Resources

Contents

Job Workflows

Lead Care Manager

Lead Care Manager

Lead Care Managers (LCMs) are required to sustain a case load capacity of 50:1

Daily Workflow – Inhouse

- Morning Team Huddle
  - Number of successful contacts for the previous workday
  - Wins from previous day
  - Goals and Plans for current day
  - Example: 45 members enrolled 6 successful contacts yesterday 26 enrolled members contacted successfully to date. Received a referral from ED, followed up with patient in the ER, successfully enrolled her, her husband and working to enroll their children. Follow up with four referrals I received, contact and complete assessments for the 2 new members enrolled with me, MDT rounding with hospital, MDT meeting with Clinical Consultant
- Run in-patient Census
  - Review for potential patients that qualify for ECM
  - Review if any enrolled members are in-house
- Run Homeless DA2
  - Review for potential patients that qualify for ECM
  - Review if any enrolled members are in-house
- Run ED Census Morning and Afternoon
  - Review for potential patients that qualify for ECM
  - Review if any enrolled members are in-house
- Hospital / CM MDT Rounding
- Receive and follow up on referrals
  - Follow Organic Referral Process
  - Update referral trackers upon acknowledgment
- Patient interview rounding
  - Provide Program Materials
  - Provide Business Card
  - Complete referral form
  - Screen further for eligibility and interest
  - Obtain patient consent for enrollment in program
    - For PHP sign ROI
    - For KFH prepare Presumptive Auth
  - Provide referral information to Referral Specialist to input and track
- Same day documentation
  - For LCMs with Anthem members, status updates should be recorded in Availity, same day.

- Complete Transitions of Care hospital follow up for enrolled ECM patient seen in the ED or admitted to the hospital.
- Minimum of 5 unique enrolled member calls per day
    - Completing Assessments, Care plans, Goals, Pathways, etc.
    - Tier 1 – High Contact Care Management
        - Contact the member 3-4 times per month
        - Contact every 7-14 days
        - In person visits or attempts once per month
        - Update Assessment and Care Plan every 3 months
    - Tier 2 – Medium Contact Care Management
        - Contact the member 2 times per month
        - Contact every 14-21 days
        - In person visit or attempt once per month
        - Update Assessment and Care Plan every 6 months
    - Tier 3 – Low Contact Care Management
        - Contact Member at least once a month
        - Update Assessment and Care Plan every 12 months or as needed

Weekly Workflow

- Total number of successful contacts thus far this month – Every Monday
- Round at AH Clinics which accept managed medi-cal weekly and as referrals are made
- Weekly MDT meeting with Clinical Consultant bringing two cases forward
    - Each member should have a completed MDT 90 days after enrollment
    - Complete MDT Tool 1 day prior to meeting
    - MDTs should still be requested and completed as the need arises
- Review caseload for incomplete profiles/checklist for all enrolled members (must be done within 90 days of enrollment)
- Review case load for accurate status (Referral, Assigned, Enrolled, Never enrolled/Closed)
    - Update status as needed in CCS
    - For Anthem, update in Availity

Bi-Weekly Workflow

- Successful calls
    - All enrolled members should have an attempted contact by the 15th of the month

Monthly Workflow

- Monthly 1:1s with LCM Supervisor
    - Address Concerns / Questions
    - Review Wins / Successes / Accomplishments
    - Goal setting – Personal Development
    - Documentation Review / Training Opportunities
    - Caseload Review

- Gather Success Stories
    - Submit 1-2 Success stores per month
- Assess members for Graduation and Close Out
    - Complete supervisor recommendations for closeout/graduation (if applicable)
- Complete / attempt in-person visits for enrolled members according to Tier level
- Contact members on the HEIDIS report from Clinical Consultant
- Complete unmet items on Internal Audit form
    - 3-5 Members are audits monthly by Supervisor
    - Results are provided to LCM each month
    - LCM to complete all unmet items with in 5 business days of receipt
    - Return Internal Audit form to Supervisor
- ECM Authorization Status
    - KHS
        - Notice coming from Supervisor on members whose authorizations are expiring
        - LCM to evaluate if member meets graduation criteria using Graduation Tool
            - Complete graduation with member if meeting criteria
            - Jennifer to request additional authorization if not
    - Anthem
        - Notice coming from Supervisor on members whose authorizations are expiring
        - LCM to complete of Anthem Graduation tool and upload into the documents section of member's record
        - Send completed form back to Jennifer to request extended authorization
    - Partnership
        - Notice coming from Supervisor on members whose authorizations are expiring
        - LCM to evaluate if member meets graduation criteria using Graduation Tool
            - Graduate if meeting criteria
            - Jennifer to request additional authorization if not

End of Month Checks

- Profile/Checklist
    - Completed in 60 days
- Care Plans
    - Completed in 90 days
- Assessments
    - Completed in 90 days
- Successful calls
    - All attempts
- Completion of MDT meetings
    - Complete MDT for all members within 90 days of enrollment
- Care Plans / Assessments / ROIs uploaded
    - PHP – Point Click Care
    - Anthem – Availity
    - Provided to PCP

- Offered to Members

Support & Collaboration

- Attend community meetings to share program for additional referral linkage
- Attend community event
- Connect with CBOs / Provide program materials

Supporting Members

- Attending appointments with members
- Assisting with Transportation
- Connecting to Medical Support
  - PCP, Dental, Optometry, Specialty Care
- Connecting to CalAIM Community Supports
- Connecting to local resources
- Connecting to shelter
- Scheduling appointments
- Provide Appointment Reminders
- Referral follow up / closed loop referrals
- Encourage and support lifestyle choices
- Link to resources such as self-help, recovery, and chronic condition management
- Connection to Clinical Consultant for Medication Reconciliation
- Ensure member has / is compliant with medications
- Assist in transition of care from hospital and ED
- Assist and coordinate discharge plans
- Connection to food and food resources

Required Documentation

The below are required areas of documentation. These must be completed for each member within the initial 90 days of enrollment.

- Assessment Adult / Youth
- Pathways
- Tools
  - MDT
  - PAM
  - PHQ-9
  - Life Satisfaction Survey
  - ADL + IADL
  - LTSS

Lead Care Manager Supervisor

Lead Care Manager, Supervisor

Daily Workflow

- Morning Team Huddle
  - Daily to-dos / Deliverable / Schedule Review
  - Escalation
  - Needs
- Daily Team Support
- Daily Checks
  - Review Pathways
  - Review Enrollment Numbers
  - Review Disenrollment numbers
  - Outreach Monitoring
    - Address members in outreaching needing calls
      - Monitor number of contact attempts made and modalities
      - Monitor Would for disenrollment at 90 days
    - Address members enrolled needing contact
      - Every enrolled member should have at least 1 successful contact per month TaD
  - TAR Monitoring / Tracking
  - Data Clean up
    - Any data being cleaning up needs to be addressed with LCM if it is an error or Director if it is a fix that needs to be addressed
  - Monitor LCM timely completion of
    - Care Plans
    - Assessments
    - ROI
    - TARs
    - Outreach

Weekly Workflow

- Hold Weekly 1:1s with new LCMs
  - Onboarding
  - Development
  - Training
  - Workflow review
- Weekly 1:1s with CalAIM Director
- Weekly Checks
  - Chart Audit
    - 3-5 chart reviews per LCM per week

- Weekly Operations Deck
    - Information gathering
    - Compile into a Slide Deck
    - Present Data

Monthly Workflow

- Hold Monthly 1:1s with LCMs
    - Address LCM Concerns / Questions
    - Review Wins / Successes / Accomplishments
    - Goal setting – Personal Development
    - Documentation Review / Training Opportunities
    - Caseload Review
- Attending Monthly Health Plan ECM Collaborations
    - Northern California
    - Health Plan of San Joaquin
- Month End Monitoring
    - Review members for Disenrollment
        - No member to be disenrolled prior to LCM Supervisor sign off
    - Auth Expiring for ECM
    - Outreach attempts for members in Outreach
    - Outreach to members in Pending Status
    - Number of Referrals to CBOs
    - Number of Referrals received by agency
    - Graduation Tracking
        - Care Plan Review
        - Pathway completion
        - SMART Goal documentation and completion
- Gather Success Stories
    - 1-2 Success stores per LCM per Month Per Health Plan
    - Prepare success stories for presentation to AH and Health Plans
    - Review of Case Load Capacity A
- Completion of Monthly Capacity Reports
- Download and review of MIFs
    - Ensure new assigned members are provided to CCS for Registration
    - Provide new members to Outreach Specialist
    - Review member status to ensure member is in the correct status with the health plan
        - Manually update or reach out to payer to update any differences
        - Ensure CCS has the member in the correct status
    - Review members for expiring Auths

Quarterly Workflow

- Quarterly Review of Goals and Annual Review Discussion with LCMs
- KHS Quarterly Audit
- Anthem Quarterly Audit

Support & Collaboration

- Health Plan communication
- Health Plan Reporting
    - lack of medical assistance/health insurance, language barrier, RTF / OTF / IOT / Gift Cards / Utilization
- Provide support as requested for billing and documentation request
    - Denial justifications
    - Claim support
    - Audit support
    - Discrepancies

Outreach and Enrollment Specialist

Workflow

- Morning Team Huddle (M,W,F)
- Daily Team Report Outs
  - Number of successful contacts for the previous workday
  - Number of members in referral, assigned and Enrollments for that workday
  - Goals and/or plans for current day
  - Example: 86 members in referral and 106 members in outreach, 18 successful contacts yesterday with 7 of them as enrollments. Goals: to call back appointments made for 4 of the enrollments from yesterday and begin outreach on remaining members in referral status.
- Monday report out
  - Number of successful contacts
  - Number of new members enrolled
- Member Registration
  - Each day register newly assigned member for outreach
  - Each Monday Review the Missing MRN report for member requiring registration and complete registration
- Review CCS Assignments daily
  - Assigned newly referred members to your case load from Holding Agency
  - Check members in referral status for status accuracy, update as needed
  - Check members in assigned status for status accuracy, update as needed
  - Review / confirm daily appointments
  - Anthem members will need status updates made in Availity in addition to CCS
  - Check Member eligibility using provider portal (should be done prior to first outreach attempt and first week of each following month during outreach)
- Internal Referrals
  - Ensure authorization has been submitted and member is approved for ECM (verify with Michelle, Referral Specialist)
- Outreach
  - All newly assigned members must have their initial outreach attempt completed within 90 days
  - Prioritize outreach to members in referral status and members with appointments then outreaching to assigned members starting with oldest called first
  - Research additional/emergency contacts if listed contact is not good and add to CCS profile (do not delete any numbers out of CCS unless verified as wrong number and member unknown to individual)
    - Using Cerner, Provider Portal, Point Click Care, HMIS as resources for information
  - Leave voicemail if no answer with name from AH and call back number

