FOCUS, GOALS AND WORKFLOW FOR EXTENDED CARE TEAM- DRAFT

Problem	Trigger	Other triggers	Schedule With	Focus	Goals	Follow up
DIABETES (DM)	A1c > 8		Dietician	• Nutritional Assessment • Diabetic- focused nutritional Education, including Meal Planning • Motivational Assistance to patient to set dietary, weight loss and exercise goals-[1]	• Patient demonstrates understanding of nutritional goals for diabetes • Patient sets and works towards diet, weight loss and exercise goals	• Ongoing follow up: Check in during diabetes monitoring visits and/or by phone/text/emails as needed and agreed upon by ECT • Participate in extended care team meetings to agree on ECT lead and for each, completion of HRA and share updates on sub-set of patients
			Clinical Pharmacy	• Medication Review with the patient[2] • Medication adherence assessment, identify and address barriers • Education to patients on their meds	• Patient demonstrates understanding of diabetes meds, other medications • Evidence of medication adherence through refill requests, F/u with team, other means • Provider is feeling supported in medication management	• Review med review results with provider; collaborate with med management with providers • Follow ups as requested by patient or provider • Participate in extended care team meetings to agree on ECT lead and for each, completion of HRA and share updates on sub-set of patients
			Behavioral Health	• Self-Management and barrier assessment • Social determinants needs assessment (PREPARE tool?);	• Patient's needs are identified and they are connected to necessary resources • Barriers to self-care area identified with	• Set specific follow up either directly with behavioral health, or to outside BH based on PHQ-9 level • Participate in extended care team meetings to agree on ECT

[1] Aim for 7% of body weight loss and Increased physical activity, targeting at least 150 minutes per week (moderate activity)

[2] Recommend chart review ahead of visit, then thorough review of medications with the patient and family

Problem	Trigger	Other triggers	Schedule With	Focus	Goals	Follow up
				connect with resources • PHQ9 and SUD assessments, if not completed • Assess Safety issues	counseling, motivational interviewing and goal setting	lead and for each, completion of HRA and share updates on sub-set of patients
	NEW DM Diagnosis (or new to practice)		Care Coordinator or Care Manager Dietician, Pharmacist, and Behavioralist	• Diabetic education - Understanding the disease - Diet, exercise, and how to manage - Care planning with the patient/family • Insulin training coordination • Arrange for referrals for DM screenings for eyes, other • Arrange regular monitoring visits for urine, foot care, immunizations, etc. • Social determinants needs assessment (PREPARE tool?); connect with resources	• Care Plan is completed and shared with patient/family • Patient is receiving timely diabetic screenings • Patient is demonstrating proficiency in insulin use	• Close the loop on initial referrals • CC/DM monitoring via a registry with pro-active outreach ahead of needed ongoing monitoring visits or testing • Follow-up visit every 2 weeks for first month – to demonstrate insulin proficiency and discuss care plan, questions, etc. • Follow-up visit or phone follow up monthly in months 2 and 3 • Participate in extended care team meetings to agree on ECT lead

Problem	Trigger	Other triggers	Schedule With	Focus	Goals	Follow up
				• PHQ9 and SUD assessments, if not completed		
HYPERTENSION (HPTN)	BP >140/90 (over 2 visits or with use of BP meds)	BMI- if >27[3]	Dietician	• Nutritional Assessment • Cardiovascular-focused nutritional education • Motivational assistance to set goals	• Patient demonstrates understanding of nutrition in care of HPTN, risks of obesity • Patient sets 1-3 goals with timeframe on diet, exercise, wt. loss	• Follow up either in person or by phone within one month to review goals set on diet, exercise, weight loss • Ongoing follow up: Check in during routine monitoring visits and/or by phone/text/emails • Participate in extended care team meetings to agree on ECT lead and for each, completion of HRA and share updates on sub-set of patients
			Clinical Pharmacy	• Medication Review with the patient[4] • Medication adherence assessment, identify and address barriers • Education to patients on their meds	• Patient demonstrates understanding of HPTN meds, other medications, their interactions • Evidence of medication adherence through refill requests, F/u with team, other	• Review med review results with provider; collaborate with med management with providers • Participate in patient care plans • Follow ups as requested by patient or provider

[3] Some articles target those with BMI > 35 initially, although addressing at lower but elevated BMI would allow for earlier proactive engagement
[4] Recommend chart review ahead of visit, then thorough review of medications with the patient and family

