



IEHP Care Management Referral Form

The IEHP Care Management Team supports Members in managing their health. IEHP accepts referrals for Care Management for Members needing Complex Care Management (CCM) and or Long-Term Services and Supports (LTSS).

Medi-Cal Delegated IPAs can refer to CCM and LTSS. Medicare IPAs can refer only to LTSS.

The CCM program helps you manage Member's healthcare by working directly with Members and their families to coordinate complex care and services.

The LTSS program connects Members who cannot care for themselves with programs that provide in-home caregivers, adult day healthcare centers, and in-home case management programs for Members 65+ who are at risk of Long-Term Care placement.

The CM Referral form includes triggers that may indicate a need for CCM or LTSS:

- Diagnosis Triggers
- Utilization Triggers
- Psychosocial/Frailty Triggers
- Triggers for referral to Long-Term Services and Supports

Referrals will be reviewed and assessed for CCM or LTSS. Delegated Members not meeting CCM criteria will be redirected back to the assigned IPA for ongoing assistance.

Instructions

1. Complete all sections of the form.
2. Provide your direct contact information.
3. Check all triggers that are applicable.
4. Email completed referral form **securely** to CMReferralTeam@iehp.org
5. Attach supporting documentation as needed
 - a. Clinical notes
 - b. Active authorizations
 - c. Provider contact info

Thank you,
CM Referral Team

IEHP Care Management Referral Form



Member Name: _____ Member ID# _____ Date: _____

Line of Business: Medi-Cal Cal MediConnect (LTSS referrals only)

Member DOB: _____ IPA _____ Member Phone: _____ Alt Phone: _____

Caregiver/Family Member Name: _____ Caregiver/Family Phone: _____

Referral Source: Member Caregiver PCP IPA Specialist Other

Referred by _____ Contact phone _____ Contact email _____

Reason for Referral:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> High Utilization | <input type="checkbox"/> Long-Term Services and Supports (<i>In-Home Support Services, Community-Based Adult Services, Multipurpose Senior Services Program</i>) |
| <input type="checkbox"/> Social Needs | <input type="checkbox"/> Behavioral Health | |
| <input type="checkbox"/> Rx | <input type="checkbox"/> Maternity/Child Health Needs | |

Diagnosis Triggers

- | | |
|---|--|
| <input type="checkbox"/> Advanced liver disease | <input type="checkbox"/> Metastatic cancer/pediatric cancer |
| <input type="checkbox"/> Severe psychoses | <input type="checkbox"/> Decompensating neurological conditions |
| <input type="checkbox"/> New cerebral vascular accident | <input type="checkbox"/> Complex pain management control issues |
| <input type="checkbox"/> Trauma (current) | <input type="checkbox"/> Multiple chronic illnesses-uncontrolled |

Utilization Triggers

- | | |
|--|--|
| <input type="checkbox"/> 6 or more ER visits in the past 12 months | <input type="checkbox"/> Projected cost of care within a 12-month period anticipated to be >\$100,000 (including high-cost medications and/or DME) |
| <input type="checkbox"/> 2 or more readmissions to acute setting within 30 days | |
| <input type="checkbox"/> 4 or more inpatient stays in the past 12 months | |
| <input type="checkbox"/> On multiple medications for multiple chronic conditions | |

Psychosocial/Frailty Triggers

- | | |
|--|--|
| <input type="checkbox"/> Malnutrition and/or catabolic illness, loss of weight | <input type="checkbox"/> Decubitus ulcer (Stage 3, Stage 4) |
| <input type="checkbox"/> Major problems of urine/bowel retention or control | <input type="checkbox"/> Social support needs (e.g., housing/food) |
| <input type="checkbox"/> Difficulty in walking/fall risk | <input type="checkbox"/> Suspected or reported abuse of Member |

Triggers for referral to Long-Term Services and Supports

- | | |
|--|--|
| <input type="checkbox"/> 65+ and at risk of placement in a Long-Term Care facility | <input type="checkbox"/> Alzheimer's or Dementia |
| <input type="checkbox"/> Severe and persistent mental illness | <input type="checkbox"/> Needs a caregiver |
| <input type="checkbox"/> Disabled, blind, or senior unable to perform activities of daily living | |
| <input type="checkbox"/> Needs ongoing nursing monitoring and supervision at Adult Day Healthcare Center | |

PLEASE CHECK ALL THAT APPLY:

Please return completed Form via [Secure Email](mailto:CMReferralTeam@iehp.org) to CMReferralTeam@iehp.org and attach all applicable documentation.

(Please allow up to 5 business days for referral to be processed and response)