- If contacted and member confirmed, present the program and answer questions
    - Scenarios below:
    1. Members gives verbal consent to enroll: Complete profile, complete Assessment, switch CCS "enroll status" to enroll and update corresponding dates, complete all documentation. Please note, the enrolment process may take approx. 1 hour. Ok to suggests breaking enrollment up into a couple appointments.
        - Member declines: Thank member, give return call number in event they change their mind, change CCS "enroll status" to decline, "Active status" to Inactive and update corresponding dates and complete all documentation/contact notes
        - Member gives verbal consent to enroll but requests call back for assessment completion: Set appointment day and time with member, place call back appointment on your calendar and in CCS contact note, switch CCS "enroll status" to enroll and update corresponding dates, complete all documentation. Call back on scheduled day and time
        - Member unsure and requests a call back: Set appointment day and time with member, place call back appointment on your calendar and in CCS contact note, complete all documentation. Call back on scheduled day and time
- If member is unable to be contacted after multiple attempts on multiple days using multiple modalities, inform supervisor and reach out to the local LCM team to conduct an in-person visit
    - Each member will have 5 phone attempts, 1 email (if on file), 1 home visit, and 1 mailed letter over the course of 3 months.
    - After 3 months if member is unable to be reached, inform supervisor and close the member
        - Exception KHS and Partnership –keep member on referral outreach for 12 months with continued escalated outreach mandatory 5 phone calls per rolling 30-day period

- Member Enrollment
    - Member agrees to enrolled
        - Complete Member Profile
        - Complete Member Assessment
        - Assign member to LCM
        - Review Pathways for accuracy
            - Archive any unneeded Pathways
            - Open any needed Pathways
            - LCM will work with Member to complete the Pathways
        - Review Tools for accuracy
            - Archive any unneeded Tools
            - Open any needed / required Tools
            - LCM will work with the Member to complete the Tools
    - PHP members will require signed ROI
        - Members LCM will collect from member during initial meeting
    - Conduct a warm hand off to LCM

        - Share LCM Name, contact information including phone and email, and provide assurance on LCM character and work ethic to member
        - Send Teams message to LCM informing them of new member and request availability for follow up appt / 3-way call
            - Include Supervisor and LCM on TEAMs message
            - Assign to LCM based on the following
                - Case Capacity
                - Member Language
                - Proximity to member's home
                - County
        - Warm Hand Off Options
            - 3-Way Call
            - Arrange member appointment with receiving LCM
- Productivity Measure
    - 200 Outreach calls per month
    - 10 unique members call per day
    - 2 Enrollments a week

RN Clinical Consultant

Clinical Consultant, RN

Daily Workflow

- Complete Daily Chart Reviews
  - Patient Medical History
  - Medication review
  - Utilize HIE
- Review members enrolled in the PoFs High Utilizer
  - Conduct outreach to member and create a Plan of Care for prevention
- Conduct follow up calls with members who are taking medications
  - Medication reconciliation and education
  - Conduct Peer to Peer meetings with Medical Group
  - Disease Process management and Education
  - Vaccination Education
  - Review Member Health Concerns
  - Provide health related resources
  - Set up Specialty care, Follow up care, and or Establish Care
  - Support member in advocating for medication needs with PCP and or Behavioral Health
- Provide Clinical consults as requested by LCM and or Enrolled Member
- Support in the planning of Medical Interventions and procedures
- Providing services 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.
- Review Member PHQ9 and timeliness of completion of a PHQ9
  - If PHQ9 score is 15 or higher member should be reassessed in 3 months
- Review Members Provided BP, follow up as needed
  - If BP was not in normal range BP should be reassessed in 3 months
- Track completion of member care plan and sign off on all Care Plans

Weekly Workflow

- Manage MDT Meetings
  - Prep and coordinate MDT meetings
  - Conduct MDT meetings with LCMs for all enrolled members
    - Prevention
    - Challenges
    - Suggestions
    - Interventions
    - Referrals

    - Meeting to include LCM supervisor
    - Director to be included, Adhoc
    - Manage escalation shall an MD need to get involved
    - Track outcomes of MDT meetings
    - Conduct Follow up on open MDT items
- Review Enrolled Member acuity levels provided by the Health Plans

Monthly Workflow

- Provide monthly trainings and education to LCMs
    - Clinical signs of escalation
    - MDT Preparation
    - Additional Trainings as needed
- Conduct outreach and engage with medical providers
    - Provide Program education on member eligibility
    - Maintain contact and an open line of communication
    - Be the Main point of contact for Clinic and or hospital MDs
- Report member health success stories
- Clinical Training 101

Quarterly Workflow

- Audit Preparation
    - Chart Reviews
    - MDT with MCP Anthem
    - Attend KHS Audit – Based on sign off of MDT and Care Plan
- Manage and report on member health outcomes
- Create and share Health outcome, utilization, and readmission data to hospital leadership

Support & Collaboration

- Work with LCM Supervisor to balance LCM patient load
- Work with LCM Supervisor and LCMs on member eligibility for referrals
- Collaborate with MCPs on member related issues
- Escalation and advocacy to MCP clinical teams

Referral Project Manager

Referral Project

Daily Workflow

- Morning Team Huddle
  - Wins from previous day
  - Goals and Plans for current day
- Referral Channel:
  - Review referral channels and transcribe relevant information into Referral Worksheets.
  - Communicate updates to referring teams and LCMs.
- Referral Management:
  - Add new referrals to the spreadsheet.
  - Check eligibility and duplicative service immediately after adding to the tracker.
  - If a member is in-house at a hospital/clinic, notify the LCM for a bedside meeting after confirming eligibility and ensuring no duplicative service.
  - If a member is discharged and eligible with no duplicative service, add them to the Priority List for Outreach Specialist follow-up.
  - Create a CCS profile for all eligible referrals.
  - Check for approvals or denials.
- Referral Sources:
  - AH – Bakersfield/Delano
  - Lake County Referrals
  - AHRO
  - AH Tehachapi Valley
  - AH Mendocino
  - AH – ACO
  - Community Connect Inbox (Direct Referrals from Health Plans, ECM Referral Form, Direct Referrals from CBOs)
- New Referral Eligibility review – Utilize Cerner, KHS, Availity, Point Click Care, and PHC access as needed.
- Referral Submissions:
  - **Anthem:** Submit referral in Availity. Manually create a CCS profile the same day and leave in the holding agency until approved. Once approved, update the Availity status from Pending to Outreach-Enrolled with details. Assign to LCM and add the approved member to the Anthem spreadsheet with UM.
  - **KHS:** Submit the assessment in the Kern portal. Create a CCS profile the same day and keep it in the holding agency until approved. Assign to LCM once approved.
  - **PHC:** Create PHC referrals in CCS and ensure the TAR process is completed for new one-off referrals.
- Referral Updates:
  - Check KHS, Availity, and PHC daily for approvals or denials.
  - Inform the LCM of approvals or denials.
  - Update the CCS status accordingly.
  - Update the Referral Tracking spreadsheet with enrollment status.
- Community Connect Email Management – Review inbox messages, flag urgent emails, and respond or forward as needed.
- Voicemail Management – Listen to new voicemails, document key details, return priority calls, and take new

messages during return calls.

- TOC Anthem & Partnership – Add new members to the TOC spreadsheet, notify LCMs of ED admissions, and ensure LCMs complete necessary documentation.
- Point Click Care Management:
    - Review Point Click Care cohorts and identify patients meeting insurance requirements.
    - Confirm patients are not enrolled with other providers.
    - Add eligible patients to the referral tracker and submit referrals through the insurance portal.
    - Create a CCS profile and select Point Click Care as the referral source.
    - Notify LCM for bedside visits and assign LCM in CCS.
- TAR Reconciliation – Review Megan's tracker daily for new billing issues, address each issue, and update notes with completion dates.

Weekly Workflow

- Billing Denial Huddle (Tuesdays & Thursdays) – Complete updates discussed in huddle.
- Ashten 1:1 – Review questions, updates, and concerns

Biweekly

- Update the TAR tracker with newly enrolled members requiring TAR.
- Update the Kern Tracker with newly enrolled members needing AUTHs.
- Update the Anthem Tracker with newly enrolled members and add UM.
- PCC check-in.

Monthly

- Monthly Referral Reports (PowerPoint) – Gather referral data and sources, then graph referrals by county and source.
- TAR & Authorization Expiration Management:
    - Submit expired TARs on the first Monday of the month.
    - Submit expired Authorizations for Kern.
    - Report expiring Anthem Authorizations on the spreadsheet for Jennifer.

Community Connect Referral Form

CommunityConnect REFERRAL FORM

Adventist Health

MEMBER INFORMATION

First Name*

Last Name*

Date of Birth*

CIN/Member ID*

Health Insurance*

- ☐ Anthem Blue Cross
- ☐ Kern Health Systems
- ☐ Partnership HealthPlan of California

MEMBER CONTACT INFORMATION

Phone Number

Email Address

Street Address

City, State, Zip

REFERRER CONTACT INFORMATION

Referrer Name

Email Address

Phone Number

EXCLUSIONARY CHECKLIST

Members enrolled in the programs below are excluded from ECM:

- ☐ Cal MediConnect
- ☐ Hospice
- ☐ Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)
- ☐ Program for All Inclusive Care for the Elderly (PACE)
- ☐ Family Mosaic Project Services (FMPS)
- ☐ California Community Transitions (CCT)
- ☐ Money Follows the Person (MFTP)
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Assisted Living Waiver (ALW)
- ☐ Home and Community-Based Alternatives (HCBA) Waiver
- ☐ HIV/AIDS Waiver
- ☐ HCBS Waiver for Individuals with Developmental Disabilities (I/DD)
- ☐ Self-Determination Program for Individuals with Developmental Disabilities (I/DD)
- ☐ Basic Case Management (Medi-Cal Managed Care Benefit)
- ☐ Complex Case Management (Medi-Cal Managed Care Benefit)

NOTES

ECM PROVIDER ASSIGNMENT

Select only one of the following:

- ☐ Member is not working with any other ECM provider that they are aware of
- ☐ Member is already assigned to another ECM provider and chooses to switch to Adventist Health as the ECM provider
- ☐ Member is already assigned to another ECM provider and does not choose to switch providers (member is excluded)

CONSENTS

- ☐ Member verbally consents to receiving ECM services
- ☐ Release of Information (ROI) is attached

REFERRAL SUBMISSION Fax: (916) 406-2557 **Email:** CommunityConnect@AH.org

Population of Focus

Select one of the following populations of focus depending on whether the person being referred is an adult, child, or youth.

