IMPLEMENTATION GUIDE

CONTINUOUS AND TEAM-BASED HEALING RELATIONSHIPS

Improving Patient Care Through Teams

May 2013

TABLE OF CONTENTS

Introduction 1
- The Change Concepts for Practice Transformation: A Framework for PCMH..... 2

Fundamentals of Continuity of Care 4
- Long-term relationships between patients and providers matter 4
- Improving care and strengthening relationships requires teamwork. 4
- Care teams should be made up of professionals who can meet most health needs of their patients..... 5
- Forming effective teams requires substantial and on-going effort 6

Implement Continuous Team-Based Care 7
- Meet Together 7

Case Study: Care Team Development in a Rural System..... 8
- Redesign Care Team Roles 9
- Facilitate Teamwork 13
- Continuously Monitor and Adjust 15

Conclusion 15

Case Study: Moving to Team-Based Care in a Large Provider Setting with Diverse Populations 16

Additional Resources 17

Appendix A: Health Information Technology 18

Introduction

Today, healthcare is fragmented. Patients receive care from a wide variety of providers working in different locations with whom they may have no long-term relationship. However, research and patient experience show that a strong, lasting patient-provider relationship is central to good health and high satisfaction. Developing this relationship between the patient, his or her primary care provider, and the care team is key to becoming a medical home.

This Implementation Guide addresses why care teams are important for improving patient care and ways to build an effective care team that meet patients' needs and expectations. We identify four principles that should guide any effort to provide continuous, team-based care, and present detailed steps on how to implement continuous, team-based care.

Message to Readers

Practices beginning the PCMH transformation journey often have questions about where and how to begin. We recommend that practices start with a self-assessment to understand their current level of "medical homeness" and identify opportunities for improvement. The SNMHI's self-assessment, the Patient-Centered Medical Home Assessment (PCMH-A), is an interactive, self-scoring instrument that can be downloaded, completed, saved, and shared.

Readers are encouraged to download the corresponding Safety Net Medical Home Initiative Continuous and Team-Based Healing Relationships materials:

- Continuous and Team-Based Healing Relationships Executive Summary provides a concise description of the Change Concept, its role in PCMH transformation, and key implementation activities and actions.
- Types of Call Study.
- Team-Based Planning Worksheet.
- Recommended materials from other sources are provided under Additional Resources.

The Change Concepts for Practice Transformation: A Framework for PCMH

"Change concepts" are general ideas used to stimulate specific, actionable steps that lead to improvement. The Safety Net Medical Home Initiative established a framework for PCMH transformation to help guide practices through the transformation process. The framework includes eight change concepts in four stages:

- Laying the Foundation: Engaged Leadership and Quality Improvement Strategy.
- Building Relationships: Empanelment and Continuous and Team-Based Healing Relationships.
- Changing Care Delivery: Organized, Evidence-Based Care and Patient-Centered Interactions.
- Reducing Barriers to Care: Enhanced Access and Care Coordination.

The Change Concepts for Practice Transformation have been extensively tested by the 65 practices that participated in the Safety Net Medical Home Initiative and used by other collaboratives and practices nationwide. They were derived from reviews of the literature and also from discussions with leaders in primary care and quality improvement. They are supported by a comprehensive library of training materials that provide detailed descriptions and real examples of transformation strategies. These resources are free and publicly available. To learn more, see Change Concepts for Practice Transformation.



Key Changes for Continuous and Team-Based Health Relationships

The eight Change Concepts represent the critical dimensions of PCMH transformation. Each concept includes multiple "key changes." These describe the general directions for the changes—the core elements a practice undertaking PCMH transformation must adopt. The key changes for Continuous and Team-Based Healing Relationships are:

- Establish and provide organizational support for care delivery teams accountable for the patient population/panel.
- Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
- Ensure that patients are able to see their provider or care team whenever possible.
- Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.

Fundamentals of Continuity of Care

Long-term relationships between patients and providers matter

Building long-term relationships between patients and providers is often referred to as improving continuity of care. "Continuity of care" is the degree to which patients experience separate components of healthcare as coherent, organized, connected, and consistent with their needs.[1] Experts have defined three types of continuity that bridge one element of care to another over time.

- Relational continuity refers to ongoing caring relationships where a patient is known by his or her provider so that past care is linked with current care, usually with an expectation that the relationships will continue in the future.
- Informational continuity refers to the transfer of information from one episode of care to another and the notion that relevant information is taken up and acted upon over time.
- Managerial continuity refers to the notion that care is coherently organized and planned and that today's care decisions take into account yesterday's care experiences.

Primary care practices emphasize relational continuity by promoting open-ended, ongoing, healing relationships that bridge the range of patient needs including preventive, acute illness, chronic disease, and end of life care. Strong patient-provider relationships foster improved communication, trust, and knowledge of patient context and preference. Not only does a strong patient-provider relationship lead to improved patient satisfaction,[2] but it has also been consistently linked with improved health behaviors,[3] better health outcomes,[3] and less emergency department and hospital use.[4,5] Providers prefer strong long-term relationships with patients as these relationships give their work more meaning.[6]

Improving care and strengthening relationships requires teamwork

Although building strong personal relationships is a fundamental goal in primary care, there are many practical challenges to building and sustaining these relationships. Research has shown that providing all recommended evidence-based preventive and chronic illness care to an average panel of patients would take a primary care provider 18 hours a day.[7,8] A provider cannot provide this level of care without help; many burn out trying.

