Required Content for NCQA Care Plans

December 18, 2024

HUSKY HEALTH CONNECTICUT

Connecticut Department of Social Services

Making a Difference

Learning Objectives

- Review NCQA PCMH Concepts.
- Explain NCQA PCMH Care Management and Support criteria.
- Determine patient goals as part of the care plan.
- Discuss key elements of care plans.
- Examine documented examples of a care plan.
- Discuss how to incorporate care plan requirements into existing EMR systems.

NCQA PCMH Concepts

- NCQA PCMH recognition uses six concepts for their process to becoming a medical home.[1]
- Criteria that are fundamental to the concepts provide activities for which the practice must show acceptable performance to obtain NCQA PCMH recognition.
- Criteria are established from best practices and evidence-based guidelines.
- The focus for this presentation is the concept of Care Management and Support.
  - These criteria support clinicians in developing care management protocols to identify patients who need to be managed more closely.

[1]https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/pcmh-concepts/

Concept: Care Management (CM) and Support

Care Management (CM) and Support

- 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.
- There are four Core Criteria that are required for NCQA PCMH recognition.
- There are three Elective Credits that can be incorporated into a Care Plan for three elective credit points.

Information on pgs. 6-13 provided from the NCQA Patient-Centered Medical Home (PCMH) Standards and Guidelines Version 10 (effective January 1, 2025) (pgs. 73-78), with permission from NCQA

Care Management Criteria

Core Criteria

- CM 01
- CM 02
- CM 04
- CM 05

Elective Criteria

- CM 06
- CM 07
- CM 08

Care Management and Support: CM O1

- (Core) Identifying Patients for CM: Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management (must include at least three):
  - 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, patient/family/caregiver

Care Management and Support: CM O2

- (Core) Monitoring Patients for Care Management: Monitors the percentage of the total patient population identified through its process and criteria.
- The practice determines its subset of patients for care management, based on the patient population and the practice's capacity to provide services.

Care Management and Support: CM O4

- (Core) 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.
- The practice establishes a person-centered care plan for at least 75% of patients identified for care management.
- A care plan should be meaningful, realistic, and actionable.
- The practice involves the patient in the care plan's development.
  - The discussion should include patient function/lifestyle goals, goal feasibility, and barriers.

Care Management and Support: CM 05

- (Core) Provides a written care plan to the patient/ family/caregiver for at least 75% of patients identified for care management.
- The practice may tailor the written care plan to accommodate the patient's health literacy and language preferences.
- The care plan may be printed and given to the patient or made available electronically.

Care Management and Support: CM 06

- (Credit) Documents patient preference and functional/ lifestyle goals in at least 75% of individual care plans.
- Working with patients/families/caregivers to incorporate patient preferences and functional lifestyle goals in the care plan encourages a collaborative partnership 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.
- 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.

Care Management and Support: CM 07

- (Credit) Identifies and discusses potential barriers to meeting goals in at least 75% of individual care plans.
- Addressing barriers supports successful completion of the goals stated in the care plan.
- Barriers may be physical, emotional, or social.

Care Management and Support: CM 08

- (Credit) Includes a self-management plan in at least 75% of individual care plans.

- Develop self-management instructions to manage day-to-day challenges of a complex condition.

Person-Centered Care Plan Goals

Person-Centered Care

- Health care and community-based organizations and care managers are increasingly incorporating person-centered care planning principles in their work.
- The movement from provider-centered instruction to person-centered participation is being driven by both the value of person-centered care in helping individuals to achieve their desired outcomes, and by state and federal requirements.[1]
- Person-centered care begins with the individual's goals and respects and addresses their preferences and needs.

[1]https://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf

Care Plan Goals

- Providers can improve their patient's health and social outcomes by developing and implementing individualized care plans based on the goals that are most important to the individual.
- Each patient's health and medical goals are individual to them.
- Engagement of that person in setting those goals affects both their participation in, and adherence to, their treatment.

Care Plan Goals (cont.)

- People bring their needs, lifestyle preferences, and desires to the goal setting/care planning process.
- Some can state their goals clearly, describe what's most important in their lives and specify the services they need.
- Others may only hint at what is important in their lives, through stories or behavior. In these cases, the care manager can help people articulate goals.

Elicit & Discuss Goals

- Most providers have developed relationships with their patients who have conditions requiring care planning. These providers:
  - Understand the patient's history and use information from assessments.
  - Recognize the patient is the expert regarding their own goals.
  - Understand the patient's current circumstances.
  - Encourage the patient to talk by asking open-ended questions.
  - Learn the patient's capabilities and strengths.
  - Listen for readiness to change.

Elicit & Discuss Goals (cont.)

- Ask about the patient's goals, needs, and interests:
  - Support the patient in telling you what's important to them.
  - Suggest goals or preliminary steps.
  - Break long-term goals into smaller steps.
  - Prioritize the importance of the goals for the patient.
  - Educate and encourage goals that are beneficial to the patient's care.
  - Respect the individual's preferences.
  - Ensure that the individual is fully informed about the options available and the consequences of their choices if they conflict with clinical recommendations.
  - Confirm the patient's understanding of their goals.

