

Team-Based Care – the “Who” of the Patient-Centered Medical Home

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Team-based care is a key element of a successful primary care practice or patient centered medical home (PCMH). The Patient Centered Medical Home (PCMH) is a concept that has evolved over the last 40 years and has the potential to take good primary care practices to great. However, before practices can transform to PCMHs, they have to transform their staff to assume new roles and develop needed skills in the new practice paradigm. A framework is provided to implement team-based care and is tailored to address both small practices and larger practices with multiple locations. The concept “Servant Leader” is introduced as the guiding principle in the transformation process and how as a servant leader, you can help staff perform at their maximum potential.

Success not only comes from the ‘how’ and ‘what’ of transformation, but most importantly, the ‘who.’ Jim Collins’ best seller “Good to Great”, outlined the factors that influenced companies’ ability to excel. His research suggested that most people assume that the first step in taking a company from good to great is to set a new vision for the company, and then get people committed and aligned. However, his empirical data demonstrated that executives that were successful at transforming organizations from good to great didn’t focus on the destination, but rather the personnel.¹ The Patient Centered Medical Home (PCMH) is a concept that has evolved over the last 40 years and provides a road map that will take good primary care practices to great. Great, in this context, means increased quality and patient satisfaction, improved safety, and lower costs. The medical home model clearly addresses increased access, care management, self-management, team-based care and leveraging electronic health records (EHRs)/registries to facilitate population management. However, before practices can realize this transformation, they have to focus on personnel, i.e. who will make this transformation possible, and how the right “whos” align into functional teams.

The concept of PCMH is especially important to Family Medicine, a medical specialty that is facing numerous challenges to the profession. The changing healthcare environment, especially the implementation of the Affordable Care Act, the formation of Accountable Care Organizations as well as changing payment mechanisms require physician practices to re-design how they deliver care. These additional

pressures are resulting in increasing rates of physician burnout amongst primary care physicians.² Primary care physicians cite a lack of time allowed with their patients as the primary reason of their discontent.³ This time pressure will only increase as the estimated percentage of primary care clinicians in the US to the population is expected to drop 9% by 2020,⁴ while the number of patients with multiple chronic illnesses is expected to increase from 63 million in 2005, to 81 million in 2020.⁵

Evidence supporting team-based care has demonstrated that the principles can be used effectively to address a variety of these challenges. Team-based care has demonstrated improvements in glucose levels, blood pressure and cholesterol levels in diabetic patients.^{6,7} In Canada, patients and providers have reported greater satisfaction and more positive experiences related to team-based care which were attributed to “more efficient resource utilization, better access to services, shorter wait times, increased coordination of care and more comprehensive care.”⁸ A 2011 practice census by the American College of Cardiology supported the effectiveness of a team-based environment with practices reporting: increased office efficiency (63%), improved quality of care (53%), increased patient satisfaction (50%), increased staff satisfaction (36%) and improved financial outcomes (19%)⁹. The current American Medical Association (AMA) President Dr. Ardis Hoven said in a recent news release that physician-led team-based care “represents the future of health care delivery in America.”¹⁰

The concept of “team-based care” serves as a solution to many of these challenges, especially since the pipeline for increased primary care clinicians in the near future is unlikely. Bodenheimer and Smith estimated that 24% of clinician time can be saved by sharing the care among a primary care team.¹¹

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Data from the National Ambulatory Medical Care Survey estimated that 17% of the average family physicians' time is spent on preventive care and 37% on chronic care.¹² If a percentage of this care could be transferred from physicians to non-clinicians who are trained to provide standardized preventive and chronic care, this would lift a great burden from physicians and theoretically benefit patients by having a team member who is responsible for making sure they are reaching their preventive and chronic care goals.

This article first presents a framework for implementing team-based care and then shares our experiences of transformation among two diverse family medicine practices in Jacksonville, Florida - a suburban practice with 3 physicians, and an urban clinic with several physicians and non-physician providers (NPPs), which is part of a larger primary care network designed to address healthcare disparities. Our experiences have given us an appreciation of the differences in operationalizing this concept in smaller versus larger offices. There is no one size fits all answer and we suggest a reliance and development of the principles of team-based care are more important than a cookie-cutter approach for offices and organizations.