Problem	Trigger	Other triggers	Schedule With	Focus	Goals	Follow up
	BP >140/90 (over 2 visits or with use of BP meds				• Provider is feeling supported in medication management	• Determine if pharmacist follows to make dosage and med adjustments[5] • Participate in extended care team meetings to agree on ECT lead and for each and share updates on sub-set of patients
		MH diagnosis and/or PHQ9 > 9	Behavioral Health	• Self-Management and Care Planning, goal setting based on PHQ-9 results • Social determinants needs assessment; connect with resources • PHQ9 and SUD assessments, if not completed; • Assess Safety issues	• Patient's needs are identified and they are connected to necessary resources • Barriers to self-care area identified with counseling, motivational interviewing and goal setting	• Set specific follow up either directly with behavioral health, or to outside BH based on PHQ-9 level • Participate in extended care team meetings to agree on ECT lead and for each and share updates on sub-set of patients
DEPRESSION	PHQ9 >9		Behavioral Health	• Assess Safety issues • Self-Management and Care Planning and goal setting • SUD assessments, if not completed; • Social determinants needs assessment; connect with community resources	• Patient is not at risk for harm to self or others • Patient's needs are identified and they are connected to necessary resources • Barriers to self-care area identified with counseling, motivational interviewing and goal setting	• PHQ-9 between 9 – 13, follow-up monthly with phone or face to face visit, brief interventions, behavioral activation, medication review and goal setting • PHQ-9 between 14 – 19, follow-up every 2 weeks until response (50% decrease from baseline), brief interventions, behavioral activation, medication review, and goal setting

[5] Evidence in the literature that demonstrates that if pharmacist/PharmD can adjust meds, greater improvement in BP control

Problem	Trigger	Other triggers	Schedule With	Focus	Goals	Follow up
				• Medication review and side effect management if needed		• PHQ-9 between 20 – 27, follow-up weekly and/or consider BH referral for counseling or other traditional BH therapies • Participate in extended care team meetings to agree on ECT lead and for each and share updates on sub-set of patients
		BMI >27	Dietician	• Nutritional Assessment • Nutritional education, focus on role depression has on eating • Motivational assistance to set goals on food choices; weight loss; exercise	• Patient demonstrates understanding of nutritional choices in care of depression • Patient sets 1-3 goals with timeframe on diet, exercise, wt. loss	• Initial Follow up either in person or by phone • Ongoing follow up: Check in during routine monitoring visits and/or by phone/text/emails • Participate in extended care team meetings to agree on ECT lead and for each and share updates on sub-set of patients
		Also has HPTN and/or Diabetes (if not already assessed recently - last 3-6 months)	Clinical Pharmacy	• Medication Review • Medication adjustment & management recommendation for both the provider and the patients s • Education to patients on their meds	• Patient demonstrates understanding of all their medications, interactions • Evidence of medication adherence through refill requests, F/u with team, other • Provider is feeling supported in medication management	• Review results with provider • Participate in extended care team meetings to agree on ECT lead and for each and share updates on sub-set of patients

Expanded Care team needs to:

- Be in consultation with the primary provider and primary care team (PCP, MA, RN etc.)
- Respect and value each team member's contribution
- Work collaboratively for hand-offs and follows-ups with patients and extended care team
- Participate in planning visits
- Participate in team huddles and panel management as available
- Define overall goals and aims of the team (e.g. 80% of patients with diabetes will have at least one ECT visits and will have A1c completed twice in 12 months.)

Overall Role of Dietician

- Nutritional Counseling targeted to the condition/problem
- Motivational interviewing and goal setting
- Nutritional Education
- Attends huddles as able and ECT meetings

Overall Role of Pharmacist/PharmD

- Medication Management for particular conditions
- Education to patients on use of their medications
- Medication Safety and Drug Interaction Issues
- Resource to prescribers
- Attends huddles as able and ECT meetings

Overall Role of Behaviorist

- Behavioral Health assessments to understand needs/appropriate levels of care
- Brief interventions and follow-up interventions as needed
- Any needed safety and care planning for behavioral health issues
- Needs assessment focused on Social determinants and the condition/problem
- Provides behavioral health support and connecting to resources in the clinic and in the community

Role of Care Coordinator

- General coordination of services needed for medical, behavioral and social
- Outreach and reminders for appointments, preventive services, disease management

- Follow-ups for lab and x-ray as well as referrals
- Manages ECT and care team dashboard; preparing reports on patient results and processes

Role of Complex Care Manager

- Lead on ECT for high complex patients – should be managing top 5% of patients
- Assesses patient's overall assessment of health risk needs (review and completion of CHRA as needed)
- Co-create a plan of care with patient to address their gaps
- Review objective findings, lab results, med review with patient
- Set self-management goals with patient
- Discuss barriers to care and plans to address
- Transition back to usual care/maintenance when patient is ready

Role of Medical Assistant on PCP team

- Attend and participates in huddles
- Maintains room stocking and physical prep for patient appointment
- Responsible for patient flow of the day
    - Completes pre-visit plan/ visit prep
    - Reviews and completes any SDOs
    - Completed appropriate screenings and documentations
    - Completes other "tasks" (in Next Gen) between visits

Role of Primary Care Provider

- Attends and participates in team meetings and huddles
- Diagnosis and treatment of patients per clinical guidelines
- Collaborates in patient goals and care plans
- Keeps problem list, medications list and care plan updated at clinic visits
- Approves orders and referrals for health maintenance