☐ **Experiencing Homelessness (Adults)**
Must also have at least **ONE** complex need:
- ☐ Physical Health Diagnosis: _____
- ☐ Behavioral Health Diagnosis: _____
- ☐ Developmental Diagnosis: _____

☐ **Experiencing Homelessness (Families & Children)**
Must meet **ONE** of the following:
- ☐ Literally homeless
- ☐ Staying with friends or family (couch surfing) or residing in a motel, trailer park, campground, shelter, or hospital without safe place to discharge

☐ **High Utilization (Adults)**
Must meet **ONE** of the following in **6-months**
- ☐ 5 or more ED visits
- ☐ 3 or more hospital admissions and/or short-term skilled nursing facility stays

☐ **High Utilization (Children & Youth)**
Must meet **ONE** of the following in **12-months**
- ☐ 3 or more ED visits
- ☐ 2 or more hospital admissions and/or short-term skilled nursing facility stays

☐ **SMI/SUD (Adults)**
Diagnosis: _____
Must also be experiencing **ONE** complex social factor influencing their health:
- ☐ Food Insecurity
- ☐ Housing Insecurity
- ☐ Employment Insecurity
- ☐ Adverse Childhood Experiences (ACEs)/ Trauma
- ☐ Recent contacts with law enforcement due to SMI/SUD

☐ **SMI/SUD (Children & Youth)**
Diagnosis: _____

☐ **Birth Equity (Adults & Youth)**
Must meet **BOTH** of the following:
- ☐ Pregnant or postpartum (within 12 months from birth)
- ☐ Subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality

☐ **Living in the Community and At Risk for Long-Term Institutionalization**
Must meet **ALL** of the following:
- ☐ Meets criteria for skilled nursing facility (SNF) level of care **OR** requires lower acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis or treatment of acute illness or injury
- ☐ Actively experiencing at least **ONE** complex social or environmental factor influencing their health. Some examples include:
  - ☐ Needing assistance with activities of daily living (ADLs)
  - ☐ Needing assistance accessing food or stable housing
  - ☐ Communication difficulties
  - ☐ Living alone
  - ☐ Need for conservatorship or guided decision making
  - ☐ Poor or inadequate caregiving that may appear as a lack of safety monitoring
- ☐ Are able to reside continuously in the community with wraparound support (some individuals may not be eligible because of high acuity needs or conditions that are not suitable for home-based care due to safety or other concerns)

☐ **Nursing Facility Residents Transitioning to the Community**
Must meet **ALL** of the following:
- ☐ Interested in moving out of the institution
- ☐ Likely candidate to do so successfully
- ☐ Able to reside continuously in the community

☐ **Enrolled in CCS with Additional Needs Beyond CCS Condition (Children & Youth)**
Must also have at least **ONE** complex social factor influencing their health. Some examples include:
- ☐ Lack of access to food
- ☐ Lack of access to stable housing
- ☐ Difficulty accessing transportation
- ☐ High measure (four or more) of ACEs screening
- ☐ History of recent contacts with law enforcement
- ☐ Crisis intervention services related to mental health and/or substance use symptoms
- ☐ Other: _____

☐ **Involved in Child Welfare (Children & Youth)**
Must meet **ONE** of the following:
- ☐ Under age 21 and are currently receiving foster care in California
- ☐ Under age 21 and previously received foster care in California or another state within the last 12 months
- ☐ Aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
- ☐ Under age 18 and are eligible for and/or in California's Adoption Assistance Program
- ☐ Under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months

ECM Scripts

ECM Scripts

ECM Scripts

This is a guide to assist with common types of phone calls and other scripts. You are allowed to use your own words to be as comfortable and conversational as possible during your calls.

Elevator Speech

Purpose

Gives an overview of the program. When an LCM is asked "What is Enhanced Care Management?"

Script

"Enhanced Care Management is a managed Medi-Cal benefit free for its members who qualify. My role as a Lead Care Manager is to assist Members such as those experiencing homelessness, high utilizers, SMI, and/or SUD over a period of time to link them to resources and support them with any needs or goals they may have. Some things I help with are transportation to medical appointments, helping get medications prescribed, food security, access to medical and mental health services, and other health and well-being resources that help Medi-Cal Members live a better quality of life and improve their overall well-being."

Member Outreach Calls After Recent Facility Visit

Purpose

For outreach calls to members that have been seen at an Adventist Health facility in the last 90 days. Staff will reach out to advise of CommunityConnect program and engage individuals to enroll into the program.

Script

1. **Greet member –** Good morning/afternoon/evening. May I speak to [member]?
    a. **Yes –** Hi. My name is [your name] and I'm a Lead Care Manager with Adventist Health who is partnered with your health insurance plan [insurance plan].
    b. **No –** My name is [your name] and I'm calling on behalf [insurance plan]. When would be a better time to reach [member]?

        Instruction: *Document the outcome of the call in the contact notes and schedule the next outreach date for your follow-up call.*
2. **Engage member –** It looks like you've recently been in an Adventist Health facility within the last three months, and I see that you are with [contracted health plan]. I would like to give you a little bit of an overview of Enhanced Care Management, a program available to you at no cost. Do you have a moment to discuss this benefit?
    a. **Yes –** Great. Thank you. Enhanced Care Management is a program that comes with your Medi-Cal benefits and is no cost to you. My role as your Lead Care Manager will be to assist you over a period of time to link you to resources and support you with any needs or goals you may have. A few examples of things I may be able to help you with are transportation to your medical appointments, helping you get prescribed medications, food security, access to medical and mental health services, and other health and well-being resources that can help you live a better quality of life. My job is to help you address barriers that you may have and to be your advocate.
    b. **No –** I understand it might not be the best time. Would it be okay if I call you next week to check back in? Again, my name is [your name] with Adventist Health and my phone number is [phone number]. I will call you next week to check in again. Have a great day!

        Instruction: *Document the outcome of the call in the contact notes and schedule the next outreach date for your follow-up call.*
3. **Verify identity –** To make sure I'm talking with the right person, do you mind verifying your full name and date of birth?
    a. **Yes –** Thank you.
    b. **No –** {Pivot and try different ways to verify their identity}
    I want to confirm the information that your health plan provided to us.
        i. We have your full name as [member's name].

ii. We have your apartment number as [apartment number].
iii. We have your zip code as [zip code].

4. **Obtain consent** – To verify enrollment, I will be contacting your health plan to confirm eligibility, then we can set up a time to discuss what kind of support I can provide you. Would you be interested in having me work with you as your Lead Care Manager?
    a. **Yes** – Great!
    b. **No** – Okay, no problem. If you decide that you would like to enroll at a later time you can always call us. Would you like the number?

        Instruction: *Provide the number if they would like, if not, just thank them for their time and hang up the call. Document the outcome of the call in the interaction notes and schedule the next outreach date for your follow-up call.*
5. **Schedule Follow-Up** – What would be a good time to connect next week to talk more about how the program can help you?

    Instruction: *Document the outcome of the call in the interaction notes and schedule the next outreach date for your follow-up call.*

Member Outreach Calls

Purpose

To attempt initial outreach and to enroll a member who has been referred by:

1. Introducing yourself
2. Advising of program benefits
3. Verifying their identity
4. Verifying their insurance is correct
5. Obtaining their consent to enroll
6. Scheduling a follow-up time

Tips

- Review member's CCS profile prior to calling to identify their POF and what services you can offer.

Script

1. **Greet member** – Hello, my name is [your name] and I am Lead Care Manager with Adventist Health. I'm calling on behalf of [insurance plan]. May I please speak with [member]?
    a. **Yes** – Hi [member]. My name is [your name] and I am calling from Adventist Health on behalf of your health insurance plan [insurance plan].
    b. **No** – My name is [your name] and I'm calling on behalf [insurance plan]. When would be a better time to reach [member]?

        Instruction: *Document the outcome(s) of the call in the contact notes and schedule the next outreach date for your follow-up call.*
2. **Engage member** – I am calling today to let you know of a benefit that is part of your insurance benefits. You may have received a letter in the mail regarding CommunityConnect, but I would like to give you a little bit of an overview. This will only take a few minutes. Is now a good time to talk?
    a. **Yes** – Wonderful!
    b. **No** – Okay, no problem. When would be a better time for us to talk?

        Instruction: *Document the outcome(s) of the call in the contact notes and schedule the next outreach date for your follow-up call.*
3. **Verify identity** – To make sure I am speaking with the correct person, can you please verify your date of birth?
    a. **Yes** – Thank you!
    b. **No** – For us to proceed, I would need to verify you date of birth. If you don't feel comfortable now, is there a better time for us to chat?

        Instruction: *If member does not want to provide a Member Identifier… offer to resend the welcome letter & call back in a week. Record the plan for your Next Outreach Date in your encounter workflow.*

4. **Describe program –** You have been referred to Enhanced Care Management. I would like to give you a little bit of an overview.
    a. **Yes –** Enhanced Care Management is a program that comes with your medical benefits and it's no cost to you. You will have a Lead Care Manager that will assist you over a period of time to link you to resources and support you with any needs or goals you may have. We assist with things like finding doctors and making appointments, helping you understand your medications, coordinating transportation to your medical appointments, finding healthy and affordable food, connecting you with free or low-cost community services to help with things such as utilities, food, clothing, or shelter if any of that is a concern for you. If you need support for mental health, we can connect you to counselors. If you're suffering with substance abuse, we can get you connected with rehabs and addiction recovery specialists and legal supports.
    b. **No –** Okay, no problem. If you decide that you would like to enroll at a later time you can always call us. Would you like the number

        Instruction: *Provide the number if they would like, if not, just thank them for their time and hang up the call. Document the outcome of the call in the interaction notes and schedule the next outreach date for your follow-up call.*
5. **Obtain consent –** Would you be interested in having a Lead Care Manager support you?
    a. **Yes –** Thanks!
    b. **No –** Okay, no problem. If you decide that you would like to enroll at a later time you can always call us. Would you like the number

        Instruction: *Provide the number if they would like, if not, just thank them for their time and hang up the call. Document the outcome of the call in the interaction notes and schedule the next outreach date for your follow-up call.*
6. **Verify contact info –** First, I need to verify your name, number and address. Is the number I called [member phone number] the best contact number for you? Can you please verify the spelling of your name? I have your address as [member address], can you please verify your zip code as well?
    a. **Yes –** Thanks!
    b. **No –** In order for us to work with you, we'll need to verify your information.
7. **Assess needs –** What are some of the resources or needs that you have right now where our team can help?
   Do you have any current medical needs?
   Do you need help getting an appointment for any specific condition?
   Has it been a while since you have seen an eye doctor or dentist
   Have you been in the ER or hospital multiple times this year?
   Do you need help connecting with housing, food, or transportation to medical appointments?
    a. **Yes –** Your assigned Lead Case Manager can absolutely help you with that. The goal of this program is to help connect you with the resources and services you need so you can improve your health and overall well-being.
    b. **No –** Okay, no problem. If you decide that you would like to enroll at a later time you can always call us. Would you like the number?

        Instruction: *Provide the number if they would like, if not, just thank them for their time and hang up the call. Document the outcome of the call in the interaction notes and schedule the next outreach date for your follow-up call.*
8. **Enroll and schedule appointment –** Would you like to proceed and enroll in the program?
    a. **Yes –** Wonderful! The next step is connecting you to your Lead Care Manager so that they can meet with you, either in person or over the phone if you prefer. They will discuss your current health and needs and then create a care plan to help support you. Depending on your needs, your Lead Care Manager will work with you weekly or bi-weekly and act as your advocate and will work to help you get the needed services and resources. Let's get an appointment set up for you to meet your Lead Care Manager.

        Instruction: *Schedule appointment for the member with LCM.*

b. **No –** Okay, no problem. If you decide that you would like to enroll at a later time you can always call us. Would you like the number?

