

**Molina**  
**Enhanced Care Management**  
**Provider Manual**  
***CCA Users***  
**Part 3**  
January 1, 2024

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## Care Plan

The care plan will be created with the member within 90 days of enrollment. As a best practice, the ECM LCM should complete the care plan within 2 business days of CA-HRA completion to encourage engagement with the member. Each member should only have ONE active care plan. Problems and concerns identified in the CA-HRA 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 HRA and other assessments.

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, CA-HRA, 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.

The following guidelines apply to the Care Plan:

- The member's main health concern must be clearly integrated into the care plan. This may not always be related to health. 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)
- The care plan should consistently address member care gaps identified through the CA-HRA and through discussion with member/caregiver.
- ECM Providers are required to confirm, with the member, their assigned PCP's information as part of the care plan development process and document this 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 CA-HRA 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,

- 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

## 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

**SPECIFIC**      The goal should identify a specific action or event that will take place.

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

**MEASURABLE**    The goal and its benefits should be quantifiable.

(How many? How much?)

**ACHIEVABLE**    The goal should be attainable given available resources.

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

**REALISTIC**      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?)

**TIMELY**         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:

<b>Problem:</b>	<b>Diabetes Program –Blood Glucose Monitoring</b>
<b>Goal</b>	Member/caregiver/family will record the member's blood sugar levels at least 1 x daily for 30 days.
<b>Intervention</b>	The care manager will teach the member/caregiver/family how and why monitoring and logging blood sugar readings is vital.
<b>Outcome</b>	Member/caregiver/family will record blood sugar levels daily within 30 days.
<b>Barrier</b>	Member has trouble remembering to track blood sugar.

<b>Problem:</b>	<b>Diabetes Program –A1C Tracking</b>
<b>Goal</b>	Member/caregiver/family will provide the healthcare provider with a record of the member's daily blood sugar levels in 30 days.
<b>Intervention</b>	The care manager will reinforce the importance of having a record of blood sugar levels for the healthcare provider.
<b>Outcome</b>	Member/caregiver/family provided healthcare provider a record of member's daily blood sugars within 30 days.
<b>Barrier</b>	Member has trouble remembering to track blood sugar.

<b>Problem:</b>	<b>Diabetes Program –A1C Tracking</b>
<b>Goal</b>	The case manager will teach the member that the A1C test provides a picture of what their blood sugar levels have averaged over the last three months.
<b>Intervention</b>	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.
<b>Intervention</b>	The case manager will encourage the member to limit foods high in starchy carbohydrates, such as breads and pastas.
<b>Intervention</b>	The case manager will encourage the member to limit the intake of foods with added sugar, such as cookies, sodas, and syrup.
<b>Intervention</b>	The case manager will encourage the member to talk to their doctor on the next visit to discuss a safe exercise plan.

<b>Outcome</b>	Member's A1C level is 7% or below in 90 days.
<b>Barrier</b>	The member doesn't understand how to control her A1C

<b>Problem</b>	<b>Diabetes –Diet and Nutrition Monitoring</b>
<b>Goal</b>	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 at least 1x within 30 days.
<b>Intervention</b>	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>.
<b>Outcome</b>	Member engaged with diabetic educator and learned about healthy, nutritious, and diabetic-appropriate food choices in compliance with recommended diet in 30 days.
<b>Barrier</b>	The member doesn't understand how to control her A1C

<b>Problem</b>	<b>Diabetes- Alcohol Use</b>
<b>Goal</b>	Member/caregiver/family will identify two ways drinking alcohol can affect their diabetes in 30 days.
<b>Intervention</b>	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.
<b>Intervention</b>	The care manager will educate on how alcohol can impact blood sugar levels in the body and how the member feels throughout the day.
<b>Intervention</b>	The care manager will provide community resources for alcohol counseling if necessary.
<b>Outcome</b>	Member/caregiver/family repeats two ways alcohol consumption can affect diabetes within 30 days.

**COPD:**

<b>Problem</b>	<b>COPD- Knowledge of the disease process</b>
<b>Goal</b>	Member/caregiver/family will teach three (3) warning signs/symptoms of worsening COPD (Chronic Obstructive Pulmonary Disease) in 30 days.
<b>Intervention</b>	The care manager will teach member/caregiver/family signs/symptoms of worsening COPD, such as difficulty breathing when lying flat.

<b>Intervention</b>	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.
<b>Intervention</b>	The care Manager will teach member/caregiver/family the signs/symptoms of worsening COPD, such as increased shortness of breath when walking short distances.
<b>Outcome</b>	Member/caregiver/family can teach back three (3) warning signs/symptoms of worsening COPD within 30 days.
<b>Barrier</b>	Lack of information about COPD warning signs and symptoms

<b>Problem</b>	<b>COPD- Knowledge of the disease process</b>
<b>Goal</b>	Member/caregiver/family will obtain at least one educational resource on managing their COPD (Chronic Obstructive Pulmonary Disease) symptoms in the next 30 days.
<b>Intervention</b>	The care manager will educate the member/caregiver/family on signs/symptoms of COPD exacerbation and when to report early symptoms.
<b>Intervention</b>	The care manager will educate the member/caregiver/family on having all prescribed COPD medication handy at all times.
<b>Intervention</b>	The care manager will teach the member/caregiver/family when to contact the primary provider and/or specialist when symptoms worsen.
<b>Intervention</b>	The care manager will inform the member where the closest urgent care and emergency room is in the member's area.
<b>Intervention</b>	The care manager will educate the member/caregiver/family on when to use urgent care and emergency room appropriately.
<b>Outcome</b>	Member/caregiver/family received information and resources needed to manage their COPD symptoms within the last 30 days.
<b>Barrier</b>	Lack of information about COPD warning signs and symptoms

<b>Problem</b>	<b>Chronic Pain</b>
<b>Goal</b>	Member will take the pain medication only as prescribed by her one designated prescriber.
<b>Intervention</b>	Care Manager will help the member develop a strategy in addition to medication adherence to reduce pain levels.
<b>Intervention</b>	Care Manager will help the member explore alternative pain management options with the primary care physician and or pain specialist.
<b>Outcome</b>	The member takes pain medication only as prescribed by her one designated prescriber.
<b>Barrier</b>	Member feels a lack of control over pain.

Depression:



Problem	Depression - triggers
Goal	Member/caregiver/family will be able to teach back 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.
Outcome	Member/caregiver/family teaches back at least two triggers that may increase depression symptoms within 30 days.
Barrier	Depressed mood.

Problem	Depression – lifestyle
Goal	Member will identify 1-3 activities that may help combat Depression in the next 30 days.
Intervention	Case Manager will review/explore activities that improve mood/combat depression, such as <i>&lt;enter activities discussed with the member&gt;</i> .
Intervention	Member will explore which activities improve mood such as <i>&lt;enter activities discussed with the member&gt;</i> .
Outcome	Member identified 1-3 activities that help combat depression in 30 days.
Barrier	Depressed mood

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 in the next 90 days.
Intervention	Case Manager will link the member with substance use counseling <i>&lt;enter referral and resource info here&gt;</i> .
Outcome	Member engages in substance use counseling in 90 days.
Barrier	SUD interfering with daily functioning.

Problem	SUD - Peer support
Goal	Member will attend a support group in the next 30 days.

