Enhanced Care Management

Provider Program Guide

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Getting Ready to Provide Enhanced Care Management: The ECM Provider and Care Team

Enhanced Care Management (ECM) providers are community-based entities with experience and expertise in providing intensive, in-person care management services that focus on both the clinical and nonclinical needs of individuals. These entities specialize in providing culturally sensitive services primarily through in-person interaction in the communities where members, their families and support networks live, seek care and prefer to access services. CalOptima Health contracts with a diverse network of community-based providers to deliver ECM to members who qualify for services.

1.1 Provider Experience and Qualifications

I. A wide range of entities may operate as ECM providers, including but not limited to:
- Behavioral health entities
- California Children's Services (CCS)
- Community health centers
- Community mental health centers
- Community-Based Adult Services (CBAS) providers
- Community-based organizations (CBOs)
- Counties
- County behavioral health providers
- Federally Qualified Health Centers (FQHCs)
- First 5 county commissions
- Hospitals or hospital-based physician groups or clinics (including public, district and/or municipal public hospitals)
- Local health departments
- Organizations serving individuals experiencing homelessness
- Organizations serving justice-involved individuals
- Other qualified providers or entities not listed above, as approved by the Department of Health Care Services (DHCS)
- Primary care providers (PCPs), specialists or physician groups
- Regional centers
- Rural Health Clinics (RHCs)
- School-based health centers
- Skilled nursing facilities (SNFs)
- Substance use disorder (SUD) treatment providers

II. Qualifications for ECM providers include the following:
- Experience serving one or more of the ECM Populations of Focus (POFs)
- Experience and expertise in providing ECM services
- Ability to communicate in culturally and linguistically appropriate and accessible ways
- Capacity to provide culturally appropriate and timely in-person care management activities, including accompanying members to critical appointments when necessary
- Formal arrangements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health providers, specialists and other entities
- A care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support care management and implementation of care plans

ECM Population of Focus		Adults	Children and Youth
1a	Individuals Experiencing Homelessness: Adults Without Dependent Children/Youth Living With Them Experiencing Homelessness	✓	
1b	Individuals Experiencing Homelessness: Homeless Families or Unaccompanied Children/ Youth Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly High Utilizers)	✓	✓
3	Individuals With Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning From Incarceration	✓	✓
5	Adults Living in the Community and At Risk for Long-Term Care (LTC) Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in CCS or CCS Whole-Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	✓	✓

(Refer to the latest DHCS ECM Policy Guide for the most updated information)

The ECM provider must comply with all applicable state and federal laws and regulations and all ECM program requirements in the Department of Health Care Services (DHCS)-health plan ECM contract and associated guidance.

1.2 Provider Certification and Vetting Process

CalOptima Health has a robust provider certification and vetting process to identify providers best suited to fit the needs of its members. This process was developed to evaluate and verify the potential ECM provider's experience and expertise working with each POF, its ability to comply with ECM requirements as outlined by DHCS (including the provision of ECM core services to the POF) and the ability to submit data files and claims. The vetting and certification process includes an initial provider application as well as conversations and formal interviews between the provider and CalOptima Health's Medi-Cal and CalAIM departments, as well as any others as needed.

1.3 Medi-Cal Enrollment for ECM Providers

If a state-level enrollment pathway exists, the ECM provider will enroll as a Medi-Cal provider pursuant to relevant DHCS All Plan Letters (APLs). If there is no pathway for the organization to enroll in Medi-Cal as a provider, the ECM provider must comply with CalOptima Health's vetting process, which may extend to individuals employed by or delivering services on behalf of the ECM provider, to ensure it can meet the capabilities and standards required to be an ECM provider. CalOptima Health will request information from the ECM provider to fulfill this requirement. Medi-Cal enrollment is required for those ECM providers who will care for CalOptima Health's justice-involved POF members to bill Medi-Cal fee-for-service for specific prerelease services.

1.4 Credentialing and Contracting

ECM providers will work with CalOptima Health to successfully complete the credentialing process, establish and execute a business associate agreement and contract, and prepare to provide ECM services by the agreed-upon start date. If a provider is already contracted with CalOptima Health, an amendment to their original contract will be established and executed.

1.5 Staffing, Provider Capacity and Training

1.5.1 ECM Provider Care Team Staffing

Highly qualified and skilled multidisciplinary staff are essential to the success of the ECM benefit. ECM providers are required to develop and maintain a multidisciplinary care team, including all required care team roles and/or functions, to deliver ECM services to members. The ECM provider is responsible for maintaining adequate staff to carry out the required responsibilities for each assigned member consistent with the DHCS provider standard terms and conditions, the DHCS-Managed Care Plan (MCP) ECM Contract and any other related DHCS guidance. CalOptima Health will work to ensure all ECM providers' staffing models emphasize and optimize the roles of different team members while meeting the ECM requirements.

The ECM provider is responsible for maintaining, at a minimum, the following two roles/positions on the care team:

- Lead care managers (LCMs)
- ECM director/supervisor

Care team models may also include, at the ECM provider's discretion:

- ECM clinical consultant
- Community health workers (CHWs)

DHCS specifies that each ECM provider must have an LCM. An LCM is a member's designated care manager who works for the ECM provider organization. The LCM operates as part of the member's multidisciplinary care team and coordinates all aspects of ECM, including working with Community Supports providers, as applicable. To the extent a member has other care managers, the LCM is the primary care manager for the member and will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the member and non-duplication of services.

Details of the roles of the other care team members are listed below.

Lead Care Manager	
Qualifications	Professional (e.g., licensed mental health or behavioral health professional/ clinician, social worker or nurse) or paraprofessional (with appropriate training and oversight)
Role	• Responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the member and nonduplication of services • Engages eligible members • Oversees the provision of ECM services and implementation of the care plan • Offers services within CalOptima Health guidelines and where the member lives, seeks care or finds the most easily accessible • Connects member to other social services and supports the member may need, including transportation • Advocates on behalf of members with health care professionals • Uses motivational interviewing, trauma-informed care and harm-reduction approaches • Coordinates with hospital staff on discharge plan • Accompanies member to office visits, as needed and according to CalOptima Health guidelines • Monitors treatment adherence (including medication) • Provides health promotion and self-management training

ECM Director/Supervisor	
Qualifications	Ability to manage multidisciplinary care teams and provide direct oversight of LCMs.
Role	• Overall responsibility for the management of the ECM team • Responsible for oversight of ECM program quality measures and data reporting for the team • Signs off on each ECM care plan • Manages ratio of case managers to members • Responds to member or provider grievances • Identifies and communicates any program issues or barriers to CalOptima Health

ECM Clinical Consultant	
Qualifications	Clinician consultant, independently licensed clinician who may be a PCP, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed behavioral health care professional, social worker or other licensed behavioral health care professional
Role	• Responsible for ensuring clinical assessment elements leading to the creation of the plan of care are under the direction of an independently licensed clinician • Reviews and informs the care team • Identifies the need for and participates in Interdisciplinary Care Team (ICT) meetings when appropriate • Acts as clinical resource for care team, as needed • Facilitates access to primary care and behavioral health providers, as needed, to assist care coordinator and team

CHW (optional)	
Qualifications	Paraprofessional or licensed vocational nurse (LVN) or peer advocate.
Role	• Administrative support to care coordinator. • Engages and outreaches to eligible ECM members • Accompanies ECM member to office visits, as needed, and in the most easily accessible setting, within CalOptima Health guidelines • Promotes health and conducts self-management training • Arranges transportation • Assists with linkage to social supports • Distributes health promotion materials

As DHCS may provide additional guidance regarding staffing, this section of the guide may be updated in the future.

1.5.2 Staffing Ratios

CalOptima Health expects providers to staff appropriately for the POF being served with the goal of providing trauma-informed, person-centered care.

1.5.3 Provider Caseloads

The LCM caseload ratio recommendation is 30:1, but should not exceed 60:1.

1.5.4 Staffing and Capacity Report

ECM providers are required to submit an initial prospective staffing and capacity report to CalOptima Health before providing ECM. After ECM goes live, providers are required to submit staffing and capacity reports on at least a weekly and quarterly basis. The required report will include the following, subject to change:

- Team members' current caseload capacity for ECM-enrolled members (daily in CalOptima Health Connect)
- Total Number of Members (Adult) Currently Serving: Total number of adult members the ECM provider is currently serving at the end of the reporting period (quarterly)
- Total Number of Members (Children/Youth) Currently Serving: Total number of children/youth members the ECM provider is currently serving at the end of the reporting period (quarterly)

- Total ECM Provider Capacity (Adult) Able to Serve: Total number of adult members the ECM provider is able to serve at the end of the reporting period, regardless of whether the ECM provider is actually serving them (quarterly)
- Total ECM Provider Capacity (Children/Youth) Able to Serve: Total number of children/youth members the ECM provider is able to serve at the end of the reporting period, regardless of whether the ECM provider is actually serving them (quarterly)

CalOptima Health will utilize the report data provided to monitor the ECM provider's caseload thresholds.

1.5.5 Training

ECM providers are expected to participate in and complete CalOptima Health's ECM Academy. The ECM Academy consists of ongoing ECM training and technical assistance provided by CalOptima Health and its contracted training partners. It includes in-person sessions, webinars and/or calls, as necessary. The following modules are examples of the training provided:

Care Philosophy
• **Trauma-Informed Care 101** • **Harm Reduction and Introduction to Substance Use Disorder** • **Housing First** • **Health Equity** • **Social Determinants of Health 101** • **Cultural Humility and Implicit Bias** • **SOGI training – Gender and Sexual Orientation Affirming Care** • **Promoting Safety and De-escalation** • **Supporting Individuals With Substance Use Disorders** • **Disability Acceptance and Etiquette Training (DMC Provides)** • **Mental Health First Aid** • **Supporting Our Unhoused Neighbors**

ECM Service
• **ECM Core Service Components** • **ECM Policy Guide Review** • **Review of 14 Community Supports** • **Justice-Involved ECM Services Overview** • **Transitions of Care Services Overview & ICT Meetings Best Practices** • **Best Practices for Outreach & Engagement** • **BH Levels of Care: How to Navigate the System**

ECM Provider Administration and Operations
• **Claim Submissions and Operations** • **CalOptima Health Connect Training** • **Data and Reporting Requirements** • **Oversight and Monitoring**

ECM Member Eligibility, Assignment and Enrollment

This section outlines information regarding ECM member eligibility, assignment and enrollment (including disenrollment). This section also includes a description of the ECM eligibility screening and referral process.

2.1 ECM Eligibility Criteria

Medi-Cal managed care members are eligible for the ECM benefit if they meet the following eligibility criteria as part of one or more ECM POFs. ECM providers can serve one or more POF.

1. **Individuals and Families Experiencing Homelessness** **AND** have at least one complex physical, behavioral or developmental health need with an inability to successfully self-manage and for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services. See DHCS definition of homelessness below.

2. **Adults at Risk for Avoidable Hospital or Emergency Department (ED) Utilization** (formerly High Utilizers) are members with five or more ED visits **AND/OR** three or more unplanned hospital admissions and/or multiple short-term SNF stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

3. **Adults With Serious Mental Health or SUD Needs** who meet the eligibility criteria for participation in or obtaining services through the county Specialty Mental Health (SMH) services, the Drug Medi-Cal Organization Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program **AND** are actively experiencing one complex social factor influencing their health (e.g., food, housing or employment insecurities; history of adverse childhood experiences [ACEs]; history of recent contacts with law enforcement related to serious mental illness [SMI]/SUD; former foster youth, etc.) **AND** meet one or more of the following criteria: high risk for institutionalism, overdose and/or suicide; uses crisis services, EDs, urgent care or inpatient stays as the sole source of care; two-plus ED visits or two-plus hospitalizations due to SMI or SUD in the past 12 months; or are pregnant or postpartum (12 months from delivery).

4. **Adults Transitioning from Incarceration** or have transitioned within the last 12 months **AND** have at least one of the following conditions: Chronic mental illness, SUD, chronic disease (e.g., hepatitis C, diabetes), intellectual or developmental disability, traumatic brain injury, HIV, or pregnancy.

   This list of criteria is aligned with the eligibility criteria for prerelease coverage in California's 1115 Demonstration Amendment and Renewal Application (pg. 34): www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1115-Waiver-Renewal-Application.pdf

5. **Adults Living in the Community and at Risk for LTC Institutionalization** who, in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient nursing facility. Individuals must be able to live safely in the community with wraparound supports.

6. **Adult Nursing Facility Residents Transitioning to the Community**, who are strong candidates for successful transition back to the community and have a desire to do so.

7. **Children or Youth Up to Age 21** who are: (1) Unaccompanied children/youth experiencing homelessness, (2) At risk for avoidable hospital or ED utilization (formerly High Utilizers),

(3) Identified as having serious mental health or SUD needs, (4) Transitioning from a youth correctional facility, (5) Enrolled in CCS/CCS WCM with additional needs beyond CCS, (6) Involved in child welfare (including those with a history of involvement and foster care up to 26) **OR** (7) Pregnant or postpartum.

8. **Birth Equity Population of Focus** is individuals who are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

Based on the U.S. Department of Housing and Urban Development [HUD] definition of homelessness, with some modifications, DHCS defines homelessness as one of the following:

- An individual or family who lacks adequate nighttime residence
- An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation
- An individual or family living in a shelter
- An individual exiting an institution to homelessness
- An individual or family who will lose housing in the next 30 days
- Unaccompanied youth and homeless families with children and youth who are defined as homeless under other federal statutes
- Victims fleeing domestic violence
- Individuals exiting an institution who were homeless immediately prior to entering that institution, regardless of the length of the institutionalization

The timeframe for an individual or family who will imminently lose housing has been extended from 14 days (HUD definition) to 30 days. No further criteria are required to qualify for this ECM POF.

2.2 ECM Exclusion Criteria and ECM Overlapping Programs

DHCS examined other programs with an existing element of care management and/or care coordination to determine approaches to program coordination and to prevent duplication across programs. DHCS determined three potential approaches for how ECM may overlap with existing programs that provide care management/care coordination services, listed below, along with programs that fall under each category.

1. ECM and the other program

MCP members can be enrolled in both ECM and the other program. ECM enhances and/or coordinates across the case/care management available in the other program. MCP must ensure nonduplication of services between ECM and the other program.

2. Either ECM or the other program

MCP members can be enrolled in ECM or in the other program, but not in both at the same time.

3. Not Eligible to Enroll in ECM

Medi-Cal beneficiaries enrolled in the other program are excluded from ECM.

(Refer to the latest DHCS ECM Policy Guide for the most updated information)

CalOptima Health members with a share of cost, excluding LTC share of cost, are excluded from managed care and are thus not eligible for ECM. Given the number of care management and care coordination programs, initiatives or waivers in existence today, the exclusion and overlapping criteria are intended to ensure that the most appropriate individuals who would benefit from ECM can participate.

ECM providers are encouraged to review the latest DHCS guidance for more information on exclusion criteria and overlapping programs.

2.2.1 ECM Provider Expectations

If a member is receiving care management from multiple sources or systems of care, ECM providers are expected to coordinate across all sources or systems of care to provide care management. If a member is receiving care management or duplication of services from multiple sources/systems, ECM providers are expected to alert CalOptima Health. ECM providers are also expected to follow CalOptima Health instructions and participate in efforts to ensure ECM and other care management services are not duplicative.

2.3 Methods to Identify Potentially Eligible Members

Members may be identified as potentially eligible for the ECM benefit using multiple methods and may be referred via the following routes:

- **External/community referrals:** Referrals for ECM may be made on behalf of members and submitted by family members, homelessness services providers, shelters, recuperative care providers, community partners and other service providers.
- **ECM provider self-referrals:** ECM providers are encouraged to reach out to and identify members they serve in the community and believe would benefit from ECM and submit referrals on their behalf.
- **Member self-referrals:** Members who believe they meet the criteria for ECM can self-refer to the program by calling CalOptima Health's customer service line and requesting a referral.
- **POF List:** Contracted ECM providers are sent monthly lists of members who may potentially meet ECM eligibility criteria based on internal CalOptima Health data. Providers are required to utilize this list to identify, screen and enroll members into ECM services.

CalOptima Health may request supporting documentation from referring entities (e.g., ECM and non-ECM providers, members of other organizations) to assist in determining eligibility for members who are identified as potentially eligible for ECM. CalOptima Health will ask referring entities to complete and submit a referral form. CalOptima Health will provide the ECM referral form to providers, community partners and other relevant service providers to complete and submit to CalOptima Health. For members who have been assigned to a provider through the POF List, the providers can request ECM services authorization following member consent.

CalOptima Health is responsible for determining and communicating member assignments to ECM providers no later than 10 business days after ECM authorization. **ECM providers are responsible for immediately accepting all members assigned by CalOptima Health unless the provider has reached capacity for services.** If an ECM provider is at capacity, they must notify CalOptima Health that they cannot accept a new member assignment and update their Capacity page on CalOptima Health Connect.

2.3.1 ECM Eligibility Referral Process

ECM providers, non-ECM providers, CBOs and other entities are encouraged to refer members identified as potentially eligible for ECM directly to CalOptima Health. Providers may see members not listed on the POF List distributed to providers from CalOptima Health following a referral and authorization.

