Team Based Care and Practice Organization

(TC- Competency A, B and C)

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Community Health Solutions

Team-Based Care and Practice Organization (TC)

The practice provides continuity of care, communicates roles and responsibilities of the medical home to patients/families/ caregivers, and organizes and trains staff to work to the top of their license and provide effective team-based care.

TC – Competency A

The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
TC 01* (Core)	Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.	*Details about the clinician lead **AND** Details about the PCMH manager*	*No equivalent*
TC 02 (Core)	Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions.	*Staff structure overview **AND** Description of staff roles, skills and responsibilities*	*2D1-2; 2D4-8 support TC02.*

TC – Competency A

The practice is committed to transforming the practice into a sustainable medical home. Members of the care team serve specific roles as defined by the practice's organizational structure and are equipped with the knowledge and training necessary to perform those functions.

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
TC 03* (1 Credit)	The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).	*Description of involvement in external collaborative activity*	*No equivalent*
TC 04* (2 Credits)	Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.	*Documented process* ***AND*** *Evidence of implementation*	*No equivalent*
TC 05 (2 Credits)	The practice uses a certified electronic health record technology system (CEHRT).	*Certified Electronic Health Records System (EHR) name*	*6G1, 6G2*

Note: TC 05 was revised 9.30.17

TC 01 (Core)

Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.

- The practice identifies the clinician lead *and* the transformation manager (the person leading the PCMH transformation). This may be the same person. The practice provides details including the person's name, credentials and roles/responsibilities.
- PCMH transformation is successful when there is support from a clinician lead. Their support sets the tone for how the practice will function as a medical home. The intent is to ensure that the practice has clinician and leadership support to implement the PCMH model and to acknowledge the role of staff in the practice's everyday operations.

TC 02 (Core)

Defines practice organizational structure and staff responsibilities/skills to support key PCMH functions.

- The practice provides an overview of practice staff; an outline of duties the staff are expected to execute as part of the medical home; and how the practice 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 medical home functions.

TC 03 (1 Credit)

The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).

- The practice demonstrates involvement in at least one state or federal initiative (e.g., CPC+, care management learning collaborative led by the state, two-way data exchange with a local health information exchange; population-based care or learning collaborative) or participates in a health information exchange.
- The practice recognizes the value of participation in external collaboration and has the support of leadership to implement collaborative activities.

TC 04 (2 Credits)

Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.

- The practice demonstrates involvement by:
  - Giving patients/families/caregivers a role in the practice's governance structure or Board of Directors.
  - Organizing a patient and family advisory council (i.e., stakeholder committee).
- At a minimum, the process specifies how patients/ families/caregivers are selected for participation, their role and 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.

TC 05 (2 Credits)

Certified EHR System: The practice uses a certified electronic health record technology system (CEHRT).

- The practice enters the name of the electronic system(s) implemented in the practice. 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