<b>Intervention</b>	The case Manager will provide the member with a list of available support groups <i>&lt;enter referral resources here&gt;</i> .
<b>Outcome</b>	Member attended one peer support group in the next 30 days.
<b>Barrier</b>	Lack of sober support.

<b>Problem</b>	<b>SUD – Harm Reduction</b>
<b>Goal</b>	Member will teach back one action to reduce harm and risk associated with <i>&lt;insert method and substance&gt;</i> while not ready to abstain in 30 days.
<b>Intervention</b>	The case manager will encourage self-care and risk reduction while the member is not ready to abstain.
<b>Outcome</b>	Member teaches back one action to reduce harm and risk associated with <i>&lt;insert method and substance&gt;</i> while not ready to abstain in 30 days.
<b>Barrier</b>	Lack of Harm Reduction information and access

<b>Problem</b>	<b>SUD – Meds/MAT</b>
<b>Goal</b>	Member will take <i>&lt;insert medication dose&gt;</i> every <i>&lt;insert frequency&gt;</i> to treat substance use disorder in the next <i>&lt;30/60&gt;</i> days.
<b>Intervention</b>	Case manager will encourage adherence to Medication for Addiction Treatment (MAT).
<b>Outcome</b>	The member takes <i>&lt;insert medication dose&gt;</i> every <i>&lt;insert frequency&gt;</i> to treat substance use disorder in the last <i>&lt;30/60&gt;</i> days.
<b>Barrier</b>	SUD interferes with daily functioning.

**Community-Based LTSS:**

<b>Problem:</b>	<b>Member is at risk for needing institutionalization due to lack of community support.</b>
<b>Goal</b>	Member will maintain community-based living with CBAS support x days per week.
<b>Intervention</b>	Care Manager will discuss with the member and PCP a referral to CBAS and help facilitate as appropriate.
<b>Outcome</b>	Member will maintain community-based living with CBAS support x days per week.
<b>Barrier</b>	Lack of community support

<b>Problem:</b>	<b>Member's capacity for self-care in the community is compromised due to frailty or disability.</b>
<b>Goal</b>	Member will maintain community-based living with support from IHSS x hours per month.
<b>Intervention</b>	Care Manager will help the member apply for an IHSS evaluation.
<b>Intervention</b>	Member will cooperate with the IHSS evaluation process.
<b>Outcome</b>	Member will maintain community-based living with support from IHSS x hours per month.
<b>Barrier</b>	Needs help with Daily Living Activities

**Housing Insecurity/Unhoused:**

<b>Problem:</b>	<b>Member is currently unhoused</b>
<b>Goal</b>	Member will attain income, vouchers, and/or benefits sufficient to pay for adequate housing for x number of people within 90 days.
<b>Intervention</b>	Care Manager will work with the members <Community Support> agency to help the member obtain housing.
<b>Intervention</b>	Member will attend necessary appointments related to housing.
<b>Outcome</b>	Member will attain income, vouchers, and/or benefits sufficient to pay for adequate housing for x number of people within 90 days.
<b>Barrier</b>	Member is unhoused.

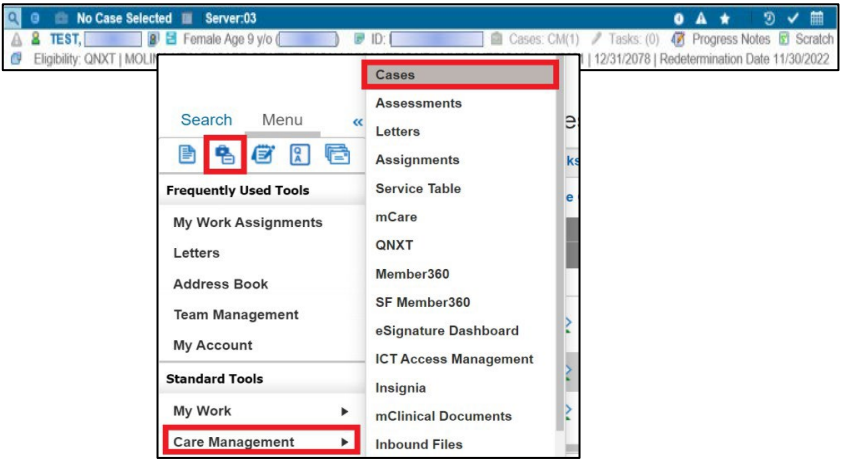
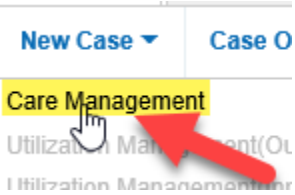
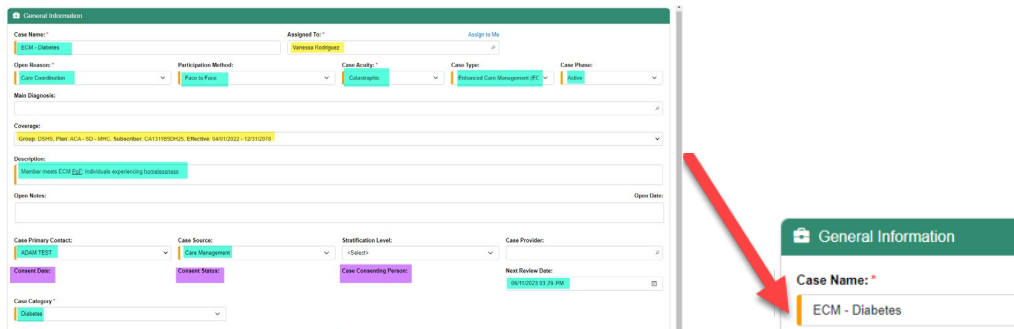
<b>Problem:</b>	<b>Housing Insecurity</b>
<b>Goal</b>	Member will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
<b>Intervention</b>	Care Manager will work with member and member <Community Support agency> to restore or develop skills necessary to maintain housing.
<b>Intervention</b>	Member will attend necessary appointments related to housing.
<b>Outcome</b>	Member will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
<b>Barrier</b>	Housing insecurity.

<b>Problem</b>	<b>Overcrowded, substandard housing</b>
<b>Goal</b>	Member will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
<b>Intervention</b>	Care Manager will work with the members <Community Support> agency to help the member obtain housing,
<b>Intervention</b>	Member will attend necessary appointments related to housing.
<b>Outcome</b>	Member will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
<b>Barrier</b>	Substandard housing.

