<table>
<tr><td colspan="2">Member No.
Member Name:.</td><td>CIN:</td></tr>
<tr><th>Documentation Type/Name</th><th>Description</th><th>Provided Y/N
If No, please explain why</th></tr>
<tr><td>Intake and Authorization Forms</td><td>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</td><td>Provided:

Notes/Comments:</td></tr>
<tr><td>Outreach/Encounter Logs</td><td>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:
• Date of Service – When the outreach or encounter occurred.
• Type of Service – The nature of the interaction (e.g., phone call, in-person visit, care coordination, follow-up).
• Start and End Time – Duration of the service provided.</td><td>Provided:

Notes/Comments:</td></tr>
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	• *Comments* – 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 members' cultural and linguistic needs into the delivery of services to ensure care is responsive, inclusive, and person-centered. This may include:	**Provided:** **Notes/Comments:**

	• 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.	
ENHANCED CARE MANAGEMENT (ECM)		

Outreach and Engagement	*Member Visit Log*
	• 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)
	  ○ 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
	
	Minimum Visit Frequency
	• Enrolled members: At least once every 30 days
		Provided:
		
		Notes/Comments:

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- Non-enrolled members: At least three engagement attempts every 30 days

Engagement Strategies Used

- 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

<u>Please Note</u>: If using an *Outreach/Encounter Log* to demonstrate this information, please indicate this clearly in the Notes/Comments section.

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<td>Comprehensive Assessment and Care Management Plan</td>
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ECM Care Plan Documentation

- Submit all care plans within the lookback period, including:
  - Initial and updated care plans
  - Documentation of goal progress

Clinical Oversight of Care Plans

- 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

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Provided:

Notes/Comments:

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	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)
	
	Member Needs Assessment
	• 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)
	
	Individualized, Person-Centered Planning
	• 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 *Areas of Need Addressed* • 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 *Ongoing Reassessment and Updates* • 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 *ECM Release of Information (ROI)* • Ensure that the ECM Release of Information is completed and uploaded to PointClickCare (PCC)	

	<u>Please Note</u>: If *Progress Notes* are used to help to demonstrate this information, please indicate this clearly in the Notes/Comments section.	

Enhanced Coordination of Care	*Coordination Activities*
	• 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
	
	Contact with Multi-Disciplinary Team
	• 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
	
	PCP Engagement
	• 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
		Provided:
		
		Notes/Comments:

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<td>Integrated and Continuous Care

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

Member Contact and Monitoring

Maintain regular contact with the member (and/or parent, caregiver, guardian) to:

Monitor health status, care planning, medication usage, and side effects
Communicate member needs and preferences to the care team
Ensure updates and changes are shared across all parties involved

<u>Please Note</u>: If an Outreach/Encounter Log and/or Progress Notes are used to help to demonstrate this information, please indicate this clearly in the Notes/Comments section.</td>
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<td>Health Promotion</td>
<td>Health Promotion Services

Document all activities that support and encourage members to make healthy lifestyle choices and manage or prevent health conditions. These may include:
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<td>Provided:

Notes/Comments:</td>
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	○ Coaching, education, and counseling ○ Motivational interviewing or other evidence-based practices ○ Skill-building to help members identify and access resources *Resource Identification and Sharing* • 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 *Member Engagement and Support* • 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	

	<u>Please Note</u>: If *Progress Notes* are used to help to demonstrate this information, please indicate this clearly in the Notes/Comments section.	

Comprehensive Transitional Care	*Monitoring Transitions Using PCC*
	• Utilize PCC to monitor:
	    o Admissions
	    o Discharges
	    o Transfers (ED, inpatient, SNF, residential / treatment facilities, incarceration, etc.)
	    o Ensure timely notification to the member's lead care manager for follow-up and coordination.
	    o Example: PCC dashboard reports, encounter logs, care manager notifications
	
	Transitional Care Services
	• Document completion of transitional care services, including:
	    o Discharge risk assessments
	    o Sharing discharge planning documents with appropriate parties
	    o Scheduling timely follow-up appointments with outpatient providers or community partners
	    o Medication reconciliation
	    o Closed-loop referrals
	    o Transportation arrangements (per NMT/NEMT policies)
	    o Support for rehabilitation, self-management, and medication adherence
		Provided:
		
		Notes/Comments:

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Example: Log of encounters, progress notes, discharge planning forms
Strategies to Reduce Avoidable Admissions/Readmissions
Provide a detailed overview of your team’s strategies and operational processes, such as:
<ul style="list-style-type:circle">
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

Communication and Coordination
Ensure documentation reflects:
<ul style="list-style-type:circle">
Communication with the member’s care team
Contact with the member and/or parent/caregiver/guardian
Sharing of member needs and preferences
Monitoring of post-discharge progress and adherence
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<tr><td>Member and Family Supports</td><td> Identification and Authorization
Document the member’s authorized support persons, including:
<ul style="list-style-type:circle">
Parent</td><td> Provided: Notes/Comments: </td></tr>
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	○ Caregiver ○ Guardian ○ Other family member(s) ○ Other authorized support person(s) ○ Ensure all required authorizations are in place to allow communication between ECM providers and the member's support network. *Primary Point of Contact* • ECM lead care manager should document the primary contact for the member and/or their support persons *Care Plan Access and Education* • 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 *Knowledge and Engagement* • 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	

	Support Identification and Access
	• 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
	
	Communication and Documentation Format
	• Maintain regular contact with the member and/or their support persons
	• Clearly indicate this in the notes/comments section of each relevant entry
	
	<u>Please Note</u>: If an *Outreach/Encounter Log* and/or *Progress Notes* 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	*Identification of Member Needs*
	• 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
	
	Referrals to Community Resources
		Provided:
		
		Notes/Comments:

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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.)
Date of referral
Receiving organization or provider
Example: Referral forms

Closed-Loop Referrals

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

<u>Please Note</u>: If an Outreach/Encounter Log and/or Progress Notes are used to help to demonstrate this information, please indicate this clearly in the Notes/Comments section.
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<td>Member Experience Survey</td>
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Implement a Member Experience Survey Process

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)

Submit Annually
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	• 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: o Response rates o Key findings o Themes or trends o Any actions taken based on feedback	
Other (Please include Documentation Name/Type):	Please include description:	Please include notes/comments: