

Enhanced Care Management (ECM) Care Plan Guide



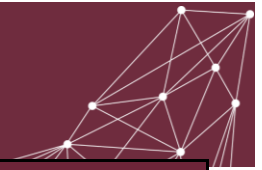
Patient Information			
First Name:		Last Name:	
DOB:			
Gender:	Preferred Pronouns:	Primary Language:	
Address Information			
Street:			
City:	State:	Zip Code:	County:
Mailing Address Same as Home Address?		Yes	No
Street:		PO Box:	
City:	State:	Zip Code:	County:
Contact Information			
Email:			
Phone #:			
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:			

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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 from a juvenile facility to the community.	

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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:			

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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 illness)		
<input type="checkbox"/> Other:			
Additional Notes:			
Advanced Care			
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)		Has One	Does Not Want One
Additional Notes:			

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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: _____

Title: _____

Date: _____