Note: TC 05 was revised 9.30.17

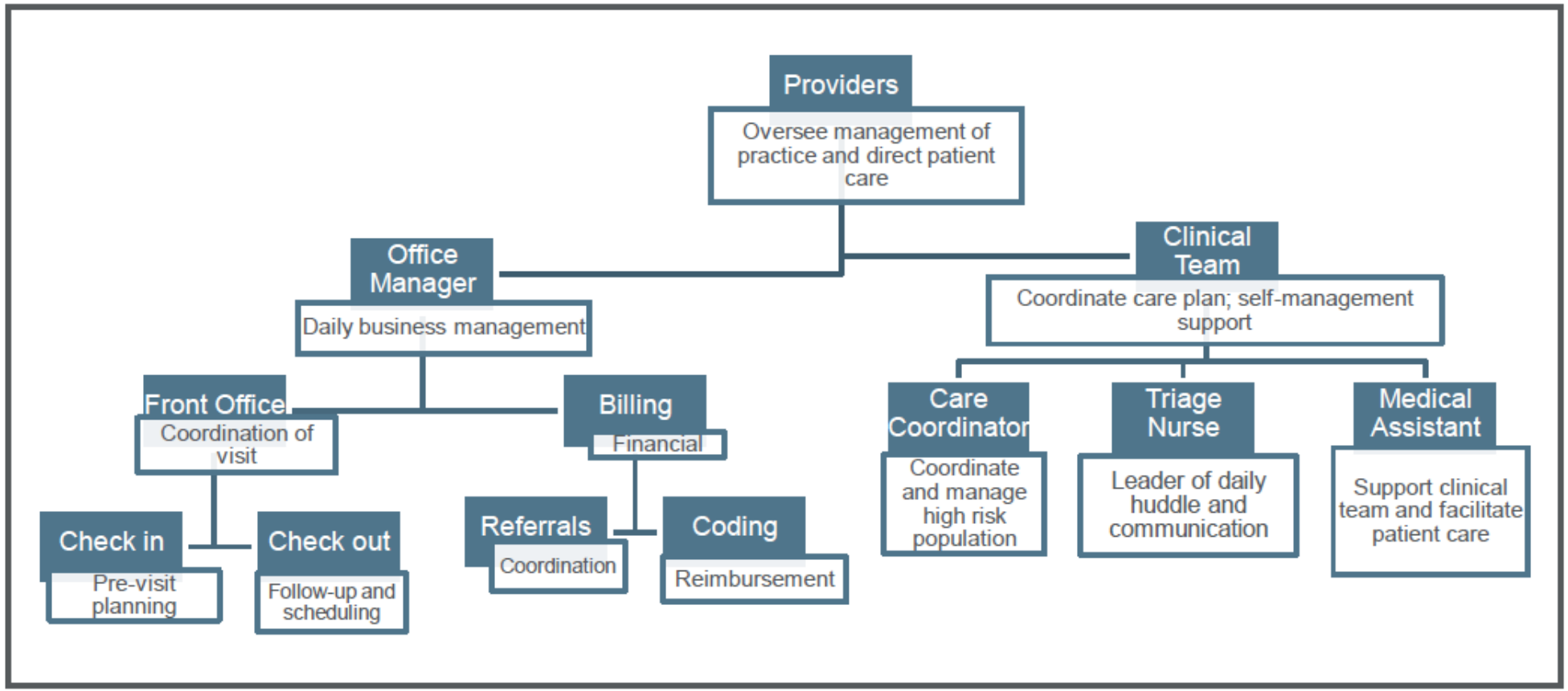
Team-Based Care and Practice Organization

TC 02: Example

Health Information Technologist	• Creates and generates reports and dashboards from the EMR. • Assists in the coordination of UDS, Meaningful Use, and PCMH measures and metrics. • Active member on QI committee to improve processes and meet UDS goals.
Medical Records and Privacy Coordinator	• Ensures patient information is added to chart in a timely fashion • Provides confidential patient information counseling to staff. • Processes event reports in order to improve processes within the organization.
AmeriCorps – PCMH and Community Wellness Coordinator	• Works with after school programs to educate students on healthy lifestyles. • Assists with PCMH efforts by educating staff; presenting survey questions; assisting Care Manager in recall lists. • Coordinating employee wellness activities.
Help Team Member	• Assists patients in the healthcare marketplace. • Utilizes resources in the community. • Assists with outreach services.
Spanish Interpreter	• Assists patients during appointments with understanding provider and paperwork. • Acts as a liaison for staff. • Provides cultural support for patients.
Registration Professional	• Provides patients the necessary paperwork for their appointment and per the organization. • Assists with the Healthy Neighbor Plan (sliding fee scale) application. • Confirms patient demographics, insurance, and completes check-in or patients; communicates with patients about payments.

Structure and Staff Responsibilities

TC 02: Example



External PCMH Collaborations

TC 03: Example

TC 03

Primary Care Practice participates in the Health Center Controlled Network of NY in collaboration with CHCANYS. Our clinical measure performance data is shared with the other 42 participating health centers in a data warehouse called CPCI or Azara DRVS. Please see below for full descriptions.

STATEWIDE HEALTH IT

Health Center Controlled Network of NY

HEALTH CENTER NETWORK
NEW YORK
CARING FOR OUR COMMUNITIES TOGETHER

The Health Center Network of New York (HCNNY) is a federally designated health center controlled network dedicated to ensuring that its members have the ability to effectively leverage information technology to provide high quality, cost effective, patient focused primary health care to the communities they serve. HCNNY was founded in 2007 by six (6) health centers and the Community Health Care Association of New York State (CHCANYS), and today is comprised of eight member health centers and CHCANYS. As of July 1, 2013, HCNNY is operating as an independent 501(c)(3) organization.

