About The Patient-Centered Care Plan

Creating, providing the services for, monitoring, revising, and sharing a Patient-Centered Care Plan is a requirement of the CCM Scope of Service.

The electronic patient-centered care plan must reflect the patient's environmental, psychological, functional, and physical needs. The plan must be updated regularly (annually at a minimum). Information in the plan should include details about all practitioners and suppliers of care, as well as their assessments of the patient's condition and status with regard to the chronic illnesses. The patient's overall health issues and plan for self-management should also be described within the care plan. Medication review, medication reconciliation, and patient self-management of medications must be evaluated and recorded.

The care plan must be detailed and typically includes the following:

- List of health issues, prognosis, likely outcome, goals of treatment
- Coordination plan with other providers
- Medication Reconciliation:
    - Structured recording of medications and medication allergies
    - Medication reconciliation with review of adherence and potential interactions
    - Oversight of patient self-management of medications
- Description of access to social services
- Management of symptoms and preventive care
- List of persons responsible for various interventions
- Schedule for periodic reviews or plan revisions

By definition, CCM services are non-face-to-face services and therefore do not include home or domiciliary visits or community-based care.

The patient must have access to Care Plan. All members of the clinical care team within the practice are required to have 24/7 access if their time is counted towards the 20-minute minimum. 24/7 access is not required for outside providers, but a copy must be shareable with the outside provider through electronic means including secure email, secure messaging, e-portal, but specifically not via fax.

Paper copies of and/or electronic access to the plan must be provided to the patient and documented in the certified EHR technology.

There is no requirement that practitioners use a specific electronic technology to share care plan information electronically with other practitioners and providers who are not billing for CCM. Practitioners may meet this sharing requirement as explained above. HIPAA standards apply.

Time spent updating the care plan may be logged as part of the CCM time requirement. The practice must engage and educate patients and caregivers. Monitoring and updating the plan demonstrates the clinicians' engagement with patient care.

Dulcian believes that creation of a well written patient-centered care plan achieves increased cooperation and buy-in from the patient.

See the Dulcian, Inc. Blog "Benefits of CCM"