Share 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:							
Other tasks:							
Other tasks:							
Other tasks:							
Other tasks:							