

ECM Adult Screening 21+ Years

Purpose: This data gathering, and attestation tool will be used to identify appropriate Case Management Program that patients, adults aged 21 and older, may qualify for in IEHP: Enhanced Care Management (ECM) or Complex Case Management (CCM). This tool will help the ECM Provider determine if the patient meets eligibility criteria for one or more ECM Population of Focus (PoF). Finally, when completed it serves as a referral request for authorization / enrollment for ECM services.

All questions are required unless otherwise indicated.

1. Referral Date:	
2. Requester: Who initiated the request for Care Management services?	<input type="checkbox"/> External ECM Care Teams <input type="checkbox"/> Provider <input type="checkbox"/> Patient <input type="checkbox"/> Family member or authorized representative <input type="checkbox"/> IEHP Department (Internal) <input type="checkbox"/> Other external entities
3. Source: How was patient referred to ECM?	<input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Health Information Exchange <input type="checkbox"/> IEHP Dept. <input type="checkbox"/> Telephone <input type="checkbox"/> Walk-In/Face to Face <input type="checkbox"/> Web/Portal
4. Health Indicator; Intellectual or Developmental Disabilities (IDD): Does the patient have any one of the following diagnoses? (Not a qualifying PoF)	<input type="checkbox"/> Intellectual or developmental disability <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Epilepsy <input type="checkbox"/> Autism <input type="checkbox"/> Not applicable
5. a. PoF Birth Equity (BE): Select the statement that best applies. Select all that apply.	<input type="checkbox"/> I am currently pregnant <input type="checkbox"/> I had a pregnancy in the last 12 months <input type="checkbox"/> Not applicable
5. b. What date was last day of your most recent pregnancy? (Not required)	
5. c. PoF Birth Equity (BE): Does the patient identify with any of the following racial or ethnic groups? Select all that apply.	<input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> None of the Above

<p>6. PoF Homelessness: Families or Adults without dependent children / youth living with them.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Is patient an adult without dependent children / youth living with them? If selected, go to next question. <input type="checkbox"/> Is patient part of a homeless family? If selected, skip to Q8. <input type="checkbox"/> Not applicable If selected, skip to Q10.
<p>7. PoF Homelessness: Does the patient have a complex physical, behavioral, or developmental health need with inability to successfully self-manage?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Yes If selected, skip to Q9. <input type="checkbox"/> No If selected, skip to Q10.
<p>8. PoF Homelessness: For adults with dependent children / youth (birth through age 20) living with them, do any of the following apply?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations <input type="checkbox"/> Living in emergency or transitional shelters; or abandoned in hospitals (in hospital without a safe place to be discharged to) <input type="checkbox"/> Couch surfing <input type="checkbox"/> No <p>If 'No' selected, go to next question. Otherwise, skip to Q10.</p>
<p>9. PoF Homelessness (HM): Do any of the following homeless definitions apply?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Lacks a fixed, regular, and adequate nighttime residence <input type="checkbox"/> Has a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings including a car, park, abandoned building, bus or train station, airport, or camping ground <input type="checkbox"/> Living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements <input type="checkbox"/> Is exiting an institution to homelessness (regardless of length of stay in the institution) <input type="checkbox"/> Will imminently lose housing in the next 30 days <input type="checkbox"/> Is fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence <input type="checkbox"/> No
<p>10. Does patient meet PoF Homelessness?</p>	<p>Yes, patient qualifies for PoF Homelessness. No, patient does not qualify for PoF Homelessness.</p>
<p>11. PoF At Risk for Avoidable Hospital or ED Utilization (HU): Does patient meet any utilization criteria?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Five (5) or more emergency room visits in the last 6 months. <input type="checkbox"/> Three (3) or more unplanned hospital and/or short-term skilled nursing facility stays in the last 6 months. No

