Purpose

The Care Coordinator’s Handbook will provide you with:

- Care Delivery Transformation Team member role descriptions
- Definitions of terms commonly used
- Self-guided learning activities
- Quick links to frequently referenced sites
- Information on special topics - for example, pediatric resources

How to Use This Handbook

- Review it as an introduction and overview of Enhanced Personal Health Care (EPHC).
- Follow the user-friendly lessons to boost your Care Coordination skills and understanding.
- Use links to quickly find key EPHC resources such as Collaborative Learning Opportunities and Provider Toolkit.
- Care management programs are available to most member and vary by plan. Your Care Consultant will assist you with any referral or resource questions you may have.

Quick Links

Terminology

Practice Transformation Learning Opportunities e-Catalog

Top Three Actions for the Care Coordinator

- Take action based on findings in the clinical reports
- Submit referrals to internal programs
- Reach out to members to schedule follow-up appointments
Quick Links

**Availity/Provider on Line Reporting**
Log in to access Enhanced Personal Health Care (EPHC) reports

**Patient 360**
Please visit Availity using Google Chrome (www.availity.com). Then select the ‘REGISTER’ link and follow the registration process

**EPHC’s Provider Toolkit**
Link to Anthem’s provider home page

**Referral Automation through Availity/EPHC reports**
Log in to access Enhanced Personal Health Care referral automation
- To generate a referral, access any screen in EPHC reports where patient level data is present (emergency room, inpatient admissions, gaps in care, etc.) as well as from the action center itself.
**Enhanced Personal Health Care Support Team Roles**

The **Care Consultant** will assist with:

- Access to **Pharmacist Consultant**
- The development of care planning and care coordination skills
- Demonstrating the automated referral process to Anthem Care Management programs
- Population Health Management and Registries
- Achieving improved clinical and utilization cost of care outcomes
- Working through Process Redesign
- Clinical Data Analysis and Management
- Medical Home Building
- Collaborative Learning
- Program reports and progress updates
- Community Resources
Lesson Plans for Care Coordinators: Toolkit Topic Focus Areas

Care Coordination

Risk Stratifying Populations

Care Planning

Population Health Management and Registries

Health Information Technology

Patient-Centered Care

Enhanced Access to Care

The Medical Neighborhood

Improved Clinical and Utilization Outcomes

Collaborative Learning Events

Behavioral Health Resources Integration and Adult Resources

Anthem Care Management Programs and Resources

Terminology
Care Coordination

Establish internal infrastructure to coordinate care

Objectives:
- Access EPHC reports through Availity
- Establish care team duties and workflows and define your role as care coordinator
- Develop a process to identify and intervene with high-risk patients
- Identify and close patient care gaps
- Outreach to patients with recent hospitalizations and coordinate care transitions
- Develop a process for medication reconciliation and adherence at each visit
- Reach out to patients who have missed appointments
- Coordinate referrals and test results

Questions:
- Do you have a formal process for annual planned visits?
- How are you notified when a patient has been to the ER or admitted to the hospital?
- Does your practice team have established workflows to assess medication reconciliation and adherence? Is any training needed?
- Do you have a pre-visit huddle? How do you flag charts? What is your post-visit process?
- Do you have adequate time to devote to care coordination?
- What do you want to improve?

Resources on Anthem.com Enhanced Personal Health Care:
- Provider Toolkit
  Resources, including toolkits, to support establishment of infrastructure to coordinate care.
- The Care Plan Playbook
  A detailed approach to care customized to an individual patient’s needs
- Recorded Webinars
  Collaborative Learning Opportunities - a wide range of learning opportunities that are designed to inform, inspire and support you

Basic Ideas:
You are transitioning to a patient-centered medical home, which means you are assuming responsibility for coordinating the preventive and chronic care needs of your patients. Your task is to be a point of contact for patients and families, improve communication, and ensure that medical information is accurate. There are many resources to help you learn about care coordination in the Provider Toolkit. As you adjust your workflows and incorporate new tools, remember that you have a team of consultants that will help you every step of the way. Your goal is to achieve the best possible health outcomes for your patients.
Risk Stratifying Populations

Establish Internal Process to Review and Use Reports for Population Health Management and High-Risk Patient Stratification

Objectives:

○ Implement a workflow process for Patient 360 and EPHC reports
○ Demonstrate use of resources for high-risk patient stratification
○ Use reports to review cost of care implications

Questions:

○ Can you identify your target population?
○ What data do you have that can help you identify and stratify your high-risk population (utilization, diagnoses, pharmacy data, reports, etc.)?
○ How will you need to deliver care differently to meet the needs of this group of patients?
○ How will this help your practice and your patients? Impact cost of care?

