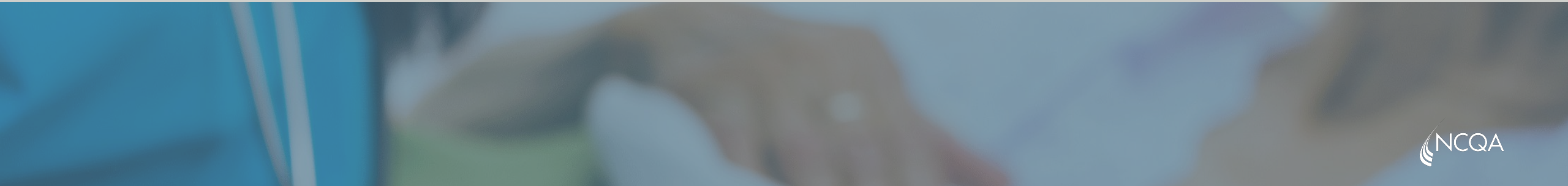
# Care Management Within PCMH

November 12, 2024: 11:30 AM Eastern

# Agenda

- Welcome and Introductions
- Care Management Requirements Review
- Can Plan Review
- Q&A

# Care Management Requirements Review



# Care Management Competencies

A. Identify patients who can benefit from Care Management

- Can set parameters to ID patients (**CM 01**) or
- Conduct comprehensive risk assessment including all patients (CM 03)
- Must monitor percentages regardless (**CM 02**)

B. Create/Maintain Patient-Centered Care Plans

- Person-Centered care plan (**CM 04**), given to patients (**CM 05**)
- Documents patient preferences/goals (CM 06)
- Include self-management (CM 08)
- Include person-driven outcomes (CM 10)
- ID barriers over time (CM 07)
- Make care plan accessible (CMO 09)
- Monitor person-driven outcomes (CM 11)

# Care Plan Content

Care plans should include:

- a problem list
- expected outcome/prognosis
- treatment goals (can be person-driven)
- medication management and
- community and/or social services
- a schedule to review and revise the plan, as needed
- evidence of review

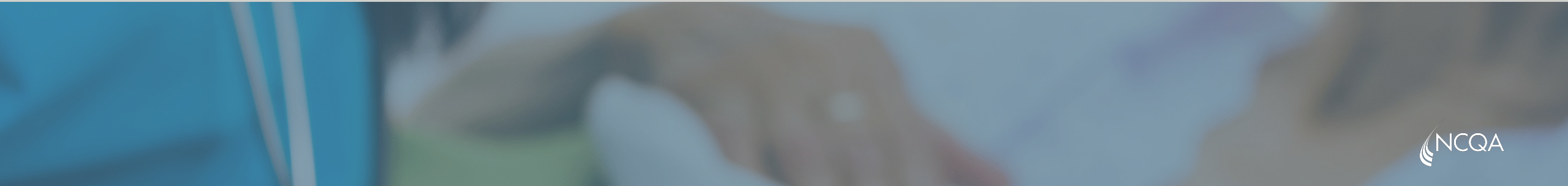
# Using Care Plans

NCQA agnostic as to who reviews or updates the care plan, or who identifies barriers

Care plan accessibility means:

- Messages, goals & strategies reinforced across staff/providers
- More potential for barriers to be identified & addressed
- Outside providers have clearer understanding of patient needs/understanding

# Care Plan Review



# Examples of CM 04

*Discussion on highs/lows*

- Problem list.
- Expected outcome/prognosis.
  - What could occur if I follow my plan?
    - A1c below 8.5
    - Lose 10 pounds by next appointment
- Treatment goals.
  - Goals pertaining to the plan.
    - Walk around the block three times a week
    - Only get take-out once a week
- Medication management.
- Schedule to review and revise the plan, as needed.

- *Plain language*
  - *Ear infection (not otitis media)*
  - *Suture removal in two weeks (not F/U for SR 2 wks)*
- *Patient involvement*
  - *Patient plans to exercise 3 times per week*
  - *Suzie hopes to lift grandchild by Christmas*

# What Stands Out to You?

**Patient Care Plan**

**Patient**: Mickey Mouse

**DOB**: 11/04/1970

**Date of Appointment**: 02/05/20xx

**Provider**: Dr. Samuels

**Problem(s):** Uncontrolled hypertension (high blood pressure), Obesity, Lower back pain

**Treatment Goals:** Mickey wants to start walking for exercise to lose weight.

- Walk at least 15 minutes three times a week.
- Have Minnie walk with you.
- Swing your arms when walking.

**Expected Outcome:** Lose 4 pounds in a month and reduce blood pressure by 2 points for both top and bottom numbers.

**Medication Management:** Added Lisinopril, 1 tab in the mornings, to the other prescriptions in the chart.

**Barriers to Goals:** Concern that he lives in a high crime area, so unsure how safe walking will be. Recommend he walks with a partner or drives to Maple Street Park, which has a nice walking path.

**Next Visit to Review Care Plan**: Schedule for 1 month from now.

# What Stands Out to You?

**Patient Care Plan**

**Patient**: Minnie Mouse

**DOB**: 03/06/1972

**Date of Appointment**: 02/12/20xx

**Provider**: Dr. Michaels

**Problem(s):** Uncontrolled diabetes, Sleep hypoventilation syndrome, History of PE

**Treatment Goals:** Lower her A1c from 9.1 to 8.7.

**Expected Outcome:** Lower A1c

**Medication Management:** Continue with same regiment.

**Person-Centered Outcome:**

| Worse (-2) | Current State (-1) | Realistic Goal (0) | Stretch Goal (+1) | Super Stretch Goal (+2) |
|---|---|---|---|---|
| A1c > 9.1 | A1c=9.1 | A1c=8.7 | A1c = 8.5 | A1c < 8.5 |

**Next Visit to Review Care Plan**: Schedule for 2 months from now.

# What Stands Out to You?

**Patient Care Plan**

**Patient**: Donald Duck
**DOB**: 12/25/1950
**Date of Appointment**: 02/12/20xx
**Provider**: Dr. Davis

*Thank you for trusting your health with our team!*

**Problem(s):** Pharyngitis

**Treatment Goals:** Improve my health

**Expected Outcome:** Improved health

**Medication Management:** Continue to take all of your medications.

**Preference and Lifestyle Goals:** Stop smoking

**Barriers to Goals:** Spouse smokes

**Self-Management Plan:**

**Person-Centered Outcomes:** Scored 4 on sleep related impairment PROM

**Next Visit to Review Care Plan**:

# What Stands Out to You?

Instructions for: [redacted]
Visit date: January 5
Clinician: Dr. Jones

Problem list: Anxiety, lower back pain, sleep apnea, asthma, overweight

Patient's goals: walk around the block three times a week, lose 20 pounds by Christmas

Self-management tools: Exercise instructions and activity log

Patient's barriers to meeting goals: Asthma can act up depending on weather

Plan: exercise, keep activity log, come in weekly for a weight check, schedule follow-up visit in 3 months.

*Questions*