**G:\CTRHS\Inst\RWJF PCT-LEAP\Phase I\Project Activities\Learning Community\October Meeting\Program book\PCT_Leap_color.jpgShare the Care: Assessment of Team Roles and Task Distribution**

*This is an example of a planning tool, to assess who is currently doing what tasks in your practice and then who should be doing each task, based on how we learned that LEAP sites define clear roles and responsibilities. There is no “right answer”; task distribution will vary from practice to practice, based on contextual and internal factors. The tool is in the discussion about roles that this worksheet can stimulate. Your practice may be able to redistribute the tasks in a way that better fits your workforce and patients.*

Instructions:

1. Modify the worksheet so that the columns reflect all care team roles and the rows contain the most important tasks in your practice. (Note: we use the term “lay person” to mean someone without medical background, so this may include lay caregivers such as Community Health Workers or administrative staff members such as Front Desk staff).
2. Gather a group of staff members who are engaged in redesigning care roles, representing all the roles on the care team.
3. Assess your practice at the current time, for each task. The tasks are organized by categories, such as “communications with patients, outside of the patient office visit.” Check boxes to indicate “**Who does it now?**”
4. Next, use the worksheet to think about “**Who Should Do It?**” Discuss which roles are capable of doing each task and how well the work is distributed across roles. Use a different color to check boxes where you think that tasks can be redistributed for improvements to everyone’s workload.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **MA** | **RN** | **Lay person** | **PharmD** | **BH specialist** | **No one** | **Other** |
| **Communication with patients, outside of patient office visit** | | | | | | | |
| Answer phones, triage calls |  |  |  |  |  |  |  |
| Help manage/triage provider electronic inbox |  |  |  |  |  |  |  |
| Serve as primary point of contact for patients |  |  |  |  |  |  |  |
| Conduct patient outreach for outstanding labs, etc. |  |  |  |  |  |  |  |
| Follow-up by phone or email after visits to make sure that patient understood instructions |  |  |  |  |  |  |  |
| Follow-up with patients after hospital discharge |  |  |  |  |  |  |  |
| Follow-up with patients after Emergency Department visit |  |  |  |  |  |  |  |
| Respond to patient calls requiring clinical assessment and decision-making |  |  |  |  |  |  |  |
| Community-based efforts to connect new patients to the practice |  |  |  |  |  |  |  |
| Notify patients about normal lab results |  |  |  |  |  |  |  |
| Notify patients about abnormal lab results |  |  |  |  |  |  |  |
| **Preparation for patient visits and proactive population management** | | | | | | | |
| Pre-visit planning/chart scrubbing |  |  |  |  |  |  |  |
| Conduct patient outreach for outstanding labs, etc. |  |  |  |  |  |  |  |
| Independent visit to prepare patients for a provider visit |  |  |  |  |  |  |  |
| Participate in care team huddles to review the plan for the day |  |  |  |  |  |  |  |
| Participate in regular meetings to review outcomes for patients who have not yet reached chronic disease-related clinical goals |  |  |  |  |  |  |  |
| Participate in regular meetings to review outcomes for patients who have not yet reached chronic mental health-related clinical goals |  |  |  |  |  |  |  |
| **Patient visit tasks** | | | | | | | |
| Perform injections |  |  |  |  |  |  |  |
| Reconcile medications |  |  |  |  |  |  |  |
| Scribe for providers |  |  |  |  |  |  |  |
| EKGs |  |  |  |  |  |  |  |
| Spirometry |  |  |  |  |  |  |  |
| Assist with basic procedures |  |  |  |  |  |  |  |
| Conduct well visits (with provider oversight) |  |  |  |  |  |  |  |
| Conduct preventive care visits (with provider oversight) |  |  |  |  |  |  |  |
| **Patient education, coaching, and care management** | | | | | | | |
| Perform “teach-back” with patient at end of visit |  |  |  |  |  |  |  |
| Orient new patients to the practice |  |  |  |  |  |  |  |
| Develop care plans with patient |  |  |  |  |  |  |  |
| Help address barriers to patient goals |  |  |  |  |  |  |  |
| Health coaching and motivational interviewing |  |  |  |  |  |  |  |
| Patient health education |  |  |  |  |  |  |  |
| Conduct group visits |  |  |  |  |  |  |  |
| Conduct home visits |  |  |  |  |  |  |  |
| Complex care management |  |  |  |  |  |  |  |
| Medication titration, by protocol |  |  |  |  |  |  |  |
| Run patient support groups |  |  |  |  |  |  |  |
| Meet with patients about concerns or resistance with taking medications |  |  |  |  |  |  |  |
| Conduct thorough medication reviews with patients |  |  |  |  |  |  |  |
| Provide self-management support to patients |  |  |  |  |  |  |  |
| Screen patients for depression and other chronic mental health disorders |  |  |  |  |  |  |  |
| Screen patients for substance use disorders |  |  |  |  |  |  |  |
| **Administrative and Quality Improvement** | | | | | | | |
| Participate in quality improvement and practice improvement activities |  |  |  |  |  |  |  |
| Lead quality and practice improvement activities |  |  |  |  |  |  |  |
| Coordinate/track outgoing referrals |  |  |  |  |  |  |  |
| Close the loop on referrals (consult notes from the specialist have been received and added to our EHR) |  |  |  |  |  |  |  |
| Administrative tasks around medication refills, labs, imaging |  |  |  |  |  |  |  |
| Pre-authorizations |  |  |  |  |  |  |  |
| Check patients in |  |  |  |  |  |  |  |
| Check patients out |  |  |  |  |  |  |  |
| Generate exception reports or registries in order to conduct population management/outreach |  |  |  |  |  |  |  |
| Generate team-level QI reports |  |  |  |  |  |  |  |
| Supervise and support MAs |  |  |  |  |  |  |  |
| Lead the care team |  |  |  |  |  |  |  |
| **Other services** | | | | | | | |
| Run specialized care services, such as programs for obstetric patients or Coumadin patients |  |  |  |  |  |  |  |
| Connect patients to resources in the community |  |  |  |  |  |  |  |
| Help patients navigate the health care system |  |  |  |  |  |  |  |
| Consult providers and clinical staff on medication use and dosing |  |  |  |  |  |  |  |
| Provide brief or short-term counseling for patients coping with an episodic behavioral health concern |  |  |  |  |  |  |  |
| Consult with providers on evidence-based treatment for depression, anxiety, or bi-polar disorders |  |  |  |  |  |  |  |
| Other tasks: |  |  |  |  |  |  |  |
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