Instruction: *Provide the number if they would like, if not, just thank them for their time and hang up the call. Document the outcome of the call in the interaction notes and schedule the next outreach date for your follow-up call.*

9. **Confirm appointment –** I have you scheduled to meet with your Lead Care Manager [LCM name], on [date and time]. Please plan about an hour for the meeting so that your Lead Care Manager can take the time to meet you and understand how they can help you. If you need to contact them before that time, you can reach them at [LCM phone number]. Thank you so much for your time today, that just about does it for this introductory call. Do you have any questions or concerns for me at this time?
    a. **Yes –** Alright. Let's talk about those questions or concerns.
    b. **No –** Great, we look forward to working with you. I think you are really going to love working with [LCM name] and we look forward to helping you improve your health and well-being. Have a great day!

Instructions: *Change the enrollment status to "enrolled" and document in the notes field that the member has agreed to enrollment. Document any needs that were discussed in the call and anything that the Lead Care Manager should know about the member.*

Voicemail

"Hi, my name is [your name], and I am a Lead Care Manager with Adventist Health. I am calling because I have a referral for you from [insurance plan] for our enhanced care management program. We assist our members with finding community resources, social services and resources to community-based organizations. That means we help get you connected to [list services that align with their POF]. I would love to give you more information, please give me a call back at your earliest convenience [phone number]."

Member Feedback Calls

Purpose

To get feedback from member to improve the program.

Tips

- "Assessment" vs "Survey" – Assessment implies "judgement" of some kind. Survey more accurately is getting "your opinion". There are no right or wrong answers on surveys.

Script

"Hello, this is [your name] and I'm calling from CommunityConnect on behalf of Adventist Health. I live nearby in [city or county] too. I'm calling to gather your thoughts and opinions of what matters most to you day to day; that effect your well-being outside of the doctor's office. Adventist Health is looking for your feedback to continually improve and create new social programs that will add value to their members. This is so important that they've asked us to meet with you face to face. I would like to come out for 20 minutes or so and have a conversation to uncover what matters most to you. What day next week works best for you?"

Partnership Building Calls

Purpose

To build or strengthen partnerships within the community that may be beneficial to members.

Script

1. **Greet and introduce –** Hi, my name is [your name] and I am a Lead Care Manager with Adventist Health's Community Connect Program. I am reaching out to identify and connect with partnerships in our community. Community Connect is working to help Anthem, Partnership and Kern Health Systems covered members that have been identified as benefiting from Enhanced Care Management. Is there someone I can speak to in your organization that would be able to talk about this a little more?
    a. **Yes –** Great!
    b. **No –** When would be a better time to call?

2. We are calling to help educate our potential community partners about our role and how your organization can support these community members. We are a new program in [insert County] County that is seeking to keep people healthy and safe. As a Lead Care Manager, I am a Community Health Worker that lives here in [County]. Our County Team identified your organization as a helpful partner for Community Connect based on your [ability/services/training potential]. Is there a contact email for your organization so I can send information about our program? After you have some time to review it, can we reconnect in a few days? I can call back on [date] around [time] if that works for you? You can also call me back sooner if you like. Can I verify your hours of operations, days, address and best contact info?"

What we do

- We help members get to appointments and provide support with transportation.
- We help identify resources to get members access to healthy, fresh food options.
- We help with housing resources for those who qualify.
- We help to support chronic health conditions and work towards keeping patients out of the Emergency Room.
- We help to access Medi-Cal benefits and navigate the system.

Community Partners that may have established relationships with individuals eligible for ECM

- Housing agencies
- Homeless services agencies
- Social service organizations
- Law enforcement
- Department of Probation
- Community clinics
- Health centers
- Hospitals
- County behavioral health and social services departments
- Health consumer centers or legal organizations

Services by Population of Focus

Purpose

To provide examples of services offered to encourage member to enroll or encourage partnership building.

Examples

Population of Focus	LCMs can connect Members to these services
Homeless	○ Shelters ○ Housing ○ Food pantries ○ Religious organizations ○ Motel vouchers ○ Medical Recuperative Care ○ Short-Term Post-Hospitalization Housing ○ Section 8 ○ Clothing ○ Survival gear/tents/sleeping bags ○ Hygiene/self-care products ○ Cooling centers ○ Cold weather shelters ○ ID vouchers ○ Transportation
High Utilization	○ Primary Care Physician ○ Medications ○ In-Home Supportive Services

	○ Urgent Care resources ○ Transportation ○ Disease management education ○ Medication review ○ DME (Durable Medical Equipment) support ○ Medical Referrals/Specialists: • Cardiologist for CHF and other heart conditions • Pulmonologist for COPD and other lung conditions • Dentist • Optometrist for Vision • Neurologist for Brain • Psychiatrist for Mental Health • Oncologist for Cancer • Urologist for Urinary • Gastroenterologist for Digestive • Dietitian • Pain management
Serious Mental Illness	○ Behavioral Health ○ Psychiatrists ○ Therapists ○ Stress management education ○ SSI (Social Security Income) support including Legal ○ Telehealth ○ Crisis resources ○ Medications ○ Primary Care Physicians ○ Support groups ○ Grievance support ○ Payee ○ In-Home Supportive Services ○ Conservatorship
Substance Use Disorder	○ Substance Use Navigators ○ Residential substance use programs ○ Substance use education ○ Harm reduction services ○ Narcan education ○ Needle exchange programs
Birth Equity	○ OBGYN ○ Pediatrician ○ Black infant health ○ Postpartum depression ○ Lactation consultants ○ WIC ○ SIDS education ○ Public health nursing ○ Breast pumps ○ Parenting classes ○ Lamaze classes ○ Gestational diabetes education and monitoring ○ FMLA/baby bonding resources
At Risk for Long-Term Institutionalization	○ In-Home Supportive Services ○ Home Health services

	○ Personal homemaker ○ Medication management ○ DME (Durable Medical Equipment) support ○ Medical Recuperative Care ○ Short-Term Post-Hospitalization Housing ○ Home modifications ○ Pharmacy support
SNF Transitioning to the Community	○ In-Home Supportive Services ○ Home Health services ○ Personal homemaker ○ Medication management ○ DME (Durable Medical Equipment) support ○ Medical Recuperative Care ○ Short-Term Post-Hospitalization Housing ○ Home modifications ○ Pharmacy support
Enrolled in CCS	○ In-Home Supportive Services ○ IEP Plan (pediatrics) ○ PCP ○ Specialty care ○ Medication management ○ Diagnostic and treatment services ○ Medical case management ○ Physical, occupational and speech therapy ○ Medical therapy at public schools ○ Mental health services ○ Orthopedic appliances ○ DME support such as wheelchairs and hearing aids ○ Incontinence supplies ○ And other pediatric services (see below)
Involved in Child Welfare	○ Pediatrician ○ Parenting education ○ Family planning ○ Budgeting ○ Employment readiness ○ Clothing and baby items ○ Domestic violence assistance ○ Education assistance ○ Food assistance ○ Childcare
Pediatrics	○ Pediatrician resources ○ IEP (Individualized Education Plan) or 504 for school ○ Developmental resources ○ Behavioral resources ○ Anti-bullying resources ○ Cyber safety/screen time ○ Lead testing ○ Vaccine education ○ Respite ○ Learning disability screenings at school ○ Audiology/hearing testing at school ○ Vision testing at school

	○ Autism testing
Any/All POFs	○ Advanced Directives ○ Meal planning ○ Healthy living ○ Exercise plans ○ Lead testing ○ Vaccinations ○ Sleep habits ○ Pharmacy ○ Pain management ○ Medication management ○ Government Benefits • CalFresh • CalWORKs • SSDI • IHSS ○ Life Skills Classes: • Anger management • Computer Lab • Effective Communication • Employment Readiness • Health Habits • Ready to Rent • NA/AA Meetings • Self-Discovery / People Skills • Time and Money Management ○ Legal ○ Transportation ○ Utilities ○ Smoking Cessation ○ In-Home Supportive Services

Tips

Calls

- At the beginning of every call identify who you are, where you are from and why you are calling. For example:
  - "Hi, my name is [first name] and I work for Community Connect with Adventist Health. I am calling to speak with [member's name]."
- Be comfortable and confident. Callers are more successful when they assume the call will be successful.
- Stay calm and try to slow down when talking. We often speed up when we are nervous, making it harder for them to follow.
- Avoid sounding like a telemarketer. Be relaxed and conversational style.
- Be positive, pleasant, and upbeat so the call is perceived as positive. Laughter increases success rates.
- When trying to reach a member and someone else answers and says the member is not available ask when they can be reached. For example:
  - "When would be a better time to reach [member]?"
- If the member does not have one of the contracted health plans, you can advise them to:
  - "Call the number on your health insurance card and they should have services that can help you. Let them know you are interested in Enhanced Care Management."
  - If they would like to work with Adventist Health, we can help them sign up for Medi-Cal or they could request to change insurance.

- Avoid long pauses unless you are waiting for them to answer your question. Long pauses trigger "why are you calling" or "get to the point".
- Avoid "potholes" or leaving out information. What you leave out of the script creates holes and causes objections.
- Using the word "assessment" can be intrusive and may set you up for objections? Try saying "conversation to learn what is important to them."
- Have 2 to 3 ways that you are comfortable telling our story (our purpose) to use in the course of a call.
- Before ending the call, establish a time, date, and place to meet with the member for follow-up.

Breaking Down Resistance

- **Do they have their guard up when receiving calls at home?** People have legitimate "fears and concerns" about callers such as fears of solicitors, scammers, or unwanted change. It is not human nature to say "yes" the first time asked to do something? It is natural for people to be resistant. Be prepared to ask 3 different ways while breaking down their natural resistance. Example script: "This is not a sales call and we are not changing your coverage. I live right by you, over by the [location]."
- **Are they resistant to participating in surveys?** Staff are very successfully using the availability of resources and social programs to get surveys. But when that is not working, staff must recognize the opportunity and the need to pivot. The real issue keeping staff from getting surveys is not taking the time to explain why this "data collection" is vital to the community at large. Getting into a specific back and forth about resources, whether transportation, food, utility bill management, etc. is not what this member needs to hear to motivate them to participate. Example script: "[Healthplan] wants to know how you are doing, your neighbor, and John down the street. As they get an accurate big picture of what your neighborhood is dealing with, good and bad, they can make good decisions on what social programs to invest in for your community 5 to 10 years down the road. And along the way we will have resources for some folks and discover where needs aren't being met. That's where we go to work advocating for change."

Examples of Successful Outcomes

Member Question/Objection	LCM Response
"What is the reason for the survey? What is the outcome of all of this?"	"This is how [health plan] knows how to allocate funds for future programs."
"Pass me up."	"I can't pass you up, your opinion is too important"
"Not enough time, too many appointments"	"It will just be a quick 20 minute chat."
"How long will this take?"	"15-20-minute conversation. If we have a 10:30 appointment, then I'll be out the door before 11:00."
"I don't have any interest in doing something like that, is it really necessary?"	"Valuable thing for retirees to identify their current and future program needs. It will only take about 15 minutes."

In-Person Outreach Safety Tips

- Bring a fellow staff person if the location is an unfamiliar or unsafe area.
- Conduct outreach during daylight hours.
- Tell a supervisor or colleague where you are going and when you plan to be back.
- If a member appears highly agitated, walk away and let them know that you will try to contact them again another day.
- Save important phone numbers (for example, a crisis line or a supervisor's number) into your cell phone prior to conducting outreach.
- Share your location on your cell phone.
- Leave if you feel unsafe.
- Staff are allowed to carry pepper spray for safety.

Outreach Supplies to Carry with You

- Business Cards

- Envelopes
- Hand Sanitizer
- Charged Cell Phone
- Paper
- Pens
- Applications for bus passes, housing, and other local resources
- A list of local resources with contact information
- ECM outreach materials in different languages

Documentation

- Call members that have been assigned to you on the spreadsheet.
- Utilize dedicated spreadsheet to call and document outreach to members. Members in outreach will not have a CCS profile created where the outcome can be documented, therefore it is important to keep notes on the spreadsheet.
- Do NOT save a copy of the spreadsheet onto your computer. Use the link provided, documentation added to the spreadsheet should save automatically.
- Document the outcome(s) of the call in the contact notes and schedule the "Next Outreach Date" for your follow-up call

SMART Goals

SMART Goals Library

Goals & Interventions

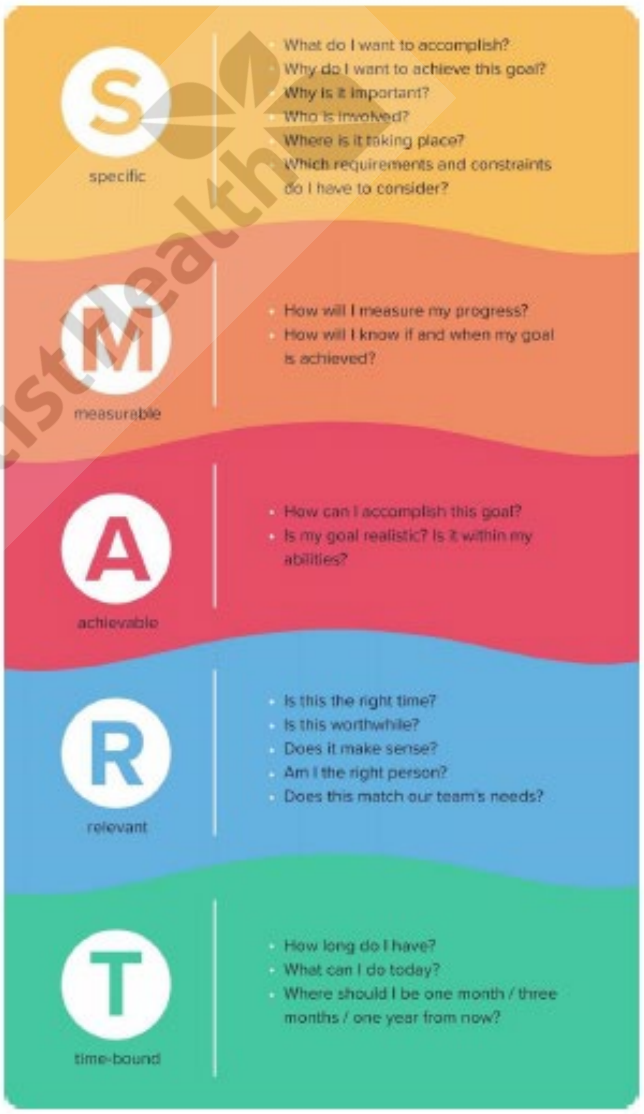
- Interventions are also called "Action Steps" in CCS.
- Interventions are smaller tasks that help to work towards the goal.
- Goals should include interventions that the member will be doing.
- Goals must be member-focused with minimal tasks that the LCM will be doing.
- Time frames set to accomplish the goals should be determined case by case.
- This library is a guide for commonly used SMART goals but is not a full list of possible goals and interventions.
- Interventions in this library should be used on a case-by-case basis depending on the Member's unique individual needs.

Strengths

- Physically active
- Strong social supports
- High self-esteem
- Mobile
- Reliable transportation
- Good impulse control
- Cautious
- Housed
- Safe living environment
- Located close to resources
- Resourceful
- Has reliable childcare
- Well educated
- Very intelligent
- Good credit score
- Good rental history

Barriers

- Wheel chair bound
- Poor social supports
- Low self-esteem
- Immobile
- Lacks transportation
- Impulsive
- Risk taking behaviors
- Unhoused
- Unsafe living environment
- Located far from resources
- Not resourceful
- Lacks childcare
- Lacks diploma or GED
- Developmental or learning disability
- Poor credit score
- Past evictions



Pathway	Goals	Interventions	Updates
GENERIC TEMPLATE	▪ Member will [indicate goal] for [indicate reason] by [indicate date].	▪ LCM will [indicate action]. ▪ Member will [indicate action].	▪ Member [indicate goal] on [indicate date].
Adult Learning			
Adult Learning	▪ Member will obtain their GED by [indicate date].	▪ LCM will provide resources on where Member can obtain their GED. ▪ Member will register for classes to work towards obtaining their GED.	▪ Member obtained their GED on [indicate date].
Behavioral Health			
TEMPLATE	▪ Member will establish care with [indicate agency] for [indicate condition] by [indicate date].	▪ Member and LCM will work together to schedule appointment. ▪ Member will attend appointment and provide an update to the LCM. ▪ Member will maintain care with [indicate agency] and provide updates to the LCM. ▪ Member will ask to have medications refilled. ▪ Member will ask to reevaluate medications.	▪ Member attended appointment with [indicate agency] on [indicate date] and [indicate outcomes].
Example #1	▪ Member will establish care with Sutter Yuba Behavioral Health for Depression and PTSD by [indicate date].	▪ Member and LCM will work together to schedule an intake appointment. ▪ Member will attend the intake appointment and provide an update to the LCM.	▪ Member attended SYBH intake appointment on [indicate date] and scheduled a follow-up visit for [indicate date].
Example #2	▪ Member will establish care with Behavioral Health for developmental delay and ADHD by [indicate date].	▪ Member's mother will ask PCP for a referral for mental health services. ▪ Member's mother will schedule an appointment for mental health services. ▪ Member's mother will ensure Member attends the scheduled appointment and will provide updates to the LCM.	▪ Member attended appointment with Behavioral Health on [indicate date] and was prescribed medications for ADHD.
Education			
TEMPLATE	▪ Member will verbalize understanding of [indicate topic] by [indicate date].	▪ LCM will provide education and materials. ▪ Member will spend time to read and understand materials. ▪ Member will explain their understanding and ask the LCM any questions regarding the materials.	▪ Member verbalized understanding of [indicate topic] on [indicate date].
Advanced Directives	▪ Member will understand advanced directives by [indicate date].	▪ LCM will educate Member by providing online resources, online informational sessions, and consulting with PCP to understand the importance, options, and process of creating advanced directives. ▪ Member will spend time to read and understand materials provided. ▪ If Member decides to create advanced directives, LCM will provide assistance if needed.	▪ Member verbalized understanding of advanced directives on [indicate date].
Diabetic Meal Plan	▪ Member will verbalize understanding of a diabetic meal plan and begin to implement by [indicate date].	▪ LCM will provide materials on healthy eating for a diabetic. ▪ Member will spend time to read and understand materials. ▪ Member will decide what diabetic friendly foods they prefer and develop a menu and grocery list. ▪ Member will begin to implement the diabetic meal plan. ▪ LCM will follow up on progress towards goals, provide support and praise for successes. ▪ LCM will refer Member to a Medically Tailored Meals provider to determine eligibility to receive meals appropriate for the Member's condition.	▪ Member verbalized understanding of a diabetic meal plan and began to implement on [indicate date]. ▪ Member qualified for Medically Tailored Meals and began receiving meals on [indicate date].

Healthy Living – Diet	▪ Member will demonstrate understanding of the importance of living a healthy lifestyle by [indicate date].	▪ LCM will assist member in adopting a healthier diet by providing education and support. This will include assessing and understanding current diet and offering practical strategies for incorporating healthier eating into daily routines. ▪ Member will spend time to read and understand materials and ask the LCM any questions. ▪ Member will decrease fast food intake. ▪ Member will increase fruits and vegetable intake. ▪ Member will practice portion control when plating their meals. ▪ Member will decrease the consumption of processed foods. ▪ Member will decrease their sodium intake by not adding additional salt to food.	▪ Member verbalized understanding of the importance of living a healthy lifestyle on [indicate date]. ▪ Member improved their lifestyle by [indicate diet change] on [indicate date].
Healthy Living – Soda	▪ Member will decrease their soda consumption from [indicate current frequency] to [indicate desired frequency] by [indicate date].	▪ LCM will educate member on the harm soda can cause. ▪ Member will identify alternative beverages. ▪ Member will stock their home with alternative beverages. ▪ Member will order water if eating at a restaurant. ▪ Member will replace 1 soda a day with water.	▪ Member decreased their soda consumption to [new frequency] by [indicate date].
Healthy Living – Fast Food	▪ Member will decrease the number of times they eat at fast food restaurants from [indicate current frequency] to [indicate desired frequency] by [indicate date].	▪ Member will ensure their home is stocked with food. ▪ Member will develop a list of quick and easy meal options as a substitute for fast food. ▪ Member will identify alternative foods they can eat to replace fast food cravings.	▪ Member decreased the number of times they ate at fast food restaurants to [new frequency] by [indicate date].
Healthy Living – Exercise	▪ Member will demonstrate understanding of the importance of exercise by [indicate date].	▪ LCM will assist member in adopting exercise routines by providing education and support. This will include assessing and understanding current exercise routines and offering practical strategies for incorporating healthy physical activity into daily routines. ▪ Member will spend time to read and understand materials and ask the LCM any questions. ▪ Member will try new exercises and decide which ones they prefer. ▪ Member will begin to implement the new exercise routine. ▪ Member will walk for 20 minutes per day. ▪ Member will set reminders on their phone to stand for 5 to 10 minutes every hour. ▪ Member will do arm exercises for 10 minutes twice daily.	▪ Member verbalized understanding of the importance of exercise on [indicate date]. ▪ Member improved their lifestyle by [indicate exercise change] on [indicate date].
Healthy Living – Water	▪ Member will increase water intake from [indicate current frequency] to [indicate desired frequency] by [indicate date].	▪ LCM will educate member on the benefits of drinking enough water regularly. ▪ Member will drink 4 to 8 ounces of water every hour. ▪ Member will resist the urge to drink beverages that aren't water. ▪ Member will keep home stocked with bottles and gallons of water. ▪ Member will track their water intake each day in a journal. ▪ Member will provide updates to LCM on progress towards increasing their water intake.	▪ Member increased their water consumption to [new frequency] by [indicate date].

