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Chronic Care Management Care Plan Requirements

Purpose

This resource is intended for home-based primary care (HBPC) providers and practice staff and provides an overview of the required elements for the Chronic Care Management (CCM) Care Plan. This content is aligned with the Centers for Medicare & Medicaid Services (CMS) fact sheet[1], which should be referenced for full details about CCM. This resource may be utilized as a guide to create a standard CCM Care Plan but is not all-inclusive. Refer to CMS guidelines for full details and requirements

CCM Service Elements

Practices providing CCM services must utilize structured recording of patient health information using certified Electronic Health Record (EHR) technology, inclusive of maintaining a comprehensive electronic care plan, managing transitions, coordinating and sharing of patient health information promptly both inside and outside of the practice and other care management services.

CMS requires that the CCM Care Plan include, at a minimum, the following elements:

- Complete problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community and/or social services ordered
- A description of how services of agencies and specialists outside of the practice will be coordinated
- When applicable, schedule for periodic review and revision of the care plan

Additional Required Service Elements for CCM

- Access to Care & Care Continuity, defined as the patient having 24/7 access to providers and a designated clinical staff member, e.g., via after-hours coverage or online portal.
- Comprehensive Care Management, defined as systematic assessments of the patient's psychosocial, medical and functional needs, system-based approach to ensure timely delivery of preventative care services, medication reconciliation with review of potential interactions and adherence, oversight of patient self-management of medications, and coordinating care at home, including other community-based clinical providers involved in the patient's care.
- Management of transitions, defined as managing transitions between and among health care providers and settings. This includes referrals and follow-up after emergency visits or inpatient facility discharge, and creating and exchanging continuity of care documents with other applicable providers in a timely manner.

[1] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

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HCCIntelligence™ Resource Center

At HCCI, we recognize the numerous challenges that can be encountered by home-based primary care (HBPC) providers and practice staff and the value of having access to knowledgeable experts and timely guidance. HCCI has developed a number of free resources to help you and your practice through our HCCIntelligence™ Resource Center at https://www.hccinstitute.org.

Hotline

Call 630.283.9222 or
email Help@HCCInstitute.org
9:00 am–5:00 pm (CST)
Monday through Friday

Webinars

Every third Wednesday of the month, HCCI hosts a free webinar on a clinical or practice management topic relevant to home-based primary care (HBPC).

Virtual Office Hours

Immediately following the monthly HCCIntelligence™ Webinar, HCCI hosts a 30-minute Virtual Office Hours session.

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