ENHANCED CARE MANAGEMENT (ECM)
CARE PLAN GUIDE

PATIENT INFORMATION

First Name: _____ **Last Name:** _____ **CIN#:** _____

Date of Birth: _____ **Gender:** ____ **Gender Identification:** _____ **Preferred Pronouns:** _____

Nationality/Tribe/Ethnicity/Race (*Select all that apply*):
☐Hispanic/Latino ☐Asian ☐Pacific Islander/Native Hawaiian ☐White ☐Black/African American ☐American Indian/Alaskan Native ☐Other: _____ ☐Choose not to disclose

Primary Spoken Language: _____ **Written Language:** _____
Interpreter Needed: ☐Y ☐N *If yes, specify which language:*_____
Vision and/or Hearing Accommodation Needed: ☐Y ☐N *If yes, please describe:* _____

Do you have any cultural, religious and/or spiritual beliefs which are important to your health and wellness? ☐Y ☐N *If yes, please describe:* _____

Address Information

Street: _____ **City:** _____ **State:** ___ **Zip:** _____ **County:** _____

Contact Information

Phone #: _____ **Email:** _____ **Primary Point of Contact:** ☐Self ☐Other:

Name:	**Relationship:**
Phone:	**Email:**

Preferred method of contact: ☐In-person ☐Phone ☐Email ☐Other: _____
Preferred location of contact: ☐Home ☐Office ☐Community

Emergency Contact	
Name:	**Relationship:**
Phone:	**Address:**

INSURANCE INFORMATION

Medi-Cal ID:			
Primary Insurance	**Plan:**		
Group #:		Policy #:	Member ID:
Secondary Insurance	**Plan:**		
Group #:		Policy #:	Member ID:

ECM CRITERIA

Population of Focus
(check all that apply)

ADULT	Adults experiencing homelessness.	☐
	Adults at risk for hospital or emergency department (ED) stays that could be avoided.	☐
	Adults with Serious Mental Health (SMH) and/or Substance Use Disorder (SUD) needs.	☐
	Adults living in the community who are at risk of needing long-term-care services.	☐
	Adults moving from a nursing home to the community.	☐

	Adults that are pregnant and postpartum and facing unfair circumstances with birth because of differences in race and ethnic background.	☐
	Adults moving from prison to the community.	☐
CHILD	Children experiencing homelessness.	☐
	Children at risk for hospital or emergency department (ED) stays that could be avoided.	☐
	Children with Serious Mental Health (SMH) and/or Substance Use Disorder (SUD) needs.	☐
	Children enrolled in California Children's Services (CCS) or CCS Whole Child Model with extra needs.	☐
	Involved in Child Welfare.	☐
	Minors that are pregnant and postpartum and facing unfair circumstances with birth because of differences in race and ethnic background.	☐
	Children moving from a juvenile facility to the community.	☐

CLINICAL ACUITY & HEALTH LITERACY

Clinical Acuity: ***Click here for scoring information.***

☐Low Risk - Stable, minimal ECM support needed (self-sufficient)

☐Moderate Risk - At risk, requires monitoring and coordination

☐High Risk - Unstable, requires intensive ECM intervention

Does the member need help taking their medicines? ☐Y ☐N

Does the member need help filling medications? ☐Y ☐N

Does the member need help filling out health forms? ☐Y ☐N

Does the member need help answering questions during a doctor's visit? ☐Y ☐N

OUTREACH AND ENGAGEMENT

☐Check this box if providing a separate Outreach/Engagement Log to demonstrate information.

Engagement log: A detailed log of all member encounters.

Number of successful member encounters (to date): _____

Frequency of Contact: ☐Daily ☐Weekly ☐Bi-weekly ☐Monthly ☐Other: _____

Date of visit/contact:	**Duration:**	**Mode of Contact:**
Location:	**Purpose:**	**Support Person Present** ☐Y ☐N ☐N/A
Staff Name:	**Job Title:**	
Care Plan Goals Addressed During Visit:		
Engagement Strategies Utilized:		
Follow Up Plan/Next Steps:		

Date of visit/contact:	**Duration:**	**Mode of Contact:**
Location:	**Purpose:**	**Support Person Present** ☐Y ☐N ☐N/A
Staff Name:	**Job Title:**	
Care Plan Goals addressed during visit:		

Engagement Strategies Utilized:
Follow Up Plan/Next Steps:

Date of visit/contact:	**Duration:**	**Mode of Contact:**
Location:	**Purpose:**	**Support Person Present** ☐Y ☐N ☐N/A
Staff Name:	**Job Title:**	
Care Plan Goals addressed during visit:		
Engagement Strategies Utilized:		
Follow Up Plan/Next Steps:		

COMPREHENSIVE ASSESSMENT AND CARE MANAGEMENT PLAN

☐Check this box if providing a separate Assessment and Care Plan to demonstrate information.