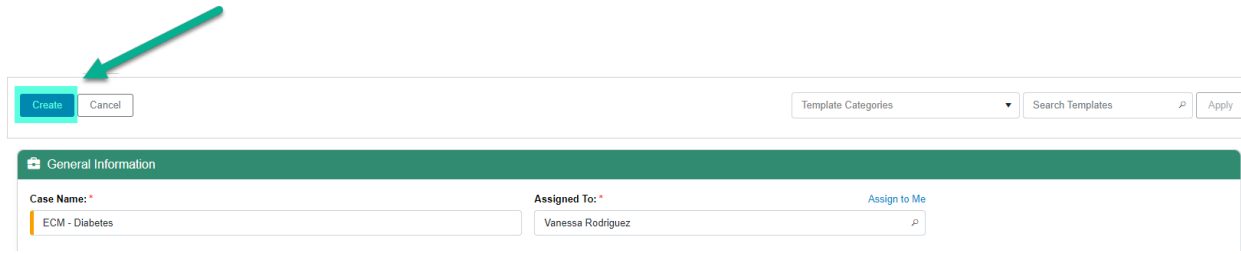
<b>Problem:</b>	<b>Unhoused and not ready to access housing</b>
<b>Goal</b>	Member will access two services for basic needs (such as food, shower, and medical care) weekly for the next 30 days.
<b>Intervention</b>	Care Manager will link the member with (insert agencies, resources).
<b>Outcome</b>	Member will access two services for basic needs (such as food, shower, and medical care) weekly for 30 days.
<b>Barrier</b>	Unhoused, not ready for housing

## 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
<p><b>Step 1:</b> With the member in focus, click on either the:</p> <p><b>Cases/Tasks</b> icon from the Quick Tools section</p> <p>Or</p> <p>Click on <b>Care Management</b> under Standard Tools, and select <b>Cases</b>.</p> <p>You will be redirected to the Member Cases &amp; Tasks landing page.</p>	
<p><b>Step 2:</b> To create a new care plan, select "New Case" and "Care Management."</p> <p><b>Note:</b> Ensure you are assigned to the member. There should <u>only be one</u> 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.</p>	
<p><b>Step 3:</b> You will be taken to the <b>General Information</b> page. Think of this as creating a label for the member's folder where you will insert all of the goals you will be working on with the member/member's care team. The <b>General Information</b> page will appear. Complete areas highlighted in <b>green</b>, (these areas need to be completed before you save the case. Areas in <b>yellow</b> will auto-populate. Areas in <b>purple</b> will auto-populate after obtaining member consent). See example below.</p> <p><b>NOTE:</b> any fields where information is entered will be flagged with an orange 'change' bar.</p>	

GENERAL INFORMATION PAGE	
FIELD NAME	INSTRUCTIONS
1. Case Name <i>*Mandatory field*</i>	<p>Enter name that describes the case, typically the member’s main health concern.</p> <p>All Case Names should start with “ECM-” followed by a hyphen and then the <b>main health concern</b>. Ex. ECM-Asthma</p> <p>This is a <b>mandatory</b> field that requires this specific naming convention.</p>
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 <i>*Mandatory field*</i>	<p>Select <b>Care Coordination</b> as the reason from the drop-down.</p> <p><i>*Note:</i> This can’t be changed after saving.</p>
4. Participation Method <i>*Mandatory field*</i>	<p>Indicates how member will participate in care management:</p> <ul style="list-style-type: none"> <li>• Digital – <i>do not use this option</i></li> <li>• Telephonic</li> <li>• Face-to-face</li> </ul>
5. Case Acuity <i>*Mandatory field*</i>	Indicate the risk level for the member ( <b>Medium, High, Catastrophic</b> ). Refer to the <i>Case Acuity</i> 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 <i>*Mandatory field*</i>	Select Enhanced Care Management Program (ECM) from drop-down menu.
7. Case Phase <i>*Mandatory field*</i>	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 <i>*Mandatory field*</i>	Enter a brief overview of the reason for why the member is enrolled in care management.
11. Open Notes	Leave blank.

GENERAL INFORMATION PAGE	
FIELD NAME	INSTRUCTIONS
12. Case Primary Contact <i>*Mandatory field*</i>	Pulls list from the Address Book ( <i>new</i> ) <ul style="list-style-type: none"> <li>If member is agreeing to the care plan, choose member's name.</li> <li>If a parent, legal guardian, POA, etc. will be the primary contact → must add to the address book first.</li> </ul>
13. Case Source <i>*Mandatory field*</i>	Choose <b>Care Management</b> 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 <i>*Mandatory field*</i>	Enter date for next care plan review. Process is to also track this through tasks.
18. Case Category <i>*Mandatory field*</i>	Select the condition from the drop-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.'
<p>Once you have completed the required fields in the <b>General Information</b> using the information above, click <b>[Create]</b> located in the upper left corner.</p> 	

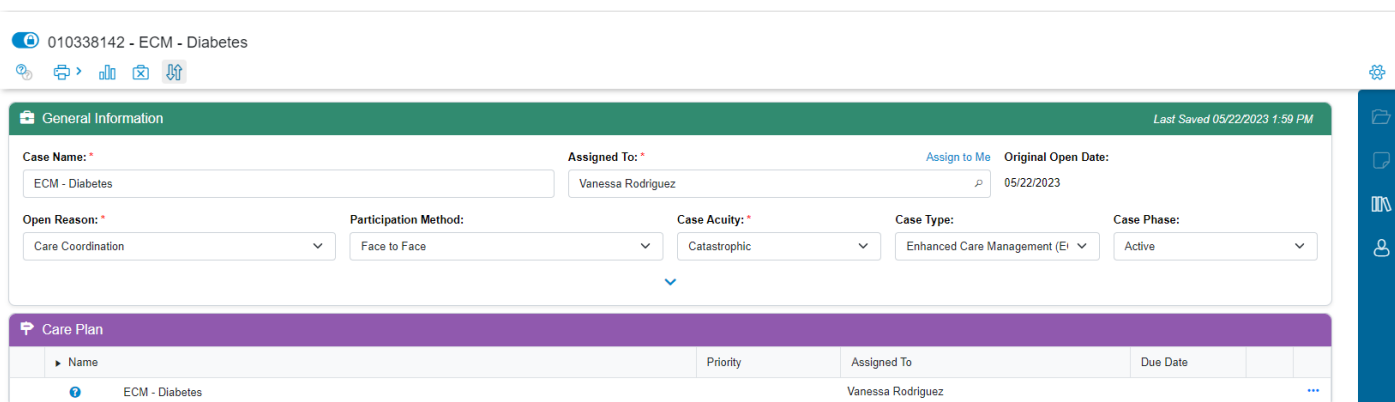
In edit mode, a 'Last Saved <date / time>' message will appear in the General information green bar on the right-hand side.



**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:



010338142 - ECM - Diabetes

General Information Last Saved 05/22/2023 1:59 PM

Case Name: \* ECM - Diabetes Assigned To: \* Vanessa Rodriguez Assign to Me Original Open Date: 05/22/2023

Open Reason: \* Care Coordination Participation Method: Face to Face Case Acuity: \* Catastrophic Case Type: Enhanced Care Management (E) Case Phase: Active

Care Plan

Name	Priority	Assigned To	Due Date
ECM - Diabetes		Vanessa Rodriguez	

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.

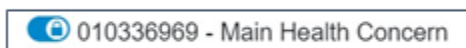
### Care Plan Tools

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.


#### EDIT MODE



#### OPEN MODE









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.

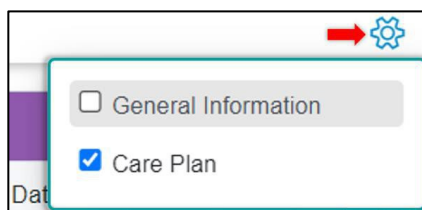
-  **icon** – allows users to toggle between showing only the *Active* Problem banners within the care plan (default setting) or showing *all* of the Problem banners.



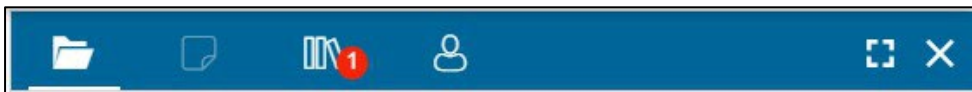
When viewing all of the Problem banners, the inactive ones will have a gray background at the bottom of the care plan list.