Reducing the size of patient panels and developing a highly functioning, well-integrated clinical team are strategies that can help. To address the full complement of patient needs, preventive, chronic, and acute, practices can draw on the expertise of a variety of clinical and non-clinical staff. Reorganizing care so it is provided to patients by a team of professionals with diverse skills and talents, rather than by a single primary care provider (physician, advanced registered nurse practitioner, physician assistant), can help to ensure patients get the education and support they need, reduce provider burn-out, and improve clinical quality as well. In one meta-analysis of multiple quality improvement interventions, the use of care teams was the most effective strategy for reducing hemoglobin A1C values for patients with diabetes.[9] Well-organized teams, those identified by the care team members themselves and, most importantly, by their patients as a unit, can provide improved capacity and high quality care without sacrificing continuity of care.[10,11]

Patients, families, and caregivers are key members of the care team. As the people most intimately aware of the effects of illness, and the only ones able to make changes necessary to improve health, patients must have an open and mutually respectful relationship with their providers and staff. Patients' needs may be well-served by soliciting input as changes are made to improve team functioning. (For more information on measuring patient feedback, see the Patient-Centered Interactions Implementation Guide.)

Care teams should be made up of professionals who can meet most health needs of their patients

There is much debate about who should lead a care team and who should be included on the team. Care teams can be effectively structured in a variety of ways depending on practice size and resources and the needs of the patient population. Ideally, primary care practices:

- Are structured to respond to all common problems for which patients seek care. Since patient populations can vary substantially in age, gender, illness patterns, and social circumstances, the composition of primary care teams must also vary. Social issues like accessible housing may be more prevalent in some populations than others, indicating the need for a social worker on the care team.

- Are organized around an accountable clinician (usually a physician, advanced registered nurse practitioner, or physician assistant) and a medical assistant or nurse dyad who interact throughout the day. Tom Bodenheimer, a primary care doctor who works at the University of California San Francisco, recommends using "teamlets" made up of a provider and a nurse or medical assistant specially trained to coach patients to manage illnesses and reach out to patients needing chronic illness or preventive care.[12] This two-person teamlet is able to address most routine primary care needs when structured and trained properly. However, clinicians aren't necessarily trained to be leaders. Practice leadership may be needed to provide assistance in delegating tasks to other team members. Strong team managers can be helpful in this regard. Leadership skills often are not taught in medical or nursing programs, and additional training and mentoring may be required.[13]

- Share more specialized team members across teamlets. Some organizations, such as Group Health Cooperative, include clinical pharmacists and nurse care managers on teams in a one-to-four ratio—one pharmacist/nurse for every four provider panels.[14]

- Give team members authority and responsibility for performing tasks. This may require a change in thinking, particularly on the part of physicians who are often used to doing all the tasks themselves. Delegation of activities requires trust among team members, something essential that often has to be built overtime as teams develop. Standing orders help teams clarify delegated tasks.

- Work most efficiently when team members function at the maximum of their training, skill-set, and abilities. Team members need to recognize the roles that others on the team can and do play; for example, how clinical pharmacists can assist patients in managing their complex medication regimens. Medical assistants in particular can play major roles in critical functions like self-management support and population management—developing and monitoring reports of sub-populations of patients like people with diabetes, identifying gaps in treatment, and inviting them in for a planned visit. Practices with limited resources can assess the strengths, interests, and skills of their medical assistants and match them with practice needs.

- Keep clinical team size relatively small (fewer than five to seven members). Team functioning tends to break down with increasing size. Some practice staff, including billing staff, front desk staff, computer technicians, and laboratory personnel, complement the care teams, but may not need to be included in daily clinical meetings. However, all staff can play an important role in building strong trusting relationships between patients and the care team. Front desk staff can help ensure that patients see their chosen team, reach out to patients when follow-up care is needed, and remind patients to bring in medications to medical visits.

- Cross-train staff so that tasks are not dropped because of staffing shortages, unpredictable changes in demand, or expected absences. In clearly defining responsibilities and roles, training gaps are often identified. Regular assessment and assurance that staff all share standard competencies can improve trust and facilitate delegation.

- Provide training programs to rapidly bring new staff up to speed when hired.

Forming effective teams requires substantial and on-going effort

Making teams work for patients and staff is a tremendous undertaking—affecting practice culture and operations. Team structure, roles and responsibility definition, fostering team collaboration, and feedback affect daily operations, such as scheduling and visit planning. Changes in human resources policies, job descriptions, and performance expectations, as well as developing functional health information technology, are necessary for care team members to share care for an established patient panel. None of these changes are possible without senior leadership, staff buy-in, and tangible financial and personnel resources, such as protected time and space for teams to meet and problem-solve.

So where do you start?



Implement Continuous Team-Based Care

PREREQUISITE: Empanel patients. It is impossible for a care team to share clinical responsibility for a set of patients without having clear, up-to-date panels. Empanelling patients is a bi-directional activity—patients choose a provider, and care teams understand who they are accountable for over time. The patient and provider team recognize each other as partners in care. Often this linking begins with practices making a tentative assignment based on historical utilization patterns. However, successfully linking patients to their providers is not just a one-time event; it is an opportunity that presents itself with every visit and phone call. Prioritizing this relationship can be a real shift in emphasis for practices that have prioritized getting patients in to see any available provider. To ensure that access to care is not affected, a commitment to constantly assessing supply and demand is essential. (For more information on how to assign patients to panels, see the Empanelment Implementation Guide.)

