Enhanced Care Management (ECM)
Comprehensive Assessment (FORM C)

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PURPOSE

To engage and evaluate services needed in areas of physical health, mental health, Substance Use Disorder (SUD), Long Term Services and Support (LTSS), Oral Health, Palliative Care, Social Supports and Social Determinants of Health (SDOH) to develop a Care Management Plan.

WHEN TO SUBMIT

Required to submit via CenCal Health Provider Portal no later than 30 days of initial ECM Service Authorization decision date.

MEMBER INFORMATION

Medi-Cal # CIN: (9 digits/letter) Service Authorization #:

First Name: Last Name:

Date of Birth:

Member's Phone Number:

Preferred written/spoken language: Requires Interpreter: ◯ Yes ◯ No

Address:

Homeless: ◯ Yes ◯ No

Highest Level of Education: ◯ Less Than High School ◯ High School ◯ More than High School/College

Primary or Emergency Contact (Name/Phone#):

Relationship:

Has an Authorized Representative (AR): ◯ Yes ◯ No Name (AR):

Relationship (AR): Phone Number (AR):

Name of Primary Care Provider (PCP): PCP Phone Number:

ECM PROVIDER INFORMATION

ECM Organization Name: Phone Number:

Lead Care Manager Email Address:

Assessment Completed: ◯ In Person ◯ Over the Phone ◯ Both (In Person and on the Phone)

Assessment Type: ◯ Initial ◯ Reassessment Assessment Date:

ECM POPULATIONS OF FOCUS: *Select all that apply*

- ◯ **HOMELESSNESS:** Adults Experiencing Homelessness
- ◯ **AVOIDABLE HOSPITAL OR EMERGENCY DEPARTMENT UTILIZATION:** Adults at Risk for Avoidable Hospital or ED Utilization
- ◯ **SERIOUS MENTAL HEALTH/SUBSTANCE USE:** Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
- ◯ **JUSTICE INVOLVED:** Adults Transitioning from Incarceration within the past 12 months
- ◯ **LONG TERM CARE (LTC) INSTITUTIONALIZATION:** Adults living in the community who are at risk for LTC Institutionalization
- ◯ **NURSING RESIDENTS TRANSITIONING TO COMMUNITY:** Adult Nursing Facility Residents Transitioning to the Community
- ◯ **BIRTH EQUITY:** Pregnant and Postpartum Individuals at Risk for Adverse Perinatal Outcomes

ENGAGEMENT PURPOSE/MEANING AND STRENGTHS

Ask at least 3 or more of these engagement questions:

◯ How strongly do you agree with this statement? I lead a purposeful and meaningful life.

◯ Agree ◯ Disagree ◯ Don't know

◯ **Strengths:** What is something that you are good at or proud of?

◯ **Self-Efficacy:** How confident are you in taking actions needed to maintain or improve your health?

◯ **Coping Skills:** When you feel sad or worried, what helps you feel better? What do you do for fun or to relax?

ENGAGEMENT PURPOSE/MEANING AND STRENGTHS (cont.)

◯ **Motivation:** What do you want to improve about your health? What will the benefits be if you improve that area of your health?

◯ **Problem-Solving Skills:** When you had a difficult situation in the past, what did you do?

CULTURE

Do you have any cultural, religious and/or spiritual beliefs that are important to your family's health and wellness?

◎ Yes ◎ No

If yes, please explain:

HEALTH LITERACY

I would like to ask you about how you are managing your health conditions:

Do you need help taking your medications? ◯ Yes ◯ No**(LTSS)**

Do you need help filling out health forms? ◯ Yes ◯ No**(LTSS)**

Do you need help answering questions during doctor visits? ◯ Yes ◯ No**(LTSS)**

How often do you have difficulty understanding written information given to you by your Primary Care Provider (like a Doctor, Nurse, Nurse Practitioner)?

◯ Always ◯ Often ◯ Sometimes ◯ Occasionally ◯ Never

Coordination of Care Needs and Referrals:

EMERGENCY DEPARTMENT VISITS OR HOSPITALIZATIONS

☐ Have you had any Emergency Department (ED) visits or hospitalizations in the last 30 days?

