

Implementing Team-Based Care to Increase Practice Efficiency



Engage the entire team in caring for patients

CME
CREDITS:
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Christine Sinsky, MD
Vice President, Professional Satisfaction,
American Medical Association and
Internist, Medical Associates Clinic and
Health Plans, Dubuque, IA

Ellie Rajceвич, MPA
Practice Development Advisor,
Professional Satisfaction and Practice
Sustainability, AMA

How will this module help me implement team-based care?

- 1 Illustrate the impact of the practice model
- 2 Provide step-by-step implementation guidance
- 3 Offer resources and documents that can assist with implementation

Increasing administrative responsibilities—due to regulatory pressures and evolving payment and care delivery models—reduce the amount of time physicians spend delivering direct patient care. Team-based care allows physicians to truly connect with their patients by involving more of the practice staff in patient care, including handling patients’ questions, calls and messages. Utilizing a physician-led, team-based care approach ensures everyone is aware of the patient’s important health information. Practices will see increased efficiency and productivity as a result of implementing team-based care.

Implementing team-based care

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Objectives

At the end of this activity, participants will be able to:

1. Describe the components of the team-based care model.
2. Increase communication among the team, practice and patients.
3. Evaluate how the team-based care model could be implemented in their practice.

Target Audience

This activity is designed to meet the educational needs of practicing physicians.

Statement of Need

Team-based care involves the physician as the champion of the patient’s care team along with other practice staff members who share in patient-care responsibilities. The team-based care approach allows physicians to spend more time communicating face-to-face with patients during visits and provide meaningful medical care. By implementing a team-based care model, practices will see an increase in efficiency and productivity, with physicians able to see a greater number of patients during a clinic session. This module will describe different elements of team-based care, so practices can implement this powerful health care delivery model.

Statement of Competency

This activity is designed to address the following ABMS/ACGME competencies: practice-based learning and improvement, interpersonal and communications skills, professionalism, systems-based practice and also address interdisciplinary teamwork and quality improvement.

Accreditation Statement

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation Statement

The American Medical Association designates this enduring material for a maximum of 0.5 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Claiming Your CME Credit

To claim *AMA PRA Category 1 Credit™*, you must 1) view the module content in its entirety, 2) successfully complete the quiz answering 4 out of 5 questions correctly and 3) complete the evaluation.

Planning Committee

Alejandro Aparicio, MD – Director, Medical Education Programs, AMA

Rita LePard – CME Program Committee, AMA

Anita Miriyala – Graduate Intern, Professional Satisfaction and Practice Sustainability, AMA

Ellie Rajceвич, MPA – Practice Development Advisor, Professional Satisfaction and Practice Sustainability, AMA

Sam Reynolds, MBA – Director, Professional Satisfaction and Practice Sustainability, AMA

Christine Sinsky, MD – Vice President, Professional Satisfaction, American Medical Association and Internist, Medical Associates Clinic and Health Plans, Dubuque, IA

Krystal White, MBA – Program Administrator, Professional Satisfaction and Practice Sustainability, AMA

Author(s)

Christine Sinsky, MD – Vice President, Professional Satisfaction, American Medical Association and Internist, Medical Associates Clinic and Health Plans, Dubuque, IA

Ellie Rajceвич, MPA – Practice Development Advisor, Professional Satisfaction and Practice Sustainability, AMA

Faculty

Ann Lindsay, MD – Co-Director Stanford Coordinated Care, Stanford University School of Medicine

Jeff Panzer, MD – Medical Director, Iora Health

Sara J. Pastoor, MD, MHA – Family Physician

Bruce Bagley, MD – Senior Advisor, Professional Satisfaction and Practice Sustainability, AMA

Ellie Rajceвич, MPA – Practice Development Advisor, Professional Satisfaction and Practice Sustainability, AMA

Sam Reynolds, MBA – Director, Professional Satisfaction and Practice Sustainability, AMA

Christine Sinsky, MD – Vice President, Professional Satisfaction, American Medical Association and Internist, Medical Associates Clinic and Health Plans, Dubuque, IA

About the Professional Satisfaction, Practice Sustainability Group

The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, “Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy,” and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity and reduce health care costs.

Disclosure Statement

The content of this activity does not relate to any product of a commercial interest as defined by the ACCME; therefore, neither the planners nor the faculty have relevant financial relationships to disclose.

Media Types

This activity is available to learners through Internet and Print.

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Introduction

In STEPS Forward™, several modules describe individual elements of a team-based care model. In this module, we show how to bring all of these elements together.

What is team-based care?

