

Enhanced Care Management Provider Manual

Part 2

Molina Healthcare of California

(Molina Healthcare or Molina)

2025

Capitalized words or phrases used in this Provider Manual shall have 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 Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated: 06/2025

MOLINA® HEALTHCARE

Enhanced Care Management Provider Manual

The Molina **Enhanced Care Management (ECM) Provider Manual** serves as the reference guide for ECM Providers and is considered an extension of the Provider contract. The manual details processes and requirements for the administration and delivery of Molina's Enhanced Care Management Program (ECM). ECM Providers are required to review this manual, participate in associated trainings, share materials with existing and new staff, and educate on program requirements. The information contained in the manual is current as of the date of its publication and is subject to change based on new DHCS requirements and/or when changes are made to Molina's ECM processes.

Please contact Molina's ECM Team at: MHC_ECM@MolinaHealthcare.com for questions about the manual or the ECM Program.

Thank you for your partnership and service to our members!

Table of contents

ECM Lead Care Manager

ECM Providers are required to ensure that each member receiving ECM has a dedicated Lead Care Manager with responsibility for interacting directly with the member and/or family, Authorized Representatives, caretakers, and/or other authorized support person(s), as appropriate. The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify gaps in the Member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, LTSS, Community Supports and other services that address SDOH, regardless of setting, at a minimum.

Assigning an ECM Lead Care Manager to an Enrolled Member

Once a member has been enrolled into ECM, the ECM Provider must assign an ECM LCM within **five (5) business days** from date the member enrolled into the program, referred to as the ECM Opt-In date. If the assigned ECM LCM leaves the organization, the ECM Provider must immediately reassign the member to another ECM LCM, no later than **five (5) business days** from the date the previous ECM LCM stopped serving the member. The member's assigned ECM LCM's full name, phone number, and email address must be included in the monthly RTF submission and evidenced in the ECM Provider's EHR. Additionally, the ECM LCM must contact the member within **5 business days** of member enrolling in the ECM Program.

ECM LCM Credentials and Confirmation of Expertise and Skills

The ECM LCM must document their full name, credentials, and confirmation of their expertise and skills to serve the individual member in a culturally relevant, linguistically appropriate, and person-centered manner post-enrollment in their EHR (including date confirming this) within **five (5) business days** from assigning an ECM LCM to the member. If there's a change in the ECM LCM assignment, the new ECM LCM must do the same exercise within five **(5) business days** from the member reassignment. If the assigned ECM LCM has not completed this for any of their active enrolled members, please document this as soon as possible, this includes members who were grandfathered from another MCP.

ECM LCM Caseload

Molina allows a maximum caseload of 50 members per ECM Lead Care Manager at any given time. This means a 50:1 ratio of members to ECM Lead Care Manager. Molina defers to the ECM Provider to decide on the minimum caseload. If any of your ECM Lead Care Managers have a caseload larger than 50 members, Molina will stop assigning members to your organization until further discussion. Please monitor your caseload on a regular basis as part of your oversight and monitoring.

Cultural Competency Trainings| Person-Centered Care Planning Trainings

Cultural Competency Trainings

To ensure the ECM LCM is providing culturally appropriate and accessible communication in accordance with Member (and/or their parent, caregiver, guardian) choice, ECM Providers are required to provide their staff Cultural Competency training. Anyone from the ECM Provider's ECM team who works with our ECM members, especially the member's assigned ECM LCM should receive Cultural Competency Training as they are on-boarded (new staff) and on an annual basis (refresher). The ECM Provider must track attendance of these trainings, as well as training dates. Molina will request attestations from the ECM Provider confirming who was provided these trainings, as well as the actual training provided.

- For LA County providers: If your organization contracts with Health Net and your staff already completed Health Net's Cultural Competency trainings, your staff is not required to receive additional Cultural Competency trainings. However, we will still require attestation that the training was completed.
- For all regions, if you have completed Cultural Competency training with another MCP, we request that you submit a copy of the training to Molina for review to determine that the requirement has been met. Attestation is still required.
- Molina will conduct Cultural Competency training annually for all ECM Providers and their staff.
- If the ECM Provider organization already has a Cultural Competency training, please submit a copy of the training to Molina for review to determine that the requirement has been met. Attestation is still required.

