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

CenCal HEALTH
Local. Quality. Healthcare.

Member Information

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

Last Name: _____ First Name: _____

Birthdate: _____ 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 (AR): _____

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

ECM Provider Information

Lead Care Manager Name: _____ Phone Number: _____

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*

- ☐ Individuals & Families Experiencing Homelessness (POF 1)
- ☐ Adult at Risk for Avoidable Hospital and Emergency Department (ED) Utilization (POF 2)
- ☐ Adult with Severe Mental Illness/Substance Use Disorder Needs (POF 3)
- ☐ Adults Living in the Community at Risk for Institutionalization (POF 5)
- ☐ Adults who are Nursing Facility Residents Transitioning to the Community (POF 6)

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?

◯ **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 think you are managing your health conditions:

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

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

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

How often do you have difficulty understanding written information your health care provider (like a doctor, nurse, nurse practitioner) gives you?

◯ Always ◯ Often ◯ Sometimes ◯ Occasionally ◯ Never

Coordination of Care Needs and Referrals:

EMERGENCY DEPARMENT VISITS OR HOSPITALIZATIONS

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

◯ No ED visit or hospitalization in the last 30 days.

Reason for ED OR Hospital Admission:

PREVENTATIVE CARE

Has had a physical with his 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
- ◯ Other:

RESPIRATORY / CARDIAC

◯ **No Concerns Noted**

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

Select all that apply for home use:

- ◯ Oxygen at Home
- ◯ Tracheostomy
- ◯ Nebulizer
- ◯ Ventilator
- ◯ Other:
- ◯ CPAP/BiPAP

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 / GENITOURINARY

◯ **No Concerns Noted**

- ◯ Kidney Disease
- ◯ Dialysis
- ◯ Cirrhosis, Hepatitis (B & C)
- ◯ Other:

Select all that apply for home use:

- ◯ Feeding Tube
- ◯ NG Tube
- ◯ PEG Tube
- ◯ Indwelling Foley Catheter
- ◯ Suprapubic Catheter
- ◯ Ostomy

MUSCULO-SKELETAL

◯ **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 meber's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
2. The member has an advanced illness, as defined in section I.B below, with appropriate documentation of 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.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.
4. 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 meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher;10 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

c. (Chemotherapy or radiation therapy).

4. 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

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

Have you had any Emergency Department (ED) visits or inpatient stay 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 experience any negative consequences from your use? ◯ Yes ◯ No

Did you previously use 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

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 need help with any of these actives? (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 Clothes	◯ 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 ENVIROMENT

◯ **No Concerns 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

◯ **No Concerns 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

◯ **No Concerns Noted**

Glasses	◯ Use	◯ Need
Walker	◯ Use	◯ Need
Grab Bars	◯ Use	◯ Need
Raised Toilet Seat/Chair	◯ Use	◯ Need
Urinary Catheters	◯ 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

Other:

Coordination of Care Needs and Referrals:

SOCIAL DETERMINANTS OF HEALTH

◯ **No Concerns Noted**

HOUSING

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 Homeless, staying at ◯ Recuperative care ◯ In a motel ◯ Vehicle ◯ Shelter or with friend ◯ Streets

Comment:

Are you at risk for eviction? ◯ Yes ◯ No

If Yes, please explain:

Is anyone helping 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

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

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

◯ **No Concerns 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 ◯ TCRC ◯ Friendly Visitor ◯ Caregiver

◯ Religious/Spiritual ◯ Congregate Meal Services ◯ Support Group ◯ Other:

LEGAL INVOLVEMENT

◯ **No Concerns Noted**

Involvement with the following in the last 12 months:

◯ Court Ordered Services

◯ On Probation

◯ On Parole

◯ Re-entry Program

◯ 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:

◯ ***Multi-Senior Services Program(MSSP)**

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

◯ ***Assisted Living Waiver (ALW)**

◯ ***HIV/AIDS Waiver**

◯ ***HCBA Waiver for Individuals with Developmental Disabilities**

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

◯ ***CenCal Health Complex Case Management**

◯ ∞Hospice

*** Member can be enrolled in ECM or these programs, not in both at the same time.**

∞ Excluded for ECM enrollment

◯ Respite Services

◯ Meals on Wheels

◯ In Home Support Services

◯ Veterans Administration

◯ California Children's Services (CCS)

◯ Community Based Adult Services (CBAS)

◯ CalFresh Benefits

◯ County Specialty Mental Health

◯ Non-Medical Transportation

◯ Subsidized Housing

◯ Independent Living Resource Center

◯ Energy Assistance Program

◯ Free Government Phone

◯ TCRC (Tri County Regional Center)

◯ 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 and 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 two to six months.
- ◯ Newly sustained treatment adherence (medications, appointments).
- ◯ Newly integrated social support.
- ◯ Secured permanent housing within last three-six 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 six 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:**