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

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:
   a. Tasks that you perform regularly
   b. Note the priority this task has in your current workload [0 (low priority) - 3 (high priority)]
   c. Note the priority you feel it should have as Care Management is developed at your clinic (0 - 3)
   d. 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.

- Diane Cardwell dcardwell@healthteamworks.org or
- Angie Schindler-Berg aschindlerberg@healthteamworks.org

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

2. *Designate the average amount of time you spend each week on each task*

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			

HealthTeamWorks®

Health. Equity. Resilience.

Care Management Tasks			
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:			