Person-Centered Planning Trainings

Per federal requirements, if the member has LTSS needs (identified during completion of the Comprehensive Assessment), the care plan must be developed by an individual who is trained in person-centered planning, using a person-centered process, as established in 42 CFR § 438.208 and 42 CFR § 441.301, and should consider and reflect what is important to the member regarding their preferences for the delivery of LTSS (e.g., specific treatment goals, services or functional needs the member prefers to prioritize).

In addition to administering Cultural Competency trainings to their ECM staff, ECM Providers must also provide Person-Centered Planning trainings to all their ECM LCMs as they are on-boarded (new staff) and on an annual basis (refresher). The ECM Provider must track attendance of these trainings, as well as training dates. Molina will request attestations from the ECM Provider confirming who was provided these trainings, as well as the actual training provided.

- Molina conducts Person-Centered Planning training for all ECM Providers and their staff. Reach out to Molina's ECM Team for the next training.

Comprehensive Assessment and Care Planning

Activities in the Comprehensive Assessment and Care Management Plan core service must include, but are not limited to:

- Engaging with each Member (and/or their parent, caregiver, guardian) authorized to receive ECM primarily through **in-person contact**.
- When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider must use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member (and/or their parent, caregiver, guardian) choice.
- Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care and may be needed to inform the development of an individualized Care Management Plan.
- Developing a comprehensive, individualized, person-centered care plan with input from the Member (and/or their parent, caregiver, guardian) as appropriate to prioritize, address, and communicate strengths, risks, needs, and goals. The care plan must also leverage Member strengths and preferences and make recommendations for service needs
- In the Member's care plan, incorporating identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing.
- Ensuring the Care Management Plan is reviewed, maintained, and updated under appropriate clinical oversight

Comprehensive Assessment

Once a member has been enrolled into ECM, a comprehensive assessment must be conducted and a care plan developed. The Comprehensive Assessment was designed as a tool for the ECM LCM to assess the member's health needs and assist in the development of the member's goals and steps that will support the member's overall health and wellness:

- The ECM LCM must start the Comprehensive Assessment within 30 days of ECM Opt-In and must complete it with 60 days of ECM Opt-In. For members who are 21 years of age or older, the Adult Comprehensive Assessment must be administered. For members who are 20 years of age or younger, the Child/Youth Comprehensive Assessment must be administered. Comprehensive Assessment templates are found in the **Attachments** section of this manual.
- ECM Provider's EHR must evidence the completed Comprehensive Assessment that was discussed with the member or member's representative.
- The Comprehensive Assessment is the foundation of the care plan and must be completed prior to completing the care plan.

- All sections of the Comprehensive Assessment need to be completed, or if a section is not applicable, the reason is documented.
- The ECM LCM may use other tools or assessments (e.g., condition-specific assessments), in addition to the Comprehensive Assessment, however, these assessments do not replace the Comprehensive Assessment. If completing additional condition-specific assessments or other tools, the ECM LCM should incorporate findings from all available assessments when completing the Comprehensive Assessment.
- There must be documentation of the member's health status assessment, including medical conditions, member self-assessment and other applicable assessments (e.g., condition-specific assessments) are documented, if applicable, based on responses to Comprehensive Assessment in the ECM Provider's EHR.
- The ECM LCM needs to narrow down the member's main health concern to **at least** 1 to 2 health conditions based on the completed Comprehensive Assessment.

Medi-Cal SPD Members

If a member changes their Medi-Cal plan to Seniors and Persons with Disabilities, known as Medi-Cal SPD, the ECM LCM must ensure the member has a completed Comprehensive Assessment on file no later than 30 days of the member's enrollment into Medi-Cal SPD. Molina's ECM Team will send notification when this occurs, along with reminders and due dates.

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 must be created within 90 days of ECM Opt-In. As a best practice, the ECM LCM should complete the care plan within **2 business days** of the Comprehensive Assessment completion to encourage engagement with the member.
- Each member should have **ONE** active care plan in the ECM Provider's EHR.
- 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 this in your EHR system.
- 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 assessments and other assessments, as applicable.

