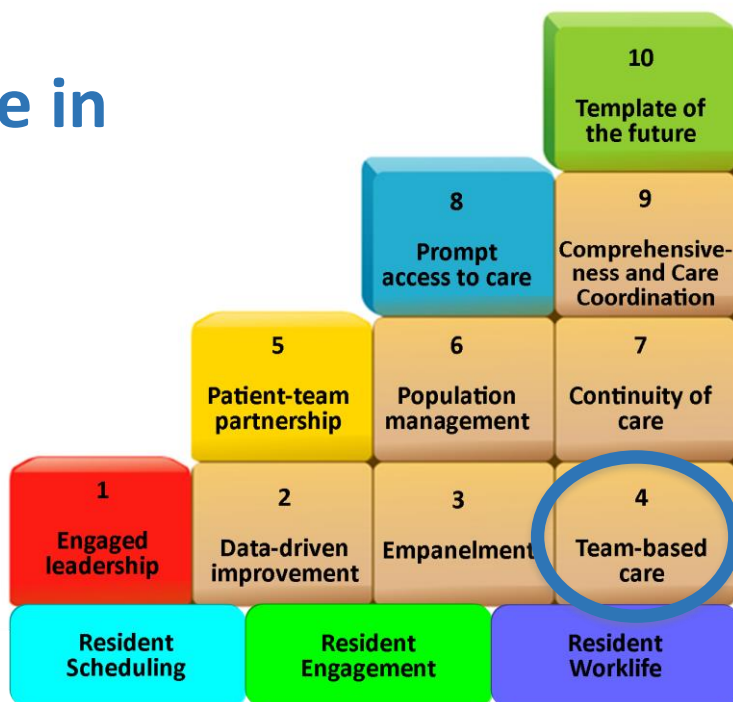


Transforming Teaching Practices

Toolkit for Team-based Care in Teaching Clinics

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Thomas Bodenheimer, January 2020



As primary care practices get larger, primary care is moving towards a team model. For teaching clinics – most of whose clinicians see patients very-part-time because they also have an educational mission – teams are both especially important and particularly challenging.

This toolkit provides an orientation toward team-based care in teaching clinics and offers some lessons from teaching clinic teams around the country. The toolkit features some case highlights from teaching clinics from the time of our site visits from 2015 - 2018.

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1. Why do we want teams in our teaching clinic?

To explain to faculty, residents and staff why teams are important, here are some discussion points and facts:

Teams create a small, comfortable place for patients

- Patients prefer small practices to large practices [1]. Teams divide large practices into smaller units that patients prefer.
- Patients want to know who is caring for them and want the people caring for them to know them [2]. This requires that patients see a small number of people – their team -- who know them and with whom the patient has developed a longitudinal relationship.

To create a small, comfortable place for residents

- Because residents rotate through many different clinical services, they like having a place that feels like home. Going into a large clinic and working with different people on different days means that residents don't get to know, and develop relationships with, the staff. Having residents always working on their home team gives them the comfort that comes from familiarity working with a small number of people.
- Many residents around the country report that they like being on a team so that they get to know the people on the team throughout their residency.

To divide a clinic into teams, with each team responsible for a panel of patients, allows the clinic to organize and measure the work of primary care

- Teams help organize the clinic's work by having a small number of people responsible for a defined panel of patients. Measuring the performance of each team on clinical, operational, and patient experience measures allows teams to learn from each other and thereby elevate quality.

To add capacity to see more patients without increasing clinician burnout by empowering team members to see patients independently

- Working under standing orders, nurses, pharmacists, behaviorists, and medical assistants can each provide a portion of the care needed by the clinic's patients without requiring clinician time, thereby adding capacity without increasing burnout [3,4].

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To increase quality beyond what a lone clinician can provide

- At Intermountain Healthcare, patients in practices with high-performing teams have better diabetes control, lower ED visits, hospital admits, and total costs compared with practices without teams [5].

To empower all team members by sharing responsibility for patient panels

- When team members, for example medical assistants, are given only tasks to do, their jobs can be alienating. If they are charged with responsibility for a portion of the care of their panel of patients -- for example making sure that all their panel's patients are up to date on routine chronic and preventive care services -- their job becomes more meaningful because they are truly helping patients. The medical assistants get to know the patients empaneled to their team and the patients get to know their MAs.

To teach residents how to work in teams

- The future of primary care is team-based care, in particular because there are not sufficient primary care clinicians to meet the population's health care needs. Working in teams is a skill that future physicians need to learn.

9 Elements of High-Performing Team-based Care [6]

1. Stable team structure
2. Co-location
3. Share the care
4. Defined roles with training and skills checks
5. Standing orders/protocols
6. Defined workflows and workflow mapping
7. Staffing ratios adequate to facilitate new roles
8. Ground rules
9. Communication: team meetings, huddles, and minute-to-minute communication

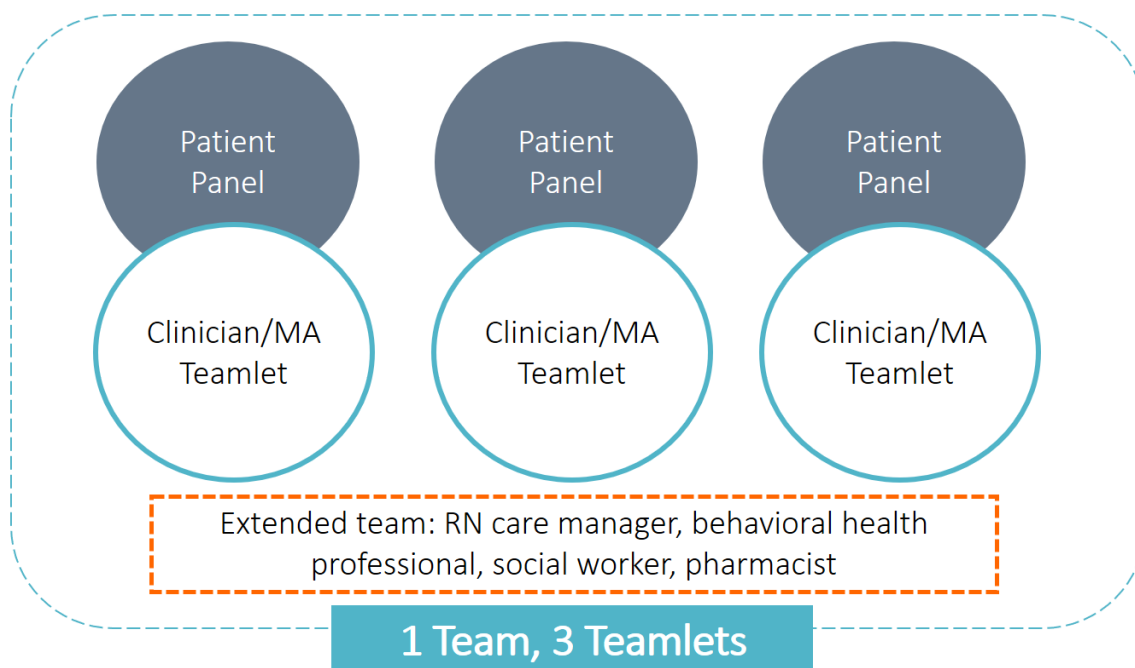
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2. How are teams structured in different teaching clinics?

Team structure refers to how the care team members are organized in the clinic, usually around a patient panel. This is the “anatomy” of the team. A typical team structure involves a core team (teamlet) – usually clinician and MA – and an extended care team (RNs, pharmacists, behaviorists, social workers, physical therapists) that supports several core teams.

This graphic shows a typical team structure in a non-teaching clinic [7]. Patients are empaneled to a core team (usually a clinician-MA “teamlet”). The extended team supports several teamlets.



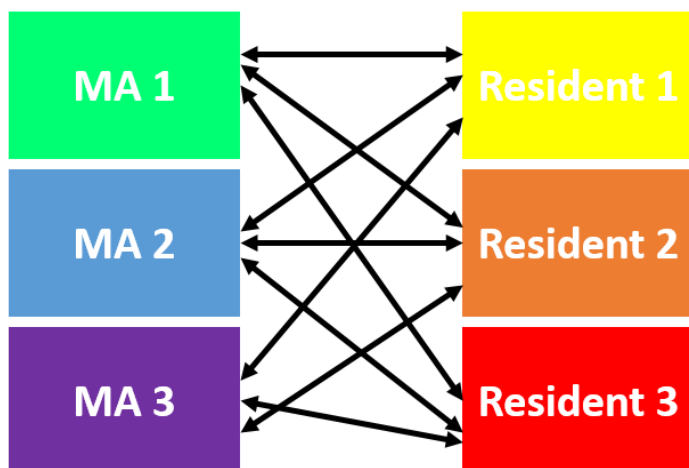
In teaching clinics, this exact core teamlet structure often isn’t possible because there are so many part-time clinicians, both faculty and residents. In some teaching clinics with a small, near-full-time faculty, this structure could work for faculty or for more full-time NPs/PAs.