Team-based care is a strategic redistribution of work among members of a practice team. In the model, all members of the physician-led team play an integral role in providing patient care. The physician (or in some circumstances a nurse practitioner or physician assistant) and a team of nurses and/or medical assistants (MAs) share responsibilities for better patient care. Common shared responsibilities include pre-visit planning and expanded intake activities, including reconciling medications, updating the patient’s history and collaborating with the patient to set the visit agenda. During the physician portion of the visit, the nurse, MA or documentation assistant scribes the visit, allowing the physician to have uninterrupted time with the patient. At the conclusion of the visit, the nurse or MA conducts essential care coordination activities, such as arranging follow-up visits or ordering requested testing and referrals.



Why team-based care?

Physician-led team-based care engages a greater number of staff in patient care and affords physicians the time they need to listen, think deeply and develop relationships with patients. Team members are aware of the patient’s health history and conditions and are thus better equipped to answer patients’ between-visit questions, calls and messages. As a result, all members of the physician-led team feel engaged in their key role of caring for the patient.



We have MA care coordinators who are responsible for their own panel of patients. They work under protocol to refill meds, perform routine health maintenance and chronic disease monitoring tests and triage calls and e-mails from patients. They scribe visits, coach patients about action plans and facilitate referrals. It is working really well for all of us. The team is better than ever.



Ann Lindsay, MD
Stanford Coordinated Care

STEPS to implementing team-based care

1. Engage the change team

2. Determine the team composition

3. Choreograph workflows to reflect the new model of care

4. Increase communication among the team, practice and patients

5. Use a gradual approach to implement the model

6. Optimize the care model

1

Engage the change team

Bring together a multi-disciplinary change team of nurses, MAs, physicians, administrators and information technology staff members with a leader who has enough authority within the practice or organization to empower the process. Consider involving patients on the change team as well.

In addition to building the change team, assemble a smaller team that will pilot the team-based care model in your practice. This pilot team may consist of one physician or a pod of physicians. The physicians and team members who are involved in the pilot should also be members of the larger change team.

2

Determine the team composition

Design the model of care that will meet the needs of your patients and team. Consider which current team members could learn a new skillset and fulfill a new role on the physician-led team. Your practice model may include a behavioral health specialist, health coach, care manager, care coordinator, nurse practitioner, physician assistant or reception staff. Depending on the physician's specialty, athletic trainers or ophthalmic technicians may also be vital team members.

While designing the team composition, start to consider which team could pilot the model. Ensure that the pilot team(s) consists of physicians and supporting team members who are eager to transform the clinic to a team-based care model. They should be trailblazers, trendsetters and good communicators who are willing to put in extra effort to prepare for the transition and continue to develop the new model once it is underway.

Q&A

[Our biggest problem is access to care. Will team-based care help with this?](#)

Yes! When the team is working efficiently, there is greater capacity to see more patients. One physician who recently implemented team-based care was able to re-open his practice to new patients after it had been closed for more than twelve years. Another physician increased his daily patient access from 21 to 28 patients.

What should we do if our nurses don't want to work as scribes?

The nurse's role in team-based care is not "scribing." It can be better thought of as a "nurse co-visit" where the nurse manages preventive care and much of the chronic illness monitoring under established protocols and begins to explore any acute symptoms that the patient may have. The physician provides oversight and additional medical decision-making. This advanced team-care role offers nurses an opportunity to continuously learn and make more meaningful contributions than they would in a traditional triage or prescription refill position.¹

Some practices have trained MAs to scribe visits and manage prevention and illness monitoring by protocols or standing orders. A nurse may supervise a group of advanced MAs. Work with your practice to identify which existing team members could work in desired capacities to implement the new model, and plan to continue to develop roles and training as the new model is adopted. Individual roles and scope of practice should be defined in accordance with your state's laws.