Meet Together

Once care teams have reasonably sized patient panels, they can begin to work more closely to ensure that preventive, chronic and acute care needs are being addressed. The first step to forming a team is to start working and meeting together. As described above, the core of clinical care teams is often a provider and nurse or medical assistant teamlet. Though other members of the care team may have schedules that flex, this core provider-nurse/MA teamlet works together regularly.

In addition to establishing regular teamlets, effective medical practices allocate specific time for teams to interact and plan their activities. Short mandatory team huddles, occurring daily or several times per day, are often used for teams to review schedules, make staffing adjustments to accommodate demands, identify patient needs, and plan care activities in advance. Huddles allow protected time for task delegation and on-the-ground problem-solving. A visual display system to list and distribute tasks and activities helps to ensure that tasks are not duplicated or omitted, and that patient flow is efficient and timely.

To learn more about huddles, see the AHRQ Daily Huddle Component Kit.

Teams also need dedicated and protected time for quality improvement activities. In other words, teams need time not only to **do** their work, but to **improve** their work. Successful teams lead a variety of quality improvement initiatives by allocating time to review metrics, celebrate successes, identify trouble spots, brainstorm improvements, and test changes. Dedicated time may occur weekly or bi-weekly. The most successful meetings deliberately elicit input from all participants and do not allow one or two individuals to dominate, which jeopardizes teamwork. Some groups have never met together before and may not have the skills needed to plan agendas, take notes, or facilitate meetings. Effective team-meetings are the engine for quality improvement work and care should be given to supporting and developing good meeting skills. See The Microsystem Academy for sample agendas, note-taking templates, and other tools. This is an area where coaching by others in the organization who do have meeting skills could be very helpful. (For more information, see the Quality Improvement Strategy Part 1 Implementation Guide.)

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Case Study: Care Team Development in a Rural System

Terry Reilly Health Services, Idaho (2013)

Implementing care teams was an early priority for Terry Reilly Health Services, a community health center network located in rural Idaho. With seven primary care clinics serving a large number of migrant farm workers and homeless patients, their executive leadership team knew there had to be a better way to meet patients' needs than relying solely on the time and effort of individual providers. "It…was about how you redesign workflows so the physician doesn't feel like she is carrying the whole load," said Bethany Gadzinski, Medical Operations Program Manager.

They began with the basics. "When we started this journey three years ago we had to define what a care team meant to the organization and to the patient." To do this, Terry Reilly staff began following patients as they visited each clinic. They watched how patients flowed through the clinic's physical space and evaluated what services patients used and who they interacted with. "We did walk-abouts in the clinics to see how to define patient flow around a team concept and to see where gaps in care or breakdowns were occurring."

Committees were established to decide what care teams should look like, including distribution of tasks, and where they might meet. Says Gadzinski, "we put managers and line staff on the committees together which was really helpful. The managers chose people on the team to drive this change. They choose people with knowledge of how the clinic works and the ability to communicate about care teams." Executive leadership also played a role, clearly communicating the importance of care teams for patients' health and satisfaction and for staff satisfaction as well.

Today, Terry Reilly uses one registered nurse (RN) per clinic to oversee the medical assistants and is moving towards using RNs as care managers for panels of high-risk patients. Care management services will include health coaching and connecting patients with information and resources. All the clinics have a registry of high-risk patients with two or more chronic diseases, predominantly diabetes and hypertension. Each clinic also has a behavioral health specialist, typically a social worker.

The majority of staff saw the movement to team-based care as a way to share the work. "We put standing orders in place for nursing so physicians were comfortable with task distribution and redefined the appointment template to support team-based care." This allowed Terry Reilly to offer same-day appointments for patients discharged from the hospital for follow-up, increasing patient access to care.

The clinics continue to train staff in team communication. "We had good technical assistance from the Idaho Primary Care Association as far as how to do team-based care. We were able to go to a couple of site visits in Colorado and Seattle, Washington to see different ways that care teams are working in clinics. "We also do new staff orientations that filter throughout the organization and continue to do internal staff satisfaction surveys."

Gadzinski says, "PCMH transformation is a journey… there is always something new to try. Clinics really have to be open to try stuff and be willing to do PDSA cycles. But that keeps it interesting!"

PCMH transformation is a journey…there is always something new to try.

Redesign Care Team Roles

Once teams start meeting regularly, care team members may see areas of inefficiency or opportunities for improvement. This is a natural opportunity to examine how to better use the skills and abilities of care team members. A major undertaking, redesigning care team roles is also one of the most important improvements a practice can make.

Secure high-level leadership commitment to redefining staff roles

There are lots of 'wins' for taking a hard look and redesigning staff roles to maximize the contribution of every member of the team. Reduction in staff turnover due to improved work satisfaction and role clarity is one. Other wins include improvement in clinical flow and preventive and chronic care process performance. However, before these outcomes can be realized, senior leaders must make a commitment to tackling this work.