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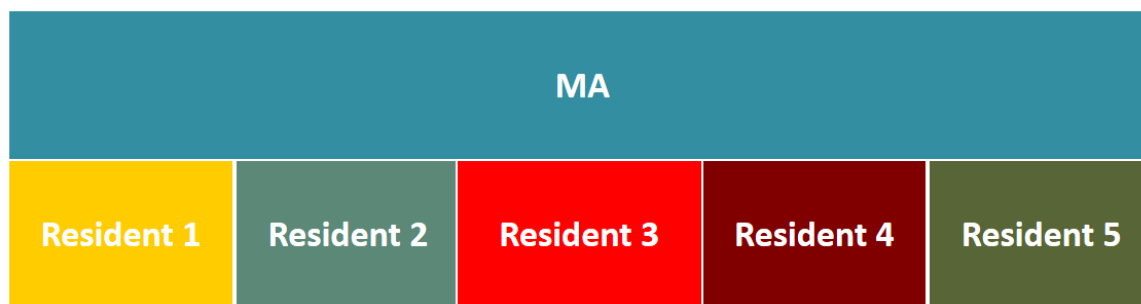
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Here are examples of the types of core team structures often seen in teaching clinics:

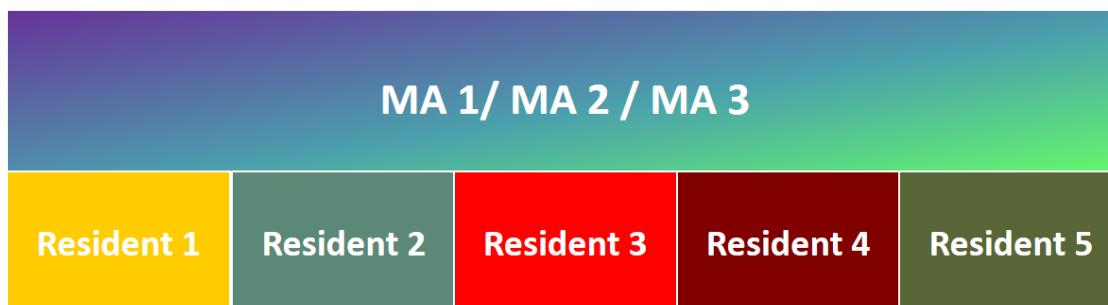
1) **No pairing.** Any resident works with any MA in the clinic at any given moment:



2) **A group of residents work with 1 MA.** Each resident always works with the same MA and the MA always works with 1 of 5 consistent residents:



3) **A group of residents work with a group of MAs.** Each resident always works one of the 3 MAs and the 3 MAs always work with one of the 5 residents:



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4) **Hybrid core team structures** feature near-full-time faculty or near-full-time NP/PA always working with the same MA (teamlet), while residents and part-time faculty work with the same small group of MAs. Some teaching clinics have inverted this structure so that residents rather than faculty have priority to work with the same MA.

To simplify things when creating a team structure, sometimes it makes sense to start by constructing core teams with near-full-time clinicians (faculty or NP/PAs). Residents and part-time faculty can then be added. Having a near-full-time faculty or NP/PA on each team offers leadership and stability to the overall chaos of resident clinics and also provides an anchor for continuity of care.

When thinking about team structure it is important to make a paper representation of the teams, but also essential is to depict how the team/teamlets look during a typical half-day session.

The following case highlights show examples of team structures in existing teaching clinics.

CASE HIGHLIGHT: Small teams at Northwestern McGaw Family Medicine Residency at Erie Family Health Center

There are 8 small teams that are paired:

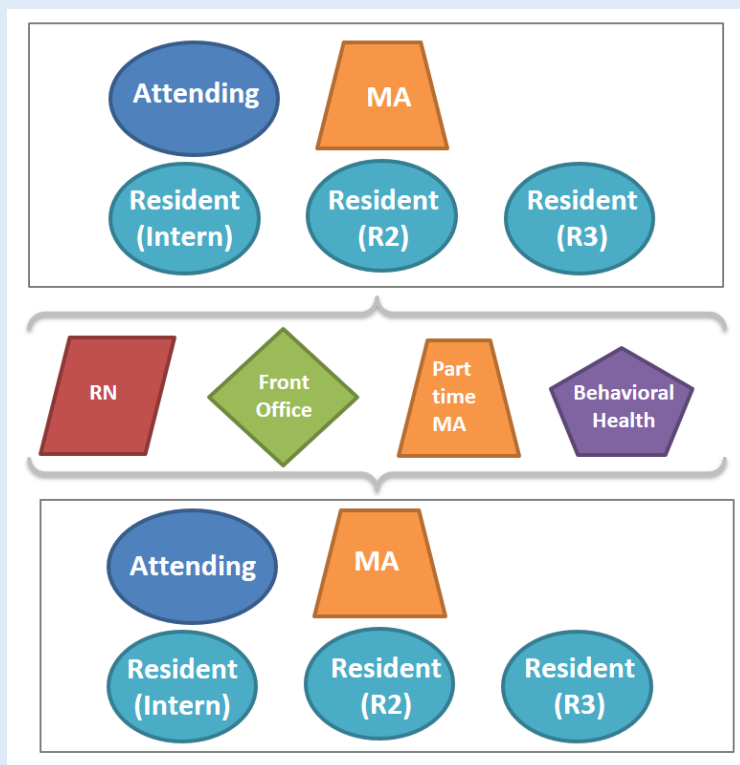
- Each team has one attending, one MA, 1 R1, 1 R2, 1 R3
- Supporting every 2 teams are: 1 RN, 1-2 front office staff, 1 part time MA, and behaviorist

When in clinic, clinicians work with the same MA 50-75% of the time.

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Overall team structure (showing a pair of teams):



Members in clinic from the team during a typical half-day clinic session:



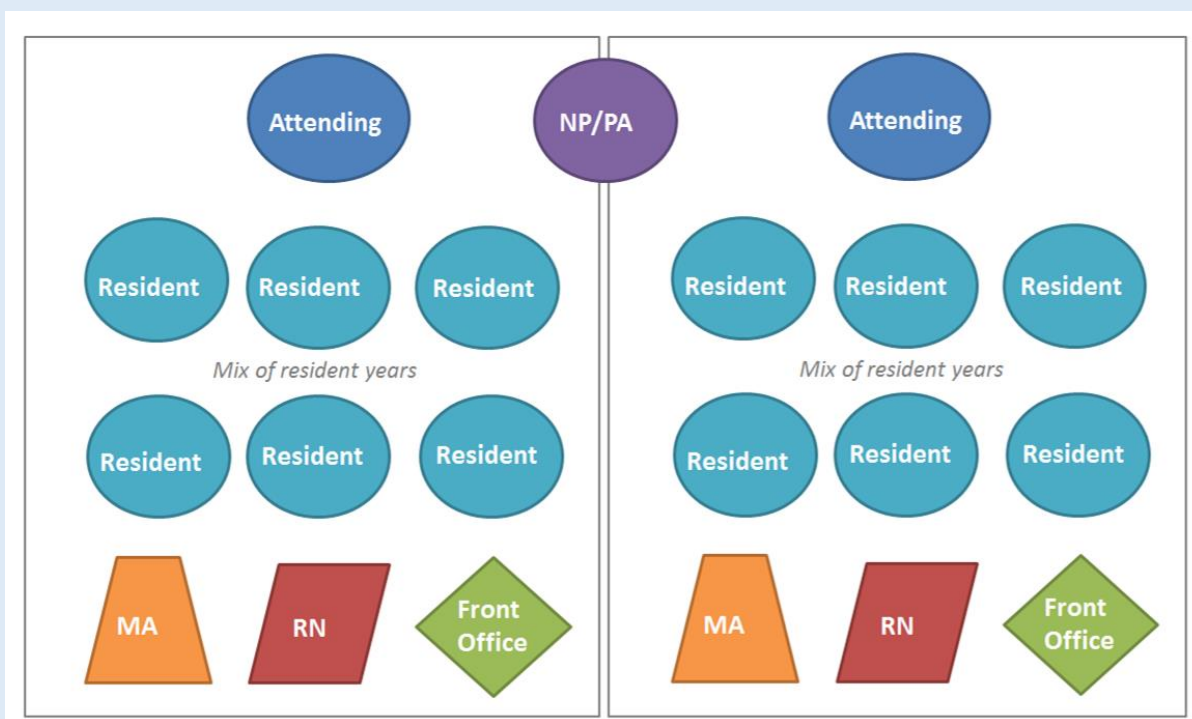
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CASE HIGHLIGHT: Medium-size teams at University of Massachusetts Medical School– Baystate Internal Medicine Residency

- There are 10 teams, paired into 5 sister teams, which share 5 co-located pods.
- Each team has 1 attending, one NP/PA, 2 R1s, 2 R2s, 2 R3s, one MA. One RN supports 2 sister teams.
- Once per week is “team day” for each of the 10 teams; all providers are seeing patients on that day. On non-team days, only 1-2 providers from the team are seeing patients
- It is rare for providers or staff not to work with their home team and for patients not to be seen by their team.