Lead Testing for Pediatrics	▪ Member will verbalize understanding of the importance of lead testing for children and adolescents by [indicate date].	▪ LCM will provide education on the importance of lead testing for children and adolescents. This education will include information on the sources of lead exposure, the potential health effects of lead poisoning, and the importance of regular lead testing for young children. ▪ Member will spend time to read and understand materials and ask LCM any questions. ▪ LCM will educate Member on how to obtain lead test results from pediatrician. ▪ Member will obtain lead test results from their pediatrician.	▪ Member verbalized understanding of the importance of lead testing for children and adolescents on [indicate date].
Risks of not being vaccinated for the flu and Covid-19	▪ Member will verbalize understanding of the risks of not being vaccinated for the flu and Covid-19 by [indicate date].	▪ LCM will provide education on flu and Covid-19 vaccines. ▪ Member will spend time to read and understand materials. ▪ Member will decide if they will get vaccinated. ▪ LCM will provide the Member with a list of vaccination locations. ▪ Member will discuss with their PCP if it is appropriate for them to get vaccinated considering their health conditions.	▪ Member verbalized understanding of the risks of not being vaccinated for the flu and Covid-19 on [indicate date]. ▪ Member was vaccinated for the flu on [indicate date]. ▪ Member was vaccinated for Covid-19 on [indicate date].
Sleep Habits for Pediatrics with ADHD	▪ Member will verbalize understanding of methods to facilitate better sleep habits for children and adolescents with ADHD by [indicate date].	▪ LCM will provide information on sleep habits for children and adolescents with ADHD. ▪ Member will spend time to read and understand materials. ▪ Member will implement better sleeping habits with their child.	▪ Member verbalized understanding of methods to facilitate better sleep habits for children and adolescents with ADHD on [indicate date].
Parenting	▪ Member will verbalize understanding of what good parenting is by [indicate date]. ▪ Member will verbalize understanding of how they can improve their parenting skills by [indicate date].	▪ LCM will educate Member on how to register their child for school. ▪ Member will work with LCM to create a transportation plan and schedule to ensure children arrive at school on time and make it home safely each day. ▪ LCM will educate Member on the importance of regular medical care for children including staying current on vaccinations and attending checkups annually. ▪ LCM will educate Member on how to maintain proper dental care for children including brushing teeth twice a day and attending dental checkups bi-annually. ▪ LCM will educate Member on how to establish and maintain good routines for children such as daily bedtime routines including brushing teeth and reading a book before bed. ▪ LCM will educate Member on how to meet all basic needs of the children in their care.	▪ Member verbalized understanding of what good parenting is on [indicate date]. ▪ Member verbalized understanding of how they can improve their parenting skills on [indicate date]. ▪ Member started implementing a regular bedtime routine for their child on [indicate date].
Stress Management	▪ Member will reduce the number of times they experience severe stress from [indicate current frequency] to [indicate desired frequency] by [indicate date].	▪ LCM will educate Member on reducing perceived stress. ▪ LCM will provide education on coping skills for stress management. ▪ Member will practice stress reducing coping skills such as breathing, yoga, listening to music, drawing, crocheting, and other calming activities. ▪ Member will practice removing themselves from stressful environments so they can reset. ▪ LCM and Member will work together to assess stress causing triggers in their environment. ▪ LCM and Member will work together to develop a plan to reduce stress causing triggers.	▪ Member reduced the number of times they experienced severe stress to [indicate desired frequency] on [indicate date].

Family Planning	▪ Member will practice safe birth control methods by [indicate date].	▪ Member will discuss birth control options with their PCP. ▪ LCM will provide resources on where to get free condoms. ▪ LCM will provide education on abstinence. ▪ Member will schedule an appointment with an OBGYN.	▪ Member started taking birth control pills on [indicate date]. ▪ Member attended their OBGYN appointment on [indicate date] and decided on a birth control method.
Pharmacy	▪ Member will demonstrate understanding of how to refill their prescriptions at the pharmacy by [indicate date].	▪ LCM will connect Member to a pharmacy that has delivery service. ▪ Member will enroll in automatic refills for their prescriptions. ▪ Member will call the pharmacy to request to refill their prescriptions. ▪ Member will pickup their prescriptions from the pharmacy.	▪ Member demonstrated understanding by picking up their refilled prescription on [indicate date].
Budgeting	▪ Member will verbalize understanding of managing their budget by [indicate date]. ▪ Member will demonstrate understanding of managing their budget by [indicate date].	▪ LCM will provide blank budgeting forms to Member. ▪ Member will complete budgeting form by filling in their income and expenses for each of the categories on the budget form. ▪ LCM and Member will review the budget together to ensure no income or expenses have been overlooked. ▪ LCM and Member will work together to identify where expenses can be reduced. ▪ LCM and Member will work together to prioritize all expenses so that the most important expenses get paid first if there is not sufficient income to cover all expenses. ▪ LCM and Member will work together to identify what expenses are most appropriate to spend surplus of income on. ▪ Member will maintain a spending log and will review with LCM.	▪ Member verbalized understanding by explaining in detail their plans on managing their budget on [indicate date]. ▪ Member demonstrated understanding of managing their budget on [indicate date] by paying all their bills on time.
Oxygen Safety	▪ Member will verbalize understanding of oxygen safety by [indicate date].	▪ LCM will educate Member on oxygen safety. ▪ LCM will provide Member with educational material on oxygen safety. ▪ Member will spend time to read and understand materials and ask LCM any questions. ▪ Member will identify changes they may need to make to stay safe. ▪ Member will take oxygen safety precautions by avoiding things such as cigarettes, candles, gas stoves, and other heat sources.	▪ Member verbalized understanding by listing oxygen safety tips on [indicate date].
Pain Management	▪ Member will verbalize understanding of pain management by [indicate date].	▪ LCM will educate Member on holistic ways to manage pain including over the counter medications, stretches, exercises, diet, sleep, and posture. ▪ LCM will provide Member with educational material on managing pain. ▪ Member will spend time to read and understand materials and ask LCM any questions. ▪ Member will practice the pain management skills they learn.	▪ Member verbalized understanding by listing ways to manage their pain on [indicate date].

Employment			
Employment Readiness	▪ Member will achieve employment readiness by [indicate date].	▪ LCM will provide job training and skill building resources such as resume building workshops or job interview coaching. ▪ LCM will provide job leads for employers that welcome justice involved applicants and are open to hiring felons. ▪ Member will obtain adequate child care. ▪ Member will utilize child care to attend employment readiness classes. ▪ Member will purchase appropriate work attire. ▪ Member will go to clothes closets to get appropriate work attire. ▪ Member will determine their transportation methods and route to and from work. ▪ Member will determine the amount of time it takes to travel to work and establish when they will leave for work each day to ensure punctuality. ▪ Member will develop or update their resume. ▪ Member will maintain proper hygiene by showering, brushing teeth, and brushing hair daily.	▪ Member began submitting employment applications on [indicate date].
Obtain Employment	▪ Member will obtain employment by [indicate date].	▪ LCM will provide job seeking resources such as employment sites and job fairs. ▪ Member will submit employment applications. ▪ Member will participant in employment interviews. ▪ LCM will educate Member on how to search for jobs online. ▪ Member will use the public library as a resource to job search online.	▪ Member obtained employment on [indicate date].
Housing			
Obtain Housing	▪ Member will obtain housing by [indicate date].	▪ LCM will connect Member to housing navigation providers including community-based organizations and government agencies. ▪ LCM will assist Member in completing rental applications. ▪ Member will participate in housing navigation services and provide LCM with updates monthly. ▪ Member will obtain all proof of income.	▪ Member obtained housing on [indicate date].
Medication Management			
Medication Management	▪ Member will take medication as prescribed regularly by [indicate date]. ▪ Member will establish a medication plan with their PCP by [indicate date].	▪ Member will obtain a pill box from their PCP. ▪ Member will set reminders to take their medications as prescribed. ▪ Member will identify a safe place to store their medication. ▪ LCM will educate Member on their medications including the purpose, frequency, amount prescribed, and any side effects they should watch for and what to do if they have severe side effects. ▪ Member will refill their prescriptions before they run out. ▪ Member will request for pharmacist to provide reading material regarding their prescription in their preferred language. ▪ Member will ask pharmacist to provide prescription information verbally.	▪ Member has taken their medication regularly as prescribed for 3 months. ▪ Member met with their PCP and have established a medication plan on [indicate date].
Medical Referrals			
TEMPLATE	▪ Member will establish medical care for [indicate condition] by [indicate date].	▪ Member will ask [indicate who] for a referral to a [indicate specialist]. ▪ Member will attend scheduled appointment and inform LCM of outcome.	▪ Member attended appointment on [indicate date]. Outcomes achieved include [indicate outcomes].
Dietitian	▪ Member will be connected to a Dietitian for [indicate condition] by [indicate date].	▪ Member will ask PCP for a referral to a Dietitian. ▪ Member will attend scheduled appointment and inform LCM of outcome.	▪ Member attended appointment on [indicate date]. Outcomes achieved include [indicate outcomes].

Primary Care	▪ Member will establish a Primary Care Provider by [indicate date].	▪ LCM will provide a list of PCPs in the area. ▪ Member will call to schedule an appointment with a Primary Care Provider. ▪ Member will attend scheduled appointment with the Primary Care Provider. ▪ Member will provide updates to LCM.	▪ Member attended scheduled PCP appointment on [indicate date] and [indicate outcomes].
Specialty Care for COPD	▪ Member will establish medical care for COPD by [indicate date].	▪ Member will ask PCP for a referral to a Pulmonologist. ▪ Member will attend scheduled Pulmonologist appointment and inform LCM of outcome. ▪ Member will maintain their follow up appointments. ▪ Member will maintain medication compliance. ▪ Member will follow their plan of care.	▪ Member attended Pulmonology appointment on [indicate date] and was scheduled a follow-up appointment for [indicate date].
Specialty Care for CHF	▪ Member will establish medical care for CHF by [indicate date].	▪ Member will ask PCP for a referral to a Cardiologist. ▪ Member will attend scheduled Cardiology appointment and inform LCM of outcome. ▪ Member will maintain their follow up appointments. ▪ Member will maintain medication compliance. ▪ Member will follow their plan of care.	▪ Member attended Cardiology appointment on [indicate date] and was scheduled a follow-up appointment for [indicate date].
Dental	▪ Member will be connected to a Dentist for a check-up by [indicate date].	▪ Member and LCM will work together schedule a dentist appointment. ▪ Member will attend scheduled dentist appointment and inform LCM of outcome. ▪ Member will maintain their follow up appointments. ▪ Member will follow their plan of care.	▪ Member attended their scheduled dental check-up appointment on [indicate date].
Vision	▪ Member will be connected to an Optometrist for glasses by [indicate date].	▪ Member and LCM will work together to call the Optometrist for an appointment. ▪ Member will attend scheduled Optometry appointment and inform LCM of outcome. ▪ Member will maintain their follow up appointments. ▪ Member will maintain medication compliance. ▪ Member will follow their plan of care. ▪ Member will refill their glasses prescription.	▪ Member attended their scheduled Optometry appointment on [indicate date].
Substance Use	▪ Member will be connected to a Substance Use Navigator by [indicate date].	▪ LCM will provide education and resources on substance use. ▪ Member will schedule appointment with a Substance Use Navigator. ▪ Member will attend appointment and inform LCM of the outcome.	▪ Member attended their scheduled appointment for substance use on [indicate date].
Pain Management	▪ Member will obtain care for pain management by [indicate date].	▪ Member will schedule PCP appointment to request pain management referral. ▪ Member will attend PCP appointment and request pain management referral. ▪ Member will schedule pain management appointment. ▪ Member will attend pain management appointment and inform LCM of the outcome.	▪ Member attended their scheduled appointment for pain management on [indicate date].
Social Services Referrals			
TEMPLATE	▪ Member will [indicate action] for [indicate reason] by [indicate date].	▪ Member will ask [indicate who] for a referral to a [indicate specialist]. ▪ Member will attend scheduled appointment and inform LCM of outcome.	▪ Member [indicate action] on [indicate date] and [indicate outcome].