◯ Yes ◯ No

Reason for ED OR Hospital Admission:

PREVENTATIVE CARE

Has had a physical with their Primary Care Provider in the last 12 months: ◯ Yes ◯ No

Member indicates blood sugar has been checked in the last 12 months: ◯ Yes ◯ No

Member indicates they had their cholesterol levels checked in the last 12 months: ◯ Yes ◯ No

COVID Vaccine: ◯ Yes ◯ No

Flu Vaccine: ◯ Yes ◯ No

Shingles Vaccine: ◯ Yes ◯ No

Pneumonia Vaccine: ◯ Yes ◯ No

Recommendations based on PCP, Age, Risk Factors:

◯ Colorectal Cancer Screening (+50) ◯ Breast Cancer Screening (+40) ◯ Bone Density (+65)

◯ Cervical Cancer Screening (+25) ◯ Prostate Exam (+50) ◯ Tuberculosis Screening

Coordination of Care Needs and Referrals:

PHYSICAL HEALTH

Problems with Vision: ◯ Yes ◯ No

Problems with Hearing: ◯ Yes ◯ No

Poorly Fitting Dentures (partial or full): ◯ Yes ◯ No

Oral Pain/Visible Decay: ◯ Yes ◯ No

Other:

Coordination of Care Needs and Referrals:

PHYSICAL HEALTH (cont.)

Have you been told by a doctor or medical provider that you have any of the following medical conditions?

NEUROLOGICAL

◯ **No Concerns Noted**

- ◯ Alzheimer's, Dementia, Memory Loss
- ◯ Stroke
- ◯ Seizures
- ◯ Parkinson's
- ◯ Chronic Pain
- ◯ Muscular Dystrophy (MS)
- ◯ Amyotrophic Lateral Sclerosis (ALS)
- ◯ Paralysis
- ◯ Traumatic Brian Injury (TBI)
- ◯ Other:

RESPIRATORY / CARDIAC

◯ **No Concerns Noted**

- ◯ Heart Failure
- ◯ Cystic Fibrosis
- ◯ Hypertension
- ◯ Asthma, COPD, Emphysema
- ◯ Other:

Select all that apply for home use:

- ◯ **No Concerns Noted**
- ◯ Oxygen at Home
- ◯ Nebulizer
- ◯ Tracheostomy
- ◯ Ventilator
- ◯ CPAP/BiPAP
- ◯ Other:

ENDOCRINE

◯ **No Concerns Noted**

- ◯ Diabetes Type I
- ◯ Diabetes Type II
- ◯ Other:

Coordination of Care Needs and Referrals:

PHYSICAL HEALTH (cont.)

Have you been told by a doctor or medical provider that you have any of the following medical conditions?

GASTROINTESTINAL

◯ **No Concerns Noted**

◯ Kidney Disease

◯ Dialysis

◯ Cirrhosis, Hepatitis (B & C)

◯ Other:

Select all that apply for home use:

◯ **No Concerns Noted**

◯ Feeding Tube

◯ NG Tube

◯ PEG Tube

◯ Indwelling Foley Catheter

◯ Suprapubic Catheter

◯ Ostomy

MUSCULOSKELETAL

◯ **No Concerns Noted**

◯ Osteoarthritis

◯ Rheumatoid Arthritis

◯ Recent Fracture or Amputation

◯ Are you wheelchair or bedbound? ◯ Yes ◯ No

◯ Other:

OTHER MEDICAL CONDITION

◯ **No Concerns Noted**

◯ HIV/AIDS

◯ Organ Transplant (Recent Transplant or on Waitlist)

◯ High-risk Pregnancy

◯ Cancer, in Treatment? ◯ Yes ◯ No

◯ Traumatic Brain Injury

Coordination of Care Needs and Referrals:

MEDICATIONS

◯ **No Concerns Noted**

People sometimes miss taking their medications. Thinking over the past week, were there any days you did not take your medications as prescribed?

