

KEYS TO HIGH-FUNCTIONING OFFICE TEAMS

Trying to do it all yourself is not only unwise but increasingly impractical.



Access to primary care services in the United States

is in a state of crisis as the demand for primary care services outpaces our supply of primary care physicians. The U.S. population is plagued with chronic diseases, which place an increasing burden on primary care practices. The population is also aging alongside our primary care workforce, and we are not producing enough primary care physicians to replace those who are retiring. In the coming years, we will likely see a significant increase in the number of Americans who have some form of health insurance and are seeking a primary care physician. In addition, many large employers are looking to primary care to improve the health of their workers and to control escalating health care costs.

In the midst of this, many primary care physicians feel overworked, underpaid and unprepared for the increase in demand for their services. Many also believe that acquiring the resources they need to establish and maintain a so-called ideal model of primary care, that is, the patient-centered medical home (PCMH), would require fundamental payment reform. This state of affairs feels like a catch-22 – a no-win situation. If this feeling prevails, primary care physicians face an even greater risk for accelerated burnout and early retirement. ▶

HIGH-FUNCTIONING TEAMS DELIVER CARE IN SUCH A WAY THAT ALL TEAM MEMBERS WORK TO THE TOP OF THEIR ABILITY AND LICENSE.



While payment reform and continued investments in primary care are certainly needed, there *is* something that practices can do in the meantime to improve their efficiency and effectiveness and prepare for an increase in demand. In a past issue of *FPM*, I proposed a 10-step model to becoming a PCMH.¹ The first eight steps, which can happen without enhanced payment, include “Improve documentation and coding to stop leaving money on the table” (step 1) and “Employ advanced-access models of care that match supply of services with demand” (step 3). This article focuses on step 2: “Hire more nurses or medical assistants and offload work from physicians onto them by creating high-functioning office teams.” I believe this step will revolutionize your practice.

that employ effective team care models see their capacity increase by at least 20 percent, and in some cases by as much as 30 percent.³

Successful office teams have clear goals, a leader who supports and coaches them (more on this later), adequate resources, effective communication and sufficient rewards. In a team setting, the patient care processes that occur during and between office visits are defined and distributed so that people who are most suited to a task – both by ability and by the meaning they attach to performing the task – are the ones doing that work. In most primary care offices, nurses room patients, reply to phone messages, triage care and fax or phone in physician-authorized prescription refills. In high-functioning primary care offices, there is adequate staff to complete all of these tasks plus look ahead to the next day’s schedule and note any needed services for chronic disease management or preventive care. For example, a nurse might note that a patient with diabetes is overdue for both a urine microalbumin check and an A1C check, or note that a patient is eligible for colorectal cancer screening. (See the related article, “An Organized Approach to Chronic Disease Management,” page 29.) This approach doesn’t necessarily require an electronic health record system (EHR) to accomplish.⁴

In some high-functioning offices, nurses also do the majority of data acquisition, organization and management.³ This frees up an enormous amount of time for the physician to do physician work – diagnosis and treatment planning – and creates the capacity to see more patients, which pays for the added staff. In these offices, triage often doesn’t exist because the old models of scheduling have been replaced with advanced access, or same-day, scheduling.

■ Primary care physicians need to prepare for the coming increase in demand for their services.

■ Creating a high-functioning office team in your practice can improve your efficiency and effectiveness.

■ When nonphysician team members work to the top of their ability and license, physicians can focus more on revenue-generating tasks that require their expertise.

Team care vs. standard care

High-functioning teams deliver care in such a way that all team members work to the top of their ability and license and play a role in delivering preventive services and managing chronic diseases. This allows the physicians – essentially the only people bringing money through the door – to focus on tasks that require their expertise. Contrast this with the typical primary care practice, in which the physicians are spending half of their time doing nonphysician work.² This is not only demoralizing, but it also greatly diminishes the practice’s capacity to provide care. High-performing practices

About the Author

Dr. Kuzel is the Harris-Mayo Distinguished Professor and Chair, Department of Family Medicine, Virginia Commonwealth University, Richmond, Va. Author disclosure: nothing to disclose.



Article Web Address: <http://www.aafp.org/fpm/2011/0500/p15.html>

Laying the foundation

So how do you begin creating your office team? Business analyst and author Patrick Lencioni argues that high-functioning teams are built on a foundation of trust.⁵ This trust allows team members to engage in constructive conflict with one another about the team's goals, which then leads to team commitment and accountability and makes it more likely that the team will achieve its goals. Think of your care team, and consider these five ways in which Lencioni says teams can function poorly:

1. Absence of trust. When team members don't trust one another, two paths will be taken: Some members will play it safe by avoiding risks, while others will pretend to be competent when they're not. Both are disastrous for team function and can lead team members to think, "Look out for number one" and "Don't let them see you sweat."

2. Fear of conflict. Facing conflict can be particularly challenging for family physicians who tend to be relationship-focused and avoid conflict. While they are well-intentioned, their avoidance of issues can be dangerous. If there is team harmony, it is likely artificial because it has never been tested. Teams that fear conflict will adopt stale patterns of behavior and statements like "We've always done it this way" and "If it ain't broke, don't fix it."

3. Lack of commitment. Lencioni's model links the lack of commitment directly to the first two dysfunctions. How can team members really commit if they haven't aired their opinions and worked out the differences, and don't feel safe doing so? Teams that lack commitment tend to have two types of members: those with listless performance and those who resent carrying an unfair share of the workload.

4. Avoidance of accountability. Team members do not want to be held accountable if they cannot fully trust their team. The consequences of this dysfunction are a lack of constructive, critical feedback and a tendency to avoid collaboration and to work in silos.