- **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 suggested milestones from a completed assessment, these will also be available here. A number in a red circle will appear indicating the total number of suggested milestones available.*

- **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.

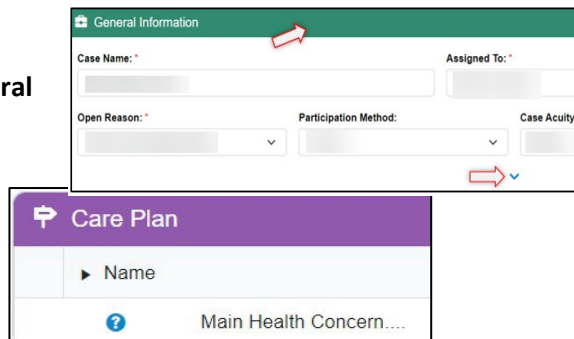
### Viewing Options:

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**.

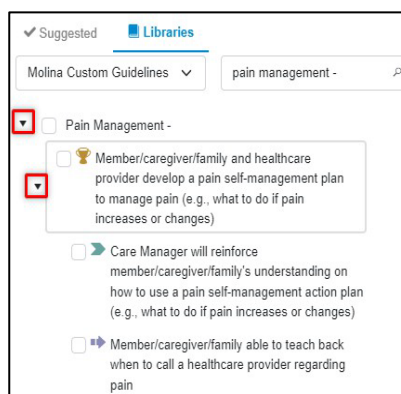
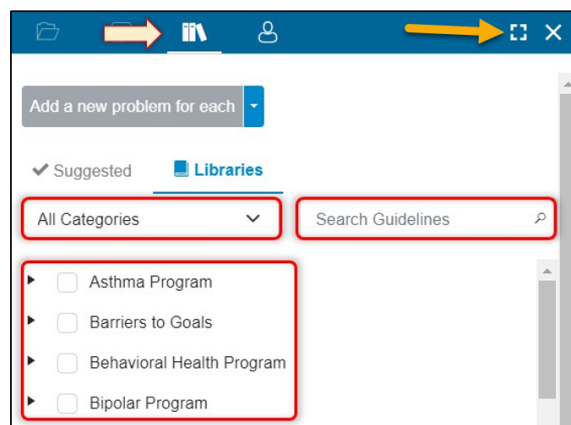
- You can enter full screen mode by clicking on the **square icon** in the right corner.

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).

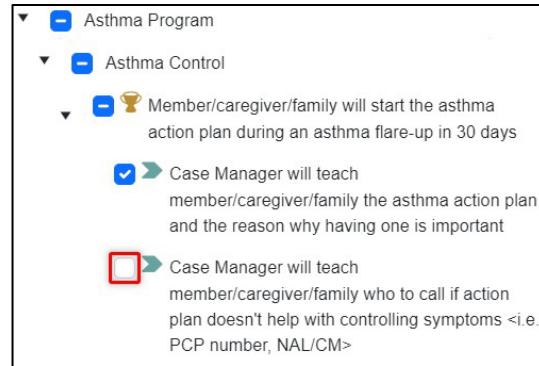
- Click the triangle to the left of the *goal* to view the associated intervention(s) and outcome(s).



- 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.

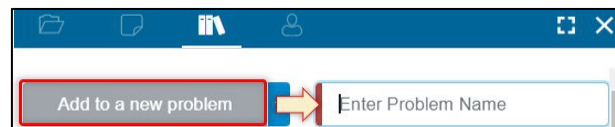
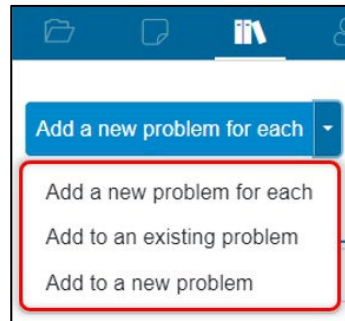
Use the drop-down menu to select the appropriate option.

**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.



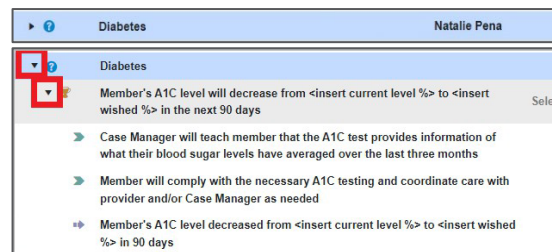
Complete your selection, then click the button itself [Add...].

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:

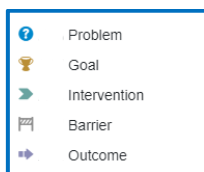


The milestones will still need to be edited to be individualized to the member's needs or situation. See the process below for how to edit the milestones.

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

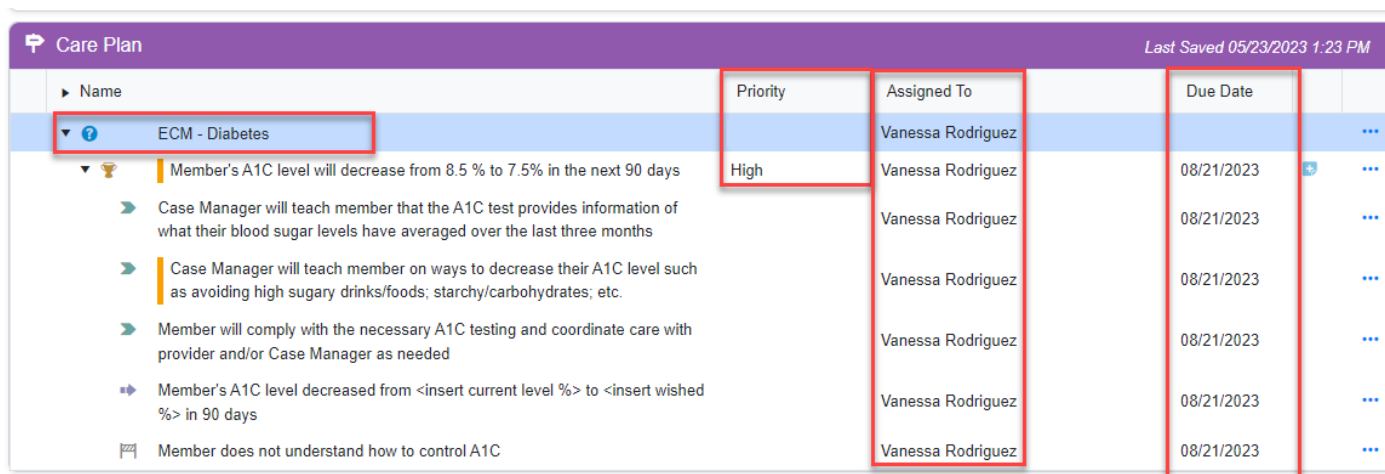
The columns within the Care Plan panel provide the following information:

**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).*



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


## 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.

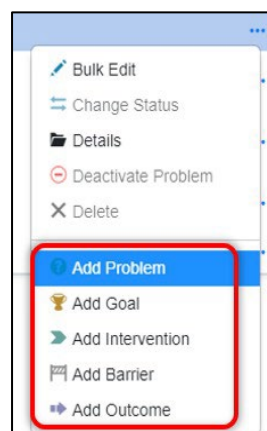
To add PGIOs *not* found in the library, click on the ellipsis.



