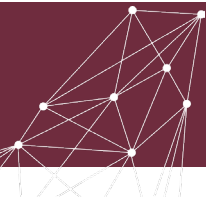


Enhanced Care Management (ECM) Care Plan Guide

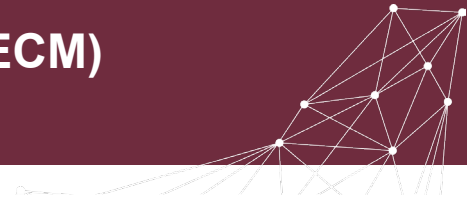


Patient Information			
First Name:	Last Name:	DOB:	
Gender:	Preferred Pronouns:	Primary Language:	
Address Information			
Street:			
City:	State:	Zip Code:	County:
Mailing Address Same as Home Address?		Yes	No
Street:		PO Box:	
City:	State:	Zip Code:	County:
Contact Information			
Email:			
Phone #:			
Other Contacts			
Family/Caregiver	Name:	May we contact if needed?	
Email:		Phone #:	
Community Team	Name:	May we contact if needed?	
Email:		Phone #:	
Program Representative	Name:	May we contact if needed?	
Email:		Phone #:	
Insurance Information			
Medi-Cal ID:			
Primary Insurance	Plan:	Group #:	
Policy #:	Member ID:		
Secondary Insurance	Plan:	Group #:	
Policy #:	Member ID:		
Acuity	How does the member feel they manage their health?		
<input type="checkbox"/> Low Risk <input type="checkbox"/> High Risk	<input type="checkbox"/> Poor <input type="checkbox"/> Moderate <input type="checkbox"/> Good		
Social Factors of Health			
If the member has any changes, check the box and fill out only the changes:			
Education:		Employment Status:	
Income Status:		Food Security:	
Housing Stability:		Transportation:	
Support Networks:			
Additional Notes:			



ECM Criteria		
Populations of Focus <i>(Check all that apply)</i>		
Adult	Adults experiencing homelessness.	<input type="checkbox"/>
	Adults at risk for hospital or emergency department (ED) stays that could be avoided.	<input type="checkbox"/>
	Adults with Serious Mental Health (SMH) and/or Substance Use Disorder (SUD) needs.	<input type="checkbox"/>
	Adults living in the community who are at risk of needing long-term-care services.	<input type="checkbox"/>
	Adults moving from a nursing home to the community.	<input type="checkbox"/>
	Adults that are pregnant and postpartum and/or facing unfair circumstances with birth, because of differences in race and ethnic background.	<input type="checkbox"/>
	Adults moving from prison to the community.	<input type="checkbox"/>
Child	Children experiencing homelessness.	<input type="checkbox"/>
	Children at risk for hospital or emergency department (ED) stays that could be avoided.	<input type="checkbox"/>
	Children with Serious Mental Health (SMH) and/or Substance Use Disorder (SUD) needs.	<input type="checkbox"/>
	Children enrolled in California Children's Services (CCS) or CCS Whole Child Model with extra needs.	<input type="checkbox"/>
	Involved in Child Welfare.	<input type="checkbox"/>
	Minors that are pregnant and postpartum and/or facing unfair circumstances with birth, because of differences in race and ethnic background.	<input type="checkbox"/>
	Children moving moving from a juvenile facility to the community.	<input type="checkbox"/>

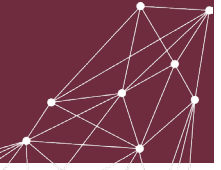
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Physical Health			
Active Medical Problems (chronic conditions, fall risk, speech, etc.)		Past Medical History	
*Blood Pressure:		*A1C (Blood Glucose) Levels:	
For members 18+ years old; if over 140 / 90, please refer to Primary Care Provider (PCP) for advice		Members who have diabetes or take antipsychotic medication	
Date:	___ Systolic / ___ Diastolic	Date:	___ A1C%
Dental Health			
Active Dental Problems/Concerns			
Dentist Name:		Last Visit Date:	
Dental Office:		Next Visit Date:	
Mental Health History			
*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	
If the member is taking antidepressants or in psychotherapy, please give more information: (For example: takes medication as instructed; improvements in mental health after therapy)			
Substance Use Disorder Screening			
Alcohol Use		Drug Use	
How often:		How often:	
		Drug type:	
* AUDIT-C Score		* DAST-10 Score	
If you have any additional information, please share:			

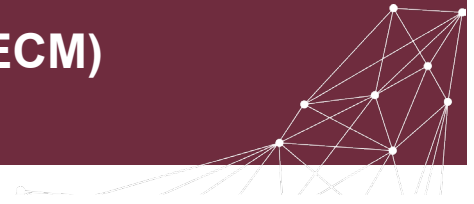
*Test results need to be communicated to member in detail, may require further disclosure

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Hospitalizations			
# of hospital visits in the last 6 months:	# of emergency room visits in the last 6 months:		
Durable Medical Equipment Currently In Use (Select All That Apply)			
___ Hospital Bed	___ Oxygen	Additional Equipment Used:	
___ Wheelchair	___ Walker		
Doctor Visits			
# of PCP visits in the last 6 months:		Last Visit Date:	
Doctor's Name:		Doctor's Office:	
# of specialist visits in the last 6 months:		Last Visit Date:	
Specialist's Name:		Specialist's Office:	
Medication List		What is the medication for?	
Allergies			
Long-Term Support Services			
<input type="checkbox"/> Community Based Adult Services (CBAS)	<input type="checkbox"/> In-Home Support Services (IHSS)		
<input type="checkbox"/> Home Health Agency (under a provider's care in a home setting)	<input type="checkbox"/> Multi-purpose Senior Services Program (MSSP)		
<input type="checkbox"/> Hospice Care	<input type="checkbox"/> Palliative Care (Medical care for serious		
<input type="checkbox"/> Other:			
Additional Notes:			
Advanced Care Planning			
Discussed Advanced Care Planning		Yes	No
Surrogate Decision Maker (person who makes medical decisions for a patient)		Has One	Does Not Want One
Advance Directive (document of medical preferences)		Has One	Does Not Want One
Additional Notes:			

Enhanced Care Management (ECM) Care Plan Guide



Goals	
Goal:	
Action:	
Obstacles:	
Outcome:	<input type="checkbox"/> Goal Met <input type="checkbox"/> Goal Not Met <input type="checkbox"/> Goal Partially Met
Goal:	
Action:	
Obstacles:	
Outcome:	<input type="checkbox"/> Goal Met <input type="checkbox"/> Goal Not Met <input type="checkbox"/> Goal Partially Met
Goal:	
Action:	
Obstacles:	
Outcome:	<input type="checkbox"/> Goal Met <input type="checkbox"/> Goal Not Met <input type="checkbox"/> Goal Partially Met
Goal:	
Action:	
Obstacles:	
Outcome:	<input type="checkbox"/> Goal Met <input type="checkbox"/> Goal Not Met <input type="checkbox"/> Goal Partially Met
Referrals Needed	
Additional Recommendations	

ECM Staff Member Name: _____

Date: _____

ECM Staff Member Signature: _____

Date: _____

Clinician Signature (Optional): _____

Title: _____

Date: _____