	Responsibilities of Complex Care Manager	Developing	In place	Comments
1	**Referral of patient for complex care management**			
2	Source of referrals: PCP, RN, health care team referral, Care manager review of MiPCT eligible patient list (BCN, BCBSM commercial, BCBSM Medicare Advantage, Medicare, Medicaid), patients on PCP schedule "today" that appear to meet Complex care management criteria			
3	Screens Referrals: Review EMR, discharge summary, medication, diagnoses, recent office visits			
4	Identifies patients for complex care management: Uses following to determine if patient is candidate for complex care management: MiPCT eligible lists, high risk/high demand, Chronically ill /multiple chronic conditions or poorly controlled, medically complex, high utilizer of health system (frequent ER visits and/or hospitalizations), frail elderly, cringe			
5	Review case with PCP as indicated to identify patients appropriate for Complex care management			
6	**Patient is appropriate for complex care management**			
7	Initial Assessment - may be phone and face to face (likely will be several visits over time)			
8	Comprehensive Assessment includes: depression, care giver support, transportation, care giver support, psychosocial, medication, fall risk (age appropriate), urologic, specific for chronic conditions(COPD, HF, DM, Asthma, HTN, CKD), DME,			
9	Uses standardized assessment tools: examples include depression screening, functionality, mini cognitive			
10	Coordinates patient care through ongoing collaboration with primary care physician, specialists, home health agencies, community resource contacts, pharmacy, DME, members of health care team			

	Responsibilities of Complex Care Manager	Developing	In place	Comments
11	Serves as a liaison to acute care hospitals, specialists and post acute care services			
12	Develops and documents individualized patient care plan in collaboration with PCP and patient/caregiver, addresses chronic conditions			
13	Conducts medication reconciliation, reviews refill history			
14	Reviews and updates individualized patient care plan			
15	Document assessment, interventions, plan of care including short and long term goals, target dates,			
16	Bills care management visit as indicated per BCBSM commercial, BCN and BCBSM Medicare Advantage			
17	Communicates pertinent patient information with provider via telephone encounter, fact to face, EMR documentation, etc.			
18	Schedules follow up patient encounter as indicated based on patient needs			
19	**Follow up**			
20	Maintains a patient caseload with follow up schedule for active patients			
21	Follow up: patient assessment, medication reconciliation			
22	Monitor patient's response to interventions and progress to goal(s)			
23	Update short and long term goals as appropriate			
24	Provides self management support and includes patient/caregiver as an active member of the health care team			
25	Patient/care giver education to address self care, exacerbations, prevent readmission			

	Responsibilities of Complex Care Manager	Developing	In place	Comments
26	Identify barriers and progress to meeting goal			
27	Conducts medication reconciliation, review refill history			
28	Coordinates services/resources as needed- Home health agency, pharmacy, DME, etc.			
29	Implement clinical interventions, monitors progress, addresses acute clinical issues based on coordination with PCP evidence based guidelines.			
30	Revises patient's plan of care as indicated			
31	Follow up schedule is based on patient acuity: new diagnosis, exacerbation, medication , social, community resource needs. Patient may need frequent follow up initially such as daily			
32	Documents care management visit, addresses plan of care including short and long term goals			
33	Bills care management visit as indicated per BCBSM commercial, BCN and BCBSM Medicare Advantage			
34	**Post Discharge/Transition of Care - Phone visit**			
35	Conducts transition phone calls post hospital discharge within 24-48 hours			
36	Telephonic review of discharge plan of care with patient/caregiver			
37	Conducts medication reconciliation, refill history			
38	Provides coordination of care: Home Health Agency, DME/Community resources			
39	Patient/care giver education regarding self action plan to prevent exacerbation/readmission, medication			
40	Assessment and triage of symptoms using protocols agreed upon by practice			
41	Communicates with PCP to address patient's immediate needs			
42	Assesses care giver support			
43	Identifies barriers and assists with addressing the barriers			
44	Facilitates timely follow up as appropriate with PCP (specialist as indicated)			
45	Documents patient visit timely, includes pertinent clinical information			