Basic Ideas:

Stratifying your patient population is one way to identify patients who can most benefit from additional guidance and attention from the practice care team. Patients may be identified and prioritized using information from EPHC reports (high-risk patients, emergency room use, inpatient authorization, readmission and gaps in care). Patient 360 provides additional detailed patient information to assist you. You will need to develop a process for using this information to reach out to patients with chronic conditions, conduct pre-visit planning, and close care gaps. Your goal is to demonstrate improved trends for chronic disease clinical outcome measures.

Resources on on Anthem.com Enhanced Personal Health Care:

○ Provider Toolkit
  Resources, including Anthem materials, to assist you in establishing processes and workflows to utilize reports for population health management and high-risk patient stratification.
Care Planning

Establish sustainable process for shared care planning including self-management support/goal setting/action planning

Objectives:
- Establish a routine process for care plan development
- Demonstrate proactive care planning and begin to incorporate self-management support
- Develop a workflow to support annual planned visits and conducting comprehensive assessments
- Implement a process to include medication adherence and reconciliation at each visit and care transition

Questions:
- Why do we need to do care plans?
- How does a care plan impact the patient’s treatment plan?
- Is there a guide or “template” that we need to use for care plans?

Basic Ideas:
A care plan is a detailed approach to care customized to an individual patient’s needs. Care plans are called for when a patient can benefit from personalized instruction and feedback to help manage a health condition or multiple conditions. A care plan enhances a patient’s plan of care by providing steps to meet identified health goals. The format will vary based on your charting process and electronic capabilities and should not require duplicate documentation.

There is no single template that must be followed, but there are critical elements that should be included:
- Collaborative approaches to health, including patient and family participation in care plan
- Prioritized goals for a patient’s health status
- Established timeframes for reevaluation
- Resources that might benefit the patient, including a recommendation as to the appropriate level of care
- Planning for continuity of care, including assistance making the transition from one care setting to another

Resources on on Anthem.com Enhanced Personal Health Care:
- Provider Toolkit
  Care planning templates and resources to support establishing a reasonable process in your practice for shared care planning that incorporates self-management support, goal setting and action planning. Includes: Patient Care Plan Template, Care Plan Playbook, Assessment Domains
- Recorded Webinars
  Collaborative Learning Opportunities Recording Library

I want to learn more:
- Tools
  - Partnering in Self-Management Support: A Toolkit for Clinicians
    Institute for Healthcare Improvement
  - Video with Techniques for Effective Patient Self-Management
    California Healthcare Foundation
  - Integrating Comprehensive Medication Management
    Patient Centered Primary Care Collaborative
Population Health Management and Registries

Establish and maintain population health registry and reports for patient outreach, closing gaps in care, and managing prevention and chronic disease needs of patients

Objectives:
○ Refine the system you use to identify high-risk and complex patients in the practice’s population
○ Identify specific steps that can be implemented to assist patients in setting goals and improving healthcare outcomes
○ Identify registry resources and current gaps, for both prevention and chronic care measures

Questions:
○ Are there ways in which you think your practice could use information systems to improve care?
○ Do you wait for patients to come in for care or do you have a way to track which patients may be due for preventive care?
○ How are evidence-based guidelines used to guide patient care in this practice?
○ What tools, resources and support do you have available at the point of care when you need to make a clinical decision?

Basic Ideas:
Population Management is based on stratifying patients from low-risk, to complex, high-risk, and uncontrolled chronic conditions. Evidence based guidelines (EBGs) are used to monitor prevention and disease management of patients. Your task is to understand the pattern and processes for how care for this population has been provided in the past and to develop new care processes for tracking, monitoring and follow-up on a more pro-active basis to maintain people at the highest level of wellness.

Resources on Anthem.com
Enhanced Personal Health Care:
○ Provider Toolkit
  Population health registry guides and other materials to help you set-up and maintain a registry and use its functionality for patient outreach, closing gaps in care and managing prevention and chronic disease needs of patients.

