	Responsibilities of a Complex Care Manager			
	Referral	**Developing**	**In Place**	**Comments**
	Identify referrals from PCP, health care team, eligible list, registry, patients on PCP schedule "today" that meet criteria			
	Screening			
	Screen referrals: review EMR, acute care/emergency department discharge summary, medications, diagnoses, recent office visits			
	Determine if the referred patient is a candidate for complex care management: utilize risk stratification: high risk, multiple chronic conditions poorly controlled, medically complex, behavioral health, high utilizer of health system, frequent ER visits, frequent hospitalizations, frail elderly			
	Review referral with PCP to gather perception of risk and patient's readiness for change. PCP confirms patient is appropriate for complex care management			
	Screen for social determinants of health to include socioeconomic, care giver support, ability to self-care			
	To help engage patients provide "warm hand-offs"			
	Assess patient	**Developing**	**In Place**	**Comments**
	Complete and document assessment, may be by phone and/or face to face over several visits			
	Include in comprehensive assessment medical, SDOH, care giver support, transportation, psychosocial, social, functional, medications and medication management, fall risk (age appropriate), urologic, chronic conditions self-management, health literacy, community needs, DME. Level of patient activation or readiness to change, barriers, strengths			
	Use standardized assessment tools. Ex. depression screening PHQ2-9, functionality IADL ADL, MoCA. Use screening tools approved by the practice.			
	Conduct medication reconciliation, review refill history, identify patient medication management practices			
	Assess caregiver support - ongoing			
	Assess gaps-in-care			
	Assess risk level			
	Obtain patient consent and enroll			
	Plan Care	**Developing**	**In Place**	**Comments**
	Develop and document individualized patient care plan collaboratively with PCP, patient/caregiver and team including short and long term goals, interventions and time line			
	Communicate pertinent patient information with provider via telephone encounter, face to face, EMR documentation, etc.			
	Schedule follow up patient encounters as indicated based on patient needs and plan of care			
	Liaison to acute care hospitals, specialists and post-acute care services			
	Coordinate patient care with primary care physician, specialists, home health agencies, community resource contacts, pharmacy, DME, members of health care team			

	Selects intervention based on assessment and evidence based practice			
	Medication Management	**Developing**	**In Place**	**Comments**
	Perform medication reconciliation with patient encounters (frequency determined by complex care manager)			
	Verify medication adherence, confirm patient is taking medications, accuracy of medication list, refill history			
	Investigate issues with pharmacist, PCP, specialty physician, social worker. Investigate financial options			
	Reinforce patient/care giver knowledge of drug purpose, dosing, administration, timing, management/reminder system			
	Discuss with PCP issues with medication efficacy, side effects, polypharmacy, financial issues, medication changes			
	Safety Management	**Developing**	**In Place**	**Comments**
	Assess fall risk and provides education on fall prevention, home safety and emergency response system			
	Communicate with PCP patient need for PT/OT, neurology referral as needed			
	End of Life Planning	**Developing**	**In Place**	**Comments**
	Collaborate with patient/family and PCP on Advance Directives, end-of-life care planning, palliative care, hospice as appropirate			
	Self-management support - Chronic Conditions	**Developing**	**In Place**	**Comments**
	Follow evidence base clinical guidelines. Examples of chronic conditions: Diabetes, Heart Failure, COPD, HTN, Asthma, Osteoporosis, CAD, CKD, ADHD, Obesity, Depression (follow the evidence based guidelines utilized by the practice)			
	Provide education for patient and care giver on condition specific self-management action plans including yellow and red flags that indicate exacerbation and need for additional care. Uses teach back to reinforce information. Include “who and how” to contact the physician office when the practice is closed.			
	Use evidence based guidelines to identify gaps-in-care, discusses with PCP, follows up on interventions, and alerts if patient is due for tests-orders per protocol			
	Use standing orders for medication management of exacerbations as indicated (per practice's protocols)			
	Establish follow-up and condition symptom monitoring as needed			
	Coordinate patient care - including appropriate PCP and specialty physician follow up			

	Gaps in care	Developing	In Place	Comments
	Identify gaps-in-care and assist patient and caregiver to get preventive services. Ex. Influenza and pneumococcal vaccinations, cancer screening, etc.			
	Community Clinical Linkages (add steps including follow up)			
	Participate in the design, implementation and Interpretation of patient need assessments			
	Use of standardized screening tools			
	Participate in the design, implementation and interpretation of community level assessments			
	Establish relationships with community partners			
	Have a clear understanding of expectations of organization, process for sharing information, include language assistance needs of patient			
	Explains the need for outside resources, offers help with contacting the resource, provide clear instructions both written and verbal			
	Create a process for follow up with the resource including successful completion of referral, outcome(s), provide patient with results, provide positive feedback to patient for completing the referral steps			
	Provide Follow up – longitudinal relationship	**Developing**	**In Place**	**Comments**
	Maintain a follow up schedule for patients in caseload both telephonic and in-person visits			
	Update patient assessment, medication reconciliation, refill history, medication management			
	Monitor patient's response to interventions and progress to goal(s). Updates short and long term goals interventions and revises patient's plan of care as indicated			
	Identify barriers and progress to meeting goal implements interventions to resolve			
	Provide self-management support and includes patient/caregiver as an active member of the health care team			
	Provide patient/care giver education to build self-care ability to manage condition, to identify and seek care for exacerbations, and prevent ED visits, admissions and readmission			
	Implement evidence based guidelines and clinical interventions, monitor progress, address acute clinical issues based on coordination with PCP			
	Schedule follow-up plan based on patient acuity/risk: new diagnosis, exacerbation history, new medications, care giver support, social support, community resource needs. Patient may need frequent follow up initially such as daily or weekly			
	Document care management visit, reviews and updates plan of care including short and long term goals and interventions			
	Coordinate care and services/resources as needed- Home health agency, specialists, pharmacy, DME, etc.			
	Transition of Care	**Developing**	**In Place**	**Comments**

	Prioritize patient risk for readmission			
	Conduct transition phone call post hospital discharge within 24-48 hours			
	Review discharge summary and plan of care with patient/caregiver			
	Conduct medication reconciliation, checks refill history, medication management practices, educate as needed			
	Assess and triage current symptoms. Uses protocols agreed upon by practice to manage symptoms, address exacerbations of acute symptoms - implement and follow up based on evidence based guidelines			
	Assess patient/care giver self-management, action plan to manage condition and alert exacerbation and how to gain access to urgent office care to avoid readmission. Provide education as needed			
	Assess care giver support			
	Identify follow-up care with PCP, identify any barriers and assists with addressing the barriers			
	Coordinate care with Home Health Agency, DME, Community resources, specialists			
	Communicates with PCP to address patient's immediate needs, facilitate timely follow up with PCP and specialist			
	Schedule on going follow up for Transition of Care based on patient acuity: new diagnosis, exacerbation, new medication, community resource needs. Patient may need frequent follow up initially such as daily. Minimally phone call follow up with patient/caregiver weekly x 4 weeks. Schedule PCP and specialists follow-up			
	Document patient visit timely, includes pertinent clinical information			
	Enroll in care management if patient meets criteria, discuss with PCP, complete the initial comprehensive assessment, plan of care with short and long term goals interventions with time line and schedule follow up dates			
	If Patient meets criteria for complex care management, does not want to participate - notify provider/referral source			
	Close case when patient stable			
	If Unable to contact patient- following two phone calls with no contact, send letter. Two weeks post letter if no response, close case. Notify provider Document phone and letter attempts in patient record			
	Maintain knowledge of Patient Centered Medical Home capabilities			
	Maintain knowledge of Behavioral Health Integration plan for practice and impact on Care Manager role			
	Closure	**Developing**	**In Place**	**Comments**
	Assess the need for case closure, i.e. patient death, hospice care, ability to self-manage chronic condition(s),			
	Discuss closure with primary care physician			

	Care Manger Skills	**Developing**	**In Place**	**Comments**
	Maintain competence in care management Motivational Interviewing, Brief Action planning, Cultural Competency , Advanced care Planning, self-management			
	Identify Medical Neighborhood Resources Home Health, PT OT Transportation Area Agency on Aging Meals on Wheels Financial assistive services Care Giver Support Respite care Hospice Palliative care Pharmacy Specialists Social Work, Pharmacist Behavioral health services and support groups Meals on Wheels or local food banks, churches			
	Micmrc.org for additional tools and resources			

Note: Bill for care management services as indicated per payer and practices billing processes.