Team-Based Care and Practice Organization (TC)

The practice provides continuity of care; communicates its roles and responsibilities to patients/families/caregivers; and organizes and trains staff to work to the top of their license to provide patient-centered care as part of the medical home.

Competency A: The Practice's Organization. The practice commits to transforming the practice into a sustainable patient-centered practice. Care team members have the knowledge and training necessary to perform their roles, which are defined by the practice's organizational structure.

TC 01 (Core) PCMH Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the transformation and ongoing patient-centered care.	
GUIDANCE	**EVIDENCE**
The practice identifies the clinician lead *and* the transformation manager (the person leading the PCMH transformation). This may be the same person. Identification of the lead/manager includes: • Name. • Credentials. • Roles/responsibilities. Practice transformation is successful when there is support from a clinician lead. The lead's support sets the tone for how the practice will function as a medical home. The intent is to ensure that the practice has clinical and operational support and resources to implement the PCMH model.	• **Details about the clinician lead** ***AND*** • **Details about the PCMH manager**
TC 02 (Core) Structure and Staff Responsibilities: Defines the practice's organizational structure and staff responsibilities/skills to support key practice functions.	
GUIDANCE	**EVIDENCE**
The practice provides an overview of practice staff roles and an outline of duties staff will execute as part of the medical home and explains how it will support and train staff to complete these duties. Structured tasks and stated staff responsibilities enable a practice to ensure that staff are providing efficient medical care and have training for the skills necessary to support the functions of the medical home.	• **Staff structure overview** ***AND*** • **Description of staff roles, skills and responsibilities**

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TC Competency A: Practice Organization.

TC 03 (1 Credit) External PCMH Collaborations: The practice is involved in external PCMH-oriented collaborative activities.	
GUIDANCE	**EVIDENCE**
The practice demonstrates that it is involved in at least one state or federal initiative (e.g., CPC+, care management learning collaborative led by the state) or population-based care learning collaborative. Participating in an ACO or clinically integrated network would not meet this requirement. Participating in ongoing collaboration with other practices or entities allows the practice's staff to learn and share best practices with their peers.	• **Description of involvement in external collaborative activity**
TC 04 (2 Credits) Patients/Families/Caregivers Involvement in Governance: Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.	
GUIDANCE	**EVIDENCE**
The practice either: • Creates a role for patients/families/caregivers in the practice's governance structure or Board of Directors, ***or*** • Organizes a Patient and Family Advisory Council (PFAC) (stakeholder committee). The practice specifies: • How patients/families/caregivers are selected for participation. • The patient/family/caregivers' role. • Frequency of meetings. Patients are more than consumers in their care, they are partners. Involving patients/families/caregivers in the practice's governance can provide additional input to improve patient services and help engage patients in the care they receive from the practice.	• **Documented process** ***AND*** • **Evidence of implementation**
TC 05 (2 Credits) Certified EHR System: The practice uses a certified electronic health record technology (CEHRT) system.	
GUIDANCE	**EVIDENCE**
The practice enters the names of the electronic systems it implements. Only systems the practice is actively using should be entered. Use of an EHR can increase productivity, reduce paperwork and enable the practice to provide patient care more efficiently. https://chpl.healthit.gov/#/search	• **CERHT name**

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Competency B: Team Communication. Communication among staff is organized to ensure that patient care is coordinated, safe and effective.

TC 06 (Core) Individual Patient Care Meetings/Communication: Has regular patient care team meetings or a structured communication process focused on individual patient care.	
GUIDANCE	**EVIDENCE**
The practice has a structured communication process or holds regular care-team meetings (such as huddles) for sharing patient information, care needs, concerns of the day and other information that encourages efficient patient care and practice workflow. A structured communication process is focused on individual patient care and may include tasks or messages in the medical record, regular email exchanges or notes on the schedule about a patient and the roles of the clinician or team leader and others in the communication process. Consistent care-team meetings allow staff to anticipate the needs of all patients and provide a forum for staff to communicate about daily patient care needs.	• **Documented process** ***AND*** • **Evidence of implementation**  Documented process only
TC 07 (Core) Staff Involvement in Quality Improvement: Involves care team staff in the practice's performance evaluation and quality improvement activities.	
GUIDANCE	**EVIDENCE**
The practice describes staff roles and involvement in the performance evaluation and improvement activities. Improving quality outcomes involves all members of the practice staff and care team. Engaging the team in review and evaluation of the practice's performance is important to identifying opportunities for improvement and developing meaningful improvement activities.	• **Documented process** ***AND*** • **Evidence of implementation** 
TC 08 (2 Credits) Behavioral Health Care Manager: Has at least one care manager qualified to identify and coordinate behavioral health needs.	
GUIDANCE	**EVIDENCE**
The practice identifies the behavioral healthcare manager and provides their qualifications. The care manager has the training to support behavioral health needs in the primary care office and coordinates referrals to specialty behavioral health services outside the practice. The practice demonstrates that it is working to provide meaningful behavioral health services to its patients by employing a care manager who is qualified to address patients' behavioral health needs.	• **Identified behavioral healthcare manager** 

Competency C: Medical Home Responsibilities. The practice defines and communicates its role and the patient's role in the medical home model of care.

TC 09 (Core) Medical Home Information: Has a process for informing patients/families/caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information.	
GUIDANCE	**EVIDENCE**
The practice has a process for informing and providing patients/families/caregivers with information about its role and responsibilities at the start of care and throughout the care trajectory. Reminding patients periodically ensures that they have ready access to essential information and available resources. The practice is encouraged to provide the information in multiple formats, to accommodate patient preference and language needs. At minimum, materials include: • Names and phone numbers of practice points of contact. • Instructions for reaching the practice after office hours. • A list of services offered by the practice. • How the practice uses evidence-based care. • A list of resources for patient education and self-management support. The practice explains to patients the importance of maintaining comprehensive information about their health care. It describes how and where (e.g., specialty practice, primary care office, ED) to access the care they need.	• **Documented process** ***AND*** • **Evidence of implementation**

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