ECM Progress Note Examples

Hospital Discharge Follow-Up

SOAP Format

S — Subjective
Client reported being recently discharged from the hospital and stated feeling overwhelmed managing medications and follow-up appointments.

O — Objective
Client confirmed discharge from the hospital three days ago. Discharge paperwork indicates a need for PCP follow-up within one week and medication reconciliation.

A — Assessment
Client requires ECM care coordination to support transition of care following hospitalization and reduce the risk of readmission.

P — Plan
ECM case manager reviewed discharge instructions with the client, coordinated scheduling of a follow-up PCP appointment, and communicated with the clinic nurse regarding medication reconciliation. ECM case manager will follow up after the PCP appointment to monitor adherence to discharge recommendations.

DAP Format

D — Data
Client reported recent hospital discharge and difficulty managing follow-up care instructions. ECM case manager reviewed discharge paperwork with the client and discussed follow-up care needs.

A — Assessment
Client requires care coordination support following hospitalization to ensure engagement with follow-up medical care.

P — Plan
ECM case manager coordinated scheduling of a PCP follow-up appointment and communicated with the clinic care team regarding medication reconciliation. ECM case manager will follow up with the client after the appointment to monitor engagement with care.

Housing Instability

SOAP Format

S — Subjective
Client reported current housing instability and expressed concern about the ability to maintain medical care while staying in temporary housing.

O — Objective
Client confirmed staying temporarily with a friend and reported uncertainty regarding long-term housing.

A — Assessment
Housing instability continues to impact the client's health stability and ability to maintain regular medical care.

P — Plan
ECM case manager assessed housing needs, provided information regarding county housing navigation services, and facilitated a referral to a housing program. ECM case manager will monitor the status of the housing referral and coordinate with the housing provider.

DAP Format

D — Data
Client reported housing instability and uncertainty about future housing arrangements. ECM case manager discussed available housing resources and assessed the client's eligibility for housing navigation services.

A — Assessment
Client continues to require ECM support to address housing instability affecting health management.

P — Plan
ECM case manager coordinated a referral to the county housing navigation program and will monitor progress with housing placement.

Behavioral Health Referral

SOAP Format

S — Subjective
Client reported increased stress and difficulty managing mood symptoms, affecting the ability to attend medical appointments.

O — Objective
Client described ongoing symptoms of anxiety and difficulty maintaining engagement with care.

A — Assessment
Behavioral health symptoms are affecting the client's ability to consistently engage in medical care and follow treatment recommendations.

P — Plan
ECM case manager assessed behavioral health needs and coordinated a referral to a behavioral health provider. ECM case manager assisted the client with scheduling an intake appointment and will follow up regarding engagement with services.

DAP Format

D — Data
Client reported ongoing stress and difficulty managing mood symptoms. ECM case manager discussed behavioral health resources and explored the client's willingness to engage in services.

A — Assessment
Client demonstrates a need for behavioral health support to improve engagement with medical care.

P — Plan
ECM case manager facilitated a referral to a behavioral health provider and assisted the client with scheduling an intake appointment. ECM case manager will monitor engagement with services.

Food Insecurity / Benefits Navigation

SOAP Format

S — Subjective
Client reported difficulty affording groceries and expressed concern about maintaining a recommended diet for diabetes management.

O — Objective
Client confirmed limited access to food resources and reported not currently being enrolled in CalFresh.

A — Assessment
Food insecurity continues to impact the client's ability to manage a chronic health condition.

P — Plan
ECM case manager provided education regarding CalFresh eligibility, assisted the client with completing an application, and provided a referral to local food pantry resources. ECM case manager will follow up regarding application status.

DAP Format

D — Data
Client reported difficulty affording food and maintaining a recommended diet. ECM case manager discussed available food resources and CalFresh eligibility.

A — Assessment
Food insecurity remains a barrier affecting the management of chronic health conditions.

P — Plan
ECM case manager assisted the client with a CalFresh application and provided a referral to a local food pantry. ECM case manager will monitor the application outcome and reassess food access needs.

Multi-Provider Care Coordination

SOAP Format

S — Subjective
Client reported confusion regarding multiple upcoming medical appointments and expressed difficulty keeping track of provider recommendations.

O — Objective
Client has appointments scheduled with PCP, cardiology, and behavioral health providers within the next month.

A — Assessment
Client requires ECM care coordination to support the organization of medical care and communication between providers.

P — Plan
ECM case manager reviewed upcoming appointments with the client, created an appointment calendar, and coordinated communication with the PCP clinic regarding specialty referrals. ECM case manager will follow up to monitor appointment attendance.

DAP Format

D — Data
Client reported confusion regarding multiple medical appointments and difficulty managing provider recommendations. ECM case manager reviewed upcoming appointments and discussed strategies for managing care coordination.

A — Assessment
Client continues to require ECM support to coordinate care across multiple providers.

P — Plan
ECM case manager created a shared appointment calendar with the client and coordinated communication with the PCP clinic regarding specialty referrals. ECM case manager will follow up to monitor engagement with care.