() 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 another 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.

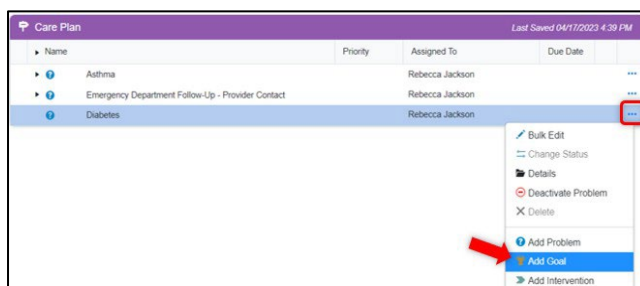
A new line item will populate; enter the problem name.

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. For self-managing problems/concerns, we want to demonstrate health promotion activities here, support with medication review, and communication/care coordination between all of the member’s treating providers.

Care Plan						
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			...

### Adding *Suggested Milestones* from the library

CCA will suggest milestones based on answers captured in several of the assessments, such as the CA-HRA & Enterprise ToC

If the system suggests Guidelines to be imported into the Care Plan, these Guidelines are listed in **Suggested** tab of the side panel (blue banner) under the **Guideline Library** section.

- The number of Guidelines is noted near the library icon.

To view any of the Suggested Guidelines, click on the Guideline Library icon in the side panel.

The system will auto-default to the **'Suggested'** sub-tab.

Click on the *triangle* next to the guideline(s) to expand the corresponding PGIOs to review.

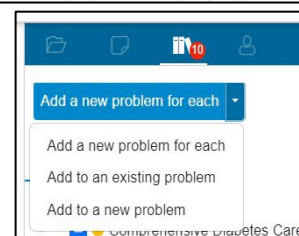
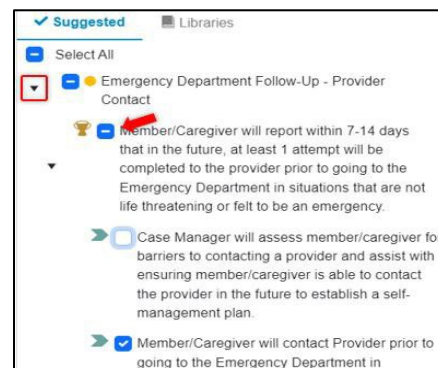
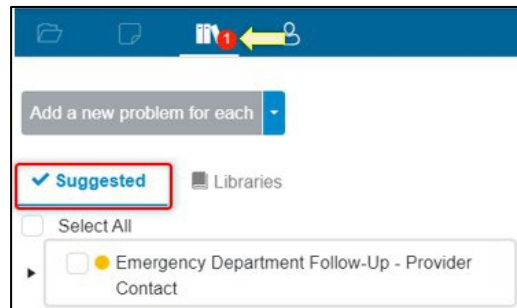
After previewing the suggested **Milestones**, click on box to the left of the milestones you want to *import* to your care plan.

- You can uncheck the Milestones that you do NOT want to add to the member's care plan.

Use the dropdown menu to select your naming option:

- Add a new problem for each.**
- Add to an existing problem**
- Add a new problem**

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



**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.

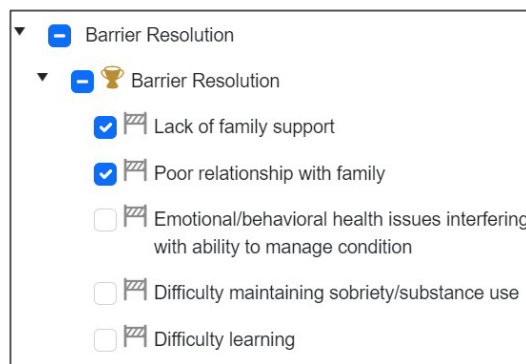
To add a barrier as a *stand-alone* item in the care plan:

From the **side panel** (blue banner), click on **Guideline Library**

**Icon**

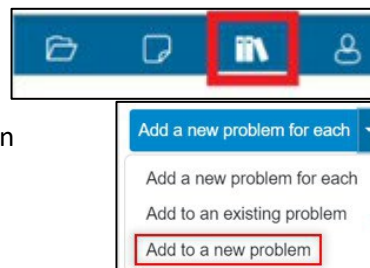
Under the **Barriers to Goals** category, click on the arrows to expand the corresponding guidelines.

- Select the appropriate barrier(s) to be added by clicking on the box next to the individual barrier(s).



Once the barrier(s) is selected, choose **[Add to a new problem]**

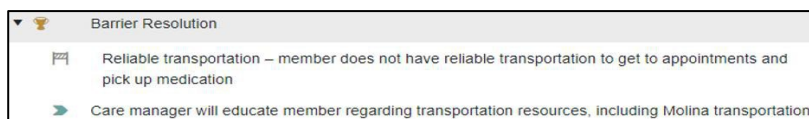
from the drop-down menu at the top and then click on the selection again to import the barrier(s) into the care plan.



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

▼ ?	Barrier Resolution		Natalie Pena	
▼ 🏆	Barrier Resolution	Select Priority	Natalie Pena	06/12/2023
	📄 Lack of family support		Natalie Pena	06/12/2023
	📄 Poor relationship with family		Natalie Pena	06/12/2023

**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:



▼ 🏆	Member's A1C level will decrease from 8.5 % to 7.5% in the next 90 days	High	Vanessa Rodriguez	<ul style="list-style-type: none"> <li>Bulk Edit</li> <li>Change Status</li> <li>Details</li> <li>Deactivate Problem</li> <li>Delete</li> <li>Add Problem</li> <li>Add Goal</li> <li>Add Intervention</li> <li><b>Add Barrier</b></li> <li>Add Outcome</li> </ul>
➤	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	
➤	Case Manager will teach member on ways to decrease their A1C level such as avoiding high sugary drinks/foods; starchy/carbohydrates; etc.		Vanessa Rodriguez	
➤	Member will comply with the necessary A1C testing and coordinate care with provider and/or Case Manager as needed		Vanessa Rodriguez	
➤	Member's A1C level decreased from <insert current level %> to <insert wished %> in 90 days		Vanessa Rodriguez	
📄	Member does not understand how to control A1C		Vanessa Rodriguez	
▼ ⓘ	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	

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

Enter Name	Natalie Pena	mm/dd/yyyy	Enter Due Date
------------	--------------	------------	----------------

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

📄 Bipolar symptoms interfering with ability to manage medications and appointments

### 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.

Care Plan				
Name	Priority	Assigned To	Due Date	
▶ ⓘ Main Health Concern		Natalie Pena		...
▼ ⓘ Diabetes		Natalie Pena		...
🏆 Member's A1C level will decrease from <insert current level %> to <insert wished %> in the next 90 days		Natalie Pena	09/13/2023	...
➤ Case Manager will teach member that the A1C test provides information of what their blood sugar levels have averaged over the last three months				

## 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.

Name	Priority	Assigned To	Due Date
▶ Main Health Concern		Natalie Pena	
▼ Diabetes		Natalie Pena	
▼ Member's A1C level will decrease from <insert current level %> to <insert wished %> in the next 90 days	<Select>	Natalie Pena	06/13/2023
▶ Case Manager will teach member that the A1C test provides information of what their blood sugar levels have averaged over the last three months	High	Natalie Pena	06/13/2023
▶ Member will comply with the necessary A1C testing and	N/A	Natalie Pena	06/13/2023



Again, an 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.