Setting SMART Goals

- Specific – Goal should be clearly stated, so anyone reading it can understand what will be done and who will do it.
- Measurable – Goal should include how the action will be measured to determine if you're making progress.
- Achievable – Goal should be realistic and related to the patient's life and community.
- Relevant – A relevant goal makes sense and fits the purpose of the action to reach the outcome.
- Time-bound – Every goal has a specific timeline for completion.

https://www.samhsa.gov/sites/default/files/nc-smart-goals-fact-sheet.pdf

Writing SMART Goals

- Specific – State the goal clearly. If the goal is, “I just want to stay healthy,” ask what that means.
- Measurable – Identify and quantify the observable markers of progress.
- Attainable – Break the goal into smaller, actionable steps. Identify expected barriers and make a plan to address them.
- Relevant – Make sure the goal reflects what’s important to the individual.
- Time-bound – Every goal should have a specific timeline for completion.

https://www.samhsa.gov/sites/default/files/nc-smart-goals-fact-sheet.pdf

Goal Attainment

- Once goals are identified, agreed upon, and documented, the individual, the care manager, and the support team (family, caregivers, and medical providers) work together to help the individual attain them.
- Sometimes the responsibility for attainment may lie solely with the patient.

Goal Barriers

- Unexpected life events, such as the death of a partner, the loss of a job or housing, changes in health status, and lack of financial or social resources, can inhibit goal attainment.
- Medical barriers, such as medication side effects, and social barriers, such as unstable housing, can affect outcomes.
- Barriers to attaining goals can be identified through documentation, behavior, or conversations.
- Helping people verbalize their experiences can help the provider gain perspective.

Monitor Goals

- Review goals, including progress and barriers, at regular intervals.
- Document conversations about goals, including those that occur at regularly scheduled times and those that occur informally.
- Retire or modify goals once attained or no longer desired (e.g., from improvement to maintenance).

Care Plan Content

Key Elements of Care Plans

- Care Plans should include:
  - Self-management goals
  - Goals of preventive and chronic illness care
  - Action Plans for exacerbations of chronic illness
- Elements of Care Plans:
  - Name/DOB (Parents/Guardians if applicable)
  - Primary dx
  - Secondary dx
  - Original date of plan
  - Date of last update
  - Current plans/actions
  - Date to be completed

Action Plans vs. Care Plans

- Key differences between Action Plans and Care Plans
  - **Care Plans:**
    - Emphasize the patient's role in managing their own health
    - Co-written with the provider, patients, and family/caregiver
    - Comprised of patient-centered elements:
      - Patient goals
      - Steps to reach their goals
      - Barriers to achieving these goals
  - **Action Plans:**
    - Are completed by providers
    - Are comprised of directions

NCQA-PCMH

Person-Centered Care Plans

	* Core ✓ Credit
Develop Care Plans for patients identified for Care Management	*
Care Plan Elements:	
Problem list	*
Expected outcome/prognosis	*
Treatment goals	*
Medication management/medication reconciliation	*
Schedule to review and revise plan	*
Provides written care plan to patient/family/caregiver	*
Documents patient preferences and functional/lifestyle goals	✓
Identifies and discussess potential barriers to goals	✓
Self-management plan	✓
Care plan integrated and accessible across settings of care	✓

Care Plan Components

Your Care Plan

First name:_____ **Date:** ____/____/2020

Reason for your care plan_____ **CM 04**

Patient/Parental/Caregiver Goal(s): **CM 04**

Patient Preference(s): _____**CM 06**

1. **Goal:** _____
2. **Goal:**_____

Actions for how to work towards your goal(s): **CM 04 & 08**

1. _____
2. _____
3. _____

Strategy to address any barrier(s): **CM 07**

- **N/A or** _____

Medication Management: **CM 04**

- **N/A or** _____

_____

Self management tools, logs or resources: **CM 08**

- **N/A or** _____

_____

Copy of care plan offered: **Provided** **Declined** **To use the portal** **CM 05**

Self Management Goals

Please check your top priorities to work on before your next visit with your provider

Name_____ **Date**_____

Follow Up ***I will follow up with my Provider in*** _____ *Weeks* _____ *Months*	**Aerobic Exercise Goal** ____ Walking ____ Biking ____ Running ____Swimming ____ Other ____ Minutes a day ____ Days a week	**Weight Loss Goal** ***My weight loss goal is…*** ____ Pounds a week ____ Pounds by _____ Weight Loss Program _____
Dietary Goal #1 ***I will INCREASE…*** ____ Vegetables ____ Fruit ____ Protein ____ Fiber ____ Water ____ Other	**Dietary Goal #2** ***I will DECREASE…*** ____Carbohydrates ____ Fats ____ Sweets ____Salt ____ Eating Out ____ Caffeine ____ Alcohol ____ Soda ____ Other	**Tobacco Use** ***I will…*** ____ *I will cut back to* ____ ____ *Quit Date* _____ ____ *Cessation Method* _____
Monitoring **I will…** **Frequency** _____ Check my blood sugar _____ ____ Check my blood pressure _____ ____ Check my weight _____ ____ See my eye doctor_____ Date of last visit ____ Other _____	**Stress Management** **I will…** ____Decrease commitments ____ Reassess priorities ____ Improve efficiency ____ Get adequate sleep ____ Schedule time off ____ Address relationship issues ____ Other	**Other Short-Term Goals** _____ _____ _____ **How can my provider help me meet my goals?** _____ _____ _____

How likely are you to follow through with these activities prior to your next visit?