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 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 care plan includes milestones: problems, goals, interventions, outcomes, & barriers.
- Every problem must have at least one SMART goal that addresses it.
- The member's main health concerns 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. Interventions should address how the barrier will be resolved.
- Additional conditions/problems: choose conditions/problems identified in the Comprehensive 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 comprehensive assessment and through discussion with member/caregiver.
- ECM LCMs are required to confirm, with the member, their assigned PCP's name as part of the care plan development process, include the PCP name in the care plan,

and evidence of member connection to PCP as appropriate, and document this via their EHR system.

- The ECM LCM should coordinate Individualized Care Team (ICT) meetings and document occurrences via their EHR system. Documentation must clearly identify who attended the ICT in the notes section and information shared with those involved as part of the member's interdisciplinary care team. Refer to the **Individualized Care Team Meetings** 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.
- The care plan should not have any overdue milestones. The care plan should be updated at a frequency appropriate for the member's individual progress or changes in needs as determined by the member's assigned ECM LCM.
    - Anytime the care plan is updated, the ECM LCM needs to document that the care plan was updated in their EHR.
- 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 document in the EHR system 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 in their EHR system. If the member declines to have their care plan sent to their PCP, document this in your EHR system. If the member requests for their care plan to be mailed or discussed with someone else, please document this in your EHR system.
- The ECM LCM needs to note in their EHR system when they plan to follow up with the member on their care plan progress.
- Acuity needs to be appropriate based on members' needs and conditions and documented in the ECM Provider's EHR system.
- The care plan should address the member's needs and conditions, including but not limited to the following elements, as applicable:
    - Physical and developmental health
    - Mental health
    - Dementia
    - Substance Use Disorders (SUD)
    - Oral Health
    - Palliative care
    - 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 ECM Provider's EHR system 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 EHR system should demonstrate the ECM Provider requested 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 in their EHR system and provide as much detail as possible. 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

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 evidence your EHR that Health Promotion services were provided to the member.

Case Management Acuity

ECM member must be assigned an acuity level when the ECM LCM creates the care plan. The appropriate acuity level must be assigned based on the member's needs and may change during the member's enrollment in ECM. For members who meet a Population of Focus, but do not fall under any acuity listed below, default member to Medium Acuity. Below are Molina's Case Management Acuity levels. Member's acuity level is reported in the RTF and need to be evidenced in the member's care plan in the ECM Provider's EHR:

Medium Acuity

If your organization assigned an ECM members fall under the following criterion, the member is considered Medium Acuity.

- 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 (specific codes)
- Three to five avoidable Emergency Department visits within six months

High Acuity

If any of your organization assigned an ECM members fall under the following criterion, the member is considered High Acuity.

- 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 (specific codes)
- Six or more avoidable Emergency Department visits within six months

Catastrophic Acuity

If any of your organization assigned an ECM members fall under the following criterion, the member is considered Catastrophic Acuity.

- 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 (specific codes)
- 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.

- **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 frame 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 at least 1 x 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.
Outcome	Member/caregiver/family will record blood sugar levels daily within 30 days.

Barrier	Member has trouble remembering to track blood sugar.
Problem:	**Diabetes Program –A1C Tracking**
Goal	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.
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	The case manager will encourage the member to talk to their doctor on the next visit to discuss a safe exercise plan.
Outcome	Member's A1C level is 7% or below in 90 days.
Barrier	The member doesn't understand how to control her A1C
Problem:	**Diabetes Program –A1C Tracking**
Goal	Member/caregiver/family will provide the healthcare provider with a record of the member's daily blood sugar levels in 30 days.
Intervention	The care manager will reinforce the importance of having a record of blood sugar levels for the healthcare provider.
Outcome	Member/caregiver/family provided healthcare provider a record of member's daily blood sugars within 30 days.
Barrier	Member has trouble remembering to track blood sugar.
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 at least 1x 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*>.
Outcome	Member engaged with diabetic educator and learned about healthy, nutritious, and diabetic-appropriate food choices in compliance with recommended diet in 30 days.
Barrier	The member doesn't understand how to control her A1C

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.
Outcome	Member/caregiver/family repeats two ways alcohol consumption can affect diabetes within 30 days.

