Sample Pathway: CHF

Patient engages in self-care and provides remote monitoring values in the patient portal

In-person visit with provider for consultation

- RN or Pharm D review medication adherence with patients. Ensure patient has a scale and BP monitor at home, and knows to provide weekly report on weight and BP
- CHW or MA educates patient on portal and video technology
- Next appointment booked via telehealth

Telemedicine visit with clinician , RN, Pham D every 3 months for follow up

Labs drawn at home or CHC every 3 months before Telemed appointment

Medications delivered to the home

6 months remote check in with provider to review adherence, weight and lab results

If in-person or E-consult required, provider makes referral

In-person visit with provider for full exam

Throughout the year, care team re-evaluates patient's care outcomes, including adherence to medication, weight, BP averages, and repeated testing if needed.

Clinical Pathways for Virtual Care & Hybrid Models

Virtual and hybrid models of care create opportunities for a variety of patient touchpoints over time.

1. **In-Person Visits**
   In-person visits at health center
2. **Telemedicine Visits**
   Billable phone or video visit
3. **Phone Check-Ins**
   Important touchpoint by a non-billable provider
4. **Home/Community-Based Care & Monitoring**
   Home visits, remote patient monitoring