

**Cross-Cutting Learning Activity:  
Care Team Roles and Responsibilities**

<p align="center"><b>Relevant PCMH Concepts</b></p>	<p><b>Team-Based Care and Practice Organization (TC)</b> 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.</p>	<p><b>Care Coordination and Care Transitions (CC)</b> The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood.</p>
<p align="center"><b>Relevant PCMH Competencies &amp; Criteria</b></p>	<p><u>Competency A: The Practice's Organization</u> 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.</p> <ul style="list-style-type: none"> <li>○ TC01 (Core): Designates a clinician lead of the medical home and a staff person to manage the PCMH transformation and medical home activities.</li> <li>○ TC02 (Core): Defines practice's organizational structure and staff responsibilities/skills to support key PCMH functions.</li> <li>○ TC03: The practice is involved in external PCMH-oriented collaborative activities (e.g., federal/state initiatives, health information exchanges).</li> <li>○ TC04: Patients/families/caregivers are involved in the practice's governance structure or on stakeholder committees.</li> </ul>	<p><u>Competency B: Referrals to Specialists</u> The practice provides important information in referrals to specialists and tracks referrals until the report is received.</p> <ul style="list-style-type: none"> <li>○ CC08: Works with non-behavioral healthcare specialists to whom the practice frequently refers to set expectations for information sharing and patient care.</li> <li>○ CC09: Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.</li> </ul>
<p align="center"><b>Learning Objectives</b> (with relevant IPEC Core Competencies)</p>	<ul style="list-style-type: none"> <li>○ Explain the roles and responsibilities of other providers and how the team works together to provide care, promote health, and prevent disease (RR4).</li> <li>○ Describe how professionals in health and other fields can collaborate and integrate clinical care and public health interventions to optimize population health (RR10).</li> <li>○ Describe the process of team development and the roles and practices of effective teams (TT1).</li> <li>○ Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions and the impact these factors can have on health outcomes (VE4).</li> </ul>	

<p style="text-align: center;"><b>IP Student Learning Activities</b></p>	<p>As a team, students will complete the Saint Louis University TeamSTEPPS Team Structure and Mutual Support modules (see <i>Resources</i> below, if not already completed during <a href="#">Orientation for Interprofessional Student Teams: TeamSTEPPS Group Activity</a>).</p> <p>Following TeamSTEPPS training, the student team will <b>complete one or more</b> of these activities:</p> <ol style="list-style-type: none"> <li>1) Draft a report describing how the practice team meets the relevant PCMH criteria, using resources such as written position descriptions, policies/procedures, and interview with at least two different practice team professions and/or patient/caregiver/family engaged in practice governance. The report should identify potential gaps or needs.</li> <li>2) Attend a population-based care or learning collaborative meeting (i.e. Community Care Team, Accountable Care Organization, high utilizer, opioid use disorder) to observe care team roles and responsibilities. The students will each complete the Jefferson Interprofessional Observation Guide (see <i>Resources</i> below) during/after the meeting for use during subsequent team discussion.</li> <li>3) <i>ADVANCED</i>: Participate in an individual or group visit with an active role in patient care, including briefing and debriefing (see <a href="#">Cross-Cutting Learning Activity: Briefing and Debriefing</a>).</li> </ol>
<p style="text-align: center;"><b>IP Student Learning Assessment</b></p>	<ol style="list-style-type: none"> <li>1) The student team will present the report to appropriate practice members who, together with the students, will determine appropriate adjustments to the practice’s care team strategies.</li> <li>2) The student team, with a facilitator, will share and discuss their assessments of the interprofessional meeting (per Jefferson Interprofessional Observation Guide), with emphasis placed on observed roles and responsibilities. The students will make written notes of the discussion and what they learned from the experience.</li> <li>3) <i>ADVANCED</i>: A member of the practice team will observe the student(s) in the encounter and provide the student(s) written feedback on their knowledge, skills and attitudes in relation to the IPEC Core Competencies.</li> </ol>
<p style="text-align: center;"><b>Resources</b></p>	<ul style="list-style-type: none"> <li>o <a href="#">Jefferson Interprofessional Observation Guide</a> (Thomas Jefferson University - Jefferson Center for Interprofessional Education, 2014)</li> <li>o TeamSTEPPS <a href="#">Team Structure</a> and <a href="#">Mutual Support</a> modules (Saint Louis University, n.d.)</li> <li>o <a href="#">IPEC Core Competencies</a> (2016)</li> <li>o NCQA <a href="#">PCMH Standards and Guidelines</a> (2017)</li> </ul>