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12. Does patient meet criteria for PoF At Risk for Avoidable Hospital or ED Utilization?	<input type="checkbox"/> Yes, patient qualifies for PoF At Risk for Avoidable Hospital or ED Utilization <input type="checkbox"/> No, patient does not qualify for PoF At Risk for Avoidable Hospital or ED Utilization
13. PoF Serious Mental Health and/or Substance Use Disorder (SMI/SUD): Does the patient have any complex Social Determinants of Health (SDOH) risk factors?	<input type="checkbox"/> Lack of access to food <input type="checkbox"/> Lack of access to stable housing <input type="checkbox"/> Inability to work or engage in the community <input type="checkbox"/> History of Adverse Childhood Experiences (ex. Abuse, neglect, mental health, divorce, substance abuse) with an ACE screening of four or more <input type="checkbox"/> Former foster youth <input type="checkbox"/> History of contacts with law enforcement related to mental health or substance use <input type="checkbox"/> Other – see appropriate Z codes in job aid <input type="checkbox"/> No <p style="color: red;">If 'No' selected, skip to Q19. Otherwise, go to next question.</p>
14. PoF SMI/SUD: Does at least one of the following apply to the patient?	<input type="checkbox"/> At high risk for institutionalization, overdose, and/or suicide <input type="checkbox"/> At high risk for institutionalization, overdose, and Use of hospital, ED, or urgent/crisis care for sole source of care <input type="checkbox"/> Two or more ED visits or two or more hospitalizations due to SMI or SUD in the last 12 months <input type="checkbox"/> Pregnant and post-partum (12 months from delivery) <input type="checkbox"/> No <p style="color: red;">If 'No' selected, skip to Q19. Otherwise, go to next question.</p>
15. PoF SMI/SUD: Is patient currently receiving specialty mental health services through the county?	<input type="checkbox"/> Yes <p style="color: red;">If selected, skip to Q17.</p> <input type="checkbox"/> No <p style="color: red;">If selected, go to next question.</p>
16. a. PoF SMI/SUD: Does patient have diagnosis of mental disorder from the Diagnostic and Statistical Manual of Mental Disorders (DSM), or one is suspected by a Provider (excluding substance use, sleep, dementia, or autistic disorders)?	<input type="checkbox"/> Yes <p style="color: red;">If selected, go to next question.</p> <input type="checkbox"/> No <p style="color: red;">If selected, skip to Q17.</p>
16. b. PoF SMI/SUD: Does patient experience personal distress, disability, or dysfunction in social/work/personal life, or are they at risk of loss of function in these areas?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>17. PoF SMI/SUD: Is the patient currently receiving services from Drug Medi-Cal Organization Delivery System or the Drug Medi-Cal program?</p>	<p><input type="checkbox"/> Yes If selected, skip to Q19.</p> <p><input type="checkbox"/> No If selected, go to next question.</p>
<p>18. PoF SMI/SUD: Does the patient have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for substance-related and addictive disorders (except for tobacco-related disorders)?</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>19. Does the patient meet criteria for PoF Serious Mental Health and/or Substance Use Disorder (SMI/SUD)?</p>	<p><input type="checkbox"/> Yes, patient qualifies for PoF SMI/SUD</p> <p><input type="checkbox"/> No, patient does not qualify for PoF SMI/SUD</p>
<p>20. PoF LTCELI and NFRT exclusions: Do any of the following statements apply to the patient's current living situation?</p>	<p><input type="checkbox"/> Lives in Intermediate care facility (ICF)</p> <p><input type="checkbox"/> Lives in Subacute care facility</p> <p><input type="checkbox"/> No</p> <p>If 'No' selected, go to next question. Otherwise, skip to Q28.</p>
<p>21. PoF Living in the Community and at risk for long term care institutionalization (LTCELI): Does patient currently live in the community?</p>	<p><input type="checkbox"/> Independent housing</p> <p><input type="checkbox"/> Residential Care Facility</p> <p><input type="checkbox"/> Residential Care Facility for the Elderly (RCFEs)</p> <p><input type="checkbox"/> Any other dwelling that meets the requirements established in the Home and Community Based Services (HCBS) Settings Final Rule</p> <p><input type="checkbox"/> No</p> <p>If 'No' selected, skip to Q25. Otherwise, go to next question.</p>
<p>22. PoF LTCELI: Is patient able to reside continuously in the community with wrap around supports?</p>	<p><input type="checkbox"/> Yes If selected, go to next question.</p> <p><input type="checkbox"/> No If selected, skip to Q25.</p>
<p>23. PoF LTCELI: Is patient actively experiencing any complex SDOH risk factors?</p>	<p><input type="checkbox"/> Needing assistance with activities of daily living</p> <p><input type="checkbox"/> Communication difficulties</p> <p><input type="checkbox"/> Access to food</p> <p><input type="checkbox"/> Access to stable housing</p> <p><input type="checkbox"/> Living alone</p> <p><input type="checkbox"/> Need for conservatorship</p> <p><input type="checkbox"/> Poor or inadequate caregiving</p> <p><input type="checkbox"/> Other – see applicable Z codes on job aid</p> <p><input type="checkbox"/> No</p> <p>If 'No' selected, skip to Q25. Otherwise, go to next question.</p>

