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?		
☐ Low Risk	☐ High Risk	☐ Poor	☐ Moderate	☐ 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:	

Enhanced Care Management (ECM) Care Plan Guide

ECM Criteria		
Populations 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/or 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/or facing unfair circumstances with birth, because of differences in race and ethnic background.	☐
	Children moving moving from a juvenile facility to the community.	☐

Enhanced Care Management (ECM)
Care Plan Guide

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

Enhanced Care Management (ECM) Care Plan Guide

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			
☐	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
☐	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:	☐ Goal Met ☐ Goal Not Met ☐ Goal Partially Met
Goal:	
Action:	
Obstacles:	
Outcome:	☐ Goal Met ☐ Goal Not Met ☐ Goal Partially Met
Goal:	
Action:	
Obstacles:	
Outcome:	☐ Goal Met ☐ Goal Not Met ☐ Goal Partially Met
Goal:	
Action:	
Obstacles:	
Outcome:	☐ Goal Met ☐ Goal Not Met ☐ Goal Partially Met

Referrals Needed

Additional Recommendations

ECM Staff Member Name: _____ Date: _____

ECM Staff Member Signature: _____ Date: _____

Clinician Signature (Optional): _____ Title: _____ Date: _____