2.3.1.1 ECM Provider-Initiated Referral

If an ECM provider identifies a potentially eligible member who is not identified via the POF List, they should complete and submit the ECM Referral Form on CalOptima Health Connect with the member's information. Once the referral form is received and reviewed, CalOptima Health may follow up with the ECM provider to request supporting documentation and/or evidence to facilitate making an eligibility determination. Once CalOptima Health makes a final ECM eligibility determination for the member, CalOptima Health will notify the ECM provider. If the member is found to be ineligible and denied for ECM, the member will receive a Notice of Action (NOA) from CalOptima Health.

If the member meets the ECM eligibility criteria, the provider will conduct outreach for ECM services to engage the member. A letter informing both the member and the referring/servicing provider will be sent as confirmation. If the ECM provider is engaged and consents to services, they will submit an authorization request for full ECM services. Based on the information received, CalOptima Health will render a decision to authorize or deny services.

2.3.1.2 Member-Initiated Eligibility Referral

Members may self-refer to the ECM benefit by completing and submitting an ECM referral form. If a member needs assistance completing the form, they can: (1) contact CalOptima Health's Customer Service department or (2) work with an ECM provider to receive assistance. ECM providers must assist any member who expresses interest in enrolling or complete a referral form on their behalf if they determine the member may be eligible for ECM.

2.4 Outreach and Member Engagement

2.4.1 Requirements for Outreach and Engagement

Outreach and engagement of ECM-eligible members are critical for the program's success. ECM providers are responsible for conducting outreach to each member assigned on the POF List and engaging with the member to enroll them into ECM. The ECM provider is expected to conduct outreach primarily through in-person interaction where members and/or their families, guardians, caregivers and/or authorized support persons live, seek care or prefer to access services.

The ECM provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate and with the member's consent. The ECM provider is responsible for ensuring that secure teleconferencing and telehealth systems meet DHCS requirements. DHCS provides information on telehealth for Medi-Cal at www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx.

The ECM provider must use the following modalities, as appropriate and as authorized by the member, if in-person modalities are unsuccessful or to meet a member's stated contact preferences: mail/letter, email, texts, telephone calls and telehealth. CalOptima Health requires ECM providers to complete at least three outreach attempts, ensuring the outreach modality is appropriately spaced out, within 30 calendar days of the receipt of ECM data file/authorization. At least two different modalities are required to be used to reach members who are unable to be contacted in person before a member is identified as an unsuccessful engagement.

Once the ECM provider determines that a member is not reachable within 90 days, declines to participate, continues to disengage or meets an exclusion criterion, the ECM provider is expected to exclude the member from further outreach and report the information to CalOptima Health in the CalOptima Health Connect online portal and the CalOptima Health ECM Activity Log.

Member engagement and response will vary based on the member's specific circumstances. The ECM providers' outreach activity protocols to assigned members must include active, meaningful and progressive attempts to reach members each month between the initial 30-day and 90-day period, until each member is notified and engaged. The outreach and engagement expectations outlined in this section apply to assigned members not yet enrolled in ECM.

The ECM provider must comply with nondiscrimination requirements set forth in state and federal law and the contract with CalOptima Health.

2.5 Member Enrollment and Authorization/Initiation of Delivery of ECM Services

2.5.1 Confirm Member Eligibility

At the time of outreach, if the member expresses interest in opting into the ECM benefit, providers are requested to confirm member eligibility and appropriateness for ECM at that time. During initial engagement, ECM providers are expected to use methods appropriate to their workflow to identify, to the best of their ability, if the member meets any exclusion criteria or is enrolled in duplicative care coordination programs. The ECM referral form provided by CalOptima Health can be used to support ECM providers in determining eligibility during the member engagement and intake process. If a member has been assigned to an ECM provider via the POF List, the ECM provider is encouraged to submit a self-referral and an authorization request as soon as the member consents to services.

2.5.2 Member Consent to Enroll

It is essential to get the member's informed consent to participate in ECM. This is necessary to ensure the member is aware of the provider's expectations and to set expectations for care from the ECM provider. Member consent for enrollment can be provided verbally, and each ECM provider should document the consent in the member's file. CalOptima Health will request evidence of member consent as needed or applicable per any monitoring request.

2.5.3 Member Authorization for Data Sharing

The ECM provider is required to obtain, document and manage member authorization for the sharing of personally identifiable information between CalOptima Health and ECM, Community Supports and other providers involved in the provision of member care to the extent required by federal law. Member authorization for ECM-related data sharing is not required for the ECM provider to initiate delivery of ECM unless such authorization is required by federal law. When federal law requires authorization for data sharing (e.g., SUD treatment information as prescribed in 42 CFR Part 2), the ECM provider must communicate to CalOptima Health that it has obtained member authorization for such data sharing. For more information, see the DHCS CalAIM Data Sharing Authorization Guide.

2.5.4 Assign a Lead Care Manager

Upon initiation of ECM, the provider must assign each ECM-enrolled member an LCM. The LCM coordinates all covered medical and non-medical supportive services the member needs, including physical, behavioral, developmental and oral health, along with long-term services and supports

(LTSS), SMH services, DMS/DMS-ODS, any Community Supports and other services that address social determinants of health (SDOH), regardless of setting. Following authorization approval in CalOptima Health Connect, the ECM provider must indicate the LCM's name and contact information within CalOptima Health Connect and provide this information to the member.

2.5.5 Member Ability to Change LCM or ECM Provider

ECM members can request to change their LCM or ECM provider at any time by calling CalOptima Health Customer Service toll-free at **1-888-587-8077** (TTY **711**) Monday through Friday from 8 a.m. to 5:30 p.m.

2.5.5.1 Provider Expectations

Upon initiation of ECM, the ECM provider must advise the member on the process for changing ECM providers, which is permitted at any time. If the member wishes to change ECM providers, the provider must notify CalOptima Health. Members may also call the CalOptima Health Customer Services department to initiate a provider change. In addition, the member's right to choose between the ECM benefit and other duplicative programs must always be maintained.

2.5.5.2 CalOptima Health Expectations

CalOptima Health is required to implement any requested ECM provider change within 30 days.

2.6 ECM Service Provision Expectations

Providers are expected to ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and nonclinical needs of high-need and/or high-cost Medi-Cal members enrolled in managed care. The ECM provider must ensure the approach is person-centered, goal-oriented and culturally appropriate.

The ECM provider must collaborate with area hospitals, PCPs (when not serving as the ECM provider), behavioral health providers, specialists, dental providers, providers of LTSS services and other associated entities, such as Community Supports providers, as appropriate, to coordinate member care.

2.7 ECM Core Service Components

CalOptima Health will work closely with contracted ECM providers to deliver all core service components of ECM to each member assigned to the provider, in compliance with CalOptima Health's policies and procedures. The core services of ECM consist of the following:

2.7.1 Outreach and Engagement of CalOptima Health Members into ECM

See Section 2.4. of this provider reference guide.

2.7.2 Comprehensive Assessment and Care Management Plan

ECM providers are required to provide person-centered care management by working with the member to assess risks, needs, goals and preferences, and have a care management plan that coordinates and integrates all the member's clinical and non-clinical health care related needs. ECM providers are required to engage with each member authorized to receive ECM primarily through in-person contact. Public health precautions and recommendations should be used to accomplish the community-based, in-person approach of ECM. When in-person communication is unavailable or does not meet the needs of the member, the ECM provider is expected to use alternative methods (including telehealth) to provide culturally appropriate and accessible communication according to the member's choice.

2.7.3 Health Needs Assessment

After the initial step of engagement, ECM providers are required to conduct a comprehensive health needs assessment utilizing CalOptima Health's required template that identifies a member's needs in the areas of physical health, mental health, substance use, palliative care and social services/ SDOH. CalOptima Health's health needs assessment is used to assess an ECM member's current health status, establish a platform to build care management goals and develop an individualized care plan.

ECM providers are required to start a member's health needs assessment within 30 days and complete it within 60 days of the member's enrollment in ECM. While this is the requirement, ECM providers are encouraged to initiate and complete the assessment as soon as possible. ECM providers must reassess the member when clinically indicated, when new needs are identified or after transitions of care, but no less frequently than every six months. CalOptima Health recommends care plans be reviewed and/or updated during reassessments as well.

CalOptima Health provides a standardized ECM Health Needs Assessment Template for ECM providers to adopt as their comprehensive assessment tool and incorporate into their workflows and systems. In addition to the member assessment, ECM providers are encouraged to review health plan data and reports, electronic health records (EHRs), medications, and other available clinical and nonclinical data sources to inform the care plan. ECM providers are required to submit assessments at a frequency communicated by CalOptima Health.

2.7.4 Member Care Plan

ECM providers are required to create the member's care plan immediately following completion of the member's health needs assessment. The care plan is a dynamic and person-centered plan of care that is maintained by ECM providers and includes comprehensive input from the member and their authorized representative, PCP, specialists and other service providers in accordance with their wishes.

The care plan centers around the identification of a member's specific problems, opportunities, interventions and goals. CalOptima Health requires goals to be written in the SMART goal format (specific, measurable, achievable, realistic and time-bound). The ECM provider should update the member's care plan at least every six months or as appropriate when goals are modified, new needs or goals are identified, after transition of care, or when a member's health is reassessed. The care plan will track and coordinate information on referrals, appointments, key events, follow-ups and transitions in care. The ECM provider will document member acuity as part of the care plan and will maintain an appropriate level of contact with ECM members according to their health status and goals. ECM providers are required to provide a copy of the care plan to the member and their PCP. The care plan should be saved in the ECM provider's EHR or case management system.

2.7.5 Enhanced Coordination of Care

ECM providers are responsible for the ongoing care coordination of ECM-authorized members. ECM providers are encouraged to use Interdisciplinary Care Team (ICT) conferences to ensure integrated, effective implementation of the care management plan. Regular, frequent member support and coordination services are essential to the success of ECM. Member contact should be in person wherever feasible and possible. Key components to this service provision include:

- Member care plan implementation
- Continuous and integrated care
- Treatment adherence

- Communication
- Fostered and ongoing engagement with member

ECM providers are responsible for organizing patient care activities (as laid out in the care management plan) and for sharing information with the member's multidisciplinary care team. The care team's input is necessary for the successful implementation of member goals and needs. ECM providers are responsible for ensuring care is continuous and integrated among all service providers, including, but not limited to, those that see the member for developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services.

ECM providers are responsible for providing support to engage the member in their treatment, including coordinating medication review and/or reconciliation, scheduling appointments, p roviding appointment reminders, coordinating transportation, accompanying members to critical appointments, and identifying and helping to address other barriers to member engagement in treatment.

ECM providers are responsible for timely communication of the member's needs and preferences, ensuring safe, appropriate and effective person-centered care. ECM providers are responsible for ensuring regular contact with the member and their support — family members, authorized representatives, guardians, caregivers and/or authorized support persons — when appropriate, consistent with the care plan. Stakeholders, such as internal CalOptima Health business units, may also reach out to ECM providers to help coordinate care or follow up with members when necessary.

2.7.6 Health Promotion

ECM providers are responsible for health promotion, following the federal care coordination and continuity of care requirements (42 CFR 438.208[b]). Key components to this service include promoting member resilience and support, as well as healthy lifestyle changes. ECM providers are required to work with members to identify and build on successes, resiliencies and potential family and/or community support networks. ECM providers should provide services to encourage and support members to make lifestyle choices based on healthy behaviors, with the goal of supporting the members' ability to successfully monitor and manage their own health. ECM providers are required to support members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

2.7.7 Comprehensive Transitional Care

ECM providers are responsible for ensuring ECM members receive comprehensive Transitional Care Services (TCS). Key components of this service include focusing on supportive care transitions, resource coordination and medication review. ECM providers are required to develop strategies to reduce avoidable member admissions and readmissions for all members receiving ECM. ECM providers must support members who are experiencing or are likely to experience a care transition by conducting an assessment to evaluate a member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges.

When a member experiences a transition of care, CalOptima Health expects the ECM provider to conduct a reassessment and update the member's care plan to reflect changes in condition, new diagnoses, referrals to a specialist, a medication review and a revision of goals within 30 days post-discharge. The provider should then upload the care plan to CalOptima Health Connect.

2.7.8 Transitional Care Service Requirements

At a minimum, LCMs are to conduct the following TCS:

- Contact the member within 48 business hours of their being discharged
- Complete a Post-Discharge Assessment within 48 business hours of the member being discharged
  - » To meet the DHCS post-discharge reporting requirements, ECM providers must outreach to the member between day one and seven post discharge, with day 0 being the day of discharge.
  - » The facilitation of member needs on day zero and/or when the member is in the hospital does not account for any needs that arise once the member transitions to home.
  - » ECM providers may explain that a member should anticipate additional outreach in the next one to seven days for purposes of ensuring no new or urgent need has developed.
- Ensure collaboration, communication and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners and service providers to facilitate safe and successful transitions
- Create a discharge planning document that will be shared with the member, authorized representatives, treating providers (including PCPs) and discharging facilities
- Conduct necessary post-discharge services and follow-ups
- Create referrals to other appropriate resources

2.7.9 Member and Family Support Services

Providers are required to provide individual and family support services to the ECM member, with the goal of ensuring that both the member and their family/support persons are knowledgeable about the member's needs, care plan and follow-up. ECM providers are responsible for documenting a member's designated supports — family members, authorized representatives, guardians, caregivers and/or authorized support persons. ECM providers are also responsible for ensuring all appropriate authorizations are in place to ensure effective communication between ECM providers, the member and/or their family members, guardians, caregivers and/or authorized support persons, and CalOptima Health, as applicable. The ECM provider must identify supports needed for the member and/or their family members, authorized representatives, guardians, caregivers and/or authorized support persons to manage the member's condition and assist them in accessing needed support services. The ECM provider must provide appropriate education to the member and/or their family members, authorized representatives, guardians, caregivers and/or authorized support persons about care instructions for the member. The ECM provider must ensure the member has a copy of their care plan and information about how to request updates.

2.7.9.1 Coordination of and Referral to Community and Social Support Services

The ECM provider must determine non-clinical services and resources that are most appropriate to meet the needs of ECM members, including those that address SDOHs, such as housing and other services offered by CalOptima Health as Community Supports. The ECM provider is responsible for coordinating and referring members to available community resources, services and programs and following up with members to ensure services were rendered (i.e., closed-loop referrals). ECM providers are encouraged to build and strengthen relationships with local CBOs and providers to support ECM service provision and to maintain a comprehensive community resource directory.

2.8 Member Discontinuation

Providers will discontinue ECM services in CalOptima Health Connect by selecting one of the following reasons:

1. The member has met all care plan goals
2. The member is ready to transition to a lower level of care
3. The member no longer wishes to receive ECM or is unresponsive or unwilling to engage (this can include instances when a member's behavior or environment is unsafe for the ECM provider)
4. The ECM provider has not been able to connect with the member and/or parent, caregiver or guardian after multiple attempts
5. The member is incarcerated
6. The member declined to participate (from original outreach)
7. The member is enrolled in a duplicative program
8. The member lost Medi-Cal coverage (disenrolled)
9. The member switched health plans (disenrolled)
10. The member moved out of the county (disenrolled)
11. The member moved out of the country (disenrolled)
12. The member's behavior or environment is unsafe for the ECM provider
13. The member is not reauthorized for ECM services (this includes if the member no longer meets the criteria for ECM services, and the current authorization expired without being renewed. It also includes if the member did not align with any other reason, i.e., the member is ready to transition to a lower level of care)
14. The member is deceased
15. Other

CalOptima Health has developed policies and procedures for discontinuing ECM and the specific program graduation criteria CalOptima Health will apply to transition a member to a lower level of care management or coordination.

2.8.1 Program Completion Questionnaire

Based on the ECM program completion/step-down criteria, ECM providers are required to conduct a member reassessment by or before six months of enrollment in ECM. In general, members will be considered ready to graduate from ECM when they have completed their care plan goals and have demonstrated improvement in self-management of their physical and behavioral health, SDOHs and activities of daily living. CalOptima Health requires ECM LCMs to go over CalOptima Health's ECM Program Completion Questionnaire (found in Appendix D) with the member to help determine readiness for ECM program completion and/or transition out of ECM to a lower level of care management.

When a provider identifies a CalOptima Health member who is ready to graduate from ECM, the provider should conduct an ECM case conference with their internal multidisciplinary ECM team to review and ensure any resources and/or care coordination needs are in place for the member. CalOptima Health staff will attend these case conferences as appropriate and will support ECM providers in identifying appropriate resources and levels of care management for graduating members.

2.8.2 ECM Provider Initiated Disenrollment

The ECM provider must notify CalOptima Health to discontinue ECM for a member under any of the following circumstances:

- Member is no longer eligible for the benefit
- Member has met their ECM care plan goals
- Member is ready to transition to a lower level of care
- Member no longer wishes to receive ECM
- Member is unresponsive or unwilling to engage and/or ECM provider has not had any contact with the member despite multiple attempts
- Member dies

2.8.3 Member Initiated Disenrollment

A member can contact their ECM provider or CalOptima Health's Customer Service department at **888-587-8088** at any time to request to disenroll from ECM if they no longer wish to receive the benefit.

