Enhanced Care Management Program Completion Questionnaire (PCQ)

Enhanced Care Management (ECM) lead care managers are encouraged to use this questionnaire with the member to help determine readiness for: the program completion of ECM, the transition out of ECM to a lower level of care management, or continuation of services.

Date:

Member First Name:	Member Last Name:
Member CIN:	Member DOB:
Provider Name:	Lead Care Manager (LCM) Name:

Care Plan: To be completed by the LCM		
The member has met all care plan goals.	☐ Yes ☐ No Provide more details:	
Physical Health: To be completed by the member		
I can do the following on my own or with help (e.g. caregiver or support person). Please check all that apply:	☐ Yes ☐ No ☐ N/A	Make appointments
	☐ Yes ☐ No ☐ N/A	Track appointments on calendar
	☐ Yes ☐ No ☐ N/A	Keep appointments or call to reschedule/cancel in advance
	☐ Yes ☐ No ☐ N/A	Know how to call the primary care physician (PCP) or Nurse Advice Line
	☐ Yes ☐ No ☐ N/A	Know where to call for interpretation and translation services, if needed
	☐ Yes ☐ No ☐ N/A	Utilize the urgent care and the emergency department (ED) appropriately
	☐ Yes ☐ No ☐ N/A	Know how to attend telehealth appointments

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I can do the following on my own or with help (e.g. caregiver or support person). Please check all that apply:	☐ Yes ☐ No ☐ N/A	Find community resources
	☐ Yes ☐ No ☐ N/A	Call Member Services to ask questions or request services (change provider, request case/care management services)
	☐ Yes ☐ No ☐ N/A	Call Transportation Services line to schedule rides to appointments, pharmacy, food pantries
	☐ Yes ☐ No ☐ N/A	Understand the member Bill of Rights
	☐ Yes ☐ No ☐ N/A	Use the Member Handbook
I understand why I take each of my medications and I take them as instructed by my doctor.	☐ Yes ☐ No	Notes:
I know when to see my care provider and I feel comfortable talking to my care provider about what is bother me and asking questions.	☐ Yes ☐ No	Notes:
I can follow my care team's recommendations (e.g., eating right, exercising).	☐ Yes ☐ No	Notes:
I feel like I can manage my stress	☐ Yes ☐ No	Notes:
I know how to take care of my health and ask for help when they need it	☐ Yes ☐ No	Notes:
Mental/Emotional Health: To be completed by the member		
I can do the following on my own or with help (e.g. caregiver or support person). Please check all that apply:	☐ Yes ☐ No	Understand my mental health diagnosis and treatment
	☐ Yes ☐ No	Know where and when to seek care and make informed decisions about care

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	☐ Yes ☐ No	Recognize warning signs related to emotional health/mental health diagnosis
	☐ Yes ☐ No	Recognize things that upset me and respond in a healthy way
	☐ Yes ☐ No	Understand why I take my medications and know how to take my medications
	☐ Yes ☐ No	Identify one or more people I can talk to (e.g., support person or group).
	☐ Yes ☐ No	Find help when I need it
Housing: To be completed by the member		
Do I have safe and stable housing? Do I know how to find help if I need it?	☐ Yes ☐ No	Notes:
Do I know my rights in my current housing situation?	☐ Yes ☐ No	Notes:
Do I know how my actions, such as paying rent late, hoarding, and smoking, can affect my housing?	☐ Yes ☐ No	Notes:
Do I understand why I need to maintain my relationship with the landlord?	☐ Yes ☐ No	Notes:
Daily Living: To be completed by the member		
Can I do things like cook, clean, and shop for myself, or with the help of a caregiver or support person? Can I ask for help when I need it?	☐ Yes ☐ No ☐ Sometimes Provide more details:	

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Can I perform activities of daily living such as bathing, dressing, toileting, transferring, continence, and feeding on my own, or with the help of a caregiver or support person?	☐ Yes ☐ No ☐ Sometimes Provide more details:
Do I have all the supplies and equipment to live on my own or with the help of a caregiver or support person?	☐ Yes ☐ No ☐ Sometimes Provide more details:
Am I able to get food, transportation, and seek help when I need it?	☐ Yes ☐ No ☐ Sometimes Provide more details:
Do I have my birth certificate, Social Security card, driver's license, and other records to prove my identity? OR I know how to get my birth certificate, Social Security card, driver's license, and other records to prove my identity.	☐ Yes ☐ No ☐ Sometimes Provide more details:

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Do I know how to keep track of my money and how and where I spend it (for example, rent, bills, and groceries)? Note: intended to be inclusive of all income sources, including CalFresh.	☐ Yes ☐ No ☐ Sometimes Provide more details:

Recommendation: To be completed by the LCM

Based on the information in the assessment above, please complete the following questions. If the answer to all questions is "yes", the member should be transitioned to a lower level of care or discontinued from the program.

☐ Yes ☐ No ☐ N/A	Demonstrate ability to self-manage their care If no, what is the expected timeline to meet the goal: ____ months
☐ Yes ☐ No ☐ N/A	Complete all active care plan goals. If no, what is the expected timeline to meet the goal: ____ months
☐ Yes ☐ No ☐ N/A	Take active responsibility for their own health and follows their medication and treatment plans. If no, what is the expected timeline to meet the goal: ____ months
☐ Yes ☐ No ☐ N/A	Reduce the use of ED or hospitalizations within a 12-month period. If no, what is the expected timeline to meet the goal: ____ months
☐ Yes ☐ No ☐ N/A	Access primary care or behavioral healthcare services when needed. If no, what is the expected timeline to meet the goal: ____ months
☐ Yes ☐ No ☐ N/A	Have safe and stable housing and knows about supportive community services. If no, what is the expected timeline to meet the goal: ____ months

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☐ Yes ☐ No ☐ N/A	Have a support system or understands resources and how to use them correctly If no, what is the expected timeline to meet the goal: ____ months
☐ Yes ☐ No ☐ N/A	Perform, or can get help with, daily activities (e.g., bathing, toileting, feeding, cooking, and cleaning). If no, what is the expected timeline to meet the goal: ____ months

REQUIRED: Provide details for the following (to be completed by the LCM)

Please identify any programs or services to which the member was linked while they were receiving ECM services. Is the member still receiving services from these programs today?		
Please describe any ongoing need for care management services related to a specific need or concern.		
Is the member prepared to move to a lower level of care of care management?	☐ Yes Please list the program(s) that may be a good fit to help the member with services after the end of ECM services:	☐ No Member requires a new 6-month authorization to continue ECM services (Include this form in your request for a 6-month authorization for services).