| **Standard Work Activity Sheet** | | **Owner:** Ambulatory CMs<br>**Author:** | **Rev. Date:** Dec. 2017 |
|---|---|---|---|
| **Step:** | **Purpose:** Describes the process/workflow of longitudinal care management. Should be used in conjunction with the Care Management Coding Document. | **Value Stream:** Longitudinal Care Management | |

| Seq. No | Task Description: | Key Point / Image / Measure (what good looks like) |
|---|---|---|
| 1. | **Patient Identification**<br>Patient is identified as a candidate for longitudinal care management. | Identification methods could include, but are not limited to:<br>- Patient list/registry (i.e. Epic risk stratification list, diabetic registry, etc.)<br>  o Run on routine basis<br>- Provider or staff referral<br>- Inpatient transition of care<br>- ED discharge<br>**Codes that Can be Dropped: NONE** |
| 2. | **Patient Outreach**<br>Once a patient is identified as a candidate for longitudinal care management, an initial outreach attempt should occur.<br>This attempt can occur via phone, or as a face-to-face visit. | Discuss potential co-pays with the patient at this time.<br>**Codes that Can be Dropped: NONE** |
| 3. | **Patient Assessment**<br>After or during the initial outreach attempt, the general care management assessment should be completed with the patient.<br>If you have determined that this patient is a candidate for longitudinal care management, add yourself to the patient's care team in Epic. | Can be completed via phone or face-to-face visit.<br>This assessment should be thorough enough to determine whether or not this patient is a candidate for longitudinal care management.<br>Update the patient's care coordination note when necessary.<br>**Codes that Can be Dropped: G9001 & G9008 (only if assessment is completed during a face-to-face visit), or G9002 if the patient is determined to be episodic** |
| 4. | **Schedule and Conduct Face-to-Face Visit with Patient**<br>During the face-to-face encounter with the patient, work with the patient to set/update a goal (or goals) for themselves, review barriers to care and interventions, and determine next steps. | Use motivational interviewing during this visit.<br>If you have not already added yourself to the patient's care team in Epic, do it at this step.<br>Add any goals that are set to the patient's goal section in Epic.<br>**Codes that Can be Dropped: G9002** |
| 5. | **Maintain Patient Panel**<br>Continue meeting with and/or reaching out to the patients that are attributed to you.<br>Make referrals to outside resources when necessary.<br>Run registries and review ED and inpatient lists to keep up with your current patients and to find potential new patients. | Update patient's care coordination note when necessary.<br>Reach out to the patient at least 1 time between face-to-face visits.<br>**Codes that Can be Dropped: G9002 (during TOC if the diagnosis discussed is different than what the patient is admitted for, or during a face-to-face visit), G9007, 98966, 98967, 98968** |

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|---|---|---|
| 6. | **Team Conference**<br>Hold regular conferences/meetings with the care team in your office to discuss your attributed patients. | Conferences/meetings need to be scheduled<br>**Codes that Can be Dropped: G9007** |
| 7. | **Patient Graduation**<br>Notify the patient of his/her graduation from care management. Remove your name from his/her care team in Epic. | ***NOTE: Patients may never advance to this step.***<br>Patients are eligible for graduation when they:<br>• Transition to hospice care<br>• Move away<br>• Move to a permanent skilled nursing facility<br>• Pass away<br>• Achieve set goals<br>• Transition from high to low risk<br>• Disengage from care management<br>**Codes that Can be Dropped: G9002 (for face-to-face visits), or 98966/98967/98968 (for telephone encounters).** |