2.8.4 CalOptima Health Initiated Disenrollment

CalOptima Health will notify ECM providers, via the POF List, of members who no longer qualify for the ECM benefit.

2.8.5 The Notice of Action

2.8.5.1 CalOptima Health Expectations

When ECM is requested and denied, CalOptima Health is responsible for sending a NOA notifying the member of the denial/discontinuation of the ECM benefit and ensuring the member is informed of their right to appeal and the appeals process. CalOptima Health ensures authorization or a decision not to authorize ECM occurs in accordance with existing federal and state regulations for processing grievances and appeals.

The Medi-Cal NOA is a written notice that explains an individual's eligibility for Medi-Cal coverage or benefits. The NOA letter includes the eligibility decision, effective date of coverage, and any changes made in an individual's eligibility status or level of benefits. The NOA letter includes information about how an individual may appeal a decision if the individual disagrees with the eligibility determination.

In addition, ECM is subject to standard utilization management medical authorization time frames.

2.8.5.2 ECM Provider Expectations

If a member does not qualify for ECM and receives a NOA, the ECM provider will communicate to the member other benefits or programs that may be available to the member, as applicable (e.g., complex care management, basic care management, etc.).

2.8.6 Complaints, Grievances and Appeals

CalOptima Health's standard grievance and appeals process applies to all members enrolled in ECM. If a member has concerns or complaints, the member can contact the CalOptima Health Customer Service department at **888-587-8088**. If the member feels they have been wrongfully denied enrollment or wrongfully disenrolled from ECM, the member can initiate an appeal via CalOptima Health's existing complaints, grievances and appeals process, available online at www.caloptima.org/en/health-insurance-plans/medi-cal/your-rights.

2.9 Data to Support ECM

2.9.1 Care Management Documentation System or Process

The ECM provider must use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities, including CalOptima Health, ECM, Community Supports and other county and community-based providers. The documentation system should support the member's care management and help facilitate the process of sharing the member's care plan with other providers and organizations involved in each member's care.

Care management documentation systems may include certified EHR technology or other documentation tools that can support the documentation of:

- Member's enrollment into ECM
- Member's authorization/approval to release information to other providers in the care team and anyone involved in the execution of the care plan
- Member's goals and goal attainment status as part of the member's care plan
- Member's care coordination and care management needs (e.g., allow for documenting closed-loop referrals to ensure the follow-up with the member is tracked and completed)
- Information from other sources to identify member needs
- The development and assignment of care team tasks
- Care team coordination and communication
- Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status)
- Referrals to other providers and support persons
- Screenings and assessments (e.g., health risk assessment, PHQ-9, etc.)

Care management documentation systems also need to be able to:

- Support the sharing of the member's care plan amongst the member's care team
- Support the sharing of the member's assessment, care plan and other required data to CalOptima Health, as requested
- Assist with informing the ECM provider's regular reporting to CalOptima Health, as requested
- Support and track the ECM services provided to the member to enable ECM providers to appropriately submit claims to CalOptima Health

2.9.2 Provision of Data/Reports from CalOptima Health to the ECM Provider

CalOptima Health and the ECM provider will exchange data on members on a regular basis. CalOptima Health will provide the following data to the ECM provider at the time of assignment and periodically thereafter, following DHCS guidance for data sharing where applicable:

- POF List, defined as a list of Medi-Cal members eligible for ECM and assigned to the ECM provider
- Encounter and/or claims data, including admission, discharge and transfer (ADT) data feeds
- Physical, behavioral, administrative and SDOH data for all assigned members
- Reports of performance on quality measures and/or metrics, as requested

2.9.3 Provision of Data/Reports from the ECM Provider to CalOptima Health

ECM providers are responsible for submitting required reports to CalOptima Health. Required ECM provider reports include, but are not limited to, the following:

- Weekly ECM Activity Log
- Staffing and capacity reports

2.9.4 Data and File Exchange Operations

On a regular basis, ECM providers must retrieve the ECM POF List file via secure file transfer protocol (SFTP) or from the CalOptima Health Connect site that contains assigned members who are eligible to receive ECM services, including both new and existing members.

At least on a weekly basis, ECM providers must update and report back to CalOptima Health on the ECM Activity Log via an SFTP file upload or CalOptima Health Connect Activity Log, identifying the services provided and status of each eligible and enrolled ECM member. Reporting requirements for ECM providers will be defined by DHCS. CalOptima Health may also utilize the SFTP or CalOptima Health Connect site to exchange other data files to support ECM provider service delivery.

APPENDIX A.

3.1 Claims Submission

The ECM provider is required to submit all claims for the provision of ECM-related services to CalOptima Health using the national standard specifications and code sets to be defined by DHCS as evidence of all ECM services provided to members. Providers can find the DHCS Coding Guidance on DHCS' website and in Appendix C of this policy guide. This ensures that CalOptima Health can effectively monitor the volume and frequency of ECM service provision and shows the true cost of providing ECM services to CalOptima Health and DHCS.

Paper claims may be submitted using the most current CMS-1500 or UB-04 form in accordance with standard guidelines. For fastest delivery and processing, claims can be submitted electronically using the HIPAA 5010 standard 837I (005010X223A2) and 837P (005010X222A1) transaction via a claims clearinghouse. For more information on CalOptima Health's contracted claims clearinghouse vendor, please contact your ECM provider liaison. Each claim submitted must include all mandatory and situational elements, where applicable.

An ECM provider will submit a claim for covered services within 365 calendar days after the date of service.

In the event the ECM provider is unable to submit claims to CalOptima Health for ECM-related services using the national standard specifications and DHCS-defined code sets, the ECM provider can submit an invoice to CalOptima Health with a minimum set of data elements necessary for CalOptima Health to convert the invoice to an encounter for submission to DHCS. Invoices can be submitted via CalOptima Health Connect.

For more information on claims submission and payment, refer to CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible and Policy FF.4002: Special Payments: Enhanced Care Management Supplemental Payment.

3.2 Billing for ECM services rendered

CalOptima Health requires ECM providers to bill for all ECM services rendered, whether the cumulative units billed exceed the eight units/two hours per calendar month reimbursement threshold. CalOptima Health reports all claims by members to DHCS, and without accurate reporting, CalOptima Health cannot demonstrate the full scope of the care provided or any adjustments needed for reimbursement.

APPENDIX B.

4.1 Quality, Monitoring and Oversight

CalOptima Health will regularly monitor ECM provider performance and compliance with ECM requirements using a variety of methods, which may include monitoring calls, on-site visits, progress reports, audits and/or corrective actions, as needed.

CalOptima Health medical directors conduct individual meeting sessions with ECM providers to discuss members with complex clinical needs, including those identified by CalOptima Health, such as high ED utilization. Medical director oversight helps ensure that ECM providers optimize the coordination of complex clinical issues, there is member engagement, and care plans appropriately address the member's complex clinical needs.

CalOptima Health will also conduct audits of ECM providers to ensure the quality of ECM and ongoing compliance with program requirements. ECM providers are provided with instructions and guidance prior to conducting an audit. This includes but is not limited to:

- ECM Audit Tool
- ECM Audit Response Template

To begin the ECM audit process, CalOptima Health will:

- Share the ECM Audit Tool and Audit Response Template
- Select five members who have been in ECM for at least six months with submitted claims, when allowable
- Email ECM providers the five members' client index numbers (CINs) and request that member documentation be submitted for each member via email if documentation is not saved in CalOptima Health Connect
- Use the ECM Audit Tool to conduct the audit and calculate an average audit score across the five members audited
- Email ECM providers their audit results and schedule a meeting to review results

ECM providers must achieve a minimum score greater than or equal to 80% on the annual audit. A score of less than 80% will result in the implementation of a corrective action plan (CAP) to address deficiencies and ensure contractual compliance. The purpose of the CAP process is to initiate a plan for the ECM provider to address deficiencies found in the audit and enforce CalOptima Health's policies and state regulatory requirements.

For ECM providers who require a CAP, CalOptima Health will email a CAP Letter and a CAP Template with identified deadlines. ECM providers must sign the CAP Letter, complete the CAP Template and return them to CalOptima Health within five business days of receipt. CalOptima Health will complete a secondary audit for the ECM providers who received a CAP 60 days after the CAP letter date. The secondary audit will include three randomly selected new member files who have been in ECM for at least six months with submitted claims, when allowable. ECM provider must receive a minimum score of 80% to ensure continuing participation. Failure to achieve an 80% will result in the termination of the contract for ECM services.

The ECM provider must respond to all CalOptima Health requests for information and documentation for ongoing monitoring of ECM as required by contract.

APPENDIX C.

5.1 ECM Coding Guidance

The codes below are 15-minute units.

DHCS guidance:
www.dhcs.ca.gov/Documents/MCQMD/Coding-Options-for-ECM-and-Community-Supports.pdf

G9008 - ECM Services Rendered by Clinical Staff	
Modifier	**Description**
U1	Services provided to an ECM enrolled member in person
U1GQ	Services provided to an ECM enrolled member via telehealth or telephone
U8	Pre-enrollment outreach ECM services provided to a member in person
U8GQ	Pre-enrollment outreach ECM services provided to a member via telehealth or telephone. Can include individualized text messages or secure email
G9012 - ECM Services Rendered by Non-Clinical Staff	
Modifier	**Description**
U2	Services provided to an ECM enrolled member in person
U2GQ	Services provided to an ECM enrolled member via telehealth or telephone
U8	Pre-enrollment outreach ECM services provided to a member in person
U8GQ	Pre-enrollment outreach ECM services provided to a member via telehealth or telephone. Can include individualized text messages or secure email
G9007 – ECM Services Rendered by Multidisciplinary Team	
Modifier	**Description**
None	Services provided when a multidisciplinary team conference occurs. Provided/initiated by the ECM provider's clinical staff

APPENDIX D.

6.1 ECM Provider Assignment Algorithm (PAA) for the Adult POFs

Assumptions:

1. Members eligible via the POF List that Enterprise Analytics (EA) creates will be part of a specific POF.
2. Members on the POF List will be assigned to an ECM provider based on the ECM PAA (see chart below).
3. Members not on the POF List will require referral submission.
    a. Members who meet the criteria will be added to the POF List and follow ECM PAA.
4. Any POF without a provider will be removed from the ECM PAA.
5. Once the POF is confirmed for the member, assignment will be based on the following in descending order:
    a. Capacity
    b. Prior relationship
    c. Geographic location
6. Health networks will remain as ECM providers for POF No. 2.
7. Due to the duplication of services between the programs, members actively involved in WCM and eligible for ECM will not be included in any of the POF Lists.

ECM PAA (Highest to Lowest of Specialization of Care for POF):

Population of Focus Assignment Order
1. Population of Focus No. 6: Adult Nursing Facility Residents Transitioning to the Community
2. Population of Focus No. 4: Individuals Transitioning from Incarceration (Justice Involved)
3. Population of Focus No. 9: Birth Equity
4. Population of Focus No. 3: Individuals with SMI/SUD Needs
5. Population of Focus No. 1: Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness
6. Population of Focus No. 2: Individuals at Risk for Avoidable Hospital or ED Utilization
7. Population of Focus No. 5: Adults Living in the Community and at Risk for LTC Institutionalization

APPENDIX E.

7.1 ECM PAA for the Children/Youth Populations of Focus

Assumptions:

1. Members eligible via the POF List that Enterprise Analytics (EA) creates will be part of a specific POF.
2. Members on the POF List will be assigned to an ECM provider based on the ECM PAA (see chart below).
3. Members not on the POF List will require referral submission.
    a. Members who meet the criteria will be added to the POF List and follow ECM PAA.
4. Any POF without a provider will be removed from the ECM PAA.
5. Once the POF is confirmed for the member, an assignment will be based on the following in descending order:
    a. Capacity
    b. Prior relationship
    c. Geographic location
6. Health networks will remain as ECM providers for POF No. 2.
7. Due to the duplication of services between the programs, members actively involved in WCM and eligible for ECM will not be included in any of the POF Lists.

ECM PAA (Highest to Lowest of Specialization of Care for Population of Focus):

Population of Focus Assignment Order
1. Population of Focus No. 4: Individuals Transitioning from Incarceration (Justice Involved)
2. Population of Focus No. 7: Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition
3. Population of Focus No. 8: Children and Youth Involved in Child Welfare
4. Population of Focus No. 9: Birth Equity
5. Population of Focus No. 3: Individuals with SMI/SUD Needs
6. Population of Focus No. 1: Individuals Experiencing Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness
7. Population of Focus No. 2: Individuals at Risk for Avoidable Hospital or ED Utilization

APPENDIX F.

8.1 ECM Program Templates

The following ECM templates are effective as of July 1, 2025. ECM providers are to adapt these templates to serve ECM members and adhere to the timing of completing each template as specified below.

ECM template	Requirement	Timing Completion	Notes
Welcome Letter	Not required but strongly recommended	If using the letter as part of notifying the member of ECM enrollment, it must be shared with the member within 10 calendar days of the authorization date.	If your organization has an existing letter, please send us a copy for review. Please document in a progress note the date the document is mailed/ shared with the member.
Health Needs Assessments **1. Child and Youth** **2. Adult**	Required	Must be completed within 60 calendar days of ECM authorization date.	If your organization uses a comprehensive assessment comparable to this assessment, please let us review.
Care Plan **1. Member facing care plan** **2. Tracking requirements**	Required	The care plan must be completed at the time of the assessment or no more than 10 days from the assessment completion date. **The care plan is required to be reviewed by an ECM supervisor/director upon completion and when notable updates are made .**	If your organization uses a comprehensive member-facing care plan comparable to this care plan, please let us review. The care plan tracking requirement template is to be used if the ECM provider cannot track documentation in a HIPAA-compliant system. This document's components are required to ensure that tracking and progress are documented.
Post-Discharge Assessment	Required	Must be completed within 48 business hours of the member getting discharged.	If the assessment is not completed, please document the reasons in a progress note.
Program Completion Questionnaire	Required.	Must be completed within seven calendar days of ending the ECM authorization.	If the form is not signed, please document the reason in a progress note

ECM Provider Logo

California Advancing and Innovating Medi-Cal (CalAIM)
Enhanced Care Management
Welcome Letter

Dear Member:

[ECM Provider Name] would like to tell you about a new Medi-Cal benefit called Enhanced Care Management (ECM). ECM provides services to members who can benefit from extra help. This service can help you stay healthy by coordinating the care you get from different doctors and providers. You can decide if you want to participate in ECM services. If you choose not to participate, your current services will not change.

What are ECM services?
Now that you are enrolled in ECM, the ECM Lead Care Manager below will be assigned to you. They will talk to you and your doctors, mental health providers, specialists, pharmacists, case managers, social services providers and others to make sure they work together to give you the care you need.

Your ECM Lead Care Manager can help you:

- Find doctors and get appointments for health-related services you may need
- Better understand and keep track of your medicines
- Set up a ride for your doctor visits
- Find and apply for community-based services based on your needs, like housing support or medically nutritious food
- Get follow-up care after you leave the hospital or after an emergency room visit
- Access behavioral health (mental health) services

ECM Lead Care Manager	**Phone Number**

I, _____ (member) agreed to participate in ECM.

Member Signature: _____ Date: _____.

Questions?
For questions about ECM, talk with your ECM Lead Care Manager or call [ECM Provider Name] [Phone Number] [ECM Provider Address].

Changing ECM Provider and/or Lead Care Manager
If you would like to change your ECM provider and/or Lead Care Manager at any time, please call CalOptima Health Customer Service toll-free at **1-888-587-8088** (TTY **711**) Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language.

Stopping ECM Services
Being a part of ECM is your choice. If you would like to stop ECM at any time, please let your ECM provider know or call CalOptima Health Customer Service toll-free at **1-888-587-8088** (TTY **711**) Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language.

Sincerely,

[ECM Provider Name]

Enhanced Care Management (ECM) Comprehensive Children Youth (C/Y) Assessment

Background Information

This assessment is designed as a tool for you, as Lead Care Manager, to assess a C/Y member's health needs and help the C/Y member participate in the Enhanced Care Management benefit. Today and over the next 1-3 visits, you and the C/Y member/authorized representative will complete this assessment together, and from there develop goals and next steps that support the C/Y member's overall health and wellness. **See appendix for list of terms used**.

Date Started:	**Date Completed:**

Section 1. Member and Family Demographics. C/Y Member's Needs / Preferences.