HCNNY provides resources for its members for electronic health record implementation and on-going optimization, customized training, workflow development, and reporting to position members to take advantage of payment reform initiatives, recognition opportunities and available incentives. The Network is governed by its board of directors comprised of executives from member centers, and operational efforts are led by clinical, finance and IT committees that meet regularly to identify priorities and share best practices surrounding common challenges. Quality improvement efforts are enhanced by a data warehouse containing demographic and clinical information on the nearly 260,000 patients served network-wide.

Team-Based Care and Practice Organization

TC 04: Example

BY-LAWS
Revised November 2015, Approved by the Board of Directors 11/18/2015

Article 1. NAME AND LOCATION

b. User Members. The majority (51%) of Directors shall be individuals who are served by the Corporation and who, as a group, represent the individuals being served by the Corporation in terms of demographic factors such as race, ethnicity, and gender. User members should utilize the Corporation as their principal source of primary care and

4.2 Duties and Responsibilities.

The Board of Directors shall have specific responsibility for:

4.4 Annual Election of Directors/Board Members.

The Board of Directors shall nominate, at least thirty (30) days prior to the Annual Meeting, a slate of qualified candidates to replace Directors whose terms are set to expire and/or to fill vacant positions. The slate of candidates shall be included with the notice of the Annual Meeting. At the Annual Meeting, any member of the Board of Directors may nominate other candidates for the available Director positions, provided that the nominees agree to serve if elected. At the conclusion of

5.2 Regular Meetings.

The Board of Directors shall have regular meetings at least monthly to accomplish the business of the Corporation. The schedule of regular meetings shall be determined by the President. Notice of such meetings shall be given by any reasonable means, including electronic mail.

d. Quality Assurance Committee. The Quality Assurance Committee shall be responsible for monitoring and making recommendations for the implementation and improvement of the quality assurance/quality improvement program of the Corporation. In addition to Board member

Frequently Asked Questions (TC-A)

Can an organizational chart be used as the only documentation provided? If not, can you please explain what exactly is needed for each?
TC 02

If the organizational chart provides details about the care team member roles and responsibilities and how the care team members work together to deliver team-based care, it could be used. The intent of this criteria is to ensure that the practice has a structure and defined roles for practice staff to facilitate optimal, team-based, coordinated care and enable staff to work at the top of their licenses.

Tips and Tricks (TC 02)

- Include job descriptions/roles for all team members who are core to PCMH functions *(e.g. anyone who is mentioned as completing a task or responsible for carrying out something in your documented processes)*
- Define care team roles and how team based care is sustained
- These descriptions should include your definition of how you train, including frequency (annual, 90 day new hire, quarterly)

TC – Competency B

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

Criteria	Criteria Description	Required Evidence	Crosswalk to 2014
TC 06 (Core)	Has regular patient care team meetings or a structured communication process focused on individual patient care.	*Documented process **AND** Evidence of implementation*	*2D3 (The Practice Team)*
TC 07 (Core)	Involves care team staff in the practice's performance evaluation and quality improvement activities.	*Documented process **AND** Evidence of implementation*	*2D9 (The Practice Team)*
TC 08* (2 Credits)	Has at least one care manager qualified to identify and coordinate behavioral health needs.	*Identified behavioral healthcare manager*	*No equivalent*

Note: TC 08 was revised 9.30.17

TC 06 (Core)

Has regular patient care team meetings or a structured communication process focused on individual patient care.

- The practice maintains a structured communication process, sharing information about patients, care needs, concerns for the day and other information that encourages efficient patient care and practice flow. The process may include tasks or messages in the medical record, regular e-mail 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 (such as huddles) provide a forum for practice staff to communicate about upcoming appointments, patient needs and workflow updates.

TC 07 (Core)

Involves care team staff in the practice's performance evaluation and quality improvement activities.

- The documented process for quality improvement activities includes a description of staff roles and staff involvement in the performance evaluation and improvement process.
- Improving quality outcomes involves all members of the practice staff and care team. Engaging the team to review and evaluate the practice's performance is important to identifying opportunities for improvement and developing meaningful improvement activities.

TC 08 (2 Credits)

Has at least one care manager qualified to identify and coordinate behavioral health needs.

- The practice identifies the behavioral healthcare manager and provides their qualifications.* The care manager has the training to support behavioral healthcare 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 healthcare services to its patients by employing a care manager who is qualified to address patients' behavioral health needs.

**Note: TC 08 was revised 9.30.17 (removed requirement about having the training and licensure to provide psychotherapeutic treatment directly*

Team-Based Care and Practice Organization

TC 06: Example

SUBJECT: Daily Huddles

PURPOSE: Each primary care site at conducts a structured team meeting at least daily. The brief "huddle" is scheduled by the site manager or a designated staff member to occur at the same time each day. The purpose of these meetings is to proactively anticipate and plan actions based on patient need and available resources.

RESPONSIBILITY: It is the responsibility of the entire team to attend the meetings and ensure the outcomes/decisions made at the meetings are carried out. It is the responsibility of the site manager to insure that the huddles are conducted daily and appropriate documentation is completed.

PROCEDURE: The care team meets at the same time daily to efficiently and effectively plan the day and to discuss known or potential patient needs. The team:

- Reviews the daily schedule
- Focuses on those patients with known chronic illnesses
- Monitors the need for health maintenance and/ or preventive care services
- Arranges for any special services that may be needed
- Provides any follow up discussion related to care provided on the previous day
- Discusses needs specific to the team's daily workflow including staff flexibility, special patient needs, sick calls, contingency plans, and proactive planning for the next day
- Documents on a Daily Huddle form (filed in a binder at the site for a minimum of 3 months)

TC 06 – Team Huddles Policy

Example Team Huddles Procedure (for 2011 PCMH Standards and Guidelines) from MGMA Policies & Procedures Guidebook

Team Huddles

The Practice uses a team to provide a range of patient care services by having regular team meetings or a structured communication process.

POLICY It is the policy of the Practice to recognize that structured and regular meetings of the teams involved in patient care services are vital to providing patient-centered care. These meetings, referred to as "huddles," are also important to facilitate communication between structured, regular meetings through more frequent, informal meetings of each care team. A huddle brings the schedule to life, allowing the care team to be actively involved with the schedule, and enables the Practice to embrace the adage, "when you can predict it, you can manage it."

PROCEDURE To promote excellent communication and coordination among the members of the care team, informal meetings of the physician, nurse, health coach, medical assistant, and scheduler who may work in a care team should occur at least daily. These meetings are more effective when held immediately prior to a clinic session (e.g., 7:20 a.m. and 12:50 p.m.) so the team members can jointly review and forecast resolutions to immediate concerns, such as the day's schedule and assessment of yesterday's mistakes.

The protocol for the huddle is:

Team members: Provider, nurse, health coach, medical assistant, and scheduler

Place: Team pod

Time: The huddle may be held in the morning before the day's clinic starts (e.g., 7:20 a.m.) or on the previous afternoon (e.g. 4:50 p.m.). Alternately, the team may choose to huddle more than twice a day (e.g., 7:20 a.m., 12:50 p.m., and 4:40 p.m.), concentrating on the patients soon to arrive.

Participants: Flexibility is encouraged to assure that the information and planning needs of the providers and staff are met. Participants can include the physician and his or her nurse, a medical assistant who assists them, the health coach, and a scheduler (or someone who can communicate with the scheduler).

Duration: A short meeting of generally less than 10 minutes to review the upcoming day's appointment schedule.