QUALITIES OF TEAM-BASED CARE

From the outset, team-based care is difficult and nearly impossible if the wrong people are "on the team" working against the concept or lacking the requisite skills to make it successful. The first challenge for practices as they begin to develop into medical homes is to identify or recruit the right people. Team members can be retrained to assume new roles and develop needed skills to achieve the transformation. However, it is possible that the current practice staff may not be the team in its entirety that will take the practice through

medical home transformation and a parting of the ways of some of the staff is needed as practices assess the skills required to function effectively.

The question is then how do we take our current primary care staff and transform them into highly functioning teams? According to Grumbach and Bodenheimer, effective primary care teams share the following qualities: established goals, clearly defined roles, improved communication, optimized systems and enhanced training.¹³ These are paramount but our experience has emphasized that the most important quality is the presence of a servant-leader at the helm. The term "Servant as Leader" was first coined by Robert Greenleaf in 1970 and identifies the "servant leader as servant first" where the leader's focus is on the needs and well-being of others and helps employees develop and perform to their maximum potential.¹⁴ As we have worked on developing our teams, their success and failure hinges most on great leadership and the desire to advance the concept of team-based care.

STRATEGIES FOR SMALL PRACTICES

Small practices (less than 5 providers) have some major advantages and disadvantages when trying to develop team-based care. Even though smaller practices provide the majority of ambulatory care within the U.S., they are less likely than larger practices to be using medical home strategies such as care coordination, enhanced access and team-based care.¹⁵ Although practices tend to be more adaptable at making changes than larger practices, they have limited financial and human resources to make change possible. In an evaluation of small practices implementing PCMH strategies, Berry et al concluded "It appears that many of these practices achieved the spirit, but not the letter of the law in terms of the key

Table 1: Six Qualities of Team-based Care

Qualities	Description
1. Physician as Servant Leader	The servant leader needs to value and support the team and set the climate. Leaders must foster a "can do" attitude and a spirit of understanding instead of blame when struggles arise.
2. Mission and Established Goals	The mission is the foundation for a successful team and allows team members to have a professional compass to turn to during challenging times and the ability to refocus during times of growth. Additionally, the team needs to identify goals to evaluate and address performance.
3. Clearly Defined Roles	It is important to determine who has ownership of specific tasks and functions. There is a risk that staff members may feel that increased work is being delegated to them; therefore, it is critical that the team is empowered with the concept of sharing the care.
4. Team Communication	Successful communication will determine whether the team flourishes or flounders. Daily team huddles and regularly scheduled staff meetings are needed to foster teamwork. These meetings are a forum for each team member to have an equal voice and to discuss current practices and future initiatives.
5. System Improvement	As teams develop, a census needs to be taken of current systems and processes. These can be clinical pathways, patient flow and administrative functions. The team should evaluate what is working well and what needs to be changed to be more effective.
6. Enhanced Training	Successful primary care teams have trained their LPNs, care managers and medical assistants to work at the upper scope of their practice.

dimensions of the PCMH. The use of more flexible, less formal strategies is important to keep in mind when considering implementation of PCMH-like initiatives with small practices and when assessing the effectiveness of such initiatives.¹⁶ Small practices can use incremental steps to develop successful team-based care by following these guidelines.

Servant Leader: The foundation of a great primary care team is set by identifying a servant leader who has the skills, passion, compassion and commitment to lead others. Great leadership by physicians will ultimately separate a great team from a good team. Physician leaders set the climate of an office unlike anyone else and their attitudes toward their staff will affect their ability to become an effective team.

Develop a mission and establish goals: Once a leader has been identified, the next step is to develop a clear mission to set the stage for team-based care. The group can designate a mandatory time for the practice to come together to evaluate whether a team-based approach is appropriate for the practice. If the team chooses to proceed, use this time to brainstorm on a mission statement which defines what the team believes in and would like to accomplish. Publish it throughout the office and encourage your team to reflect on the mission statement when times are difficult. At the next team meeting, develop a goal for the office. These goals can be clinical (i.e. lowering the percentage of patients with an A1C >9,) or process improvement goals (i.e. lowering the % of patients who wait > 30 minutes for their appointments). As soon as the baseline measurement has been established, the team needs to determine the goal they would like to achieve and the length of time allowed for intervention. At a pre-determined time, the team should meet to compare the pre- and post-data to determine effectiveness, discuss lessons learned and implementation successes, and identify the next quality improvement project.

