PCMH Team Member Roles/Responsibilities in Residency Clinic at Olive View

Resident Primary Care Provider

Role
The PCMH Primary Care Provider (PCP) is a resident physician who provides direct care to all patients in his/her panel and oversees clinical panel management provided by the PCMH team. The PCP communicates with the RN Care Manager regularly and strives to develop an effective working relationship with all PCMH staff. The PCP identifies and refers patients to the Care Manager for provision and/or coordination of additional services such as medication adherence reinforcement, self-management support, chronic disease support and education. The PCP works with all team members to achieve and maintain desired patient outcomes in a cost-effective manner.

Responsibilities

Face-to-Face Visit-Related/Day of Care

- Prepares for clinic session by scrubbing the schedule and pre-visit charting
- Leads/participates in a daily huddle with CMA to review day-of-care plan for scheduled patients
- Provides direct patient care based on patient's need (e.g. urgent vs routine follow up vs annual health assessment)
- Clearly communicates patient care priorities, including follow-up plans that involve other PCMH team members
- Initiates specialty care referrals via ORCHID or e-consult
- Clearly documents plan in medical record in a timely fashion
- Reviews no shows at the end of sessions with attending, plans F/U as appropriate and communicates with CMA

Between Visits

- Resident is responsible for the care of patients between clinic visits
- Resident (or proxy) is responsible for reviewing inbox daily to F/U results (lab/imaging) and review messages
- Reviews and follows up on specialty referrals regularly (via e-consult)

Clerk

Responsibilities

- Registers patients as they arrive
- Verifies patients' contact information
- Asks for patients' email address for Wellness Portal invitation
- Monitors Patient Flow and walk-in patients
- Answers phone calls
- Checks voice mail
- Distributes mail
- Re-schedules appointments as requested

Licensed Vocational Nurse

- Assists subspecialty clinics (Renal, Derm)
- Facilitate medication refills

Certified Medical Assistant (CMA)

Role

- The CMA is the nursing staff member who works with the provider to provide direct patient care on the day of the visit. The CMA is the main team member who assists with patient care during clinic sessions, performing intake procedures, prepping for and assisting with patient examinations, carrying out diagnostic procedures or treatments as ordered, arranging follow-up, preparing the patient visit summary and communicating disposition instructions to the patient.

Responsibilities

Day of Clinic Visit Care

- Scrubs the chart before the visit (updates immunization, looks up health maintenance requirements)
- Gathers clinical data from patients during the intake process, which includes:
  - Vital signs, height, weight and blood pressure (repeats BP if initially elevated)
  - Allergies
  - Chief concern
  - Pain
  - Document Medication by history
- Alerts RN, MD, of abnormal or out of range data
- Ensures completion of Staying Healthy Assessment/Depression/Tobacco/TB screening Forms and assists with completion as needed
  - Administers PHQ9 when PHQ2 depression screen is positive
  - Administers AUDIT-C when alcohol screen is positive
- Instructs patient to take out all medication bottles for provider review
- Ensure patient's preferred pharmacy is correctly noted in EMR
- Ensures rooms ready for patient care
- Prepares patient for the exam (undress appropriately, make necessary tools available, eg. monofilament)
- Administers immunizations
- Monitors patient flow
- Assists with procedures as needed
- Performs vision screening as needed
- Performs disposition planning at end of visit, reviewing medications, reinforcing provider instructions and setting up follow up appointments

Between Visits

- Updates vaccinations
- Performs reminder calls 2-3 days in advance, asking patient to arrive on time, bring bottles and glucose log
- Performs patient support phone calls as needed as directed by Provider and RN caregiver/care manager

RN Service Coordinator (Kathrina Puno)

The Service coordinator is responsible for coordinating, authorizing and tracking patient service needs for patients assigned to health plans (DHS managed care). The service coordinator facilitates authorizations for higher level of care, medical supplies and medical equipment in collaboration with health plans

Responsibilities

- Assistance with referrals for Out of Network Services offered through health plans (eg. Pain management, acupuncture, transplant, and dialysis)
- Assistance with transition of care from outside ER/hospitalization back to primary care (eg. obtaining records)
- Assistance with resources offered by patient's health insurance, i.e.: transportation, dental, vision
- Assistance with home health, hospice, SNF placement (SW locates SNF, service coordinator can assist in obtaining authorization)
- Assistance with obtaining DMEs (wheelchairs, power chairs, incontinence supplies, wound care supplies, etc.)

RN Caregiver (Katrina, Lupe, Jay, Ma Rissa)

Front-of-the House RN who provides nursing assessment to empaneled walk-in patients and supports day-to-day clinical operations.

Responsibilities

Day of Care

- Manages patient flow to provide timely and efficient care
- Provides walk-in patient assessment (triage) to patients seeking same-day services.
- Verifies medication administration, order verification and documentation of the CMA
- Supports the PCMH team by providing direct patient care as needed
- Participates in the evaluation of medical home clinic performance and in quality improvement activities.
- Provides patient education, such as diabetic teaching (insulin, fingerstick and glucose log teaching)
- Assists in follow up of abnormal labs and studies

Between provider face to face Visits

- Performs RN visits for Blood pressure checks, Glucose log review, Medication list review, Vaccinations

RN Care Manager (Katrina, Lupe, Jay, Ma Rissa)

Co-manages high-risk patients, provides care coordination, and assists with panel management (non-visit driven population level care).

Responsibilities

- Utilizes ELM to target high risk patients, empaneled patients with recent emergency room visits or inpatient stays and ensures these patients receive proper follow-up care.
- Schedules urgent visits for patients in need of care
- Provides patient education for high risk patients
- Assesses high-risk panel members for overdue disease management interventions or diagnostic tests, possible referral to disease management program, & health education needs.
- Contacts service coordinator to facilitate care transitions and sharing of plan of care for empaneled patients.

Community Health Worker (Clara Nunez, Walfred Lopez, Liliana Sunn)

The Community Health Worker is a trained community member who works with the PCMH team to coordinate care of high risk patients who have uncontrolled medical problems and are high utilizers of the system

Responsibilities

- Performs home visits as needed
- Perform baseline needs assessment and develop care plan with patient
- Assists with health promotion/harm reduction through education, skills building, support, and accompaniment
- Address basic social needs of patient with assistance of social work and case managers
- Assist with transitions of care (post ER/hospital admission)
- Accompany patient to appointments (medical, behavioral, social)
- Review medications monthly and provide counseling regarding adherence
- Assist with disease monitoring and health maintenance activities
- Communicate regularly with PCMH team on patient progress