Physical Health

Active Medical Problems *(chronic conditions, fall risk, speech, etc.):*

Past Medical History:

Blood Pressure: *For members 18+ years old; if over 140 / 90, please refer to Primary Care Provider (PCP) for advice.*		**A1C (Blood Glucose) Levels:** *Members who have diabetes or take antipsychotic medication.*	
Date:	___ Systolic / ___ Diastolic	Date:	___ %

Is a referral for physical health needed for this member? ☐N ☐Y

Oral/Dental Health

Active Dental Problems/Concerns:

Dental Office:	**Dentist Name:**
Last Visit Date:	**Next Visit Date:**

☐ *Check this box if the member does not remember last visit date and/or dentist's name.*

Is a referral for dental care needed for this member? ☐Y ☐N

Mental Health

Mental Health History:

Is the member currently receiving mental health care?

Please list diagnoses: ☐ *Check this box if None or Not Applicable*

Does the member have a history of trauma?

Is the member taking any medications for their mental health? *If so, list below:*

***If PHQ-2 Test Score is 3 or more, PHQ-9 Test is required. Scores of 10 or more require follow-up.**

Date:	*PHQ-2 Score:	*PHQ-9 Score:

Is a referral for mental care needed for this member? ☐Y ☐N

Substance Use Disorder

Alcohol Use: Is the member currently using alcohol? ☐Y ☐N If yes, how often?

Drug Use: Is the member currently using substances? ☐Y ☐N If yes, list drug type and how often.

***Test results need to be communicated to member in detail, may require further disclosure.**

Date:	*Audit-C Score:	*DAST-10 Score:

Additional Notes:

Is a referral for SUD needed for this member? ☐Y ☐N

Hospitalizations

# of hospital visits in the last 6 months:

☐*Check this box if member does not remember or is not sure.*

Date	Name of Hospital/Facility

# of emergency room visits in the last 6 months:

☐*Check this box if member does not remember or is not sure.*

Date	Name of Hospital/Facility

Durable Medical Equipment

Equipment(s) the member currently uses *(select all that apply):*

☐Hospital Bed ☐Oxygen ☐Wheelchair ☐Walker ☐None ☐Additional Equipment Used (list below):

Doctor Visits

# of PCP visits in the last 6 months:	**Doctor's/Clinic Name:**
Last Visit Date:	☐ *Check this box if member does not remember or is not sure.*
# of specialist visits in the last 6 months:	**Specialist's/Clinic Name:**
Last Visit Date:	☐ *Check this box if member does not remember or is not sure.*

Does the member have an upcoming appointment? ☐Y ☐N **If yes, when?**

Does the member need assistance arranging an appointment? ☐Y ☐N

Medication List *(list medication name and what it is used for below):*
☐Check this box if providing a separate Medication Log to demonstrate information.

Medication Name	Dosage	What is it used for?	Side Effects

Allergies:

ADL Assessment

Do you need help with any of these actions?	Yes	No
Taking a bath or shower	☐	☐
Eating	☐	☐
Grooming (brushing teeth, hair, shaving)	☐	☐
Getting out of bed or a chair	☐	☐
Using the toilet	☐	☐
Washing dishes or clothes	☐	☐
Getting a ride to the doctor or to see friends	☐	☐
Going out to visit family or friends	☐	☐
Keeping track of appointments	☐	☐
Going up the stairs	☐	☐
Getting dressed	☐	☐
Making meals or cooking	☐	☐
Shopping and groceries	☐	☐
Walking	☐	☐
Keeping track of money	☐	☐
Doing house or yard work	☐	☐
Using the phone	☐	☐

Additional Notes:

Is a referral needed for this member? ☐Y ☐N

Advanced Care Planning

Discussed Advanced Care Planning:☐Y ☐N

Does the member have a Surrogate Decision Maker *(person who makes medical decisions for a patient):* ☐Y ☐N

Does the member have an Advance Directive *(document of medical preferences):* ☐Y ☐N

Additional Notes:

ENHANCED COORDINATION OF CARE

Please document all ongoing care management activities and communications regarding this member.

☐Check this box if providing a separate Care Coordination Log to demonstrate information.

Medication Review & Reconcilaton

Date of Last Reconciliation:

Reconciliation Status:

☐Complete – Member's active medication list was reviewed, verified, and reconciled against the provider/pharmacy record.

☐Incomplete – List obtained, but verification is pending. Provide reason below.

☐No active medications – Member confirms they take no prescription or OTC medications.

Additional Information: *identify any issues, discrepancies or barriers found.*

Member Care Team

Type of Service	Provider/Clinic Name	Last Visit/Contact
Primary care		
Physical and developmental health		
Mental health		
Substance Use Disorder (SUD) treatment		
Long-Term Services and Supports (LTSS)		
Oral health		
Community-based and social services		
Housing support		

Appointments and Transportation Tracking

Previous & Scheduled Visits		Transportation Arrangements	
Appointment Type	Date and Time	Purpose	Date and Time

HEALTH PROMOTION ACTIVITIES

Describe educational resources provided to member and list specific topics covered. Attach or reference materials used in member education.

☐Check this box if providing a separate Health Promotion Log to demonstrate this information.