Define roles and practice role play: Assign roles to each team member and cross-train where possible. This is the foundation of team-based care and allows for empowerment and optimization of the practice's staff. Consider giving everyone in the office one hour to "walk in each team member's shoes" to understand what each member does and the interdependence within the practice. Our experiences have highlighted the importance of this concept because it is extremely common to have staffing issues during the year and the team needs to continue to function at an optimal level. It is similar to a professional football team. Almost every team sustains a major injury to a key player or players during the course of the season. The championship teams have the ability to compensate when this happens. One of the biggest challenges faced by small practices is they tend to lack the

resources to hire a care manager, diabetes educator or registry specialist. The most likely solution is to train your medical assistants (MAs) to become advanced MAs who can function at the highest scope of their license. With their input, develop standing orders and protocols for multiple clinical processes such as preventive care (ordering immunizations, completing monofilament exams in diabetic patients, ordering tests), medication refills, setting up follow-up appointments and maintaining and updating chronic disease registries. This will decrease the burden of chronic and preventative care placed on primary care physicians.

Team communication: It is important to establish ongoing communications among teams. These include a morning huddle each day to evaluate the schedule and upcoming patient needs (i.e. does Mrs. Smith need a discharge summary, does Mr. Jones need his pathology results). We also recommend developing a protocol for communicating during the day, and what tasks constitutes a knock on the door and what can be handled via email or EHR task alert. Developing a culture where each team member can question an order that may impact patients' safety is essential. In our practice, saying the word "clarity" is a trigger to stop whatever is being done and to ensure there is full understanding between team members. Effective communication is a key characteristic of a highly functioning team and a useful tool to evaluate how the team is doing is the "Team Development Measure" developed by Stock et al.¹⁷

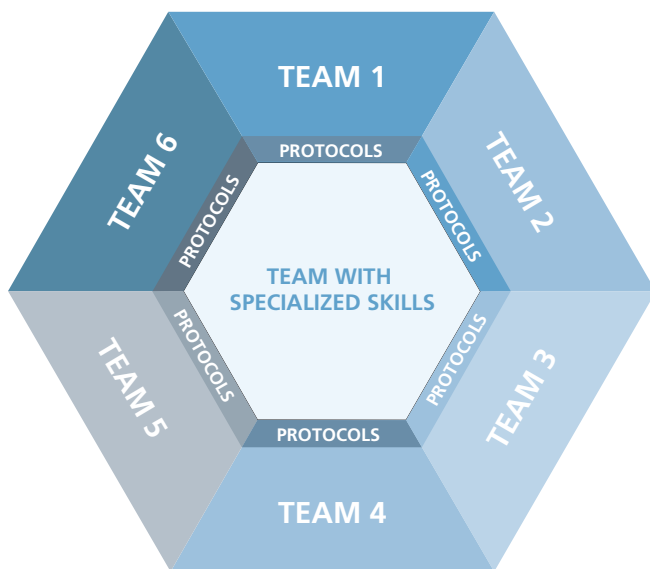
System improvement: Practices need to constantly look at how they do business and look for ways to improve patient care and efficiency. Some of the most common issues are appointment access issues, notification of both normal and abnormal results, and timely referrals. Time needs to be allowed at team meetings to brainstorm on ways to improve these systems and encourage innovation. Practices should also be encouraged to look at EHR and other information technology solutions to improve these processes. Consider new methods of access for patients such as a patient portal if your EHR supports it. Also look at chronic disease and preventive care registries either as part of an EHR or another system (i.e., an Excel spreadsheet) to track and manage your patient populations. Practices can consider developing a patient advisory board to seek patient feedback on how they are doing and get their input on ways to provide more patient centered care.

Enhanced training: Team-based care requires developing enhanced competencies of your medical assistants and other staff. Some effective ways to provide training include offering in-services trainings on implementing standing orders or other procedural changes, webinars and local medical education

seminars by community colleges or hospitals. Our practice has rotating medical students who give a monthly 10 minute educational in-service to the staff on current medical topics and issues that have come up in the office. The goal is to have your staff become healthcare coaches who can be significant contributors to managing your patients with chronic diseases.

STRATEGIES FOR LARGE PRACTICES

Large practices or multi-site practices typically have the advantage of having more resources and are better positioned to add additional technology; however, they also have the disadvantage of increased layers of bureaucracy and geography that encourages practices to function like miniature fiefdoms. A typical approach would be to use the same implementation strategy for small practices in large practices. This approach is discouraged as the challenges are likely to be exponential. We suggest a two-pronged approach: 1) work closely with each of the practices or practice units to develop the team-based culture, and 2) develop specialized multi-disciplinary teams that are either embedded in the practices or are centrally located (see Figure 1). These specialized teams can include a clinical Pharmacist, social worker, care coordinator, disease management/educator and/or IT specialist. This approach allows each practice or practice unit to gradually experience the benefits of team-based care while maintaining productivity.



The qualities of team-based care (Table 1) can also be applied to larger practices albeit slightly differently. The servant leader or senior leadership is the key to promoting successful team-based care transformation and must promote a culture that embraces the tenets of team-based care and remain committed to the transformation for the long-term. The multi-disciplinary team needs strong physician leadership and a clear mission and established goals on how they support

the individual practice teams. The individual practice teams and the multi-disciplinary team must work together to establish metrics that define success. These metrics should be a combination of structure, process and outcomes goals and be aligned with financial benchmarks such as PQRS and other incentive plans.

The practice-based teams should be involved in defining the roles and developing protocols that are used to support engagement of the multi-disciplinary team. It is encouraged that they be involved in selecting the team and have a role in the evaluation of these team members. Communication is critical and regular team meetings at the centralized system level and provider levels are necessary to discuss administrative and clinical matters to maintain sustainability, shared vision and substantive transformation into a team-based practice. Team meetings are designed to solicit questions instead of "telling" or "providing knowledge" to team members.¹⁸ The meetings are focused on operationalizing the concept of team-based care and should last no longer than needed to accomplish pre-meeting objectives and to distribute post-meeting assignments.

Upgrading practice systems to meet the needs of the teams are vital to success. The two key areas for system improvement would be Information Technology (IT) and Care Coordination. Large practices should have dedicated IT personnel trained to develop and maintain registries, implement decision support tools, provide reports that will be used for effective revenue cycle improvements, and clinical process and outcomes reporting at the practice and provider level. Particularly effective are team members that have the ability to act on the behalf of the physician. Using protocols, team members can initiate medication as needed to meet evidence based clinical goals. Finally, enhanced training and increased certification at every level is necessary for the teams to work at their maximum levels. It's critical to involve staff and providers at every level in the sharing and dissemination of best practices. A step-by-step overview on how to implement team-based care in your practice is provided in Table 2.

Even with expanded teams, it's impossible to do everything for everyone. When team-based care is not successful, it is often because practices don't have clearly defined roles or have not identified the most appropriate patients for interventions. With the additional resources and cost associated with team-based care, it is important to target the right patients to maximize return on investment. Atul Gawande's article in *New Yorker* introduced the concept of Hot Spotters which suggests that 20% of patients drive 80% of cost within large populations.¹⁹ This phenomenon holds true for large practices. To maximize value and quality, practices should develop systems to track patients at high risk, or having complex health conditions. These patients should be the focus of multidisciplinary teams

and require intensive management to insure that they avoid unnecessary Emergency Department and hospital utilization. The 20% is dynamic and changes daily, consequently practices must also develop predictive modeling capacity to determine which patients in the 80% population are likely to move to the 20%.²⁰ Many large practice systems have developed dedicated Ambulatory Intensive Care Units (A-ICU). The A-ICUs are designed to provide care for the most complex patient populations and have been shown to decrease cost, improve patient function and decrease absenteeism. The A-ICU target patients that have history of increased utilization or have a catastrophic diagnosis such as cancer, traumatic injury, Congestive Heart Failure or COPD, that often require intensive case management and care coordination.²¹ The teams have the resources and most importantly the time to work with complex patients to address their concerns and avoid complications.