Taking on issues of job descriptions can be messy. Some staff are committed to continuing the work they have been doing, whether or not it is effective. Staff may not be interested in the proposed changes. Others may feel uncomfortable with the new tasks they have been asked to do and need additional training. Some providers may bristle at management interference in standardizing the roles of clinical and operational staff. The key is having a leadership team that recognizes these barriers to change and can address concerns when they inevitably arise.

Carefully select and support the representatives of the improvement team to lead this work

There are several ways to organize a quality improvement redesign effort. One is to work through existing management infrastructure, tasking line managers to work with their staff to redesign roles. Another is to convene an improvement team with representatives from different groups across the organization. It might be helpful to start by tackling team roles with this more visible, interdisciplinary effort.

Characteristics of good care team improvement members

(Identified by Neighborcare Health)

- Respected by peers and other care team members.
- Have a positive approach and ability to share and see many different points of view.
- Good listening skills.
- Enthusiastic about the mission and the redesign of roles of all members of the care team, including non-clinical staff.
- Ability to share both positive and negative experiences in a constructive way.
- Ability to communicate and work with others whose backgrounds, experiences and styles may be different from their own.
- Problem-solvers.
- History of offering constructive input.
- Willing to be a messenger and spokesperson for this work.
- Willing to spend time on this project.
- Ability to reach out to others and value input from a variety of sources.
- Willing to expand current knowledge base to develop the best staffing model.
- Comfortable with ambiguity during the development, testing, and implementation phases.
- Willing to support the team's decisions once a decision is made.

Success requires more than just selecting good team members; leadership needs to support and empower members as they do their work. Clinic managers and assistant medical directors leading sites must be well-informed about the work of the group. If a care team improvement member is presenting, leaders must be present to provide active support. To support consistent messaging, the care team improvement members can use written talking points and speak from these notes. Leadership can celebrate openly, thanking the improvement team for their work. Most importantly, make sure the clinic managers know their job is to support the improvement team at the site and, if need be, to step into the line of fire with them.

Address staff concerns

Be prepared to address staff concerns about their and others' readiness to perform more advanced tasks. Leaders have to be honest about their motivation for redesigning roles. If redesigned roles are due to funding cuts, leaders should be honest about that. If redesigned roles are due to high levels of turnover, show staff the supporting data. Though some staff may feel relieved to be working in new or more advanced roles, others may feel nervous and/or lack confidence about their ability to perform. Some staff also may be worried about their colleagues' ability to perform more advanced tasks. These are ongoing issues and will take a sustained leadership commitment to address. Leaders should be prepared to find that a single meeting or single message is not sufficient to move to fully functioning teams.

Data can help address staff hesitancy about sharing roles and tasks. Observe staff as they work and pull raw data. For example, in one practice, blood pressure was being taken two or three times per visit because the nurse or provider was retaking it, not trusting the results of the medical assistant. Either because of lack of training, or simply a lack of confidence, waste and rework may be built into existing practice operations. Taking these things seriously means providing ongoing assessment, training, and guidance for tasks.

The practice should also conduct assessments of all staff, regardless of tenure, to identify areas where training would be beneficial, and work with internal staff to provide mentorship. Neighborcare, a community health center in the Seattle, Washington area, was faced with broader clinical issues, such as how to take a blood pressure reliably or perform an EKG. To address this, the organization partnered with a local medical assistant training program to conduct clinical refreshes. All relevant staff were required and paid to attend.

Specific tasking guidelines for medical assistants, registered nurses, and front desk staff are available. The guidelines include templates such as:

- Activities to perform by role for a well child check.
- Activities to perform by role for a diabetes planned visit.
- How to stock the exam room.
- Phone scripting for front desk staff on what questions to ask patients with clinical inquiries.

Understand state regulations for scope of practice

Licensure and scope of practice requirements differ among states. Look to the state nursing board, physician board, and corporate policies for regulations. Many practices are surprised to learn how much latitude they have to define nursing, medical/clinical assistant, and social work roles. However, legal limits for each key team member must be understood and followed. Remember to continuously update practice policy as rules and regulations change.

Foster a culture of curiosity to help uncover core issues

An early and essential component of redesigning team roles is understanding the volume and variety of work staff currently do. Staff can be surprised when taking an objective look at the type of work they spend most of their day doing. Fostering a sense of curiosity about why so many faxes come in for the same prescription or how much time is spent triaging, rather than addressing patients' phone questions can be key in uncovering and addressing major sources of wasted effort. Often when front-line staff start to look at simple data, big changes result.

Get started by tackling the phones; a template for tracking the types of calls that come in to a practice is available here.

At Community Health Partners in Montana, front desk staff took the lead in measuring areas of interest to the organization as it pursued NCQA PCMH™ Recognition. Front desk staff started to look at a range of issues including mail returns, billing errors, primary care provider continuity of care, daily call volume, and how often HIPAA consent and language needs were updated.

Set up a process to formally and regularly reevaluate how things are working

Redefining staff roles is not a static process, but one that evolves. Especially at the beginning, staff should have a way to capture their tasks and activities that are not explicitly included in their new role. By creating a formal "exception report" and a process to reevaluate how things are working, staff are less likely to be drawn back into old patterns and roles. Essential functions that may have been overlooked can be formally evaluated to see who is best positioned to address them in the future.

