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Care Management and Support (CM)

The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

CM Competency A

CM – Competency A

The practice systematically identifies patients who may benefit from care management.

Criteria	Criteria Description	Required Evidence
CM 01 (Core)	**Identifying Patients for Care Management**: Considers the following in establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria): A. Behavioral health conditions B. High cost/high utilization C. Poorly controlled or complex conditions D. Social determinants of health E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver	*Protocol for identifying patients for care management* ***OR*** *CM 03*
CM 02 (Core)	**Monitoring Patients for Care Management:** Monitors the percentage of the total patient population identified through its process and criteria.	*Report*
CM 03 * (2 Credits)	**Comprehensive Risk-Stratification:** Applies a comprehensive risk-stratification process for the entire patient panel in order to identify and direct resources appropriately.	*Evidence of Implementation*

https://chcleadership.com/wp-content/uploads/2019/05/CM_PCMH-Standards-and-Guidelines-2017-Edition-Version-4.pdf

Care Management and Support (CM)

The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.

Competency A: Identifying Care Managed Patients. The practice systematically identifies patients who may benefit from care management.

CM 01 (Core) Identifying Patients for Care Management: Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (practice must include at least three in its criteria):

A. Behavioral health conditions.
B. High cost/high utilization.
C. Poorly controlled or complex conditions.
D. Social determinants of health.
E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/ family/caregiver.

GUIDANCE	EVIDENCE
The practice defines a protocol to identify patients who may benefit from care management. Specific guidance includes the categories or conditions listed in A–E. Examples include, but are not limited to: **A.** Diagnosis of a serious mental illness, psychiatric hospitalizations, substance use treatment. **B.** Patients who experience multiple ER visits, hospital readmissions, high total cost of care, unusually high numbers of imaging or lab tests ordered, unusually high number of prescriptions, high-cost medications and number of secondary	• **Protocol for identifying patients for care management** ***OR*** • **CM 03**

Care Management and Support (CM)

CM Competency A - Documentation Examples

Identifying & Monitoring Patients for Care Mgmt

CM 01: Example

- Behavioral health patients identified – positive PHQ 9
- High utilizers – two or more ER visits in 6 months
- Two or more hospital admissions in past year
- Poorly controlled (multiple co morbidities) – HgbA1C > 9; uncontrolled hypertension
- Social determinants of health – education level < grade 8

Utilizing the criteria outlined above and in our Patient Care Planning and Management protocol, it is determined that 83 patients or 9% of the population serviced at the Ashland center could benefit from care management.

Denominator = 893 patients

Numerator = 83 patients

Percentage of patients identified as benefiting from care management = 5%

Care Management and Support

CM 02: Example

Patients Needing Care Management

	Behavioral Health	High Cost/ Utilization	Poor Control/ Complex	Social Determinants of Health	Referrals	Total Patients
Patients in Registry (may be listed more than once)	120	35	200	10	10	375
Unique Patients in Registry	-	-	-	-	-	343
Total Patients in Practice	-	-	-	-	-	3000
Patients Needing Care Management	-	-	-	-	-	11.4% (343 patients)

CM Competency A - Frequently Asked Questions

What is NCQA looking for regarding the percentage of a clinic's patients that should be receiving care management (PCMH 2017 CM 02)?

- NCQA does not document a 'percentage requirement', but emphasizes the intent of the element is that practices use a defined criteria to identify true vulnerability. **'Unofficial' guidance suggests an estimated 5-15%** of a clinic's patient population is reasonable starting point.
- The practice determines its subset of patients for care management, based on the patient population and the practice's capacity to provide services. CM 02

