

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			
Yes No NA	nts on a calendar. Ints or call to reschedule/cancel in adverties and translation so the primary care physician or Nurse and the emergency department (ED) are and telehealth appointments. The primary care physician or Nurse and the emergency department (ED) are also the emergency departments.	vance. services, if needed. Advice Line.	
☐ ☐ ☐ Call Member Serrand pharmacy. ☐ ☐ ☐ Understand the I☐ ☐ ☐ Use the Member 2) a. Do I understand why I take	vices and choose the option for transpose. Member Bill of Rights. Evidence of Coverage (EOC) Handboo		
	ed by my doctor? see my physician or other care provid		
☐ Yes ☐ No ☐ Other: b. Do I feel comfortable talking questions?		— rider about what is bothering me and askin্	
	recommendations (e.g., eating right o		
5) Do I feel like I can manage m ☐ Yes ☐ No ☐ Other:	y stress?		

6)	Do I know how to take care of my health and ask for help when I need it? ☐ Yes ☐ No ☐ Other:
M	ental/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.
Н	ousing
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:
Da	aily living
12)	a. Can I do things for myself, like cook, clean and shop? ☐ Yes ☐ No ☐ Sometimes: ☐ Can I ask for help when I need it? ☐ Yes ☐ No ☐ Sometimes: ☐ 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:

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			
II questions is rogram.	"yes", the member should be transitioned to a lower level of care or discontinued from the		
Yes No N	A		
	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		
	Please identify any programs or services to which the member was linked during ECM. Is the receiving services from these programs today?		
_	Please describe any ongoing need for care management services related to a specific need or		
concern:			
	nformation above, please check one of the boxes below:		
Based on the ir	of the member with services after the end of ECM services.		
Based on the ir Memb to help Memb	per is prepared to move to a lower level of care. Please list the program that may be a good fit		