



CARE DELIVERY



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## CARE TEAMS

### WHY

#### Focus on Care Teams?

Much has been written about the success of the “care team model” in delivering high quality, low cost, impactful health care. Developing a team-based model of care is at the heart of meeting the Quadruple Aim.

Transitioning to value-based care requires a significant shift in systems of care delivery, infrastructure, and how people are engaged and deployed. It is estimated that in the volume-based system, a primary care physician would need to spend 21.7 hours per day to provide all recommended acute, chronic and preventive care to a panel of 2500 patients.<sup>1</sup> It is, therefore, not surprising that physicians face burn-out and adults in the U.S. receive only 55% of recommended services.<sup>2</sup> The predominant model of care deployed in most primary care settings limits the quality of service delivered.<sup>3</sup> A reinvention of the care team model with more responsibility given to supportive members of the care team has been proven to optimize the experience and outcomes of primary care for the patient, providers and staff.<sup>4</sup> In addition to improving levels of service for chronic disease and preventive care, organizing care team roles differently can also help address the widely documented problem of primary care physician shortages.<sup>5,6,7</sup>

While many health centers report using a team-based approach to care, these systems may not be functioning optimally to achieve desired outcomes. This Action Guide focuses on steps health centers can take to more effectively distribute, or share, responsibility and accountability across the team.

*“Sharing the care” involves a paradigm shift and a concrete strategy for increasing capacity. The paradigm (culture) shift transforms the practice from an “I” to a “we” mindset. Unlike the lone-doctor-with-helpers model, in which the physician assumes all responsibility, makes all decisions, and delegates tasks to team members [but cannot increase capacity], the “we” paradigm uses a team of clinicians and non-clinicians to provide care to a patient panel, with a reallocation of responsibilities, not only tasks, so that all team members contribute meaningfully to the health of their patient panel.<sup>8</sup>*



#### CARE TEAMS

within the Value Transformation

Framework address how groups of staff with different skills work together to deliver and improve care, offering a wider range of services more efficiently than a provider alone. This Action Guide draws upon research and the experience of high performing health care providers to offer proven strategies for successful care teams.





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# WHAT

## Can Health Centers Do Differently When It Comes to Care Teams?

Team structure can vary by organization, and even within a health center. Teams are developed based on the needs of the patient population, the availability of personnel and services, and other resources. Care teams are most commonly led by a provider and include medical assistant(s) and nursing staff. Some teams include behavioral health professionals, pharmacists or administrative staff. Patients are a central player in their care although the degree to which they are recognized as part of the team varies greatly. Health coaches, patient navigators, community health workers, and partner organizations also play a critical role in delivering care as part of a team.

While 9 out of 10 health centers report using a care team approach, often the teams are not delivering desired outcomes without formalization and mechanisms to ensure accountability to the model.<sup>9</sup>

- **Formalization** refers to structuring the behavior and actions of individuals and teams through the development of procedures, formal job descriptions, training and other mechanisms.
- **Accountability** refers to the process of individuals and teams accepting responsibility for the actions and activities formally outlined for them. This requires systems for measuring and reporting on individual and team performance, linked to organizational systems that support skill development and training, and tie into overall performance measurement and goals.

*Team formalization (via job descriptions) meaningfully correlates with how a health center team is structured and implemented. Health centers with greater degrees of formalization are more likely to have more care team members on board, a greater diversity of team members, and expanded job roles. Most of the health centers with high degrees of formalization report having received [patient-centered medical home] PCMH recognition from a recognized entity.<sup>9</sup>*

# HOW

## To Deliver on Care Teams Through Formalization and Accountability

Given the critical role that care teams play in health center performance, it is important to optimize their role and function. Building on the evidence regarding the importance of formalization and accountability, this Action Guide seeks to offer a small set of actionable steps to optimize the work of care teams in deployment of care teams.