Primary Point of Contact for ECM Services: ☐ C/Y Member ☐Parent/Guardian/Caregiver ☐ Other (list):	Person(s) you are speaking with to complete this assessment (select all that apply): ☐ C/Y Member ☐ Parent/Guardian/Caregiver ☐ Other (list):
C/Y member name:	
Date of Birth:	Medi-Cal ID /CIN #:
C/Y member's preferred name and/or pronouns:	C/Y member's gender identification:
Preferred written/spoken language (what language are you most comfortable speaking and reading?): C/Y: Parent/Guardian/Caregiver:	Interpreter needed: ☐ Yes ☐ No Language:

Do you have any cultural, religious, and/or spiritual beliefs that are important to your family's health and wellness?
☐ Yes ☐ No ☐ Declined to Answer.
If yes, describe:

Relationship status of C/Y member: ☐ N/A ☐ Single ☐ Married ☐ Divorced ☐ Domestic partnership ☐ Widower ☐ Declined to Answer ☐ Other:	Relationship status of Parent/Guardian/Caregiver: ☐ N/A ☐ Single ☐ Married ☐ Divorced ☐ Domestic partnership ☐ Widower ☐ Declined to Answer ☐ Other:

Parent Guardian/Caregiver Name:
Contact Information:
☐ Biological ☐ Adoptive ☐ Foster ☐ Guardian/Conservator ☐ Court Appointed Guardian
☐ Joint Legal Custody ☐ Sole Legal Custody ☐ Joint Physical Custody ☐ Sole Physical Custody
☐ Unaccompanied Youth/Minor ☐ Asylum Seeker ☐ N/A Emancipated Minor

C/Y member's nationality/tribe/ethnicity: Select all that apply.
☐ Hispanic or Latino ☐ Asian ☐ Pacific Islander / Native Hawaiian ☐ White ☐ Black / African American
☐ American Indian / Alaskan Native ☐ Other:

C/Y member's current level of education:
☐ Elementary school ☐ Junior high school ☐ High school ☐ Some College ☐ College completed
☐ Technical school or training ☐ N/A ☐ Other (list):

Does the C/Y member have a caregiver assisting them? ☐ Yes ☐ No
If provided, list names and contact information:

Does the C/Y member have an In-Home Supportive Services (IHSS) worker? ☐ Yes ☐ No

Section 1. Member and Family Demographics. C/Y Member's Needs / Preferences.

If yes, please provide the IHSS worker's name(s) and contact information:

Does the C/Y member need a caregiver?
☐ Yes ☐ No
If yes, please explain:

Does the C/Y member's caregiver need additional help or training to provide care?
☐ Yes ☐ No
If yes, please explain:

Additional family members or other caregivers assisting the C/Y member (for example, daycare, nanny, family member, friends, siblings)?
☐ Yes ☐ No ☐ N/A ☐ Declined to Answer
If yes, (list):

C/Y Member Needs and Preferences

What is the C/Y member's most important issue or need right now, as related to health, wellness, living situation, or something else?

Contact Information

Preferred place to receive mail:	Home phone(s):	Cell Phone(s):	Email Address(es):

Preferred method of contact (select all that apply): ☐ In-Person ☐ Phone ☐ Email ☐ Text

Emergency Contact Name:	Relationship:	Contact Information:

Section 2. Indicate the C/Y member's Population of Focus and other Orange County Programs the C/Y member is involved in.

The purpose of this section is to identify other programs the C/Y member is involved in; and support you to coordinate the C/Y member's care and health-related social needs. Select the Population Of Focus (POF) as identified in the referral form.

☐ Experiencing Homelessness	☐ At Risk for Avoidable Hospital/ED Utilization	☐ Justice Involved: Transition from Youth Correctional Facility	☐ CSS or CSS WCM	☐ Foster Care: Child Welfare	☐ Serious Mental Health or Substance Use Disorder	☐ Birth Equity: Pregnant/Postpartum

Programs the C/Y Member is Involved in:

☐ SMHS	☐ DMC	☐ DMC - ODS	☐CCS	☐ Juvenile Justice
☐ CCS WMC	☐ Child Welfare		☐ Regional Center Services	

☐ Local program serving pregnant/postpartum individuals (e.g., Comprehensive Perinatal Services Program [CPSP], California Home Visiting Program [HVP], etc.)
List:

☐ Other(s), List:	☐ N/A

ECM Enrollment and Consent

Date of Consent:	☐ Verbal ☐ Written ☐ C/Y Member ☐ DCFS ☐ Parent/Guardian/Caregiver ☐ Court ☐ Foster parent(s) If caregiver/authorized representative provided consent, please provide the name of the individual:

ECM Enrollment and Consent

Is anyone else in the family enrolled in ECM? ☐Yes ☐No
If yes, list family member name(s), relationship(s) to C/Y member, and ECM Provider(s):

Indicate if you used any of the following, recently completed assessment or tools to complete/inform this assessment.

The Lead Care Manager should incorporate findings from all available assessments. Assessments do not replace this comprehensive assessment but should inform development of the care plan.

☐ ACEs or PEARLS	☐ Yes.	☐ No ☐ N/A

If no ACEs or PEARLS screening were completed, refer to PCP/SW for screening.

☐ CANS Assessment[1]	☐ Yes	☐ No ☐ N/A
☐ PSC-35[2]	☐ Yes	☐ No ☐ N/A
☐ Needs Evaluation Tool[3]	☐ Yes	☐ No ☐ N/A
☐ Youth Screening Tool[4]	☐ Yes	☐ No ☐ N/A
☐ (DPH Foster Care) Child Health Evaluation	☐ Yes	☐ No ☐ N/A
☐ Protective Factors Survey[5]	☐ Yes	☐ No ☐ N/A
☐ (DCFS) Multidisciplinary Assessment Team[6]	☐ Yes	☐ No ☐ N/A
☐ (CCS) Patient Care Assessment	☐ Yes	☐ No ☐ N/A
☐ (DDS) Regional Center Assessment	☐ Yes	☐ No ☐ N/A
☐ (Pregnant/Postpartum) CPSP Assessment	☐ Yes	☐ No ☐ N/A
☐ (Justice Involved) Re-entry Transition Plan	☐ Yes	☐ No ☐ N/A

☐ Other(s) (list with date completed):

Section 3. Health Literacy

The following questions will be used to assess how the C/Y member (or their parent/guardian/caregiver, if applicable) believes they are managing their health conditions.

Does the C/Y member (or their parent/guardian/caregiver, if applicable) need education or resources to help them understand the C/Y member's care and treatment needs?

☐Yes ☐No ☐N/A ☐Declined to Answer

Does the C/Y member (or their parent/guardian/caregiver, if applicable) express needing help in answering questions during a doctor's visit? ☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

Does the C/Y member (or their parent/guardian/caregiver, if applicable) express needing help in filling out health forms?
☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

Does the C/Y member (or their parent/guardian/caregiver, if applicable) express needing help with managing and taking medications?

☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

[1] The Child and Adolescent Needs and Strengths Assessment is used by DCFS/Child Welfare and by SMHS/DMH
[2] The Pediatric Symptom Checklist is used by SMHS/DMH
[3] The Needs Evaluation Tool is used by DMH
[4] The Youth Screening Tool is used for Medi-Cal Mental Health Services, DHCS
[5] The PFS is used by the Prevention and Aftercare Network, DCFS
[6] The Multidisciplinary Assessment Team includes their level of care tool and the Resource Family Reporting Tool, used by DMH for a child newly entering the foster care system

Section 4. Physical Health

The following questions will be used to assess the C/Y member's current physical health needs and conditions.

Has the C/Y member (or their parent/guardian/caregiver, if applicable) been told by a doctor or medical provider that they have any medical conditions? ☐ Yes ☐No ☐N/A
If yes, please check all that apply:

☐ Asthma/Chronic Lung Disease	☐ Hypertension *(high blood pressure)*	☐ Physical disability/para /quadriplegic/amputation	☐ Muscular Dystrophy
☐ Cancer	☐ Cystic Fibrosis	☐ Kidney Disease	☐ Spina Bifida
☐ Pre-Diabetes	☐ Diabetes Type 1	☐ Diabetes Type 2	☐ Seizures/Epilepsy
☐ Sickle Cell Disease	☐ Organ Transplant (list):		
☐ Genetic condition(s) (list):		Other conditions not listed above (list):	

Does the C/Y member have trouble with vision?
☐Yes ☐No If yes, describe:

Glasses/Contacts: ☐Yes ☐No ☐ Need
TTY (visual support): ☐Yes ☐No ☐ Need
Other:

If the C/Y member has diabetes, has a Diabetic Eye Exam been done in the last year?
☐Yes ☐No ☐ N/A

Does the C/Y member have trouble with hearing? ☐Yes ☐ No If yes, describe:

Hearing Devices(s): ☐Yes (list): _____ ☐ No ☐ Need

In general, would the C/Y member (or their parent/guardian/caregiver, if applicable) say their physical health is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Declined to Answer
Please give more information about why the C/Y member (or parent/guardian/caregiver) chose this rating:

Has the C/Y member been to the hospital, emergency room, or a skilled nursing facility in the past 12 months?
☐Yes ☐No ☐ N/A ☐ Declined to Answer
If yes, how many times and what for? (list all):

Does the C/Y member have a regular primary health care provider or Medical Home: ☐Yes ☐ No
If yes, please fill out the following information.

Name of Primary Care Provider:	
Contact Number:	
Office Address:	
Purpose of Last Visit:	
Date of Last Visit (if known or approximate date):	

Does the C/Y member have a regular dentist or Dental Home: ☐Yes ☐ No
If yes, please fill out the following information.

Name of Primary Care Provider:	
Contact Number:	
Office Address:	
Purpose of Last Visit:	
Date of Last Visit (if known or approximate date):	

Does the C/Y member currently have any dental issues or needs? ☐Yes ☐No ☐ N/A ☐ Declined to Answer

Section 4. Physical Health

Does the C/Y member receive care from any additional providers/specialists (mark all that apply):

☐ Cardiology	☐ Developmental-Behavioral Pediatrics	☐ Immunology/Infectious Disease	☐ Endocrinology
☐ Hematology	☐ Neurology	☐ Oncology	☐ Orthopedics
☐ Respite	☐ Physical Therapy	☐ Occupational Therapy	☐ Speech Therapy
☐ Other (list):			

Medications

Please tell me what medications the C/Y member is currently taking. Please attach a list if needed for additional medications.

Medication Name	How Often (Frequency)	How Administered (Route)[7]	Dosage	Pharmacy Name/Location

Has the C/Y member (or their parent/guardian/caregiver, if applicable) had difficulty filling the Member's medications in the last year? ☐ Yes ☐ No

If yes, explain why:

Were there any days in the past week the C/Y member did not take medications as prescribed? ☐ Yes ☐ No

If yes, please describe what gets in the way:

Pain and Symptom Management

Does the C/Y member currently experience pain? ☐ Yes ☐ No ☐ Declined to Answer

If yes, answer the questions below.

During the past week, how much did the C/Y member's pain, or medical condition, interfere with normal activities (including going to school, playing with friends, or working outside the home and/or housework)?

☐Not at all	☐A little bit	☐Moderately	☐Quite a bit	☐Extremely	☐Declined to Answer

Does the C/Y member have supports, services, or routines to help them manage their pain and/or medical condition(s) (e.g., palliative care provider, meditation, therapies [list], medications, family/friend support)? Write in the space below if applicable.

☐Yes ☐No ☐Declined to Answer

If yes, please write below which supports, services, or routines the C/Y member currently has.

Section 5. Pregnancy/Postpartum

Only complete if C/Y member is of child-bearing age. *If not, skip to Section 6***.**

☐ Questions not reviewed for C/Y Member (child has not reached puberty/first menstrual period)

[7] A medication route means by which a drug is introduced into the body - such as oral or intravenous.

Section 5. Pregnancy/Postpartum

☐ Questions not reviewed for C/Y Member (other reason – indicate reason):

Is the C/Y member currently pregnant? ☐Yes ☐No ☐N/A ☐Declined to Answer
If no or N/A, skip to postpartum questions.

Pregnancy and Postpartum Questions

If yes, how many weeks pregnant?

Has the pregnancy been disclosed to the parent/guardian/caregiver? ☐Yes ☐No ☐N/A

Has the C/Y member given birth in the last 12 months? ☐Yes ☐No ☐N/A ☐Declined to Answer

If yes to currently pregnant, please complete below.

Expected Date of Delivery: ☐Not Sure ☐Declined to Answer

First prenatal care appointment (date and weeks): ☐Not Sure ☐Declined to Answer

Does the Member have an OB or midwife? ☐Yes ☐No ☐Declined to Answer

Does the Member have a doula or do they plan to have a doula? ☐Yes ☐No ☐Declined to Answer

Does the Member know where they plan to deliver the baby? ☐Yes ☐No ☐Declined to Answer

Does the Member plan to breastfeed? ☐Yes ☐No ☐Unsure ☐Declined to Answer

Has the Member selected a pediatrician for the baby? ☐Yes ☐No ☐Declined to Answer

If yes, please fill out the following information.

Name of Primary Care Provider:	
Contact Number:	
Office Address:	

Does the C/Y member have the essentials they need for when baby comes home from the hospital (e.g. car seat, formula, blankets, crib, clothes, diapers, bottles? ☐Yes ☐No ☐Declined to Answer

If no, list what the Member needs:

Does the C/Y member plan to go to any birthing classes? ☐Yes ☐No ☐Declined to Answer

Does the C/Y member need education/resources on pregnancy, breastfeeding and infant health?
☐Yes ☐No ☐Declined to Answer

If the C/Y Member has given birth in the last 12 months, the following questions must be completed. ☐ N/A

Is the C/Y member working with a doula? ☐Yes ☐No ☐Declined to Answer

If yes, please fill out the following information:

Name of Doula:	
Contact Number:	

Is the C/Y member working with a lactation consultant? ☐Yes ☐No ☐Declined to Answer

Name of Contact:	
Contact Number:	

Has the C/Y member had a postpartum appointment? ☐Yes ☐No ☐Declined to Answer

If yes, please fill out the date of the last appointment (if known):

Has the baby been going to their pediatrician for their appointments? ☐Yes ☐No ☐Declined to Answer

If yes, please fill out the following information:

Name of Provider:	
Contact Number:	
Office Address:	
Date of Last Visit (if known or an approximate date):	

Section 5. Pregnancy/Postpartum

Does the C/Y member need education/resources on post-pregnancy and infant health?
☐ Yes ☐ No ☐ Declined to Answer

Section 6. Activities of Daily Living (ADLs)

The following are questions regarding the C/Y member's ability to perform basic self-case activities; complete questions only related to age of child/youth, skip other questions.

Does the C/Y member need help with any of these activities?

If C/Y member is 0-5 years old:

Eating (as developmentally or age-appropriate – e.g., chewing, swallowing, latch) ☐ Yes ☐ No ☐ Declined to Answer	Using hands (as developmentally or age-appropriate) ☐ Yes ☐ No ☐ Declined to Answer
Coordination/moving around (as developmentally or age-appropriate) ☐ Yes ☐ No ☐ Declined to Answer	Toileting (as developmentally or age-appropriate – e.g., potty trained, dry through the night) ☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

If C/Y member is school-aged (6-18 years old):

Bathing ☐ Yes ☐ No ☐ Declined to Answer	Grooming (brushing teeth & hair, washing hands & face) ☐ Yes ☐ No ☐ Declined to Answer
Dressing ☐ Yes ☐ No ☐ Declined to Answer	Eating ☐ Yes ☐ No ☐ Declined to Answer
Toileting ☐ Yes ☐ No ☐ Declined to Answer	Mobility (walking, climbing stairs) ☐ Yes ☐ No ☐ Declined to Answer

If C/Y member is 18+ years old

Taking a bath or shower ☐ Yes ☐ No ☐ Declined to Answer	Going up stairs ☐ Yes ☐ No ☐ Declined to Answer
Eating ☐ Yes ☐ No ☐ Declined to Answer	Getting Dressed ☐ Yes ☐ No ☐ Declined to Answer
Brushing teeth, brushing hair, shaving ☐ Yes ☐ No ☐ Declined to Answer	Making meals or cooking ☐ Yes ☐ No ☐ Declined to Answer
Getting out of a bed or a chair ☐ Yes ☐ No ☐ Declined to Answer	Shopping and getting food ☐ Yes ☐ No ☐ Declined to Answer
Using the toilet ☐ Yes ☐ No ☐ Declined to Answer	Walking ☐ Yes ☐ No ☐ Declined to Answer
Washing dishes or clothes ☐ Yes ☐ No ☐ Declined to Answer	Writing checks or keeping track of money ☐ Yes ☐ No ☐ Declined to Answer
Getting a ride to the doctor ☐ Yes ☐ No ☐ Declined to Answer	Doing house or yard work ☐ Yes ☐ No ☐ Declined to Answer
Going out to visit family or friends ☐ Yes ☐ No ☐ Declined to Answer	Using the phone ☐ Yes ☐ No ☐ Declined to Answer
Keeping track of appointments ☐ Yes ☐ No ☐ Declined to Answer	

Has the member fallen in the last month? ☐ Yes ☐ No
Are you afraid of falling? ☐ Yes ☐ No

Do the member's friends or family members express concerns about their ability to care for themself?
☐ Yes ☐ No
If yes, ECM Provider, consider exploring available support services and consulting a supervisor for further guidance.

