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# **HealthTeamWorks TASK LIST ACTIVITY**

## PURPOSE:

* Define current tasks completed by CARE MANAGER, with emphasis on tasks that take up the majority of CARE MANAGER time
* Understand the current priority for CARE MANAGER tasks
* Solicit input on what an IDEAL Priority should be

## PREP:

* Ask care managers to make a list of tasks that they do frequently (all tasks) or occasionally (non-CM tasks) and review the list to ensure that these tasks are included on the list.

## PROCESS:

1. Review TASK LIST ACTIVITY document - **Page 2** of this Word document
2. Add any tasks that you perform frequently or that take significant time in your day/week
3. Reflect on the previous 4-5 days and complete the TASK LIST ACTIVITY or Capture Task List activity daily for 4-5 day
4. Document Priority & Time for:
	1. Tasks that you perform regularly
	2. Note the priority this task has in your current workload [0 (low priority) - 3 (high priority)]
	3. Note the priority you feel it should have as Care Management is developed at your clinic (0 - 3)
	4. Estimate the amount of time per week spent completing this task
5. Review completed TASK List – determine if this validates that the majority of time is spent on priority care manager tasks or validates that significant time is spent on non-care manager tasks.
6. Review with your manager or Care Management leader as appropriate

Feel free to reach out if you have any questions:

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| 1. ***Designate the current level of priority and ideal level of priority for each task***

*Priority level key: 3 =High; 2=Medium; 1=Low, 0= task not done by CARE MANAGER*1. ***Designate the average amount of time you spend each week on each task***
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|  **CARE MANAGER Task List** | **Current Priority****0,1,2 or 3** | **Ideal CM Priority****0,1,2 or 3** | **Avg. time spent/ week** |
| ***EXAMPLE: Fill-in for MA when MA is out on PTO or sick*** | ***2*** | ***0*** | ***1-2hrs*** |
| **Care Management Tasks** |  |  |  |
| Referral for imaging appointment: CT/MRI |  |  |  |
| Referral for imaging appointment: Other (please list) |  |  |  |
| Referral for preventive screening : Colonoscopy, mammo, etc  |  |  |  |
| Referral for specialty provider / clinic appointment  |  |  |  |
|  |  |  |  |
| Prior authorization for imaging, pharmacy-Rx or specialty care |  |  |  |
|  |  |  |  |
| Referral for physical therapy appointment |  |  |  |
|  |  |  |  |
| Referral for community resources: Home health |  |  |  |
| Referral for community resources: Housing or transportation |  |  |  |
| Referral for community resources; Other |  |  |  |
|  |  |  |  |
| ED or Hospital Discharge Follow up for med or high risk pts |  |  |  |
|  |  |  |  |
| Work with member to ensure they have skills/ resources to manage their health - self management resources for chronic conditions |  |  |  |
| Assess or address social needs (SDoH) |  |  |  |
| Develop/review/update patient identified goals |  |  |  |
| Develop/update a personalized care plan with patient |  |  |  |
| Provide education on a members health condition/conditions |  |  |  |
|  |  |  |  |
| Provide follow up after a specialty consult  |  |  |  |
| Track down consult or xray results following a referral  |  |  |  |
|  |  |  |  |
| Contact patient to review lab results for med/high risk patients |  |  |  |
| Quality Gap management – lab or screenings (HgbA1c, PhQ-9; breast/colon) |  |  |  |
| Coordinate with mental/behavioral health team |  |  |  |
| Coordinate care with health coach or CDE |  |  |  |
| Coordinate care with other primary care team members  |  |  |  |
| Complete Annual Wellness Visit (AWV)  |  |  |  |
|  |  |  |  |
| *Add others not listed:*  |  |  |  |
|  |  |  |  |