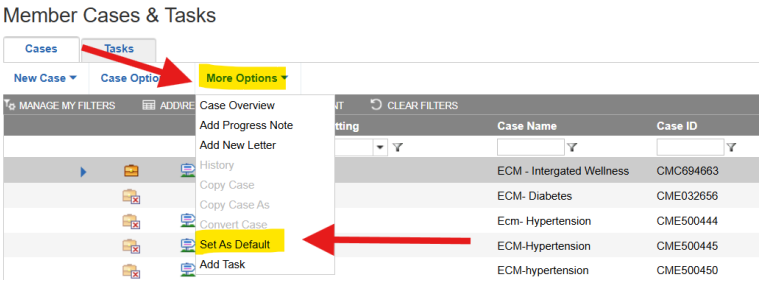
Step 12: To attach the ECM Care Plan, check “Add Empty Page” and “Care Plan.” This will automatically add a blank page to ensure the care plan does not print on the back of the letter.

- **You will only be able to attach the ECM Care Plan using this method if the ECM Care Plan is the primary case in CCA’s Cases Tab.**

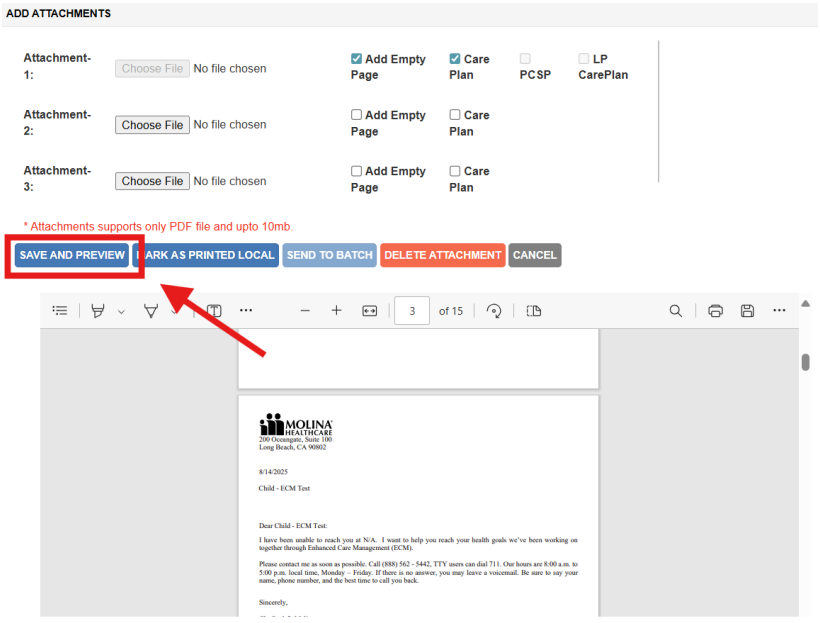
To make the ECM case primary, highlight the ECM case, select [**More Options**] and click [**Set As Default**].

Follow Steps 13 below to print a copy of the Care Plan if your system is not compatible with the Letters Module in CCA





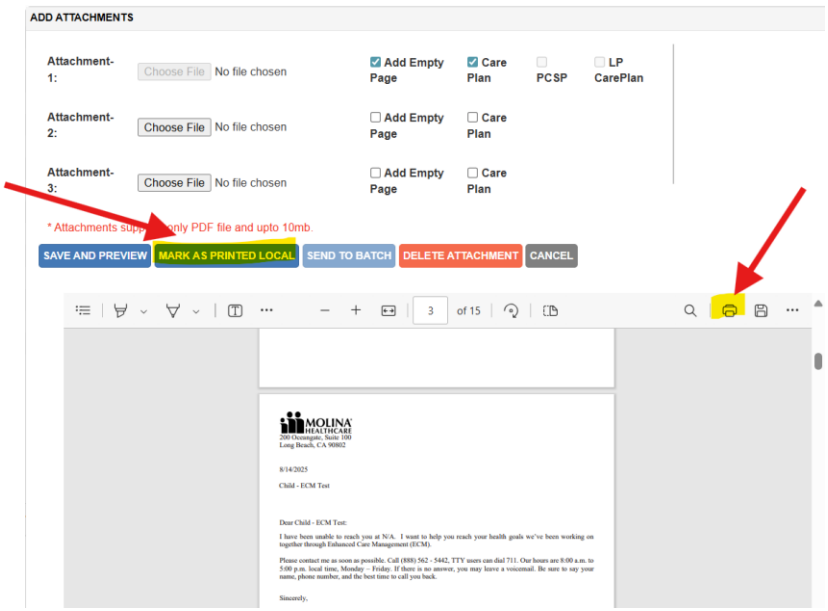
Step 13: Save and Preview your draft letter in the editor.



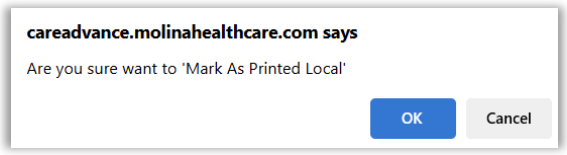
Step 14: Select Print option:

Select the printer icon.

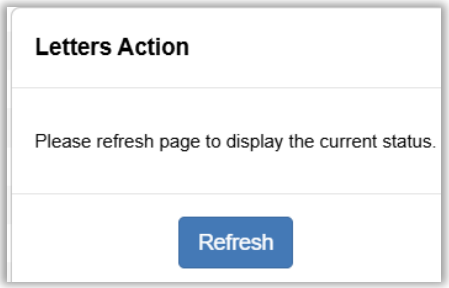
Once document has printed, click [**Mark as Printed Local**]



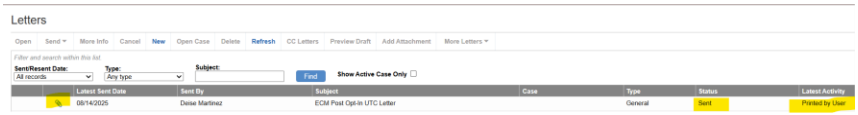
You will receive a prompt message asking if you want to mark the letter printed locally. Click [**OK**].



Click [**REFRESH**] when prompted.



The letter should now reflect printed status.



Congratulations, you have printed the ICP report and care plan letter! Keep in mind there are two care plan letters, and both need to be mailed:

- **ECM Care Plan Letter** (initial and updates)- For the member
- **ECM PCP Care Plan Letter**- For the member's PCP

ICT Meetings

The interdisciplinary care team's (ICT), also known as the multi-disciplinary team or members, role is to provide input to the development and ongoing maintenance of the member's care plan. The ICT meetings help ensure that the member's care is continuously integrated among all service providers.

Interdisciplinary Care Team Meetings

The ECM LCM is required to coordinate meetings with the member's ICT. ICT participants should include the member's assigned ECM LCM, ECM Director, ECM Clinical Consultant (if ECM LCM is non-clinical), ECM Community Health Workers, and Housing Specialist (as needed). In addition, depending on the member's needs/preferences, the ECM LCM may invite the following individuals:

- ECM Provider Subject Matter Experts, as applicable
- Pharmacist
- Nutritionist
- Caregiver
- PCP/Specialists
- Behavioral Health Providers
- Community Supports Providers
- MedZed HC 2.0 care coordinator (if the member is enrolled in this program)
- My Care Palliative Care (if member enrolled is enrolled in this program)
- Major Organ Transplant (if member enrolled is enrolled in this program)

If a member requested an ICT meeting at any point while enrolled in ECM, an ICT meeting must be held within 30 days of the member requesting it. The ECM LCM should coordinate frequent ICT meetings for all members with high and catastrophic acuity levels based on Molina's Case Management Acuity, members who are homeless and authorized to receive Housing Community Supports, members with recent ED visits or hospitalization (including skilled nursing facility stays), and members with safety concerns, unmet BH/SUD, and/or APS/CPS reports. Nevertheless, all members, even those who have not requested an ICT meeting, the ECM LCM should coordinate ICT meetings at least twice a year.

How is it documented?

- All ICT Meetings must be documented via a Contact Form in CCA. Documentation should include the following:
    - Names of all case conference attendees (titles and relationship to member)
    - Notes on the outcome of the ICT meeting. Evidence that case conference recommendations were discussed with the member and incorporated into the care plan as applicable.
    - Evidence that meeting details were shared with all ICT members.

Follow up after ICT Meeting

- The ECM Care Plan must be updated based on case conference recommendations.
- Documentation should evidence of ongoing information sharing among the member's ICT. The updated care plan must be shared with the member, their assigned PCP, and other members of the care team as appropriate, as outlined in the Comprehensive Assessment and Care Plan section of this manual. Refer to ICT Documentation section above for more information.

ICT Meetings- Contact Forms

Below is an example of how to document an ICT meeting via a contact form in CCA:

Scenario #1: Post-enrollment. Member approved for Community Support Service. ECM LCM conducted an ICT meeting with the member's CS Provider. *Note: If a CS Provider already entered a contact form evidencing the ICT meeting with the ECM Provider, the ECM Provider is not required to do this again.

Contact Form Fields	How to Complete the Contact Form Fields
Subject	[Insert name of your Organization - ECM] ICT with CS Provider 4/25/23
Contact Type	Interdisciplinary Care Team
Contact Date	04/25/2023
Contact Method	Phone
Contact Method Other	
Contact Direction*	Outbound
Respondent*	ECM Provider
Respondent Other	
HIPPA Identity/Authority Verification	Address DOB
Purpose Of Contact	ECM ICT Meeting
Purpose Of Contact Other	
Outcome Of Contact	Successful Contact
Outcome Of Contact Other	
Length Of Contact	30
Name of Provider	
Adult Day Healthcare	
Personal Care Assistance	
Behavioral Health	
Community Transition MFP	
HCBS Waiver	
Other Resources	
Specify Agency or Program	
Notes	On 4/25/23, I met with the member's CS Provider, Hilda Chavez, from Care #1, and we held an ICT meeting to discuss the member's current care. Care plan will need to be updated. I will discuss care plan updates with the member and get the member's consent during our next meeting. I provided an ICT meeting summary to Hilda Chavez, CS Provider, and agreed to meet in a month from today for another ICT meeting.

Member Reassignments

At any point while enrolled in the program the member might request to be assigned to another ECM Provider. The member can call Molina's Member Services at (888) 665-4621. For TTY/TDD, use 711. Molina will accommodate the request and inform the new ECM Provider of the member reassignment. The previous ECM Provider will need to warm handoff the member to the new ECM Provider within 5 business days of member reassignment. Molina's ECM Team will assist with coordinating a meeting between both providers. The previous ECM Provider should provide a copy of the care plan, assessments, and any other pertinent member information to the new ECM Provider. The new ECM Provider should continue working on the member's previously identified needs but should still assess the member for any new conditions.