If yes to any of the above ADLs, is the C/Y member getting all the help you need with these actions?
☐ Yes ☐ No ☐ Declined to Answer
Comments:

Section 6. Activities of Daily Living (ADLs)

Does the C/Y member use or need any of the following? (Select all that apply):

☐ Devices to help with mobility/transfers (e.g., wheelchair, lifts/seats, grab bar) (list):
☐ Devices to help with feeding/nutrition (e.g., feeding tube, special formula, food supplements) (list):
☐ Devices to help with continence (e.g., catheters, diapers, ostomy supplies) (list):
☐ Devices to help with airway/breathing (e.g., oxygen, ventilator, trach supplies) (list):
☐ Other medically necessary devices for ADLs (list):

Does the C/Y (or their parent/guardian/caregiver, if applicable) need help understanding how to use medical equipment? ☐ Yes ☐ No ☐ N/A ☐ Declined to Answer
Comments:

Section 7. Psychosocial, Mental, and Behavioral Health

The following questions will be used to assess the C/Y member's current psychosocial, mental, and behavioral health needs and conditions.

Has a healthcare or mental health provider ever told the C/Y member (or their parent/guardian/caregiver, if applicable) that they have a mental health diagnosis, or emotional or behavioral problem?
☐ Yes ☐ No ☐ Declined to Answer ☐ N/A due to age of child
If yes, what diagnosis has the C/Y member been given?
☐ Depression ☐Bipolar Disorder ☐Psychotic Disorder ☐Anxiety ☐Eating Disorder
☐ Other (list):
Comments, including how this currently affects the C/Y member's ability to manage daily activities:

If no, are there mental health concerns present? ☐ Yes ☐ No *If No, please skip to Social Interactions*
If yes, please explain:

Does the C/Y member currently have a provider that is treating them for this diagnosis?
☐ Yes ☐ No ☐ N/A ☐ Declined to Answer
If yes, please fill out the following information:

Name of Provider:	
Contact Number:	
Office Address:	
Date of Last Visit (if known, or an approximate date):	

Social Interactions

How often does the C/Y member see or talk to people that they care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

☐ Less than once a week	☐ 1 or 2 times a week	☐ 3 to 5 times a week	☐ 5 or more times a week
☐ N/A due to age of child/youth	☐ Decline to Answer		

Over the past month (30 days), how many days has the C/Y member felt lonely? (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	☐ N/A due to age of child/youth	☐ Decline to Answer

(If Parent/Guardian/Caregiver answering) Are they interested in parenting programs about their child's development?
☐ Yes ☐ No ☐ Declined to Answer

Mental/Behavioral Health Assessment Questions

For all C/Y Members:

Section 7. Psychosocial, Mental, and Behavioral Health

Does the C/Y member (or their parent/guardian/caregiver, if applicable) have any concerns about their behavior or mood?
☐ Yes ☐ No ☐ N/A ☐ Declined to Answer
Describe concerns here:

Would the C/Y member (or their parent/guardian/caregiver, if applicable) like more information and or receive additional support regarding their mental/behavioral health? If yes, indicate supports requested.

For C/Y members 11 years and older

Depression – Patient Health Questionnaire (PHQ-9) – For youth aged 11 and older.
If a recent (within past month) PHQ-9 has been completed by another provider and is in member's chart.

Enter Score:	
Date Completed:	

If no PHQ-9 in chart, complete the PHQ-2+Q.9 below. Follow scoring guidelines below.
☐ N/A ☐ Declined to Complete (and reason, if provided):

PHQ-2 plus Question 9

Over the last two weeks, how often have you been bothered by any of the following?

1. Have you felt down, depressed or hopeless?
   Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐
2. (Q.9) Thoughts that you would be better off dead or of hurting yourself in some way
   Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐

Scoring: Not at all = 0, Several days = 1, More than half the days = 2, Nearly every day = 3.

- For PHQ-2+Q.9: Score of 2 or greater AND/OR checks YES on Q.9 — Individual completes the PHQ-9 (recommend self-administer). Printable PHQ-9 in multiple languages: https://www.phqscreeners.com/
- If PHQ-9 score is >10 consult with clinical consultant and supervisor. If >15 or positive for Q.9 request immediate consultation.

If the score indicates risk factors are present, document actions taken (consultation, referral for mental health assessment):

Section 8. Substance Use

The following questions are about the C/Y member's experience with alcohol, nicotine products, marijuana products and other substances. Some of the substances discussed here are prescribed by a doctor, but this part of the assessment will only be focusing on whether the C/Y member has taken them for reasons other than prescribed or in doses other than prescribed.

☐ Declined to Complete ☐ N/A – the C/Y Member is too young to complete screening

In the past 6 months, how often has the C/Y member taken the following:

Substance	Never	1-2 times	Monthly	Weekly	Daily	Date of Last Use	Is this substance use currently a problem for them?
Alcohol	☐	☐	☐	☐	☐		☐ Yes ☐ No
Nicotine Products (Cigarette, vaping, chewing tobacco)	☐	☐	☐	☐	☐		☐ Yes ☐ No
Using Prescription drugs not as prescribed (circle any relevant): ▪ Pain medicines ▪ ADHD medicines ▪ Sleeping pills Other:	☐	☐	☐	☐	☐		☐ Yes ☐ No
Marijuana including edibles or other cannabis products:	☐	☐	☐	☐	☐		☐ Yes ☐ No

Section 8. Substance Use

Other substances: For example, cocaine, meth, heroin, hallucinogens, inhalants, designer drugs	☐	☐	☐	☐	☐		☐ Yes ☐ No

Have the C/Y member ever expressed wanting to cut down on drinking or drug use? ☐ Yes ☐ No ☐N/A
☐ Declined to Answer
If yes, the Member must complete the following question.

Would the C/Y member like to talk with someone about their substance use, especially if the Member is thinking of quitting or cutting back? ☐ Yes ☐ No ☐ N/A

Comments:

Section 9. Developmental and Cognitive Functioning

The following questions will be used to assess the C/Y member's current developmental and cognitive health needs and conditions. **Only answer questions relevant to the age of the C/Y member**.

Has a healthcare provider, mental health provider, or educational professional ever told the C/Y member (or their parent/guardian/caregiver, if applicable) that they have a developmental delay, disability, or brain injury that impacted their cognitive/intellectual functioning, or a neurodevelopmental disorder?
☐Yes ☐ No ☐ Declined to Answer *If no, skip to age-specific questions.*
If yes, what diagnosis has the C/Y member been given?

☐ Intellectual disability	☐ Developmental disability	☐ Learning Disability	☐ ADHD
☐ Autism Spectrum Disorder	☐Other (list):		

Comments, including how this affects the C/Y member's current ability to manage daily activities:

Does the C/Y member currently have a provider that sees them for the condition(s) described above?
☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

If yes, please fill out the following information:

Name of Provider:	
Contact Number:	
Office Address:	
Date of Last Visit (if known, or an approximate date):	

If C/Y member is (0-5)

Is the Member enrolled in any early learning programs or in Early Intervention services?
☐ Yes ☐ No ☐ Declined to Answer
Is yes, list:

Does the Member's parent/guardian/caregiver have any concerns about their child's learning?
☐ Yes ☐ No ☐ Declined to Answer

Describe:

Would the parent/guardian/caregiver like more information and to see somebody about their concerns?

If C/Y member is school-aged (6-18)

Section 9. Developmental and Cognitive Functioning

Doe the Member currently receive any treatment, supports or services related to this not identified elsewhere on this form (e.g., Individualized Education Program (IEP) or 504 Plan)?

☐ Yes; list treatment/supports/services received:

☐ No ☐ N/A ☐ Declined to Answer

Does the Member (or their parent/guardian/caregiver, if applicable) have concerns about the C/Y member's learning? (may also include concerns with bullying, truancy, behavioral, etc.)
☐ Yes ☐ No ☐ Declined to Answer

Describe:

Would the C/Y member (or their parent/guardian/caregiver, if applicable) like more information and to see somebody about their concerns?

Educational opportunities and grants:
If C/Y member is in foster care: ☐ Cal Grant B for Foster Youth ☐ Chafee Foster Youth Grant Program
☐ Other (list):

If C/Y member is 18+

Has the Member had any changes in thinking, remembering, or making decisions?
☐ Yes ☐ No ☐ Declined to Answer

In the past month, has the Member ever felt worried, scared, or confused that something may be wrong with their mind or memory? ☐ Yes ☐ No ☐ Declined to Answer

Housing

Where does the C/Y member live? (check all that apply)
☐ House ☐ Apartment complex ☐ Board and care facility ☐ Residential treatment center ☐ Group Home ☐ Skilled Nursing Facility ☐ Permanent Supported Housing ☐ Protective housing ☐ Shared housing (i.e. couch surfing if loss of housing) ☐ Motel/Hotel ☐ Trailor Park ☐ Campground ☐ Emergency or Transitional Shelter ☐ Hospitalized with no safe discharge plan ☐ Homeless ☐ Other:
☐ Decline to Answer

Does the C/Y member feel physically and emotionally safe where they currently live?
☐ Yes ☐ No ☐ Decline to Answer
If no, please describe:

Would the C/Y member (or their parent/guardian/caregiver, if applicable) like more information and to see somebody about their concerns?
☐ Yes ☐ No

Is the C/Y member (and/or their parent/guardian/caregiver) worried about losing their housing?
☐ Yes ☐ No ☐ Decline to Answer
If yes, please explain:

Is anyone currently helping the Member (or their parent/guardian/caregiver, if applicable) with their housing support (for example, Housing Navigator, case management, or tenants' rights)? ☐ Yes ☐ No ☐ N/A

C/Y Member lives with: ☐ Biological Parent ☐ Adoptive Parent ☐ Foster Parent ☐ Guardian/Conservator ☐ Caregiver ☐ C/Y member lives alone

If time is shared between living spaces, please explain:

Housing

How many people live in the C/Y member's household (include ages and relationship to C/Y member)?

Please describe any other housing concerns that have not been identified above:

Environmental Safety

Has the C/Y member and/or parent/guardian/caregiver expressed concerns about their safety or well-being in the community? ☐ Yes ☐ No ☐ Decline to Answer
If yes, describe:

Would the C/Y member (or their parent/guardian/caregiver, if applicable) like more information and to see somebody about their concerns?
☐ Yes ☐ No

Is the C/Y member afraid of anyone or is anyone hurting them? ☐ Yes ☐ No ☐ Decline to Answer
If yes, please explain:

Is anyone using the C/Y member's money without their permission? ☐ Yes ☐ No ☐ Decline to Answer

If yes, please explain:

C/Y member exposure to substances in the home:

☐ Alcohol	☐ Narcotics	☐ Smoking/Vaping Tabacco	☐ Marijuana

☐ Other toxins (describe):

☐ Declined to Answer
Comments:

Firearms/weapons in the home: ☐ Yes ☐ No ☐ Decline to Answer

If yes, how are they stored?:

Can the C/Y member live safely and easily around their home? ☐ Yes ☐ No ☐ Decline to Answer

Does the place where the C/Y member live have:

Good lighting: ☐ Yes ☐ No	Good heating: ☐ Yes ☐ No	Good cooling: ☐ Yes ☐ No
Rails for any stairs/ramps: ☐ Yes ☐ No	Hot water: ☐ Yes ☐ No	Indoor toilet: ☐ Yes ☐No
A door to the outside that locks: ☐ Yes ☐ No	Stairs to get into their home or stairs inside their home: ☐Yes ☐No	Elevator: ☐ Yes ☐ No
Space to use a wheelchair: ☐ Yes ☐ No	Clear ways to exit their home: ☐ Yes ☐ No	Lead paint: ☐ Yes ☐ No
Mold/mildew/dampness: ☐ Yes ☐ No	Overcrowding: ☐ Yes ☐ No	Unreliable utilities: ☐ Yes ☐ No
Mice, cockroaches, or other pests: ☐ Yes ☐ No	Additional housing and/or home environment safety concerns? ☐ Yes ☐ No ☐ Decline to Answer If yes, please explain:	

Section 11. Benefits, Other Services and Access to Necessities

The following questions will be used to help understand any additional needs to accessing services and supports that the C/Y Member may have.

Funding/benefit source/services that the C/Y member or the parent/guardian/caregiver (if applicable) uses:

☐ CalFresh Benefits (SNAP)	☐ TANF recipient	☐ School meals
☐ CalWORKs	☐ C/Y Employment	☐ Unemployment
☐ Resource Family Income (Foster Care)	☐ Child Support	☐ Spousal Support
☐ Other:		
☐ WIC (list site):	☐ SSI/SDI recipient:	

List any needs:

Does the C/Y member (or their parent/guardian/caregiver, if applicable) sometimes run out of money to pay for any of the following necessities: food, rent, basic utilities, phone and internet, clothing, childcare, medicine, or other?
☐Yes ☐No ☐ Declined to Answer

Transportation Barriers: ☐Yes ☐No ☐ Declined to Answer
If yes, please list:

Childcare Barriers: ☐Yes ☐No ☐ Declined to Answer
If yes, please list:

Section 12. Legal Involvement

The following questions will be used to help understand any legal/justice involvement of the C/Y Member.

In the past 12 months, has the C/Y member been involved with the following?:

☐ Court ordered services	☐ On probation	☐ On parole	☐ Re-entry program
☐ DUI/restricted license	☐ Child Protective Services (CPS)	☐ Community Legal Services	☐ None
☐ Other (list):			

Comments, (including additional legal needs/resources:

Does the C/Y member have a re-entry support provider and/or parole/probation officer?
☐ Yes ☐ No ☐ Decline to Answer
If yes, please fill out the following information:

Name of Provider:	
Contact Number:	
Office Address:	
Date of Last Visit (if known, or an approximate date)	

Section 13. End-of-life Planning

These questions pertain to the C/Y member if they are 18+.

Does the Member have a life-planning document or advance directive in place?
☐ Yes ☐ No ☐ Declined to Answer

Do you want information on these topics? ☐ Yes ☐ No ☐ Declined to Answer

Section 14. Member Priorities

These questions pertain to the C/Y member if they are 18+.

Based on our meeting today, what are the top 2-3 priorities for the member's health, wellness, social and/or living situation over the next 3-6 months?

Goal 1:

Section 14. Member Priorities
Goal 2:
Goal 3:
Narrative Summary
Include Primary Needs identified from Assessment (please also add this summary in the ECM Member Care Plan).

Next Steps	**Person Responsible**
1.	
2.	
3.	
Next Appointment Date:	Next Appointment Location:

Appendix: List of common terms used in this document.	
ACEs	Adverse Childhood Experiences
ADHD	Attention-deficit/hyperactivity disorder
CANS Assessment	Child and Adolescent Needs and Strengths
CCS	California Children Services
CPSP	Comprehensive Perinatal Services Program
DCFS	Department of Children and Family Service
DDS Regional Center	Department of Developmental Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
DPH	Department of Public Health
DUI	Driving Under the Influence
IEP	Individualized Education Program
SNAP	Supplemental Nutrition Assistance Program
SSI/SSDI	Supplemental Security Income, Social Security Disability Insurance
SMHS	Specialty Mental Health Services
TANF	Temporary Assistance for Needy Families
PEARLS	Predictive Early Assessment of Reading and Language
WCM	Whole Child Model
504 Plan	A plan developed under section 504 of the Rehabilitation Act

Enhanced Care Management (ECM)
Comprehensive Adult Assessment

Background Information	
This assessment is designed as a tool for you, as Lead Care Manager, to assess a member's health needs and help the member participate in the Enhanced Care Management benefit. Today and over the next 1-3 visits, you and the member will complete this assessment together, and from there develop goals and next steps that support the member's overall health and wellness.	
Date Started:	**Date Completed:**

Indicate if you used any of the following, recently completed assessments or tools to complete/inform this assessment		
The Lead Care Manager should incorporate findings from all available assessments. Assessments do not replace this comprehensive assessment but should inform the development of the care plan.		
☐ ACEs or PEARLS. If no ACEs completed refer to PCP/SW for screening.	☐ Yes.	☐ No ☐ N/A
☐ PHQ-9	☐ Yes.	
☐ (Pregnant/Postpartum) CPSP Assessment	☐ Yes.	
☐ (Justice Involved) Health Risk Assessment	☐ Yes.	
☐ Other(s) (list with date completed):		

Section 1. Member Demographics		
Member Name:	Date of Birth:	Medi-Cal ID / CIN#:
Preferred name and/or pronouns:	Gender identification:	
Preferred written/spoken language:	Interpreted needed: ☐Yes ☐No If yes, list language:	
Nationality/tribe/ethnicity: (select all that apply) ☐ Hispanic or Latino ☐ Asian ☐ Pacific Islander / Native Hawaiian ☐ White ☐ Black / African American ☐ American Indian / Alaskan Native ☐ Other:		
Relationship status: ☐ N/A ☐ Single ☐ Married ☐ Divorced ☐ Domestic partnership ☐ Widower ☐ Declined to Answer ☐ Other:	Veteran/discharged from the U.S. Armed Forces? ☒ Yes ☐ No ☐ Declined to answer	

Contact Information		
Home phone(s):	Cell Phone(s):	Email Address(es):
1. Preferred place to receive mail (include physical address and location type, e.g., friend's house, Department of Public Social Services (DPSS), office, etc.)		
2. Is in-person contact, OK? ☐ Yes ☐ No *(Reminder ECM preferred contact is in-person)* If no, what is your preferred method of contact: ☐ Phone ☐ Text ☐ Email ☐Other:		
3. Is there a person or location that we can contact if we need to get in contact with you? (List relationship of person and contact information or location address and description – e.g., shelter)		

