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| **Team Member** | **Direct patient care** | **Indirect patient care** | **Additional PACT Team functions** |
| **DON’T FORGET THE PATIENT!** |
| **Provider** | -assist team with walk-in/urgent patient issues-be on time for scheduled clinic visits and telephone visits-chronic disease management  -preventive care a -pertinent clinical reminders-Address + PTSD, depression, etoh reminders -prescribe/renew medications and complete medication reconciliation with patient-patient education -order appropriate diagnostics and refer to self-management/consults as needed-facilitate hospital admission, doc-doc sign out-complete Aftervisit summary | -communicate lab and test results to patients-complete patient paperwork-review outside records -complete view alerts in timely manner-collaborate with team to meet patient needs outside of clinic appointment-Secure messaging (in CPRS) | -Team huddle-Team and clinic meeting participation-Utilize PACT data to guide improvement |
| **LPN (Licensed Practical Nurse)** | -Patient check in for assigned daily provider- first 15 minutes of appointment -complete indicated clinical reminders and medication reconciliation at every appointment-use flag system to notify when pt. is ready - “warm handoff” to provider- Clinical Associates can perform in clinic:* PHQ Depression Screen
* FIT cards and instructions – DO NOT GIVE TO PATIENT (must be properly labeled)
* Orthostatic BPs
* 02 Sat’s at rest and ambulatory
* Download CBG meters
* Fit wrist splints/elbow brace/sling
* Assist with wound care
* ECGs
* Bladder Scans (PVRs)
* Nebulizer treatments
* Vaccinations/PPD
* CBG/BP monitors education
* Order labs
* Assist with/chaperone examinations
* Set up/chaperone PAP smears
 | **First line of non-urgent (> 72 HOURS) communication to patients and facilities should go through LPN.** -Basic data gathering with specific? from provider -Give basic patient information from provider (ex. step by step directions for simple medication changes)-Medication reconciliation -Clarify medication regimens-renew medications, enter OTC meds-medication reviews to ensure adherence with prescribed regimen -patient medication education-preparation of medication list -Inform patient of PCP’s interpretation of lab/imaging results appropriate for patient understanding-Provide patient education materials**-**Secure messaging triage**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Verbal relay of approved orders for HH, PT, OT | -Generate twice weekly Lab Letters for team providers-Filter all secure messaging emails for team-Work with team on chronic illness management performance measures |
| **Team Member** | **Direct patient care** | **Indirect patient care** | **Additional PACT Team functions** |
| **NCM (Nurse Care Manager)** | -Triage patients via telephone or walk-in -Call report to VA hosp for patients being admitted from clinic (nurse to nurse communication)-help triage and transfer pts to ECU when indicated-provide wound care and other skilled needs, ie catheter changes, as needed-heart failure f/u after hospitalization: instruction in ideal management of HF, including daily wts, meds as ordered, reduced sodium diet, stress/weight management-participate in instruction of vets via heart failure and hypertension classes. | -Complex issues requiring urgent assessment - (call or page NCM)-Non- urgent triage; contact NCM by cc: additional signer to your note-Triage nurse care issues, evaluating interim issues-Review complex plans of care: orders, med changes, need for labs/imaging, ordering DME, prosthetics consults- Follow up on efficacy or side effects or medications-Assist in titration for opioid or other pain medication with review of pain/functional status.-Assist in titration of bp meds via hypertension protocol.-Follow up on self-management patient goals-Instruct/reinforce in management of chronic diseases-F/U outside hospital discharges- 2-day discharge/Ed follow up phone calls**Communication with facilities/ outside providers**-Work closely with SW on discharge planning from outside facilities-Liaison for hospitals HH, and ancillary services-Call in non-scheduled prescriptions to outside pharmacies | -CCHT RN assessments (if CCHT RN or HBPC RN is actively managing patient, add them as additional signer instead of team nurse)-Act as lead for bi-monthly PACT team meetings |
| **MSA (Medical Support Assistant)** | -Print out PC - Aftervisit Summary-Scheduling all continuity clinic appointments needed within 3 months-Direct schedule consults -give patients scheduling information to self-schedule US, CT scan, MRI and Vascular imaging tests, bone density exams, Echo and mammo. -Schedule Nurse Treatment Room (NTR) appointments -Release of Information (ROI) requests for non-VA records -Help patient complete ROI for provider forms -Help resolve patient care issues, patient flow, record control, scheduling issues | **Communicating with patients –**-Reminder to get ordered tests (MSA are not allowed to discuss labs/meds results with patients) -complete clinical reminders-contact patients with information about scheduling imaging -send letters by certified mail (if needed send Admin Free Text order)-respond to instructions in PC note when additional signer - schedule a Nurse Treatment Room appointment**Coordinate patient schedules/records** -Obtain urgent reports for patient appt.-move patient appointment times per clinician request **-**Release of Information (ROI) requests for non-VA records **FAX number 503-721-7903****-**All VA Patient records/data given to anyonemust go through facilitator to ROI-exception - **current** patient data (imaging/labs) may be given/mailed to patient directly without ROI | **PACT Team functions -**-Assist change PCP designation in CPRS –done by PC admin-Manage patient consults -coordinate multiple appointments with PCP f/u - reschedule appointments-track consults (administrative order, cc: additional signer)Assist with Recall management-Contact patient to schedule labs and other appointments for chronic illness management/panel population management-Work with PC Administration who is responsible for computer changes to matrix for resident leave  |
| **Team Member** | **Direct patient care** | **Indirect patient care** | **Additional PACT Team functions** |
| **Social Work** | **Call or page** the Social Worker if patient needs to be seen for **urgent psychosocial issues requiring immediate triage**. If is unable to see veteran same day, arrangements will be made to contact veteran for follow up as appropriate. * VA benefit questions
* Financial hardships
* New disability or employment issues
* Housing needs
* Family issues
* Suspected abuse of Veteran
* Difficulty of veteran living independently or assessment for in-home care needs
* Assessment for and facilitation of LTC placement
* Coordinating services with outside agencies, facilities and medical centers
* Caregiver support/respite care
* Substance abuse and treatment needs
* Transportation resources
* Dental/ hearing /vision resources
* Legal issues
* Advance Directives
 | Can put SW on as additional signer to notes indicating patient need when questions are not urgent SW will call patient  |  |
| **Clinical Pharmacist** | **Rapid processing of med orders****-**Urgent mail out or pick up -Review zoster vaccinations or EFERS (electronic non-formulary requests)-Extend chronic medications/temp supplies (non-controlled meds)-Patient teaching, medication reconciliation, medication counseling | - Medication info for providers and patients-Medication selection/VA formulary alternatives, equivalent doses, antibiotic drug selections, medication cost initiatives, adverse event reporting-Provide consultation on pharmacy issues to clinic staff-Medication reviews and therapeutic recommendations -prescription drug monitoring program(**PDMP)** searches | Chronic disease management (CDM consult)* Diabetes
* Lipids
* Hypertension
* Med recon in complex, specialized situations
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