

INLAND EMPIRE HEALTH PLAN Monthly Care Management Log

Delegate Name:																		
Report for Month of	f:										Submitted	By:		Phone #:				
Member First Name	Member Last Name	IEHP Member ID #	DOB	Referral Source					Individualized Care		Issues		Interventions Documented (ex. monthly follow up, transition in care)	Care Plan Sent to PCP Documented	Case Notes	Communication w/Member Documented	Case Closure Date	Reason for Closure/ Case Outcome Documented
John	Doe	12345678910111	XX/XX/XXXX	SOURCE	REASON	OPEN / CLOSED	HIGH / RISING / LOW	XX/XX/XXXX	YES / NO	ICD CODE	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	XX/XX/XXXX	
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	Report for Month of Member First Name	Member First Member Last Name Name	Member First Member Last Name Name IEHP Member ID #	Member First Member Last Name Name IEHP Member ID # DOB	Member First Member Last Name Name IEHP Member ID # DOB Source	Member First Member Last Name Name IEHP Member ID # DOB Source Reason	Member First Member Last Name IEHP Member ID # DOB Source Reason or Closed)	Member First Member Last Name IEHP Member ID # DOB Source Reason or Closed) Referral Case Status (Open or Closed) Low)	Delegate Name: Report for Month of: Member First Name Name IEHP Member ID # DOB Source Reason or Closed) Report for Month of: Case Open Date (or Ref to waiver, CCS) community based services or BH	Member First Name Name IEHP Member ID # DOB Source Reason Or Closed) Report for Month of: Case Open Date (or Ref to waiver, CCS) community based services or BH Plan Documented	Report for Month of: Member First Name Name IEHP Member ID # DOB Source Reason Or Closed) Report for Month of: Case Status (Open Case Level (High, Rising or Community based Services or BH Plan Documented Description)	Report for Month of: Member First Name IEHP Member ID # DOB Source Reason Plan Documented Doescription) Case Level (High, Rising or Closed) Case Level (High, Rising or Services or BH Plan Documented Description) Description) Description) Description D	Begort for Month of: Report for Month of: Submitted By: Case Open Date (or Ref to waiver, CCS) Community based Name Name Name Name IEHP Member ID # DOB Source Referral Referral Reason or Closed) Reform Case Level (High, Rising or Or Closed) Low) Case User (High, Rising or Case User) Low Problems/ Ref to waiver, CCS) Community based Services or BH Plan Documented Description) Diagnosis (ICD Problems/ Issues Issues Identified Goals Identified	Delegate Name: Report for Month of: Submitted By: Case Open Date (or Ref to waiver, CCS) Name Name IEHP Member ID # DOB Source Referral Referral Referral Reson or Closed) Reson or Closed) Case Level (High, Rising or Community based services or BH Plan Documented Description) Diagnosis (ICD Problems/ Issues of Codes/ Issues services or BH Plan Documented Description) Joan Source Joan Source	Report for Month of: Report for Month of: Submitted By: Phone #: Submitted By: Interventions Documented (ex. monthly follow up, transition in Name Name Referral Name Name Referral Referra	Delegate Name: Report for Month of: Submitted By: Submitted By: Phone #: Case Open Date (or Ref to waiver, CCS) Name Name Name EHP Member ID # DOB Source Reason Or Closed) Low) Description Low Submitted By: Submitted By: Problems/ Diagnosis (ICD Problems/ Issues Source Case Vete (High, Rising or Community base) Case Level (High, Rising or Community base) Individualized Care Codes/ Susues Source Case Vete Case Vete (High, Rising or Community base) Individualized Care Codes/ Susues Source Case Vete Case Vete Case Vete (High, Rising or Codes/ Services or BH Plan Documented Description) Identified Goals Identified Goals Identified Goals Identified Care Documented Case Notes Case Vete Case Vete	Delegate Name: Report for Month of: Submitted By: Phone #: Submitted By: Phone #: Communication Wember First Name Name IEHP Member ID # DOB Source Reason or Closed) Referral Referral Referral Reson or Closed) Reson or Closed) Case Status (Open Case Level (High, Rising or Closed) Low) Case Open Date (or Ref to waiver, CCS) Communication Volumented Description) Diagnosis (ICD Problems/ Issues Codes/ Issues Source Reason or Closed) Diagnosis (ICD Problems/ Issues IEHP Member ID # DOB Source Reason or Closed) Case Notes Documented Description) Documented Description) Diagnosis (ICD Problems/ Issues IEHP Member ID # Gare Plan Sent to PCP Documented Case Notes Documented Description) Communication W/Member Description)	Delegate Name: Report for Month of: Submitted By: Phone #: Phone #: Name Name Referral Referral Name Name

