**Primary Care Team Members and Their Roles**

**Provider**

* Prepares for, attends and participates in team meetings and huddle(s)
* Contributes to the development of team priorities, patient goals, and care plans
* Maintains problem list, medication list and patient care plan for team members
* Approves orders and referrals for health maintenance

**Nurse**

* Prepares for, attends and participates in team meetings and huddle(s)
* Collaborates in developing team priorities and patient goals and care plans
* Participates in patient education, goal setting, self-management teaching & coaching
* Provides medication reconciliation/education and chronic disease care management

**Medical Assistant**

* Prepares for, attends and participates in team meetings and huddle(s)
* Responsible for patient flow on day of visit:
  + Completes required pre-visit and visit preparation using the MA Standards of Care checklist
  + Reviews and completes any overdue health maintenance and open orders at every visit
  + Completes appropriate documentation of questionnaires
  + Completes follow up work after visit
* Completes planned care team outreach assignments between visits
* Maintains room stocking

**Medical Receptionist**

* Prepares for, attends and participates in team meetings and huddle(s)
* Completes team outreach assignments including but not limited to scheduling appointments and outreaching to patients by phone and mail

**Planned Care Coordinator**

* Facilitates team meetings and participates in follow up
* Acts as a bride between patients and their healthcare team
* Prepares reports for team meetings and tracks results
* Provides support and coaching for patient/planned care teams
* Assists in organizing group visits for patients with chronic diseases

**Clinical Pharmacist**

* Attends team meetings for chronic disease management and helps to develop patient care plans
* Collaborates with providers on medication management
* Reviews patient medical record and health status and makes suggestions to other team members regarding medication management
* Conducts medication review with patients, makes recommendations for medication adjustments and educates patients about use of their medications

**Volunteer Health Advisor**

* Assists in outreach calls for health maintenance issues and chronic disease management
* Participates in peer-led group visits and community-based health fairs

**Mental Health Specialist**

* Assists patients with identifying mental health resources
* Provides counseling and facilitates support groups for patients living with chronic conditions
* Provides expert consultation and supports the work of the primary care teams

**Resource Specialist**

* Works closely with patients and their care teams to facilitate community connections and access a range of psychosocial resources
* Performs a wide range of functions which safely, effectively, and efficiently support patients to address their personalized health goals
* Helps remove barriers to social supports that facilitate patient health and safety

**Nutritionist**

* Assists patients with nutritional counseling
* Helps conduct group visits for patients living with chronic disease conditions
* Supports the work of the PCP in enhancing the overall health of the patient

**Complex Care Manager - Nursing**

* Receives Complex Care Management referrals, assesses appropriateness for Complex Care services, works with patient/caregiver/co-learner to develop goals and makes care plan recommendations
* Provides clinical support and care management services including patient education, goal setting, self-management education and coaching for high risk patients
* Provides guidance during transitions of care between the patient’s primary care team and other settings of care
* Works in coordination with Complex Care Manager – Social Work

**Complex Care Manager - Social Work**

* Receives Complex Care Management referrals, assesses appropriateness for Complex Care services, works with patient/caregiver/co-learner to develop goals and makes care plan recommendations
* Provides mental health support, linkage to ongoing mental health treatment, direct care management including patient education, goal setting, self-management teaching and coaching for high risk patients
* Provides guidance during transitions of care between the patient’s primary care team and other settings of care

**Source**: http://www.integration.samhsa.gov/workforce/team-members/Cambridge\_health\_alliance\_team-based\_care\_toolkit.pdf