A prerequisite to delivering quality care through teams is empanelment. It is impossible for a care team to share responsibility for a set of patients without a clear, up-to-date panel.<sup>10</sup>

Care teams play a central and pivotal role in health center transformation and achieving the Quadruple Aim. Below are steps health centers can take in maximizing the role of care teams:





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### CARE TEAM ACTION STEPS:

- STEP 1 Define Care Standards:** identify a minimum set of patient care and services, by age and/or risk group.
- STEP 2 Distribute Tasks to Meet Standards and Document Workflow:** reconsider who within the care team completes tasks for each standard – ‘share the care’; assign an appropriate staff position to each task of defined services. Map workflow.
- STEP 3 Update Job Descriptions:** summarize job tasks for each role into a performance dashboard. Create individual and team dashboards.
- STEP 4 Monitor Task Performance in Dashboards.**
- STEP 5 Train Staff:** train staff in job-specific skills based on their redefined role within care teams, including quality improvement.
- STEP 6 Hardwire Accountability into Personnel Systems and Performance Reviews:** document task accountability in personnel systems and performance reviews.
- STEP 7 Educate Patients on Redesigned Care Team:** create patient education tool(s) that orient patients to new job roles of care team members, including their own role with self-care.

**STEP 1 Define Care Standards.** Delivering on the Quadruple Aim of improved health outcomes requires attention to clinical measures of importance as well as attention to social risk and other factors impacting health outcomes. For instance, is there agreement on the care and services to be delivered to a 50-year old woman or 30-year old male who comes in for care? Will care be measured against U.S. Preventable Task Force Grade A recommendations? Uniform Data Systems (UDS) measures? HEDIS? High levels of clinical performance cannot be achieved on measures that are not explicitly agreed upon and, more importantly, designed into the system.

Standardized systems of defining care, distributing the workload, and holding everyone accountable for performance are necessary. Using the 50-year old female example, a health center may agree that care to individuals in this age group includes: blood pressure, weight, body mass index, glucose screening, breast, cervical and colorectal cancer screening, depression screening, tobacco screening, immunizations, and sexual risk screening (which could trigger additional testing for HIV, chlamydia, gonorrhea, syphilis, or other diseases or infections). Other agreed upon screenings or services could include a review of medications, social risk assessment or other. An agreed upon list of clinical, social and other care and services, by age group and/or risk stratification, needs to be agreed upon and documented.



**Action item:** Identify the minimum set of care and services to be provided to patients, by age and/or risk group (e.g., 0-2 years, 2-17 years, males/females 18-39 years, males/females 40-49 years, males/females 50-64 years; and 65+ years).



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**STEP 2 Distribute Tasks to Meet Standards and Document Workflow.** Once your health center has agreed to the minimum set of clinical and other services for each target group, the tasks for accomplishing these standards need to be assigned to roles across the health center. In much the same way that airline pilots utilize pre-flight checklists, health care organizations must delineate each step or task to accomplishing a clinical or other service and then delegate each task to a member of the team. This simple, yet profoundly impactful, step of assigning accountability for the full set of tasks needed to deliver on a set of services is not typically a part of health care operations.

- In redeploying care teams, health centers need to avoid automatically assigning tasks to the staff person who traditionally performed the work but, rather, consider ways to move tasks downstream where possible. The goal is to move work that can legally be done by someone other than the physician to other key members of the care team and support staff, including administrative staff where this is appropriate. This enhances the responsibility and role of non-physician trained professionals to reach their licensed capacity, while freeing the time of physicians for diagnosis and treatment tasks. For example, while the task of discussing colorectal cancer screening may gravitate to the provider, evidence indicates screening rates are highest when standing orders are in place and responsibility for this task rests with a support member of the team, such as the Medical Assistant or Nurse.<sup>11,12,13</sup> The provider's role then shifts to handling other questions regarding the screening. Patients should also be engaged in completing self-care tasks, as relevant and appropriate.