Table 2: Keys to Establishing a Primary Care Team Model

1. Determine if there is a desire among your current office to pursue these changes.
2. Identify a servant-leader to lead this change.
3. Seek input from the whole team to develop a mission statement.
4. Commit to regular team meetings at a minimum of twice a month.
5. Develop MA-provider teams who are regularly paired and have a daily morning huddle.
6. Establish standing orders and protocols for chronic care and preventative care and ensure buy in of this throughout the practice.
7. Allow for open discussion of processes and protocols
8. Optimize your current EHR for chronic disease registries and improved patient access.
9. Use these chronic disease and preventative care registries to establish a baseline and measure the team's improvements.
10. Educate, cross-train and provide opportunities for advancing your staff.
11. Consider adding/sharing second level team care (such as pharmacists, case managers) as the team becomes increasingly financially successful.

CHALLENGES FOR TEAM-BASED CARE

The largest barrier to team care is finding the time, energy and resources to make the changes necessary to transform a practice into an effective team. In a time when most physicians are overburdened, one more responsibility can push many physicians closer to burnout. In a 2012 study of 7288 physicians, 45% felt at least one symptoms of burnout and 40% were dissatisfied with their work life balance.² Team-based care presents an interesting challenge because it offers a

viable solution to the root causes of these symptoms but it also requires innovation, energy, time and passion to transform the workplace.

A second barrier is the lack of financial resources and reimbursement for coordinated care in our current healthcare delivery system. Dr. Bodenheimer states "Without a multidisciplinary team, consistently good chronic care is impossible...without payment reform, such teams are impossible."⁴ A large majority of the work that could be performed by a visit with a medical assistant or care coordinator is not currently billable. The Center for Medicare and Medicaid Services (CMS) have announced in December 2013 that they will start reimbursing for coordination of care but the details have not been published yet.^{21,22}

A third barrier is physician openness to the team-based care concept. Physicians are valued for being subject matter experts and may view a team-based approach as a loss of autonomy. For teams to operate at their best, physicians need to be the servant leader. Physicians can then, at their discretion, allow all members of the team to perform up to the level of their training. The State of Virginia instituted a first of its kind law in 2012 which recognized the physician's role in leading health care teams.²³ The AMA recently adopted recommendations that "physician leaders should be the ones who receive payment for services and they should also make decisions about how much each of the other team members get paid...those disbursement decisions should be based on a number of factors, including volume and intensity of services, quality of care, and team members' professions."¹⁰

A fourth barrier is having the wrong "who's" on your team. Team-based care is not for every physician or staff member. It takes a strong belief and commitment that together a team can optimize patient care greater than any individual effort. For a team to flourish, an environment of mutual respect and psychological safety must be established and maintained. Teams or servant leaders may need to make difficult decisions on who continues on their journey to becoming great.

Another barrier is the underuse or lack of metrics to see if the changes are working and worth sustaining. Improvements in patient outcomes and satisfaction will serve as a motivator to both the team leader and the team. The last barrier is possible increased liability risk related to the actions by both physician and non-physician team members. Most of this risk is attributed to a lack of communication and documentation amongst team members. Clear protocols and ongoing evaluation of team communication is one way to minimize this risk as well as encourage team members to be aware of safety issues and to speak up when they arise.

CONCLUSION

Team-based care is an effective way to help transform family medicine practices from "good to great" for both patients and providers. There is an old true adage "It takes a village to raise a family" which we feel in our current medical climate should be changed to "It takes a village to properly take care of a patient population." In our experience, successful teams in both small and large office settings develop a culture of continual innovation, improvement and learning. It is important that a servant leader take the first steps to initiate this culture and to continue its growth. Small and large practices face different challenges in establishing effective teams. Small offices can use their size to their advantage; they can develop effective teams by using their flexibility of being a smaller entity in making definitive changes. They need to be innovative with staffing and financial burdens to do this. Larger offices need to maximize their resources and manpower to make changes to establish team-based care as a permanent part of their culture. The greatest challenge larger practices need to overcome is developing an effective way to communicate changes throughout the system for the greatest buy-in in implementing these strategies. Operationalizing this concept will be different amongst the spectrum of practices but they should share a similar spirit in their core principles.

The transformation to team-based care is worthwhile but definitely challenging in our current fee-for-service system. There will need to be payment reform to support work that is performed by non-clinicians or care that is not face to face for team-based care to become a permanent part of our culture. Our experiences in trying to advance this model in both small and large office settings have stressed the importance of flexibility, patience and persistence.

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