

CalAIM Audit and Oversight:
Look-Back Period:

Member No. Member Name:		CIN:
Documentation Type/Name	Description	Provided Y/N If No, please explain why
Intake and Authorization Forms	A set of documents completed typically at the beginning of a member's enrollment into a program. They establish the legal, clinical, and logistical framework for care delivery and communication. These forms are essential for ensuring that services are provided ethically, safely, and in alignment with regulatory requirements. Examples include, but are not limited to: - Consent Forms - HIPAA Authorization Forms - Disclosure Forms - Demographic and Contact Information Forms - Authorized Representative Documentation - Screenings - Program-Specific Acknowledgments	Provided: Notes/Comments:
Outreach/Encounter Logs	A tracking tool used to document service delivery activities provided to members. It helps ensure accountability, consistency, and transparency in care coordination. This log typically includes, but is not limited to, the following details: <i>Date of Service</i> – When the outreach or encounter occurred. <i>Type of Service</i> – The nature of the interaction (e.g., phone call, in-person visit, care coordination, follow-up). <i>Start and End Time</i> – Duration of the service provided.	Provided: Notes/Comments:

CalAIM Audit and Oversight:
Look-Back Period:

	• <i>Comments</i> – Notes or observations relevant to the member’s care, needs, or next steps. This document supports care teams in monitoring member engagement, identifying service gaps, and maintaining accurate records for reporting and compliance purposes.	
Progress Notes	Progress notes are structured narrative summaries used to document a member’s experience and engagement throughout their care journey. Typically written in a standardized format such as SOAP (Subjective, Objective, Assessment, Plan), these notes offer a clear and comprehensive view of the member’s challenges, progress, and responses to services over time. They help care teams: • Track goal achievement and changes in the member’s condition or circumstances. • Demonstrate consistent documentation of services provided. • Support care coordination by offering insight into the member’s needs, interventions, and outcomes. • Ensure compliance with clinical and program standards. Progress notes are essential for maintaining continuity of care and for evaluating the effectiveness of services delivered.	Provided: Notes/Comments:
Culturally and Linguistically Appropriate Care	Please describe how your organization assesses and integrates member’s cultural and linguistic needs into the delivery of services to ensure care is responsive, inclusive, and person-centered. This may include:	Provided: Notes/Comments:

CalAIM Audit and Oversight:
Look-Back Period:

	• Identifying language preferences and providing interpreter services when needed • Offering vision and/or hearing accommodations • Documenting and honoring preferred names and pronouns • Recognizing and respecting gender identity • Acknowledging nationality, Tribal affiliation, ethnicity, or race Additionally, please share any internal staff training efforts that help ensure team members are aware of and equipped to respond to these preferences appropriately. These practices help promote equity, build trust, and ensure services are delivered in a culturally respectful and linguistically appropriate manner.	
Organizational Policies and Procedures	Policies and procedures are needed to demonstrate: • Compliance with contractual, regulatory, and CalAIM program requirements • Standardized and consistent service delivery • Defined staff roles, responsibilities, and oversight • Operational readiness and audit preparedness • Alignment between documented processes and actual practice Policies and procedures may include, but are not limited to, the following examples: • <i>Service Delivery and Care Coordination:</i> Standards for member outreach, assessments, care planning, and coordination with providers and community partners (e.g., ICT collaboration, PCP communication).	Provided: Notes/Comments:

CalAIM Audit and Oversight:
Look-Back Period:

	• <i>Documentation and Record Management:</i> Requirements for timely and complete documentation, use of systems, record retention, and confidentiality (e.g., platform entries, usage, secure file storage). • <i>Staffing and Training:</i> Staff qualifications, onboarding and ongoing training, scope of practice, and culturally competent, trauma-informed care expectations (e.g., training completion, supervision). • <i>Quality Assurance & Performance Improvement:</i> Monitoring processes, performance reporting, corrective actions, and member feedback mechanisms (e.g., chart audits, grievance tracking). • <i>Compliance and Risk Management:</i> HIPAA compliance, incident reporting, fraud, and ethical standards (e.g., privacy safeguards, escalation protocols). • <i>Authorization and Billing (if applicable):</i> TAR submission and coordination with health plans (e.g., TAR tracking and workflows).	
ENHANCED CARE MANAGEMENT		
Outreach and Engagement	<i>Member Visit Log</i> • A detailed log of all member encounters that includes: ○ Date of each visit or contact ○ Duration of the meeting(s) (especially for enrolled members) ○ Type of engagement (e.g., in-person, phone, text, email, mail)	Provided: Notes/Comments:

**CalAIM Audit and Oversight:
Look-Back Period:**

	○ Location of engagement (e.g., member's home, care site, community setting) ○ Purpose and outcome of each interaction ○ Care plan goals addressed during the visit <i>Minimum Visit Frequency</i> • Enrolled Members: At least once every 30 days • Non-Enrolled Members: At least three engagement attempts every 30 days <i>Engagement Strategies Used</i> • Document the variety of strategies used to engage members, including: ○ In-person meetings (at home, care sites, or community locations) ○ Mail ○ Text messages ○ Telephone calls ○ Email ○ Street-level outreach ○ Follow-up after member contact with ECM network partners Please Note: If using an <i>Outreach/Encounter Log</i> to demonstrate this information, please indicate this clearly in the Notes/Comments section.	
Comprehensive Assessment and Care Management Plan	<i>ECM Care Plan Documentation</i> • Submit all care plans within the lookback period, including: ○ Initial and updated care plans ○ Documentation of goal progress	Provided: Notes/Comments:

	<i>Clinical Oversight of Care Plans</i> • Provide documentation that demonstrates how clinical staff provide oversight to non-clinical staff regarding member care. This may include: • Calendar invites or scheduled meeting logs showing recurring or ad hoc meetings between clinical and non-clinical staff. • Meeting minutes summarizing discussions and decisions, including care plan reviews, member updates, and guidance provided • Sign-off sheets confirming review and guidance • Clinical staff signatures confirming oversight of care plans or member cases • Workflows or operational procedures, outlining how and when clinical oversight occurs, including: ○ Frequency of reviews ○ Roles involved (e.g., RN, LCSW) ○ Topics typically addressed (e.g., medication management, goal progress, referrals) <i>Member Needs Assessment</i> • Care plans must reflect: ○ Identification of clinical and non-clinical needs ○ Assessment of member health status and gaps in care ○ Use of appropriate resources to support assessment (e.g., clinical data, social determinants, provider input) <i>Individualized, Person-Centered Planning</i> • Each care plan must be:	
--	--	--

	○ Comprehensive and tailored to the member ○ Developed with input from the member (and/or parent, caregiver, guardian) ○ Reflective of the member's strengths, risks, needs, and goals ○ Inclusive of member preferences and recommendations for services <i>Areas of Need Addressed</i> • Care plans should incorporate strategies to address: ○ Physical and developmental health ○ Mental health ○ Dementia ○ Substance Use Disorder (SUD) ○ Long-Term Services and Supports (LTSS) ○ Oral health ○ Palliative care ○ Community-based and social services ○ Housing needs <i>Ongoing Reassessment and Updates</i> • Care plans must be reassessed periodically based on member progress or changes in needs • All updates must be documented and reflect clinical oversight, when applicable <i>ECM Release of Information (ROI)</i> • Ensure that the ECM Release of Information is completed and uploaded to PCC	
--	---	--

	Please Note: If <i>Progress Notes</i> are used to help to demonstrate this information, please indicate this clearly in the Notes/Comments section.	
Enhanced Coordination of Care	<i>Coordination Activities</i> - Document all communication and activities related to the member's care management, including: - Organizing care activities as outlined in the care management plan - Implementing care plan strategies - Sharing information with the member's multi-disciplinary care team <i>Contact with Multi-Disciplinary Team</i> - Maintain and document regular contact with all providers involved in the member's care, including coordination for: - Medication review / reconciliation - Scheduling appointments - Appointment reminders - Transportation arrangements - Accompaniment to critical appointments <i>PCP Engagement</i> - The ECM lead care manager must: - Ensure the member has an assigned Primary Care Provider (PCP) - Confirm the member is engaging with their PCP for appropriate care - Document any referrals, follow-ups, or coordination efforts with the PCP <i>Integrated and Continuous Care</i>	Provided: Notes/Comments:

**CalAIM Audit and Oversight:
Look-Back Period:**

	• Ensure care is coordinated across all relevant services: ○ 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 <i>Member Contact and Monitoring</i> • Maintain regular contact with the member (and/or parent, caregiver, guardian) to: ○ Monitor health status, care planning, medication usage, and side effects ○ Communicate member's needs and preferences to the care team ○ Ensure updates and changes are shared across all involved parties Please Note: If an <i>Outreach/Encounter Log</i> and/or <i>Progress Notes</i> are used to help to demonstrate this information, please indicate this clearly in the Notes/Comments section.	
Health Promotion	<i>Health Promotion Services</i> • Document all activities that support and encourage members to make healthy lifestyle choices and manage or prevent health conditions. These may include: ○ Coaching, education, and counseling	Provided: Notes/Comments:

	○ Motivational interviewing or other evidence-based practices ○ Skill-building to help members identify and access resources <i>Resource Identification and Sharing</i> • Provide details on resources shared with members, such as: ○ Brochures ○ Websites ○ Classes or workshops ○ Handouts, guides, or visual aids ○ These resources should support: ▪ Wellness education ▪ Preventive screenings ▪ Nutrition support ▪ Chronic disease management ○ Attach or reference materials used in member education <i>Member Engagement and Support</i> • Document how members are supported in: ○ Monitoring and managing their health ○ Preventing chronic conditions ○ Strengthening self-management skills ○ Include: ▪ Contact with the member and/or parent / caregiver / guardian ▪ Follow-up on health promotion goals and progress	
--	--	--