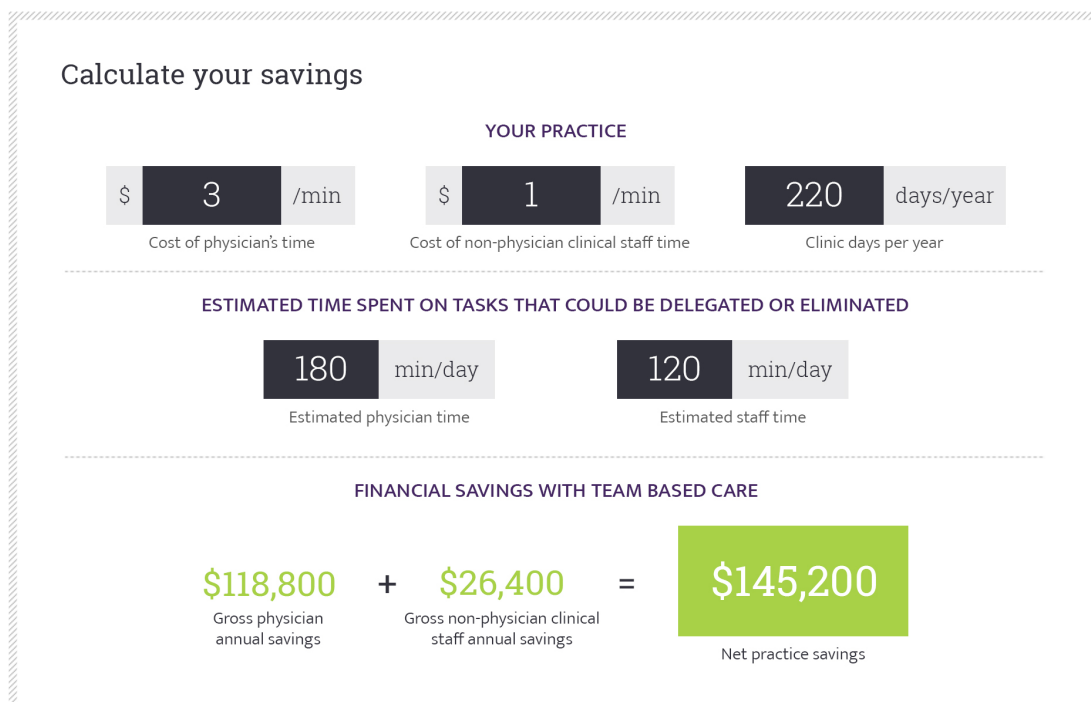
One of our pilot physicians has concerns about the adaptability of his team. Do you have any suggestions?

Adopting a new practice model requires adaptability, openness and innovation. It is natural for providers and staff to feel uncomfortable with change. Some people are so busy working in a less functional model of care that it is hard to find time to imagine and plan for a better way. Strong support from a project champion high in the organization is critical. Ensuring that everyone who will be impacted by the change has an opportunity to shape the change increases the chance of success. Also, try to have a little fun along the way.

Estimate Savings From Team-Based Care

Visit www.stepsforward.org/TeambasedCare to estimate the cost and benefit of implementing Team-Based Care in your practice. Enter amount of time per day spent by physicians on activities that could be eliminated by implementing Team Based Care and the estimated cost of the specialist. The result will be daily physician time saved and annual savings of implementing Team Based Care.

Savings calculator example:



*includes inbox work, calls, letters and other communication regarding test results

Source: AMA. Practice transformation series: implementing team-based care. 2015.

3

Choreograph workflows to reflect the new model of care

Determine your new team-based care workflows. Remember, you are creating your ideal future state, so think outside the box when designing your dream team and ideal practice. If you have access to a Lean expert, work collaboratively to identify opportunities for greater efficiency in the current and newly designed processes. If certain aspects of your current workflow function well, feel free to incorporate them into your future state! Try not to limit yourself; consider how an already great process can be made better.

A Effective pre-visit activities

Ensuring that your patients and team are prepared for patient visits is one of the cornerstones of team-based care. Pre-visit planning activities can be completed by a designated nurse, MA or other team member. Some offices focus pre-visit planning efforts on the more complex patients or chronic care patients. Using a registry can streamline this work by making it easy to see the gaps in care or missing elements of critical clinical information.

Q&A

What can increased efficiency do for my practice?

Increased efficiency can result in increased productivity. The physician-led team is able to see more patients during a single clinic session. The increase in patient revenue is usually more than the cost of any additional staff.

Increased efficiency can also improve quality. When the care team is efficient, the correct routine care happens naturally. In addition, the physician can focus more of his/her efforts on listening deeply to the patient, making accurate diagnoses, creating treatment plans consistent with the patient's preferences and communicating with other professionals involved in the patient's care.

What activities should we complete when conducting pre-visit planning?

Conduct **pre-visit planning** two to three days prior to the visit.

- Review notes from the previous visit and ensure that follow-up results (e.g., laboratory test results, x-ray or pathology reports, other provider notes from a referral) are available for physician review
- Use a registry or visit-prep checklist to identify any care gaps or upcoming preventive and chronic care needs
- Identify whether any further information is required for the visit (e.g., hospital discharge notes, emergency department notes or operative notes from a recent surgery)
- Remind patients of their appointments by sending automated (if possible) appointment reminders, including the accurate check-in time and accounting for the additional time it will take to complete any necessary paperwork, such as a pre-appointment questionnaire

DOWNLOAD [Pre-visit questionnaire](#)

What should we do to complete pre-visit laboratory testing?

Order **pre-visit labs** at the end of each appointment to be completed prior to the next appointment using a visit planner checklist. Providers can review results with the patient in person. This saves time and allows the care team to discuss progress and/or interventions with the patient.

DOWNLOAD [Visit planner checklist](#)

Is it important that we start the day or session with a team huddle?

