Enhanced Care Management Program
Completion Questionnaire

Enhanced Care Management (ECM) lead care managers are encouraged to use this questionnaire with the member to help determine readiness for the program completion of ECM, transition out of ECM to a lower level of care management, or continuation of services.

Member first name_____ Member last name_____

Member birth date_____ Member CIN_____ Date_____

Physical health

1) Select the box that shows the member's ability to complete the following tasks without help:

Yes	No	NA	
☐	☐	☐	Make appointments.
☐	☐	☐	Track appointments on a calendar.
☐	☐	☐	Keep appointments or call to reschedule/cancel in advance.
☐	☐	☐	Know where to call for interpretation and translation services, if needed.
☐	☐	☐	Know how to call the primary care physician or Nurse Advice Line.
☐	☐	☐	Use urgent care and the emergency department (ED) appropriately.
☐	☐	☐	Know how to attend telehealth appointments.
☐	☐	☐	Find community resources.
☐	☐	☐	Call Member Services to ask questions or request services (change physician or other provider, request care management services).
☐	☐	☐	Call Member Services and choose the option for transportation to schedule rides to appointments and pharmacy.
☐	☐	☐	Understand the Member Bill of Rights.
☐	☐	☐	Use the Member Evidence of Coverage (EOC) Handbook.

2) a. Do I understand why I take each of my medications?
   ☐ Yes ☐ No ☐ Other: _____
   b. Do I take them as instructed by my doctor?
   ☐ Yes ☐ No ☐ Other: _____

3) a. Do I know when I need to see my physician or other care provider?
   ☐ Yes ☐ No ☐ Other: _____
   b. Do I feel comfortable talking to the physician or other care provider about what is bothering me and asking questions?
   ☐ Yes ☐ No ☐ Other: _____

4) Can I follow my care team's recommendations (e.g., eating right or exercising)?
   ☐ Yes ☐ No ☐ Other: _____

5) Do I feel like I can manage my stress?
   ☐ Yes ☐ No ☐ Other: _____

6) Do I know how to take care of my health and ask for help when I need it?
   Yes No Other: _____

Mental/emotional health

7) I can do the following on my own (check all that apply):
   - ☐ Understand my mental health diagnosis and treatment.
   - ☐ Know where and when to seek care and make informed decisions about care.
   - ☐ Recognize warning signs related to emotional health/mental health diagnosis.
   - ☐ Recognize things that upset me and respond in a healthy way.
   - ☐ Understand why I take my medications and know how to take my medications.
   - ☐ Identify one or more people I can talk to (e.g., support person or group).
   - ☐ Find help when I need it.

Housing

8) a. Do I have safe and stable housing?
   Yes No Other: _____

   b. Do I know how to find help if I need it?
   Yes No Other: _____

9) Do I know my rights in my current housing situation?
   Yes No Other: _____

10) Do I know how my actions can affect my housing (e.g. paying rent late, hoarding, smoking)?
   Yes No Other: _____

11) Do I understand why I need to maintain my relationship with the landlord?
   Yes No Other: _____

Daily living

12) a. Can I do things for myself, like cook, clean and shop?
   Yes No Sometimes: _____

   b. Can I ask for help when I need it?
   Yes No Sometimes: _____

13) Can I perform or get help with activities of daily living such as bathing, dressing, toileting, transferring, continence and feeding?
   Yes No Other: _____

14) Do I have all the supplies and equipment to live on my own?
   Yes No Other: _____

15) Am I able to get food, transportation, and seek help when I need it?
   Yes No Other: _____

16) Do I have my birth certificate, Social Security card, driver's license, and other records to prove my identity?
   Yes ☐ No ☐ Other: _____

17) Do I know how to keep track of my money and how and where I spend it (e.g., rent, bills, groceries)? Money includes all sources of income such as CalFresh, etc.

☐ Yes ☐ No ☐ Other: _____

Recommendation (To be completed by the lead care manager)

Based on the information in the assessment above, please complete the following questions**. If the answer to all questions is "yes", the member should be transitioned to a lower level of care or discontinued from the program.**

Yes	No	NA	
☐	☐	☐	Demonstrate ability to self-manage their care? If no, what is the expected timeline to meet the goal: ____ months
☐	☐	☐	Complete all active care plan goals. If no, what is the expected timeline to meet the goal: ____ months
☐	☐	☐	Take active responsibility for their own health and follows their medication and treatment plans. If no, what is the expected timeline to meet the goal: ____ months
☐	☐	☐	Reduce the use of ED or hospitalizations within a 12-month period. If no, what is the expected timeline to meet the goal: ____ months
☐	☐	☐	Access primary care or behavioral healthcare services when needed. If no, what is the expected timeline to meet the goal: ____ months
☐	☐	☐	Have safe and stable housing and knows about supportive community services. If no, what is the expected timeline to meet the goal: ____ months
☐	☐	☐	Have a support system or understands resources and how to use them correctly. If no, what is the expected timeline to meet the goal: ____ months
☐	☐	☐	Perform, or can get help with, daily activities (e.g., bathing, toileting, feeding, cooking, and cleaning). If no, what is the expected timeline to meet the goal: ____ months

18) **[REQUIRED]** Please identify any programs or services to which the member was linked during ECM. Is the member still receiving services from these programs today?

_____

_____

19) **[REQUIRED]** Please describe any ongoing need for care management services related to a specific need or concern:

_____

_____

_____

Based on the information above, please check one of the boxes below:

☐ Member is prepared to move to a lower level of care. Please list the program that may be a good fit to help the member with services after the end of ECM services.

_____

☐ Member is not ready to exit the ECM program.

☐ Member is ready to graduate from the ECM program.