I want to learn more:
○ Tools
  – Population Health Management in the Medical Neighborhood
  – Patient Centered Primary Care Collaborative
○ Guidelines
  – HEDIS® Measures
Health Information Technology

Maximize e-health record and/or available health Information technology (HIT) for evidence-based care delivery and relevant clinical decision support

Objectives:
- Use evidence-based resources to determine interventions for patients
- Develop processes for exchange of information to decrease gaps in care
- Use available technology to improve coordination of care
- Incorporate resources such as a Personal Health Record and patient self management materials/tools

Questions:
- Are there ways in which you think your practice could use information systems to improve patient care?
- How does your practice identify patients who need visits, labs, or other services?
- How do you currently link patients to resources?

Basic Ideas:
Health Information Technology includes all the digital tools you use to manage patient health, such as an electronic medical record (EMR), patient portal, e-prescribing, registries with embedded evidence based guidelines, and clinical alerts. Improved use of technology will impact clinical outcomes and cost of care. Your task is to utilize Availity Provider online reports, P360 and other web-based resources to minimize gaps in care and improve continuity of care. Your goal is to facilitate information exchange.

Examples:
- **EMR** - document diagnoses, vital signs, tests and treatments, populate registries
- **Registry** - for patient monitoring, patient outreach, point-of-care reminders, care management, health risk stratification, care gap identification, quality reporting, performance evaluation, and other purposes
- **Risk stratification** - classify patients by their current health status and their health risk
- **Automated Outreach** - generate automated messaging to patients who need preventive or chronic disease care (according to standardized clinical protocols) and keep track of referrals to other providers, receive results

Patient portal - share records with patients and engage patients in self-management via your website
Telehealth/telemonitoring - remote examination and treatment of patients using audio and video conferencing between face-to-face visits can also enhance access to care (i.e., LiveHealth Online)
Web resources - WebMD, Mayo Clinic, American Heart Association, American Pediatric Association, etc.

Resources on on Anthem.com

Enhanced Personal Health Care:
- **Provider Toolkit**
  Materials to assist your practice maximize EHR or other available HIT for evidence-based care delivery and relevant clinical decision support.
- **Guidelines**
  - Practice Guidelines — Health and Wellness
- **E-Prescribing**
  - E-Prescribing — Plans and Benefits

I want to learn more:
- **Creating a Personal Health Medical Record**
  (4min Audio/Video)
  - Agency for Healthcare Research and Quality
Patient-Centered Care

Transition to a culture of patient-centered care

Objectives:
○ Empower patients to claim their place at the center of our health care system
○ Engage patients so that they understand and embrace your culture of patient-centered care

Questions:
○ How can you motivate patients to achieve their health care goals?
○ How can you develop collaborative partnerships with patients and their caregivers?
○ What tools are available to promote patients’ self-management?

Basic Ideas:
Your practice will begin to holistically evaluate patients for strengths and barriers, not just looking at the medical condition but at every aspect of a patient’s mind and body, including social/family support networks. Your task is to reduce the impact of culture, language, lack of resources and other limitations in the care planning process, and to include patient experience in quality improvement processes. Your goal is to empower patients with the right resources and processes for shared decision-making.

Resources on on Anthem.com
Enhanced Personal Health Care:
○ Provider Toolkit
  Methods to engage your patients and support your practice in transitioning to a culture of patient-centered care.
○ Improving the Patient Experience Change Package
  California Quality Collaborative
○ Patient Brochure
  – Describes the basic elements of a medical home, what they should expect from their medical home, and gives a brief checklist of what to bring to appointments. English and Spanish Versions.

I want to learn more:
○ Tools
    Institute for Healthcare Improvement
  – Encourage Participation in Self-Management Programs
    CDC two-page guide for providers
  – How to Implement Self-Management Support
    California Healthcare Foundation
**Enhanced Access to Care**

**Provision of enhanced access for patients**

**Objectives:**
- Provide patients with options for communication such as email or texting
- Have clinical staff available 24-7
- Make arrangements for 24/7 electronic access to personal health information including after-hours personnel or on-call providers
- Move toward open access (same day) scheduling of appointments
- Plan appointment types and standing orders to streamline care
- Develop a process for documentation and follow up on scheduling and clinical advice
- Provide patients with a documented process for choosing a PCP
- Develop a process for timely appointments for new patients

**Questions:**
- What are the current options for patients to schedule appointments?
- Do all on-call providers have access to patients' health information?
- What are the barriers to open access scheduling?

**Basic Ideas:**
You are being asked to focus on patient needs and preferences as you guide your patients to the right care at the right time in the right setting. New approaches such as email exchange, after-hours care and patient portals can help you achieve these goals without having to keep the practice open 24-7, but allowing for 24-7 service availability.