ECM Enrollment and Consent	
Date of Consent:	☐ Verbal ☐ Written ☐ Caregiver/Authorized Representative

	If caregiver/authorized representative provided consent, please provide the name of the individual:

4. Is anyone else in the family enrolled in ECM? ☐ Yes ☐ No
If yes, list family member name(s) relationship(s) to member and their ECM Provider(s):

Population of Focus (as identified on the referral/authorization form)

☐ Experiencing Homelessness	☐ At Risk for Avoidable Hospital or ED Utilization	☐ Justice Involved: Transitioning from incarceration	☐ Serious Mental Health / Substance Use
☐ Nursing Facility Residents Transitioning to Community	☐ Long Term Care (LTC) Institutionalization	☐ Birth Equity: Pregnant and Postpartum	

Section 2. Culture

1. Do you have any cultural, religious and/or spiritual beliefs that are important to your family's health and wellness?
☐ Yes ☐ No ☐ Declined to answer
If yes, describe:

Section 3. Physical Health

1. In general, would you say your health is: ☐ Very Good ☐ Good ☐ Poor ☐ Declined to answer
Please give more information about why you chose this rating:

2. Compared to one (1) year ago, your health is: ☐ Much better ☐ Somewhat better ☐ About the same
☐ Somewhat worse ☐ Much worse now than one (1) year ago ☐ Declined to answer
Comment about why you chose this rating:

3. Have you been to the emergency room in the past 6 months?
☐ None ☐ 1 time ☐ 2 times ☐ 3 times or more ☐ Don't remember/Not sure ☐ Declined to answer
If yes, what was the reason for the visit(s):

4. How many times have you been a patient in the hospital (admitted) in the past 6 months?
☐ None ☐ 1 time ☐ 2 times ☐ 3 times or more ☐ Don't remember/Not sure ☐ Declined to answer
Comments:

5. In the last 12 months, how many times have you been in a nursing home, rehab, and/or recuperative care?
☐ None ☐ 1 time ☐ 2 or more times ☐ Declined to answer
Comments (include which settings):

6. Do you know who your regular assigned healthcare providers are, including any specialists?
☐ Yes ☐ No
Provider name(s)/clinics(s)/phone #(s):

If yes, when was the last time you saw your regular doctor?
☐ Less than 3 months ☐ Less than 6 months ☐ 6-12 months ☐ More than 1 year ☐ Not sure

7. Do you have a provider for women's health? ☐ Yes ☐ No ☐ N/A

8. Have you had a dental visit in the past 12 months? ☐ Yes ☐ No ☐ Not sure ☐ Declined to answer
If yes, what is the dentist name/phone #:

9. Do you have any problems eating (for example, appetite, chewing, or swallowing)?
Comments:

Section 3. Physical Health

10. Have you been told by a doctor or medical provider that you have any medical conditions? ☐ Yes ☐ No
If yes, please include the date(s) estimated of diagnosis(es):
If yes, please check all that apply.

☐ Arthritis/chronic pain	☐ Diabetes, Type 2	☐ Parkinson's
☐ Asthma (difficulty breathing)	☐ Pre-Diabetes	☐ Physical disability/ para/quadriplegic/amputation
☐ Ankle/leg swelling	☐ Heart problems (heart attack, chest pain)	☐ Recent Fractures
☐ Alzheimer's/dementia/ memory loss	☐ HIV/AIDS	☐ Seizures
☐ Cancer	☐ Hepatitis (liver problems)	☐ Sickle Cell Disease
☐ COPD/emphysema/bronchitis (breathing problems)	☐ High Cholesterol	☐ Transplant:
☐ Congestive Heart Failure	☐ Hypertension (high blood pressure)	☐ History of tuberculosis (TB)
☐ Circulation problems	☐ Kidney disease	☐ Urinary problems
☐ Diabetes, Type 1	☐ Osteoporosis	
☐ Other conditions not listed above (including a wound that needs care):		

11. Do you have trouble with your vision? ☐ Yes ☐ No
If yes, describe:

12. If you have diabetes, have you had a Diabetic Eye Exam done in the last year? ☐ Yes ☐ No ☐ N/A

13. Do you have trouble with your hearing? ☐ Yes ☐ No
If Yes, do you have a hearing aid? ☐ Yes ☐ No
If Yes, how often do you use them?
When was the last visit to the audiologist doctor?

Preventive Care

14. Have you had any of the following vaccines? Check the box next to the vaccine for Yes.

☐ COVID 19		☐ No ☐ Unsure
☐ Flu		☐ No ☐ Unsure
☐ Tetanus		☐ No ☐ Unsure
☐ Pneumonia		☐ No ☐ Unsure
☐ Shingles		☐ No ☐ Unsure
☐ Other		☐ No ☐ Unsure

15. Do you have any questions or need support getting your vaccinations? ☐ Yes ☐ No

16. Have you had the following screenings/tests?

☐ Colonoscopy (5 years)	☐ Mammogram (2 years)	☐ Pap smear (3-5 years)	☐ Bone Density
☐ Blood sugar (HbA1C,12 months)	☐ Kidney function:		☐ Eye exam:

Section 4. Medications

1. Please tell me what medications (including birth control, over-the-counter medications, vitamins, etc.) you are currently taking. If more spaces is needed, please include information on the back of this assessment or available blank space. Additionally, if actual medication names and doses are unknown, attempt to capture general information as you are able (e.g., medication for diabetes, high blood pressure). **Please attach list for additional medications**.

Medication Name	How Often (frequency)	How Administered	Dosage	Pharmacy Name/Location

Section 4. Medications

		(route)[1]		

2. Are you having any trouble getting or filling your medications? ☐ Yes ☐ No
If yes, comments:

3. 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:

4. Do you need help or require assistance taking your medications? ☐ Yes ☐ No

Section 5. Activities of Daily Living (ADLs)

1. Do you need help with any of the following actions? Check the box Yes or No and add comments if needed.

Taking a bath or shower ☐ Yes ☐ No Comments:	Going up the stairs ☐ Yes ☐ No Comments:
Eating ☐ Yes ☐ No Comments:	Getting dressed ☐ Yes ☐ No Comments:
Brushing teeth, brushing hair, shaving ☐ Yes ☐ No Comments:	Making meals or cooking ☐ Yes ☐ No Comments:
Getting out of bed or a chair ☐ Yes ☐ No Comments:	Shopping and getting food ☐ Yes ☐ No Comments:
Using the toilet ☐ Yes ☐ No Comments	Walking ☐ Yes ☐ No Comments:
Washing dishes or clothes ☐ Yes ☐ No Comments:	Writing checks or keeping track of money ☐ Yes ☐ No Comments:
Getting a ride to the doctor or see your friends ☐ Yes ☐ No Comments:	Doing house or yard work ☐ Yes ☐ No Comments:
Getting out to visit family or friends ☐ Yes ☐ No Comments:	Using the phone ☐ Yes ☐ No Comments:
Keeping track of appointments ☐ Yes ☐ No Comments:	Other:

2. If yes to any of the above, are you getting all the help you need with these actions? ☐ Yes ☐ No
Comments:

3. Have you fallen in the last month? ☐ Yes ☐ No
4. Are you afraid of falling? ☐ Yes ☐ No
Comments:

5. Do friends or family members express concerns about your ability to care for yourself? ☐ Yes ☐ No
If yes, consult with the clinical consultant or supervisor.
Comments:

6. Do you need or need any of the following? (Select all that apply, or select N/A)

[1] A medication route means by which a drug is introduced into the body – such as oral or intravenous.

Section 5. Activities of Daily Living (ADLs)

☐ Glasses ☐ Use ☐ Need ☐ N/A	☐ Cane ☐ Use ☐ Need ☐ N/A	☐ Walker ☐ Use ☐ Need ☐ N/A	☐ Hearing device ☐ Use ☐ Need ☐ N/A
☐ TTY (visual support) ☐ Use ☐ Need ☐ N/A	☐ Crutches ☐ Use ☐ Need ☐ N/A	☐ Grab bars ☐ Use ☐ Need ☐ N/A	☐ Raised toilet seat/chair ☐ Use ☐ Need ☐ N/A
☐ Feeding tube ☐ Use ☐ Need ☐ N/A	☐ Wheelchair ☐ Use ☐ Need ☐ N/A	☐ Food supplements ☐ Use ☐ Need ☐ N/A	☐ Hospital bed ☐ Use ☐ Need ☐ N/A
☐ Oxygen ☐ Use ☐ Need ☐ N/A	☐ Ostomy supplies ☐ Use ☐ Need ☐ N/A	☐ CPAP/BiPAP ☐ Use ☐ Need ☐ N/A	☐ Diabetes supplies ☐ Use ☐ Need ☐ N/A
☐ Large print ☐ Use ☐ Need ☐ N/A	☐ Sideboard ☐ Use ☐ Need ☐ N/A	☐ Urinary catheter ☐ Use ☐ Need ☐ N/A	☐ IV infusion for meds ☐ Use ☐ Need ☐ N/A
☐ Incontinence supplies ☐ Use ☐ Need ☐ N/A	☐ Trach/suction supplies ☐ Use ☐ Need ☐ N/A	☐ Lift device (for transferring) ☐ Use ☐ Need ☐ N/A	☐ Other: ☐ Use ☐ Need

Section 6. Pain Management

1. Do you experience pain? ☐ Yes (answer questions below) ☐ No ☐ Declined to answer

2. During the past week, how much did pain interfere with your normal activities (including work outside the home and/or housework)?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐ Declined to answer

Section 7. Pregnancy/Postpartum

☐ N/A for section 7 (e.g., not of child-bearing age, etc.) *Skip to Section 8*

1. Are you currently pregnant? ☐ Yes ☐ No ☐ Declined to answer
Comments:

2. Are you receiving services from CalWORKs, Black Infant Health, Home visiting Provider, CPSP?
☐ Yes ☐ No ☐ Other
Comments:

3. Have you given birth in the last 12 months? *Includes live or stillbirth delivery; miscarriages (SAB-spontaneous abortion); or an abortion induced for medical reasons (TAB – therapeutic abortion).*
☐ Yes ☐ No ☐ Declined to answer
Comments:

4. Are you planning to become pregnant? ☐ Yes ☐ No ☐ Not sure ☐ Declined to answer
Comments:

If yes to currently pregnant, the following questions must be completed. ☐ N/A

5. How many months pregnant are you? _____ ☐ Not sure ☐ Declined to answer

6. Due date: ☐ Not sure ☐ Declined to answer

7. Have you been told you are carrying more than one baby? ☐ Yes ☐ No ☐ Not sure ☐ Declined to answer

8. Do you have the following plans for pregnancy and labor and delivery?
   A. Birth plan: ☐ Have ☐ Don't have, but want ☐ Don't have and don't want
   B. Delivery wishes: ☐ Vaginal ☐ Natural (unmedicated/no epidural) ☐ C-Section ☐ Vaginal birth after C-Section (VBAC)
   C. Delivery Location:
   D. Birthing classes: ☐ Have ☐ Don't have, but want ☐ Don't have and don't want
   E. Labor supports person(s) including doulas: ☐ Have ☐ Don't have, but want ☐ Don't have and don't want
   If have (list):

Section 7. Pregnancy/Postpartum

F. Going into labor: when to call someone and/or go to your birthing location:
☐ I know what to do ☐ I need help with this

G. Goals/plans for transportation to the hospital: ☐ Have ☐ Don't have, but want ☐ Don't have and don't want

H. Childcare goal/plans for other kids: ☐ Have ☐ Don't have, but want ☐ Don't have and don't want ☐ N/A

I. Breastfeeding plans: ☐ Have ☐ Don't have, but want ☐ Don't have and don't want

Comments:

If yes to having given birth* in the last 12 months, the following questions must be completed. ☐ N/A
**Includes live or stillbirth delivery, miscarriages (SAB – spontaneous abortion; or an abortion induced for medical reasons (TAB – therapeutic abortion)*

9. Do you have any issues with delivery? ☐ Yes ☐ No ☐ Declined to answer
Comments:

10. Does your baby (babies) have any special health care needs?
☐ Yes* ☐ No ☐ Unsure ☐ N/A (e.g., stillbirth, SAB, TAB)
Comments:

11. Do you need any mental health support as a result of your birthing experience?
☐ Yes* ☐ No ☐ Declined to answer
*Note: consider needed connections for baby, such as California Children's Services or Enhanced Care Management Services.

12. What are you enjoying most about your new baby?

13. What is most challenging?
☐ N/A ☐ Declined to answer

14. Are your family members adjusting to the baby? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer
Comments:

15. Are you breast feeding? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer

16. If no, would you like to, or do you plan to? ☐ Yes ☐ No ☐ Unsure ☐ Declined to answer
If yes to either:

A. Do you feel like you need help with breastfeeding? ☐ Yes ☐ No ☐ Declined to answer

B. Do you need a breast pump? ☐ Yes ☐ No ☐ Declined to answer

17. Do you have any concerns about your baby's feeding (breastfeeding, bottle feeding?)
☐ Yes ☐ No ☐ N/A ☐ Declined to answer

If yes to having given birth* in the last 12 months, complete below.
☐ N/A *(e.g., pregnancy resulted in still birth, SAB, or TAB, or only ask applicable questions)*

18. When was your most recent prenatal or postpartum appointment?
☐ Not sure ☐ Declined to answer ☐ Have not gone to an appointment
Comments:

19. When is your next prenatal or postpartum appointment:
☐ Not sure ☐ Declined to answer ☐ No appointment scheduled

20. Has the doctor told you that there are health issues that need follow up? ☐ Yes ☐ No ☐ Not sure
If yes, do you need support in the following up with those issues? ☐ Yes ☐ No ☐ Not sure
Comments:

21. Do you feel supported in your pregnancy/during your postpartum period?
☐ Yes ☐ No ☐ Unsure ☐ Declined to answer
Comments:
Based on response, consult with a clinical consultant and supervisor if needed for any follow-up support.

22. Are there people that smoke around you and/or your baby? ☐ Yes ☐ No ☐ Declined to answer
If yes, have you discussed this with your provider? ☐ Yes ☐ No ☐ Declined to answer

23. Do you need any of the following during your pregnancy or postpartum care: (check all that apply)

Section 7. Pregnancy/Postpartum

☐ Education/resources on pregnancy/post-pregnancy (body changes, baby growth, postpartum discomforts, self-care after pregnancy, etc.)
☐ Education/resources on family planning/birth control
☐ Education/resources on infant health (nutrition, developmental milestones, safe sleeping)
☐ Education/resources on immunizations for self and baby
☐ Education/resources on parenting skills/parenting classes
☐ Essential baby supplies (crib, diapers, formula, bottles, breast pump, clothing, blankets, and other supplies)
☐ Car seat
☐ Finding childcare or assistance paying for childcare
☐ Other:
☐ Declined to answer

24. Do you have a doctor for your baby? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer
If yes, provider name and phone #:

25. When (day and/or month) did you most recently take your baby to the doctor?
☐ Not sure ☐ N/A ☐ Declined to answer

26. Has the doctor told you that there are health issues with your baby that need follow up? ☐ Yes ☐ No ☐ Not sure
If yes, do you need support in following p with any of those issues? ☐ Yes ☐ No ☐ Not sure

27. Do you have a dentist for your baby? ☐ Yes ☐ No ☐ N/A *(no teeth present less than age 1)*
☐ Declined to answer
If yes, provide name/phone #:
Date of last visit (if known, or an approximate date):

28. Edinburgh Postnatal Depression Scale (EPDS) Screener
☐ Declined to complete (and reason, if provided):
- Have Member self-complete the screener here: https://www.mcpapformoms.org/Docs/EdinbPostDepScale%20english%20no%20numbers.pdf.The member should complete the scale themself, unless they have limited English or have difficulty with reading.

Scoring:
- Score of 9 and above: consult with clinical consultant and supervisor.
- Score of 13 and above: consult with clinical consultant and supervisor and initiate referral for behavioral health.
- Positive score (1, 2, or 3) on question 10: immediate discussion required: consult with clinical consultant and supervisor *and* initiate referral for behavioral health.

Section 8. Behavioral Health

Mental Health History

1. Has a healthcare or mental health provider ever told you that you have a mental health diagnosis (including postpartum depression or postpartum anxiety)? ☐ Yes ☐ No ☐ Unsure ☐ Declined to answer
Comments:
If yes, what diagnosis have you been given? ☐ Depression ☐ Bipolar Disorder ☐ Schizophrenia ☐ Anxiety ☐ PTSD ☐ Declined to answer ☐ Other (list):
Comments:
If yes, have you had a psychiatric hospitalization? ☐ Yes ☐ No ☐ Unsure ☐ Declined to answer
If Yes, list date(s), reason(s), outcome(s), location(s):
If yes, have you received outpatient treatment? ☐ Yes ☐ No ☐ Unsure ☐ Declined to answer
If Yes, list date(s), reason(s), outcome(s), location(s):
If yes, have you received any other types of treatment? ☐ Yes ☐ No ☐ Unsure ☐ Declined to answer
If Yes, describe:

2. Can you provide the contact information of your current or past mental health provider?

Section 8. Behavioral Health

Provider Name:
Contact Number:

3. Over the past month (30 days), how many days have you felt lonely? (check one)
☐ None – I never feel lonely ☐ Less than 5 days ☐ More than half the day (more than 15)
☐ Most days – I always feel lovely ☐ Decline to answer

Depression
The following are questions from the Patient Health Questionnaire PHQ #1, #2, and #9
☐ Not completed because the EPDS was completed above.

