ECM Case Management Progress Note Guide

Purpose:

This tool helps ECM lead case managers translate complex care coordination activities into clear, audit-ready progress notes that demonstrate medical necessity and link interventions to care plan goals.

Documentation Table (Need → Intervention → Monitoring)

Client Need / Barrier (Assessment)	ECM Intervention (Case Manager Action)	Monitoring / Outcome / Next Step
Client reports difficulty attending primary care appointments due to lack of transportation. *Care plan goal:* Improve engagement with medical care.	ECM case manager assessed transportation barriers, educated client regarding Medi-Cal transportation benefits, and coordinated linkage to Non-Emergency Medical Transportation (NEMT) through the Alliance.	Transportation arranged for PCP visit on 4/10. Client confirmed appointment attendance. ECM CM will follow up after appointment to support care plan adherence.
Client experiencing housing instability affecting ability to manage chronic health conditions (diabetes and hypertension). *Care plan goal:* Stabilize housing to support health management.	ECM case manager assessed housing needs, coordinated referral to county housing navigation program, and facilitated communication between client and housing caseworker to support application process.	Housing application submitted. ECM CM will monitor housing placement status and coordinate with housing provider weekly.
Client recently discharged from hospital and lacks follow-up care coordination. *Care plan goal:* Reduce avoidable hospital readmissions.	ECM case manager reviewed hospital discharge instructions, coordinated follow-up PCP appointment, and communicated with clinic care team to ensure medication reconciliation and post-discharge support.	PCP appointment scheduled within 7 days of discharge. ECM CM will monitor adherence and coordinate with PCP if additional needs arise.
Client demonstrates difficulty managing multiple medical appointments across providers. *Care plan goal:* Improve care coordination across systems.	ECM case manager coordinated communication between PCP, behavioral health provider, and specialty care team, and developed shared appointment calendar with client.	Client reports improved understanding of appointment schedule. ECM CM will continue monitoring appointment attendance and provider coordination.

Client Need / Barrier (Assessment)	ECM Intervention (Case Manager Action)	Monitoring / Outcome / Next Step
Client experiencing symptoms of depression affecting engagement in medical care. *Care plan goal:* Improve behavioral health engagement.	ECM case manager assessed behavioral health needs, facilitated referral to behavioral health provider, and supported client with scheduling intake appointment.	Behavioral health intake scheduled for next week. ECM CM will follow up after appointment and coordinate care with BH provider.
Client eligible for Cal Fresh but not enrolled, affecting food security and diabetes management. *Care plan goal:* improve food access and health stability.	ECM case manager educated client about Cal Fresh eligibility, assisted client with benefit application, and coordinated referral to local food pantry resources.	Application submitted. ECM CM will track benefit approval and reassess food access needs during next contact.
Client has difficulty understanding treatment plan and medication regimen. *Care plan goal:* Improve medication adherence.	ECM case manager assessed client health literacy, reviewed medication instructions, and facilitated communication with PCP nurse for clarification of treatment plan.	Client demonstrated improved understanding of medication schedule. ECM CM will monitor adherence and reassess during next care coordination visit.

Identify the Need

Document the health condition, risk factor, or social barrier.

Examples:

- Housing instability impacting chronic condition management
- Transportation barriers limiting access to care
- Difficulty coordinating multiple providers
- Behavioral health symptoms affecting engagement in care

Document ECM Intervention

Clearly describe care coordination work performed by the ECM case manager.

Examples:

- Coordinated care across providers
- Facilitated referral to community resources
- Assisted client with benefits navigation
- Educated client about treatment plan
- Supported client engagement in care

Document Monitoring & Follow-Up

Show ongoing ECM engagement and intensity of coordination.

Examples:

- Follow-up scheduled with provider
- Care manager will monitor engagement
- Coordination with housing navigator ongoing
- Case manager will reassess needs at next contact

Example ECM Progress Note

Need:
Client reports difficulty attending primary care appointments due to lack of transportation. This barrier affects the client's ability to manage chronic medical conditions and meet care plan goal of consistent primary care engagement.

Intervention:
ECM case manager assessed transportation barriers and educated client regarding available Medi-Cal transportation benefits. Case manager coordinated linkage to Non-Emergency Medical Transportation (NEMT) services and assisted client with scheduling transportation for upcoming PCP appointment.

Outcome / Next Steps:
Transportation arranged for PCP visit scheduled on 4/10. Client confirmed plan to attend appointment. ECM case manager will follow up after appointment to monitor engagement in care and address additional barriers.

ECM Progress Note Example — SOAP Format

S — Subjective
Client reported difficulty attending medical appointments due to lack of reliable transportation. Client stated that missed appointments have made it difficult to manage chronic health conditions and expressed concern about maintaining regular follow-up care.

O — Objective
Client appeared engaged during the encounter and discussed recent missed appointments with primary care provider. Client confirmed lack of access to reliable transportation and was unaware of available Medi-Cal transportation benefits.

A — Assessment
Client continues to experience transportation barriers affecting engagement in primary care services and management of chronic medical conditions. Ongoing ECM care coordination is necessary to support access to medical services and reduce risk of worsening health outcomes.

P — Plan
ECM case manager assessed transportation barriers and educated client regarding available Medi-Cal transportation benefits. ECM case manager coordinated linkage to Non-Emergency Medical Transportation (NEMT) services and assisted client with scheduling

transportation for upcoming PCP appointment scheduled for 4/10. ECM case manager will follow up with client after appointment to monitor engagement in care and address additional barriers.

ECM Progress Note Example — DAP Format

D — Data
Client reported difficulty attending medical appointments due to lack of reliable transportation. Client shared that missed appointments have made it difficult to manage chronic health conditions. ECM case manager assessed transportation barriers and discussed available transportation support through Medi-Cal.

A — Assessment
Client continues to experience transportation barriers affecting engagement with primary care and management of chronic health conditions. Client demonstrates need for ECM care coordination to support access to medical services.

P — Plan
ECM case manager educated client regarding Medi-Cal transportation benefits and coordinated linkage to Non-Emergency Medical Transportation services. Transportation arranged for upcoming PCP appointment on 4/10. ECM case manager will follow up after appointment to monitor engagement in care and address any ongoing barriers.

ECM Documentation Reminders

Strong ECM documentation should show:

✓ Did I explain why the encounter happened?
✓ Link to care plan goal
✓ clear case manager action
✓ Evidence of care coordination across systems



✓ Client response or engagement

✓ Next step or follow-up plan