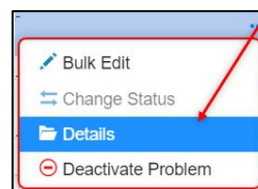
\*Repeat this same process to change information under the Assigned To and Due Date columns for individual milestone.

## Details

**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 
- ...or...
- 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*.

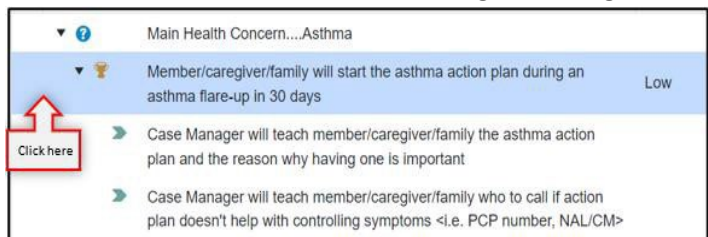
### Silence Milestones

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.



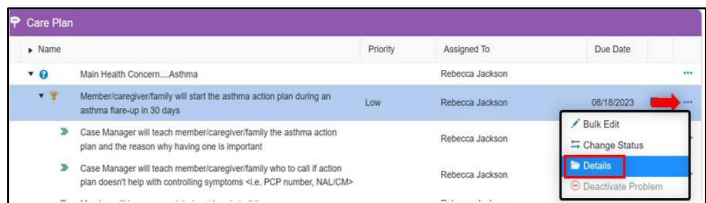
You may either:

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

...or

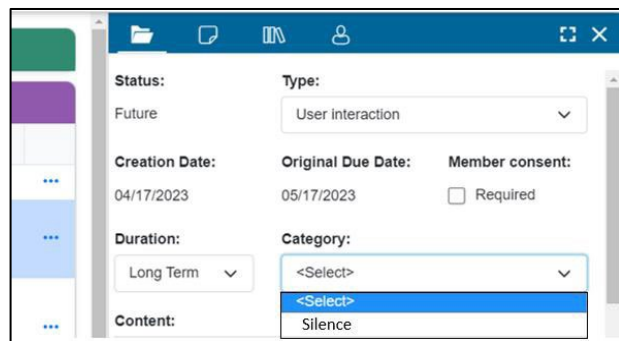
...

- Click on the ‘Details’ icon in the side panel.



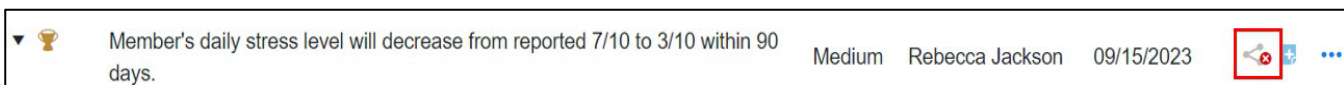
The side panel will expand.

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.

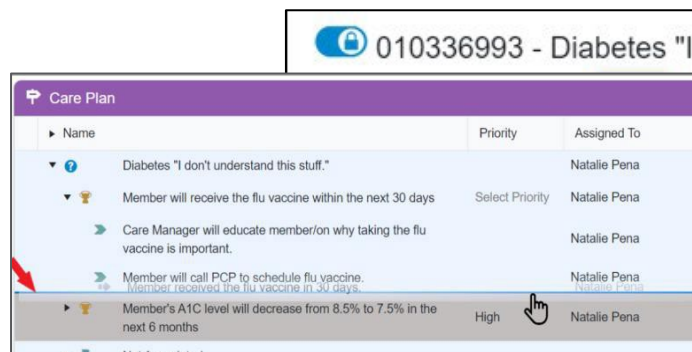
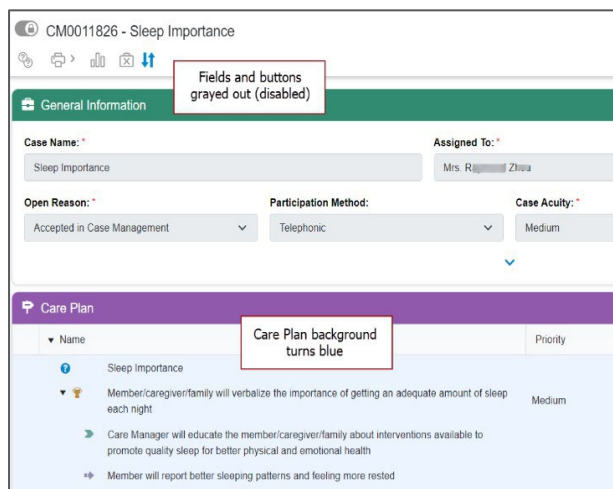
The button and page are put into Reorder mode: the Care Plan line items are highlighted in blue, and all other fields are disabled.

You may do any of the following activities:

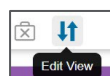
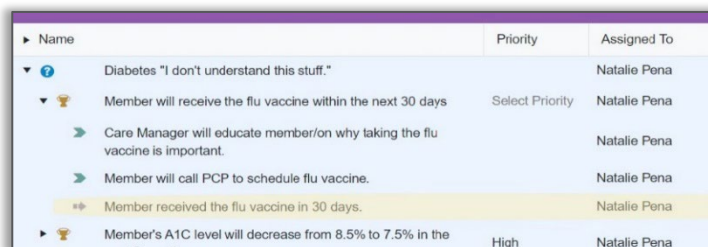
- Move a milestone to a *different* goal
- Move a milestone to a different position under the *same* goal
- Move a goal (along with the associated milestones) to a *different* problem banner
- Move a goal (along with the associated milestones) to a different position under the *same* problem banner
- 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

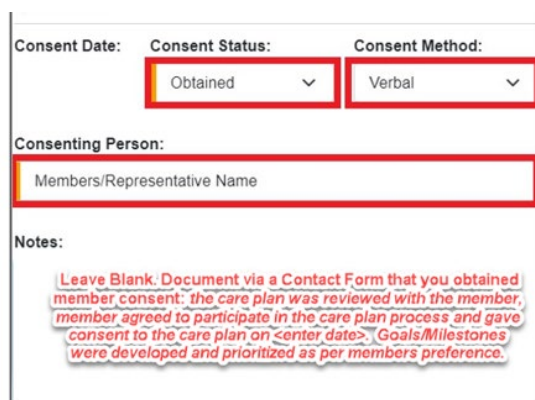
- Obtained

**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 member’s representative consented to care plan, enter full name of individual, along with relationship to 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.



Consent Date:      Consent Status:      Consent Method:

                         Obtained      Verbal

Consenting Person:

Members/Representative Name

Notes:

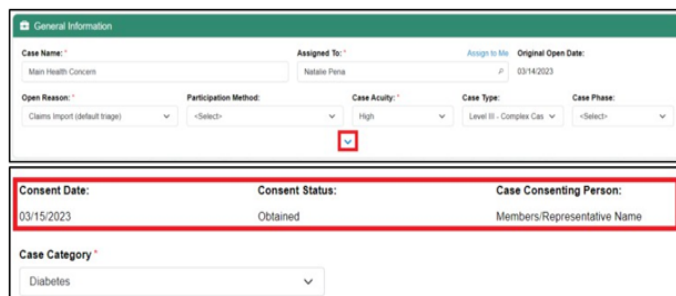
*Leave Blank: Document via a Contact Form that you obtained member consent: the care plan was reviewed with the member, member agreed to participate in the care plan process and gave consent to the care plan on <enter date>. Goals/Milestones were developed and prioritized as per members preference.*

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.