Overall team structure showing a pair of sister teams:



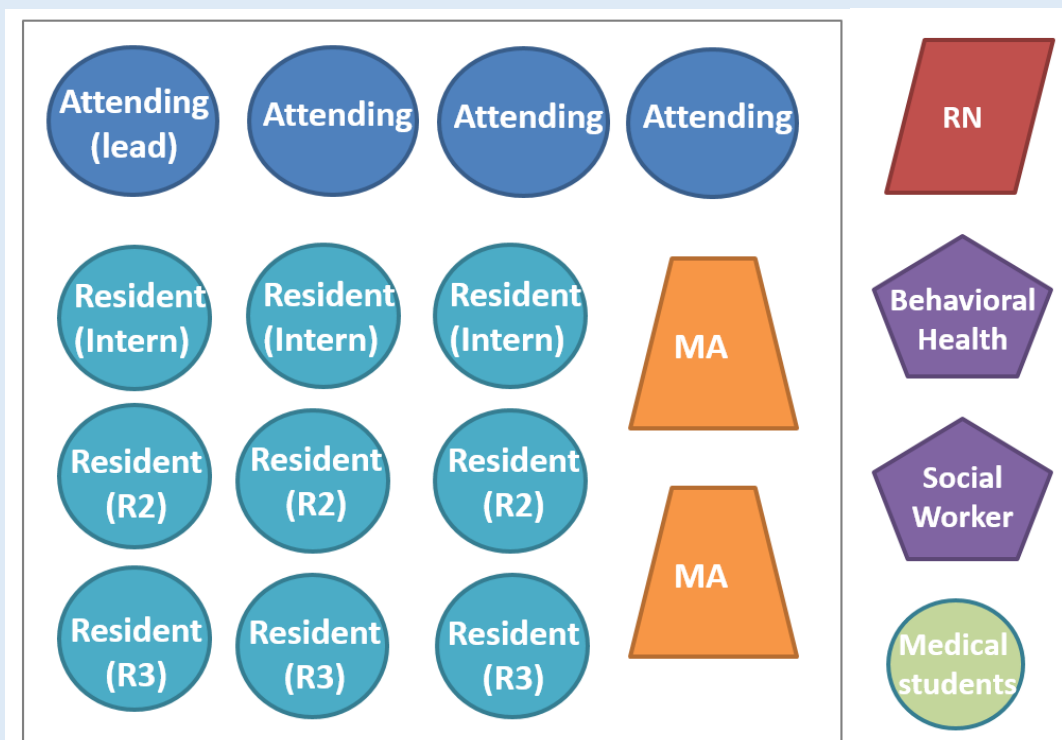
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CASE HIGHLIGHT: Large teams at Crozer-Keystone Family Medicine Residency

- There are 3 teams. Each has one lead attending, 3 other attendings, 3 R1s, 3 R2s, 3 R3s, and 2 MAs. One RN supports all three teams.
- Residents might work with all 6 MAs, but they work with the same MA 60% of the time, and with one of their team MAs almost all of the time.
- In a clinic day, the MA : clinician ratio is 1:1 (except for interns the first 6 months of the year, when the ratio is 1:2 as starting interns see only a few patients per half day).
- The clinician and MA work in a stable teamlet during the clinic session. Each clinician is matched with a team MA who always manages their desktop.
- About 3 medical students are in clinic at a time, and work with teamlets with R2s or R3s. An RN care manager, pharmacist, social worker, and psychology students work across all 3 teams.

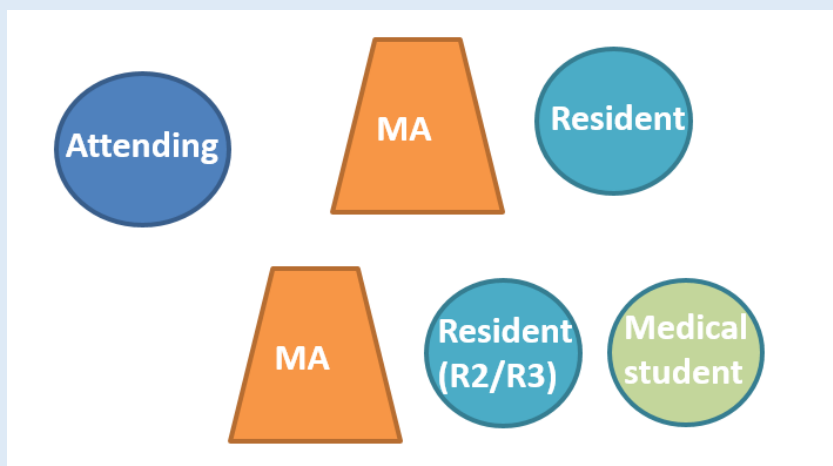
Overall team structure showing 1 of 3 teams with shared extended team:



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6 teamlets are in clinic each half day. Example of who might be in clinic from each team during one half-day clinic session:



Small teams are best for patients who want to be familiar with a few people who care for them. However, larger teams have more flexibility for resident scheduling. Team size is a balancing act. Some clinics start with large teams but **divide each team into smaller teamlets** to balance between having the organization of small teamlets with the flexibility of a larger team.

3. What is a stable team and why is it important?

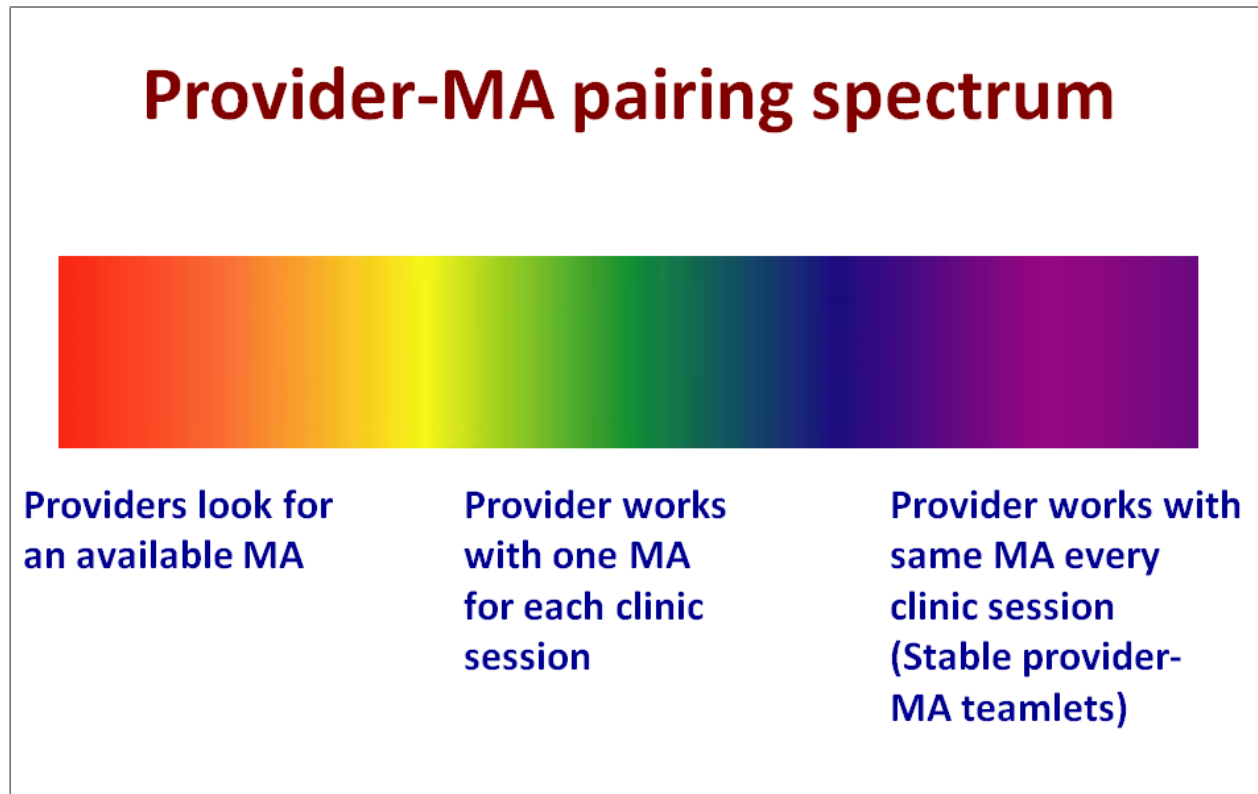
Definition of a stable team:

- The same people always work together
- Patients empaneled to the clinicians on the team are always cared for by that team
- The team is responsible for the health of its patient panel and only sees patients on its panel

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Team stability exists on a spectrum:



Why is team stability important?

- **Familiarity** is important to patients [2]: “I want to know the people caring for me” and “I want the people caring for me to know me”
- Clinicians working with the same MA every day tend to have **lower levels of burnout** than clinicians working with different team members on different days [8].
- Research shows that patients prefer small practices [1]. A stable team divides a large, impersonal practice into small, comfortable units that **feel like small practices**. If team personnel frequently change or patients are seen on a different team, the small practice quality of a team is lost.
- Stable resident-MA pairings allow residents and MAs to learn each other’s styles and adapt their working relationship over time, reducing day-to-day workflow variability and **improving efficiency and communication**.

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- Stable clinician-MA pairings allow residents and MAs to **share responsibility for the health of a panel of patients** which make the MA's work meaningful and relieves residents of work that doesn't require a medical degree, such as making sure that patients on the panel have their routine preventive and chronic care services completed on a timely basis.

Stable teams are a challenge for teaching clinics. With the complex schedules of residents and faculty, it's easier to move team members to other teams on certain days. However, if patients and team members are shifted from one team to another, the assumption of responsibility by a team for a panel of patients is fractured.

It will never be possible to have 100% team stability. But if residency and clinic leadership prioritizes team stability over scheduling convenience, it possible to implement stable teams most of the time.

What are some strategies to optimize team stability?

1. Make it a clinic goal and explain the reasons for stable teams to all faculty, residents, and staff why it is important.

CASE HIGHLIGHT: Erie Family Health Center – Humboldt Clinic

Erie is a Teaching Health Center with a small faculty and about 20 residents. The clinic has small color teams with one faculty attending, one resident from each year, and one full time MA. The clinic leadership has set a goal for stable clinician-MA-patient pairings. The lead MA who creates the team schedules each week is committed to ensure that the clinicians work with the same MA as much as possible and that patients have continuity with one MA. Estimates of the frequency of stable clinician-MA pairings were 50-75%.

