Care Management Guide For Referral

L.A. Care's High Risk & Complex Care Management programs are designed to help members understand their current health status, health care needs, and treatment plan. In order to be eligible for the High Risk program, members must have multiple unmanaged chronic conditions and/or evidence of functional decline. Eligibility for the Complex Care Management program is reserved for the most at-risk members who display both medical severity and associated high-cost utilization. Some examples of triggers used to identify members appropriate for L.A. Care CM are outlined below.

Specific Diagnosis Triggers include (but are not limited to):

- Major Recent Physical Trauma or new onset of Paralysis, Paraplegia or Quadriplegia (diagnosed within 90 days)
- Severe Neuromuscular Disorder
- Advanced Organ Failure
- Major Organ Transplant
- Pediatric or Metastatic Cancer
- Complex NICU (e.g. gestation less than 28 weeks at birth, or birth weight <500 grams)

Social Triggers may include (but are not limited to):

- Functional Decline
- Homelessness
- Recent loss of caregiver

Utilization Triggers are:

- 4 or more ER visits in past 6 months
- 3 or more inpatient admissions in past 12 months
- Total care projected to exceed $100,000 in 12 months

L.A. Care's Care Management department will review referrals and will make final determination on the member risk level and CM services best aligned to meet the members' needs.

Care Management Referral Form

L.A. Care HEALTH PLAN
For All of L.A.

FAX TO: L.A. CARE (213) 438-5077 OR EMAIL (MUST BE ENCRYPTED): cmreferral@lacare.org

Please attach the most recent care plan and all relevant progress notes. If you are a medical provider or are referring on behalf of one, please attach relevant medical records.

REFERRAL INFORMATION:

Referred By: **Date Referred:**

Referrer Phone: **Referrer Email:**

Referral Source: ◯ Member Self-Referral ◯ Hospital Discharge ◯ LA Care Internal Dept. ◯ PPG/Medical Group

◯ PCP (Name) ◯ Other

Product Line: ◯ Dual Special Needs (DSNP) ◯ Medi-Cal / SPDal (MCLA) ◯ L.A. Care Covered (LACC) ◯ PASC-SEIU

MEMBER INFORMATION:

Name: **Member ID (CIN):**

DOB: **Preferred Language:**

Preferred Phone: ◯ Mobile ◯ Home

Caregiver: **Relationship:** **Phone:**

Referral Explanation and Relevant Diagnoses (list reasons the member is appropriate for CM)

Within the past 30 days, the member has visited:

Facility Type: (ER) **Facility Name:**

Date: **Additional Date:**

Admission Notes:

Facility Type: (Hospital) **Facility Name:**

Date: **Additional Date:**

Admission Notes:

Facility Type: (SNF) **Facility Name:**

Date: **Additional Date:**

Admission Notes:

LA4310 12/22

Thank you for your referral. L.A. Care's CM Team will review this referral and attached member information.