ECM Documentation Sentence Starters
Progress Note Writing Guide for ECM Case Managers

These sentence starters help document medical necessity, care coordination, and interventions in ECM progress notes.

Identifying the Client Need / Barrier (Assessment Language)

Use these to describe why ECM services were needed during this encounter.

• Client reported difficulty with _____, affecting their ability to manage their health condition(s).
• Client continues to experience barriers related to _____, which affect access to medical care.
• Client identified ongoing challenges with _____, requiring ECM care coordination support.
• Assessment identified a need for assistance with _____ to support the client's health stability.
• Client expressed concern regarding _____, affecting their ability to follow treatment recommendations.
• Client requires support navigating _____ due to the complexity of service systems.
• Client continues to demonstrate a need for ECM support related to _____.
• Client reported barriers to care, including _____, affecting engagement with providers.
• Client's current health and social needs include _____, requiring care coordination.

ECM Intervention Sentence Starters (What the Case Manager Did)

These show active care coordination and case management work.

• ECM case manager assessed the client's needs related to _____.
• ECM case manager coordinated communication between _____ and _____.
• ECM case manager facilitated linkage to _____ to address identified needs.
• ECM case manager assisted the client with accessing _____ services.
• ECM case manager provided education regarding _____ to support health management.
• ECM case manager supported the client in navigating _____ services.
• ECM case manager collaborated with _____ to support care plan goals.
• ECM case manager helped the client schedule an appointment with _____ provider.
• ECM case manager reviewed treatment recommendations with the client and clarified next steps.
• ECM case manager advocated with _____ provider/system to address client needs.
• ECM case manager provided guidance regarding available community resources, including _____.
• ECM case manager assisted the client with completing an application for _____ benefits/services.

Care Coordination Documentation (Cross-System Coordination Language)

These demonstrate ECM value and system navigation support.

• ECM case manager coordinated care between the client's primary care provider and _____ provider.
• ECM case manager communicated with _____ provider to support continuity of care.
• ECM case manager collaborated with _____ team to address client needs.
• ECM case manager facilitated information sharing between _____ and _____.
• ECM case manager supported coordination of services across medical, behavioral health, and community providers.
• ECM case manager participated in care coordination activities with _____ provider/team.

Client Engagement / Response

These document client participation and progress.

• Client verbalized understanding of the information discussed.
• Client agreed to follow through with a referral to _____.
• Client participated in discussion regarding care plan goals.
• Client reported willingness to engage with _____ service.
• Client demonstrated improved understanding of _____.
• Client shared concerns regarding _____, which were addressed during the encounter.
• Client confirmed a plan to attend an upcoming appointment with _____.

Monitoring / Follow-Up Sentence Starters

These show ongoing ECM involvement and coordination intensity.

• ECM case manager will follow up with the client regarding _____.
• ECM case manager will monitor progress related to _____.
• ECM case manager will coordinate with _____ provider to support ongoing care.
• ECM case manager will reassess client needs related to _____ during the next contact.
• ECM case manager will continue supporting the client with _____.
• ECM case manager will track progress toward the care plan goal related to _____.
• ECM case manager will follow up after the scheduled appointment to monitor outcomes.

Linking to Care Plan Goals (Golden Thread)

These ensure the note connects back to the care plan.

• Intervention provided today supports the care plan goal related to _____.
• Activity completed today aligns with the client's care plan objective to _____.



• ECM services provided today support the client's goal of _____.
• Care coordination provided today addresses the care plan focus area of _____.

ECM Progress Note Example — SOAP Format

S — Subjective
Client reported difficulty attending medical appointments due to a 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 their primary care provider. Client confirmed a 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 the risk of worsening health outcomes.

P — Plan
ECM case manager assessed transportation barriers and educated the client regarding available Medi-Cal transportation benefits. ECM case manager coordinated linkage to Non-Emergency Medical Transportation (NEMT) services and assisted the client with scheduling transportation for an upcoming PCP appointment scheduled for 4/10. ECM case manager will follow up with the client after the 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 a 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 a need for ECM care coordination to support access to medical services.

P — Plan
ECM case manager educated the client regarding Medi-Cal transportation benefits and coordinated linkage to Non-Emergency Medical Transportation services. Transportation was

arranged for an upcoming PCP appointment on 4/10. ECM case manager will follow up after the appointment to monitor engagement in care and address any ongoing barriers.