Prepare the team by reviewing the day’s schedule during a five to 15 minute **team huddle**. The huddle should include the extended care team, such as registration or check-in staff, the physician, nurses, MAs, behavioral health specialist, care manager and health educator, as appropriate. The team can discuss important items that are pertinent to all team members to sustain the greatest efficiency and cohesion throughout the clinic day and to make sure that resources are allocated where the anticipated need will be. For example, the team may discuss who is covering for a team member who is sick and for another who will be out in the afternoon. They can make sure that the procedure room will be set up for the 10:00 a.m. appointment where the patient will need an endometrial biopsy. The huddle should involve and engage all members of the team.

Pre-visit planning activities and huddles prepare the clinic team and shift the model from one that is reactive, in which the team feels as though they are playing catch-up, to one that is proactive, in which the team anticipates, coordinates and delivers the best patient care. It also involves the care team and engages them in their enhanced roles that are essential to the delivery of patient care.

B The team-based patient visit

The nurse or MA manages the first component of the visit, including updating the medical record, closing care gaps and obtaining an initial history. When the physician joins the appointment, the nurse, MA or documentation specialist helps document the visit. At the end of the visit, the team member emphasizes the plan of care with the patient and conducts motivational interviewing and education as appropriate. The nurses and/or MAs become more knowledgeable about the treatment plan, can more effectively coordinate care between visits and develop closer independent relationships with patients and their families.

Q&A

Under Medicare payment rules, can non-physician staff, such as a registered nurse (RN), licensed practical nurse (LPN) or medical assistant (MA), enter elements of an evaluation and management (E/M) visit without the physician present?

Yes, certain elements, like the Review of Systems (ROS) and Past, Family, and/or Social History (PFSH), may be recorded in the EHR by non-physician staff. Medicare guidance specifically allows ancillary staff to enter information derived from the patient for the ROS and/or PFSH. However, the physician must provide a notation in the medical record supplementing or confirming the information recorded by others to document that the physician reviewed the information. For other elements of a visit, like the History of Present Illness (HPI) or Chief Complaint (CC), Medicare rules do not explicitly indicate who may enter documentation. However, several Medicare Administrative Contractors (MACs) currently interpret Center for Medicare & Medicaid Services (CMS) regulations to prohibit the physician (or non-physician practitioner (NPP), if billing for the service) from delegating these elements of the service. Practitioners should check with their respective MACs before allowing individuals other than the treating physician to document an HPI or CC. If the non-physician is entering information about an HPI or CC on behalf of the physician while the physician is present in the room with the patient, some MAC guidance suggests that this practice is allowable as long as the physician actually performed the E/M service billed, the scribe simply served to transcribe the service provided by the physician, and the scribe’s entry is authenticated by the physician. Other MACs, however, restrict this practice. Providers should consult with their MAC before using a scribe to complete entry of an HPI or CC.

Under Medicare payment rules, can an RN document a patient’s medication list in the EHR as part of medication reconciliation (MR) during E/M visit?

Yes, where MR is part of the ROS or PFSH for the E/M service, under Medicare payment rules, the medication list may be recorded by any ancillary staff, and then signed by the physician. MR is included

in the Advancing Care Information performance category in the Merit-Based Incentive Payment System (MIPS) as well as the Meaningful Use (MU) program.

What are some of the expanded rooming activities that the team could do?

In **expanded rooming**, the nurse or MA is empowered to:

- Reconcile medications
- Update medical, family and social history
- Provide immunizations
- Screen for conditions based on practice protocols
- Identify the reason for the visit and help the patient set the visit agenda
- Arrange preventive services based on standing orders
- Assemble medical equipment or supplies prior to the visit
- Hand off the patient to the physician
 - The nurse or MA quickly briefs the physician with the patient’s visit objective, goals and any other pertinent information

DOWNLOAD [Rooming checklist](#)

How does team documentation work?

In **team documentation**, either a clinical person (nurse or MA) or trained clerical person documents, or “scribes,” the visit. There are benefits to both approaches:

- The MA or nurse is able to remain with the patient throughout the visit, conducting rooming activities before the visit, documenting the visit while the physician is in the room and reemphasizing and educating the patient at the end of the visit. He or she is able to provide real continuity for the patient, building trust between the patient and care team. Between visits, the same team member is also well prepared to answer any questions from the patient that may arise. This approach enhances the nurse’s or MA’s relationship with each patient.
- The primary responsibility of the clerical documentation specialist is to shadow the physician and document all patient visits, enabling the physician to connect with his or her patients. In some practices, documentation specialists may have additional responsibilities, such as care coordination and scheduling follow-up appointments.

How can we use the annual visit to synchronize prescription renewals?

At an annual visit, the physician can indicate which chronic medications may be refilled for the entire upcoming year (or the maximum duration allowed by state law), and which, if any, to modify or discontinue. This can reduce the number of calls and amount of work associated with more frequent renewal requests. Of course, the team can provide refills upon request based on protocols.

When should planning for the next visit start?

