IF YOUR STAFF'S JOB IS TO KEEP PATIENTS MOVING THROUGH THE SYSTEM AND

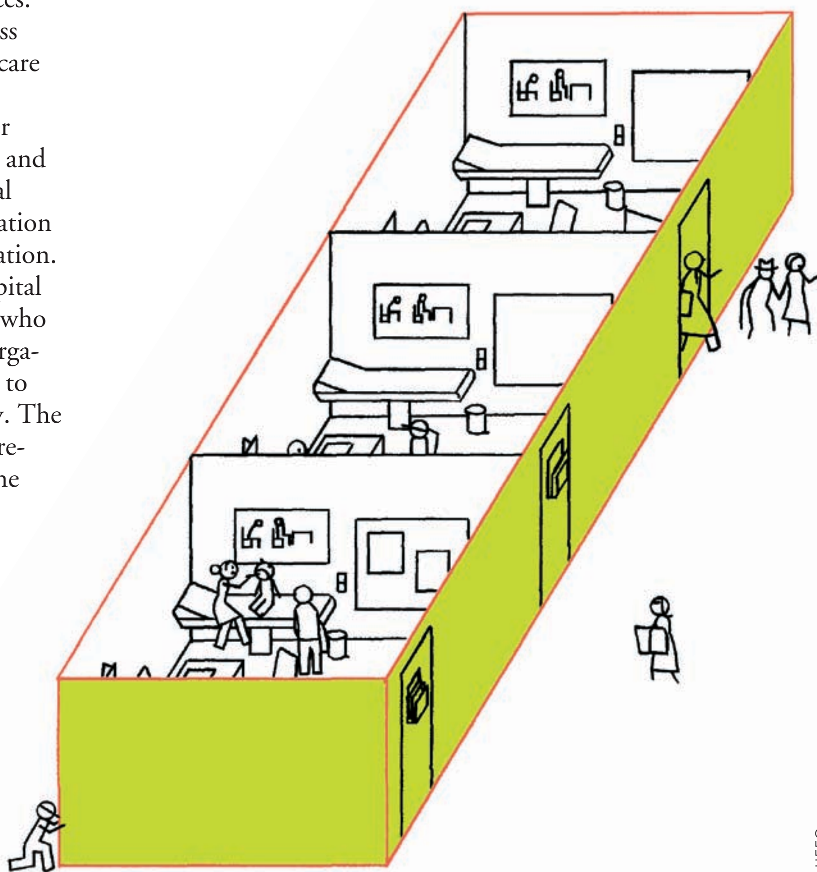
Closing the Physician– A Step Toward

Benjamin F. Crabtree, PhD, Reuben R. McDaniel, EdD, Paul A. Nutting, MD, MSPH,

Innovative family physicians around the country are struggling to embrace the new models of family medicine defined in the AAFP's Future of Family Medicine Report.[1-3] These models suggest the implementation of a patient-centered medical home[4] and require transformation of the fundamental principles, structures and processes of family medicine practices. The models incorporate care teams to better address chronic conditions[5] and promote coordination of care across the medical landscape.

In our research program we have sought a better understanding of how primary care offices operate and have found that nearly all practices operate as "dual organizations." That is, there is a purposeful separation between the physicians and the rest of the organization. This division, which is also seen in traditional hospital organizations, produces a federation of physicians who emphasize autonomy and independence, and an organization of support staff whose primary purpose is to process patients for the physicians to see efficiently. The primary care support organization is expected to create patient schedules, triage phone calls, manage the flow of ancillary information (labs, consults, etc.), respond to patient telephone requests and present a prepared patient to the physician every 10 to 15 minutes. The support organization also manages post-encounter tasks such as coding, billing, referrals and record management.

As we observe primary care practices, we often find an office manager minding the gap between the clinical organization and the support organization. He or she is often expected to be a "gatekeeper," managing the flow of information across the dual organization and is often expected to protect physicians from the mundane activities of the support organization while maintaining communication, morale and coordination within it. The office manager is expected to "deal with all that" and purposefully isolate the physicians so