Having a formal process for reevaluation also means that hard won changes can be held constant for a while before being considered again as an improvement topic. Consistency can lower staff anxiety and give all staff a chance to get used to the new changes before diving in again. Some practices wait to make changes to any standard new work until all clinical teams have been trained and have used the new templates for a given period of time. This enables everyone to give feedback on what works and what does not before updating the tool.

Be willing to 'peel the onion'

Examining any one team member's role invariably forces questions about how other team members work. For example, front desk staff have a role in customer service, referral management, care coordination, scheduling, call management, prescription refills, phone consultations, and financial collections, among others. Clarifying the role of front desk staff in any of these areas forces questions about how registered nurses, medical assistants, and providers work.

Ultimately, there is no way to redesign just one team role. Practices do not have to address all staff roles at once, and probably should not, but practices also cannot leave related roles hanging for too long. So where to start? It may make the most sense to start where there is a burning platform. In many cases, this may be a place where there is high staff turnover, or where staff are seriously under-used. As one leader said, "When the nurses start joking that they are 'fax jockeys' you know it's time to reexamine their work."

One approach is to start by looking at a single role and peeling off the inevitable questions that arise about closely related roles and charging a separate group to address those. For example, tackle the role of the registered nurse and then deputize a related team to examine the medical assistant role if and when questions arise. Other more discrete roles, like front desk staff or providers, can then be looked at in sequence.

One tool that can help start a conversation about roles and tasks is to use a team-based planning worksheet, available here.

Have a plan for spread and sustainability at the start

Too often we think about all the hard work of designing and implementing a new change, and we focus very little on what it will take to spread and sustain that change over time. In the case of team role redesign, there is tremendous inertia for returning to old ways of working. Without a serious plan for embedding change, sustainability is unlikely.

What does it mean to embed change?

- Make the changes explicit. Embed them in job descriptions, tasking guidelines, workflow diagrams, scripts, and protocols. These can be valuable communication and training tools.
- Put a measurement system in place that monitors outcomes over time. When staff satisfaction decreases or results on clinical or operational process measures decline, roles must be revisited. Community Health Partners in Montana uses a staff survey to assess how staff feel about providing patient-centered care and what could be improved.
- Provide on-going training. Turnover and new staff demand that a formal system for ongoing training and mentorship be in place.
- Focus on local leaders. For changes to be sustainable, they must become embedded in the daily operations of the practice. Most often, when changes do not 'take' it is because local leadership does not have the resources, expertise, or inclination to support the new way of working. Keeping priorities clear and finding ways to help local leaders continue to monitor and adjust roles is essential.

Explain new staffing roles to patients

Helping patients understand the new roles of the team greatly improves team function and the relationship to the patient. Practice staff often assume that patients have a shared understanding about appointments, how team members interact, and the difference roles of medical assistants, nurses, and physician assistants. However, these assumptions can be faulty, leading to miscommunication, confusion, and mistrust. Patients may not understand what a medical assistant does or why their primary care provider is not taking their blood pressure. Communication strategies to help patients understand who is on their care team include:

- Verbal introductions from the provider to individual team members.
- Letters for new patients introducing the team.
- New patient orientation programs.
- Care team business cards.
- Waiting room pamphlets with team member names, descriptions, and pictures.
- Waiting room bulletin boards or posters describing the care teams.
- Color-coded badges worn by care team members to help patients visually link members of their care team.
- Updates to the practice website (if possible) that reflect care team organization.



Celebrate the returns and find the joy in work

Change is hard. Changes like PCMH transformation affect the culture of an organization, but the returns on these investments can be remarkable. Cambridge Health Alliance, Union Square in Boston, MA reported these returns after optimizing staffing roles:

- Vastly reduced telephone call abandonment rate.
- Improved relations between front desk staff and nurses.
- Increased nurse satisfaction.
- Improved teamwork within the teams and clinic.
- Front desk staff took over the nursing clerical duties quickly and efficiently.
- Patients receive enhanced education and attention to their needs from nurses and a wider team, including social workers.
- Improved flow.
- Improved provider and staff satisfaction.
- Better work environment, less staff burnout.
- Registered nurses have been challenged to let go of old beliefs like "it is just faster if I do it myself."
- MD/RN interactions have become more balanced, a "meeting of equals."

Facilitate Teamwork

After the hard work of redesigning team roles, it is time to make sure the infrastructure is in place to keep the team functioning and that patients are able to see their provider or care team whenever possible. This process is not static but instead changes as the team develops. The following are a sample of the infrastructure needs to consider.

Ensure relevant patient information is available to those who need it

As part of sharing care for a panel of patients, team members such as an RN care manager may need access to patient information through the electronic health record. Information technology permissions may need to be changed to support access to and documentation in the medical record by non-provider staff. In the same way, a medical assistant may need standing orders to support preventive care responsibilities. Using evidence based care guidelines as a starting point for developing standing orders can be helpful in clearly delineating shared care tasks. An example of standing orders is provided here.

Consider information technology as a strategy to support continuity of care. Secure email messaging and telephone visits are ways to connect with patients when they have concerns or questions and as follow-up to in-person visits. These alterative types of visits can lessen the feeling of endless demand that some safety-net practices experience. However, reimbursement and payment policies need to be taken into account. Practices that integrate telephone and email into their everyday workflows often find efficiencies, allowing them to connect with more patients more often and facilitate pre-visit work. However, redesigning phone systems or investing in health information technology is a tremendous undertaking, and one that is most effective when built around a team with strong care processes already in place. (For more information about expanded modes of communication, see the Enhanced Access Implementation Guide.)