CM Competency B

CM – Competency B

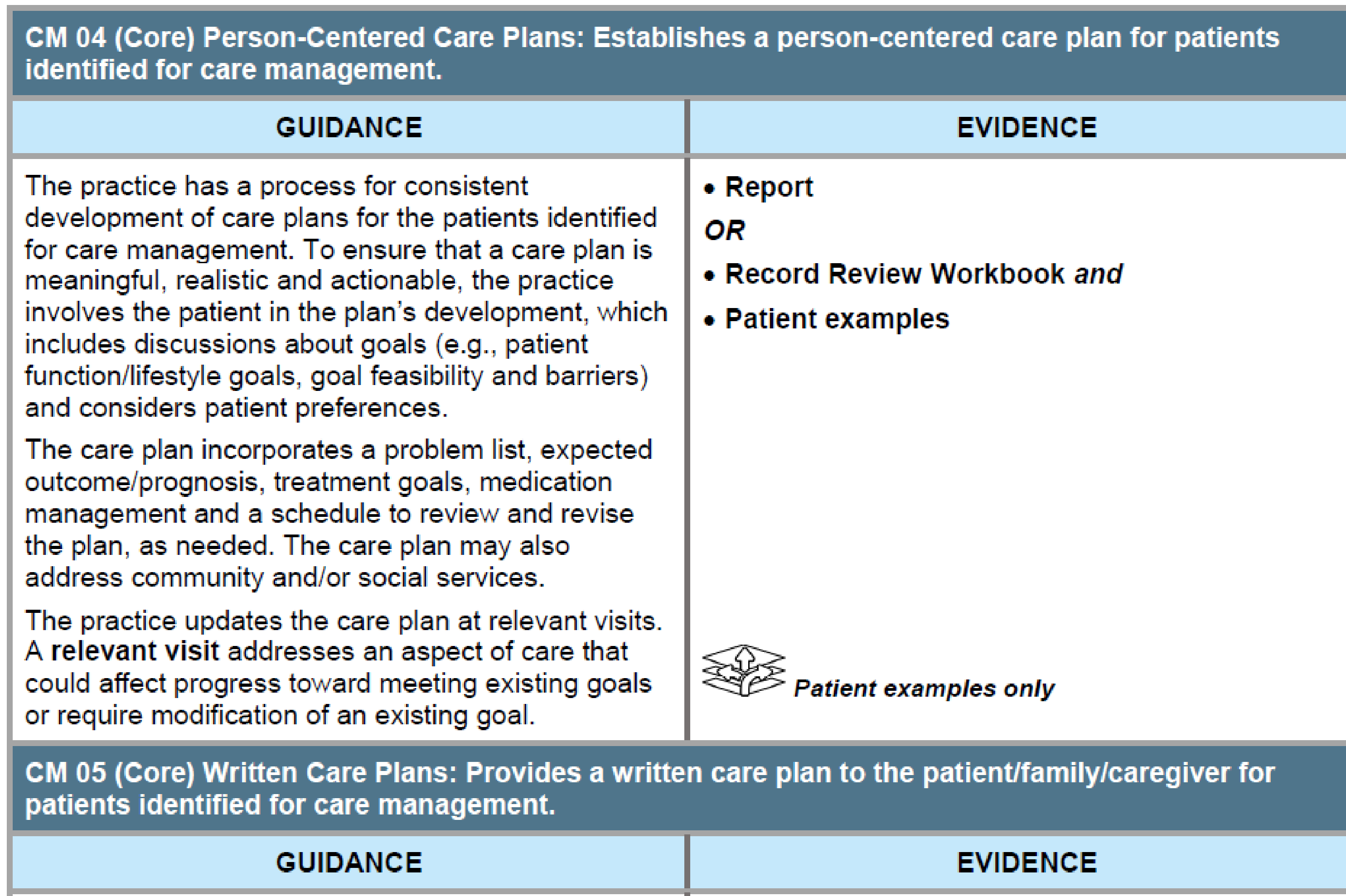
For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/ caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart.

Criteria	Criteria Description	Required Evidence
CM 04 (Core)	**Person Centered Care Plans:** Establishes a person-centered care plan for patients identified for care management.	*Report* ***OR*** *Record Review Workbook AND Patient examples*
CM 05 (Core)	**Written Care Plans:** Provides a written care plan to the patient/family/caregiver for patients identified for care management.	
CM 06 (1 Credit)	**Patient Preferences and Goals:** Documents patient preference and functional/lifestyle goals in individual care plans.	
CM 07 (1 Credit)	**Patient Barriers to Goals:** Identifies and discusses potential barriers to meeting goals in individual care plans.	
CM 08 (1 Credit)	**Self-Management Plans:** Includes a self-management plan in individual care plans.	
CM 09 (1 Credit)	**Care Plan Integration:** Care plan is integrated and accessible across settings of care.	*Documented Process* ***AND*** *Evidence of implementation*

https://chcleadership.com/wp-content/uploads/2019/05/CM_PCMH-Standards-and-Guidelines-2017-Edition-Version-4.pdf

CM Competency B: Care Plan Development.

Competency B: Care Plan Development. For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart.