<p>24. a. PoF LTCELI: Select which of the following short term Skilled Nursing Facility (SNF) level of care criteria that best applies to the patient.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Time limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis or treatment or recovering from acute illness or injury. <input type="checkbox"/> Unskilled assistance with activities of daily living and household tasks <input type="checkbox"/> A condition which needs therapeutic procedures such as catheter care, decubitus or ulcer dressings, post-surgical wounds, tube feedings, ostomy care, bowel, and bladder training. <input type="checkbox"/> None <p style="text-align: center; color: red;">If 'None' selected, go to next question. Otherwise, skip to Q25.</p>
<p>24. b. PoF LTCELI: Select which of the following long term SNF level of care criteria that best applies to the patient.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Continuous skilled nursing observation (BP, pulse, respiration) <input type="checkbox"/> Regular observation of skin for conditions such as decubiti, edema, color, and turgor <input type="checkbox"/> Careful measurement of intake and output <input type="checkbox"/> Medications which cannot be self-administered and requires skilled nursing services for administration of the medications, non-compliant with prescribed medical regimen <input type="checkbox"/> A physical or mental functional limitation (bedfast, quadriplegics or other severe paralysis, unable to feed self) <input type="checkbox"/> Mental limitation including persons with a primary diagnosis of mental illness (including intellectual disability), when such patients are severely incapacitated by mental illness or intellectual disability <input type="checkbox"/> Mental limitation including persons who exhibit early signs of dementia with few or no natural supports <input type="checkbox"/> None <p style="text-align: center; color: red;">If 'None' selected, go to next question. Otherwise, skip to Q25.</p>
<p>24. c. PoF LTCELI: Select which of the following lower acuity SNF level of care criteria that best applies to the patient.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Post-surgical patients who need assistance with tube feedings and ostomy care <input type="checkbox"/> Maintenance of the affected site (surgical or complex wound care) <input type="checkbox"/> Personal care services <input type="checkbox"/> Assistance with medication administration <input type="checkbox"/> Weakness in ambulating with bouts of instability and risk for falls <input type="checkbox"/> None
<p>25. Does the patient meet criteria for PoF LTCELI?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Yes, patient qualifies for PoF LTCELI <input type="checkbox"/> No, patient does not qualify for PoF LTCELI

<p>26. PoF Nursing Facility Residents Transitioning to the Community (NFRT): Do all three of the following criteria apply to the patient? (1) Patient interested in moving out of the institution (2) Able to reside successfully in the community (3) Able to reside continuously in the community</p>	<input type="checkbox"/> Yes, all three criteria apply <input type="checkbox"/> No
<p>27. Does the patient meet criteria for PoF NFRT?</p>	<input type="checkbox"/> Yes, patient qualifies for PoF NFRT <input type="checkbox"/> No, patient does not qualify for PoF NFRT
<p>28. PoF Justice Involved/Incarceration (JI): Is the patient transitioning from a correctional facility or have they transitioned within the last 12 months?</p>	<input type="checkbox"/> Yes <p style="text-align: center; color: red;">If selected, go to next question.</p> <input type="checkbox"/> No <p style="text-align: center; color: red;">If selected, skip to Q30.</p>
<p>29. PoF JI: Do any of the conditions apply?</p>	<input type="checkbox"/> Chronic Condition/Significant Non-Chronic Clinical Condition <input type="checkbox"/> Mental illness <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Intellectual or developmental disability (I/DD) <input type="checkbox"/> Pregnancy or Postpartum <input type="checkbox"/> Substance Use Disorder (SUD) <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> No
<p>30. Does patient meet PoF JI?</p>	<input type="checkbox"/> Yes, patient qualifies for PoF JI? <input type="checkbox"/> No, patient does not qualify for PoF JI?
<p>31. PoF Child Welfare (YCW), Former Foster Youth: Have you aged out of foster care in California or another state?</p>	<input type="checkbox"/> I am 21-26 years old AND I have been in foster care on/or after my 18 th birthday <input type="checkbox"/> Not Applicable
<p>32. Does patient meet PoF CW Foster Care</p>	<input type="checkbox"/> Yes, patient qualifies for PoF CW Foster Care? <input type="checkbox"/> No, patient does not qualify for PoF CW Foster Care?
<p>33. I have performed the necessary due diligence to determine the appropriate case management program that this patient qualifies for:</p>	<input type="checkbox"/> a. Meets PoF criteria. Based on patient interview and/or record review, I attest that to my knowledge this Member meets eligibility criteria for at least 1 PoF for ECM and request authorization of ECM services. <p style="text-align: center; color: red;">If selected, form completed.</p> <input type="checkbox"/> b. Patient Meets criteria for lower level of care. <p style="text-align: center; color: red;">If selected, go to next question.</p>
<p>34. Alternative care management program</p>	<input type="checkbox"/> a. I discussed another alternative care management program with Member, and Member declines. <input type="checkbox"/> b. I discussed another alternative care management program with Member, and Member is interested. I will ensure that a program referral will be sent to appropriate CM program. <p style="text-align: center; color: red;">END OF FORM</p>