See Appendix A: Continuous and Team-Based Healing Relationships and Health Information Technology for more information.

Improve communication

Organizing team member roles and responsibilities is a start, but to keep a team functioning well, attention must be paid to team dynamics and communication. In medicine as well as education, power hierarchies are entrenched. For teams to really share care, staff must have confidence in their team members, (see redesigning care team roles above). Staff must be able to communicate clearly and respectfully to one another about shared work. Often these 'soft' skills go unaddressed, to the detriment of the practice and patients. Training can prove a worthwhile investment especially when new teams are formed or new hires are introduced. Practices are increasingly looking at initial training and orientation session as an opportunity to clarify specific roles and tasks for staff and offer training in team communication.

Consider co-location

Some practices with the most impressive health outcomes for patients physically co-locate team members. Instead of organizing staff by professional degree—the nurses sit in one area and physicians in another—all the clinical team members sit together. Co-location is a physical manifestation of the cultural change occurring in team-based care. When all the professionals who care for a panel of patients are located together they can share insights and address questions in real time. Informal communication is strengthened, and teams develop rapport.

Get real about part-time providers and other policies

One common barrier to continuity of care in practice today is the near total reliance on part-time providers. Very few providers offer clinical care in the office five days a week; so finding ways to ensure patients get their needs met can be a challenge. Several models for how to deal with this issue exist. At Group Health Cooperative, for example, clinicians who are in practice less than 50% time do not have their own patient panel, but are assigned to a local pool that provides substitute care when others are temporarily out of the office due to vacation or family/medical leave. Those clinicians who practice more than 50% time but less than 100% time have their own panels but are paired with another part-time provider with clear coverage arrangements. For this pairing to work, providers cannot both be out of the office on the same day (say Fridays or Mondays) and need to be in the office at the same time occasionally to facilitate information sharing. (For more information, see the Empanelment Implementation Guide.)

Examine scheduling practices

How patients get appointments can support or seriously undermine attempts at building continuity of care between patients and care teams. Sometimes real operational changes must be made to link patients and care teams. Appointment systems should be designed to preferentially book patients with their care team. Staff should routinely ask patients if they would prefer to see their own provider, even if means foregoing speedier access to a non-team provider.

Continuously Monitor and Adjust

How will you know that the changes you are making to team roles and practice infrastructure are an improvement? You have to select and monitor metrics. A variety of measures are helpful in guiding efforts and monitoring how changes affect patients and staff. One important metric is continuity of care. Organizations such as the Multnomah County Health Department in Oregon measure how often patients see their preferred care teams to ensure that continuity of care is actually happening. When patients are not regularly receiving care from their preferred care team, action can be taken. Often seemingly mundane operational issues stand in the way of continuity of care including vacations, part-time providers, or scheduling policies that place availability over continuity of care. However, understanding and managing the potential downsides of continuity of care on patient access is important as well such as longer wait times for patients.

A robust and active quality improvement program, including regular team meetings and support for data gathering and analysis, help improve continuity of care when problems arise. Using Plan-Do-Study-Act (PDSA) cycles can keep care team meetings focused on improving care, rather than only dealing with important, but tangential issues like vacation time or the break room. (To learn more about choosing and using a quality improvement strategy, see the Quality Improvement Strategy Part 1 Implementation Guide.)

Finally, look at care outside your walls. When patients are seen by other care providers, coordination strategies are helpful to ensure that patients receive organized care and are systematically connected back to their team for follow-up. One tool for ensuring that care is organized, even if relational continuity of care is disrupted, is a shared care plan. Shared care plans outline the patient and provider's shared goals for treatment and enable new providers to fit into the established approach as well as understand the historical challenges and future goals. With a shared care plan, a new provider can say: "I see you and your doctor are working on X, here is how I might help to make X successful." This simple acknowledgement of the patient's existing relationship and goals can reduce confusion and rework. In clinical settings where continuity of care has not historically been a priority, patients and staff need to be included in and committed to the culture shift toward emphasizing patient-team partnership. For patients who continue to bounce around the system, it may take encouragement from a provider to say: "One of the most important things you can do for your health is to establish a relationship with a provider and team who you trust." (For more information, see the Care Coordination Implementation Guide.)

Conclusion

A continuous, healing relationship benefits both patients and providers and is an essential component of primary care and the PCMH Model of Care. Yet no one provider can meet all the care needs of a panel of patients. To improve patient health outcomes, patients need a team. Strong clinical teams rely on trust, good communication, clear roles, and available, actionable data to do their work. Reorganizing care along these lines is no small task, but the studies, tools, and stories provided here may help you along the way.

How will you know that the changes you are making to team roles and practice infrastructure are an improvement? You have to select and monitor metrics.

Case Study: Moving to Team-Based Care in a Large Provider Setting with Diverse Populations

Santa Clara Valley Medical Center, Santa Clara County, California (2010)

Santa Clara Valley Medical Center is a large public health system with 8 health centers and one 553-bed hospital serving over 200,000 patients in 750,000 visits per year. Moving toward proactive, continuous, team-based care in such a vast system is challenging, says Margo Maida, MSW, Program Director of Medical Home and Leadership Development for the health system.