Open access scheduling allows for patients to see a provider-preferably their own provider-on the day they call to set an appointment, regardless of the reason for the visit. Practices that have adopted this method have reported improved patient satisfaction, increased productivity and higher physician compensation.

**Resources on on Anthem.com Enhanced Personal Health Care:**
- **Provider Toolkit**
  Resources to establish expanded office hours, cross-coverage arrangements after hours, and online communication and visits for your patients within the patient-centered care model.
The Medical Neighborhood

Establish external processes/infrastructure to achieve coordination of care with the medical neighborhood and community

Objectives:
○ Establish relationships with medical and community providers outside the practice
○ Develop tools and procedures to communicate and coordinate patient care
○ Incorporate medication reconciliation and care plan updates for all care transitions
○ Refine your process for tracking referrals and test results

Questions:
○ What arrangements do you have with other providers in your area?
○ How satisfied are you with access to care for your patients?
○ What protocols are in place for transitions of care and medication reconciliation?
○ What is your process to track referrals?
○ Do you include patient preferences and concerns in the referral process?

Basic Ideas:
A patient-centered medical home provides continuity between settings and collaboration among everyone involved in a patient’s care. Shared decision-making with the patient and family and care coordination promotes better health outcomes - fewer readmissions and medication issues, better patient safety and patient satisfaction, reduction in duplication of services and increased delivery of preventive services. Your task is to avoid mistakes, reduce delays in accessing services, and improve processes for getting and using information and recommendations from specialists, hospitals and other service providers. Your goal is to develop more sophisticated relationships with outside providers and community resources over time.

Resources on Anthem.com
Enhanced Personal Health Care:
○ Provider Toolkit
  Resources to support the setting up of external processes and infrastructure to sustain coordination of care outside of the medical home.

I want to learn more:
○ Graphic
  - Welcome to the Medical Home Neighborhood
  Healthcare Intelligence Network
○ Guidelines
  - Key Changes and Resources for Care Coordination
    Improving Chronic Illness Care
Achieve improved clinical and utilization/affordability outcomes

Objectives:
- Use in-network resources that provide cost savings
- Use resources to make better informed referrals
- Decrease utilization, ER visits, and hospitalization
- Implement quality improvement activities using clinical and utilization data
- Measure patient and staff satisfaction to monitor quality

Questions:
- What does quality improvement look like in your practice?
- How do you use quality improvement to make changes?

Basic Ideas:
The best guides for chronic illness care and preventive care outcomes are evidence-based measures. Use of a population health registry will provide you with data about your patients. Anthem also provides participating providers several reports to help you improve patient outcomes and measure your clinical quality performance. You can track your performance using the EPHC reports and see your progress toward Shared Savings. You can view all reports on Availity.

Resources on Anthem.com
Enhanced Personal Health Care:
- **Provider Toolkit**
  Program metrics, report how-to, and options for helping patients to decrease ineffective and unnecessary use of clinical resources are all examples of supports available to help you achieve improved clinical and utilization outcomes.
- **HEDIS 101 for Providers**
  Health and Wellness > Quality Improvement
- **Tools and Resources for Providers**
  Health and Wellness > Tools and Resources
- **Quality Improvement Program Brochure and Practice Guidelines**
  Health and Wellness > Quality Improvement
- **Provider Toolkit - Cost and Quality Resources**
Medical Home and other Advanced Activities

Achieve Level III NCQA Recognition

Objectives:
○ Use Quality Improvement tools such as Plan-Do-Study-Act
○ Track your progress on milestones and other indicators
○ Attend Learning Collaboratives
○ Research and understand standards needed for NCQA recognition

Questions:
○ Is there support for quality improvement in your practice?

Basic Ideas:
The National Committee for Quality Assurance (NCQA) awards Patient Centered Medical Home recognition to practices that are “functioning as medical homes by using systematic, patient-centered and coordinated care management processes.” We highly recommend and encourage achieving recognition as part of our Patient-Centered Primary Care program, though it is not required. There are resources for NCQA recognition and continuous process improvement including training, in the Provider Toolkit.

I want to learn more:
○ Training
  – NCQA Free Online Training Modules
Practice Transformation Learning Opportunities e-Catalog

The spirit of learning and collaboration is the spark that can ignite powerful change. To help you adopt a patient-centered care model and fulfill participation requirements under Enhanced Personal Health Care, we offer a wide range of learning opportunities that are designed to inform, inspire and support you. Most of these opportunities are offered online and can be viewed on demand.

