# 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 (must include at least three; pediatric-specific practice-sites must include at least two):**

**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 |
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| At least annually, the practice defines a protocol for identifying 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:<br>**A.** Diagnosis of a serious mental illness, psychiatric hospitalizations, substance use treatment, ADHD, anxiety, learning disorders, eating disorders etc.<br>**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 high number of secondary specialist referrals.<br>**C.** Patients with poorly controlled or complex conditions such as obesity, uncontrolled asthma, continued abnormally high A1C or blood pressure results, consistent failure to meet treatment goals, multiple comorbid conditions.<br>**D.** Availability of resources to meet daily needs, such as ~~food and transportation; 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).~~ economic access and quality, health care access and quality, neighborhood and built | • **Protocol for identifying patients for care management**<br>***OR***<br>• **CM 03** |

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| environment, and social and community context (Healthy People 2030).<br><br>**E.** Direct identification of patients who might need care management, such as referrals by health plans, practice staff, patient, family members or caregivers.<br><br>Because the intent of care management is identification of a subset of patients who need concentrated care, beyond what is required of a traditional treatment plan, it is offered only to a limited population. | |

| **CM 02 (Core) Monitoring Patients for Care Management: Monitors the percentage of the total patient population identified through its process and criteria.** | |
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| **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.<br><br>At least annually, the practice uses the criteria defined in CM 01 to identify patients. The practice should ensure that criteria are specific enough for any identified patient to have their care managed. The practice must identify at least 30 patients in the numerator. ~~Patients who fit multiple criteria count once in the numerator.~~<br><br>~~With NCQA approval, small practices or satellite sites may share a care management population if fewer than 30 patients meet the criteria defined in CM 01.~~<br><br>At minimum, a practice must identify at least 30 patients must be identified for care management, or 1% of its total patient population, whichever is smaller, to meet the criteria defined in CM 01.<br><br>For example, a practice with one provider and a patient population of 1,500 patients would report a minimum of 15 patients identified for care management. Alternatively, a practice site with a patient population of 5,000 patients would report a minimum of 30 patients identified for care management (50 patients is 1% of the patient population).<br><br>Patients who fit multiple criteria count once in the numerator.<br><br>The patient population is the total number of unique patients seen at the practice site in the last 12 months.<br><br>A unique patient is a patient who is counted only once during the reporting period. | • **Report**<br><br>  |

**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 at least 75% of patients ~~identified for~~ engaged in care management.** | |
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| **GUIDANCE** | **EVIDENCE** |
| The practice has a process for consistent development of care plans for 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 is written at a health literacy level accessible to the patient (i.e., does not contain medical jargon, abbreviations/acronyms or billing codes).<br><br>The care plan incorporates ~~a comprehensive problem list, expected clinical outcome/prognosis (e.g., lower A1c by 2 points), patient treatment goals to meet the expected clinical outcome (e.g., exercising three times a week), medication list and management and a schedule to review and revise the plan, as needed (such as a date or a cadence [e.g., in 3 months]) for all enrolled patients.~~ the following:<br><br>• **Names and roles of care team members.** In an instance where the primary provider is also the care manager, the primary provider's name and credential may be listed, in place of the designation as the care manager.<br>• **An active, comprehensive problem list.** Listing all active problems provides a comprehensive view of the patient—not only to the care team, but also to the patient/family/caregiver.<br>• **A SMART goal** (specific, measurable, attainable, relevant, time-limited). A SMART goal should be relevant to the care plan and be mutually agreed upon between the patient/family/caregiver and the primary provider. The SMART goal should inform the expected outcome(s) and/or patient treatment goal(s).<br>○ "Within the next 3 months, the patient will achieve well-controlled asthma (i.e., defined as daytime symptoms ≤2 days per week, no nighttime awakenings, no more than 1 rescue inhaler use per week, and | • **Report**<br>***OR***<br>• **Record Review Workbook *and***<br>• **Patient examples**<br><br>***Report or Record Review Workbook***<br><br>***Patient examples*** |

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| zero emergency room visits for asthma, as documented at follow-up visits.<br>• **Medication list and management.** A full list of active medications is included in the care plan.<br>• **Barriers to care.** Addressing barriers supports successful completion of the goals stated in the care plan.<br>Barriers may be physical, emotional or social. The practice works with patients/families/ caregivers, other providers and community resources to address potential barriers to achieving treatment and functional/lifestyle goals.<br>If there are no barriers to care then this is documented within the care plan.<br>• **A schedule to review and revise the plan, as needed** (such as a date or a cadence [e.g., in 3 months]) for all enrolled patients.<br>The care plan may also address community and/or social services.<br>The practice may use motivational interviewing to assess patient readiness to change and self-management abilities through patient questionnaires and self-assessment forms. Assessing self-management abilities enables the practice to adjust plans to fit patient/family/ caregiver capabilities and resources. Patients/ families/caregivers will have greater success if they feel they can manage a condition, learn needed self-care skills and adhere to treatment goals.<br>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.<br>The practice reviews all elements of the care plan at least twice a year.<br>**Note:** After-visit summaries may only be used if they contain plain language and show patient involvement in the plan's creation. | |

| ~~CM 07 (1 Credit) Patient Barriers to Goals: Identifies and discusses potential barriers to meeting goals in at least 75% of individual care plans.~~ | |
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| **~~GUIDANCE~~** | **~~EVIDENCE~~** |
| ~~Addressing barriers supports successful completion of the goals stated in the care plan. Barriers may be physical, emotional or social.~~<br><br>~~At least twice a year, the practice works with patients/families/ caregivers, other providers and community resources to address potential barriers to achieving treatment and functional/lifestyle goals.~~ | ~~• **Report**~~<br>~~***OR***~~<br>~~• **Record Review Workbook *and***~~<br>~~• **Patient examples**~~<br><br>***Report and Record Review Workbook***<br><br>***Patient examples*** |