Functions, Tasks, & Activities	Embedded Process	In Development	Not Started	Notes
COMMUNICATION & VISIBILITY				
Job description complete	☐	☐	☐	
Training plan in place	☐	☐	☐	
Location determined– office, cube, or pod	☐	☐	☐	
○ Ability to have confidential conversations	☐	☐	☐	
Email available including practice distribution lists	☐	☐	☐	
Direct phone line assigned	☐	☐	☐	
Practice brochure includes care management services	☐	☐	☐	
Website includes care management services	☐	☐	☐	
Included in Staff/Care Team Meeting	☐	☐	☐	
Care Management Elevator Speech for providers & care team	☐	☐	☐	
PATIENT IDENTIFICATION & RISK STRATIFICATION				
Practice has empanelment process in place to identify active patients and assign to provider/care team.	☐	☐	☐	
Establish algorithm or set of criteria to identify patients for care management	☐	☐	☐	
Risk stratify all patients by assigning a risk level/score	☐	☐	☐	
Identify other data sources to validate risk (provider gestalt, health plan data, claims data, other care/case managers)	☐	☐	☐	
Consider psychosocial factors and how to capture those data points in the stratification process	☐	☐	☐	
Ability to identify/flag patients risk stratification level/score in the EHR	☐	☐	☐	
Ability to identify/flag patients enrolled in CM in the EHR	☐	☐	☐	
Evaluate your risk stratification approach and refine the method over time	☐	☐	☐	
Determine case load size based on the complexity of your patient population	☐	☐	☐	

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Functions, Tasks, & Activities	Embedded Process	In Development	Not Started	Notes
INTAKE & REFERRALS				
Create template for patient intake assessment	☐	☐	☐	
Create referral template in the EHR	☐	☐	☐	
Create protocol/process for referral to Care Management	☐	☐	☐	
Provide staff education around Care Management program	☐	☐	☐	
Communication plan with Care Team to ensure referrals are appropriate and follow-through occurs	☐	☐	☐	
Define the process for warm handoffs	☐	☐	☐	
Determine if needs are episodic, longitudinal, or both	☐	☐	☐	
Determine frequency that complex patients will need to be reassessed	☐	☐	☐	
DOCUMENTATION & TRACKING				
Documentation of Care Management with patient in the EHR – determine how and where you will document	☐	☐	☐	
Determine need for Care Management program or overlay software	☐	☐	☐	
Create a tracker for setting up in-person or telephonic follow-up with patient	☐	☐	☐	
Ability to communicate with patients via a patient portal	☐	☐	☐	
Create plan to “graduate” patients from care management	☐	☐	☐	
Dashboard to monitor progress	☐	☐	☐	
Develop a scorecard to define measures of success including process, performance, and outcome measures	☐	☐	☐	

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Functions, Tasks, & Activities	Embedded Process	In Development	Not Started	Notes
DAY-TO-DAY ACTIVITIES				
PATIENT ENGAGEMENT				
Schedule Care Management focused visit with provider, care manager, and other team members as appropriate	☐	☐	☐	
○ Conduct intake assessment at initial visit	☐	☐	☐	
○ Set self-management goals using motivational interviewing or coaching methods	☐	☐	☐	
○ Decide interval of subsequent Care Management visits with provider, care manager, and other team members	☐	☐	☐	
○ Decide interval of regular Care Manager contact (in-person and virtual)	☐	☐	☐	
Use motivational interviewing or coaching methods to provide support on self-management goals and conduct interventions between visits				
○ In-person Care Manager visits	☐	☐	☐	
○ Phone outreach	☐	☐	☐	
○ Home visits	☐	☐	☐	
Intervention and patient follow up between chronic care provider visits				
○ Perform ongoing assessment of frequency of intervention and patient follow up between chronic care provider visits	☐	☐	☐	
○ Use a tracker to keep track of and schedule minimum one touch per month with care management patient	☐	☐	☐	

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Functions, Tasks, & Activities	Embedded Process	In Development	Not Started	Notes
CARE PLANNING				
Care plan template established in the EHR	☐	☐	☐	
Process created for engaging the patient, family, and care team in the care plan	☐	☐	☐	
○ Goals incorporated into the care plan including plan for follow-up	☐	☐	☐	
○ Patient can access their care plan and there is a bi-directional communication structure in place	☐	☐	☐	
Schedule interdisciplinary care team meetings to review complex patients and their care plans	☐	☐	☐	
CARE TRANSITIONS				
Same day notification of ED and hospital visits (through portal or other automatic notification)	☐	☐	☐	
○ Outreach to patients within 24-48 hours	☐	☐	☐	
○ Patient visits at hospital as appropriate	☐	☐	☐	
Conduct care coordination for high risk patients (medical referral, community resources, behavioral health resources)				
○ Scheduling	☐	☐	☐	
○ Follow up on completion	☐	☐	☐	
○ Review and communication of results within care team	☐	☐	☐	
○ Outreach to patient as appropriate	☐	☐	☐	
Communicate with the Care Team about patient status as appropriate following communication plan	☐	☐	☐	
Build your medical neighborhood				
○ Meet with care teams to identify frequent referral sources and community resources	☐	☐	☐	
○ Set regular meetings with identified medical neighbors and develop communication standards	☐	☐	☐	

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