Team Roles & Responsibilities: Care Planning

This template may be used to guide team discussions about assigning roles and responsibilities related to the care planning process. It has been created using the PaCT 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 <u>able</u> 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!

Process Steps			Who? could do it (in scope)	Who? has interest/ experience/availability	Who? RESPONSIBLE	Who? CROSS-TRAIN
ID	Identify patients for care planning (CP) appointments	Could benefit (new)				
		Due (recurrence)				
	Contact patient to offer care planning appointment (explain benefits, etc.)					
PREPARE	Update EMR from Netcare/other					
	Invite patients for CP appointments					
	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.)					
PLAN	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)					
	Discuss and collaboratively prioritize goals and actions					
	Action plan with patient					
	Proactively plan for addressing barriers					
MANAGE	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					