Your Care Consultant can tell you more about any of the events described in the e-Catalog.
Behavioral Health Resources Integration and Adult Resources

Resources on Anthem.com
Enhanced Personal Health Care Program

- Behavioral Health Clinical Practice Guidelines
  Health and Wellness > Behavioral Health Clinical Practice Guidelines
- Behavioral Health Management - Clinical Utilization Guidelines
  Plans and Benefits > Behavioral Health Management
- Alcohol and Other Drugs Toolkit and Provider Guidelines
  Health and Wellness > Provider Toolkits

Web-based Resources

- Standards for Levels of Integrated Healthcare
  SAMSHA-HSRA Center for Integrated Health Solutions
- Alcohol and Substance Use, Depression Assessment and Guidelines
  HealthTeamWorks
- The Academy: Integrating Behavioral Health and Primary Care - Resources
  US Dept. of Health and Human Services, Agency for Healthcare Research and Policy
- Advancing Care Together
  University of Colorado School of Medicine demonstration projects on integration of primary care and behavioral health

Care Management Programs and Resources

Behavioral Health Case Management

Offers immediate and longer term mental health management and information to eligible members.

- Health and Wellness Guidelines and Resources
  Health and Wellness
- 24/7 Nurseline — toll free number to access a nurse anytime — located on the back of the member’s insurance card

Case Management

Case Management offers telephonic and video chat nursing support following a major hospitalization or procedure due to illness or injury. Cancer, NICU and transplant services are included. Case Management support can help members maximize medical benefits; arrange post discharge care and community resources. Includes a Social Worker to assist with financial and community resources.
Condition Care

Depending on their benefit plans, some members have additional resources available to help them better manage chronic conditions. The Condition Care program is designed to help participants improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care. A referral to the program allows your patient access to a team of professionals, with guidance and coaching by phone. There is no extra charge for this benefit. You can consult with the Care Consultant if you have any questions about the referral process or what to expect when you refer.

The Condition Care program helps members better understand and control certain medical conditions like:

- Diabetes (Type I and II)
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure
- Asthma (Pediatric and Adult)
- Coronary Artery Disease
Referral Automation: Anthem Care Management Referral Programs

○ Provides the ability for providers to submit Case Management (CM), Disease Management (DM) and Behavioral Health (BH) Referrals using Provider Portal (EPHC reports) functionality.
  - Case Management offers telephonic and video chat nursing support following a major hospitalization or procedure due to illness or injury. Cancer, NICU and transplant services are included. CM support can help members maximize medical benefits; arrange post discharge care and community resources. Also included is a Social Worker to assist with financial and community resources.
  - Disease Management is a collaborative and holistic health management approach to help patients better manage chronic conditions such as:
    · Asthma - Pediatric and Adult
    · Diabetes - Pediatric and Adult (Type I and Type II)
    · Chronic Obstructive Pulmonary Disease (COPD)
    · Coronary Artery Disease (CAD)
    · Heart Failure (HF)
  - Behavioral Health Programs may be available to patients who have acute, chronic or complex behavioral health needs that are not adequately managed in the current treatment setting.
○ Providers can generate referrals at point of reference in the population health management tool (Availity provider portal).

What Your Patient Can Expect

Patients should expect a contact from their health plan to provide support for meeting their health goals such as:
  ○ What to expect during and after hospital stay
  ○ Assistance with navigating the health system
  ○ Access to educational information from medical professionals like dietitians, social workers, or pharmacists
  ○ Support for managing a serious or complex condition
  ○ Answers to family questions and referrals or recommendations to other programs provided at no additional cost
    - Care Management will explain what to expect during and after hospital stay
    - Coordination of care, assistance with navigating health plan system
    - Access to Anthem Care Management multi-disciplinary team consisting of Nurse Care Managers, Social Workers, Dietitians, Pharmacists, Behavioral health clinicians and Medical Directors to provide additional resources and support
    - Assistance with how to handle a serious or complex condition
    - Answer questions about patient and caregivers needs and and/or recommend available resources to best support the needs
What the Provider Can Expect

Providers can expect easy access to referral status for their patients:

- A secure automated process to submit patient information to Health Plan clinical programs for collaboration
  - Ease of use to generate automated referrals at any point of reference in the population health management tool (accessed using our provider portal)
  - View results of referrals via status and outcome in EPHC reports
    - Request care management nurse contact practice via note section in referral form
    - View list of referrals sent and received in the last 12 months
    - View patient engagement with care management programs
- Providers have the ability to see program status and start the referral in a familiar tool.