◯ Yes ◯ No

If Yes, please describe what gets in the way:

PALLIATIVE CARE

Palliative Care

◯ Enrolled in Palliative Care Services

◯ Does not meet criteria for Palliative Care

◯ **Meets Criteria (Needs Referral)**

◯ **Meets Criteria (Declined Referral)**

1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
2. The Member has an advanced illness, with appropriate documentation of the continued decline in health status and is not eligible for or declines hospice enrollment.
3. The member's death within a year would not be unexpected based on clinical status.
4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
5. The member and, if applicable, the family/member-designated support person, agrees to:
   a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
   b. Participate in Advance Care Planning discussions.

Coordination of Care Needs and Referrals:

Disease-Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF): Must meet (a) and (b)

a. The Member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meet criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; and

b. The Member has an Ejection Fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease: Must meet (a) or (b)

a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or

b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)

a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and

b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

3. Liver Disease: Must meet (a) and (b) combined or (c) alone

a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and

b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or

c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

◯ **No Concerns Noted**

Has a healthcare or mental health provider ever told you that you have any of the following:

◯ Anxiety
◯ Obsessive-Compulsive Disorder
◯ Bipolar Disorder
◯ Schizophrenia
◯ Depression
◯ ADHD
◯ PTSD
◯ Intellectual Disability
◯ Autism
◯ Other:

Have you had any Emergency Department (ED) visits or inpatient stays in the last 6 months due to your mental health condition? ◯ Yes ◯ No

Coordination of Care Needs and Referrals:

SUBSTANCE USE

◯ **No Concerns Noted**

Do you use substances (Alcohol, Street Drugs or Misuse Prescriptions)? ◯ Yes ◯ No

If Yes, have you experienced any negative consequences from your use? ◯ Yes ◯ No

Have you previously used substances and stopped? ◯ Yes ◯ No

What substance(s) have you found to be a problem:

Do you smoke, vape or chew tobacco? ◯ Yes ◯ No

Have you ever felt you ought to cut down on your drinking or drug use? ◯ Yes ◯ No

If Yes, go to next question.

Would you like to talk with someone about your substance use, especially if you are thinking of quitting or cutting back? ◯ Yes ◯ No ◯ NoConcerns Noted

Coordination of Care Needs and Referrals:

COGNITIVE FUNCTION

☐ **No Concerns Noted**

Have you had any changes in thinking, remembering, or making decisions? ◯ Yes ◯ No **(LTSS)**

In the past month, have you felt worried, scared, or confused that something may be wrong with your mind or memory? ◯ Yes ◯ No

Coordination of Care Needs and Referrals:

SAFETY

☐ **No Concerns Noted**

Are you afraid of anyone or is anyone hurting you? ◯ Yes ◯ No **(LTSS)**

If yes, please explain:

Is anyone using your money without your ok? ◯ Yes ◯ No **(LTSS)**

If yes, please explain:

ACTIVITIES OF DAILY LIVING

◯ **No Concerns Noted**

LIMITATIONS/FUNCTIONAL CAPACITY RISK FACTORS

Do you need help with any of these activities? (LTSS) (answer Yes or No to each individual activity)

Taking a Bath or Shower ◯ Yes ◯ No

Using a Toilet ◯ Yes ◯ No

Getting Dressed ◯ Yes ◯ No

Brushing Teeth, Brushing Hair, Shaving ◯ Yes ◯ No

Walking ◯ Yes ◯ No

Getting out of Bed or a Chair ◯ Yes ◯ No

Going Up Stairs ◯ Yes ◯ No

Eating ◯ Yes ◯ No

Making Meals or Cooking ◯ Yes ◯ No

Shopping and Getting Food ◯ Yes ◯ No

Writing Checks or Keeping Track of Money ◯ Yes ◯ No

Keeping Track of Appointments ◯ Yes ◯ No

Using the Phone ◯ Yes ◯ No

Doing Housework or Yard Work ◯ Yes ◯ No

Washing Dishes or Laundry ◯ Yes ◯ No

Going out to Visit Family or Friends ◯ Yes ◯ No

Getting a Ride to the Doctor or to See your Friends ◯ Yes ◯ No

Other please explain:

If yes, are you getting all the help you need with these activities? ◯ Yes ◯ No **(LTSS)**

Do you have family members or others willing and able to help you when you need it? ◯ Yes ◯ No **(LTSS)**

Do you ever think your caregiver has a hard time giving you all the help you need? ◯ Yes ◯ No **(LTSS)**

Do friends or family members express concerns about your ability to care for yourself? ◯ Yes ◯ No

Coordination of Care Needs and Referrals:

HOUSING ENVIRONMENT

◯ **NoConcerns Noted**

Can you safely and easily move around your home? ◯ Yes ◯ No **(LTSS)**

If No, does the place that you live have: **(answer Yes or No to each individual item)**

Good Lighting ◯ Yes ◯ No

Good Heating ◯ Yes ◯ No

Good Cooling ◯ Yes ◯ No

Rails for any Stairs or Ramps ◯ Yes ◯ No

Hot Water ◯ Yes ◯ No

Indoor Toilet ◯ Yes ◯ No

A door to the outside that locks ◯ Yes ◯ No

Elevator ◯ Yes ◯ No

Space to use a wheelchair ◯ Yes ◯ No

Clear Ways to Exit Home ◯ Yes ◯ No

Stairs to get into your home or stairs inside your home ◯ Yes ◯ No

Coordination of Care Needs and Referrals:

FALL RISK

◯ **NoConcerns Noted**

Are you afraid of falling? ◯ Yes ◯ No**(LTSS)**

Have you fallen in the last month? ◯ Yes ◯ No**(LTSS)**

Coordination of Care Needs and Referrals:

MEDICAL EQUIPMENT

◯ **NoConcerns Noted**

Glasses ◯ Use ◯ Need

Walker ◯ Use ◯ Need

Grab Bars ◯ Use ◯ Need

Raised Toilet Seat/Chair ◯ Use ◯ Need

Urinary Catheters ◯ Use ◯ Need

Cane ◯ Use ◯ Need

Lift Device ◯ Use ◯ Need

Shower Chair ◯ Use ◯ Need

Incontinence Supplies ◯ Use ◯ Need

Hearing Aids ◯ Use ◯ Need

Wheelchair ◯ Use ◯ Need

Hospital Bed ◯ Use ◯ Need

Power Chair ◯ Use ◯ Need

◯ Other:

Coordination of Care Needs and Referrals:

SOCIAL DETERMINANTS OF HEALTH

HOUSING ◯ No Concerns Noted

Where do they live?

◯ Live alone in my home/apartment

◯ Live with family or other person's home/apartment

◯ Residential Treatment Center

◯ Board and Care facility

◯ Assisted Living Nursing Home

◯ Protective housing

◯ Homeless

If experiencing homelessness, staying at:

◯ Recuperative Care ◯ In a motel ◯ Vehicle ◯ Shelter or with friend ◯ Unsheltered

Comment:

Are you at risk for eviction? ◯ Yes ◯ No

If Yes, please explain:

Is anyone helping you with housing support? (e.g. Housing Navigator, Case Management, Adult Protective Services)
◯ Yes ◯ No

Are you on a housing waitlist? ◯ Yes ◯ No

If Yes: ◯ County ◯ City ◯ Other:

FINANCIAL INSECURITY ◯ No Concerns Noted

What is your monthly income? $ Source of Income:

◯ Employment ◯ SSI (Supplemental Security Income) ◯ SSDI (Social Security Disability Insurance)

Do you sometimes run out of money to pay for food, rent, bills and medications? ◯ Yes ◯ No **(LTSS)**

FOOD INSECURITY ◯ No Concerns Noted

In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there was not enough money for food? ◯ Yes ◯ No

How often are you hungry or do not eat because there is not enough food in the house?
◯ Often ◯ Not Often

Do you eat less than you feel you should because there is not enough food? ◯ Yes ◯ No

Coordination of Care Needs and Referrals:

ISOLATION

◯ **NoConcerns Noted**

Over the past month (30 days), how many days have you felt lonely? (LTSS) (Check one)

