Enhanced Care Management (ECM) Encounter Note Guide

1. Member and Encounter Details

Each encounter note should clearly identify the member and include all relevant encounter information, including:

- Member full name and/or member ID
- Date of service
- Type of encounter, such as phone, in-person visit, home visit, telehealth, or community-based contact
- Duration of the encounter
- Location of the encounter, such as the member's home, office, hospital, or community setting

2. Reason for Encounter

The note should clearly document the purpose of the contact or visit. This may include, but is not limited to:

- Follow-up contact
- Post-discharge outreach
- Comprehensive assessment
- Resource navigation
- Care coordination
- Care plan review
- Support with identified needs

3. Member Status and Updates

The encounter note should include relevant updates regarding the member's current status, including physical health, behavioral health, and social needs. Documentation should include:

- Current condition or concerns reported by the member
- Any changes since the last contact
- New or ongoing needs identified
- Updates regarding housing or living situation
- Safety concerns, if applicable

4. Interventions and Services Provided

The note should clearly describe the specific actions taken by the staff during the encounter. This section should reflect active case management and should not be limited to general statements or check-ins.

Examples of interventions include:

- Coordinating care with providers or community agencies
- Scheduling or assisting with medical, behavioral health, or social service appointments
- Providing education related to disease management, medications, benefits, or available services
- Assisting with housing, food, transportation, or other social needs
- Completing applications, referrals, forms, or other required documentation
- Providing emotional support, advocacy, or assistance with system navigation
- Documentation should be specific and clearly state what was completed, discussed, or initiated.

5. Care Coordination

For Enhanced Care Management documentation, care coordination is a critical component. The note should identify any providers, agencies, or systems involved in the member's care and describe the outcome of the coordination.

This may include collaboration with:

- Primary care providers
- Specialists
- Behavioral health providers
- Substance use treatment providers
- Hospitals or discharge planners
- Social service agencies
- Community-based organizations
- Housing, food, transportation, or other resource providers
- The note should include who was contacted, the purpose of the coordination, and the result or next step.

6. Member Response

The encounter note should document how the member responded to the intervention or service provided. This may include:

- Level of engagement
- Willingness to participate
- Questions or concerns expressed by the member
- Understanding of education or information provided
- Agreement with the plan
- Refusal or decline of services, if applicable

7. Progress Toward Care Plan Goals

Documentation should clearly connect the encounter to the member's care plan goals. The note should identify:

- Which care plan goal or need was addressed
- Progress made toward the goal
- Ongoing barriers impacting progress
- Any updates needed to the care plan

8. Barriers Identified

The note should include any barriers affecting the member's ability to access care, follow through with services, or meet care plan goals. Barriers may include:

- Transportation limitations
- Housing instability
- Financial hardship
- Limited health literacy
- Behavioral health needs
- Substance use concerns
- Lack of social support
- System barriers, such as waitlists, access delays, or authorization issues

9. Next Steps and Plan

The plan section should clearly outline what will occur after the encounter to ensure continuity of care. This should include:

- Follow-up tasks for staff
- Follow-up tasks for the member
- Referrals pending or submitted
- Appointments scheduled or needing to be scheduled
- Coordination that needs to continue
- Documentation or forms requiring completion

10. Follow-Up Plan

The note should include a clear follow-up plan, including:

- Date or timeframe for the next contact
- Type of follow-up, such as phone call, in-person visit, home visit, or provider coordination
- Purpose of the next follow-up

11. Compliance Elements

Encounter notes should include all required compliance elements, as applicable. These may include:

- Member consent, when required
- HIPAA-compliant and professional language
- Staff signature and credentials
- Timely documentation, completed the same day or within the required timeframe
- Accurate and objective information

What Makes an Encounter Note Audit-Ready

An audit-ready encounter note should:

- Demonstrate active case management rather than a general check-in
- Include both clinical and non-clinical needs, including social determinants of health
- Clearly document care coordination efforts
- Be specific to the member's situation and needs

- Reflect the member's response and level of engagement
- Connect interventions to the member's care plan goals
- Clearly identify barriers and next steps
- Align with ECM Core Services

Team Documentation Reminder

A strong encounter note should answer the following three questions:

- Why was the member engaged today?
- What specific actions or interventions were completed?
- What is the plan moving forward?

If these three questions are clearly answered, the encounter note is more likely to reflect meaningful, audit-ready case management documentation.