CM 04 (Core) Person-Centered Care Plans: Establishes a person-centered care plan for patients identified for care management.	
GUIDANCE	**EVIDENCE**
The practice has a process for consistent development of care plans for the patients identified for care management. To ensure that a care plan is meaningful, realistic and actionable, the practice involves the patient in the plan's development, which includes discussions about goals (e.g., patient function/lifestyle goals, goal feasibility and barriers) and considers patient preferences. The care plan incorporates a problem list, expected outcome/prognosis, treatment goals, medication management and a schedule to review and revise the plan, as needed. The care plan may also address community and/or social services. The practice updates the care plan at relevant visits. A **relevant visit** addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal.	• **Report** ***OR*** • **Record Review Workbook** ***and*** • **Patient examples** ***Patient examples only***

CM 05 (Core) Written Care Plans: Provides a written care plan to the patient/family/caregiver for patients identified for care management.	
GUIDANCE	**EVIDENCE**

Care Management and Support (CM)

CM Competency B - Documentation Examples

CM 04, 05, 06, 07, 08 – Example of Person-Centered Care Plan

IOM (Institute of Medicine). 2013. Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis. Washington, DC: The National Academies Pr

TABLE 3-4 Example of a Written Plan for Communication

Plan component	Purpose
Name_____	Lets you personalize the plan; make a copy for medical record.
Medical Record No._____	
Date_____	
1. Diagnosis:_____	Gives the disease a name so the patient can look it up.
2. Stage (where it has spread):_____ (list all areas)	Allows discussion of prognosis. Showing metastases to the brain and liver quickly points out the seriousness of the illness.
3. Prognosis:_____ List whether curable or not curable and expected average lifespan	Ask first if patients want to know the full details of their illness! Allows open communication about goals, rest-of-life planning. Some patients will persist in denial, but this allows open dialogue with the family.
4. Treatment Goals:_____ List cure, long- or short-term control, pain relief, hospice care	Makes explicit what you can and cannot do; for curable disease, this reinforces your goal, and that cure is possible. Use this to bring up do-not-resuscitate and cardiopulmonary resuscitation issues. Allows you to emphasize that hospice care does not mean "no treatment", but a different set of treatment goals.
5. Treatment Options:_____ List all that apply	List treatments, response rates, and common toxicities. Specifically mention vomiting and hair loss, the two most feared symptoms Remember, if you cannot define a real benefit then there is no justification for treatment.
6. Call the doctor if:_____ List your threshold for fever, pain, and other symptoms	Gives explicit reasons to call and gives explicit permission to call.
7. How to reach me:_____ List the phone numbers during office and off-hours	Tell patients to keep this handy. They will call, and for real events. Emails for nonemergency purposes work well for prescription refills, questions about new drugs, encouragement, etc.
8. Signed: _____MD	Personalizes the plan as well as making it a part of the medical record.

SOURCE: Adapted from Smith, T.: *J Clin Oncol* 21(9 Suppl), 2003: 12s-16s. Reprinted with permission.
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Care Management and Support

CM 05: Example

Patient is provided a copy of individualized care plan

CLINICAL SUMMARY PRINT [X] Print Patient Copy [X] Copy Provided to Patient

CARE PLAN PRINT [X] Print Patient Care Plan

Electronically Signed By: LPN-OPD

Date: 10112016 Time: 1117 VTB3

RTC Appointment Date/Time: ______________________

CM 04, 05, 06, 07, 08 – Care Planning and Self-Care Support Record Review Workbook

Organization Name:	
Completion Date:	

Patient Number	CM 04	CM 05	CM 06	CM 07	CM 08
	Care Planning and Self-Care Support				
	Establishes a person-centered care plan for patients identified for care management	Provides written care plan to the patient/family/caregiver for patients identified for care management	Documents patient preference and functional/lifestyle goals in individual care plans	Identifies and discusses potential barriers to meeting goals in individual care plans	Includes a self-management plan in individual care plans
1					
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22					
23					
24					
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26					
27					
28					
29					
30					
Count of Patients Met (Yes + NA)	0	0	0	0	0
Count of Patients Not Met (No + Not Used)	0	0	0	0	0
Total Count of Patients (Met + Not Met)	0	0	0	0	0
% of Patient that Meet Criteria					