Planning should occur at the conclusion of the current visit. A visit planner checklist or an equivalent electronic checklist can help by clarifying the upcoming appointments and the corresponding laboratory and diagnostic work that should be completed prior to those visits, including the next annual comprehensive care visit.

DOWNLOAD [Visit planner checklist](#)

When the physician portion of the visit is complete, he or she can exit the room, review the notes, make any modifications and sign the note. The physician is then ready to transition to the next patient's room.

Q&A

What work can be completed by the nurse or MA after the physician portion of the visit is complete?

The nurse or MA can either stay in the room or reenter to conduct **expanded discharge** responsibilities.

- Coordinate follow-up care by scheduling visits and corresponding laboratory work
- Review orders and instructions with the patient, conducting motivational interviewing to help patients understand what behavior changes are necessary to see desired results
- Print and review an updated medication list and visit summary
- Reiterate medical instructions indicated by the physician
- Answer any questions about the visit or plan of care

DOWNLOAD [Discharge checklist](#)

The patient should leave the visit with a sense of commitment and support from the clinic staff.

Q&A

How many people does it take to carry out all of these responsibilities?

Every practice is different. In one practice, team-based care is most effective with two MAs per physician. Another utilizes three RNs per physician. Practices develop varied extended care-team compositions as well. Some practices delegate pre-visit planning activities to panel managers or other care coordinators.

Can licensed staff enter electronic orders, such as laboratory or x-ray requests?

Yes, certain credentialed individuals may enter orders for diagnostic tests in an office (non- facility) setting. Medicare generally requires that services provided/ordered be authenticated by the author. A physician's failure to properly authenticate an order could lead to denial of payment by a MAC. However, there are circumstances where Medicare does not require a physician signature, such as for diagnostic tests (e.g., clinical diagnostic laboratory tests and diagnostic x-rays), when ordered in an office setting. While these orders need not be signed by the physician, he or she must clearly document in the medical record his or her intent that the test be performed. Providers should also check state, local, and professional guidelines.

4

Increase communication among the team, practice and patients

Start by keeping the practice aware of the change team's pilot work. Physicians and staff may feel out of the loop and disengage if they are not involved.

Q&A

What kind of communication tactics can we use with our team?

- Include the change team's work as a standing agenda item at **team meetings** and department gatherings
- Broadcast updates in a weekly email and/or an intranet discussion board
- Co-locate physicians with the rest of their team in a common workspace to organically support communication and team culture
- Conduct regular **huddles** and **team meetings**

Communicate the change team’s work to your patients as well. You may want to draft a letter announcing this exciting transition so patients know what to expect, incorporate information about the change into a personalized pre-visit phone call or simply let patients know of the changes during the rooming process. Pamphlets in the waiting and exam rooms could also be used to remind patients of the changes before their visit begins.

Q&A

What should we communicate to our patients about team-based care?

When communicating to patients, share some of these important details:

- Patients can expect that the entire team will take ownership for them. The practice will refer to them as “our patient.”
- Patients will be asked to come into the office before their appointment to have their pre-visit labs drawn. Explain to patients that this will allow their physician the opportunity to discuss results and any changes to care during their visit.
- Their physician will be more connected with them during their visits. The physician will no longer sit at the computer during the visit; they will sit next to the patient and have a discussion about their needs and care plan.
- Patients can expect to be joined by another team member during visits. Let patients know that having another pair of ears in the room will ensure that all of their concerns are noted and as a result, their care will be more thorough.
- Assure patients that if they have privacy concerns, other team members can leave the room when the physician enters.
- Solicit patient feedback. Add a question to your current patient survey about the care received in the new model, or create a brief survey specifically for patients who received care from the pilot team so you can determine how the patients perceive the care they are receiving.

5

Use a gradual approach to implement the model.

Team-based care implementation will be a gradual process. It will take time, and every day will not be perfect. Be patient; know that several months may go by before the team feels like they are really gelling in their new system.

One physician who has implemented team-based care recommends that physicians who are considering implementation make sure that they are completely committed because it is not easy. He followed up with, “I cannot imagine practicing any other way.”

An MA who works in a team-based care model said that it took her about two months to feel like she was really getting the hang of documenting patient visits for her physician. She worked very closely with him as he taught her his preferences and showed her how he edited every single patient note. This type of time commitment is necessary to successfully implement team-based care. As the model expands, an experienced MA can mentor or assist with training a new MA.



6

Optimize the team-based care model

A Co-location

Teams that sit in closer proximity communicate with greater frequency and ease. Questions can rapidly be answered, reducing the time that someone may have to wait before completing a task or responding to a patient. Everyone will be aware of the work that their teammates are doing, enabling easier task-sharing and division of work. Finally, after a busy clinic day, your inbox will not be filled with messages that could have quickly been triaged by another team member during the day.

B Inbox management

In a team-based care model, the number of inbox messages that are sent to the team should decrease for several reasons.

