

# Enhanced Care Management Provider Documentation Standards

## Enhanced Care Management (ECM) Provider Documentation Expectation:

ECM providers shall ensure proper documentation for every encounter with a Partnership member.

Please organize your notes using the following methods:

- **Specific, Measurable, Attainable, Relevant, and Time-Bound (SMART) Notes:**
  - **Specific:** Add as many details as possible. What will be done? Why and by when?
    - Example: The member reports struggling with addiction and wants to start attending meetings for substance use disorder. The member wants to find housing assistance and apply for Housing and Urban Development (HUD). The member wants to look for possible employment and will create an Employment Development Department (EDD) account profile and sign up for CalJobs.
  - **Measurable:** Make sure your goal is trackable. How will you measure the goal?
    - Example: The member will attend one meeting for substance use disorder per week. The member will apply for Housing and Urban Development (HUD) by February 1, 2026. The member will create an Employment Development Department (EDD) account profile by January 15, 2026, and sign up for CalJobs by January 30, 2026.
  - **Attainable:** Take time to reflect and start smaller. Can this realistically be accomplished within a certain timeline?
    - Example: The member needs to see a primary care provider and discontinue going to the emergency room for non-emergent, routine types of visits. The member will attend one primary care appointment within the next 30 days with support from their lead care manager.
  - **Relevant:** Think about what is important to the member and to you as the ECM provider. Does this goal align with the member's values and larger objectives and goals? Be willing to make suggestions if one goal isn't possible without another goal in front of it.
    - Example: The member wants to regain control of their health, lower their A1c, and feel better. The member will see their primary care provider in the month of January, attend three diabetes education classes, take the prescribed diabetes medication daily, and check blood sugar at least once per day.
  - **Time-bound:** Keep the member and you as the ECM provider accountable. When does the member want to accomplish this goal by? How long will it take?
    - Example: Over the next three months, the member wants to lower their stress levels. The member will practice one stress-reduction activity at least three times per week for the next 28 days.

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- **Subjective, Objective, Assessment, and Plan (SOAP) Notes:**
  - **Subjective:** Member's description of their need(s) and purpose of encounter.
    - Example: Member reported experiencing homelessness.
  - **Objective:** ECM provider's factual observation
    - Example: Member has no residence and is living on a park bench. We discussed starting an ECM care plan.
  - **Assessment:** Based on available information to the ECM provider, impressions of subjective and objective information.
    - Example: Member is reporting experiencing homelessness and living on a park bench.
  - **Plan:** Develop next steps for support
    - Example: Member needs housing supports. Prepare housing referral.
  
- **Behavioral, Intervention, Response, and Plan (BIRP) Notes:**
  - **Behavior:** Member's observable action and demeanor, including their self-reported feelings, thoughts, and challenges.
    - Example: Member shared they are experiencing homelessness and need a walker.
  - **Intervention:** List action, technique, or exercise used during the session. This should connect with the member's plan and goals.
    - Example: Member would like to find housing, start seeing a physician for medical needs, and get a walker.
  - **Response:** Document how the member responded to the intervention(s). Be sure to note any changes, progress, insights, or barriers to progress.
    - Example: Member is engaged and committed to finding housing, seeing a regular physician, and getting a walker.
  - **Plan:** Outline next steps for future encounters including homework for next visit for both member and ECM provider.
    - Example: We will start to develop an ECM care plan and send a referral for durable medical equipment (DME).