Team Members and their roles:

Team Member	Supporting Competencies	Role
Physician/NP/PA	Physician – Direct Patient Care All categories in a supervisory role, except care coordination NP/PA – Direct Patient Care, Care Management, Disease Prevention and Management	• Prepares for, attends and participates in team meetings • Collaborates in developing team priorities and patient goals and care plans • Keeps problem list, medication list and patient care plan updated for team members • Approves orders and referrals for health maintenance Source: Cambridge Health Alliance (CHA)
Nurse/LPN	Nurse/LPN – Direct Patient Care Comprehensive Medication Management Care Coordination	• Prepares for, attends and participates in team meetings • Collaborates in developing team priorities and patient goals & care plans • Actively educates patients, sets goal, assists with self-management teaching & coaching • Administers medications and vaccines • Reconciles medications • Engages in chronic disease care management • Provides telephone advice and triage Source: CHA and see also, "Primary Care Nursing Role and Care Coordination: An Observational Study of Nursing Work in a Community Health Center" Daren R. Anderson, MD, Daniel St. Hilaire, Margaret Flinter, PhD, APRN
Medical Assistant	Direct Patient Care Care Coordination	• Prepares for, attends and participates in team meetings • Responsible for patient flow on day of visit: o Completes required pre-visit and visit preparation using the MA Standards of Care checklist o Reviews and completes any overdue health maintenance and open orders at every visit o Completes appropriate documentation of questionnaires o Completes follow up work after visit • Completes planned care team outreach assignments between visits • Maintains room stocking Source: CHA
Care Coordinator	Care Coordination	• Facilitates team meetings and participates in follow up. • Provides a bridge between patients and their healthcare team • Manages dashboard, prepares reports for team meetings and tracks results. • Provides support and coaching for patient /planned care teams

		• Works with team members to organize group visits for patients with chronic diseases Source: CHA
Clinical Pharmacist	Comprehensive Medication Management Disease Prevention and Management	• Medication reconciliation/ best possible medication list • Comprehensive medication management for patients with multiple chronic conditions using evidence-based guidelines: • Medication regimen optimization (e.g., most effective dosing, evidence-based treatment guidelines) Decrease medication waste (e.g., meds with no indication, meds patient not filling or taking) Prevent potential medication interactions or adverse events Improved medication adherence Cost-effective therapy • Medication monitoring/follow-up care coordination across multiple prescribers and pharmacies • Tailored medication action plans for patients • Pharmacy-focused population health analytics to inform and direct attention to populations in need of the aforementioned services Source: Michael Vessicchio and Marie Smith UConn School of Pharmacy
Community Health Worker	Care Coordination Patient Navigation	Connecticut law defines a Community Health Worker (CHW) as a “a public health outreach professional with an in-depth understanding of the experience, language, culture and socioeconomic needs of the community who: • serves as a liaison between individuals within the community and health care and social services providers to facilitate access to such services and health-related resources, improve the quality and cultural competence of the delivery of such services and address social determinants of health with a goal toward reducing racial, ethnic, gender and socioeconomic health disparities, and • increases health knowledge and self-sufficiency through a range of services including outreach, engagement, education, coaching, informal counseling, social support, advocacy, care coordination, research related to social determinants of health and basic screenings and assessments of any risks associated with social

		determinants of health" (CT SIM DRAFT Report of CHW Advisory Committee July 2018). American Public Health Association and CDC define a CHW as: "a **frontline public health worker** who is a trusted member of (and/or has an unusually close understanding of) the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health (PCP practice)/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."
Nutritionist	Direct Patient Care Disease Prevention and Management	• Assists patients with nutritional counseling • Facilitates and participates in group visits for patients living with chronic disease conditions • Provides expert consultation and supports the work of the primary care relationship and overall health of the patient. Source: CHA
Dietician	Direct Patient Care Disease Prevention and Management	A dietician works collaboratively with care members to evaluate and treat patients of all ages identified as possessing nutrition risk. Areas of responsibility include assessment of nutritional needs, provision of medical nutrition therapy and nutrition education. He or she will also serve as a resource to care team members to improve patient outcomes to physician staff and others. Source: Memorial Hermann Health System
Care Manager	Care Coordination Patient Navigation Population Health Management	Has responsibility for the care management of a patient in partnership with the patient's Primary Care Physician: • Coordinates services for patients (including coordinating care with specialists, across settings, and for conditions/diseases); • Prepares individualized patient health care plans (especially for patients with complex conditions); assess/routinely reassess patient care needs; • Effectively communicates with patients and all of the patient's specialists/healthcare providers;