- Lab results are discussed during the visit, so the number of messages sent back and forth to discuss results or set up a call is significantly reduced.
- Patients receive additional education at the conclusion of their visit, resulting in fewer questions after the visit.
- Care coordination is enhanced. Patients will leave with their follow-up appointments, corresponding labs and diagnostics scheduled, so they should have fewer requests after leaving the office.
- Referrals to supportive services such as behavioral health or to a health educator can be made during the visit. Involving additional team members in a patient's care provides them with a point of contact for follow-up questions regarding these specific services.

Of the questions that do come into the office, the physician's team should be able to handle most of them. The physician may delegate most questions and concerns to the nurses or MAs who work with him or her. Their knowledge of each patient's case will be much greater in a team-based care model, and they will be able to answer most questions according to what was said during the visit or the plan of care that was determined. They will also build their skillset over time, further engaging them in this critical work.



AMA Pearls

Learn more about team-based care

Visit our STEPS Forward™ modules that explore all of the topics covered in this module in even greater detail:

- [Building team culture](#)
- [Expanded rooming and discharge protocols](#)
- [Pre-visit laboratory testing](#)
- [Pre-visit planning](#)
- [Synchronized prescription renewals](#)
- [Team documentation](#)
- [Team huddles](#)
- [Team meetings](#)

Consider role flexibility

Create a culture that is patient-centric rather than task-oriented. The practice culture is one where everyone works together to care for patients; you would never hear someone say, “That’s not my job,” when a patient needed them. The MAs on the doctor’s team may share responsibilities between rooming and answering calls and inbox messages, flexing to cover where patients need them most throughout the day.

Create time for new responsibilities

Work with the physicians and staff to remove less critical activities and waste. Expecting valued workers to add even more to a full plate could lead to dissatisfaction or burnout. See the STEPS Forward™ [Lean](#) module for more information.

“

The benefits from team-based care have gone beyond what I envisioned.

Originally, I simply hoped to regain eye contact with patients, as this is such an important assessment tool for me during visits. What I’ve seen has really gone way beyond that. Yes, my face time with patients is increased, but the visit is also more efficient and relevant. Since my documentation is now in “real time,” my notes are better and timelier. Our clinical staff is learning so much more now that they feel like they are truly part of a team and they enjoy the added dimensions to their clinical practice. They have more confidence when teaching patients during office visits as well as when they’re on telephone triage. Team care has been a win-win here. And best of all, families love it!

”

David Lautz, MD

Conclusion

In the team-based care model, patient-care responsibilities are shared among members of a team, which enables physicians and staff to better connect with their patients. Quality, efficiency and productivity should increase, and taking care of patients becomes fun again. The whole team is able to provide care to patients, changing the practice culture from one that refers to “my patient” to one that shares “our patient” in this powerful practice model.



STEPS in practice

1

How's it working in Kaukauna, WI?

Michael T. Werner, MD, is a family physician with a small independent practice in Kaukauna, WI. After recently implementing a team care model for his practice, he has seen more patients, achieved higher quality scores and has eight to ten hours more free time each week to spend with his family.

Dr. Werner's practice had been following a traditional care model for seven years. One day, he read a letter written by his seven-year-old daughter and was saddened to find that she wondered why he wasn't home very much. In speaking with his group, he discovered that other physicians and their families were experiencing the same frustration, and they were interested in pursuing a team care approach to improve office efficiency.

Dr. Werner's practice began the team care approach by assigning three team care assistants (TCAs) to support each physician: two registered nurses (RNs) and one certified medical assistant (MA). Initially the practice tried to implement the model with just two RNs per physician, but they found that it was difficult to keep up with the work load. Therefore, each of the three physicians in the practice who use the team-based care model hired an additional staff member to form their TCA team.

The TCAs are now an integral part of the practice and provide continuity for patients during their visits. During rooming, the TCA collects patient information. When the physician enters the exam room, the TCA synthesizes this information so the most pertinent details are presented. The TCA then stays in the room to act as a scribe. When the physician portion of the visit is complete, the TCA assists in the discharge process and makes sure that the patient understands the doctor's recommendations.

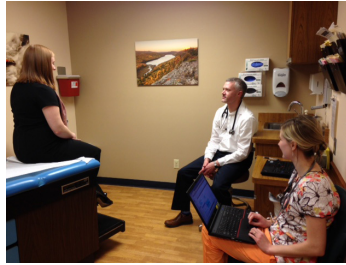
Dr. Werner reported, "At first the TCAs were nervous about using question sets and then reporting data to me in front of patients. They were also worried about documenting the visit. It didn't take long for them to see the positive impact it was having both on my side and on the patients' side. They are now much more comfortable with the process and their role in patient care. They are an integral part of the patient's experience with our practice."

