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

CM 01 (Core): 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 specialist referrals. **C.** Patients with poorly controlled or complex conditions such as, continued abnormally high A1C or blood pressure results, consistent failure to meet treatment goals, multiple comorbid conditions. **D.** Availability of resources such as food and transportation to meet daily needs; access to educational, economic and job opportunities; public safety; social support; social norms and attitudes; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020). **E.** Direct identification of patients who might need care management such as, referrals made from health plans, practice staff, patient, family members, or caregivers.	• **Protocol for identifying patients for care management** *OR* • **CM 03**

 = Evidence sharable across practice sites

CM 02 (Core): Monitors the percentage of the total patient population identified through its process and criteria.	
GUIDANCE	**EVIDENCE**
The practice determines its subset of patients for care management, based on the patient population and the practice's capacity to provide services. The practice uses the criteria defined in CM 01 to identify patients who fit defined criteria. Patients who fit multiple criteria count once in the numerator.	• **Report**

CM 03 (2 Credits): Applies a comprehensive risk- stratification process for the entire patient panel in order to identify and direct resources appropriately.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. Practice identifies and directs resources appropriately based on need.	• **Report**

Care Management and Support (CM)

= Evidence sharable across practice sites

CM Competency B

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.

CM 04 (Core): Establishes a person-centered care plan for patients identified for care management.	
GUIDANCE	**EVIDENCE**
The practice has a process to consistently develop patient 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/life style, 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**

CM 05 (Core): Provides a written care plan to the patient/family/caregiver for patients identified for care management.	
GUIDANCE	**EVIDENCE**
The practice provides the patient's written care plan to the patient/family/caregiver. The practice may tailor the written care plan to accommodate the patient's health literacy and language preference. (i.e., the patient version may use different words of formats from the version used by the practice team).	• **Report** *OR* • **Record Review Workbook *and*** • **Patient examples**

= Evidence sharable across practice sites

CM Competency B

CM 06 (1 Credit): Documents patient preference and functional/lifestyle goals in individual care plans.	
GUIDANCE	**EVIDENCE**
The practice works with patients/families/caregivers to incorporate patient preferences and functional lifestyle goals in the care plan. Including patient preferences and goals encourages a collaborative partnership between patient/family/caregiver and provider, and ensures that patients are active participants in their care. **Functional/lifestyle goals** can be individually meaningful activities that a person wants to be able to perform but may be at risk due to a health condition or treatment plan. Identifying patient-centered functional/lifestyle goals is important because people are likely to make the greatest gains when goals focus on activities that are meaningful to them and can make a positive difference in their lives.	• **Report** *OR* • **Record Review Workbook** *and* • **Patient examples**

CM 07 (1 Credit): Identifies and discusses potential barriers to meeting goals in individual care plans.	
GUIDANCE	**EVIDENCE**
Addressing barriers supports successful completion of the goals stated in the care plan. Barriers may include physical, emotional or social barriers. The practice works with patients/families/caregivers, other providers and community resources to address potential barriers to achieving treatment and functional/ lifestyle goals.	• **Report** *OR* • **Record Review Workbook** *and* • **Patient examples**

[Table of Contents](#)

 = Evidence sharable across practice sites

CM 08 (1 Credit): Includes a self-management plan in individual care plans.	
GUIDANCE	**EVIDENCE**
The practice works with patients/families/ caregivers to develop self-management instructions to manage day-to-day challenges of a complex condition. The plan may include best practices or supports for managing issues related to a complex condition identified in the care plan. Providing tools and resources to self-manage complex conditions can empower patients to become more involved in their care and to use the tools to address barriers toward meeting care plan goals.	• **Report** *OR* • **Record Review Workbook** *and* • **Patient examples**

CM 09 (1 Credit): Care plan is integrated and accessible across settings of care.	
GUIDANCE	**EVIDENCE**
Sharing the care plan supports its implementation across all settings that address the patient's care needs. The practice makes the care plan accessible across external care settings. It may be integrated into a shared electronic medical record, information exchange or other cross-organization sharing tool or arrangement.	• **Documented process** *AND* • **Evidence of implementation**

Care Management and Support (CM)

= Evidence sharable across practice sites