Content: The huddle focuses on the needs of each patient scheduled that day. Content can include:

Team-Based Care and Practice Organization

TC 06: Example

Clinical Measures Guide

❖ Total Patients Scheduled: 24 ❖ # Previous Follow Up N/S: 5			- Colorectal/FIT - A1c/Ft Exm/Opht - HTN - Depression Scr -BMI	- Annual WC - All Imm's by 2y - Asthma - Oral Health -BMI Counsel 2	- Mammo Scrn - Cervical/Pap - Birth Control - STD Screens	- LABS - REFERRALS - IMAGING - ER RECORDS
Time	**Chief Complaint**	**Age or/and M/F**	**GENERAL MEDICINE**	**PEDIATRIC**	**WOMENS HEALTH**	**RECORDS/ RESULTS**
800a	• Lab results	• 59yrs/F	•			
900a	• 9:00am PE • 9:10am Cough • 9:20am F/u H. pylori • 9:50am Fatigue/Blood	• 48yrs male • 37yrs/F • 51yrs./M • 27yrs/F	• Labs needed			
1000a	• 10:10 Lab results • 10:20 Lab results • 10:30 MRI results	• 25yrs./F • 42yrs/M				
1100a	• Results. • New PE • Physical.	• 27yrs. female • 35yr female • Male 32yr.	• Mammogram		•	

TC 06 – Documentation Example (from 2014 1G2)

Patient #	Reason for Encounter	Chief Complaint	General Notes	Date Created	Sign Off User	Date Signed
[redacted]	Care Team Huddle	discussion regarding anger management referrals	Discussed with care manager types of outside resources available for anger management. FSGNO- has an anger management program.	12/1/2011	CATHERIN	12/1/2011
	Care Team Huddle	PAP-medication for client	Discussed with care manager the status of client's Risperdal medication she recieves through the PAP program, she will need a refill 1/1/2012.	12/1/2011	CATHERIN	12/1/2011
	Care Team Huddle	Daily Team Huddle: medication	Discussed with assistant care manager issues client has with her taking her medication and exploration of tackling these barriers. 1. Bring medication to each therapy session and doctor visit. 2. Put schedule on refrigerator. Enlist the help of daughter and grandson.	12/5/2011	CATHERIN	12/5/2011
	Care Team Huddle	Daily Huddle: New client to SW.	SW discussed with assistant care manager, my first visit plan with client. History taking and case conceptualization.	12/5/2011	CATHERIN	12/5/2011
	Care Team Huddle	TCC- No show	NO Show- Client will be called and rescheduled to 12/12 at 11:00 am.	12/5/2011	CATHERIN	12/5/2011
	Care Team Huddle	Daily Huddle: getting to her BH appts.	Explored with ass.care manager the ways we addressed client' s barriers getting to her BH appt. Call before appt. and client writes appt. down in her book.	12/5/2011	CATHERIN	12/5/2011
	Care Team Huddle	TCC- 3rd NO Show- request for letter	Letter will be sent to client. 3rd NO Show.	12/5/2011	CATHERIN	12/5/2011
	Care Team Huddle	Daily Huddle: consultation with assistant care manager regarding client's medication		12/5/2011	CATHERIN	12/5/2011
	Care Team Huddle	TCC- No Show	Left message for client, rescheduled for 12/12 at 10:00. Medication not in yet, I hope by 12/12.	12/5/2011	CATHERIN	12/5/2011

TC 06– Example Huddle Sheet

Huddle Sheet

- What can we proactively anticipate and plan for in our work day/week? At the beginning of the day, hold a review of the day, review of the coming week and review of the next week. Frequency of daily review is dependent on the situation, but a mid-day review is also helpful.
- This worksheet can be modified to add more detail to the content and purpose of the huddles.

Huddle Sheet

Practice: _____ Date: _____

Aim: Enable the practice to proactively anticipate and plan actions based on patient need and available resources, and contingency planning.

Follow-ups from Yesterday
"Heads up" for Today: (include special patient needs, sick calls, staff flexibility, contingency plans)
Meetings:
Review of Tomorrow and Proactive Planning
Meetings:

28

Team-Based Care and Practice Organization

TC 07: Example

Date: 01/01/2017

SBCHC Staff Process Improvement (PI) Committee

The SBCHC Staff Process Improvement Committee will consist of SBCHC staff from a variety of departments. The Staff PI Committee will meet monthly to review event reports, department metrics, satisfaction survey results, and comment cards. The Staff PI Committee will support quality improvement and risk management work through discussion of trends, identification of improvement needs, and development of improvement cycles to address negative trends. The Staff PI Committee is led by the COO. Staff PI Committee members will support the integrity of QI and risk management work that is done within their work departments.