The team care model took approximately two months to get off the ground, but once it was established, patient visits became more efficient and the computer less of a distraction during patient interactions. Dr. Werner now spends less time searching for old notes or records because the TCA has already pulled up relevant files for him. In addition, this approach alleviates pressure to take notes during the visit or dictate later. Between-visit care has also improved. With the expanded team, patient calls are returned promptly and between-visit concerns are addressed in a more timely fashion. Fewer questions require Dr. Werner's direct input because his TCAs can answer most patient inquiries.

As their comfort with the new team-based process has grown, the TCAs have started taking an increasingly proactive role in the practice. For example, they now review charts the day before visits to prepare for each patient's arrival. During the pre-clinic huddle each day, they give a report on why a patient is coming in, what health maintenance needs should be brought up during the visit and whether any labs, immunizations or additional screening is anticipated. This has greatly improved the office's efficiency.

The main challenge encountered during implementation was documenting visits in real time in the electronic health record (EHR). To address the EHR challenges, Dr. Werner and his colleagues created modifications in the form of "dot phrases" or "smart phrases" that were shorthand for commonly used documentation. Once these were developed, the process became more fluid and efficient because the TCAs were able to work more quickly and consistently.

Dr. Werner is very pleased with the results. “I have seen 235 more patients in the first six months since implementation. For me, this is equivalent to approximately four additional weeks of patient care. I have done more, billed more, dictated less, and have more face time with my patients. And, my family gets to see me!” Dr. Werner and his team are constantly refining their model, but they continue to see improvements in the clinic’s bottom line while improving quality of care with more appropriate use of staff in a team care environment.



Reference

Team Care Medicine. <http://www.teamcaremedicine.com/>. Accessed November 1, 2015.

2

How’s it working in Elyria, OH?

North Ohio Heart has followed an efficient, team-based care approach for more than 20 years. With an established staff the clinic’s team functions like a well-oiled machine with the more than 20 cardiologists often seeing upwards of 55 patients a day each. As more quality improvement (QI) efforts came into play and with the recent merger between the cardiology clinic and a primary care group, North Ohio Heart found they needed to adapt their team-based care approach across multiple sites. In the cardiology setting, there are two LPNs and one MA assigned to each physician. In primary care there is one LPN and one MA per physician.

Quality improvement (QI) placed more pressure on the clinic to address every measure, which increased rooming time. For example, additional time was required to perform hypertensive measures and have conversations about Pneumovax with anyone over age 65. These tasks could be shifted from the physician to the nurse, but as the nurse’s plate became fuller they realized that the staffing model needed to change.

Medical assistants began to take on some of the rooming duties that nurses usually performed, such as gathering information on immunizations and labs, updating the patient record and reconciling medications to capture QI and Meaningful Use measures. This shifted the workflow so that nurses now entered the room with the physician and took over the computer to prompt the doctor with pertinent patient information. Nurses still handled after-visit responsibilities, including instructions, education and the clinical summary. Team meetings were critical for determining who on the team would take on a new task.

To accommodate the new workflow, North Ohio Heart has had to hire additional MAs. These MAs receive ongoing training so that they could be flexible and take on new responsibilities as the practice required. Training is implemented as soon as the MA is hired and covers topics that directly relate to the practice’s quality measures. Every office has a clinical trainer who meets with the team on a monthly basis to assess performance and discuss training needs, as well as performs competency checks. The trainers share ideas across sites for consistency. The practice manager held regular meetings to get input on how to improve the approach and then huddled with the doctors and staff to implement changes. These conversations are key to the success of team-based care.

One challenge with the new workflow was keeping the registration team updated on new or different steps. As a result, they initially did not always ask patients the right questions or enter information in the correct places in the EHR. This has since been fixed, but it took some time for the team to become comfortable with the new approach. Metrics are now tracked using reports from the EHR.

The practice manager at North Ohio Heart is always thinking about ways to increase employee and patient satisfaction. Communication has helped the team stay positive and also is also helping make the expansion of team-based care into the primary care setting successful. The practice's patients are now more involved in their healthcare, asking questions about the clinical summary and overall feel more empowered. Charts are more accurate with a team approach, which patients also appreciate. North Ohio Heart wouldn't be able to provide excellent care with the volume of patients they see without using team-based care.

3

How's it working in Palo Alto, CA?

As the health care industry continues to shift towards value-based reimbursement, team-based care has correspondingly increased in popularity. Team-based care allocates responsibilities among the care team to enhance patient care. Additionally, this model enriches value-based elements that are being incorporated into much of the patient care we see today. Stanford Coordinated Care had a team-based care model in place; however, they chose to take it one step further than traditional models.

Stanford Coordinated Care utilizes MA care coordinators to serve as cornerstones in their team-based care model. The MA care coordinators are responsible for their own panel of patients for which they refill medications, perform routine health maintenance and chronic disease monitoring tests, answer initial patient phone calls and emails, scribe patient visits, advise patients on action plans, acquire authorizations and facilitate referrals. All of these activities are completed by standing orders and protocols under the supervision of the physicians they work with.