"It's very difficult in a large public hospital system to move to innovation, team-based care, or care coordination," says Maida. "Teams are in very different phases in a sometimes-damaged system. But we are committed to the medical home model so we find ways to make it work."

Santa Clara is rolling Patient-Centered Medical Home transformation across their system: selecting teams at some sites and providing the resources for them to meet regularly, helping remove barriers, challenging them to share best practices, and moving toward more efficient team meetings with data.

"Each team is in a different place," says Maida. "In our system, we're beginning to move the teams toward population management, proactive, and team-based care. We've also staffed up our teams," she adds, by changing some roles, and creating different ratios of medical assistant to physician to physician assistants, for example.

Team-based care is a huge paradigm shift for teams and for patients.

"Team-based care is a huge paradigm shift for teams and for patients. How ready the team is becomes important to how this unfolds for patients. And patients want care to be there when they want it and they want a care plan to revolve around their needs," says Maida. "So there are really two variables for success: how ready is the team to make changes, and how ready is the patient to see a member of the team and not the doctor."

Santa Clara also effectively uses coaches who are on-site and who can "move mountains." "We develop strong coaches within organizations that perpetuate this. There is training for the coaches such as meeting-management training. Coaching is very important to moving team-based care forward," says Maida.

This system-wide commitment to staffing, coaching, collaborating, and providing resources to plan for improvements is making the difference in transforming care.

Important payoffs to implementing team-based care are patient satisfaction and provider satisfaction. "Medical home teams always fare better in patient satisfaction than non-medical home teams," says Maida. "Also, what is consistent among all teams is team satisfaction—they are happier with the work they are doing. We're a unionized county health system, and the unions are saying that their members in medical home are happier at work."

The example of Santa Clara Valley Medical Center illustrates how, even in a very large system, with diverse patient populations such as migrant workers, the homeless, non-English speakers, and high mental health need patients, continuous and team-based care is working for patients and providers.

Additional Resources

Tools

The Microsystem Academy
The Microsystem Academy offers free tools, including a great quick team assessment, to help pinpoint areas of improvement in team functioning.

ACT Center
The ACT Center developed a free, step-by-step toolkit called "Integrating Chronic Care and Business Strategies in the Safety Net" that provides a step-by-step practical approach to guide teams through quality improvement, focused on the chronically ill in safety net populations.

Institute for Healthcare Improvement
IHI provides free guidance and tools around forming the team and using team huddles to improve communication.

Team STEPPS
Strategies and tools developed by AHRQ to improve team communication and functioning.

Patient Centered Primary Care Collaborative
PCPCC offers a PowerPoint presentation from leading national experts on developing teams and continuity of care, among other elements of the medical home.

American Academy of Family Physicians
AAFP offers a variety of tools to support family physicians, including clinical guidance and patient care resources.

Patient Safety Program Briefs and Huddles Toolkit
This toolkit from the US Department of Defense Patient Safety Program documents the benefits of briefs and huddles.

Articles

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Appendix A:
Continuous and Team-Based Healing Relationships and Health Information Technology

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This addendum is supplemental to the primary Continuous and Team-Based Healing Relationships Implementation Guide.

In a Patient-Centered Medical Home (PCMH), interdisciplinary care teams provide comprehensive, coordinated care for a panel of patients. Health information—whether electronic or paper-based—is the care team's nervous system. An electronic health record (EHR) can strengthen a care teams' ability to provide patient-centered care—it is a powerful tool that, if used well, can support providing comprehensive care to a complex panel of patients and help engage patients in their health and healthcare. However, the utility of an EHR depends on how carefully the care team manages entering information and, most importantly, how that information is used in clinical decision-making and quality improvement. The care team must understand information flow, workflow, and the use of information management tools within the EHR in order to get the most utility from HIT.

Below are tips and strategies practices can use to optimize technology to best support care teams and enhance the patient-centeredness of care they deliver.

Incoming Information

Information is only valuable if it is accurate, timely, and easily located. Manual data entry tends to be error prone, but properly functioning EHR interfaces can improve the accuracy and speed of data collection. The care team must update patient information frequently, enlist patients in checking their own information for errors, and standardize workflows to ensure that data are entered properly and in the correct field. The following strategies can help ensure that information entered into the EHR is accurate.

Safeguard Data Accuracy

- **Set expectations.** The care team must agree on which members gather and enter information, and understand who needs what information when.
- **Clarify team data entry roles.** Clearly specify which team member is responsible for gathering and entering each type of information in every workflow. By sharing the care of basic data gathering for such things as family history, allergies and smoking history with non-clinician team members and patients, providers can have more time for entering data that require clinical judgment and/or clinical decisions.[12] This type of teamwork requires providers to be actively involved in teaching and supervising other team members.
- **Define essential information that must be entered.** Visit workflows should specify how key information is gathered, entered, and/or validated at each visit. Give specific attention to demographic data, primary care provider (PCP), vital signs, medications, allergies, and tobacco use, which can be gathered and entered by non-provider care team members.

