

Focusing on their strengths and borrowing concepts from family therapy helped bring this family medicine group together in pursuit of a common goal.

A Team-Building Model for Team-Based Care

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Delivering patient-centered care using a team-based approach can require significant changes in how work is distributed – changes that may meet resistance, create anxiety, and necessitate developing new levels of trust and communication among physicians and staff. Our practice, a family medicine residency of 21 residents and seven faculty physicians providing 22,000 patient visits annually, wrestled with these issues after an internal survey suggested that our health care delivery was fragmented and not team-oriented. Although we had four designated “teams,” faculty physicians were responsible for a disproportionately large share of the teams’ work, nurses and clinical support staff lacked autonomy and did not work to the top of their licenses, consistency and accountability were lacking, and team members were dissatisfied.

We came to realize that achieving our overarching goals of improving efficiency, increasing satisfaction among physicians, staff, and patients, and positioning our group to seek patient-centered medical home (PCMH) recognition would require not only redefining our teams, job descriptions, and performance expectations but also changing our relationships. Efforts to deliver integrated care succeed or fail based on team relationships – not solely on workflow and processes. Team building and training that involved a strengths-based (rather than problem-based) approach, combined with concepts and practical techniques borrowed from family systems theory and family therapy, helped us to improve relationships and, ultimately, efficiency as evidenced by increases in satisfaction and productivity. We hope that other practices might learn from the experiences we describe in this article.

Redefining our teams

We began by examining the form and function of our existing teams and then redefining them. We created three teams that consisted of not only faculty and resident

physicians and clinical support staff but also others whose work focused on front-desk functions, referrals, lab tests, medical records, medical library, pharmacy, and messaging. Each team had a designated member from these critical support areas; some of these individuals served on more than one team because of low numbers.

An emphasis on growing the positive, rather than identifying and eliminating problems, helped to reduce team members’ resistance. We focused on the processes within the clinic and teams that were going particularly well, which allowed us to build on our successes. This strengths-based approach minimized staff attempts to defend and justify current practices that needed to be changed, and instead it focused their attention on things their peers were already doing that would improve the practice.

Of our existing teams, the highest functioning team was made up of physician assistants (PAs) and nurse practitioners (NPs) who ran their own acute care clinic for same-day appointments. We wanted other teams to implement many of their best practices, so we decided to disband this team and assign each member to one of the three new teams. We also incorporated same-day appointments for acute care into each team’s schedule. This allowed the PAs and NPs to assume some teaching responsibilities and gave resident physicians the opportunity to provide more same-day, acute care.

The next step was to study our job descriptions and expectations, redefining or reasserting them as necessary to achieve optimal function from each team member and streamline processes to eliminate redundancy and unnecessary work. Some individuals, particularly faculty physicians, were over-functioning by doing things that were part of someone else’s job description but not their own. We also found many examples of people who were not performing tasks that were well within the scope of their practice and job descriptions. For example, nursing staff were not completing medication lists, not giving out screening tools, not ordering immunizations, and not

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opening the electronic health record (EHR) and previous visit documentation (which takes one to three minutes using our system).

Finally, we developed a training plan that would entail three half-days of training for each team. We mitigated the resulting decrease in productivity and access to care by having only one team at a time participate in the training. The first half-day of training focused on team building, which allowed the redefined teams to get to know each other as individuals and to gain an understanding of their new roles together. The other two half-days of training focused on clinic processes, with opportunities to practice them using simulated patient encounters. It was extremely important that staff saw the potential for these changes to directly benefit patients and improve their own satisfaction in caring for them. We emphasized that this was not something we were doing only to achieve our goal of PCMH recognition, but rather an effort to improve overall patient care and help everyone work more efficiently in ways that would help ease job-related stress and frustration.