By shifting the majority of these responsibilities to other team members, physicians are able to utilize their time more efficiently. For example, in many practices, physicians field their own patients' phone calls and emails. This often distracts physicians from patient care. At Stanford Coordinated Care, MA care coordinators resolve many patient inquiries based on protocol or knowledge of the patient's case. Out-of-scope correspondence is then forwarded to their nurses, and finally, the physician handles the complex inquiries. This simple task incorporated into the clinic's team-based care workflow alleviates unnecessary work for physicians, allotting them more time for providing meaningful patient care. While the clinic has been very successful in integrating its new model, one of the most notable accomplishments is their achievement of a Press Ganey® likelihood to recommend score in the 99th percentile for 19 of the last 20 months.

4

How's it working in New Berlin, WI?

Forest View Pediatrics in New Berlin, WI, has helped their community raise and nurture kids for three generations. In 2013, several changes contributed to dissatisfaction among the practice's providers, patients and their families. First, going live on EPIC introduced major confusion and inefficiency. This was compounded when the group simultaneously began a 20-month process of becoming recognized as a patient-centered medical home. These changes, along with greater emphasis on meeting quality metrics, resulted in providers becoming increasingly frustrated with the growing demands of their work.

Dr. David Lautz, one of eight pediatricians in the practice, found that the introduction of the computer screen in the exam room was the biggest problem. It was a distraction and detrimental to communication with patients. He felt he was missing important cues from patients and parents because he was no longer able to make eye contact. In addition, he often found himself working late into the night to complete his charting. Initially, he requested a scribe to support him. Then in 2015, in an attempt to support providers in meeting similar challenges across Children's Hospital of Wisconsin's primary care clinics, the concept of team-based care was introduced. Dr. Lautz immediately saw the potential and agreed to pilot the new model at Forest View Pediatrics.

He piloted the team-based care model with two full-time nurses for one year. At the beginning of the day, the team huddles to discuss their schedule. This is essential to prepare for patients who have behavioral issues and may require a longer visit time. In addition, it helps the nurse identify which templates need to be opened at the outset of the exam. The nurse is present for the entire visit. After she completes the history and Dr. Lautz enters

the room, she stays in the room as the scribe during the physical. This ensures that the physical is completely documented. At the conclusion of the visit, the nurse remains in the exam room to reinforce Dr. Lautz's recommendations and offer training for the parents. The content of the patient's after-visit summary is now less generic and more useful.

The team-based care model also allows flexibility in the nurses' schedule, in that they can be reassigned first thing in the morning to meet the needs of the clinic for that day. For example, if Dr. Lautz's first appointment of the day is with two siblings, it is most efficient to have a computer-savvy nurse in the room. This capacity for "flexing" also better accommodates staff vacations, sick time, and nurse preferences. Some nurses are more skilled and enjoy team care whereas others find it stressful because it means more patients must be seen during the day. In addition, some nurses are less comfortable than others with using the EHR system to document visits. In these rare situations, the nurse acts as a scribe-runner, meaning that they are not the primary scribe accompanying Dr. Lautz in the exam room but instead spend the majority of their day rooming patients or administering vaccines.

With one year of the team-based approach under their belts, nurses at Forest View Pediatrics are now able to pick up on Dr. Lautz's signals to adapt the physical as needed. They feel comfortable interjecting and asking for clarification on terminology or the patient's follow-up care. The team works more efficiently, which has translated to improvements in scheduling. Wait times have decreased and more patients can be scheduled during the day.

This model has also greatly improved care delivery at Forest View Pediatrics. For Dr. Lautz, making eye contact with the patient and being able to pick up on nonverbal cues has reduced the possibility of overlooking potentially important problems. "I was having a busy day and had just come from a visit with a child who had behavioral issues. My next exam was with a teenage patient. We recently introduced adolescent depression screening and she scored high on the screen. I didn't know her score when I entered the room but I could see that she was visibly upset about something. If we weren't using team-based care, I probably would have gone straight to the computer and not noticed her distress. Instead, I was able to take the time to talk to her, comfort her, and figure out how to take care of her."

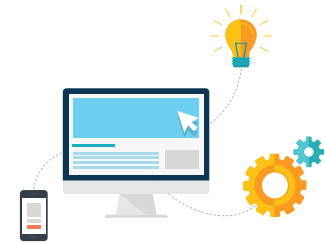
Overall, team-based care has created a collegial atmosphere in the practice. Patients and staff alike feel the change and appreciate it. Patients and their families can depend on experiencing consistency and continuity during and across visits for years to come. Dr. Lautz now describes himself as happier than he has ever been in pediatric practice.



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