CASE HIGHLIGHT: Family Medicine Residency at Natividad Medical Center

The clinic has 8 teams, each with 4 residents (at least one from each year) and 2 medical assistants with one faculty member supporting at least 2 teams. Resident-MA pairings used to take place about 50% of the time. The clinic decided that team stability was a goal and made it a scheduling priority. Teams are now very stable with residents and one of their medical assistants working together about 80-90% of the time. If residents need to move due to space or precepting ratio balance, one of their team medical assistants moves with them.

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Priority for team pairings is given first to R3s, then R2s, then R1s. One resident noted that working with stable MAs has been an extremely positive experience.

2. Measure it.

- One team stability metric is the number of half-day sessions on which at least one team member was moved to a different team. This metric could be broken down into faculty having to move, residents having to move, or medical assistants having to move. A run chart could be created tracking how many people had to be moved each week. This could be done as spot checking rather than continuous monitoring.
- Another metric: In what percent of half-day clinic sessions are clinicians and MAs working together in their team pairing(s)? This metric can be applied to any grouping of people: resident/MA, faculty/MA, NP-PA/MA. For example: Resident Blue is on the blue team with 3 blue team MAs. Resident Blue is in clinic 3 half-days each week. Over the course of a month, what % of half-day sessions is Resident Blue working with one of the blue team MAs?

3. Create a clear team structure on a one-page document that shows how many teams exist, their names, and which people are on which team. Post the document on clinic walls and waiting rooms so that patients learn which team they are on and who works on that team.

CASE HIGHLIGHT: Banner-University of Arizona at Phoenix Family Medicine Center

The clinic is divided into spaces for each of the 4 color teams: Blue, Red, Green, and Orange. Patients are seen on their color team as much as possible and are messaged which color team they are on. Patient appointment cards are printed with the 4 team colors and list the MA and physicians on each team. When patients leave, they are given the appointment card with their next appointment information and the names of their team clinician and MA checked off under their team color.

4. Make scheduling decisions that facilitate team stability. Schedule resident clinic sessions predictably and consistently. The clinic needs to know far in advance which residents are in clinic to align team schedules. If the residents' clinic schedules are unconfirmed the month before the clinic sessions, or have frequent last-minute changes because of scheduling inconsistencies, it is difficult to schedule them to work with their team members.

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5. Schedule the same number of providers (residents and faculty) in clinic each half-day session. If there are 8 clinicians scheduled for clinic on Tuesday morning and 2 clinicians on Wednesday morning, it's difficult to have consistent levels of clinicians, staffing, patients, and available rooms to have team stability. This results in providers, medical assistants and patients having to move from their home team. Some programs have built into their resident and faculty schedules to have a target number of clinicians scheduled for clinic for every half day.

CASE HIGHLIGHT: University of North Carolina Family Medicine Center (FMC)

The FMC has a large number of very-part-time providers (faculty and residents). To minimize providers or staff having to switch teams due to shifting numbers of providers on different days, the FMC has adopted a 16/16 goal. There should be 16 providers each morning and afternoon. Because resident schedules are not under the control of the FMC, achieving 16/16 requires that faculty fill in gaps around the residents' clinic scheduling. For example, if there are only 6 residents in clinic on a particular morning, 10 faculty are needed. The 16/16 policy is implemented through a system of faculty preferences. Each year, each faculty physician lists 7 options of the half-days in the week when he/she is able to be in clinic. If a faculty member, for example, has contracted for 4 half-day clinics per week (either seeing patients or attending), the 7 options state which half-days can be scheduled in clinic. After providing those options, faculty members keep those half-days protected. Respecting those preferences, after the resident schedules are entered, faculty are scheduled so that the combined resident and faculty schedule achieves 16/16. This system ensures that the FMC will have a consistent number of providers each half-day. While this does not guarantee that each of the teams will have the same number of providers every half-day, it is a great step toward team stability as it limits the scheduling challenges of having too few or too many providers in clinic on a given half-day.

CASE HIGHLIGHT: Banner-University of Arizona at Phoenix Family Medicine Center

This teaching clinic has a small faculty (about 11) whose entire professional life takes place in the clinic, either seeing patients or precepting. Each of the 4 color teams includes 2-3 faculty, 2 R1s, 2 R2s, 2 R3s (total of 24 residents, 6 on each team with 4 teams), and 1-2 MAs. The residency manager/scheduler makes sure that there are at least 6 and no more than 9 residents scheduled to see patients in clinic each day, and faculty patient-care days are relatively evenly distributed. Thus there is not a large discrepancy between the number of providers seeing patients day to day. When patients call for appointments and their PCP is not available, the priority is to schedule them with another team physician to provide continuity with the team.

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6. Label each resident schedule template with a team designation, and create the year-long and monthly resident scheduling templates to have a consistent number of residents from each team in clinic on each particular day.

CASE HIGHLIGHT: East Tennessee State University Family Medicine Residency at Kingsport

The clinic has created 6 teams, A, B, C, D, E, and F. Rather than simply R1, R2, and R3, each resident schedule is labeled with their team initial: R1A, R1B, R1C... R2A...R3A, etc. The scheduling templates were reorganized so that residents from a team are in clinic on different half-days of the week, so that the team resident in clinic will be able to work with their team MA/LPN/nurse. Patients will be able to see the team nurse and a resident from their team on any day, and the team nurse can get to know the team's panel. The organized templates allow the front desk to know when each resident will be in clinic for the next 12 months, and simplifies consistent team pairings in clinic. At the end of each academic year, the rising R1A will move into the schedule for the outgoing R2A, which will also simplify keep the resident working with the same team nurse and patient panel.

7. Distribute the residents into several smaller clinics rather than one large clinic to make scheduling easier. Residents stay in their small clinic during their entire residency.

CASE HIGHLIGHT: University of Wisconsin Family Medicine Residency

The residency has 48 residents. Instead of having all the residents based at the same continuity clinic, residents are trained at 4 clinics, with residents staying in the same clinic throughout the residency and faculty dedicated to each clinic. At the Verona clinic, each of the four teams has 2 faculty, 1 physician assistant (available for same-day access), 3 residents and 3 MAs. To help stabilize the teams, the clinic level-loads the number of clinicians seeing patients each half-day session with the goal of 10-12 clinicians per half-day (similar to UNC's 16/16). Mornings are more faculty-heavy, afternoons more resident-heavy.

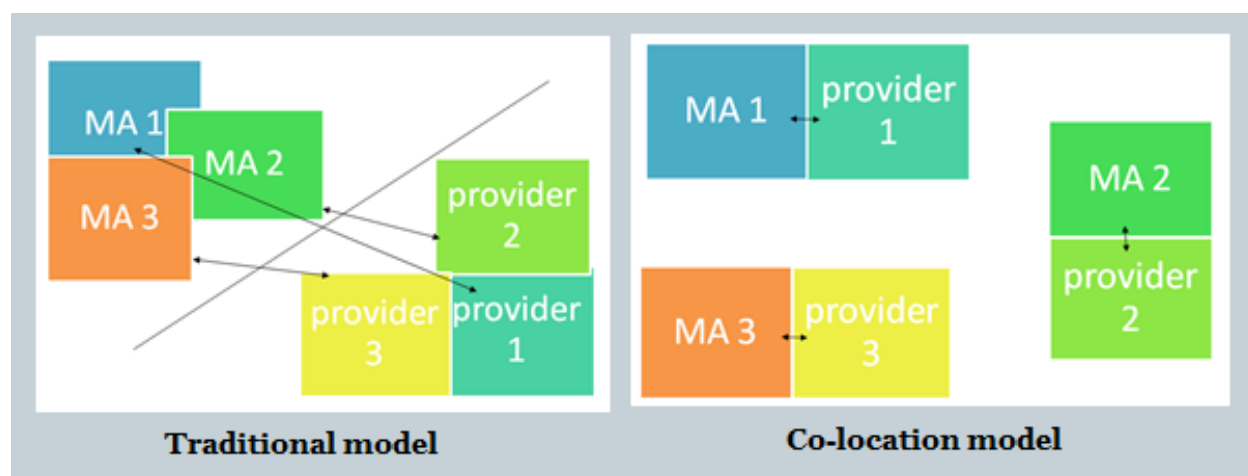
4. What is co-location, why is it important, and how can we do it?

Co-location means that team members (clinicians and support staff) work side-by-side in an open space, often called a pod, allowing them to easily communicate minute-to-minute throughout the day.

What are the benefits of co-location?

- It is easier to share responsibilities and tasks among the team,
- it saves time by not having to search for another team member,
- it encourages consistent and frequent communication,
- it breaks down the power dynamic between clinicians and staff, and
- it makes the team visible and concrete to team members and patients.

Teams with dense daily face-to-face interactions among all team members are better positioned to deliver higher quality cardiovascular disease care at a lower cost [9]. In three studies, co-location was associated with **improved team collaboration and coordination** [10,11,12]. Co-located practices report that some physicians initially resist colocation but embrace it when finding that it saves them time.