Identify the number of:
New Opened Cases: Previously Opened Cases:
Total Cases reported for this month:



Monthly <u>Medi-Cal</u> Care Management Log Instructions and Data Dictionary

Instructions: Submit a monthly report of Care Management completed in the reporting month. The Care Management activities that are being captured on this log are assessments, Individualized Care Plan (ICP) and referrals. Send records that are new or have an update from a previous submission (e.g. updated date of care goal discussion). Refer to the data dictionary for specifics on what each field should contain. Do not alter the templates in any way (e.g. adding or deleting columns or header rows). Always submit the most current template in Excel (.xlsx) format.

Column ID	Field Name	Field Type	Field Length	Drop Down Options	Description
Α	Member First Name	CHAR Always Required	50	-	First name of the Member
В	Member Last Name	CHAR Always Required	50	-	Last name of the Member
С	IEHP Member ID #	14 digit numeric characters	14	-	Cardholder identifier used to identify the beneficiary. This is assigned by IEHP and is 14 digits long.
D	DOB	MM/DD/YYYY	10	-	Member's Date of Birth
Е	Referral Source	CHAR Always Required	50	-	Source of referral for Member to be in care management program
F	Referral Reason	CHAR Always Required	50	-	Reason for referral Member being enrolled into care management program
G	Case Status (Open or Closed)	CHAR Always Required	6	Open / Closed	At time of reporting month is Member's care management program status Open or Closed
Н	Case Level (High, Rising or Low)	CHAR Always Required	7	High / Rising/ Low	At time of reporting month is Member's care management case level High, Rising or Low.
1	Case Open Date (or Ref to waiver, CCS) community based services or BH	MM/DD/YYYY	10	-	Date of when care management case was opened
J	Individualized Care Plan Documented	CHAR Always Required	3	Yes / No	Is there documentation of an individualized care plan?
K	Diagnosis (ICD Codes/ Description)	CHAR Always Required	3	Yes / No	Member's diagnosis code(s) or description
L	Problems/ Issues Identified	CHAR Always Required	3	Yes / No	Is there documentation of Members identified problems and issues?
М	Goals Identified	CHAR Always Required	3	Yes / No	Are Member's goals identified within the individualized care plan?
N	Interventions Documented (ex. monthly follow up, transition in care)	CHAR Always Required	3	Yes / No	Is documentation shown within individualized care plan of interventions?
0	Care Plan Sent to PCP Documented	CHAR Always Required	3	Yes / No	Is documentation shown that Member's care plan was sent to the Member's PCP?
Р	Case Notes	CHAR Always Required	3	Yes / No	Is there documentation of case notes within the Member's individualized care plan?
Q	Communication w/ Member Documented	CHAR Always Required	3	Yes / No	Is documentation shown of successful contact with Member?
R	Case Closure Date	MM/DD/YYYY	10	-	If Case Status (column G) is 'Closed' was is the date the care management case was closed?
S	Reason for Closure/ Case Outcome Documented	CHAR Always Required	50	Yes / No	If Case Status (column G) is 'Closed' what was the reason for closure or the case outcome?