

Enhanced Care Management (ECM)

Program Completion/Transition Questionnaire

This questionnaire supports clinical and care management assessment of a member's readiness for ECM program completion and/or transition to a lower level of care. It is comprised of two sections to be completed by the Lead Care Manager (LCM):

Section	How to complete the section
1: Member Self-Assessment	Ask the member and/or their authorized representative the questions and fill in their answers on the form
2: Care Manager Assessment	Consider questionnaire responses alongside clinical judgment, Care Plan progress, utilization history, social risk factors and interdisciplinary care team input

Member information

Member's name:

Date of birth:

Client Identification Number (CIN):

HPSM member ID#:

Today's date:

Section 1: Member Self-Assessment

1) Care Plan

I have met my Care Plan goals.

Yes No Other (if "Other" please explain): _____

2) Physical health

I can do the following on my own or with the help of a caregiver or support person	Yes (on my own)	Yes (with support)	No	N/A	Other
Know when I need to see my care provider					
Make medical appointments					
Track appointments on a calendar					
Keep appointments or call to reschedule/cancel in advance					
Call my primary care provider (PCP) or the Health Plan of San Mateo (HPSM) Nurse Advice Line					
Talk to my care provider about what is bothering me and ask questions					
Follow my care team's recommendations (such as eating right or exercising)					
Use the emergency room (ER) appropriately					
Attend telehealth appointments					
Take care of my health					
Ask for help when I need it					

I can do the following on my own or with the help of a caregiver or support person	Yes (on my own)	Yes (with support)	No	N/A	Other
Follow my care team's recommendations (such as eating right or exercising)					
Use the emergency room (ER) appropriately					
Attend telehealth appointments					
Take care of my health					
Ask for help when I need it					
Understand why I take each of my medicines					
Take my medicines as instructed by my doctor					
Find community resources and food pantries					
Call Member Services to ask questions or request services (such as changing my provider or asking for case management)					
Call HPSM to schedule rides for appointments or the pharmacy					
Understand the Member Bill of Rights					

3) Mental/emotional health

I can do the following on my own or with the help of a caregiver or support person	Yes (on my own)	Yes (with support)	No	N/A	Other
Understand my mental health diagnosis and treatment					
Know where and when to seek care					
Make informed decisions about care					
Recognize warning signs related to my emotional health/mental health diagnosis					
Recognize things that upset me and respond in a healthy way					
Understand why I take my medicines					
Know how to take my medicines					
Identify one or more people I can talk to (such as a support person or group)					
Manage my stress					

4) Housing

I can do the following on my own or with the help of a caregiver or support person	Yes (on my own)	Yes (with support)	No	N/A	Other
Have safe and stable housing					
Know how to find help if I need it					
Know my rights in my current housing situation					
Know how my actions can affect my housing (such as paying rent late, hoarding or smoking)					

I can do the following on my own or with the help of a caregiver or support person	Yes (on my own)	Yes (with support)	No	N/A	Other
Know how to maintain stable housing and communicate with my landlord/property manager when issues arise					

5) Daily living

I can do the following on my own or with the help of a caregiver or support person	Yes (on my own)	Yes (with support)	No	N/A	Other
Cook, clean and shop					
Ask for help when I need it					
Perform or get help with activities of daily living such as bathing, dressing, toileting, transferring, continence and feeding					
Get any supplies and equipment I need to live on my own that I don't already have					
Get food and transportation					
Get any records I need to prove my identity (such as my birth certificate, Social Security card or driver's license)					
Keep track of my money* and how and where I spend it (such as rent, bills and groceries)					

Section 2: Care Manager Assessment

- Based on the Member Self-Assessment, the member believes they have the knowledge, skills and supports needed to independently manage their health and social needs without ongoing ECM Services.
Yes No (if no, please describe the member's concerns or barriers)
- The member has demonstrated stability in utilization patterns over the past three to six months (e.g., reduced avoidable ER visits, inpatient admissions or crisis episodes).
Yes No (if "No" please explain)
- Select *one* of the three bolded options below, then provide additional details as required.

The member has met all Care Plan goals and is ready to graduate from ECM; a lower level of care management is *not required*.

Consider reassessment for continued ECM eligibility and support if "No" is selected for any answer to questions a-c or "Yes" is selected for question d	Yes	No
a) The member demonstrates sustained stability		
b) The member is able to independently access services with minimal ECM support		
c) Appropriate natural and/or community supports are in place		
d) I have ongoing safety concerns about the member (if "Yes" please explain)		

The member is prepared to move to a lower level of care.

Members transitioning from ECM who may benefit from ongoing care management should be referred to HPSM's Complex Care Management Program. Download, complete and submit the [Complex Case Management Referral form](#).

Referral Form Submission Date (DATE) _____

Identify any programs or services the member was linked to during ECM and any programs/services they are still linked to.

The member requires a new six-month authorization to continue ECM services. Include this form in your request for a six-month authorization for services.

Member Acknowledgment and Review

1) This ECM Member Self-Assessment was reviewed and completed with the:

Member Member's authorized representative

2) The LCM discussed the results of this assessment with the member/representative, including whether the member appears ready to graduate from ECM services or requires continued ECM services based on current needs. The member/representative:

- Was provided the opportunity to ask questions
- Verbalized understanding of the assessment outcome
- Verbalized understanding of the next steps in the care planning process

Yes No (if "No" please explain)

3) The LCM addressed the member's/representative's questions:

Yes No (if "No" please explain)

4) Member or authorized representative agrees with the plan:

Yes No (if "No" please explain)

LCM's name (please print):

LCM's signature:

Today's date: