Using Teams to Share the Care
Who does it now?

Use the worksheet below as a starting point for maximizing your care team and the role of the care coordinator.

Care Coordination Tasks	**MD/PA/NP**		**RN or Care Mgr.**		**LPN/MA**		**Clerical Assoc**		**Care Coord**		**Someone Else**		**No One**	
Who does it? ***Who should do it?***														
Make appointment reminder calls to patients														
Confer with patient to identify any barriers to keeping appts (office, specialist, test, etc.)														
Arrange transportation														
Outreach to no-show office appointments														
Provide clinical summary to patient														
Document any cultural, socio-economic, educational considerations in EHR														
Run reports & conduct outreach to patients past due for preventive and/or chronic care														
Closed-Loop Test Tracking														
Order tests														
Outreach to no-show for tests														
Track and follow-up on test results														
Flag abnormal test results to bring attention to clinician														
Document if patients have received tests since last office visit (and obtain info for EHR)														
Notify patient/family of test results and document in EHR														
Map test order process from placement of order to patient notification of all results (imaging, lab, other, normal and abnormal)														

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Closed-Loop Referrals														
Create agreements with referral partners														
Order referrals in the EHR														
Schedule patients in with specialist(s)														
Outreach to no-show for referrals														
Create and send referral requests including patient summary of care documents														
Track and follow-up on completion of referrals														
Receive reports, communication from facilities/providers														
Ensure reports / communication are uploaded to EHR and that clinicians acknowledge receipt														
Map referral process from initiation to clinician acknowledgement of receipt														
Transitions														
Identify patients admitted to ED or inpatient service														
Contact patients within given time after discharge from hospital														
Identify if recently DC'd patients have additional care needs or pending tests; perform med rec, etc.														
Document in transition of care templates														
Ensure ED notes and discharge summaries are in EHR														
Document if patients have been seen elsewhere since last office visit (and obtain info for EHR)														
Provide care and document under the Transitional Care Management codes														

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Care Plans														
Identify patients that need care plans (may be different population than just high-risk patients)														
Ensure care plans are completed for appropriate patients														
Ensure care plans include all required components and are updated at appropriate intervals														
Provide care plans to patients														
Community resources/medical neighborhood														
Maintain master list of community and social service organizations, State and local public health agencies, etc.														
Document shared care partners in EHR														
Identify patient barriers and needs														
Connect patients with resources														
Circle back with patients to ensure resource(s) meets needs														

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Medication Management														
Perform medication reconciliation according to standard script including side effects and adherence														
Assess understanding of medications														
Documents OTC meds in EHR														
Renew prescriptions														
Identify solutions for patients to reduce primary nonadherence (e.g., cost, mail order pharmacy)														
Identify solutions for patients to reduce secondary nonadherence (e.g., dosing regimens, med boxes)														
Care Management														
See companion document														