Workflow Documentation Template

The development and planning of a care transformation initiative requires buy-in and participation from all staff to ensure that processes run smoothly and that tools/resources are utilized appropriately. As such, it is also important that all staff have an opportunity to include their perspectives when thinking through the program elements to account for how different types of roles can impact success and be impacted by the changes. A useful way to detail the new roles and responsibilities to accomplish the program's goals is to **document the team's workflows**.

Workflow documentation outlines key roles and responsibilities in coordinating and delivering care for the program's patient population. The documentation should include detailed steps carried out for an individual patient including by whom within the organization's staff. A best practice is to describe each staff member's 'swim lane' to clearly show their role, and when they will be called upon to support the program functions. A 'swim lane' diagram visually distinguishes shared and individual responsibilities for each part of the program's process. This allows staff to fully understand when, how, and with whom they are expected to be involved.

A visually clear and detailed workflow document can be developed, revised, added to, and refreshed as needed to ensure that staff understand the program and their role in it.

The following example of a workflow documentation diagram can help you think through your current program design, necessary staff roles & responsibilities, interaction between staff members, and involvement of the patient in their own care. Leverage this as a starting point for designing your program and work with your staff to refine for optimal performance!

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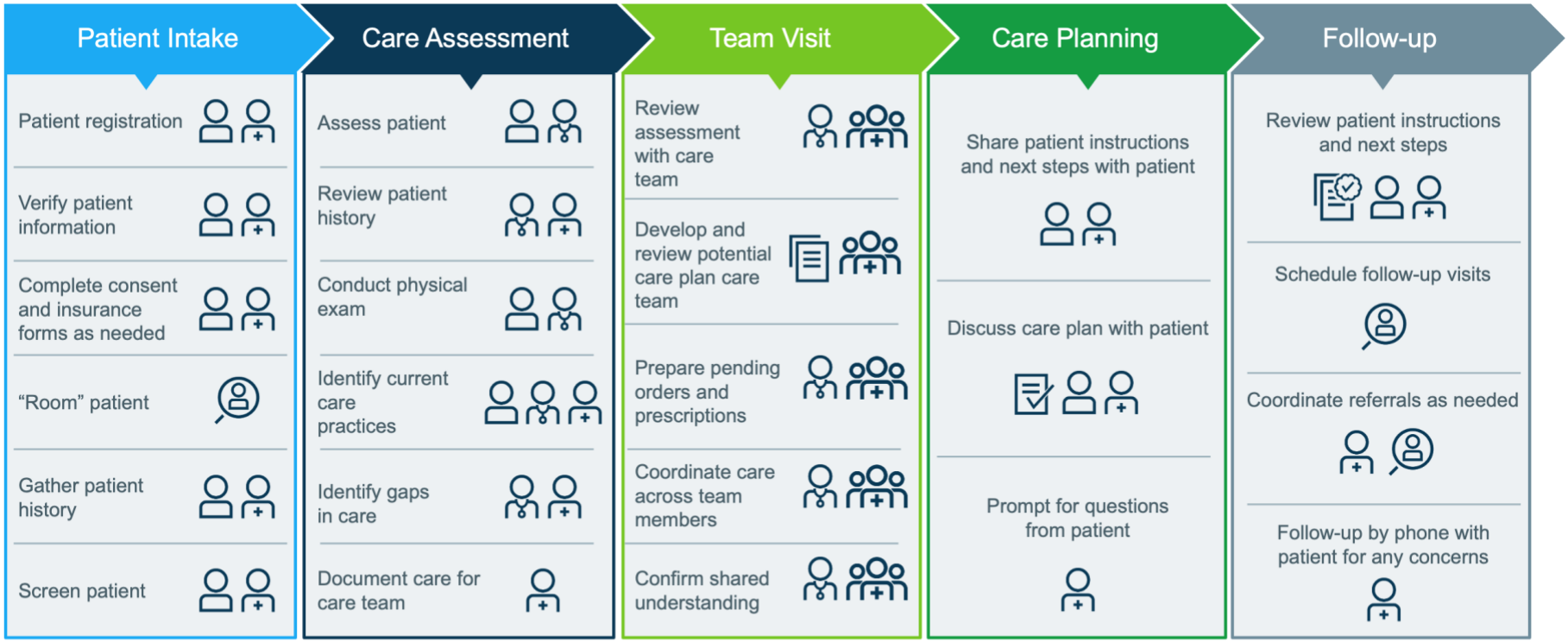
Care Team Coordination Process Map

The Care Team Coordination Process Map outlines the patient's journey through care navigation to show the resources required for each step. This will support care teams to coordinate decision-making to provide improved care delivery for patients and integrate various services across their health and social needs. The process map can also serve to reveal immediate opportunities for process improvement and cost reduction.



Patient

Care Coordinator
Liaison for the patient in the health system, connection between patient, primary provider, multidisciplinary team, and office management

Primary Provider
Primary medical provider for patient, care plan and patient health outcomes

Care Team
Multidisciplinary team of providers, care coordinator, and patient navigators consulted to develop the patient care plan

Patient Navigator
Patient support for office management functions including intake, scheduling, referral processing, records management, etc.

Patient Care Plan
Comprehensive plan of care for patient, meeting all social and health needs, coordinating services across providers;
- Plan is developed by the full care team,
- Reviewed with the patient, and
- Leveraged for follow-up and accountability