COPD:

Problem	COPD –Knowledge of the disease process
Goal	Member/caregiver/family will teach 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	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	Lack of information about COPD warning signs and symptoms
Problem	**COPD –Knowledge of the disease process**
Goal	Member/caregiver/family will obtain at least one educational resource on managing their COPD (Chronic Obstructive Pulmonary Disease) symptoms in the next 30 days.
Intervention	The care manager will educate the member/caregiver/family on signs/symptoms of COPD exacerbation and when to report early symptoms.

Intervention	The care manager will educate the member/caregiver/family on having 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.
Intervention	The care manager will inform the member where the closest urgent care and emergency room is in the member's area.
Intervention	The care manager will educate the member/caregiver/family on when to use urgent care and emergency room appropriately.
Outcome	Member/caregiver/family received information and resources needed to manage their COPD symptoms within the last 30 days.
Barrier	Lack of information about COPD warning signs and symptoms

Chronic Pain:

Problem	**Chronic Pain**
Goal	Member will take the pain medication only as prescribed by her one designated prescriber.
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.
Outcome	The member takes pain medication only as prescribed by her one designated prescriber.
Barrier	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 <*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	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 <*enter referral and resource info here*>.
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.
Intervention	The case Manager will provide the member with a list of available support groups <*enter referral resources here*>.
Outcome	Member attended one peer support group in the next 30 days.
Barrier	Lack of sober support.
Problem	**SUD –Harm Reduction**
Goal	Member will teach back one action to reduce harm and risk associated with <*insert method and substance*> while not ready to abstain in 30 days.
Intervention	The case manager will encourage self-care and risk reduction while the member is not ready to abstain.
Outcome	Member teaches back one action 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 dose*> every <*insert frequency*> to treat substance use disorder in the next <*30/60*> 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 in the last <*30/60*> days.
Barrier	SUD interferes with daily functioning.

Community-Based LTSS:

Problem	Member is at risk for needing institutionalization due to lack of community support.
Goal	Member will maintain community-based living with CBAS support x days per week.
Intervention	Care Manager will discuss with the member and PCP a referral to CBAS and help facilitate as appropriate.
Outcome	Member will maintain community-based living with CBAS support x days per week.
Barrier	Lack of community support
Problem	**Member's capacity for self-care in the community is compromised due to frailty or disability.**
Goal	Member will maintain community-based living with support from IHSS x hours per month.
Intervention	Care Manager will help the member apply for an IHSS evaluation.
Intervention	Member will cooperate with the IHSS evaluation process.
Outcome	Member will maintain community-based living with support from IHSS x hours per month.
Barrier	Needs help with Daily Living Activities

Housing Insecurity/Unhoused:

Problem	Member is currently unhoused
Goal	Member will attain income, vouchers, and/or benefits sufficient to pay for adequate housing for x number of people within 90 days.

Intervention	Care 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 will attain income, vouchers, and/or benefits sufficient to pay for adequate housing for x number of people within 90 days.
Barrier	Member is unhoused.
Problem	**Housing Insecurity**
Goal	Member will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
Intervention	Care 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 will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
Barrier	Housing insecurity.
Problem	**Overcrowded, substandard housing**
Goal	Member will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
Intervention	Care 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 will reside in a desired, stable, housing code-compliant residence adequate to house X adults and x children within 90 days.
Barrier	Substandard housing.
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	Care Manager will link the member with (insert agencies, resources).
Outcome	Member will access two services for basic needs (such as food, shower, and medical care) weekly for 30 days.
Barrier	Unhoused, not ready for housing

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 member consent is not obtained within 90 days of enrollment, the Care Plan is considered non-compliant, even if it was created on-time. Your documentation should reflect when member consent was obtained.

Member Reassignments

At any point while enrolled in the program the member might request to be assigned to another ECM Provider. 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.