***TEAM CARE PLANNING ROLES & RESPONSIBILITIES***

***Opioid Process Improvements***

This template may be used to guide team discussions about assigning roles and responsibilities related to opioid process improvements and the care planning process. It has been created using the Care Plan template as a guide, but it may be modified and adapted to suit you team’s needs.

**TIPS:**

* Use your current state **process map** as a reference
* Consider adding steps that may be missing from your current state process map that could be worth adding – potentially involving PDSA trials
* The first two ‘Who?’ columns allow for exploration of who **could** technically be responsible for the step with regard to:
	+ Scope of practice, professional designation, etc.
	+ Previous experience
	+ Personal interest
	+ Time and availability
* In some instances, the person or role currently responsible for the process may make perfect sense – after a brief discussion, simply document and move on to the next step
* It’s helpful to keep in mind that the physician or NP may be able to do all of the steps; however, sharing the load across the team is the goal
* The grey ‘Who?’ columns are intended to clarify who specifically will be **responsible** for each process step
	+ This could be one person, more than one person, or a ‘role’ (e.g. MOAs)
	+ For each process step, consider also designating at least one person to be cross-trained as back-up
	+ Cross training also allows team members to ‘stretch’ in their roles and build their skills
	+ Ultimately, as many members of the team as possible should be able to do as many of the tasks as possible
* Remember to PDSA – what seems like it will work in a planning meeting may not work exactly as planned in practice!

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| ***Process Steps*** | ***Who?*** |
| *could do it**(in scope)* | *has interest/**experience/availability* | *RESPONSIBLE* | *CROSS-TRAIN* |
| *I**D* | *Identify opioid patient population* | *Patients starting opioids (e.g. post-op)* |  |  |  |  |
| *Patients currently being maintained on opioids**(e.g. chronic pain)* |  |  |  |  |
| *Patients reducing opioid dose (e.g. high dose, pain unmanaged)* |  |  |  |  |
| *Check to see if patient has upcoming appointment* *Contact patient to offer appointment* *(e.g. opioid management care planning)* |  |  |  |  |
| *P**R**EPARE* | *Update EMR from Netcare/other* |  |  |  |  |
| *Pre-populate medical history in care plan for review with patient* |  |  |  |  |
| *Determine labwork/tests needed in advance of appointment* |  |  |  |  |
| *Coordinate with patient to complete* *‘pre-work’**(Assessments, labs, etc.)* |  |  |  |  |
| *P**L**A**N* | *Review medical summary with patient**(e.g., health conditions & targets, medications, allergies, family & medical Hx, care outside of clinic, modifiable risk factors, assistive devices)* |  |  |  |  |
| *Gather social history with patient**(e.g., finances, housing, support systems)* |  |  |  |  |
| *Assess patient function, medication side effects, developing tolerance, etc.* |  |  |  |  |
| *Discuss and collaboratively prioritize goals and actions* |  |  |  |  |
| *Action plan with patient**Proactively plan for addressing barriers* |  |  |  |  |
| *M**A**N**A**G**E* | *Plan for follow-up with patient* |  |  |  |  |
| *Follow-up with patient* |  |  |  |  |
| *Coordinate follow-up among team (internal)* |  |  |  |  |
| *Coordinate sharing of care plan with external care providers* |  |  |  |  |