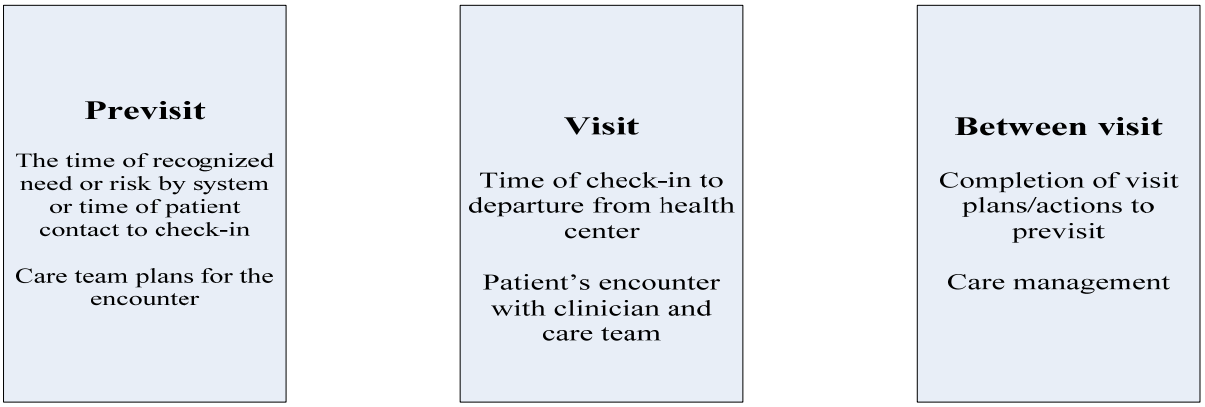
Who is on a care team? What is their role? What are their functions and tasks?

How is the work of a Care Team Organized?
The work of care teams to deliver proactive, population-based, patient-centered primary care is divided into 3 domains of work: pre-visit, visit, and between visit work.



Care Team tasks:	**Who?**
Previsit	
• Assist patient to prepare for visit:	MA, receptionist via letter
o bring medications to visit	
o prepare questions to ask provider	
o come in for pre-visit lab tests	
o invite family member to visit if patient prefers	
o do previsit questionnaires on MyChart	
• Confirm need for interpreter	Receptionist
On the day before/of the visit—before the patient arrives	
• Make sure all rooms are stocked per standards with supplies, including printer paper.	MA

• Prepare intake packet in advance for each patient and place at the reception desk. o Previsit forms to identify patient goals for the visit o Medication lists o Patient-specific screens (PHQ9, PEDS/PSC, ACT questionnaire, etc)	MA or receptionist
Place orders in advance in EPIC for anticipated labs, radiology, immunizations	MA/provider depending on whether standing orders exist
• Huddle	Provider-MA (minimum); RN and receptionist strongly preferred

On the Day of the Visit – After the Patient Has Arrived	**Who?**
• Verify address and phone number	Receptionist
• Verify MyCHArt and text message preferences	Receptionist
• Give med reconciliation list to patient and verify pharmacy	Receptionist/MA
• Give intake form(s) to the patient: meds, allergies, family history, past medical history and encourage patient to fill out in the waiting room.	Receptionist
On the Day of the Visit--In the Exam Room Before the Provider Has Arrived	
• Complete vitals and previsit work per MA Standards.	MA
• Review health maintenance needs and close as many gaps as possible	MA
o Obtain healthcare proxies and pend order	MA
• Visibly place FOBT cards in exam room for patient overdue for colorectal cancer screening	MA
o Schedule mammogram, eye exam, colorectal screening, etc. as health maintenance needs are identified; update HM	MA/receptionist
• Administer PHQ-9/other mental health patient self-assessment for patients being screened or monitored for mental health disorders	MA
• Place monofilament on counter and have patients take their shoes off if they have diabetes	MA
• Administer ACT questionnaire for patients with asthma	MA
• Complete falls assessment for elderly patients	MA
• Complete all age-specific assessments (eg, hearing and vision screening)	MA
• Help patients identify their goals for the visit and for their health	MA, CRS (Community Resource Specialist)
• Review and reconcile medications and identify refill needs	MA and Provider
• Assess for tobacco use and domestic violence	MA
• Review EPIC Snapshot and lock on exam room computer screen	MA
• Provide prescriptions for medications that are due to expire	Provider
• Update problem list	Provider
• Assess patient's educational needs	All team members

• Create care plan as needed for patients who are at higher risk (eg, diabetics with A1C >= 8, persistent asthmatics, patients with depression PHQ9 >= 15, patients perceived by the team as high risk)	Provider, RN, complex care manager
• Share care plan with patient	Provider, RN
• Provide appropriate educational/self-management tools for patient	MA, RN, Provider
• Administer immunizations	RN or LPN
• Give after visit summary to patient and review with the patient	Provider, MA
• Schedule patient for primary care follow-up, specialty appointments	Receptionist, MA
Between visits	
• Follow-up on test results	Provider
• Monitor Health Maintenance and use Planned Care outreach process to help patients address gaps.	MA, receptionist, Planned Care Coordinator, Community Resource Specialist
• Normal Pap, Mammogram tracking	MA
• Track all important appointments to completion	Receptionist or referral coordinator, community resource specialist
• Follow-up on missed appointments (primary care/specialty/radiology)	Receptionist, referral coordinator
• Schedule additional primary care and specialty appointments	Receptionist, referral coordinator, MA
• Utilize prescription renewal as opportunity to manage patient's care	RN/Provider
• Routine Care Management	RN
o follow-up with patients with ED and inpatient discharges	Team RN
o follow-up with patient for abnormal cancer screening	RN with team support
o follow-up with patients with newly diagnosed or poorly controlled chronic diseases, such as diabetes and depression	RN
o Provide coaching and support with patients enrolled in care management; revise treatment plan as needed; adjust treatment per guidelines or per provider recommendations; communicate treatment changes to PCP; continue follow-up until patient meets goals or opts out of care management	Team RN, Provider, RD, MA
o proactively outreach by phone (and/or mail) re: chronic illness care and health maintenance needs; review progress toward goals; reinforce self-management goals	Team RN, CCM-depending on needs, pharmacist
o proactively outreach by phone (and/or mail) re: chronic illness care and health maintenance needs	Team RN/nurse care manager depending on complexity