Enhanced Care Management (ECM)

Care Management Plan (CMP) (FORM D)

CenCal HEALTH
Local. Quality. Healthcare.

Member and Provider Information

Member Name: Member Date of Birth:

Medi-Cal #:

Acuity (Reference Assessment): ◯ High Acuity ◯ Moderate Acuity ◯ Low Acuity

Auth #:

ROI Obtained: ☐ Yes ☐ No ☐ Limited Permission ☐ Refused to Sign

Lead Care Manager (LCM): LCM Phone Number:

◯ Initial Care Plan ◯ Revision of Care Plan (ongoing progress/changes) Date:

Care Plan Completed: ◯ In Person ◯ On the Phone ◯ Both (In Person and on the Phone)

Care Management Plan Development (select all that apply)

Strengths Identified:	Care Plan goals address the following needs but not limited to:	Developed Care Plan with Assistance From:
◯ Social Support (Family/Friends)	◯ Physical and/or Developmental Health	◯ Member
◯ Appropriate Coping Skills	◯ High Utilization of Health Care	◯ Family/Caregiver
◯ Engaged in Self Care	◯ Dementia	◯ Authorized Representative
◯ Adherent with Treatment Plan (Medical, Oral, or Behavioral Health)	◯ Substance Use Disorder	◯ Primary Care Provider/ Specialist
◯ Engaged (Leisure/Recreational) Interests	◯ Long Term Social Services	◯ Other
◯ Spirituality (Rituals, Faith, Beliefs, Spiritual Community)	◯ Oral Health	
◯ Other	◯ Palliative Care	
	◯ Housing	
	◯ Community Based and Social Service	

Needs/Goals/Desired Outcomes Expressed and Prioritized by Member or Authorized Representative during Assessment Process

INDIVIDUALIZED CARE PLAN (ICP) WITH GOALS		
GOAL (short and long-term)	INTERVENTION	DUE DATE (MM/DD/YY)
PHYSICAL HEALTH		
ORAL CARE		
PALLIATIVE CARE		

INDIVIDUALIZED CARE PLAN (ICP) WITH GOALS (cont.)		
GOAL (short and long-term)	INTERVENTION	DUE DATE (MM/DD/YY)
SUBSTANCE USE		
BEHAVIORAL HEALTH		
DEVELOPMENTAL HEALTH		

INDIVIDUALIZED CARE PLAN (ICP) WITH GOALS (cont.)		
GOAL (short and long-term)	**INTERVENTION**	**DUE DATE (MM/DD/YY)**
Long Term Services and Supports (LTSS)		
	◯ In Home Support Services (IHSS) ◯ Community Based Adult Services (CBAS) ◯ Multi-Senior Services Program (MSSP) ◯ Home and Community Based Alternatives Waiver (HCBA) ◯ Skilled Nursing Facility Care	
COMMUNITY BASED, SOCIAL SERVICES, AND HOUSING (SDOH)		
OTHER		

INDIVIDUALIZED CARE PLAN (ICP) WITH GOALS (cont.)

GOAL (short and long-term)	INTERVENTION	DUE DATE (MM/DD/YY)
MEMBER'S PERSONAL GOAL (self-manage)		

POTENTIAL RISK FACTORS AND BARRIERS

- ◯ Behavioral - mental health diagnosis
- ◯ Behavioral - other
- ◯ Caregiver - other
- ◯ Caregiver - unavailable
- ◯ Caregiver - unwilling to help
- ◯ Cognitive impairment
- ◯ Cultural/Ethnic - diet limitations/restrictions
- ◯ Cultural or Religious Beliefs impacting treatment adherence
- ◯ Drug related – other
- ◯ Drug related - side effects
- ◯ Dependent relative needing care at home
- ◯ Financial constraints
- ◯ Functional - manual dexterity
- ◯ Functional – mobility
- ◯ Functional – other
- ◯ Food Insecurity
- ◯ Hearing Impairment
- ◯ Homelessness
- ◯ Housing instability, housed, with risk of homelessness
- ◯ Inadequate support system(s)
- ◯ Lack of access to healthy food
- ◯ Lack of child-care resources
- ◯ Extreme Poverty
- ◯ Lack of motivation
- ◯ Lack of reliable transportation
- ◯ Language barrier – family/ caregiver
- ◯ Language barrier – member
- ◯ Low health literacy
- ◯ Problems related to release from jail, prison
- ◯ Problems related to living alone
- ◯ Visual Impairment
- ◯ Environmental – safety
- ◯ Other

Additional Information: Use space to include any additional explanations about the Member's (needs/goals/desired outcomes) learned through assessment process.

FORM COMPLETED BY

Printed Name: **Signature/Credentials** **Date:**