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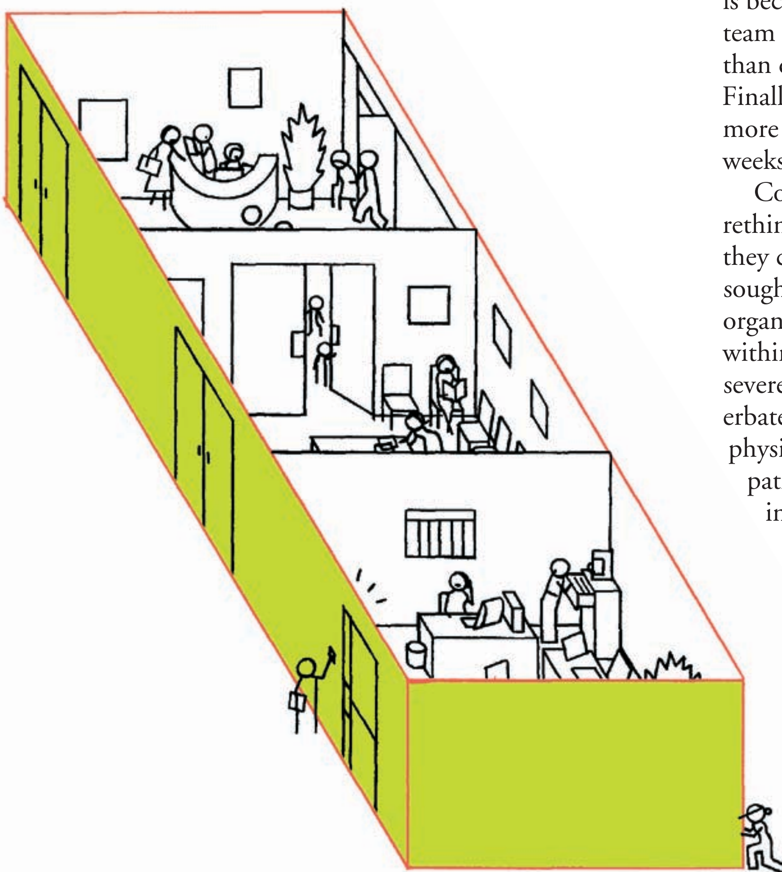
YOURS IS TO TAKE CARE OF THE PATIENTS THEY SUPPLY, YOUR PRACTICE IS FLAWED.

–Staff Divide: Creating the Medical Home

Holly J. Lanham, MBA, J. Anna Looney, PhD, and William L. Miller, MD, MA

they can focus on patient care. This expectation often puts the office manager in a particularly vulnerable position.

The dual organization of primary care practice evolved during an era when most patients were seeking acute care and the physician was the primary source of service. Expectations for primary care are rapidly changing, however, with the growing challenges of complex chronic disease and mental health care. Small practices are becoming larger and more complicated "systems" as they keep pace with increasing volumes of business and regulatory requirements. The value of midlevel clinicians is becoming recognized, but integrating them into a care team in a way that enables them to complement rather than duplicate the physician role remains problematic.[6] Finally, growing numbers of physicians are seeking a more reasonable work-life balance through reduced work weeks and scope of practice.



Contemporary family medicine practices need to rethink their organizational structure and roles before they can achieve the transformation required to become sought-after medical homes. While elements of the dual organization may be useful, separation and isolation within the suborganizations inhibit communication and severely limit collaborative teamwork. This is often exacerbated in the support organization because of significant physical distance between front and back offices. Patient pathway analysis[7] shows that patients interact with all individuals in the office and that lack of coordination across the entire support organization inhibits smooth transition of tasks and information within the patient visit, usually in ways noticeable to the patient and family. Without better coordination and information exchange across intra-organizational boundaries, improving chronic care and fully integrating preventive services will continue to be difficult.

One effect of breaking down the barriers between the two suborganizations in primary care practices is that support

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staff become part of the care team, taking on more responsibility, taking more initiative and becoming a more integral part of the practice. These ideas bring to mind the example of the now almost mythical NASA janitor who saw his work not as cleaning but as helping to land a man on the moon. Change of this magnitude will require a fundamentally new mindset among physicians and staff alike – a mindset different enough that some, both physicians and staff, may opt to leave rather than change.

As entrenched as the dual organization may be in our thinking and practice, there are three important strategies for preserving what is valuable while also moving beyond the limitations of this structure.

1. Promote boundary spanning in key practice roles.

In the dual organization, office managers have been socialized to emphasize a "gatekeeping" role in the practice. They are responsible for managing (and are often tacitly encouraged to restrict) the flow of information and ideas through the practice. While gatekeeping may serve some important functions, such as protecting confidentiality, it needs to be balanced by boundary-spanning activities that ensure the flow of information and ideas throughout the practice. In larger practices, boundary spanning becomes a particularly important role of other key midlevel supervisors, such as clinical nursing supervisors, as well. The leadership team in a practice needs to clarify the role and expectations of the office manager and how he or she is to balance gatekeeping and boundary-spanning activities to make and sustain important connections within the practice.

