Comprehensive Primary Care
Care Management Framework

Background:

This document will begin to develop the framework for the establishment of a care management program. Understanding that many health plans have language in their contracts outlining their responsibilities for care management, this becomes a great foundation for providers to develop a care management program. This care management program framework is built around other care management guidelines such as those developed by CMS Chronic Care Management (CCM) program and the Comprehensive Primary Care (CPC) program at the state and federal levels as it is being developed to ensure compliance with those programs.

Components of Care Management:

Understanding that a care management program must be comprehensive and yet flexible enough to meet various needs of the network, developing key components of the care management plan is imperative to consistency and effectiveness. The following components will be included in the care management plan;

1. Assessment and Evaluation
2. Risk Stratification
3. Individual Care Plan Development
4. Care Plan Management, Outreach and Outcome Evaluation
5. Care Transitions

Clearly defining these components will help shape the implementation of the program.

1. **Assessment and Evaluation**
   All patients will need to participate in an assessment and evaluation to determine health status, health history and any related conditions that can impact on patient quality of life. There are many assessment tools available. The provider should consider an assessment tool that will evaluate physical and behavioral health status as well as social determinants that affect health status. An assessment tool that produces a score or level will be helpful to determine risk stratification.

2. **Risk Stratification**
   Once the assessment process is completed, stratifying patients by risk becomes important as this will determine the level of care management activities to be implemented to affect health outcomes for the individual. An individual in a low risk stratification level will need "health coaching" on a quarterly or semi-annual basis. An individual with a high-risk stratification level, for example multiple chronic conditions such as diabetes, COPD, obesity and depression, will need more frequent clinical and behavioral interactions by a team of providers to improve health outcomes and quality of life. Identifying an assessment tool that can both score and determine risk categories would result in a standardized process that is consistent for all patients.

3. **Individual Care Plan Development (Single Plan of Care)**
   Patient-centered care means that all activities revolve around that individual's personal need. After the individual has been assessed and risk determined, an individual care management plan can be developed. It is imperative in this process that the individual is involved as an active participant in their health care. NCQA states in its publication *Goals to Care – How to keep the person in "person-centered"*; "While person-centered care planning places the individual at the center of WHAT care is to be provided, by WHOM and WHEN, the care manager is often the center of HOW that care is coordinated." Developing a care plan that is important to the patient creates a pathway for achieving desired outcomes. If the patient is involved in the development of the care plan, they can assume some ownership of the plan, which leads to success.

   The care manager plays an important role in establishing trust with the patient, understanding their lifestyle preferences and developing goals that are meaningful and achievable. Also, based on the assessment, all appropriate care providers and payor need to be involved in the development of this single plan of care, have access to the plan to enter information/data, and be able to communicate with other care providers about the plan. A care management plan that operates on an electronic platform giving access to all providers while adhering to HIPAA compliance is an important factor to managing the plan.

NCQA outlines the SMART goal for care management plans. To be effective a SMART goal will be:

Specific

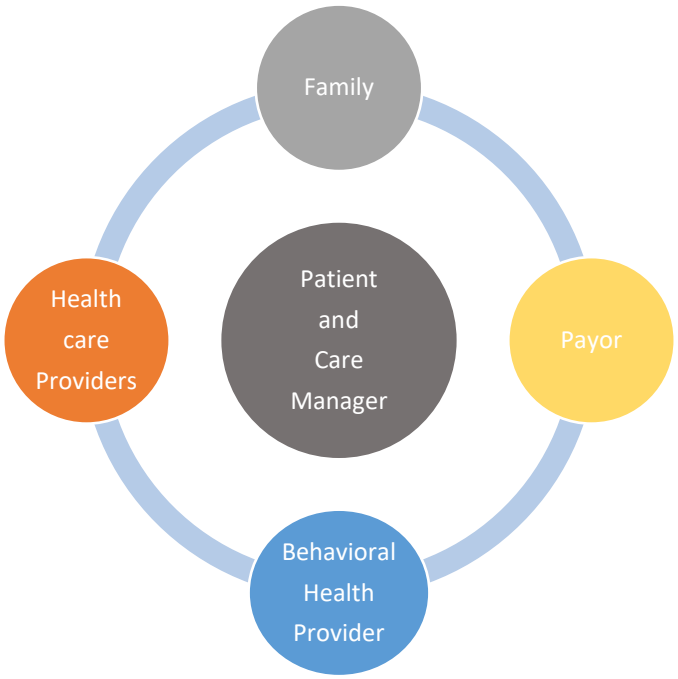
Measurable

Attainable

Relevant

Time-Bound

An effective care management plan will have the patient at the center with his/her care manager with the family, health care providers and payors working in collaboration to help positively impact the plan's outcomes.



4. Care Plan Management, Outreach and Outcome Evaluation

With the care plan in place on an electronic platform that can pull and push data to the patient's Electronic Medical Record (EMR), care management can be accomplished. Management of the plan will include but is not limited to; identification of the primary care provider (PCP) who monitors the plan, ongoing assessments of the plan to measure compliance to the plan by the patient, achievement of health outcomes, communication with other care providers about

plan progress, and the ability to make changes to the plan as needed based on changes in health status. The PCP will also evaluate any necessary clinical data to assess achievement of health outcomes such as lower A1C levels, lower cholesterol levels, etc. This data then can translate to benchmarks in payor contracts that lead to pay-for-performance bonus payments for the PCP.

5. **Care Transitions**
   Lastly, patient care management should include a process for care transitions to ensure safe transitions between settings of care. Research has demonstrated the importance of providing more effective coordination of transitions to address issues like medication reconciliation, follow up care in the community after a hospitalization, continuity of services and better flow of information among providers and to the patient and family.

These components are the foundation of a highly developed care management program. Also, the provider can develop criteria for the development of an RFP to evaluate potential electronic care management platforms for potential use within a care management plan.

Understanding that many providers are not prepared to implement patient care management plans on an electronic platform that can be accessible by the patient, the payor and other providers, a phased in approach may be a more reasonable method.

An effective care management plan based on an electronic platform that allows providers to communicate with each other regarding the coordination of the patient's care can lead to optimum health outcomes which control health care spending. Involving the patient in this process encourages them to become active participants of their own health care. These are all major component of the patient centered medical home model of care.