Care Coordination Task Plan and Weekly Schedule

This tool identifies the types of tasks that a care coordinator (CC) might perform in a given week within a community-based care coordination (CCC) program, and provides a set of tips for effectively managing those activities. The tool includes an example schedule and a suggested approach to planning and scheduling weekly care coordination tasks.

**Time needed:** 30 minutes

**Suggested other tools:** Care Coordinator Sample Job Description; Resource Checklist for CCC; Provider Resource Directory; Community Resource Directory

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**How to Use**

1. **Review** the overview section of this tool to understand the general tasks to be performed by the care coordinator within the context of the community-based care coordination (CCC) program, and the section on suggested approaches to planning and scheduling tasks to consider how to set up the CC weekly schedule.

2. **Review** the tips for effective time management by the care coordinator.

3. **Plan** the first week’s schedule, or a sketch out a sample weekly schedule, to initiate the weekly scheduling process. Make adjustments over time to meet the specific needs of the CCC program.
Overview of Care Coordinator Tasks and Scheduling

The care coordinator must plan for a variety of tasks to be performed throughout each week, including program development and maintenance, communicating with providers and community resources, following up on patient referrals, and, of course, meeting with individual patients enrolled in the CCC program. The allocation of time to each activity will vary with the number of patients in the CCC program and the program’s maturity.

Initiation of the CCC program will require:

- **Upfront planning** (e.g., preparation to recruit patients into the CCC program, ensuring adequate resources for care coordination, compilation of CCC tools, documentation and communication mechanisms, and so on.)

- **Proactive intensive communications and education** to engage providers and community resources in the CCC program (with direct and indirect providers and staff, referral providers, community resources and agents) and in ongoing care coordination with patients

- **Proactive patient introduction communications** (e.g., calls, mailings, responses to questions regarding communications)

As the CCC program matures, the tasks to be planned for the weekly schedule will shift to:

- **Responding to requests** for care coordination services, assessing patient needs, engaging patients in developing a care plan, and arranging for and following up on needed services

- **Documenting patient assessments** and services rendered

- **Monitoring patient progress** (care plan adherence, diaries, etc.).

- **Holding team meetings and huddles** for a focused review of patient needs, conflict resolution, and escalation of variances to risk management as necessary

- **Maintaining CCC program integrity and clinical expertise** – ensuring ongoing relationships, keeping clinical guidelines and patient care plans current with respect to the latest evidence-based practices, and learning new skills and gaining new knowledge

- **Collecting data for, and coordinating with the quality assurance program**

- **Ongoing workflow and quality improvement** – strategizing for, and building tactical plans to continuously improve on both quality scores and Triple Aim goals of the CCC program
Suggested Approach to Planning and Scheduling CC Tasks

1) **Review the care coordinator job description**, general tasks to be performed (identified above), tips for effective time management, and status of the CCC program as represented by previous weeks’ accomplishments.

2) **Plot tasks on the Weekly Schedule**, leaving some time flexibility to respond to requests for care coordination services. *For example*, in the Weekly Schedule example (below) the care coordinator made an exception for a special presentation to a quarterly physician meeting. The care coordinator was able to identify one patient in the care coordination cohort who was scheduled to be seen in the clinic and with whom a quarter hour could be spent to introduce the care coordination program. A hospital in the CCC program also scheduled a half hour of care coordination for a patient being discharged. However, one patient’s need for care coordination on Saturday was not able to be accommodated.

3) **Use the weekly schedule** to ensure that all tasks are performed, are appropriately delegated, or are added to a later schedule.

4) **Document actual time** as each task is performed. *In the example*, an additional half hour was used to respond to a care coordination need and one hour of clinic time that was not scheduled with patients was used for care coordination. The need for one care coordination event over the weekend was also documented.

5) **Review actual time against planned time** at the end of the week or start of the next week to assess where there is a need for better time management or resource allocation. Plan adjustments as the next week’s schedule is developed. Use the weekly schedules to make adjustments in overall time allocation and resources.
## Example Weekly Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Plan schedule</td>
<td>Plan presentation to Providers</td>
<td>Team Huddle</td>
<td>Visit 2 community resources</td>
<td>Document Patient Cohort Data</td>
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<tr>
<td></td>
<td>Plan community resources directory</td>
<td>Review clinic schedule to introduce CC to patients</td>
<td>Clinic</td>
<td></td>
<td></td>
<td>S.H. Coaching</td>
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<tr>
<td>9:00</td>
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<tr>
<td>10:00</td>
<td>Set up appts with 4 community resources</td>
<td>Clinic</td>
<td>Clinic</td>
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<td>Clinic</td>
<td>Clinic</td>
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<tr>
<td>11:00</td>
<td>Clinic</td>
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<td>12:00</td>
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<td>1:00</td>
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<tr>
<td>2:00</td>
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<td>CCC for Patient John</td>
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<td>3:00</td>
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<tr>
<td>4:00</td>
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<td>Call 4 patients about F/U &amp; CCC</td>
<td>Visit 1 community resource</td>
<td>Call 4 patients F/U &amp; CCC</td>
<td>Call 4 patients F/U &amp; CCC</td>
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<td>5:00</td>
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<tr>
<td>6:00</td>
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<td>Provider Meeting on CCC</td>
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</table>

12 1/2 hours scheduled, 1/4 hour in clinic, 1/2 hour not scheduled, 1 hour available.
**Time Management Tips for the Care Coordinator**

1. **Set and respect realistic objectives**, priorities and deadlines for tasks to be accomplished. Monitor that these can be met and adjust accordingly. (These may be documented on a separate task plan.)

2. **Use an electronic device to manage time** as the primary resource for the care coordinator to manage the weekly schedule, such as MS Outlook on a tablet or laptop that has alerting and tracking functions. Keep the weekly task plan and schedule up-to-date.

3. **Distinguish between urgent, important, and non-essential tasks** in the event that some tasks must be delegated or dropped due to limited resources.

4. **Delegate activities** that can be delegated. Especially work closely with case managers, quality assurance specialists, and others as applicable to avoid duplicate effort. Remember that the care coordinator’s role is not to treat the patients for whom care coordination is provided, but to ensure appropriate treatment services are provided by applicable providers and community resources.

5. **Seek help when needed**, such as from information technology (IT) specialists, physician champion, case manager, CCC program leaders, local pharmacists, and others. Community-based care coordination is a team effort.

6. **Communicate effectively** and in a respectful manner, especially surrounding new concepts of care coordination and new models of care. Test understanding with providers, patients, and community representatives.

7. **Avoid being a perfectionist**, Set standards that are reasonable and acceptable. Accept tasks that are only within the boundaries of the job responsibilities and allocated time.

8. **Collect only appropriate and necessary data** that will support planning, making decisions, providing feedback, and assuring compliance with clinical quality measures (CQMs) and other regulated requirements.

9. **Use an agenda and document decisions made** in order to manage and recall all communications, including those for virtual rounds/huddles with the care team, with patients/family, and in dealing with community resource representatives, etc.

10. **Recognize time wasters** and have the confidence and drive to rise above them.