

# PCMH4: Care Management and Support

Effective individual and population health management is a core concept of the PCMH model of care. The ability to provide organized, high-quality care supported by evidence-based guidelines is critical to improved patient outcomes.

It is important to understand the conditions that have the most impact for your patient population. In Standard 4, NCQA requires practices to establish a systematic process and criteria for identifying patients who may benefit from care management. ***This is one of the most important and time consuming elements so your practice may wish to start with this important PCMH model of care core concept.***

## Element A: Identify Patients for Care Management

(Element 4A is a prerequisite to must-pass element 4B). 4A requires practices to establish a systematic process and criteria for identifying patients who may benefit from care management. Factor 6 is a critical factor.

The process includes consideration of the following 6 Factors:

- Behavioral health conditions
- High cost/high utilization
- Poorly controlled or complex conditions
- Social determinants of health
- Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff or patient/family/caregiver
- **The practice monitors the percentage of the total patient population identified through its process and criteria**

Key Consideration: How will these patients be identified and tracked for follow-up?

Documentation Requirements for 4A:

*Factors 1-5:* Criteria and process for identifying patients.

*Factor 6:* Report showing number and percentage of patients identified as likely to benefit from care management through one or any combination of the other five factors or other criteria determined by the practice.

## Element B: Care Planning and Self Support — Must Pass

In Element 4B, NCQA requires practices to demonstrate how care is managed for individual patients as well as for the overall practice patient population. The care team and

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patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of patients identified in Element A:

- Incorporates patient preferences and functional/lifestyle goals
- Identifies treatment goals
- Assesses and addresses potential barriers to meeting goals
- Includes a self-management plan
- Is provided in writing to the patient/family/caregiver

Examples include:

- Individualized Care Plans: Collaborating with the patient (and patient's family, when appropriate) to create a care plan appropriate for the patient's condition and individual needs and abilities. Care plans must include treatment goals that are reviewed with the patient and updated at each relevant visit
- Written Care Plans: Providing a written care plan tailored for the patient's use at home and to the patient's understanding.
- Assessment of Barriers: Assessing possible barriers when patients do not meet their treatment goals. Changing goals as needed to overcome barriers and help patients achieve success.
- Written Clinical Summaries: Providing a written clinical summary to patients at relevant office visits. (Relevant visits should include chronic and important condition visits, visits that result in changes to treatment or care plans, or visits where new instructions are provided to patient).
- Additional Care Management Support: Identifying patients that may need or benefit from additional care management support. And, when appropriate, referring them to resources (internal or external), such as disease management programs or case management programs.

## **Documentation Requirements for 4B:**

Element 4B is a must-pass element so a minimum score of 50% is required to receive credit. To achieve a 50% score, practice must be able to show NCQA that staff provided at least 3 of the items listed above to at least 75% of identified patients.

*Factors 1-5:* Report from electronic system or submission of Record Review Workbook and examples showing each required data element.

## **Recommended Link/Resources:**

[www.medicalhomeinfo.org](http://www.medicalhomeinfo.org)

- Pediatric care plan
- Action plan template

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- Care Guideline
  - Asthma
  - ADHD

<https://www.communitycarenc.org/emerging-initiatives/pcmh-central1/2011-pcmh-resources/>

- Webinars on all standards
- Tools/practice examples for all measures/NCQA standards
- Practical tools/resources for practice transformation
- Specific tools to consider: (<https://www.communitycarenc.org/media/files/web-based-pcmh-2011-workbook-1-xls.xls>)
  - Asthma Action Plan
  - Red Yellow Green Diabetes Action Plan
  - Barriers to Care Screenshot
  - PPC3A – dsme pathway
  - PPC3C – Standing flu-order
  - Local Education Agency referral form

<http://www.safetynetmedicalhome.org/>

- Safety Met Medical Home Initiative

<http://www.safetynetmedicalhome.org/resources-tools/peer-learning/2011-summit-materials/storyboards>

- Storyboards from practices

<http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf>

- Care coordination toolkit

<http://clinicalhealthcoach.com/>

- Free Webinars/information – Learning community – care coordination and health coaching

<http://www.oregon.gov/oha/news/Pages/ArticleListHealthcareProviders.aspx>

- Practice Best Practice Examples, (Community Health Workers, Coordinated care and appropriate use of ER)

<https://www.communitycarenc.org/provider-tools/>

- Patient engagement and self-management tools

Element 4E: Support Self-Care and Shared Decision-Making *(Included due to relevance to Medicaid Population)*

The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice:

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- Uses an EHR to identify patient-specific education resources and provide them to more than 10 percent of patients+
- Provides educational materials and resources to patients
- Provides self-management tools to record self-care results
- Adopts shared decision making aids
- Offers or refers patients to structured health education programs such as group classes and peer support
- Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates
- Assesses usefulness of identified community resources.