Clothing/Baby Items	▪ Member will express confidence in how to access free clothing resources by [indicate date].	▪ LCM will provide a comprehensive list of clothing resources in the community which may include thrift stores, clothes closets, cold weather clothing distributions, and other agencies such as day shelters that assist with clothing. ▪ Member will go to clothes closet and select several outfits.	▪ Member expressed confidence in how to access free clothing resources on [indicate date].
Domestic Violence Assistance	▪ Member will be connected to domestic violence services by [indicate date].	▪ LCM will discuss domestic violence resources available to them including DV shelters, support groups, and hotlines. ▪ Member will determine a plan for fleeing domestic violence.	▪ Member started staying at a Domestic Violence shelter on [indicate date]. ▪ Member began receiving services from Casa de Esperanza on [indicate date].
Education Assistance	▪ Member will obtain Math tutoring resources for ADHD by [indicate date].	▪ LCM will provide tutoring resources to Member. ▪ Member will attend appointment scheduled for [indicate date] at [indicate agency] to verify eligibility for services. ▪ LCM will educate member on how to obtain their GED. ▪ LCM will educate Member on how to begin the process of registering for college. ▪ LCM will educate member on supports provided through college or other vocational training programs such as assistance from school counselors to get registered for college and childcare services. ▪ LCM will connect Member to Children Home Society of California for childcare assistance. ▪ Member will complete the "Ability to Succeed" test for placement into college without diploma or GED ▪ LCM will educate Member on how an IEP or 504 can assist their child at school.	▪ Member attended appointment on [indicate date] and is eligible for services.
Food Assistance	▪ Member will express confidence in how to access food resources by [indicate date].	▪ LCM will provide a comprehensive list of food resources in the community which may include food banks, soup kitchens, farmers' markets, community gardens, and government assistance programs, along with details on their locations, operating hours, eligibility criteria, and types of assistance provided. ▪ Member will spend time to read and understand the list of resources. ▪ LCM will connect Member to CalFresh benefits. ▪ LCM will connect Member to WIC program. ▪ LCM will refer Member to CAN for food assistance. ▪ LCM will work with Member to reestablish their CalFresh benefits.	▪ Member verbalized understanding of how to access food resources on [indicate date].
Government Benefits & Services	▪ Member will obtain a government issued ID by [indicate date].	▪ LCM will provide the Member with DMV's No Fee Identification Card Verification Form. ▪ Member will complete the form, turn it in to DMV, and inform LCM. ▪ Member will inform LCM when ID is obtained.	▪ Member obtained ID on [indicate date].
Government Benefits & Services	▪ Member will obtain a Social Security card by [indicate date].	▪ Member will go to the Social Security Administration office to obtain a new card. ▪ Member will inform LCM when new card is obtained.	▪ Member obtained Social Security card on [indicate date].
Government Benefits & Services	▪ Member will obtain a birth certificate by [indicate date].	▪ Member will contact the County Clerk in the county where they were born to ask how they can obtain a certified copy of their birth certificate. ▪ Member will go down to the County Clerk to apply for a copy of their birth certificate. ▪ Member will inform LCM when ID is obtained.	▪ Member obtained birth certificate on [indicate date].

Legal Assistance	▪ Member will be connected to legal services for [indicate barrier] by [indicate date]. ▪ Member will be connected to California Rural Legal Assistance for their eviction by [indicate date].	▪ LCM will provide free or low-cost legal assistance resources for fines, tickets, evictions, etc. ▪ Member will find out if they can participate in community services to reduce their fines. ▪ Member will attend expungement workshops. ▪ LCM will connect Member to free legal services to assist in applying for Social Security benefits.	▪ Member met with a legal counselor on [indicate date].
Parenting Assistance	▪ Member will be connected to parenting assistance by [indicate date].	▪ LCM will connect Member to FamilySOUP for parenting counseling. ▪ LCM will provide information on any free parenting classes in the community. ▪ LCM will work with Member to find a mediator for custody disputes. ▪ Member will follow through with obtaining parenting assistance and inform LCM of outcome.	▪ Member received parenting assistance from [indicate agency] on [indicate date]. ▪ Member attended a parenting class on [indicate date].
Substance Use	▪ Member will verbalize understanding of the risks of substance use by [indicate date].	▪ LCM will provide substance use education to Member, focusing on raising awareness about the risks associated with substance abuse and promoting healthy behaviors. This education will include information on the effects on physical and mental health, and local resources for treatment and support. ▪ Member will be open to understanding the risks.	▪ Member verbalized understanding of the risks of substance use on [indicate date].
Transportation Assistance	▪ Member will express confidence in how to access transportation services for appointments by [indicate date].	▪ LCM will provide a comprehensive list of transportation resources including public transportation, Dial-a-Ride, and ride share services. ▪ Member will spend time to understand transportation resources. ▪ Member will schedule medical transportation through their Managed Care Plan for their next PCP appointment. ▪ LCM will educate Member on where to find the transportation scheduling phone number on the back of their insurance card. ▪ LCM will educate Member on how to navigate the bus system in their community.	▪ Member explained accurately how to get from their home to Ampla Health via Yuba Sutter Transit on [indicate date].
Utilities Assistance	▪ Member will obtain financial assistance for utilities by [indicate date].	▪ LCM will provide a list of utility assistance resources available to the Member in the community. ▪ LCM will assist Member in scheduling an appointment with KCAO. ▪ Member will attend scheduled appointment and inform LCM of outcome. ▪ Member will call REACH for utility assistance. ▪ Member will call HEAP for utility assistance. ▪ Member will call PG&E to get on an Arrearages Management Plan (AMP) or payment plan. ▪ Member will call PG&E to apply for CARE or FERA discount for income qualifying households. ▪ Member will call PG&E to apply for Medical Baseline Program for residential customers who depend on power for certain medical needs. ▪ Member will call PG&E to apply for vulnerable customer status if their health or safety is at risk if their services are disconnected.	▪ Member attended scheduled appointment on [indicate date]and was approved for utility assistance.

Tobacco Cessation			
TEMPLATE	▪ Member will decrease [indicate habit] from [indicate current frequency] to [indicate desired frequency] by [indicate date].	▪ Member will [indicate action]. ▪ LCM will help motivate Member by providing education and praise for decreased [indicate habit].	▪ Member decreased [indicate habit] to [new frequency] by [indicate date].
Vaping	▪ Member will decrease vaping from 5 times a day to 3 times a day by [indicate date].	▪ Member will keep track of how often she vapes each day using a journal or an app. ▪ LCM will help motivate Member by providing education and praise for decreased tobacco use.	▪ Member decreased vaping to 4 times a day by [indicate date]. ▪ Member decreased vaping to 3 times a day by [indicate date].
Cigarette Use	▪ Member will decrease tobacco use from 1 pack a day to ½ pack a day by [indicate date].	▪ Member will increase the amount of time between each cigarette each day. ▪ LCM will help motivate Member by providing education and praise for decreased tobacco use.	▪ Member decreased tobacco use to ½ pack a day by [indicate date].

MDT Tool

The purpose of the MDT:

The purpose of the MDT is to provide the LCM with support in the care of their members. The goal is to address prevention strategies, listen to challenges for the member, provide suggestions in overcoming those challenges, provide possible interventions for the member and to suggest referrals for the members. This MDT meeting provides care coordination for the member and support to the LCM as they care for their member.

The goal for the MDT:

- To come prepared to make each meeting as efficient as possible.
- For the information in CCS to be as comprehensive as possible for the RN's and the supervisors to review before the meeting
- Each member should take 15 minutes to discuss
  - 5 min for LCM to present
  - 5 min for MDT to discuss
  - 5 min to wrap up recommendations
- The LCM will feel supported and have a plan of action

LCM to do before the meeting:

- Review CCS
  - ☐ Assessment Completed
  - ☐ Medication Assessment Completed
  - ☐ Required Tools completed
    - ☐ MDT Tool completed 1 day prior to meeting
  - ☐ Pathways open with recent documentation

*Any missing information in CCS is added prior to the MDT

- Review members record in Cerner
  - ☐ Medication Reviewed
  - ☐ Any recent H&Ps are reviewed
  - ☐ All recent DC paperwork is reviewed
  - ☐ Review Report notes
    - CM notes
    - DC Summary
    - Homeless DCP
- Have a list of the client's needs ready
  - ☐ What resources are needed
  - ☐ What does the member see as the priority for their needs
  - ☐ What does the LCM see as the priority for the members needs
  - ☐ What are the barriers to meeting the needs of the member
  - ☐ What is the LCM's biggest struggle/concern
  - ☐ What are the LCM's wins
- Review last MDT Tool if one was held
  - ☐ LCM's next steps

- ☐ Read MDT Notes
- ☐ Review resources given for completeness

LCM present during the meeting:

- Present all medical, behavioral, educational, and social barriers. <u>(No matter how small the LCM may think it is, every detail matters)</u>
  - ☐ Chart/notes from the hospital or medical clinic that the LCM would like help understanding
  - ☐ Differing information from what the client is sharing with the LCM with what is in the medical files
  - ☐ Discuss the members situation based on premeeting findings
  - ☐ Seek suggestions from the RN
  - ☐ Note interventions and referrals suggested

LCM after the meeting:

- LCM Required follow up Post MDT within 1 week
  - ☐ Provide needed information to the member
  - ☐ Document interventions, resources, and outcomes in the MDT tool
  - ☐ Document in Pathways medical or behavioral updates
  - ☐ Document expected completion dates of the Next Steps in the MDT tool in the Intervention box
  - ☐ Follow up on / record incomplete items identified in CCS
  - ☐ Read final RN MDT Note

RN after the meeting:

- RN Required follow up Post MDT
  - ☐ Create successful MDT Contact note (within 24 hours)
  - ☐ Ensure that MDT note is placed by RN

ECM Internal Chart Audit

Enhanced Care Management

Internal Chart Audit

CommunityConnect | Adventist Health

Member Information

Member Name	Reviewer Name	LCM Name
Member CIN	**Review Date**	**Due Date**

Eligibility

Met	Unmet	Measure	Notes
☐	☐	Opt-in to ECM Date	
☐	☐	Population of Focus	

Profile

Best practice is to complete profile within first 3 interactions and within 60 days of enrollment.