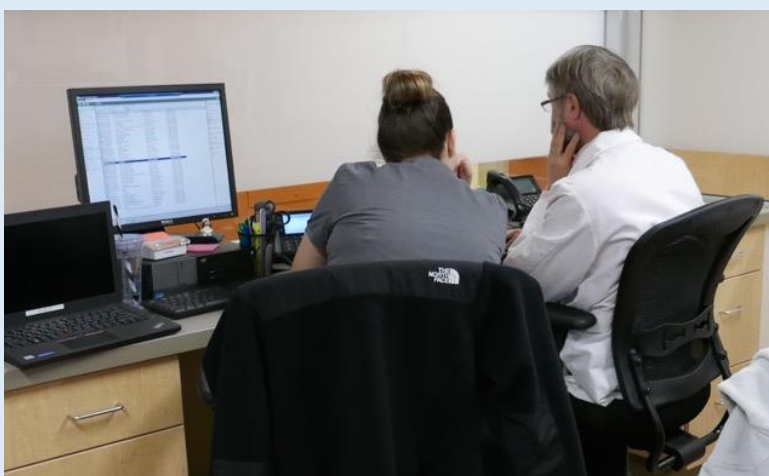
This figure compares the traditional model of workspaces for MAs and providers, where MAs and providers work in their respective silos. In the co-location model, MAs and providers work side by side in their teamlets. This enhances a collaborative and cohesive team culture and streamlines/facilitates minute-to-minute communication among team members.

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CASE HIGHLIGHT: Central Washington Family Medicine Residency

Starting in 2016, each team was co-located in a large room with 4 work stations around the edges -- MA sitting next to provider -- and an RN station in the middle. There is a separate precepting room for residents away from the co-location team room but precepting can also take place in the colocation space. Everyone loves the co-location design and find it makes minute-to-minute communication very easy.



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CASE HIGHLIGHT: Family Medicine Residency at Natividad Medical Center

The new clinic space was designed for co-location. Providers and medical assistants sit at side-by-side desks that can be adjusted for standing or sitting. Medical assistants and residents communicate constantly. The co-location seems to facilitate stable teams with resident-MA pairing about 80-90%.

How does a clinic co-locate if there are no resources for changing the architecture?

It is possible to enjoy the benefits of co-location without a clinic remodel. Clinics can be creative in repurposing space for co-location even without breaking down any walls.

CASE HIGHLIGHT: University of North Carolina Family Medicine Center (FMC)

While the FMC has hallways rather than a co-located pod, co-location has been achieved with stand-up work stations, each used by the provider and medical assistant working with that provider that day. Exam rooms used by that teamlet are contiguous with their work station.

CASE HIGHLIGHT: White Memorial Medical Center Family Medicine Family Health Center

The clinic has an open central nursing station, around which the exam rooms are located. While not formally co-located, residents usually station themselves with their laptops around the nursing station near the MA they are working with, which allows frequent face to face communication in real time.

5. What is a collaborative team culture and how do we foster it?

A clinic can have a perfect team structure with excellent team stability, yet the teams don't work well because of problems with team culture. Team culture is not a precise concept, and to improve team culture it helps to have some tools and metrics.

Let's break team culture down into 2 parts: **1) how team members get along with each other**, including ground rules, and **2) how teams share the care**.

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How team members get along with each other

A number of metrics exist to measure team culture. One example is the Team Culture Scale [8].

- The group of staff and providers I work with most regularly work well together as a team.
- My most important task in clinic is to manage patient flow.
- We have a “we are in it together” attitude at my clinic.
- I feel unprepared for many of the tasks that I am asked to do every day.
- My professional skills are used to the fullest at my clinic.
- It is hard to get things to change in my clinic.
- I can rely on other people at my clinic to do their jobs well.
- We regularly take time to consider ways to improve how we do things at my clinic.

To improve team culture, a variety of tools exist. “Getting to the Heart” is a simple 8-week program by which each clinician and the medical assistant(s) they work with meet together and build trust. This process can be used with residents and nurses, nurses and medical assistants – essentially any team members who could benefit from trust-building. The full Getting to the Heart Workbook is available at <https://cepc.ucsf.edu/teamlets>.

CASE HIGHLIGHT: University of New Mexico Family Medicine Residency, Southeast Heights Clinic

The clinic has a strong team culture centered on team members’ commitment to serving their unique patient population. Because many staff members are from the neighborhood and have been patients of the clinic themselves, they are highly committed to their work and their colleagues. Clinic staff described Southeast Heights as a place with “honesty, dialogue, and fun.” The culture is a big draw for residents when they are selecting a primary care site. Residents feel well integrated into their teams and describe strong working relationships and friendships with their MAs.

Ground rules are an essential element of team culture, forging agreement on norms of behavior among all team members. Ground rules need to be agreed upon by unanimous consensus, otherwise they lose their power. For example, if everyone – including physicians – agrees that physicians are expected to come to clinic on time, then physicians can be held accountable because they agreed to it. If ground rules, agreed upon by everyone, stipulate that team members will give constructive feedback, positive and negative, to one another on a regular basis, then it is easier for doctors to offer feedback to MAs on their performance and for MAs to give similar feedback to doctors on their behavior.

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Some example ground rules for the care team during patient-care hours:

- Define situations when MAs should interrupt the clinician to address an urgent patient need
- Policies on patients coming late
- Policies on no-shows and on squeezing in extra patients
- How staff can give feedback if a clinician is not appropriate or empathetic with a patient
- How a clinician can give feedback if another team member is not appropriate or empathetic with a patient
- Be cheerful. Primary care is stressful and a cheerful attitude helps everyone on the team. Both cheerfulness and grumpiness are contagious.

CASE HIGHLIGHT: Cambridge Health Alliance Family Medicine Residency

The “Ten Commandments of Human Relations” are distributed to the clinicians and staff:

1. Speak to people. There is nothing so nice as a cheerful word of greeting.
2. Smile at people. It takes 72 muscles to frown, only 14 to smile.
3. Call people by name. The sweetest music to anyone’s ears is the sound of his/her own name.
4. Be friendly and helpful. If you would have friends, be a friend.
5. Be cordial. Speak and act as if everything you do is genuine pleasure.
6. Be genuinely interested in people. You can like almost everybody if you try.
7. Be generous with praise – cautious with criticism.
8. Be considerate with the feelings of others. There are usually three sides to a controversy: Yours, the other fellows, and the right side.
9. Be alert to give service. What counts most in life is what we do for others.
10. Add to this a good sense of humor, a big dose of patience and a dash of humility, and you will be rewarded many-fold.

CASE HIGHLIGHT: University of Texas Medical Branch at Galveston Family Medicine Residency

Employees are to sign a “Standards of Conduct” document each year which is like a set of ground rules. The nurse manager says that the gist of the rules are: “Work hard and be nice.”

6. What does “share the care” mean and how do we make it happen?

Share the Care is a **paradigm shift: from “I” to “We”**. “I” is the traditional, lone doctor-with-helpers model. Clinicians assume all responsibility, make all decisions, and delegate tasks to other team members, whose job is to assist the clinician. The language “delegating tasks from doctor to team” suggests that team-building means less work for the doctor and more work for others, and creates a negative connotation for non-clinician team members.

Share the Care, the “We” paradigm, means re-allocated responsibilities, in addition to tasks, so that all team members share responsibility for, and contribute meaningfully to, the health of their patient panel. The patient panel is the team’s panel, not the clinician’s panel. A culture of empowerment, bolstered by training, standing orders, and workflows, engages everyone to be meaningful members of the patient’s care team. Thus, in addition to responsibility for patient care tasks, share the care means that team members have assumed responsibility for certain functions on the team [13, 14, 15].

Discuss with your clinic: Which of the following medical assistant-clinician relationships represents share the care vs. delegated tasks?

- The MA faxes a doctor’s prescription refill to the pharmacy
- The MA does an EKG
- The MA makes sure that every patient between 50-75 years is up to date on colorectal cancer screening
- The MA works with the same clinician every day as much as possible, forming a stable teamlet; the patients trust both teamlet partners to assist them in their health care
- The MA makes sure all patients have the doctor’s business card
- The MA’s and doctor’s names are on the business cards
- The clinician huddles with the MA on his/her teamlet to discuss issues related to their patient panel

Share the care exercise

This is a helpful exercise for teams to think outside the box about sharing the care. In your clinic, have everyone meet and fill out the two Share the Care charts: “Who does it now?” and “Who could do it?”. For “Who could do it?”, **encourage everyone to consider an ideal clinic without barriers**. Then discuss the process together and think about which responsibilities could be better shared. An expanded version of this exercise, along with potential solutions and examples/evidence for sharing the care, can be found in the Appendix.

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Share the Care: Who does it now?

Place a tick mark in the column that matches who performs each of these tasks in your clinic. If more than one person, pick whoever is mainly responsible. Add up the tick marks vertically.

Tasks	PCP	RN	MA/ LPN/ LVN	Front desk	Pharmacist	Behaviorist	Nobody
Orders mammograms for healthy women 50 -75 years old							
Refills high blood pressure medications for patients with well-controlled hypertension							
Performs diabetes foot exams							
Order routine immunizations							
Treat uncomplicated urinary tract infections							
Inform patients of normal lab test results							
Prescribes statins for patients with cardiovascular risk							
Medication reconciliation for patient(s)							
Conduct depression follow-up							
Titrate insulin for diabetic patients							
Discuss colorectal screening options with patients							
Identify patients with overdue chronic disease related labs							
Obtain hospital/discharge information							
Totals							

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Share the Care: Who could do it?

Place a tick mark in the column that matches who – under ideal circumstances, with no barriers – could perform each task. Add up the tick marks vertically.