Boundary spanning should involve physicians as well. It is essential for them to appreciate, model and participate in boundary-spanning activities such as practice meetings and huddles.[8,9] The sense of physician autonomy that produces the divide between physicians and support staff also subdivides the physician portion of the practice, inhibiting cooperation and conversation about patient care among physicians as well as between physicians and support staff. Traditionally, primary care physicians have not been held accountable, either to their physician colleagues or to their practice staff, for the quality of their care. These disconnects encourage a "conspiracy of autonomy" and allow aberrant care patterns to remain invisible to the other members of the health care team. Breaking down the barriers in the dual organization

- Nearly all primary care practices function as "dual organizations."
- Physicians and staff constitute suborganizations with different functions.
- Modern primary care requires the practice to function as a single care team.

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purposefully isolate the physicians so they can focus on patient care.

will enable a broader set of conversations that will not only improve office functions, but also the quality of patient care. Physicians can model boundary-spanning leadership by actively engaging in discussions with practice members about such things as when to standardize clinical processes and when to preserve appropriate variation.

2. Increase connections.

Increasing connections is an important role for practice leadership and involves attention to communication and relationships within the practice. Communication mechanisms range from rich (face-to-face, one-on-one meetings) to lean (a posted memo), and those chosen should be appropriate for the purpose.[10] For example, posting a memo about sensitive personnel issues is much less effective than holding an in-person, one-on-one meeting or a small-group discussion. Practice meetings are essential for promoting communication and maintaining coordination, and although they are universally unpopular, they are indispensable, they are manageable, and they can be made more efficient and productive.[11]

Research has shown the central importance of relationships among practice staff in improving office operations and morale.[10] For example, practices characterized by diversity of perspective, mindfulness and trusting relationships are more open to new ideas and innovation. Heedful interrelating, the ability of staff members to understand how all aspects of the practice are interrelated and to heed the effect of their actions on other parts of the practice, is crucial to optimal practice function. For example, when addressing problems, staff should be encouraged to think about solutions beyond their immediate work area, as well as to consider how solutions in their work area will affect other staff.

Team development is also a critical strategy for increasing connections. It has been shown to be essential for improving chronic care.[12] Care teams in many practices are finding that regular huddles can promote good relationships and communication patterns, helping to anticipate and head off predictable discontinuities in patient flow and reducing stress during patient care sessions.[9]

3. Encourage second-order problem solving.

The dual organization puts excessive pressure on the support system to focus only on maintaining a steady flow of patients to the physicians, a focus that promotes first-order problem solving.[13] This is the tendency to "put a Band-Aid on the problem," rather than clearly identify and systematically address the underlying system issues. For example, this happens when a nurse habitually replenishes supplies in one exam room with those from another or when staff members repeatedly spend time searching for missing charts or lab values.

To promote second-order problem solving, practices should encourage members at all levels to take initiative in improving the practice. Practices should also reward the "noisy" staff members who call attention to recurring problems and help all staff to reframe problems from sources of annoyance to opportunities for learning.[13] This is a key to increasing patient safety and quality.

Healing the split

The dual organization is no longer sufficient for contemporary primary care practice. It serves to perpetuate an outmoded practice model and inhibit the emergence of the "medical home" that seems to be the model of primary care for the future.[4] The strategies suggested in this article are aimed at addressing this challenge. We acknowledge that these strategies may require significant change in

- Activities that span the physician-staff boundary can help develop a unified team.
- Physicians must transcend the sense of autonomy that isolates them from the staff.
- Improving communication and interrelationships within the practice can also help.

how people think about their role in a practice and that this change may not come easily. For assistance, we refer the reader to the sources cited in this article and to *The Team Handbook* (Madison, WI: Oriel Incorporated; 2003). This book contains a wide range of practical team-building strategies and is written in a very accessible style.

Replacing Band-Aid fixes with second-order problem solving can improve practice function.

Despite the potential difficulties, we believe that promoting boundary spanning in key practice roles, increasing the quality of connections and relationships among people, and encouraging second-order problem solving will help diminish the destructive consequences of the dual organization in primary care practices and open the door to a far more effective practice model. FPM

Strategies such as these are important steps on the road to the "medical home."

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