CM 08: Example

COPD Action Plan

When you are well, be aware of the following:	Action
• How much activity you can do each day • What your breathing is like when you are resting and when you are active • How much phlegm you cough up and what colour it is • Anything that makes your breathing worse • What your appetite is like • How well you are sleeping • Do you have any swelling to your feet/ankles	• Have something to look forward to each day • Plan ahead - pace yourself and allow enough time to do things • Exercise every day • Eat a balanced diet and drink plenty of fluids • Avoid things that make your condition worse • Take your medication as directed by your doctor • Never allow your medications to run out

The following are signs that your symptoms are getting worse:	Action
• Feeling more breathless or wheezy than usual • Reduced energy for daily activities • Coughing up more phlegm • Change in colour of phlegm • Poor sleep and/or symptoms waking you in the night • Starting to cough or increased cough • You may also have loss of appetite • New or increased swelling to feet/ankles	• Increase your reliever medication • Contact your ____________________ on ____________________ for advice • Consider starting your 'standby' antibiotics and/or Prednisolone • 'Standby' medication details (see next page) • Antibiotics: to use if your sputum becomes coloured or the amount increases due to infection • Prednisolone (Steriod): to reduce inflammation in the lungs when your breathing is bad

The following are signs of a severe attack:	Action
• Breathlessness and cough getting worse • You are not able to carry out your normal daily activities • Your medications are not working	• If you have not done so already, start your 'standby' medication • Phone your nurse or doctor if you have started 'standby' medication - and you are not improving - for an urgent appointment or home visit

The following are signs of a severe attack:	Action
• Very short of breath when you are at rest, with no relief from medication • Chest pains • High fever (temperature) • Feelings of agitation, fear, drowsiness or confusion	• Dial 999 for an ambulance or ring the GP Out of Hours service

Norfolk Community Health and Care NHS Trust COPD action plan

Documentation Tips

- CM 04 - CM 08
  - Report from electronic system or
  - Record Review Workbook (RRWB) **and** 1 example for each criteria
- Report may be used to meet some criteria and RRWB with examples for other criteria – choose based on what is easiest to pull

Documentation Tips (continued)

Most Common errors:

- No examples to support RRWB responses (CM 04-CM 08); site specificity for multisite practices
- Missing components of the care plan
- No evidence of actually giving patients care plans; reports acceptable if performance threshold of 75% is satisfied. CM 05
- Neglecting to assess and address barriers to meeting care plan goals CM 07

Community Health Solutions

CM Competency B – Frequently Asked Questions

Does a clinical summary meet the requirement for a “plan of care”? CM 04, CM 05

- **No**, not on its own, although a plan of care can be a component of a clinical summary.
  - Clinical summary might include a diagnosis, medications, recommended treatment and follow-up, and information about home management of an acute or chronic condition, when appropriate.
  - Plan of care is tailored for the patient’s use at home and to the patient’s understanding (e.g., an asthma action plan).

What are the parameters for a care plan? CM 04

A care plan is based on the acute, chronic and preventive care needs of a patient and can include:

- Patient preferences and goals;
- Treatment goals and status;
- Assessment of barriers and strategies to address them;
- Problem list
- Expected outcome/prognosis
- Medication Management;
- Allergies;
- Self-care plan
- Schedule to review and revise plan, as needed

What are the parameters for a care plan? (cont.) CM 04

- This criteria requires practices to document a patient-centered view of the care plan and share the plan with the patient between visits. A care plan does not need to be re-created at each visit but must be reviewed and updated as needed (document when this is done).

- A practice updates the care plan at ‘relevant visits’. A *relevant visit* addresses an aspect of care that could affect progress toward meeting existing goals or that require modification of an existing goal.

Can practices make the individualized care plan available via patient portal, or are they required to provide the document in writing? CM 05

- Although the care plan can be made available via the patient portal, it is essential that all patients have access to the document.
- If patients are not registered for the portal, they will not have access.
- Practices should use an alternative method to provide the written care plan to patients, to ensure that all patients have access after an appointment.
- Practices must document that the care plan is provided in writing to the patient **in the patient's medical record**.

Are practices required to document that they identify and discuss potential barriers to meeting goals in individual care plans? CM 07

- **Yes.** Practices must assess whether there are barriers to meeting goals and should address any identified barriers.
- Both components must be listed in the medical record in order to select “Yes” in the Record Review Workbook.
- If the practice assesses potential barriers and none are identified, the practice may answer “Yes.”
- Note: **Practices must provide an example of how they meet each criteria and complete the Record Review Workbook**. Examples are not required if a practice provides a report as documentation.