Tasks	PCP	RN	MA/ LPN/ LVN	Front desk	Pharmacist	Behaviorist	Nobody
Orders mammograms for healthy women 50 -75 years old							
Refills high blood pressure medications for patients with well-controlled hypertension							
Performs diabetes foot exams							
Order routine immunizations							
Treat uncomplicated urinary tract infections							
Inform patients of normal lab test results							
Prescribes statins for patients with cardiovascular risk							
Medication reconciliation for patient(s)							
Conduct depression follow-up							
Titrate insulin for diabetic patients							
Discuss colorectal screening options with patients							
Identify patients with overdue chronic disease related labs							
Obtain hospital/discharge information							
Totals							

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Standing orders

Sharing the Care requires standing orders approved by the medical leadership, following state-level regulations on the scope of practice of MAs, RNs, and other team members.

Sample of a standing order for medication refills:

Prescription Refill Standing Orders for RNs			
Hypertension			
Appointment last 6 months	Systolic BP = 130/80 or below	Normal creatinine and potassium in last 6 months	How to renew
Yes	Yes	Yes	3 month supply + 1 refill
	Yes or No	No ^a	1 month supply + order labs, give appt, no refill
	No	Yes	1 month supply + give appt, no refill
No	Yes	Yes	3 month supply + give appt, no refill
	No	Yes or No ^a	1 month supply + give appt, no refill

^a The standing order would provide seriously abnormal levels that would trigger urgent clinician review.

More examples of standing orders for RNs and MAs are available at the Center for Excellence in Primary Care website: <https://cepc.ucsf.edu/standing-orders>.

How do we share the care with busy MAs and RNs?

Transferring responsibility to MAs and RNs requires close attention to workload. If a clinic cannot hire additional personnel, adding work to team members requires either greater efficiency or taking away work that is less important. Any change in who does what must be discussed fully with the team. A number of teaching clinics have figured out how to add responsibilities to the medical assistant rooming process by having clear check lists that allow more to be done with little added time [16].

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CASE HIGHLIGHT: Crozer-Keystone Family Medicine Residency

Medical assistants, who were involved in the redesign of their roles, are trained in a standardized manner to work similarly with different providers. MAs review patient charts and do pre-visit planning. Before each clinic session, MAs prepare a routing slip on each patient by filling in the status (due/up to date) for each relevant item and when the patient will need appointments for colonoscopy, mammogram, and pap smears. Upon patient checkout, the front desk uses the routing slip to make appointments for the patient.

During intake, MAs take a brief history, review medications and ask if refills are needed, screen for depression, and ask whether the patient has a DPOA, smokes/is open to quitting, and has religious beliefs affecting their healthcare. MAs can order labs, referrals, mammograms, and colonoscopies for providers to review and sign. For patients with blurry vision, MAs check visual acuity, if dizzy they do orthostatics, if they have a respiratory issue they do pulse ox, if urinary complaints they do a urinalysis. For patients with diabetes they make sure A1c, microalbumin, lipids, eye exams and foot exams are completed in a timely manner.

Checklists and other relevant clinic workflow documents are kept in binders at every teamlet station. Between patients, MAs check their EMR inboxes, help providers with forms, and update the patients' proactive care flowsheets. MAs attend "Lunch and learn" sessions to deepen their education. The clinic is continuing to work on promoting MAs as the team member running the teamlet, and teaching residents to work with MAs in their expanded roles.

Registered Nurses

RNs in many clinics spend their time on phone triage, a responsibility most do not like because they are not empowered to make decisions about the issues patients bring up. Part of making triage more interesting while giving RNs more responsibility is through standing orders. RNs can quantify the different kinds of triage calls they receive and standing orders can be written for the most common issues RNs face, thereby allowing them to independently handle significant numbers of triage calls without requiring direct clinician involvement. Furthermore, RNs can be empowered to function as care managers, assisting patients with chronic conditions to improve their health-related behaviors and managing their medications under standing orders [17-19].

CASE HIGHLIGHT: Baystate Internal Medicine Residency

RNs are "the glue" of the team and establish therapeutic relationships with many of the team's patients. RNs provide nurse visits with diabetic, asthmatic, and hypertensive patients and with those taking Coumadin and chronic controlled substances.

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RNs made a major contribution to the average HbA1c decreasing in the past few years. They give all injections through standing order protocols. The RN goal is 40 independent visits per month.

RNs spend considerable time handling in-basket or phone messages coming from the call center, front desk, MAs, or providers. Because the RNs know their teams' patients, they can address many issues without provider input. Many refills are performed by the team RN via protocol. On team days, RNs are available for everything that comes up -- vaccines, forms, calls, lab results, refills, answering resident questions. On non-team days, RNs have more time for RN visits and patient follow-up.

Each day, 2 RNs perform phone triage. During triage sessions, RNs often refer patients to the team RN who knows them best. Having phone calls routed quickly to the team RN increased the rate of first call resolution, reducing delays and backlog.

CASE HIGHLIGHT: Oregon Health Sciences University Family Medicine Residency, Gabriel Park Clinic

RNs, one per team, focus much of their time as care managers for the team's high-needs, high-cost patients with RN visits, pre- or post-visits before or after a physician visit, and phone calls. Care manager RNs also check the discharge list from the hospital each morning, call patients within 72 hours of discharge, and arrange for them to be seen within one week. The care management RNs meet once a week to problem-solve and standardize their work. To free up RN time for care management, LPNs have assumed the triage function. They forward problems they cannot handle to the team RN. RNs directly take triage calls from their high-needs, high-cost patients.

CASE HIGHLIGHT: University of Cincinnati Internal Medicine Residency

Several years ago, the clinic switched from medical assistants to RNs. Though RNs perform traditional MA functions, the clinic management feels the change had a dramatic impact on improving teamwork. RNs function as the continuity anchor for the teams' patients over years - patients remain on the same team with the same RN. The RNs know the team's panel of patients and the patients know their RN.

During each clinic session, residents work one-on-one with the team RN in stable teamlets. In addition to rooming patients, RNs do panel management (inreach and outreach),

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care coordination and prior authorizations. Several staff and faculty said: “patients know the nurse on the team,” “patients comment how great the nurse is as much as the doctors,” “the nurses really are the continuity.” RNs love the team role. They have autonomy, enjoy the relationships with their team residents, and consequently there is little RN turnover.

RN triage is done by the team RN who knows the patients, making triage more efficient and increasing the likelihood that the RN can handle triage issues independently. RNs respond to all inbox messages and handle many messages themselves. RN visits for hypertension and diabetes include medication titration and patient education. They are strong participants in team meetings, do PDSA cycles and QI projects with their team residents. RNs look at team quality metrics monthly.

What are recommended staffing ratios for teaching clinics?

Advocating for appropriate staffing to support high functioning teams is a common challenge for teaching practices. Existing models of staffing among teaching clinics are highly variable and dependent on many factors in the local institution, payment model, and hiring environments. A commonly cited paper looking at staffing ratios in primary care clinics (not specific to teaching clinics) estimated that the staffing ratios per 1 FTE (full-time equivalent) of a primary care clinician would need to increase from a base of 2.68 FTE to 4.25 FTEs of staff to support a patient-centered medical home model of care [20].

In the case of core teamlets (**medical assistant or LPN/LVN to clinician ratio**), there is often a **minimum of 1:1 ratio of MA to provider in a particular clinic session** (with the exception of interns in the beginning of the year, who might share an MA given their lower volume of patients, ie. 0.5:1). The overall MA to clinician FTE ratio for the clinic may be slightly higher if the staff get protected time outside of clinic sessions for work on panel management or QI projects, and if the clinic can staff for float MAs, etc. **This level of staffing allows expanded MA roles**, such as that described in the case highlight above for Crozer-Keystone. In the case highlight for University of Colorado's AF Williams Family Medicine Clinic below under question 8, we describe an **advanced team based care model utilizing a 2-2.5:1 MA to provider ratio** in clinic, wherein the MA care team role is vastly expanded [21,22].

Current ratios of **expanded care team members** such as pharmacists, behavioral health and social work, nutritionists, RN care managers, health coaches, physical therapists, or clinical data analysts/quality improvement managers often depend on what historically has been available and invested in by the local institution and health care environment.

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Many practices start building support for expanded care team members by projecting how one of these additional team members can **add capacity for patient care and visits** to the primary care clinic (such as how a pharmacist or nurse providing chronic care visits for hypertension and diabetes can offload visits from primary care clinicians and improve access), and how they can help **improve quality metrics currently of value to the clinic/health system** (such as how behavioral health staff could help the clinic meet pay for performance metrics around depression or smoking cessation).

Other practices have been able to partner successfully with health professional training programs such as pharmacy schools, behavioral health training programs, or with local pre-health profession students to add team members in training to the clinic who gain experience while providing interdisciplinary team support to the clinic.

7. What are the best ways for team members to communicate in team meetings, huddles, and minute-to-minute interactions?

At the teamlet level, communication takes place at huddles and minute-to-minute interactions. For the larger team, entire practice staff, or sub-groups of the practice staff (clinicians or RNs/MAs or front desk staff), regular meetings are scheduled into the work week or work month. Each practice decides what regular meetings to have and how often to have them.

Team and staff meetings

Many tools exist on organizing effective meetings. Two important issues to consider is whether teams have truly protected time to meet, and whether meetings are structured to engage and involve input from all members of the teams.