- While delegation of tasks provides structure and accountability, all members of the team need to have the freedom and authority to provide care and services as needed and appropriate. Ultimately, patient care is a team sport and all members of the health center team are accountable for the delivery of high quality care to patients. Workflows need to be created to document and assign individual tasks while acknowledging overall team accountability. Workflow maps are a visual representation of all of the actions, steps, or tasks needed to achieve a certain result. For a health center, registering patients for appointments, rooming patients, refilling medication, ordering screening tests, etc. are all processes that happen daily. A workflow map breaks down each part of the process and helps everyone understand who is doing what. It illustrates what each team member is doing and allows for better coordination and less duplication of effort.

 **Action items:** Assign appropriate staff positions to each task of defined services. Adapt the "[Team-Based Planning Worksheet](#)" developed by the Safety Net Medical Home. Maximize the capacity and licensure of team members to expand responsibilities beyond the primary provider. Consider applying care team tools available through the American Medical Association's [STEPSforward](#) initiative.

After having agreed to the core set of clinical and care standards and services your health center will deliver, and having assigned the tasks to accomplish this work to staff throughout your organization, create workflow maps that standardize work processes. Consider the Agency for Healthcare Research and Quality [workflow mapping tips](#).





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**STEP 3 Update Job Descriptions.** It is not enough to agree upon clinical and care standards, identify the tasks needed to accomplish the standards, and assign the tasks to members of the care team. These expectations then need to be hardwired into the expectations of staff. To do this, staff job descriptions need to be updated to include the agreed upon set of tasks for each role. Job descriptions should also reference team accountability in addition to individual tasks and patient engagement.



**Action item:** Update job descriptions for each position on the care team to reflect the set of skills and activities that team members will be responsible for given the health center's agreed upon care standards. Include patient engagement as a responsibility to which each staff person is accountable.

**STEP 4 Monitor Task Performance in Dashboards.** 'What gets measured gets improved'. Applying this to the newly defined tasks of each job role in the organization requires that health centers organize the set tasks for each role into a spreadsheet or dashboard so that performance can be measured, monitored and shared. For instance, a *medical assistant dashboard* may track performance in completing items such as: vitals, colorectal cancer screening, and depression screening. The *provider dashboard* may include the percent of patients with uncontrolled diabetes (per UDS guidelines) or percent of hypertensive patients who have blood pressure control (UDS measurement of <140/90). A *team dashboard* would monitor performance on the Quadruple Aim measures for a panel of patients.



Develop a mechanism to regularly (e.g., monthly) share dashboard data on individual and team performance. Individual level data can be shared in care team meetings as well as meetings by job role (e.g., provider or nursing meetings). Individuals and teams with lower levels of performance should be offered appropriate training and support. Systems of formalization and accountability must be designed within a system that is supportive (see the *Leadership Action Guide* for information on instituting structure with 'psychological safety').



**Action item:** Summarize job tasks for each role into a performance dashboard.

**STEP 5 Train Staff.** Health care organizations that achieve high levels of performance train staff in required skills and provide ongoing support and advancement. Appropriate training should be incorporated into new hire orientation.



**Action Item:** Train staff in job skills, including quality improvement. For the performance dashboard created for each role, include a place to document specific skills or training that may be required of individuals to complete a given task. Incorporate necessary training into new hire orientations.



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**STEP 6 Hardwire Accountability into Personnel Systems and Performance Reviews.** In addition to ongoing performance monitoring on tasks, overall progress and performance should be incorporated into the health center's formal annual performance review.



**Action item:** Update the organization's employee performance review process to measure against new job role expectations based on the overall organizational goals.

**STEP 7 Educate Patients on Redesigned Care Team.** As part of providers' job role, include the expectation that providers introduce/reinforce the broad role of the care team in patient care (e.g., speak to the fact that care team members, including the MA and RN, are highly skilled and trained professionals that can write scripts, order tests, offer education and provide other services). Create fact sheets, letters, care team business cards, or other materials to communicate the important role that care team members play in overall patient care. Consider ways to visually distinguish and personalize care teams for patients (e.g., colors or graphics).



**Action item:** Create patient education tool(s) that orient patients to new care team member job roles. Create or access patient education resources to help patients with their role on the care team and improve patients' skills in self-care and treatment decisions.

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