General Information

Case Name:      Assigned To:      Assign to Me      Original Open Date:

Main Health Concern      Natalie Pena      #      03/14/2023

Open Reason:      Participation Method:      Case Acuity:      Case Type:      Case Phase:

Claims Import (default triage)      <Select>      High      Level II - Complex Cas      <Select>

Consent Date:      Consent Status:      Case Consenting Person:

03/15/2023      Obtained      Members/Representative Name

Case Category:


Diabetes

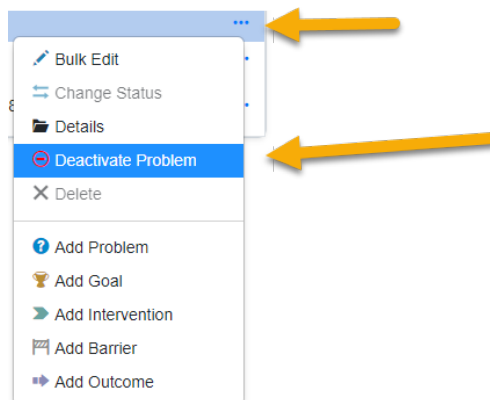
### REMINDER:


- 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! \**

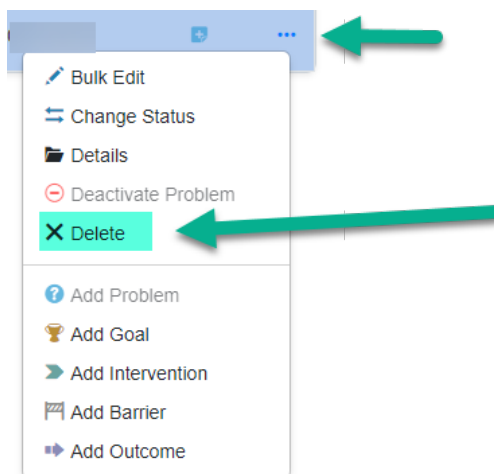
## How to Deactivate a Problem and Delete Milestones

**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.

...Or...

- 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)\_

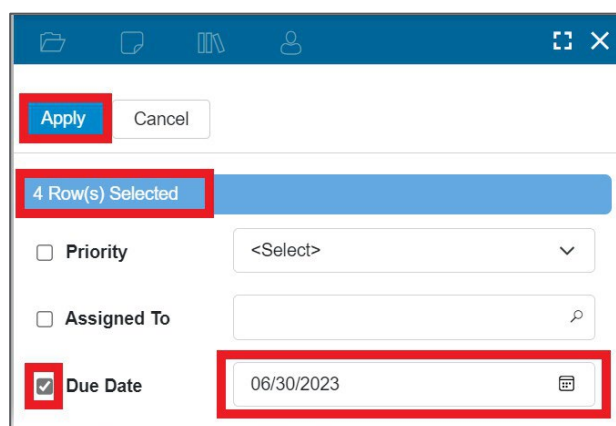


The number of line items you selected is noted at the top of the Side Panel:

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**.



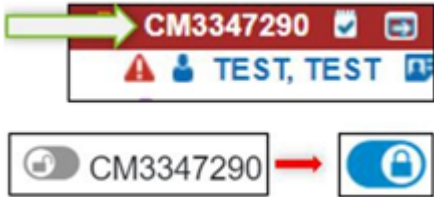
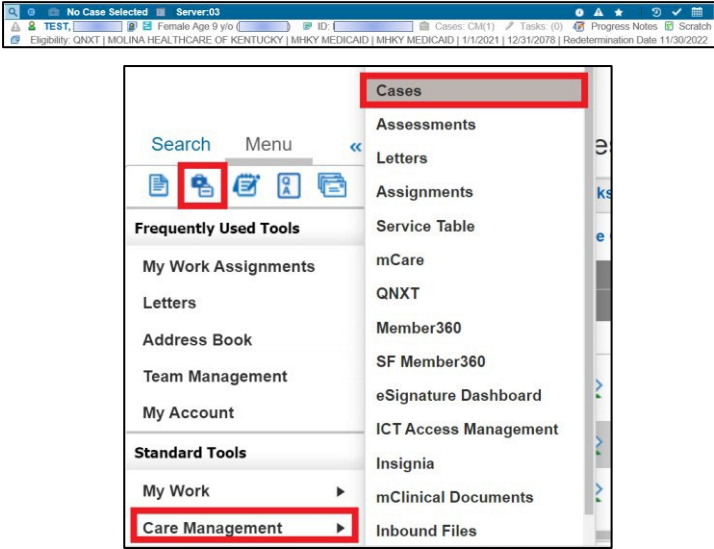
### Result:

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

SMART Goal	Medium	Natalie Pena	06/30/2023	...
CM Intervention		Natalie Pena	06/30/2023	...
Member Intervention		Natalie Pena	06/30/2023	...
Outcome		Natalie Pena	06/30/2023	...

## Accessing a Member's Care Plan

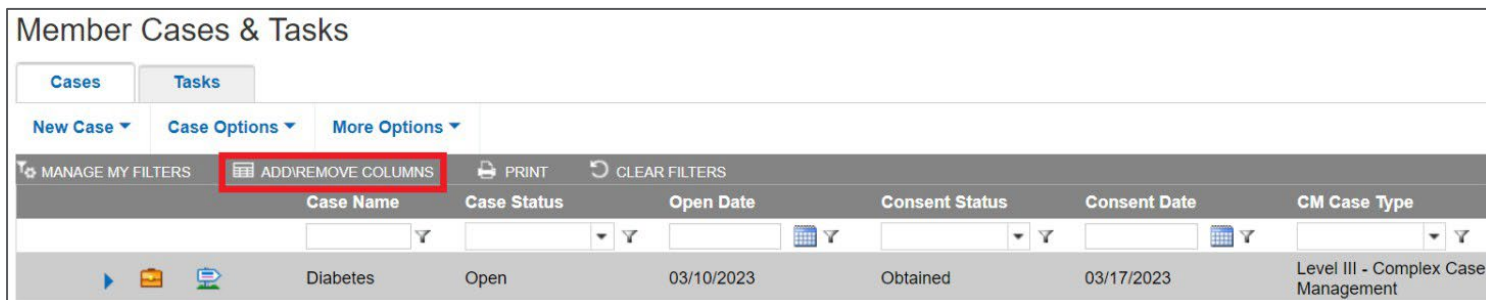
There are two routes you can take to access a member's care plan.