4. Over the last two weeks, how often have you been bothered by any of the following?
A. Little interest or pleasure of doing things?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
B. Feeling down, depressed or hopeless?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
C. Thoughts that you would be better off dead or hurting yourself?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
If "several days" or more to any of these, consult with a clinical consultant and supervisor.

Anxiety
The following are questions from the Generalized Anxiety Disorder 2-item [GAD-2]

5. Over the last 2 weeks, how often have you been bothered by the following problems?
A. Feeling nervous, anxious, or on edge?
Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
B. Not being able to stop or control worrying?
Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
If "several days" or more to any of these, consult with a clinical consultant and supervisor.

Trauma and Stressors

6. Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic that leave an impact on our day-to-day life. Are you interested in getting support with this (e.g., referral behavioral health professional, support groups, coping skills, etc.)?
☐ Yes ☐ No ☐ Declined to answer

Cognitive Functioning

7. Have you had any changes in thinking, remembering, or making decisions?
☐ Yes ☐ No ☐ Declined to answer
Comments:

8. In the past month, have you felt worried, scared, or confused that something may be wrong with your mind or memory?
☐ Yes ☐ No ☐ Declined to answer
Comments:
Scoring: If the patient checks yes to either box in question 7 and 8, consult with a clinical consultant and supervisor.

Section 9. Substance Use

☐ **Member declined to complete this section**.
Comments

I have some questions about your experience with alcohol, nicotine products, marijuana, and other substances.
Some of the substances we will talk about are prescribed by a doctor, but I will only be focusing on whether you have taken them for reasons other than prescribed or in doses other than prescribed.

1. In the last 6 months, how often have you used the following?	**Never**	**1-2 times**	**Monthly**	**Weekly**	**Daily**
A. Alcohol	☐	☐	☐	☐	☐
B. Nicotine products (cigarettes, vaping, chewing	☐	☐	☐	☐	☐

Section 9. Substance Use

tobacco)					
C. Using Prescription drugs not as prescribed (circle any relevant): pain medicines, ADHD medicines, sleeping pills, other:	☐	☐	☐	☐	☐
D. Marijuana including edibles or other products with Tetrahydrocannabinol (THC)	☐	☐	☐	☐	☐
E. Other substances: For example: cocaine, meth, heroin, hallucinogens, inhalants, designer drugs	☐	☐	☐	☐	☐

2. Have you ever felt you ought to cut down on your drinking or drug use?
☐ Yes ☐ No ☐ N/A ☐ Declined to answer If yes, go to the next question.

3. Would you like to talk with someone about your substance use, especially if you are thinking of quitting or cutting back? ☐ Yes ☐ No ☐ N/A ☐ Unsure ☐ Declined to answer

4. Are you currently or have you received treatment for substance use?
☐ Yes ☐ No ☐ N/A ☐ Unsure ☐ Declined to answer
If yes, can you describe the treatment you received (e.g., residential treatment, outpatient treatment, or Medication Assisted Treatment, such as Vivitrol, Suboxone, Naltrexone, Methadone, Subutex, etc.):
   - Can you provide the contact information of where you are/were receiving treatment?
     Provider Name:
     Contact Number:
   - ☐ Currently receiving treatment ☐ Previously received treatment

5. Please share any additional information about your past substance use (e.g., longer than the past 6 months, family history):

Note: If there are any safety concerns for the member or their family, consult with the clinical consultant and supervisor.

6. Additional Comments:

Section 10. Developmental Factors
Ask the following questions only if this information is not already available to the ECM Provider Team.

1. Question for patient OR family/caregiver/case manager (depending on individual's ability to answer): Has a healthcare provider ever told you or your family that when you were a child or adult that you had a developmental delay, disability or brain injury that impacted your ability to think clearly (for example, traumatic brain injury, autism spectrum disorder, ADHD, learning disability)?
☐ Yes ☐ No ☐ Unsure ☐ Declined to answer
Comments:

Section 11. Health Literacy

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

1. Do you need help filling out health forms? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer
2. Do you need help answering question during a doctor's visit? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer
3. How confident do you feel managing your medications on your own?
☐ Not confident ☐Slightly confident ☐ Somewhat confident ☐ Fairly confident ☐ Completely confident
4. Would you like additional resources for managing your medication such as educational/management resources for your medical needs? ☐ Yes ☐ No

Section 12. Social Determinants of Health (SDoH)

Housing

Section 12. Social Determinants of Health (SDoH)

1. What is your current housing condition? ☐ Stable and sage ☐ Motel ☐ Garage or portion of living space ☐ Staying with friends ☐ Car ☐ Transitional housing ☐ Temporary shelter ☐Frequent migration ☐ Other:
☐ Declined to Answer
Comments

2. Are you worried about losing your housing? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer
If yes, please explain:

3. What concerns you the most about hour housing situation?

4. Is anyone currently helping you with your housing support? (for example, Housing Navigator, case management, or tenant's rights) ☐ Yes ☐ No ☐ N/A
Comments:

5. Housing Environment: Can you live safely and easily around your home? ☐ Yes ☐ No ☐ Declined to answer
If no, does the place where you live have the following:

Good lighting ☐ Yes ☐ No	Good heating ☐ Yes ☐ No	Good cooling ☐ Yes ☐ No
Rails for any stairs/ramps ☐ Yes ☐ No	Hot water ☐ Yes ☐ No	Indoor toilet ☐ Yes ☐ No
Space to use a wheelchair ☐ Yes ☐ No	Clear ways to exit your home ☐ Yes ☐ No	

Comments:

Safety

6. Do you feel physically and emotionally safe where you currently live? ☐ Yes ☐ No*
If no, please describe:
*If no, consult with the clinical consultant and supervisor.

7. Is anyone stating in your home without your permission? ☐ Yes* ☐ No
If yes, please describe:
*If yes, consult with the clinical consultant and supervisor.

8. Are you afraid of anyone or is anyone hurting you?☐ Yes* ☐ No
If yes, please describe:
*If yes, consult with the clinical consultant and supervisor.

9. Is anyone using your money without your OK? ☐ Yes* ☐ No
If yes, please explain:
*If yes, consult with the clinical consultant and supervisor.

Food Security

10. 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 ☐ Declined to answer

11. How often are you hungry or do not eat because there is not enough food in the house?
☐ Often ☐ Not often ☐ N/A ☐ Declined to answer

12. Do you eat less than you feel you should because there is not enough food?
☐ Yes ☐ No ☐ Declined to answer

13. Comments:

Social Connections/Support

14. Who do you live with?
☐ Unhoused
☐ Live alone

Section 12. Social Determinants of Health (SDoH)

☐ Live with spouse or significant other. If checked, please list more information about relationship(s) and age(s):

☐ Live with children or other relatives/friend. If checked, please list more information about relationship(s) and age(s):

☐ Live with caregiver. If checked, please list more information about relationship(s) and age(s):

☐ Live with other residents in my facility/program.
☐ Declined to answer
☐ Other, please describe:

15. Do you have any children not already listed above (including ages)? ☐ Yes ☐ No

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)
☐ Less than once a week ☐ 1-2 times a week ☐ 3-5 times a week ☐ 5 or more times a week ☐ Declined to answer

17. Are you caring for anyone and/or any pets? ☐ Yes ☐ No
If yes, describe:

Family Member/Individual Support (Including Caregiver Resources and Involvement)

18. Do you have family members, friends, or others willing to help you when you need it?
☐ Yes ☐ No ☐ Declined to answer
Comments:

19. Do you have a caregiver assisting you? ☐ Yes ☐ No ☐ Declined to answer
If yes, what is the name/contact information (phone/email):

20. Do you ever think your caregiver has a hard time giving you all the help you need?
☐ Yes ☐ No ☐ N/A
If yes, please explain:

21. Do you have an In-Home Supportive Services (IHSS) worker? ☐ Yes ☐ No ☐ Declined to answer
If yes, how many IHSS hours are you receiving?
- IHSS Worker Name:
- IHSS Contact Number:

22. Additional Comments:

Section 13. Benefits and Other Services

1. Funding/benefit sources/services: ☐ None

☐ CalFresh Benefits (SNAP)	☐ SSI recipient	☐ SSDI recipient
☐ CalWORKs	☐ TANF recipient	☐ Other retirement income
☐ Employed	☐ SSA (retirement) recipient	☐ Spousal Support
☐ General Relief	☐ VA Benefits	☐ Home Visting Program
☐ WIC (list site):	☐Others:	

2. Do you sometimes run out of money to pay for food, rent, bills and medicine?
☐ Yes ☐ No ☐ Declined to answer

3. What is the current work situation? ☐ Declined to answer
☐ Part-time ☐ Full-time ☐ Student ☐ Retired
☐ Other:
Unpredictable (e.g., day labor) ☐ Yes ☐ No

Section 13. Benefits and Other Services

4. Are there any concerns or challenges with your job? ☐ Yes ☐ No ☐ Declined to answer
If yes, describe:

5. Are you receiving any services from any of the programs below? ☐ None

☐ Long-term care and support (SNF, Rehab Center)	☐ Family PACT	☐ Community-Based Adult Services
☐ Veterans Administration	☐ Palliative care programs	☐ Regional Center
☐ California Children's Services	☐ Others:	

Section 14. Legal Involvement

1. In the past 12 months, have you been involved with the following: ☐ None

☐ Court-ordered services	☐ On probation	☐ On parole	☐ Re-entry program
☐ Adult Protective Services (APS)	☐ Child Protective Services (CPS)	☐ Community Legal Services	☐ Declined to answer
☐ Other (list):			

Comments:

2. Contact information as applicable (name, number, organization):

3. In the past year, have you spent more than two nights in a row in a jail, prison, detention center, or juvenile correctional facility? ☐ Yes ☐ No ☐ Declined to answer
If yes, "I would like to coordinate with anyone you are working with related to your stay in_____ so we can work together to support you and your goals. May I contact that person with you?"

4. Have you ever associated with members of a gang or been involved in one? ☐ Yes ☐ No ☐ Declined to answer
If yes, what is your current status?

Section 15. Advanced Care Planning

Life planning is an important aspect to one's holistic health and planning needs.

1. Do you have a life-planning document or advance directive in place? ☐ Yes ☐ No ☐ Declined to answer
2. Do you have an authorized representative to speak on your behalf about issues?
☐ Yes ☐ No ☐ Declined to answer
If yes provide name and relationship:

3. Do you want information on these topics? ☐ Yes ☐ No ☐ Declined to answer

Section 16. Member Priorities

1. What concerns you the most about your physical and mental health?

2. What is one thing you would like to do right now to improve your health (such as cutting back on caffeine or sugary drinks)? *Provide easy, harm reduction examples:*

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

4. From our meeting today what comes to mind as your top 2-3 goals for your health, wellness, and social and/or living situation for the next 3-6 months?
Goal 1:

Section 16. Member Priorities
Goal 2:
Goal 3:

Narrative Summary
Include Primary Needs identified from Assessment (please also add this summary in the ECM Member Care Plan).

Next Steps	**Person Responsible**
1.	
2.	
3.	
Next Appointment Date:	**Next Appointment Location:**

Enhanced Care Management (ECM)
Member Care Plan

This Member Care Plan has been developed in collaboration with the member/authorized representative and the ECM Lead Care Manager to address current needs, goals, and preferences. The care plan will be reviewed regularly to ensure it continues to meet the member's needs.

Initial Date Completed:	**Last Reviewed:**

ECM Provider Information	
ECM Provider Name	Lead Care Manager Name:
Lead Care Manager Phone Number:	Lead Care Manager Email Address:

Member Information			
Member First Name	Member Last Name	Member DOB	Medi-Cal ID / CIN
Preferred Language	ECM Enrollment Date	ECM Target Graduation Date[1]	

Primary Care Provider (PCP) Information: (please update if PCP changes)		
Community Clinic/Medical Group Name:	PCP Address:	
PCP Name:	PCP Phone:	Date member last saw PCP[2]:

Care Team: list the members' care team names, titles, license (if applicable) and phone number. Add rows if needed.	
Caregiver/Representative:	
Specialist:	
Behavioral Health:	
Other:	

[1] The ECM target graduation is the last day of the authorization. However, once the member graduates this date needs to be updated. If the member does not graduate or leaves the program do not update this date.

[2] This date must be in the past from the date the care plan was created. Do not put a future date. Update the date if the member does see their PCP in the future. Keep this date current.

Member Appointments (please list all appointments the member plans to attend) Use additional pages if needed.			
Appointment Type	Appointment Date/Time	Location/Address	Status[3]

[3] Status: Not-Started, In-Progress, Completed, Canceled or if other please describe.

Please use this page as a template to create Problems, Goals and Interventions. Use as many pages as needed. ***Page 1 of____***

Problem 1 of _____

Problem Description – Write a few sentences that gives an overview of the problem. Avoid overgeneralization statements.

Start Date:	Last Reviewed:	Target Completion Date:

Use the following table to create goals and interventions for the problem. Copy the table to add more goals and interventions.

SMART Goal (Specific, Measurable, Achievable, Realistic, Time-Bound)

Goal Description – Write a few sentences that gives sufficient narrative about the goal and by when the goal is estimated to be completed. Ensure to follow the SMART Goal format.

Start Date:	**Target Completion Date**:	**Priority**: ☐Low ☐ Medium ☐ High ☐ Critical

Member Strengths:	
Member Barriers:	

List the interventions (activities, referrals, etc.) to help support the completion of the goal. Add more rows if needed.

Intervention	Person(s) Responsible	Outcome / Status	Outcome Date
	☐ Member ☐ LCM ☐ Both ☐ Parent/Caregiver ☐ Other:	☐ Not Started ☐ In-Progress ☐ Completed ☐ Canceled ☐ Other:	
	☐ Member ☐ LCM ☐ Both ☐ Parent/Caregiver ☐ Other:	☐ Not Started ☐ In-Progress ☐ Completed ☐ Canceled ☐ Other:	
	☐ Member ☐ LCM ☐ Both ☐ Parent/Caregiver ☐ Other:	☐ Not Started ☐ In-Progress ☐ Completed ☐ Canceled ☐ Other:	

Outcome of Goal: ☐ Completed ☐ Not Completed	**Goal Closed Date**:

Goal Outcome Reason: provide a summary of the goal outcome and/or other comments.

Care Plan Agreement: upon completing the care plan with the member/authorized representative, please gather a signature or verbal consent.

☐ **Verbal Consent:** use only if the member or their authorized representative was informed of the items written in the care plan via phone/telehealth and gave verbal consent.

This document was read on (mm/dd/yyyy) _____

to the member or authorized representative by:_____.

If signing in-person: member and/or their authorized representative agree to the items listed in the care plan.

Name	Signature	Date
Name	Signature	Date

Directions for ECM Providers

The Member Care Plan is provided to contracted CalAIM Enhanced Care Management (ECM) providers to equip the ECM Lead Care Manager (LCM) to develop a comprehensive, individualized, person-centered care plan that coordinates and integrates the member's clinical and non-clinical healthcare-related needs.

The **initial care plan must be created immediately** after the initial Health Needs Assessment (HNA) or no more than 10 days after the HNA is completed. Problems and concerns identified in the HNA should be addressed in the member's care plan. If the member refuses to work on an identified need, the LCM must clearly document this finding in a progress note in their Electronic Health Records (EHR) / Electronic Medical Record (EMR) or other case management system.

The care plan includes but is not limited to members' identified concerns, goals, and preferences in the areas of physical health, mental health, substance use disorder (SUD), community-based Long-Term Services and Support (LTSS), palliative care, trauma-informed care needs, social support, and housing (as appropriate for individuals experiencing homelessness), with measurable objectives and timeframes, and it should evolve as the member's needs change.

Please add as many Problems, Goals, and Interventions as necessary. The goals must follow the SMART goal format (Specific, Measurable, Achievable, Realistic and Time-bound). The Member Care Plan should be updated **at least every 6 months** or as often as needed by the LCM. For questions in the care that are not applicable please write N/A – **do not leave sections blank**.

