

Competency Checklist: Building a Care Management Program

This page outlines ten steps for building a care management program for high-risk patients. These steps are adapted from the [NACHC Care Management Action Guide](#). This list of ten steps can be used to identify actions or competencies that have been completed by your health center as well as areas where additional work or development is needed.

This tool is not a 'report card' but, rather, is intended to guide your learning and development. You can also use the Notes space to identify any priorities for action. Additional tools made available through the Care Management Learning Stream can help you further develop care management capabilities at your health center.

| Ten Steps for Building a Care Management Program | Completed/ In Place | Needs Action |
|---|------------------------|-----------------|
| Step 1. Identify or Hire a Care Manager. We have at least one team member who is designated as a Care Manager. | | |
| Step 2. Identify High-Risk Patients. We use a systematic process and criteria for identifying high-risk patients who can benefit from care management based on their clinical and social risk factors. | | |
| Step 3. Define the Care Management Model. We have a clearly defined care management model that is patient-centered and aligns with payer billing requirements. | | |
| Step 4. Define Care Manager-Care Team Interface. We have a clear and efficient process in which the Care Manager works with the care team to carry out the patient's individual care plan. | | |
| Step 5. Enroll in Care Management. We have a care management enrollment process that includes a warm handoff to the care manager, a clinical and non-clinical assessment of the patient, a visit with a provider, and creation of an individualized care plan. | | |
| Step 6. Create Individualized Care Plans. Each patient identified for care management has an individualized, patient-centered care plan that is documented in the EHR and shared with the patient and the patient's providers. | | |
| Step 7. Enhance and Expand Partnerships. Our care manager connects patients to community resources and partners that can support the patient in carrying out their care plan. | | |
| Step 8. Graduate Patients from Care Management. We have a defined set of criteria and a process for graduating patients from care management based on their health status and goal attainment. | | |
| Step 9. Document and Bill. We have an efficient system for tracking and documenting time spent on care management services and submitting claims for payment to CMS for Chronic Care Management (CCM) services. | | |
| Step 10. Measure Outcomes. We have an efficient system for measuring care management effectiveness, including measures of care plan goal attainment and key clinical and quality indicators. | | |
| Notes: | | |