		• Arranges medication management for patients using several medications; • Coordinates patient education programs/encourage self-management for patients with chronic conditions such as asthma or diabetes; • Helps patients navigate the system; and connects patients to community resources and social services Source: The Michigan Care Management Resource Center PCMH Care Managers: http://micmrc.org/
Social Worker	Direct Patient Care Care Coordination Patient Navigation Behavioral Health Integration	• Receives Complex Care Management referrals, assesses appropriateness for Complex Care, works with patient/caregiver/co-learner to develop goals, informs care team if inappropriate for complex care and makes recommendations for care plan in usual care team meetings • Provides mental health support, linkage to ongoing mental health treatment, direct care management including patient education, goal setting, self-management teaching & coaching for the care team's top 5% highest risk patients. • Assess readiness for transition back to usual care team or to more intensive level of care such as SNF Source: CHA
Patient Navigator	Patient Navigation	The Patient Care Navigator (PCN) has several different responsibilities when it comes to providing patients with access to quality care. The PCN coordinates patient-centered care which ensures that patients feel comfortable and understand their medical needs. Navigators are there to educate and guide patients in an efficient and simple manner. • Identify client needs in terms of access to healthcare, and any barriers to a treatment plan • Coordinating appointments with providers to ensure timely delivery of diagnostic and treatment services. • Facilitating the process for charity care for uninsured patients. • Maintaining communication with patients and the health care providers. • Ensuring that appropriate medical records are available at scheduled appointments. • Arranging transportation if needed. • Encourage patients to comply with treatment goals and routinely review their progress toward these goals. • Educate and explain to patients how to follow the prescribed care plan. Source: Medina Community Clinic, medinahealthcare.org

Population Health Specialist (PHS):	Population Health Management	A PHS works directly in collaboration with physician practices with opportunities for improved performance, and is a valuable resource in process improvement, providing practice staff assistance in quality reporting, and helping the practice to meet organizational quality and efficiency goals through optimizing practice work flow and focusing on patient engagement. Source: Steward Health Care
Health Coach	Disease Prevention and Management Care Coordination Patient Navigation	A Health Coach is responsible for a panel of patients and, in collaboration with other members of an integrated primary care team, helps patients meet their preventive, chronic and acute care needs. Specifically, a health coach's primary duties include: • Serve as an integral part of an outreach team either with care management or care transitions • Accompany patients to their appointments with the health care and social service systems • Coach patients to schedule their own health care appointments and transportation • Assist patients to arrange for food and housing • Assist patients in their chronic disease management as directed by a nurse clinical coordinator • Coach patients to better their communication with physicians, nurses, and other members of the health care system • Assist patients in meeting their goals • Perform other duties assigned by the care team to better the health and wellness of patients Source: Camden Coalition of Healthcare Providers
Medical Interpreter	Direct Patient Care	Medical interpreters provide medical translation services to non-English speakers. They help patients communicate with medical staff, doctors, and nurses.
Certified Diabetic Educator	Direct Patient Care Disease Prevention and Management	A certified diabetic educator functions within a health team; possesses comprehensive knowledge of and experience in diabetes prevention, prediabetes, and diabetes management; and provides community based nutritional and health assessments, nutritional care services, self-management education, insulin management and behavior change support for patients with type 2 diabetes. Source: see NCBDE

Certified Asthma Educator	Direct Patient Care Disease Prevention and Management	An expert in teaching, educating, and counseling individuals with asthma and their families in the knowledge and skills necessary to minimize the impact of asthma on their quality of life. Source: National Asthma Educator Certification Board. Certified Asthma Educator (AE-C) Candidate Handbook. http://www.naecb.org.Accessed May 4, 2013.
Behavioral Health Clinician (APRN, Psychologist, LCSW)	Behavioral Health Integration	Behavioral Health Clinicians (BHCs) work side-by-side with all members of the clinical care team (including primary care providers (PCPs) and nursing staff) to enhance preventive and clinical care for behavioral health problems. BHCs support the team in conducting behavioral health screenings and initial assessments, brief interventions, consultations, medication and episodic care. BHCs are trained in defined core competencies, such as ☐ Population care ☐ The culture of primary care ☐ Common chronic medical conditions ☐ Psychopharmacology, brief screening/assessment ☐ Brief intervention ☐ Brief documentation ☐ Team functioning Source: Behavioral Health Integration design group recommendations