Elements of an effective meeting

1. The facilitator sends out the agenda in advance, asking for additional items.
2. The facilitator clarifies the objectives of the meeting.
3. A running attendance sheet is kept from meeting to meeting.
4. Timekeeper and recorder are assigned.
5. The final agenda is agreed upon.
6. The participants work through the agenda items.
7. The recorder writes decisions, next steps, and who does what by when on the meeting record sheet.
8. The next meeting is scheduled and the meeting record sheet is distributed.
9. The facilitator for the next meeting is chosen.
10. There is a brief evaluation of the meeting.
11. Important decisions become topics for provider and staff meetings.

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CASE HIGHLIGHT: Family Medicine Residency of Idaho

The clinic closes from 11AM - 1:30PM once a month for team meetings. All members of the team, including clinical and administrative staff attend: RNs, MAs, NPs, faculty, residents, business office and clerical staff, dietician, referral coordinator, and medical records staff. The meeting has a fixed agenda starting with a round of kudos to build a sense of team culture and appreciation. The next agenda item is to review the previous meeting's minutes and clarifications. After this, the team goes over clinic data such as unused appointments, cycle times, no-show rates, and quality measures at a clinic and team level. The meeting wraps up with a discussion on team coverage issues, upcoming absences, and last minute additions. Resident clinic and rotation time shuts down so they can attend their team meeting, which is considered part of their curriculum and learning.

Healthy huddles

Huddles allow the team to meet briefly on a daily basis to go over the patients with appointments today, determining what tasks need to get done and by whom. Some practices huddle in the morning; others have a 5-8 minute huddle at the start of the AM and the start of the PM.

Ground rules for an efficient huddle include:

- What time will the huddle start?
- What time will the huddle end?
- Where will the huddle take place?
- Who is at the huddle?
- Who is the huddle leader?
- What is the huddle checklist used at every huddle?
- What happens if someone is late?
- What happens when someone regularly fails to show up?
- Who takes notes? Is there a huddle form for notes?
- Participation – What to do if someone is present but regularly doesn't participate?
What if one person regularly dominates the huddle?

CASE HIGHLIGHT: Erie Family Health Center

Teams huddle for 5 minutes at the beginning of each half-day session. Residents have spearheaded the institution of huddles. Residents and the assigned MA for the session each hold a copy of the patient schedule.

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In some cases, the resident had scrubbed the chart and led the huddle by walking through each patient and asking for certain tasks to be completed by the MA. In another cases, the MA scrubbed the chart and initiated and facilitated the huddle. One medical assistant would check the immunizations for her resident systematically to ensure that her resident did not make any mistakes or miss an immunization.

Residents and staff estimated that huddles happen 75% of the time. The biggest barrier is residents not coming early enough. One resident stated that he huddles “every session without fail,” and that “huddles shave minutes off each patient visit and dramatically improve the patient care session.”

Huddle videos

<http://www.leanblog.org/2010/08/video-of-a-daily-huddle-at-everett-clinic>

This video features a huddle of everyone working at a site of the Everett Clinic. Some practices have separate huddles of each teamlet; this video is of a larger full team huddle.

<http://www.youtube.com/watch?v=Wttxm7jAnb4>

This is a teamlet huddle going over the patients for the day.

Scrubbing charts (pre-visit planning) for huddles

Scrubbing the charts of the next day’s patients **greatly enhances the usefulness of the huddle**. The MA reviews the charts of each patient scheduled for her teamlet the day before the patient visit. Scrubbing is defined as **reviewing charts before the visit** to identify the gaps in care for each patient.

To scrub the chart, the MA reads the previous chart note, looking for 1) **missing information** (for example if a lab or imaging study or specialty referral was ordered and the result is not in the chart; or if the visit is a post-hospital discharge visit and there is no discharge summary), 2) **preventive care gaps** (the patient is overdue for a mammogram or an immunization), and 3) **chronic care gaps** (a diabetic patient is overdue for a HbA1c or LDL blood test or a foot or eye exam). The MA notes the missing information on the patient list for the next day to use at the next morning’s huddle.

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In scrubbing the chart, the MA could also assess **whether the visit is really needed**. For example, if the visit is to review lab results but the lab was not done, the patient could be called to cancel or reschedule the visit. If the patient made the appointment to discuss his/her hypertension and the patient has had no coaching on lifestyle changes or medication adherence, perhaps the visit should re-scheduled with a RN or pharmacist or health coach. Unnecessary visits waste capacity. Some clinics have found that scrubbing charts can reduce visits by 20%, helping to improve access. Other notes the MA may write on the appointment list might be: patient is coming in too early for refills or results and should be offered to reschedule, or this patient will need more time so do not squeeze in any extra patients this morning.

Scrubbing the charts saves time during the clinic session, and allows the MA to run the huddle. Teamlets are then able to use information from scrubbing to **strategize** about the flow of the clinic session and anticipate needs or delays, which allows teamlets to optimize patient care and efficiency of the team.

Sample teamlet huddle template:

Huddle date and time: _____

Huddle leader: _____

1. Review patients scheduled for today. Communicate what you know about them, including preventive and chronic care gaps
2. Ask if the provider knows of anything they anticipate needing for the visit.
3. Ask if anyone knows of a patient who will likely be late.
4. Ask if anyone knows if a patient will likely no-show.
5. Ask how many walk-ins you can schedule for the day and where will we put them.
6. Ask if there are any other issues?

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Minute-to-minute communication

This is best facilitated by co-location, such that teamlets can quickly and easily communicate throughout the clinic session. Plans on how to communicate if one of the teamlet members is busy with a patient should be made as well, such as by using instant messaging features through the EMR, or by visual flags or notes.

CASE HIGHLIGHT: White Memorial Medical Center Family Medicine Family Health Center

The clinic has an open central nursing station, around which the exam rooms are located. Residents usually station themselves with their laptops around the nursing station, which allows frequent face to face communication. Residents report developing better rhythm and structure with their MAs as they work with them longer. As interns, they work with their MA about half the time, 80% of the time as R2s, and virtually all the time as R3s. For residents, minute-to-minute communication works better when they work with the same MA over time.

8. Building a powerful team

The beginning of this toolkit listed the key reasons why teams are needed. Perhaps the most important of these reasons is to add capacity to see more patients without increasing clinician burnout by empowering team members to see patients independently.

To create powerful teams that can accomplish this goal requires increased staffing of both core and extended care teams and sharing the care with those teams. University of Colorado Family Medicine has developed powerful core teams that add capacity and reduce clinician burnout.

CASE HIGHLIGHT: University of Colorado Family Medicine Residency A.F. Williams Family Health Clinic

The teams use increased MA staffing with at least 2 MAs per provider. MAs stay with the patient throughout visit; visits are team visits rather than provider visits. The MA conducts an expanded rooming process (15 minutes): taking the history using pre-set questions based on symptoms, doing medication reconciliation, and identifying and pending orders to close preventive and chronic care gaps. When the provider comes in, the MA does a warm handoff and then serves as a scribe responsible for all EMR documentation.

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After the provider leaves to join the second MA with another patient, the first MA makes sure the patient understands the care plan, may help the patient navigate referrals and diagnostic tests, and asks, “Have all your questions been answered?” When the patient leaves, the MA completes documentation and charge entry.

All in-basket messages go to the MA pool, and are then routed to providers only if necessary. Because MAs are present in the visit, know the plan, and really know the patients, they are able to handle many in-basket messages themselves. Because the MAs perform the EMR documentation, clinicians are relieved of alienating and time-consuming work.

From early 2015 to the end of 2018, capacity to see more patients increased -- with marked growth in the clinic’s panel size – while clinician burnout dropped from 56% to 25%. Clinical metrics improved and the additional staffing was paid for by having clinicians see a few extra patients per day, which was doable given the reduction in documentation time for clinicians [21,22].

Summary

Creating high-performing teams in residency teaching clinics is a major challenge. This toolkit provides a list of the key elements of effective teams, some ideas how to implement such teams, and some examples from teaching clinics that have made good progress on team-building.

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Appendix: Share the Care Activity

The 10+3 Building Blocks of High Performing Primary Care: Share the Care™ Activity

Background and Description

In order to meet the primary care needs of the 21st century, we must utilize the skills of every member of the care team. Empowering non-clinician team members – nurses, medical assistants, and health coaches – can help meet the demand for care while providing opportunities for more fulfilling patient interactions. This activity can help gauge how well your clinic is currently sharing the care and identify opportunities for improving team-based care.

UCSF Center for Excellence in Primary Care

The Center for Excellence in Primary Care (CEPC) identifies, develops, tests, and disseminates promising innovations in primary care to improve the patient experience, enhance population health and health equity, reduce the cost of care, and restore joy and satisfaction in the practice of primary care.

Acknowledgments

The UCSF Center for Excellence in Primary Care would like to acknowledge Amireh Ghorob, MPH for her contribution to this work.

Supplies

For each group doing the activity, print one set of **role cards** and **task cards** (see below). For an additional visual in this activity, each group should have 8 cups and about 100 marbles or M&Ms.

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Role Cards:

Primary Care Clinician (MDs, DOs, NPs, PAs)	MA/LPN/LVN
RN	Front office staff
Pharmacist	Behavioral Health
Other	Nobody

Task Cards:

Take initial patient history using EMR template	Order mammograms for women 50-75 years of age
Refill high blood pressure medications for patients with well-controlled hypertension	Manage refills for patients taking chronic opioids for pain
Review lab tests to separate normal from abnormal results	Inform patients of normal lab test results
Warfarin management (anti-coagulation)	Order and give routine immunizations
Lead daily huddles	Medication reconciliation for patient with 9+ meds
Medication reconciliation for diabetes patients with 2 meds	Depression screening and follow-up
Keep daily track of third next available appointments	Discuss colorectal cancer screening options with patients
Treat uncomplicated urinary tract infections	Find patients overdue for chronic disease monitoring and order labs
Management of most patients with hypertension	Inform patient of abnormal lab test results
Assess/manage uncomplicated acute back pain	Lead complex care management team
Prescribe statins for patients with high ASCVD risk	Help patients make plans to increase physical activity or remember to take medications

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Share the Care™ Activity: Directions

Part 1: Who does it now?