Met	Unmet	N/A	Measure	Notes
☐	☐		Date of Birth	
☐	☐		Gender Identification	
☐	☐		Preferred Name and/or Pronouns	
☐	☐		Nationality/Tribe/Ethnicity	
☐	☐		Preferred Language (spoken/written)	
☐	☐		☐ Preferred Method of Contact ☐ Phone Number ☐ Email Address	
☐	☐		☐ PCP Clinic ☐ Phone ☐ Address	
☐	☐	☐	☐ Emergency Contact ☐ Relationship ☐ Phone	
☐	☐	☐	Insurance Information ☐ Medi-CAL ID/CIN ☐ Plan	
☐	☐	☐	☐ Legal Guardian ☐ Family Member ☐ Caregiver ☐ Support Person ROI	
☐	☐		ROI for ECM Services and Data Sharing	
☐	☐		LCM Provided Name and Contact Information to Member	

Assessment

Met	Unmet	NA	Measure	Description	Notes
☐	☐		Culture	☐ Cultural beliefs ☐ Religious beliefs ☐ Spiritual beliefs	
☐	☐		Health Literacy	☐ Understands medical problems ☐ Fills out medical forms ☐ Follows instructions for taking medications	

☐	☐	[redacted]	Physical Health	☐ Allergies/reactions ☐ Current (acute/chronic) medical conditions/treatments ☐ Past (inactive) medical conditions/treatments ☐ Current medical providers/specialists name and phone ☐Ongoing medications ☐ Vaccinations ☐ Tuberculosis history ☐ A1C Levels	
☐	☐		Oral Health	☐ Last dental visit ☐ Dental Provider Name ☐ Dental Office ☐ Next Visit Date	
☐	☐		Vision & Hearing	☐ Vision ☐ Hearing ☐ Diabetic vision exam	
☐	☐	☐	Medications	☐ Name ☐Dose ☐ Purpose or reason prescribed ☐Prescriber (name and phone)	
☐	☐	☐	Pain Management	☐ Pain experience ☐ Pain management specialist care, provider, and last visit ☐ Impacted condition or body part and treatment response	
☐	☐	☐	Behavioral Health	☐Anxiety (GAD-7) ☐ Depression ☐ Trauma and stress ☐ Cognitive functioning ☐ Developmental factors ☐ Any other mental health history	
☐	☐	☐	Substance Use Disorder	☐ Information about last use ☐ Referrals needed for counseling	
☐	☐	☐	Housing	☐ Location of housing ☐ Concern about losing housing ☐ Assistance with housing ☐Safety of housing environment	
☐	☐	[redacted]	Safety	☐ Physical and emotional safety ☐ Using residence without permission ☐ Someone using their money without permission	
☐	☐		Food Security	☐ Enough food ☐ Frequency of hunger ☐ Amount of food	
☐	☐	☐	Benefits and Other Services	☐ Government benefit programs ☐ Employment status ☐ Community based and social services ☐ Long Term Services and Supports	
☐	☐	☐	Legal Involvement	☐Court ordered services ☐APS or CPS	
☐	☐	☐	Life/End of life planning	☐ Advanced planning in place ☐ Ways to improve health ☐ Priorities and goals for the next year	

				☐ Barriers to implementation of plan	
☐	☐		Member priorities	☐ Member concerns about overall health ☐ Member chosen first steps to improve health ☐ Member chosen first steps to work on in ECM	

Tools

Tool	Notes	Met	Unmet	NA
ADL + IADL*		☐	☐	☐
Birth Information		☐	☐	☐
Caregiver PAM 13		☐	☐	☐
Edinburgh		☐	☐	☐
ED/ER Information Tool		☐	☐	☐
GAD-7		☐	☐	☐
Graduation Questionnaire		☐	☐	☐
Home Safety		☐	☐	☐
Life Satisfaction Survey*		☐	☐	☐
MDT*		☐	☐	☐
Medication Assessment		☐	☐	☐
Other Client Details-HH		☐	☐	☐
PAM*		☐	☐	☐
PHQ-9 (Partnership*)		☐	☐	☐
Blood Pressure Screening Tool (Partnership*)		☐	☐	☐

* Required Tool

Documentation & Reporting

Met	Unmet	Component	Description	Notes
☐	☐	Assessment	• Comprehensive assessment completed within 90 days of ECM consent/enrollment. Best practice is to complete assessment within first 3 interactions and within 60 days of enrollment. • ECM Provider utilized an in-person approach to complete the assessment when necessary	
☐	☐	Reassessment	Reassessment occurred due to a major change in health status according to the member's risk tier (see below)	
☐	☐	Care Plan	• Care plan created and updated according to member's individual progress or changes in needs as they are identified per risk tier. • ECM Provider utilized an in-person approach to complete the care plan when necessary	
☐	☐	Contacts	ECM Provider maintains documentation of all outreach (whether successful or unsuccessful) attempts within their EHR	

Risk Tiers

Tier 1 High Contact Care Management	Tier 2 Medium Contact Care Management	Tier 3 Low Contact Care Management
• Contact member 3-4 times per month • Contact every 7-14 days • In person visit or attempt once per month • Update Assessment and Care Plan every 3 months	• Contact member 2 times per month • Contact every 14-21 days • In person visit or attempt once per month • Update Assessment and Care Plan every 6 months	• Contact member at least once a month • Update Assessment and Care Plan every 12 months or as needed

Comprehensive Assessment

Met	Unmet	Measure	Description	Notes
☐	☐	Communication	• Provided communications to member appropriately, consistently, and primarily in-person as available • Utilized alternative methods of communication as necessary •ECM Provider makes 2 additional outreach attempts within 30 days at different times during the day and on different days of the week if unable to reach the member during initial outreach	
☐	☐	Annual Assessment	Annual comprehensive assessment completed to confirm eligibility and appropriateness for ECM enrollment	
☐	☐	Gaps in Care	Gaps in care are identified through the comprehensive assessment and address gaps in care within the care plan as appropriate. Complete list of gaps in care per DHCS	
☐	☐	Caregiver / Emergency Contact	Member's chosen caregiver or support person is incorporated in the creation of the care plan as member allows	
☐	☐	Readiness to Change	Member's readiness to change is assessed (PAM)	
☐	☐	Consent	Consent received from member or authorized representative to engage in services and to contact Caregiver / Emergency Contact	

Care Management Plan – Pathways

Component	Description
Goals	• Goals are chosen by the member based on the problems identified • Priority is assigned to each goal by the member • Goals are written in the SMART (specific, measurable, achievable, relevant, and timely) format
Interventions	Planned interventions to accomplish this goal are identified: • What the member does for themselves • What you do for the member • What you do with the member
Dates	Date the goal was initiated and date the goal was completed
Updates	Best practice is to update pathway notes monthly
Strengths	Strengths are self-identified by member and are incorporated when providing services to the member to remind and reinforce during readiness to change talks
Barriers	Potential barriers that may prevent the accomplishment of the intervention are identified
Encouraged & supported	Encouraged and supported member to make lifestyle choices based on healthy behavior and support the member's efforts to do so
Linked to Resources	Linked member to resources such as smoking cessation, self-help recovery and chronic condition management as appropriate
Evidence-Based Practices	Utilized evidence-based practices, such as motivational interviewing to engage and encourage the member to participate in their care and treatment plans

Pathways

Met	Unmet		Pathway	Goals	Interventions	Strengths	Barriers	Dates	Updates	Encouraged & supported	Linked to Resources	Evidence Based Practices	Notes
☐	☐	1		☐	☐	☐	☐	☐	☐	☐	☐	☐	
☐	☐	2		☐	☐	☐	☐	☐	☐	☐	☐	☐	
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☐	☐	29		☐	☐	☐	☐	☐	☐	☐	☐	☐	
☐	☐	30		☐	☐	☐	☐	☐	☐	☐	☐	☐	
*Met if all 9 boxes are checked													

Outreach & Engagement

Met	Unmet	Measure	Description	Notes
☐	☐	Culturally Appropriate Communications	All communications were provided to the member in a culturally and linguistically appropriate manner (interpreter or translation used as appropriate)	
☐	☐	Outreach	ECM Provider outreached to member within 30 days of member being assigned	

Enhanced Coordination of Care

Met	Unmet	Measure	Description	Notes
☐	☐	MDT/ICT Collaboration	Presented member's care plan, needs and preferences to MDT/ICT Team within 90 days of ECM enrollment and annually to ensure safe, continuous, and integrated care among all providers	
☐	☐	PCP Collaboration	Shared care plan, member's conditions, health status, medication usages and side effects to other PCP (if AH site is not the PCP)	
☐	☐	Care Plan Review	Reviewed the care plan with the member and offered a copy of the Care plan to the member, parent, caregiver, guardian, other family member(s), and/or other authorized support person(s) in their preferred language and format (i.e., Print, Email).	
☐	☐	Care Coordination	Coordinated essential aspects of care. Examples: • Medication reconciliation • Providing appointment reminders • Coordinating transportation • Accompaniment to critical appointments	
☐	☐	Referral Follow-up	Care coordination team followed-up on referrals in a timely manner with appropriate parties	

Comprehensive Transitional Care (only used if ED/ER is utilized)

Met	Unmet	NA	Measure	Description	Notes
☐	☐	☐	Post Discharge Follow-Up	Followed up with member with post-discharge follow-up care coordination contact within 48 hours of discharge from treatment facility	
☐	☐	☐	Transition Plan Coordination	Coordinated transition plan with discharge facility and member, member's chosen caregiver and/or support person upon receiving notification of member admit or discharge from treatment facility	
☐	☐	☐	Referrals & Services	Coordinated appropriate referrals and services, including, but not limited to medication reconciliation to meet individualized member needs upon discharge	
☐	☐	☐	Hospital DC PCP Follow-Up	PCP visit within 7 days post hospital discharge	
☐	☐	☐	Hospital DC SMI Follow-Up	Follow up visit with mental health provider within 30 days of hospital discharge for treatment of mental illness or intentional self-harm diagnosis	
☐	☐	☐	Post ED Visit Follow-up	Contacted member following ED visit to discuss visit and provide discharge follow up appointment	
☐	☐	☐	SMI ED Visit Follow-Up	Follow up visit with any practitioner within 30 days of ED visit with discharge	

				diagnosis of mental illness or intentional self-harm	
☐	☐	☐	SUD ED Visit Follow-Up	Follow up visit with any practitioner within 30 days of ED visit with discharge diagnosis of alcohol or other drug (AOD) use or dependence	

Narrative Summary (document in coordinator notes section of assessment)

Met	Unmet	Measure	Description	Notes
☐	☐	Narrative Summary	Member has a complete narrative summary in this format: [insert member name] is a [insert age and gender] with dx/acuity of [insert dx/acuity]. Completed initial assessment with the member and identified areas to support the member: [list needs identified in the assessment]. Developed an action plan with the member prioritizing these goals of care: [list 2-3 goals including any referrals generated with details of who, where, when, why]. Will continue to meet with the member to build rapport and to learn more about member SDoH and ability to self-manage (understanding of health condition, definition of success, motivation/readiness to change, social environment, coping skills, list out the elements from the audit that are missing including plans for health promotion/education). Based upon member needs, will schedule calls/meetings on a [insert weekly/bi-weekly/monthly] basis to start transitioning to once a month as we complete goals and member reports greater confidence and self-efficacy in managing their health. At next meeting, will meet with the member to discuss [list goals/interventions] within [identify 1 week/2 weeks/1 month]. Reviewed plan with the member. Member agreed to plan.	

Additional Notes