INSTRUCTIONS	SCREENSHOT
<p><b>Route 1:</b> With the member in focus, click on the <b>Case ID#</b> 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'</p>	
<p><b>Route 2:</b>  <b>Cases/Tasks</b> icon from the Quick Tools section</p> <p>Or</p> <p>Click on <b>Care Management</b> under Standard Tools, and select <b>Cases</b></p> <p>You will be redirected to the <b>Member Cases &amp; Tasks</b> landing page.</p>	



## 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*

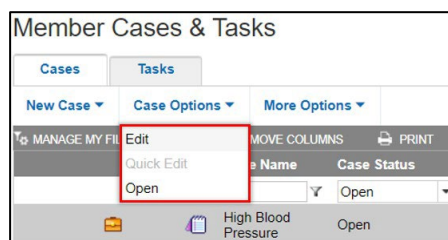


Case Name	Case Status	Open Date	Consent Status	Consent Date	CM Case Type
Diabetes	Open	03/10/2023	Obtained	03/17/2023	Level III - Complex Case Management

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.



Case Name	Case Status
High Blood Pressure	Open

## 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:

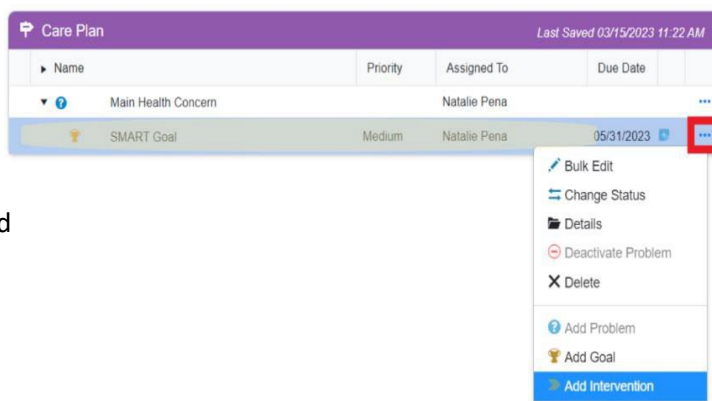
- Changing the status of milestones
- Documenting a Progress Note
- Adding milestones or editing existing milestones (i.e. adding ICT recommendations as applicable).

## 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  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:

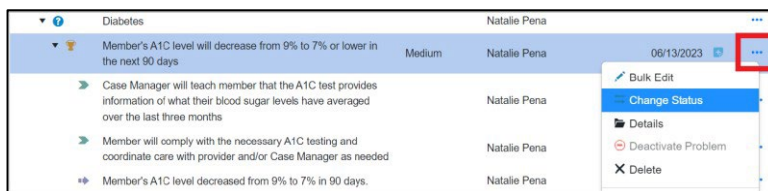
Any changes made to the care plan after a formal ICT meeting must be accompanied by a member outreach as evidenced by a completed Contact Form, refer to ICT Meetings section below for more information.

## 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.

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

### Change status to:

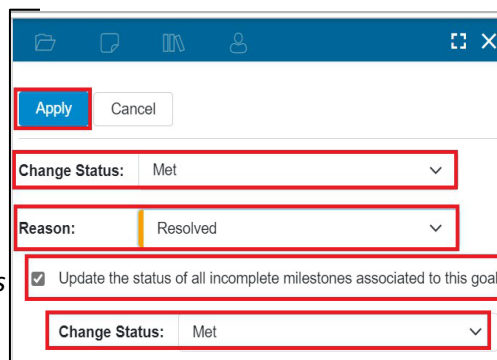
- Met
- Not Met
- Redefined
- *N/A, do NOT used this option*



### Reason:

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

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



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**.

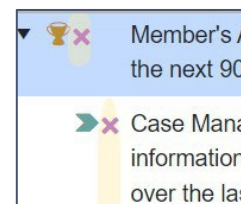
### Result:

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'.

Click on the [**Close Case**] icon located above the Care Plan (and General Information) panel.

The Side Panel will open up.

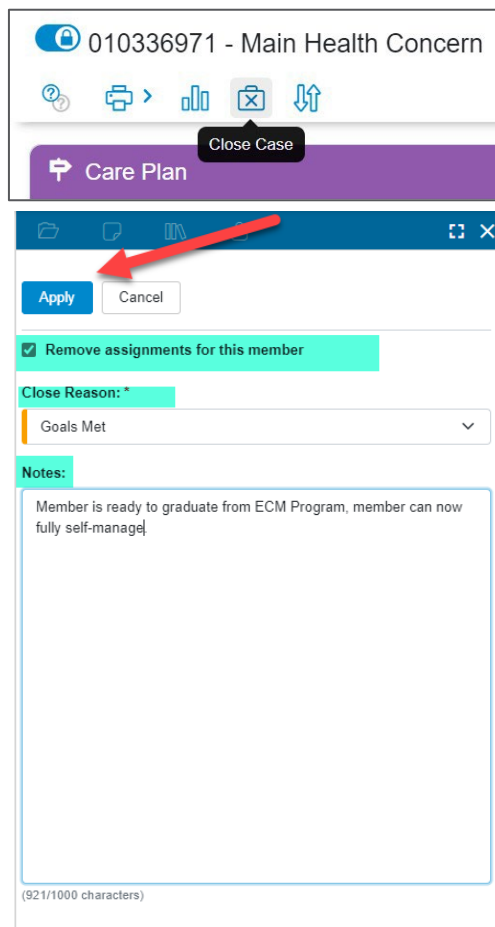
Select "Remove assignments for this member"

Select the appropriate **Close Reason** from the drop-down menu.

Enter a brief **note** supporting the reason for closing the case.

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](mailto:MHC_CS@MolinaHealthCare.Com). The CS Provider will need to open a new care plan.

## ICT Meetings

The purpose of the interdisciplinary care team meetings is to help ensure that the member's care is continuous and integrated among all service providers. The role of the interdisciplinary care team is to provide input to both the development and the ongoing maintenance of the member's care plan.

### Who coordinates the ECM ICT meeting?

- The ECM Lead Care Manager

### Who is required to participate?

- ECM Lead Care Manager
- ECM Director
- ECM Clinical Consultant
- ECM Community Health Worker
- Housing Specialist (as needed)

### Who can also be invited based on the member's needs/preferences?

- ECM Provider Subject Matter Experts as applicable
- Pharmacist
- Nutritionist
- Caregiver
- PCP/Specialists
- Behavioral Health 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)

### What members should be presented in an ICT meeting?

- All ECM members who have high and catastrophic acuity based on Molina's Case Management Acuity.
- Members who are homeless and authorized to receive Housing Community Supports
- Any members who request a case conference. Molina has this question in the CA-HRA. A case conference meeting needs to happen **within 60 days** of the CA-HRA completion date. If no ICT was requested, there still needs to be evidence of ongoing information sharing among the member's multidisciplinary care team.
- Members should also be present if the ECM Lead Care Manager needs help with the care plan or is having difficulty implementing the goals of the care plan.
- Members with recent ED visits or hospitalization (including skilled nursing facility stays) should be reviewed, and the care plan should be updated based on changes in condition or housing status.
- Members with safety concerns, unmet BH/SUD, and/or APS/CPS reports
- If any of your assigned members do not meet the above criteria to be presented at an ICT meeting, we ask that you at least host one (1) ICT meeting with members ICT while the member is in enrolled in ECM at least bi-annually.

### Timeframes to present cases in ICT meetings

- Within **60 days** of identified need, dependent on the acuity of the situation.

### 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.
- Updated ECM Care Plan must be shared with the member, PCP, and other members of the care team as appropriate.
- 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	ECM Program - Best ECM Provider 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.