	Responsibilities of Complex Care Manager	Developing	In place	Comments
46	Bills care management visit as indicated per BCBSM commercial, BCN and BCBSM Medicare Advantage			
47	**On going follow up for Transition of Care**			
48	Follow up schedule is based on patient acuity: new diagnosis, exacerbation, medication , social, community resource needs. Patient may need frequent follow up initially such as daily			
49	Minimally phone call follow up with patient/caregiver weekly x 4 weeks			
50	Interventions targeted to address exacerbations, acute symptoms - implement and follow up based on evidence based guidelines			
51	Patient/ caregiver education: Medication, self action plan, teach warning signs			
52	Conducts medication reconciliation			
53	Addresses barriers, progress to overcome barriers			
54	Assesses progress to goals and expected outcomes			
55	Identifies short and long term goals for patients enrolled in care management			
56	Documents patient visit timely, includes pertinent clinical information			
57	Bills care management visit as indicated per BCBSM commercial, BCN and BCBSM Medicare Advantage			
58	If stable evaluate patient for case closure			
59	If patient meets criteria for complex care management , discuss with PCP, enroll patient, complete the Initial comprehensive assessment			
60	**Patient will not be enrolled in Complex Care Management**			
61	Based on screening patient is not appropriate for Complex Care Management- communicate with referral source/provider			
62	Patient meets criteria for complex care management, does not want to participate - notify provider/referral source			

	Responsibilities of Complex Care Manager	Developing	In place	Comments
63	Unable to contact patient-Place 2 phone calls. Following two phone calls with no contact, send letter. Two weeks post letter if no response, close case. Notify provider			
64	Document phone and letter attempts in patient record			
65	**Patient is Enrolled in Complex Care Management - Care Management Interventions**			
66	Create a tickler system to track patient follow up dates			
67	Maintain a patient caseload list, on going tickler system			
68	Confirm/coordinate appropriate DME/community resources			
69	Develops and maintains knowledge of Medical Neighborhood:			
70	Home Health			
71	Transportation			
72	Area Agency on Aging			
73	Meals on Wheels			
74	Financial assistive services			
75	Assess and confirm caregiver support			
76	Respite care			
77	Hospice			
78	Palliative care			
79	Pharmacy			
80	Specialists			
81	PT, OT, Social Work, Pharmacist			
82	Behavioral health services and support groups			
83	Meals on Wheels or local food banks			
84	2-1-1			
85	Assess and confirm caregiver support - ongoing			
86	**Confirm develop written Individualized patient care plan with patient and Primary Care Physician**			
87	Targeted action plan to prevent readmission			

	Responsibilities of Complex Care Manager	Developing	In place	Comments
88	Standing orders for medication management of exacerbations as indicated (per practice's standing orders, protocols)			
89	Condition symptom monitoring			
90	Assessment of cost drivers and gaps in care			
91	Treatment strategies targeted at preventing admission/re-admission			
92	Coordinates patient care - including appropriate PCP and specialty physician follow up			
93	**Medication reconciliation with patient encounters (frequency determined by Complex care manager)**			
94	Medication Adherence			
95	Confirm patient is taking medications, accuracy of medication list			
96	If issues with medication reconciliation - investigate, collaborate with pharmacist, PCP, specialty physician			
97	Check medication refill history - Payer list, patient pharmacy			
98	Patient/care giver education - purpose dosing, administration, timing			
99	Medication reminder systems - as needed assist patient/care giver			
100	Investigate financial options - ex. Needy meds			
101	**Medication management**			
102	Discuss with PCP regarding medication efficacy, side effects, etc.			
103	Request to PCP for orders: medication changes, titration			
104	**Safety Management**			
105	Education on fall prevention and home safety			
106	Education on facilitation of emergency response system			

	Responsibilities of Complex Care Manager	Developing	In place	Comments
107	Based on assessment - communicate with PCP; order PT/OT, neurology referral as needed			
108	**Life Planning**			
109	In Collaboration with PCP, facilitates the following:			
110	Advance Directives			
111	Medical Power of Attorney			
112	End of life care planning if indicated: Palliative care, hospice referral			
113	**Disease Management - Chronic conditions**			
114	Diabetes, Heart Failure, COPD, HTN, Asthma, Osteoporosis, CAD, CKD, ADHD, Obesity, Depression			
115	Assess if patient is due for tests- order tests per PCP approval			
116	Follow evidence base clinical guidelines			
117	Per evidence based guidelines, identifies gaps, discusses with PCP, and follows up on interventions			
118	Provide education for patient, care giver on red flags that lead to exacerbation			
119	Establish teach back			
120	For patients in caseload, identifies gaps and encourages patient/ caregiver to get Influenza and pneumococcal vaccinations			
	Updated 1/18/16			
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