1. Make sure your group has 2 sets of cards—**role cards** and **task cards**.
2. Arrange/secure **role cards** horizontally across your workspace to create the tops of columns. Each team should have 8 roles (thus, 8 columns).
3. As a group, place each **task card** under a role ***based on who is currently doing this task at your clinic***. (In cases where more than 1 role performs the task, choose 1 role to place task card under. In groups where there are members from different clinics, place card based on the group majority.)
4. Count the number of tasks in each role column. Place 5 marbles ***per task*** in the cup that corresponds to each role column.
5. **Discuss** with the group: How many tasks are falling under each role? Who has the most responsibilities? What members of the care team are underutilized? What else could they be doing to help with patient care?

Part 2: Who could do it?

1. Reflect on what you have recently learned about team-based care and your group's current assignment of task cards.
2. As a group, reassess each task in an ideal ***team based care environment***, where each member of the care team is working to the top of their abilities. Move task cards to a new role, if appropriate. (In cases where more than 1 role can perform the task, choose 1 role to place task card under.)
3. When time is called, count the number of tasks in each role column. Reallocate the marbles to reflect shifts in tasks (5 marbles ***per task*** in a cup that corresponds to each role column).
4. **Discuss** with the group: What observations came up in your group while reassigning tasks? How does the second round compare to the first? What standing orders or workflows would help achieve the ideal state?

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Share the Care Activity Potential answers:

There are no “correct” answers to this activity, as the idea is to encourage rethinking of what team members are capable of doing. To help foster discussion, below are some potential ideas as to who can do what on the team, with examples of supporting research or of how this has been implemented in real-world practices.

Take initial patient history using EMR templates / MA

The University of Colorado health system MAs take and enter into the EMR the patient history using questions specific to the patients’ complaints using EMR templates. The clinician reviews this history and may ask patients some additional questions.

Order mammograms for women 50-75 years of age / MA

A number of clinics have empowered MAs to place these orders without clinician involvement using standing orders.

Refill high blood pressure medications for patients with well controlled hypertension per standing protocol / RN

RNs can do most management of hypertension, as can pharmacists. Evidence for a number of RN competencies is reviewed in Bodenheimer and Smith, Primary care: proposed solutions to the physician shortage without training more physicians. Health Affairs 2013;32:1881-1886.

Manage refills for patients taking chronic opioids for pain / Pharmacist or RN

Some clinics have an MA, RN or pharmacist meet with chronic pain patients, make sure they are adhering to their pain agreement, and give them the secure scripts that the clinician has signed based on a clinic workflow. This can add considerable capacity because chronic pain visits are frequent and the clinician is not needed for every visit.

Use protocols to squeeze in same day patients / Front desk

At a number of clinics, clinicians write standing orders about which chief complaints can be squeezed in, what is the maximum number of patients on the schedule, and how no-show slots can be used for squeeze-ins. These protocols empower the front desk to make decisions and reduce the number of times that the front desk has to check with the clinician about whether or not to squeeze in a patient.

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Perform diabetic foot exams / MA

Many clinics have trained MAs to perform these exams. At Ocean Park Health Center in San Francisco, MAs are trained and observed by RNs; those that perform the exam correctly for 20 patients receive a certificate of competence. This function falls within California MA scope of practice as long as there is training and supervision and standing orders. (Dower C. Medical Assistants in California: Legal Scope of Practice. July 2012. www.futurehealth.ucsf.edu)

Review lab tests and separate normal from abnormal results / RN

At Kaiser Permanente Washington (formerly Group Health Cooperative) in Seattle, RNs do this function and most clinicians say that they do not need to see normal results.

Inform patient of normal lab tests / MA or Front desk

This is done at Kaiser Washington by the teamlet MA, who knows the patients. At Clinica Family Health Services in Colorado, the front desk performs this function. Research has shown that many patients are never told the results of their lab tests. (Poon EG, Wang SJ, Gandhi TK, Bates DW, Kuperman GJ. Design and implementation of a comprehensive outpatient results manager. J Biomed Inform. 2003;36:80-91.)

Warfarin management (anti-coagulation) / Pharmacist

At San Francisco General Hospital Family Health Center and many other practices – including the huge Veterans Affairs health system -- pharmacists manage anti-coagulation, not involving clinicians in this function. A meta-analysis of warfarin management performed by pharmacists found that patients managed by pharmacists had better anti-coagulation control than those managed by physicians. (Saokaew S et al. J Thromb Haemost 2010;8:2418 – 2427.)

Order and give routine immunizations / MA

At San Francisco General Hospital Family Health Center and other San Francisco safety-net clinics, MAs give immunizations without clinician involvement, using standing orders. This is considered within the California MA scope of practice. (Dower C. Medical Assistants in California: Legal Scope of Practice. July 2012. www.futurehealth.ucsf.edu)

Medication reconciliation for diabetes patient with 2 meds/MA

In a number of practices, for example HealthPartners in Minnesota, MAs do medication reconciliation during the rooming process. MA health coaches at Mission Neighborhood Health Center also do this function.

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Medication reconciliation for patient with 9+ meds / Pharmacist or RN

For patients with many medications, medication reconciliation can be complicated; at Crozer-Keystone Center for Family Health in Pennsylvania, pharmacists or pharmacy students do medication reconciliation for patients with lengthy/complicated medication lists.

Depression screening and follow-up / MA or Behavioral health

A randomized controlled trial in small primary care practices showed that patients for whom MAs did depression screening and follow-up phone calls had better depression outcomes than patients cared for by physicians alone. (Gensichen J et al. Ann Internal Medicine 2009;151:369-378.)

Keep daily track of third next available appointments / Front desk

Front desk personnel can easily daily count the number of days until the third next open appointment slot for each clinician and record those numbers to put onto run charts. This is done in a number of practices that have instituted same-day scheduling.

Treat uncomplicated urinary tract infections / RN

At Clinica Family Health Services in Colorado, RNs treat this acute problem using standing orders. A research study showed that RNs using a protocol can treat UTIs with high quality. (Saint S et al. Am J Med 1999;106:636-641.)

Discuss colorectal cancer screening options with patients / MA

At SF Department of Public Health clinics, MAs have been trained to explain the options to patients, to give patients the FOBT or FIT tests, to follow up if the patients do not return the tests, and to send the tests to the lab or process the tests themselves. Studies have shown that if colorectal cancer screening is done by someone other than clinicians (who don't have time), more people are screened. (Baker AN et al. Improving colon cancer screening rates in primary care: a pilot study emphasizing the role of the medical assistant. Qual Saf Health Care. 2009 Oct;18:355-359.)

Prescribe statins for patients with high ASCVD risk / Pharmacist

Kaiser Permanente Washington has pharmacists perform this function. (Charrois TL et al, A systematic review of the evidence for pharmacist care of patients with dyslipidemia. Pharmacotherapy 2012;32:222- 233.)

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Find patients overdue for chronic disease monitoring and order labs / MA

A number of clinics who have expanded the MA role to include panel management are doing this. A study at Kaiser Permanente found that panel management performed by MAs improved 13 clinical outcomes including LDL screening rates. (Zhou YY et al. Pop Health Management 2011;14:3-9.)

Lead daily huddles / MA

Many practices have trained MAs to scrub charts prior to patients' visits and lead the daily huddle that discusses the patients coming in that day.

Management of most patients with hypertension / Pharmacist

A research study found that pharmacist-run treatment of hypertension, including prescribing higher medication doses and new medications controlled blood pressure better than usual physician-run care. (Magid DJ et al. Am J Managed Care 2011;17:e96-103.)

Inform patient of abnormal lab test results/ Clinician or RN

Depending on the result this is often a clinician-level function, though some clinics set up standing orders and workflows empowering RNs to inform patients of certain types of abnormal lab test results.

Assess/manage uncomplicated acute back pain / RN

RNs have been shown to perform this role with high quality under standing orders. See the examples of studies of the RN role in Bodenheimer and Smith Health Affairs 2013;32:1881-1886.

Lead complex care management team / RN

RNs acting as care managers for complex patients can improve care and reduce costs for these patients. (Bodenheimer and Berry-Millett, Robert Wood Johnson Foundation, 2009. www.rwjf.org)

Help patients make plans to increase physical activity or remember to take medications / MA

MAs trained as health coaches have done excellent work engaging patients in action plans to improve healthy behaviors. A randomized controlled trial found that patients with diabetes and/or high cholesterol who worked with MAs trained as health coaches had significant improvement in HA1c and LDL compared with patients without coaches. (Willard-Grace et al., Annals of Family Medicine, 2015 Mar;13(2):130-8.)



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Toolkit Produced by

The Center for Excellence in Primary Care, University of California, San Francisco (UCSF)

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Acknowledgements

Special thanks to our case highlights sites and to team members from the Center for Excellence in Primary Care who conducted site visits informing toolkit development including Margae Knox, MPH; Reena Gupta, MD; Sara Syer, PA-C; and Rachel Willard-Grace, MPH.

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