Make Data Entry Efficient and Accurate

Data interfaces that bring laboratory, pathology, imaging, and referral results into the EHR from other data systems should be constructed in ways that make the information easy for providers to find and to view. Interfaces must be operational and well maintained. They should also allow gathered information to be stored as structured data so it can be used by decision support tools and, if desired, for clinical reporting.

- **Data entry fields** reduce data entry errors by requesting confirmation of values falling outside an expected range.
- **Structured data and text information.** The care team must enter information in a structured format that the computer and care team members can understand and use. The narrative portion (text or unstructured data) of a chart tells the patient story in the provider's words with nuanced information intended for other care team members. Protect this information from over processing by the computer. Labor saving EHR tools (e.g., copy-paste, note-writer applications) that build narrative text from structured data carry the risk of inaccurate documentation. Communicate the process of entering information across team all team members so that each member understands the information for which they are responsible, and how to enter it correctly.
- **Templates.** Use templates for common situations (e.g., office visits, physical exams, common procedures) to ensure that staff are prompted to ask for key information. Chart template structure should encourage providers to finish their charting as close to time of the encounter as possible.

Engage Patients in their Health Information

The patient is a critical member of the care team who can and should be called on to enter information and help identify data errors in the EHR.[15]

- Encourage patients to review information in their charts for accuracy through a patient portal by giving patients chart summaries to review. Allow patients to observe their information as it is entered in the exam room by arranging the room so that patient seating has a clear line of sight to the computer.
- Encourage patients to assemble their own clinical information such as family history, alcohol and tobacco use, allergies, and medication changes. Consider encouraging patients to enter data into their own charts through a patient portal or a kiosk in the waiting room. Although evidence to support patient entry is minimal, there is growing popular interest, which is reflected in health IT policy.[16,17]

Use HIT to Strengthen the Relationship Between Patient and Their Care Team

Care teams must make an effort to ensure that HIT does not become a barrier to communication.

- Patient care hand offs are points where face-to-face communication improves efficiency and reduces errors.
- After the medical assistant has roomed a patient and before the provider enters the exam room, face-to-face communication can alert the provider to updates in the visit plan from the huddle and new findings that the provider might otherwise overlook.

Clinical Decision Support Interventions

In all patient care workflows, care teams rely on information technology to organize and display clinical data to make appropriate decisions. Information must be easy to find and readily understandable. EHR tools that facilitate the presentation of information to the care team are called clinical decision support interventions (CDSI). CDSI include flow sheets, graphs, dashboards, order sets, charting templates, care gap/patient safety alerts, and reports.

To be effective, CDSI must accomplish the "5 rights:" 1) get the right information, 2) to the right person, 3) at the right time, 4) using the right medium, and 5) formatted the right way. Unless the "5 Rights" are carefully observed, CDSI may go unused, or worse, may complicate or disrupt decision-making.

A care team uses CDSI throughout the workday, including:

- In the huddle.
- In workflows associated with the patient visit.
- To strengthen working relationships among care team members.

The Huddle

The huddle is an opportunity at the start of the day to quickly review and prepare for patient visits.
Configure CDSI in the form of a dashboard or report for use in the huddle so the care team can clearly see:

- Important problem list omissions through side-by-side comparison to the medication list.
- Recent orders for imaging tests, referrals, hospitalizations, and emergency department visits with links to results and documentation to show missing information required for the visit.
- Special resources that may be required for the visit (e.g., translation).
- Dates that preventive or chronic illness care or procedures were last performed to highlight care gaps and overdue items.
- If the visit is a transition in care, following after an emergency department visit or hospital discharge.

Office Visits

In-person patient visits are and will remain one of the most important ways of delivering primary care.
CDSI supports care delivery throughout the office visit.

- Chart note templates structure visits and can remind the care team of questions they might otherwise forget to ask. Preventive visits and procedures lend themselves to dedicated templates. Unpredictable visits (typically for acute care needs) and procedures lend themselves to modular templates where elements of the physical exam can be inserted based on patient history.
- Order sets group orders by context to help care team members select items that might otherwise be overlooked. Build decision support into referral orders for particular clinical questions. An order to cardiology for a rhythm disturbance can include a prompt for the ordering provider to order specific blood work and cardiac monitoring tests so the cardiologist can complete the assessment on the first visit.
- Order protocols give care team members a framework in specific settings for ordering clinical tests. These can be signed by the provider later (e.g., urine test, a strep screen, an ECG) speeding assembly of information needed by the provider.

- Pended orders entered by a medical assistant while rooming the patient can prompt providers to sign orders and close care gaps identified in the huddle as requiring a discussion with the patient before placing the order.
- Alerts demanding immediate attention are an intrusive form of decision support. Alerts are frequently ignored unless delivered when a provider is looking for the information in the alert. Alerts can tell providers when signing a medication order if medication allergies and interactions are occurring. However, identifying the correct point to deliver an alert in other workflows can be difficult.
- Reviewing an after-visit summary on the computer screen with the patient at the end of the visit can help both provider and patient identify absent or erroneous information. Review reinforces and clarifies the agreed-upon treatment plan.

Combining the power of HIT with multidisciplinary care teams in a PCMH expands the care teams' ability to provide comprehensive, coordinated, and continuous care to their panel of patients. The multidisciplinary team dramatically increases the scope of issues that can be addressed for each patient seen in the practice. HIT puts necessary information at the team members' fingertips.

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