Not likely 1 2 3 4 5 6 7 8 9 10 Very Likely

CPTS Assistance

- The CPTS Team is made up of certified experts in the requirements of NCQA Care Plans.
- The CPTS Team is familiar with most EMR systems and can make recommendations for the practice to direct their vendors to add information for Care Plan templates.
- The CPTS Team can provide practice examples to illustrate the content of a Care Plan.

Example as Part of After Visit Summary

PCMH Care Management:

- Care Plan:
  - BH:>65YO with depression on medication treatment *No*
  - High Cost/Utiliz: Patients 65YO on 8+ medications *Yes*
  - Patient Treatment preferences *Remain on current medication list*
  - Provider Treatment goals *Assess the need for each medication*
  - Expected Outcome *Improve Health Conditions*
  - Diabetes w/ A1C > 9 *No*
  - Social determinant: literacy *No*
  - Patient's Functional/Lifestyle goals *Eat more plant-based foods, Choose health fats , Acheive/maintain a healthy weight*
  - identified and discussed barriers in meeting treatment goals *Cultural*
  - self management plan provided *No*
  - Care plan provided *Yes, Visit Summary Given*
  - Provided RX education for new RX *NA, Patient was not given new medication*
  - Assessed understanding of medication *Yes*
  - Assessed and addressed medication barriers *Patient does not have barriers regarding medications*
  - Discussed use of OTC and supplements and herbals *Yes*
  - Review Care Plan in: *3 Months*

Example of Components

[redacted]/2023 - Patient Outreach in Care Navigation

Progress Notes

Progress Notes by [redacted]

Author: [redacted] | Service: — | Author Type: Registered Nurse
Filed: [redacted]/2023 10:28 AM | Encounter Date: [redacted]/2023 | Creation Time: [redacted]/2023 10:26 AM
Status: Signed | Editor: [redacted] (Registered Nurse)

[redacted] returned today for a follow-up Care Coordination appointment. We reviewed preventative care visits and health maintenance goals. We reviewed current health status and progress made toward goals set during last vist. The following was reported:

Level of Patient Engagement: Level 3. Engaged - Taking action
Current Frequency of LWC visits: Monthly
Topics covered:: Preventative/healthcare appointments, Eating habits
Topics covered:: Diet/Exercise, Medication compliance, Preventative exams, Stress management, Home BP Monitoring
System Barriers (including scheduling with provider, understanding of healthcare system, ability to navigate referrals, etc): No
Financial Barriers (including cost of food, transportation, medical care, medications, etc): No
Psychosocial Barriers (including behavioral health concerns or fears/perceptions of healthcare interventions): No
Communication Barriers (including language, literacy, and technology required to access resources): No
Time Barriers (including time off from work or free time to devote to self-care): No
Motivation Barriers (including participant desire and readiness to change): No
Referred By: Outreach
Referral Made to: Dietitian/Medical Nutrition Therapy

Refer to goals for details:

Goals Addressed

Example of Components (cont.)

This Visit's Progress

Patient Stated

- Eat according to the LWC Healthy Plate *(pt-stated)* — Progressed

  Nutritionally balanced meals that focus on lean proteins, fiber, nonstarchy vegetables, heart-healthy fats

  [redacted]/23:

  Pt reports eating more fruits and vegetables and eating less fast food and meal prepping more

- Increase physical activity *(pt-stated)* — Progressed

  Will utilize stand up desk feature and stand up at least 2x during work day.

  [redacted]/23: Pt reports walking 6-8miles a week for exercise and stepper in office to go on for workouts

  [redacted]/23

  Pt reports getting at least 7,000 steps a day for exercise; up and down stairs

- Increase water intake, decrease soda intake *(pt-stated)* — Progressed

  [redacted]/23:

  Set goal to not drink any soda in the morning as 1st step to decrease soda intake. Set goal 1 with lunch and 1 with dinner and water inbetween

  [redacted]/23:

  PT reports some days decreasing to 1/2 can and some days having 4 cans a day. Pt in prediabetes class and motivated to continue to decrease soda intake. Pt reports learning from pre-diabetes program and focusing on healthier eating.

Resources

- NCQA has a free link in QPASS to ***Resource Guide for PCMH.***
- Page six has an outline of all core and credit criteria for Care Plans
- Your CPTS can also provide you with a document from NCQA, *Goals to Care, How to keep the person in "person-centered"*
- FAQs

Questions/Comments

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