◯ None – I never feel lonely

◯ Less than 5 days

◯ More than half the days (more than 15)

◯ Most days – I always feel lonely

Coordination of Care Needs and Referrals:

SOCIAL SUPPORT (select all that apply)

◯ Family ◯ Adult Day Care ◯ Friendship Line ◯ Tri-Counties Regional Center (TCRC)

◯ Friendly Visitor ◯ Caregiver ◯ Religious/Spiritual ◯ Congregate Meal Services

◯ Support Group ◯ None ◯ Other:

LEGAL INVOLVEMENT

◯ **No Concerns Noted**

Involvement with the following in the last 12 months:

◯ Court Ordered Services

◯ Probation

◯ Parole

◯ Re-entry Program

◯ Deferred Action for Childhood Arrivals (DACA)

◯ Immigration “e.g., Refugee”

◯ DUI/restricted License

◯ Child Welfare Services

◯ Adult Protective Services

◯ Other:

END-OF-LIFE-PLANNING

Do you have a life-planning document or advance directive in place? ◯ Yes ◯ No

Do you want information on these topics? ◯ Yes ◯ No

COMMUNITY AND LTSS SERVICES

Select Agencies or Services Member is connected with:

◯ * **Dual Eligible Special Needs Plan (D-SNP)**

◯ * **Hospice**

◯ * **Fully Integrated Special Needs Plans (FIDE - SNPs)**

◯ * **Program For All-Inclusive Care for the Elderly (PACE)**

◯ * **Multipurpose Senior Services Program (MSSP)**

◯ * **Self-Determination Program for Individuals with I/DD**

◯ * **Assisted Living Waiver (ALW)**

◯ * **California Community Transitions (CCT)**

◯ * **Home and Community-Based Alternatives (HCBA) Waiver**

◯ * **Medi-Cal Waiver Program (MCWP) (formerly HIV/AIDS Waiver)**

*** Members may be excluded from receiving ECM and these similar services at the same time.**

◯ Respite Services

◯ Meals on Wheels

◯ In-Home Supportive Services

◯ Veterans Administration

◯ California Children's Services (CCS)

◯ Community Based Adult Services (CBAS)

◯ CalFresh Benefits

◯ County Specialty Mental Health

◯ CalAIM Community Supports

◯ Non-Medical Transportation

◯ Subsidized Housing

◯ Independent Living Resource Center

◯ Energy Assistance Program

◯ Free Government Phone

◯ Tri-Counties Regional Center (TCRC)

◯ Other:

Coordination of Care Needs and Referrals:

MEMBER PRIORITIES

What is one thing you would like to do right now to improve your health? (Such as cutting back sugary drinks or initiating daily walks – provide an example of one personal goal.)

1)

What would you like to achieve from our work and time together?

From our meeting today, what comes to mind as your top 2-3 goals for your health, mental wellness, social and/or living situation for the next 3-6 months?

1.

2.

3.

Tier 1: High Acuity, Recommended minimum one contact per week if any of the below apply

- ◯ Emergency Department (ED) visit or hospitalization (in the last 30 days)
- ◯ New diagnosis or new initiation of treatment (in last 30 days)
- ◯ Documented or known non-adherence (medication, treatment, or appointments)
- ◯ Little or no identified social support
- ◯ Homeless or recently secured permanent housing (within the last 90 days)

Tier 2: Moderate Acuity, Recommended minimum (3x/month) contact if any of the below apply

- ◯ ED visit or hospitalization within the last 2-6 months
- ◯ Newly sustained treatment adherence (medications, appointments)
- ◯ Newly integrated social support
- ◯ Secured permanent housing within last 3-6 months
- ◯ At risk of homelessness

Tier 3: Low Acuity, Recommended minimum one contact per month if any of the below apply

- ◯ No ED visit or hospitalization (in the last 6 months)
- ◯ Ongoing treatment adherence (medications, appointments)
- ◯ Strong family/social support
- ◯ Stable housing

Narrative Summary (Include primary needs identified from Assessment)

Assessor's Printed Name: **Signature/Credentials:** **Date:**