	Please Note: If <i>Progress Notes</i> are used to help to demonstrate this information, please indicate this clearly in the Notes/Comments section.	
Comprehensive Transitional Care	<i>Monitoring Transitions Using PCC</i> - Utilize PointClickCare (PCC) to monitor: - Admissions - Discharges - Transfers (ED, inpatient, SNF, residential / treatment facilities, incarceration, etc.) - Ensure timely notification to the member's lead care manager for follow-up and coordination. - Example: PCC dashboard reports, encounter logs, care manager notifications <i>Transitional Care Services</i> - Document completion of transitional care services, including: - Discharge risk assessments - Sharing discharge planning documents with appropriate parties - Scheduling timely follow-up appointments with outpatient providers or community partners - Medication reconciliation - Closed-loop referrals - Transportation arrangements (per NMT/NEMT policies) - Support for rehabilitation, self-management, and medication adherence - Example: Log of encounters, progress notes, discharge planning forms	Provided: Notes/Comments:

	<i>Strategies to Reduce Avoidable Admissions / Readmissions</i> • Provide a detailed overview of your team’s strategies and operational processes, such as: ○ Use of PCC to track transitions and flag high-risk discharges ○ Protocols for timely care manager notification ○ Best practices for discharge planning ○ Follow-up scheduling workflows ○ Medication reconciliation procedures ○ Transportation coordination policies ○ Education and coaching for post-discharge self-management ○ Example: SOPs, workflows, desktop guides, checklists <i>Communication and Coordination</i> • Ensure documentation reflects: ○ Communication with the member’s care team ○ Contact with the member and/or parent / caregiver / guardian ○ Sharing of member’s needs and preferences ○ Monitoring of post-discharge progress and adherence	
Member and Family Supports	<i>Identification and Authorization</i> • Document the member’s authorized support persons, including: ○ Parent ○ Caregiver ○ Guardian ○ Other family member(s) ○ Other authorized support person(s)	Provided: Notes/Comments:

	○ Ensure all required authorizations are in place to allow communication between ECM providers and the member's support network. <i>Primary Point of Contact</i> • ECM lead care manager should document the primary contact for the member and/or their support persons <i>Care Plan Access and Education</i> • Ensure the member and/or their support persons: ○ Have a copy of the care plan ○ Know how to request updates ○ Receive education on care instructions and condition management <i>Knowledge and Engagement</i> • Conduct activities to ensure the member and/or their support persons are: ○ Knowledgeable about the member's condition(s) ○ Able to participate in care planning and follow-up ○ Supported in adherence to treatment and medication management ○ Example: Coaching sessions, educational materials <i>Support Identification and Access</i> • Identify and document supports needed by the member and/or their support persons to: ○ Manage the member's condition	
--	--	--

	○ Access needed services ○ Make informed choices ○ Example: Resource referrals, social service coordination <i>Communication and Documentation Format</i> • Maintain regular contact with the member and/or their support persons • Clearly indicate this in the notes/comments section of each relevant entry Please Note: If an <i>Outreach/Encounter Log</i> and/or <i>Progress Notes</i> are used to help to demonstrate this information, please indicate this clearly in the Notes/Comments section.	
Coordination of/and Referral to Community and Social Support Services	<i>Identification of Member Needs</i> • Determine and document the specific services needed to meet the member's clinical and non-clinical needs. • Include services that address: ○ Social Determinants of Health (SDOH) ○ Housing ○ Community supports offered by contracted providers <i>Referrals to Community Resources</i> • Document referrals made to appropriate community-based organizations and services. • Include: ○ Type of service referred to (e.g., housing, food assistance, transportation, behavioral health, etc.)	Provided: Notes/Comments:

**CalAIM Audit and Oversight:
Look-Back Period:**

	○ Date of referral ○ Receiving organization or provider ○ Example: Referral forms <i>Closed-Loop Referrals</i> ● Follow up with the member (and/or parent, caregiver, guardian) to ensure: ○ The service was received ○ The referral was completed ○ Any barriers to access were addressed Please Note: If an <i>Outreach/Encounter Log</i> and/or <i>Progress Notes</i> are used to help to demonstrate this information, please indicate this clearly in the Notes/Comments section.	
Member Experience Survey	<i>Implement a Member Experience Survey Process</i> ● Provide a brief description of how your organization conducts member experience surveys, including: ○ Frequency (at least once per year) ○ Survey method (e.g., paper, phone, online) ○ Topics covered (e.g., satisfaction with services, communication, care coordination, access to resources) <i>Submit Annually</i> ● Providers are required to administer at least one member experience survey per participating member and retain a copy of the completed survey. Additionally, a summary of the survey results must be submitted. We encourage that summaries include, but are not limited to, the following: ○ Response rates ○ Key findings	Provided: Notes/Comments:

**CalAIM Audit and Oversight:
Look-Back Period:**

	○ Themes or trends ○ Any actions taken based on feedback	
Other <i>Please include Documentation Name/Type</i>	<i>Please include description</i>	<i>Please include notes/comments</i>