The following guidelines apply to the Member Care Plan:

- The members' main health concern must be clearly integrated into the care plan. This may not always be related to medical health care needs. All concerns can be integrated into any of the problems/goals/interventions developed.
- Members' self-management activities can be listed within the specific interventions.
- Member barriers must address the condition or event that may delay or prevent reaching plan goals. Each goal must have a barrier.
- Additional conditions/problems: choose conditions/problems that put the member at risk for deterioration in health status/unstable conditions (homeless, inadequate caregiver) and conditions that need immediate attention/clinical (e.g., behavioral health, transition of care, continuity of care needs, etc.)
    - **Clinical:** (e.g., behavioral health, transition of care, continuity of care, etc.)
    - **Non-clinical:** (e.g., homeless, inadequate caregiver support, personal goal, etc.)
- For individualized goals and interventions, use the member's language when possible (member-directed goals)
- LCM is required to confirm, with the member, their assigned PCP's information as part of the care plan development process and documentation. **If the member does not have an assigned PCP, the LCM is responsible for assisting the member in identifying one**.
- LCM should coordinate Care Team meetings and document occurrences in section – Care Team Meetings/Case Conferences.
- LCM should use strategies to reduce avoidable emergency department visits, admissions, or readmissions.
- LCM is responsible for coordinating follow-up appointments for the member when a key event occurs. See section – Key Events. Hospitalizations must follow the Transitional Care Services coordination process.
- *The care plan should not have any overdue goals or interventions*. The care plan should consistently be updated at a frequency appropriate for the member, when there is a change in condition, upon reassessment, care conference and/or care plan progress updates; however no later than 6 months from the last care plan update.
    - Use the section in the care plan called – Version History – to track updates.
- LCM is required to provide a copy of the completed care plan to the member and/or authorized representative and the member's PCP (**within 14 days** of completing or updating the care plan). If the member/authorized representative or PCP refuse to receive a copy of the care plan, please document this in section – Care Plan Oversight.

When completed, save the document in the ECM provider's EHR/EMR/Case Management System. The document may also be saved in the member's profile in CalOptima Connect. The Member Care Plan must be made available to CalOptima Health upon request. If you have questions regarding how to complete the Member Care Plan, please contact CalOptima Heath via email CalAIM@caloptima.org with subject line "Care Plan".

The following pages are designed to help the LCM track administrative items related to the member's care plan. This document should be used when no other case management system is available. If you are using an EHR/EMR or other case management system, please ensure that the information presented here is consistent and aligned with what is documented in those systems.

ECM Provider Information	
ECM Provider Name	Lead Care Manager Name:
Lead Care Manager Phone Number:	Lead Care Manager Email Address:

Member Information			
Member First Name	Member Last Name	Member DOB	Medi-Cal ID / CIN

Version History/Date Updated[1] (add additional rows as needed)		
Date Completed or Closed	Lead Care Manager Name	Reason for updating or indicate if this is the initial care plan.

Health Needs Assessment Information		
Assessment Completion Date	Re-Assessment Completion Date[2]	Last Review Date

Provide a brief summary of key items in the Health Needs Assessment (HNA)	
Housing:	
Income	
SMI/SUD:	
Public Benefits	
Medical/Dental/Vision:	
Transportation or other Social Determinants of Health:	
Activities of Daily Living:	

[1] ECM provider must maintain the care plan updated (at least every 6 months) and may alternatively use other tracking tools/progress notes that clearly demonstrate the information in this section.
[2] Provide date only if a reassessment was completed.

Care Team Meetings/Case Conferences[3] (add more rows if needed)		
Date	Topic/Related Goal or Problem	Attendance

Key Events (add more rows if needed)		
Event Type: (1) ED visit, (2) Hospitalization visit, (3) PCP Change		
Date (mm/dd/yyyy)	Event Type	Provide a short summary of follow-up or TCS coordination.

Care Plan Notification		
Please indicate who received a copy of the care plan. The care plan must be shared with the member and/or authorized representative AND the PCP within 14 calendar days of completion and can be shared with other individuals as appropriate.		
Did the member receive copy of the care plan? ☐Yes ☐ No If yes, please select one of the following: ☐ Copy provided in-person		
☐ Copy mailed to (address):		
☐ Copy emailed to (address):		
☐ PCP	Name:	Date:
☐ Parent/Guardian	Name:	Date:
☐ Caregiver/Authorized Representative	Name:	Date:
☐ Other	Name:	Date:
Notes:		

[3] LCM should coordinate Care Team meetings as often as necessary to review goals/updates.

Care Plan Oversight: complete/update this section as needed. The initial care plan should be signed by the LCM.	
The LCM consulted with ECM supervisor/director or another professional in the creation and overview of the care plan.	☐ Yes ☐ No
Lead Care Manager Signature:	Date:

Care Plan Completion (only complete if the member graduates from the ECM Program)	
If the member graduates from the ECM Program, please update the Care Plan. All problems, goals and interventions must have a completion/last reviewed date.	
I (LCM name), _____, hereby attest that the information written is true and accurate to the best of my knowledge, and all areas in the care plan are updated.	Date:

Enhanced Care Management (ECM)
Post Discharge Assessment

A post discharge risk assessment evaluates a member's care and outcomes after they leave the hospital or healthcare facility to ensure a smooth transition and prevent complications. The Lead Care Manager (LCM) should use this assessment form with the member and/or caregiver(s) within 48 hours following hospital discharge and to support updating the member's care plan.

Please upload this completed form to the member's records in your Electronic Health Records (EHR) or other case management system.

Date of Admission	Date of Discharge	Date of Assessment

LCM Name	LCM Phone Number	LCM Email
Member Name	**Member DOB**	**Member Medi-Cal ID**
PCP Name	**PCP Phone Number**	

Questions
1) Do you have a follow-up appointment scheduled with your (PCP) provider? ☐ Yes ☐ No If not, please explain:
2) Do you need assistance with scheduling a follow-up visit? If yes, when is the member's appointment? (**Date**: mm/dd/yyyy **Time**: hh:mm AM/PM)
3) Do you have reliable transportation to home or for your next appointment(s)? *To request a ride for authorized services, call CalOptima Healths transportation line at 1-833-648-7528 (TTY) 771) at least 2 business days (Monday-Friday) before your appointment. Or call as soon as you can when you have an urgent appointment. Have your member ID card ready when you call* ☐ Yes ☐ No **If not, explain the next steps to arrange transportation (e.g., call CalOptima Health to schedule a ride).**
4) Did you get new prescriptions? ☐ Yes ☐ No
5) Are there any issues with filling your prescription? ☐ Yes ☐ No
6) If issues with filling prescription: What are the issues?

CalOptima Health

Enhanced Care Management (ECM)
Post Discharge Assessment

Questions
7) Do you have someone to help you at home? The following individual(s) help the member at home:
8) What do you need help with?
9) Did the doctor order any home health care for you? "Like a nurse, physical therapy, etc." ☐ Yes ☐ No If **yes**, has Home Health started? ☐ Yes ☐ No
10) Who is your home health provider? "Name and phone"
11) Was any DME (Durable Medical Equipment) ordered for your discharge? ☐ Yes ☐ No A. **If yes, what DME vendor name and phone**: B. **Have you been contacted by the DME vendor?** ☐ Yes ☐ No C. **What is the expected DME delivery date**:
12) Would you like someone from the Enhanced Case Management team to help you after your hospital stay? ☐ Yes ☐ No ☐ N/A Member is in ECM
13) You may be eligible for Community Supports Meals upon discharge. Would you like a referral for this benefit? ☐ Yes ☐ No
14) Do you have any additional concerns that have not been addressed?

Enhanced Care Management (ECM) Program Completion Questionnaire

The Lead Care Manager (LCM) will ask these questions to decide if the member is ready to finish the ECM program or move to a lower level of care management. These questions aren't needed if the member no longer qualifies or has left the ECM program.

Date Completed (mm/dd/yyyy)	ECM Provider	
LCM Name	LCM Phone Number	LCM Email
Member Name	DOB (mm/dd/yyyy)	Medi-Cal ID

1) [REQUIRED] **Please explain why the member first joined the ECM program.**

Care Plan
2) Has the Member met the goals in the care plan? ☐ Yes ☐ No ☐ If no, explain:

Physical Health	
3) Access to care: Member can do the following on their own (check all that apply):	
☐ Make appointments. ☐ Track appointments on a calendar. ☐ Keep appointments or call to reschedule or cancel in advance. ☐ Know how to call the primary care provider (PCP) or Nurse Advice Line.	☐ Use the emergency room (ER) appropriately. ☐ Know how to attend telehealth appointments. ☐ Find community resources. ☐ Call Customer Service to ask questions or request services (change provider, request case management).
Transportation	
4) Does the Member have access to reliable transportation to attend all appointments, and know how to contact CalOptima Health to schedule rides? ☐ Yes ☐ No ☐ Other:	

Enhanced Care Management (ECM) Program Completion Questionnaire

Health Literacy
5) Does the Member understand why he/she takes each medication and knows how to take them as told by their doctor? ☐ Yes ☐ No ☐ Other:
6) Does the Member know when to see their doctor? Does the Member feel comfortable talking to their doctor about what is bothering them and asking questions? ☐ Yes ☐ No ☐ Other:
7) Can the Member follow their care team's recommendations such as eating right or exercising? ☐ Yes ☐ No ☐ Other:
8) Does the Member know how to take care of their health and ask for help when needed? ☐ Yes ☐ No ☐ Other:

Mental and Emotional Health	
9) Does the Member feel like they can manage their stress? ☐ Yes ☐ No ☐ Other:	
10) Member can do the following on their own (check all that apply):	
☐ Understand mental health diagnosis and treatment. ☐ Know where and when to get care and make informed decisions about getting care. ☐ Recognize warning signs related to emotional health or mental health diagnosis. ☐ Recognize things that are upsetting and respond in a healthy way.	☐ Understand the reason for taking medicines and know how to take them. ☐ Identify one or more people to talk to, such as a support person or group. ☐ Find help when needed.

Housing
11) Does the Member have safe and stable housing? Does the member know how to find help if they need it? ☐ Yes ☐ No ☐ Other:
12) Does the member know their rights in their current housing situation? ☐ Yes ☐ No ☐ Other:
13) Does the member understand how their actions such as paying rent late, hoarding or smoking can affect their housing? ☐ Yes ☐ No ☐ Other:
14) Does the member understand why keeping a good relationship with the landlord is important? ☐ Yes ☐ No ☐ Other:

Daily Living
15) Can the Member do things for themselves, like cooking, cleaning and shopping? Can the Member ask for help when need it? ☐ Yes ☐ No ☐ Sometimes:
16) Can the Member do or get help (if needed) with activities of daily living such as bathing, dressing, toileting, transferring, continence and feeding? ☐ Yes ☐ No ☐ Other:
17) Does the Member have all the supplies and equipment to live on their own? ☐ Yes ☐ No ☐ Other:
18) Is the Member able to get food and transportation and ask for help when needed? ☐ Yes ☐ No ☐ Other:
19) Does the Member have their birth certificate, Social Security card, driver's license, and other records to prove their identity? ☐ Yes ☐ No ☐ Other:
20) Does the Member know how to manage their money and track how it was spent, such as rent, bills and groceries? Note: This includes all types of income such as CalFresh and Social Security. ☐ Yes ☐ No ☐ Other:

21) [REQUIRED] **Is the Member still receiving services from any programs they were previously referred to or services today? If so, what are they?**
22) [REQUIRED] **Please describe any ongoing needs for care management services for specific issues or concerns.**

Names and Signatures		
How was this form completed: ☐ **In Person** ☐ **Over the Phone** ☐ **Telehealth**		
If the form was completed over the phone or via telehealth, LCM must meet with the member to get this form signed.		
Member/Authorized Representative Name	**Member /Authorized Representative Signature**	**Date (mm/dd/yyyy)**
Lead Care Manager Name	**Lead Care Manager Signature**	**Date (mm/dd/yyyy)**

Please upload this completed form to the member's patient record within CalOptima Health Connect and email a copy to the CalAIM inbox at CalAIM@caloptima.org.

ECM Administrative Questions
1. Is a wet signature required in the templates that contain a signature? Can we use an electronic signature instead? ➢ Electronic signatures are acceptable.
2. What documents are required to be uploaded to CalOptima Health Connect? ➢ The only document that is required to be uploaded to CalOptima Health Connect is the Program Completion Questionnaire. ➢ Please maintain all other documents, including the CalOptima Health templates and member progress notes, in your Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic health records (EHR) system. ➢ For a short-term absence of having a HIPAA-compliant EHR system, providers may temporarily use CalOptima Health Connect to save documents in the member's ECM Services section. CalOptima Health will only allow this short-term use with an approved plan to transition to an EHR system for the ECM Provider. Please refer to the instructions on how to upload attachments written in the CalOptima Health Connect User Guide under "Our Services."

Health Needs Assessment (HNA)
1. Are we supposed to use the assessments listed in the HNA template as well? ➢ These are not required but are highly encouraged. Beyond the HNA, ECM providers will need to determine which additional assessments would be useful for each member.
2. Can we remove items in the HNA that are not pertinent to our population? ➢ We expect standard questions that are applicable for all members to remain in the template. ➢ ECM providers may add questions to the HNA template based on the population served.
3. What is the age group for the Child and Youth Health Needs Assessment? ➢ Members under 21 years of age.
4. Are we required to complete a reassessment? ➢ The lead care manager (LCM) should review the latest HNA to confirm if there are any changes or updates at least every six months or whenever there is a major change in the member's life. Please document in a progress note the name of the reviewer and the date the HNA was reviewed with the member.
5. If reauthorization is needed, do we need to complete the HNA again? ➢ No. See above for the frequency of HNA completion.

Care Plan
1. For members who have a care plan before July 1, 2025, should we transition them to the new care plan? ➢ Members currently receiving ECM services should be transitioned to the new care plan at their six-month care plan update. The new care plan will be required to be used for all members starting July 1, 2025.
2. If certain goals of the care plan cannot be completed, can the member still graduate from ECM? ➢ It is the member's choice to decide how long they want to stay in the ECM program. The LCM must make sure to document the status of the goals and date of closure or completion in the care plan, along with a short summary of those goals that were not met.
3. Is it a requirement for the LCM to consult with a supervisor for every care plan? ➢ Yes. The reason for this new requirement is to require oversight of the LCM and the care plan. ➢ The ECM supervisor should review the care plan even if a registered nurse (RN) or licensed vocational nurse (LVN) completes the care plan. ➢ The supervisor does not need to co-author the care plan but should review it.
4. Does the ECM supervisor need to be a licensed professional? ➢ Although that is highly recommended, a non-licensed, paraprofessional supervisor can review the care plan.
5. Do we need to use the ECM Care Plan Tracking Requirement template if we track this information in our case management system? ➢ Please compare what is being captured in the ECM Care Plan Tracking Requirement template with what is in your EHR system. We expect all the information in the template to be captured in your system, and that you can document this information when requested during an audit.
6. Do we need to submit care plans to request reauthorization? ➢ No. However, please provide the care plan if CalOptima Health's clinical team requests it prior to issuing a reauthorization.
7. The care plan seems to be a living document, but once the document is signed, the system does not let us make updates. How can we troubleshoot this? ➢ ECM providers have the flexibility to use their own EHR systems to maintain and keep documents updated. ➢ Other suggestions: o Consult with your EHR vendor about maintaining a living document. o Save a copy of the initial care plan document that will be signed by the LCM and the member as an attachment to the member's profile. o When the care plan is updated, save a new copy with a new date.

8. Should the Appointment List have all the appointments or only upcoming appointments?

- The appointment list should reflect upcoming appointments.

9. Does the care plan need to be signed by the member?

- The LCM should have the member sign the care plan or verbally consent.

Post Discharge Assessment

1. If a member is hospitalized or inpatient in a facility, when should the LCM conduct outreach and complete the Post Discharge Assessment?

- The LCM should contact the member within 48 hours of the member being discharged. Please document outreach activities in a progress note.
- The LCM should complete the Post Discharge Assessment within 48 hours of member being discharged. Please document completion of the assessment in a progress note.

2. Is this document to be completed within 48 business hours or does it include weekends?

- 48 business hours.
- CalOptima Health highly recommends that the LCM contact the member while they are still an inpatient and coordinate a follow-up visit with the member before they are discharged to ensure no disruption in care.

3. What is the difference between the ECM Post Discharge Assessment and the Post Discharge Report by DHCS?

- The ECM Post Discharge Assessment is to be completed while the member is still in the hospital (inpatient) or right after discharge to ensure all services are coordinated as outlined in the member's discharge plan.
- The Post Discharge Report is a specific report required by DHCS to monitor providers who deliver Transitional Care Services to high-risk ECM members. This report does not supersede requirements regarding the ECM Post Discharge Assessment.

4. What if the member is discharged and we are unable to contact them?

- Please document in a progress note any activities performed to contact the member and the doctor's office.
- If the LCM contacts the member after 48 hours, please complete the ECM Post Discharge Assessment as soon as possible and ensure coordination of all follow-up items in the member's discharge plan.

5. Is the Post Discharge Assessment to be used for emergency department (ED) visits?

- Please use the Post Discharge Assessment only if the member is admitted to a hospital or other inpatient facilities.
- If the member visits the ED, the LCM should contact the member to help coordinate follow-up appointments and document the outreach and outcome in a progress note.

Program Completion Questionnaire (PCQ)?
1. Who should complete the PCQ? ➢ This document is to be completed only if the member graduated from the ECM program. ➢ This document is not required to be completed if the provider continues to provide services, the member cannot be contacted or ECM services are ended for any reason other than graduation/successful completion of ECM services.
2. Is the timeframe to complete the PCQ seven days before or after the end of the authorization? ➢ Ideally, the LCM should complete the PCQ before ending the ECM authorization and submit it when discharging the ECM authorization. CalOptima Health has provided ECM providers flexibility for the LCM to complete the PCQ no later than seven business days after ending the ECM authorization without penalty on the annual ECM audit.

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