**Note:** If a status shows “Unable to Reach,” a provider should follow-up with the patient to encourage participation.

Provider Role

- Provider should discuss the referral in order to support engagement in clinical programs and to avoid patient confusion. Providers should advise patients that through their health plan, at no additional cost, they may have access to a trained professional health consultant. Inform patients that they should expect contact from their health plan to work on support with meeting health goals.

**Note:** These programs are available at no additional cost for eligible members. Patients are assigned to the various case management programs (NICU, Maternity, Transplant, Behavioral Health, Disease Management, Bariatric etc.) based on their membership type and eligibility.

BlueCard patients should be referred to their BlueCross Blue Shield Home plan. Please check the back of the member’s card for the Provider Service phone number.
Pharmacist Consultant

The Pharmacist Consultants with the Enhanced Personal Health Care program serve as subject matter expert to support program development and population health guidance. The Pharmacists can also serve as a resource to provide insight into strategies and considerations for practices when making transformations to their medication management processes. They can provide additional support and resources surrounding medication related reports, applications, scorecard metrics, and cost effective drug utilization.

If you would like to consult with a Pharmacist, ask your Care Consultant for assistance.

Resources on Anthem.com Steps — Enhanced Personal Health Care Program

- **Medication Adherence Flyer**
  Includes references for:
  - Adherence to Long Term Therapies Evidence for Action [World Health Organization 2003]
  - Strategies to Enhance Patient Adherence: Making it Simple [National Institutes of Health]
  - Improving Medication Adherence in Older Adults [Adult Medication]

- **PCMH: Integrating Comprehensive Medication Management to Optimize Patient Outcomes Resource Guide June 2012**
  This guide from the Patient-Centered Primary Care Collaborative (PCPCC) discusses the reasons medication management is so important to a functioning patient-centered medical home, and outlines how to adopt a formal process for medication management.

- **Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation**
  This paper from Agency for Healthcare Research and Quality (AHRQ) offers a step-by-step guide to planning and implementing a medication reconciliation process in a health care organization.

Web-based Resources

- **How-to Guide: Prevent Adverse Drug Events by Implementing Medication Reconciliation**
  Institute for Healthcare Improvement

- **Creating a Personal Health Medical Record**
  (4min Audio/Video)
  Agency for Healthcare Research and Quality

- **Be a Prepared Patient**
  Center for Advancing Health

- **Electronic Prior Authorization Submission**
  – [CoverMyMeds](#)
  – [ExpressPath](#)
Terminology

Patient-Centered Primary Care - Anthem patient-centered care program that includes payment for care coordination and potential shared savings.

NCQA - National Council on Quality Assurance - NCQA Patient-Centered Medical Home (PCMH) recognition is the most widely-used way to transform primary care practices into medical homes.

PCMH - Patient Centered Medical Home - A model for delivering primary care that is patient-centered, comprehensive, coordinated, accessible, and continuously improved through a systems-based approach to quality.

Your Patient-Centered Primary Care Team:

○ Transformation Team - The individuals in your practice who participate in transformation activities focused on improving patient care using recognized quality improvement methodology. Ideally this group of individuals should include a representative from each area in the practice.

○ Practice Champion - The leader of your practice’s transformation approach. This individual has the authority to support the needed activities, resources, and communication with other staff to ensure success of the Patient-Centered Primary Care program.

○ Care Coordinator - Staff member who facilitates coordination of patient care and care plan creation.

○ Practice Manager - Staff member who manages day to day activities in your primary care office.

Registry - A registry is a mechanism for keeping all pertinent information about a specific group of patients at your fingertips. The information can be used to schedule visits, labs, educational sessions, as well as generate reminders and guidance for the care of patients. Example: all diabetic patients with A1C>7

Evidence Based Guidelines (Clinical Quality Measures) - Results of population research used to guide clinical decision making.

Population Management - Comprehensive strategy to improve the quality of care and outcomes for patients with complex, chronic and uncontrolled conditions.

Risk Management - Refers to the periodic and systematic assessment of each patient’s health risk status, using criteria from multiple sources to develop a personalized care plan.

Self-Management Support - Engaging with and inspiring patients to become informed about their conditions and take an active role in their own treatment.

Practice Essentials - Self-paced curriculum for practice transformation supported by live and recorded webinars. Link located on the Patient-Centered Primary Care home page.

SMART Goals - When developing care plans with patient and family involvement, use the acronym SMART to define goals that are Specific- Measurable- Assignable- Realistic and Time-related.