The practice clinical manager and business office manager also organized voluntary, pre-training opportunities for staff to “walk a mile in someone else’s shoes” by working alongside someone in another area of the practice. It was apparent that most people had little understanding of the responsibilities and workloads of staff members outside their immediate work areas. Many perceived that they worked

harder than others and had little recognition of the impact of their action (or inaction) on other departments. This opportunity helped participants gain insight into the importance of everyone’s role in the practice and left them better prepared for our training.

Team building

The team-building agenda was similar for each team. Each participant had written a short personal introduction prior to the session that described what he or she believed was important for the others to know. We began the first sessions by distributing these introductions randomly and having the recipients introduce their fellow team members by reading their personal story and adding their own comments as desired. Although many team members had worked with each other for years, not everyone was aware of the personal information that was shared. The teams then broke up into small groups and worked on identifying the characteristics that they believed were essential for a strong team. At the end of the small group meetings, the teams came to consensus around the four most important characteristics and adopted these “pillars” as their team goals: respect, communication, patient-centered care, and team-based roles. Interestingly, but not surprisingly, all three teams independently identified essentially the same characteristics.

Using relational and communication concepts of family therapy to build our new teams also helped to reduce anxiety and increase trust. Any change, even if it is positive, brings anxiety, and people often respond by resisting the change and trying to return to the familiar. The discipline of family therapy seeks to reduce anxiety and resistance by helping people to think about issues and solutions in the context of interpersonal relationships and communication, rather than thinking only about intrapersonal feelings, personalities, and deficits. The focus is on how the overall context must

■ To improve efficiency and staff satisfaction, the authors’ practice set out to build stronger teams.

■ They redefined teams, job descriptions, and performance expectations, and emphasized developing relationships.

■ One objective was to ensure that physicians and clinical staff were working to the top of their licenses.

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change for the relationship to be different.

Some say physicians and other clinical providers are the most difficult to integrate into a team. In our case, the physicians had been over-functioning for a long time and, understandably, felt some animosity about being part of a team. In addition, medical education has not been team-based, which makes it more difficult for some physicians to see how they can fit into a care team. We used two unique approaches to improve physician commitment.

First, we met separately with the faculty physicians. With the group in a circle, two of us led a visioning exercise. The imagery we described was a beach with relaxing cues of warm sun, cool water, calming waves, and peace. The group was then asked to notice islands in the distance that appeared separate, but that on closer inspection were actually connected by multiple bridges and land masses. The imagery was a metaphor, of course, emphasizing the interconnectedness of individual team members. After this exercise, the group reviewed common goals and plans to achieve their group expectations.

Residents and faculty physicians then participated in a sculpting exercise. Borrowed from family therapy, sculpting is a therapeutic technique used by multiple disciplines such as nurses, social workers, and physicians to help groups physically demonstrate perceived relationships. The technique helps participants, or “sculptors,” to transform inner thoughts and feelings into observable situations and behaviors and allows those who are “sculpted” to see how others perceive them. (It should be noted that Dr. Marlowe is a marriage and family therapist, but it is not necessary to have experts in marriage and family therapy to lead guided imagery or sculpting exercises. Multiple websites, books, and journal articles review both guided imagery and sculpting in ways that make them easy to perform.)

Here’s how sculpting works: The participants were broken into smaller groups, and half were designated as sculptors. The sculptors worked together to move the other members of the group into positions that reflected how they viewed them. For example, the program director and the president were positioned outside the group looking down on them in a model of authority. Other members were positioned closely together while others were positioned alone. At the end, the group

TASK ANALYSIS: BEFORE AND AFTER

The table below illustrates the increase in autonomy and function of nursing and administration staff that resulted from encouraging all staff to work at the top of their license.

Task	Before	After	
	Physician	Nurse	Administrative staff
Use standing orders.	X	X	
Open electronic chart and update patient information including medication list, past medical history, and social history.	X	X	X
Write excuses, school notes, etc.	X		X
Complete screenings.	X	X	X
Provide patient education.	X	X	X

discussed the process as well as formal and informal aspects of their relationships, many of which were either unintended or unknown prior to the exercise. This created the opportunity to talk about how perceptions can unconsciously shape our behaviors with others in the work setting and how awareness of these perceptions can bring about behavior change.