SBCHC Medical Quality Improvement Team

The Medical Quality Improvement Team will consist of at least two staff Registered Nurses, the COO, the electronic health record superuser and the Executive Assistant. This Team will meet every other week to focus on medical quality of care data and discuss and plan for system changes to make improvements to medical data. It is anticipated this Team will transition in 2017 to focus on overall Health Center clinical measures. The Team's work is shared with the medical staff at monthly meetings and with the staff PI committee.

TC 07 – Sample Team Practice Performance Evaluation and Quality Improvement Documentation

Evaluate and Improve

Time to Complete: Ongoing
Difficulty: Easy - needs ongoing support
Outcome: Feedback and a plan for improvement

Steps

- Discuss at staff meetings
- Get patient feedback
- Analyze results and create improvement plan

What You'll Need

- Staff meetings
- Patient survey
- Time to analyze feedback, make an improvement plan and implement it
- Decision-making authority

Resources
Use this survey (1-page Word document; About downloading files) to get patient feedback.

Where to go for Help

If you need help conducting the patient survey, consider bringing in a consultant. FP Assist is AAFP's clearinghouse for consultants.

When you're ready to offer another service through your secure portal, watch the AAFP video "Improve the Patient Experience" for an introduction to e-visits.

Steps

Discuss at staff meetings

At each regular staff meeting, ask how online appointment scheduling is working and what patients have said about setting appointments with it.

Get patient feedback

Download this survey (1-page Word document; About downloading files) or develop your own survey, and use it to learn what patients think about your online appointment scheduling system. This could be done as part of your annual patient survey.

Analyze results and create an improvement plan

Analyze feedback about the system, then discuss as a team. Create a plan to work on areas that need improvement. The plan should include:

- What needs to be done to improve online appointment scheduling?
- Who's going to do the work?
- What are the deadlines?

What You'll Need

- Time for staff meetings
- A patient survey
- Time to analyze feedback, make a plan and implement improvements
- Decision-making authority

Resource

Use this survey (1-page Word document; About downloading files) to get patient feedback. You could ask these questions as part of your annual patient survey, if you conduct one.

Where to go for Help

If you and your staff don't have the time or desire to field the patient survey, a consultant could help. FP Assist is AAFP's clearinghouse for consultants.

When you're ready to add an additional service through your secure patient portal, one possibility is e-visits. Watch the AAFP video "Improve the Patient Experience" for an introduction to e-visits.

TransforMED

Tips and Tricks (TC 06)

- Documented process should include:
  - frequency
  - participants
  - meeting content
- Examples demonstrating execution
- Not relevant for the entire practice, only care teams

Frequently Asked Questions (TC-B)

I work with a clinic that generates a daily huddle sheet that includes all scheduled patients and information to include-information about items needing attention for diabetes, lipids, asthma, pap test, mammogram, colonoscopy, smoking, PHQ, etc. They currently print these out for review between provider and clinical staff. They are then signed off and scanned into a huddle sheet file. They now have 5 years of files scanned into their system. Do they need to keep these forever? Is there a better way to show that they are using the sheets?

For TC 06 NCQA will review the practice's documented process for structured communication between clinician and other team members, which states the frequency of communication; and reviews at least three samples of meeting summaries, checklists, appointment notes or chart notes for evidence that the practice follows it's process.

Note: Samples must come from the dates within a year of recognition application. For example, if application date is May 23, 2017, you should select samples from May 23, 2016 to May 23, 2017. It is suggested that you keep documentation for the time period used for recognition - as well as new documentation created during recognition period. Using the previous example, that would mean you should save May 2016-May 2017 and any new documentation for the recent period May 2017-May 2020.

Frequently Asked Questions (TC-B)

Are practices required to have daily, structured meetings with the entire care team? Is the clinician required to attend? TC 06

Practices are required to engage in frequent communication to discuss care for patients scheduled for a visit on that day or, if the meeting is held in the afternoon, on the next day.

Note: The meeting is not to discuss practice transformation activities or vacation schedules. This requirement can be satisfied by scheduled team meetings or scheduled electronic team communication that all members of the practice care team, including clinicians, attend.

There must be regular communication between team members who work together to provide care for a group of patients. Practices are required to provide a documented process and at least three examples of meeting materials (e.g., meeting summaries, checklists, appointment notes).