Date of Service:	**Staff Name/Job Title:**	**Type of Activity:**
Topic:	**Delivery Method:**	**Resource Name:**
Intervention Provided:		

Member Response/Engagement:		
Outcome/Next Steps:		
Date of Service:	**Staff Name/Job Title:**	**Type of Activity:**
Topic:	**Delivery Method:**	**Resource Name:**
Intervention Provided:		
Member Response/Engagement:		
Outcome/Next Steps:		
Date of Service:	**Staff Name/Job Title:**	**Type of Activity:**
Topic:	**Delivery Method:**	**Resource Name:**
Intervention Provided:		
Member Response/Engagement:		
Outcome/Next Steps:		

COMPREHENSIVE TRANSITIONAL CARE

☐Check this box if providing a separate Transitional Care Log to demonstrate information.

Does your organization use ADT Notifications from PointClickCare (PCC) to be notified? ☐Y ☐N

Does your organization use other methods to be notified of ADT? ☐Y ☐N **If yes, please list:**

Encounter Date:

Encounter Details of ADT Notification:

Discharge Date:

Were you able to schedule a PCP/Specialist appointment within ADT Notification 7 days of discharge? ☐Y ☐N

If yes, please provide date and time of appointment:

Outreach Date:

Were you able to outreach within ADT Notification 24 hours of discharge? ☐Y ☐N

If yes, please provide date and time of outreach:

Checklist of TCS activities completed:

☐D/C risk assessment ☐Medicine reconciliation

☐Closed loop referral ☐Transportation

☐Support & educate ☐Other - please specify:

Additonal Notes:

MEMBER AND FAMILY SUPPORTS		
☐Check this box if providing a separate Supports Log to demonstrate information.		
Member's authorized support person: ☐Parent ☐Caregiver ☐Guardian ☐No Support Person Identified ☐Family Member (*please specify*): _____ ☐Other (*please specify*): _____		
Name:		Relationship:
Phone:	Email:	May we contact if needed: ☐Yes ☐No
Community Team		
Name:		Organization:
Phone:	Email:	May we contact if needed: ☐Yes ☐No
Program Representative		
Name:		Organization:
Phone:	Email:	May we contact if needed: ☐Yes ☐No

Are necessary authorizations on file to allow coordination with the member's support network?☐Y ☐N
Would the member and/or their support persons like a copy of the care plan? ☐Y ☐N
Do they know how to request updates? ☐Y ☐N
Is the member and/or their support persons receiving education on care instructions and condition management? ☐Y ☐N

COORDINATION OF/AND REFERRAL TO COMMUNITY AND SOCIAL SUPPORT SERVICES	
☐Check this box if providing separate Referral Forms to demonstrate information.	
Social Factors of Health	
Education:	**Employment Status:**
Income Status:	**Food Security:**
Housing Status:	**Transportation:**
Long-Term Support Services	
Please check all services the member is currently receiving:	
☐Community Based Adult Services (CBAS)	☐In-Home Support Services (IHSS)
☐Home Health Agency (under a provider's care in a home setting)	☐Multi-purpose Senior Services Program (MSSP)
☐Hospice Care	☐Palliative Care (Medical care for serious illness)
☐Other:	☐None/Not Applicable
Additional Notes:	
Is a referral needed for this member? ☐Y ☐N *If yes, please specify which service(s):*	

Referrals to Community Resources		
Date of Referral	**Type of Service**	**Receiving Organization/Provider**

MEMBER GOALS		
Goal I:		
Target Date:	☐Member Goal ☐Staff Goal	Goal Outcome: ☐Goal Met ☐ Not Met ☐ Partially Met
Intervention:		
Barriers:		

Next Steps	Person Responsible	Target Dates
1.		
2.		
3.		

Goal II:		
Target Date:	☐Member Goal ☐Staff Goal	Goal Outcome: ☐Goal Met ☐ Not Met ☐ Partially Met
Intervention:		
Barriers:		

Next Steps	Person Responsible	Target Dates
1.		
2.		
3.		

Goal III:		
Target Date:	☐Member Goal ☐Staff Goal	Goal Outcome: ☐Goal Met ☐ Not Met ☐ Partially Met
Intervention:		
Barriers:		

Next Steps	Person Responsible	Target Dates
1.		
2.		

3.		

Goal IV:		
Target Date:	☐Member Goal ☐Staff Goal	Goal Outcome: ☐Goal Met ☐ Not Met ☐ Partially Met
Intervention:		
Barriers:		

Next Steps	Person Responsible	Target Dates
1.		
2.		
3.		

ADDITIONAL RECOMMENDATIONS BY CLINICAL STAFF

☐Check this box if providing a separate Clinical Oversight document to demonstrate required information.

☐ I attest that the care plan has been reviewed and **no additional feedback or recommendations** have been identified.

☐ I attest that the care plan has been reviewed and additional feedback or recommendations have been identified below.

Additional Recommendation	Date of Completion

***Clinician Name & Title** **License Number** **Signature** **Date**

**Optional*

ECM Staff Member Name **Signature** **Date**