Care Manager Orientation Program Checklist

Is this information covered in your care manager orientation?			Plan
	Yes	No	
Care Manager Orientation to CM Role			
1. CM role and responsibilities in the practice • Job Description • MiCMRC Care Manager Responsibilities document • PO Specific duties			
2. Access to computer system, phone system, desk/office space			
3. Schedule foundational training and longitudinal education check your program requirements – examples may include: • MiCMRC Complex Care Management Course • MiCMRC Approved Self-Management Course • Longitudinal educations: Sources MICMRC educational offerings, educational offerings by other organizations/PO			
4. A plan to build the care manager case load and manage the case load • Embedment plan • Referral criteria, process and sources identified (TOC, ADT, GAPS in Care report, same day visits) • Enrollment process and how to engage in longitudinal or episodic relationship • Patient education materials for chronic conditions, self-management strategies • System to schedule initial visit and follow up visits with alerts • CM metrics and tracking system • Introduction to CM script, elevator speech, letter for patient and business cards			
5. Coaching and mentoring over time • Case review • Care manager peer meetings – lead by preceptor or leader • 1 to 1 meeting with preceptor or leader			

CM Orientation to Practice Patient Population			
1. Access to data to target the patients who may benefit from CM Patient list, registry reports, Gaps in Care report, Hospital/ED Discharge list, Same day visits			
2. Community Resources and Community Clinical Linkages used by practice, Operationalizing CCL implementation			
3. SDOH screening tool, process and data review used by the practice			
4. Other screening tools used by the practice			

CM Orientation to the Practice:			
1. Role and responsibilities of practice staff members Shadowing experiences to deepen relationship and increasing understanding • Front desk, back desk, coder/billers • Practitioners (MD, PA, NP) • Medical Assistant • Social Worker • Practice Manager • Other care team members			
2. Baseline practice assessment (see LEAP tool)			
3. Patient access, communication methods (portal) and education materials			
4. Specialists utilized frequently by practice, collaborative agreements			
5. Practice Meetings and other communication methods: • Operations, staff meeting, provider meetings • Clinical - huddle • Quality or Metrics			
6. Health care team communication, documentation systems, and tracking codes: • Electronic Medical Record • Care Management visit note templates • Registry • Access to hospital EMRs • Use of other software systems • Health Information exchange			
7. Practice programs enrolled in (SIM, CPC+, PDCM, Priority Health, HICM, PCMH) Description, Monitoring and Metrics, Reports, System			
8. Practice Policy, Procedures, Protocols			
9. Champion for the care manager – provider, office manager			
10. Performance feedback for CM – who, what, how, when, frequency Tools, infrastructure - examples			
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