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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 |
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| **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 |
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| **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 |