Overall, the exercises were well received, according to participant questionnaires. Group function and cohesion improved noticeably as evidenced by diminished complaints and bickering. Despite implementing considerable change, teams exhibited minimal resistance and worked better together. Shifts in responsibilities that resulted in increased nurse and administration autonomy and improved utilization of resources are listed in the table above.

Lessons learned

Family therapy concepts can be useful in improving the effectiveness of an already high-functioning staff or in implementing a major culture change. Experience taught us a few additional lessons:

Anxiety is contagious, but so is calm.

Planning change strategies and training is time-intensive, but the reductions in staff stress and resistance and improved performance make it worthwhile. The resultant changes went smoother than most major change endeavors. ➤

■ Team building and training sessions were key to bringing about the desired changes.

■ Sharing personal stories, developing shared goals, and engaging in exercises borrowed from family therapy helped to build trust and reduce anxiety and resistance.

Because staff had an opportunity to be informed, involved, and heard throughout the activities, they felt less anxiety and uncertainty about what was expected of them.

The timing of training is important.

Our training had to take place over several months to minimize the effect on productivity and access. We lost some momentum as a result. The size of the group and the ability to continue to provide care are limiting factors. Small practices may find that evenings or weekends are the best times for training.

The more participation, the better the outcomes. The “walk in your shoes” experience was voluntary but so valuable that we wish everyone, including the physicians, had spent at least an hour doing it.

Set performance expectations, train, and give feedback, in that order. Physicians tend to over-function due to a sense of responsibility, fears about loss of control over important issues, and the potential for poor patient outcomes. Physician over-functioning can be effectively reduced by appropriately delegating tasks, which is done by setting clear and measurable performance objectives from the beginning and using standardized orders. Training may also be necessary for staff to achieve the expected performance. After training, frequent, specific feedback should be given.

Active resisters have to be held accountable for their behavior. They won't “just get over it.” Some resistance to change is normal, but active undermining and passive resistance

are toxic to the entire team. Several of our medical assistants were comfortable with their previous levels of responsibility and reacted negatively when asked to practice at the top of their license. All but two team members eventually embraced the change as positive; the remaining chose to find new jobs.

Team building requires the support of practice leadership. The tendency in most medical practices is to focus on practical and business aspects of health care and forget the underlying personal and relational facets. When changing a culture, we are actually changing how people understand and organize themselves in relationship to one another in order to achieve a stated end, in this case, providing health care to a community. This is no small task, and it will be virtually impossible if your leadership isn't on board.

Supporting team care

As with any change initiative, there are limitations and questions about how to apply the approach to other practices. We believe that productivity lost during team building was offset by productivity gained from team cohesiveness and clarity of roles and responsibilities. Organizational health and well-being are related to individual health and well-being.

Team-based care has been embraced by administrators, physicians, support staff, and patients because it promises to decrease workload and cost, improve efficiency, increase continuity, and improve patient and provider satisfaction. However, this type of care also requires re-organizing the practice to emphasize increasingly close working relationships between all members of the team, including patients. Family systems theory and family therapy offer a conceptual and practical framework for augmenting relationships so that all team members feel validated and ultimately hold a degree of ownership over the team and its function. Team building that conceptualizes integrated care as an interconnected series of relationships supports the practical and personal aspects of team care. **FPM**

■ The teams in the authors' practice are now working more effectively and productively together.

■ Although team building may be costly in the short-term, the gains in productivity and satisfaction make it well worth the investment.

RESOURCES

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The Guided Meditation Site: <http://www.the-guided-meditation-site.com>.

FPM Topic Collection on Care Teams and Staffing: <http://www.aafp.org/fpm/careteam>.

Send comments to fpmedit@aafp.org, or add your comments to the article at <http://www.aafp.org/fpm/2012/1100/p19.html>.