5. Inattention to results. If team success is not clearly measured or if team metrics are not shared with the group, team members will tend to focus on individual success over team success, and the overall operation will suffer. If your practice is making it financially with

low staff turnover and relatively few patient complaints, you may be tempted to think that things are OK. But pay attention to how your practice is performing in these critical areas: Is your practice helping patients become confident in managing their own health care? Would most patients recommend your practice to their friends? Would staff members say they feel empowered and that the practice is a great place to work? How well is the practice performing on measures related to preventive service delivery and chronic disease management? The results of these questions can be far more telling than the basic indicators of financial stability, staff turnover and patient complaints.

Advice for team leaders

Team leaders should first and foremost work on establishing the foundation of trust described above. This can happen by first making themselves vulnerable. Lencioni suggests that leaders need to get comfortable saying things like "I was wrong," "I need your help" and "You're better than I am at that." If a leader is supportive, is coaching-oriented and responds nondefensively to questions and challenges, team members will conclude that the team environment is safe. If the team leader acts like an authoritarian, team members will not be willing to admit errors, ask for

■ Create your office team by first laying a foundation of trust.

■ Team leaders can begin establishing trust by making themselves vulnerable.

TIPS FOR OFFICE TEAMS

Consider these additional tips for creating and sustaining a high-functioning office team.

Hold regular team meetings during office hours. At the first meeting, ask your teammates about their goals and vision for the practice. Don't sell your ideas to your team members; instead ask what they envision. Also ask what support they need from you.

Celebrate your team's successes – big and small. Share stories about particularly meaningful patient interactions or other team member successes as a regular part of your team meetings.⁸

Let someone else lead the team some of the time. If you are the practice's owner, act like an employee some of the time.

Consider adding a patient advisory panel. An advisory panel with carefully chosen patient members can offer your office team great patient insight.


LEADERS NEED TO GET COMFORTABLE SAYING THINGS LIKE “I WAS WRONG,” “I NEED YOUR HELP” AND “YOU’RE BETTER THAN I AM AT THAT.”



help, experiment or seek feedback, which can be a tremendous block to team learning and improvement.⁶

Practical ways to make your practice a safe place for your team to be vulnerable and take chances include sharing a worry or dilemma with the team or asking them for advice and following it. If their advice doesn't work, go back to them for another solution to try. This shows them that you don't have all the answers, that you respect their ideas and views, and that it is OK to fail as long as the team learns from the experience. See “Tips for office teams” on page 17 for more practical advice.

It is important to realize that providing psychological safety does not mean that people are not held accountable; Lencioni's model makes it clear that accountability is the basis for results. In fact, organizations that have high psychological safety and high accountability for challenging tasks are the ones that accomplish the most.⁷

Primary care practices need “servant leaders” now more than ever. Physician leaders who adopt and sustain the advice described here will find their care team thriving. Be the change you want to see in your practice. 

Send comments to fpmedit@aafp.org.

■ Show that your practice is a safe place for your team by asking for their advice on a dilemma or worry – and following it.

■ Providing psychological safety does not mean that people are not held accountable.

■ Organizations that have high psychological safety and high accountability are the ones that accomplish the most.

FPM ARTICLES ON TEAM CARE

The following articles from the *Family Practice Management* archives can be accessed online at <http://www.aafp.org/fpm/careteam>.

- “A New Approach to Making Your Doctor-Nurse Team More Productive.” Anderson P, Halley MD. July/August 2008:35-40.
- “Closing the Physician-Staff Divide: A Step Toward Creating the Medical Home.” Crabtree BF, McDaniel RR, Nutting PA, et al. April 2008:20-24.
- “Why Teamwork Will Make or Break Your Practice.” Bagley B. April 2008:8-9.
- “Getting Beyond Blame in Your Practice.” Pawar M. May 2007:30-34.
- “Effective Work Relationships: A Vital Ingredient in Your Practice.” McBride JL. November/December 2006:45-46.
- “Creating a High-Performing a Clinical Team.” Moore LG. March 2006:38-40.
- “Ideas for Optimizing Your Nursing Staff.” Weymier RE. February 2003:51-52.
- “How Many Staff Members Do You Need?” Reeves CS. September 2002:45-49.

1. Kuzel AJ. Ten steps to a patient-centered medical home. *Fam Pract Manag*. November/December 2009:18-24; <http://www.aafp.org/fpm/2009/1100/p18.html>.
2. Barron RJ. What's keeping us so busy in primary care? A snapshot from one practice. *NEJM*. 2010;1632-1636.
3. Anderson P, Halley MD. A new approach to making your doctor-nurse team more productive. *Fam Pract Manag*. July/August 2008:35-40; <http://www.aafp.org/fpm/2008/0700/p35.html>.
4. Sinsky CA. Improving office practice: working smarter, not harder. *Fam Pract Manag*. November/December 2006:28-34; <http://www.aafp.org/fpm/2006/1100/p28.html>.
5. Lencioni P. *Overcoming the Five Dysfunctions of Teams: A Field Guide for Leaders, Managers, and Facilitators*. San Francisco: Jossey-Bass; 2005.
6. Edmondson AC. Psychological safety and learning behavior in work teams. *Administrative Science Quarterly*. June 1999:350-383.
7. Edmondson AC. The competitive imperative of learning. *Harvard Business Review*. July/August 2008:60-67.
8. Sinsky CA. Remember why you came to work today. In: Ten big ideas that could make your practice better. *Fam Pract Manag*. September/October 2008:41; <http://www.aafp.org/fpm/2008/0900/p33.html>.