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CME

Taking Team-Based Care to the Next Level

The need to delegate tasks to other members of the health care team has never been more urgent. Here's how to move toward advanced team-based care.

Team-based care is not just another buzzword. It is a model of care delivery that, when done well, can greatly reduce physicians' administrative burden and elevate clinical staff's role, while improving patient experience, quality, and safety.[1] While many physicians are likely aware of basic team-based care models, advanced team-based care is a comprehensive, integrated model in which physicians perform only the functions they are uniquely trained and qualified to do, and delegate other tasks to capable staff.

This article builds on the awareness of basic team-based care and aids practices in moving to the "next level" by expanding the team and optimizing its performance. The value of effective teamwork

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in medicine has never been more widely understood than it is today. Many practices face persistent staffing challenges due to intermittent absenteeism, open positions with few qualified applicants, and caregivers who are exhausted or burned out from the grind of the last two pandemic years.

Nurses and medical assistants can take on many tasks previously performed by physicians, including agenda setting.

Considering the workload for most primary care physicians was unmanageable even pre-COVID,[2,3] we presently find ourselves at a crossroads of circumstance and opportunity.

BASIC TEAM-BASED CARE

Team-based care is designed to enhance efficiency and access, improve quality of care, and increase satisfaction for all involved in medical care (physicians, employees, and patients).[1,4,5] The physician leads the care team in building relationships with patients, interprets available data, and performs medical decision making, while delegating other tasks.

Engaged, capable, and well-trained clinical staff such as medical assistants (MAs), registered nurses (RNs), and licensed practical nurses (LPNs) are key to successful team-based care. Nurses and MAs can take on many tasks previously performed by physicians, including agenda setting, history gathering, record retrieval, EHR navigation, updating charts, medication review, data entry, order entry, and the bulk of required visit documentation.[1,4,5] (See "Tasks physicians may delegate to clinical support staff" on page 27.) When the clinical team completes documentation collectively, the quality of the notes can be as good or better than when the physician does it alone.[6]

For team members to take on additional tasks, they need the time and support to do them well. This may require challenging historical staffing ratios. For optimal team-based care, each physician should have 2.0-2.5 full-time equivalents (FTEs) of dedicated clinical support.[7] MAs or nurses are critical to effective team-based care, and they represent the most basic and important building blocks of the team. Expanding the team with additional MAs or nurses allows their skills to be meaningfully used across the spectrum of primary care work. They can serve as embedded patient navigators, allowing practices to avoid introducing additional, more specialized team members, which could inadvertently create more fragmentation in care rather than less. One effective method for starting basic team-based care is to evaluate a practice's existing staff and resources and reimagine who does what. The increased efficiency and revenue associated with team-based care will eventually allow you to add more FTEs as needed. (See "Team-based care resources" on page 28.)

EXPANDING THE TEAM: SIX ROLES TO CONSIDER

When practices can expand the team, it is usually more effective to first add another "generalist," such as an MA or nurse, rather than a staff member whose role is more limited. Once the generalist clinical support staff has been optimized and tasks delegated, adding other roles may further an advanced team-based care model.

Even if it were possible, we would not advocate adding all of the following positions to a practice because as the number of people and roles on a team grows, at a certain point the work of handing off patients and getting each person up to speed outstrips the benefits. Instead, identify a few key opportunities for team expansion from the following choices, based on your practice's needs.

KEY POINTS

- Basic team-based care allows physicians to delegate tasks such as agenda setting, history gathering, and record retrieval to nurses or medical assistants, freeing more time for medical decision making.
- Practices can further enhance team-based care by adding behavioral health professionals, clinical pharmacists, care coordinators, or other providers to the care team.
- Strategies such as daily huddles, panel management meetings, and synchronized prescription renewals can help teams of any size achieve greater efficiency and better health outcomes.

RN care coordinators were the first additional patient care resource added in my (Dr. Hopkins') practice after we were successful with the two-MA team-based care model. The efficiency we gained from that model allowed us to see enough patients to add care coordinators without adversely affecting the budget. A suggested ratio is one RN care coordinator for every 2-4 physician FTEs. Nurse care coordinators can be invaluable as a shared resource for multiple primary care teams and the main point of contact for patients who need them most. They connect with high-risk patients being discharged from the hospital, assist with transitional care management (TCM) outreach and visits, contact patients who need follow-up after trips to the emergency department, and help manage patients on chronic disease registries. Patients active with our care coordinators have their direct telephone numbers. This has been instrumental in reducing our readmission rate and avoiding unnecessary emergency department utilization. While care coordination work is not directly reimbursable on its own, it is bundled into other billable services such as TCM. Also, organizations participating in value-based payment models are generally paid an upfront "care management fee" to support the cost of care coordination.

Population health navigators could be MAs, LPNs, clinical techs, medical techs, or even clerical team members who can do panel management and help patients navigate the often-intimidating health care system. Navigators can provide access and scheduling assistance to patients for primary care, specialty referrals, and recommended tests or procedures. They can routinely monitor and revise reports such as care-gap registries and shared patient lists, and they can do proactive, targeted outreach for patients who are due for routine follow-up and screenings. If you're unable to hire a designated population health navigator, all of the MAs and nurses within a practice can take on the role on an ad hoc basis, flexing between rooming and desk work as needs ebb and flow.

Clinical pharmacists embedded within a primary care practice can help educate patients to raise health literacy, perform medication instruction to encourage adherence, and partner with physicians to monitor and manage chronic diseases for better patient outcomes. The ratio of pharmacists to physicians will vary from approximately 1:6 to 1:12 based on the social and medical complexity of the patient population. Pharmacists may conduct in-office or virtual visits and be available for real-time in-office or informal consults. In some practices, physician-designed collaborative practice agreements allow pharmacists to start, stop, and adjust medications for chronic conditions, under the physician's direction.[8] These services are billable, whether they occur in office or virtually.

Primary care social workers would ideally be physically present in every practice, but in most cases that may not be practical. However, a centralized group of social workers available to patients and caregivers by telephone or electronic referral can offload some patient assistance tasks. Social workers should be familiar

TASKS PHYSICIANS MAY DELEGATE TO CLINICAL SUPPORT STAFF

This is not intended to be an exhaustive list. Nurses and medical assistants may be able to take on more tasks depending on state scope-of-practice regulations.

- Performing traditional rooming duties (intake, allergies, medications, vitals, etc.)
- Determining chief complaint (drives note template selection)
- Agenda setting
- Taking preliminary history of present illness/review of systems
- Administering pre-ordered vaccines
- Considering point-of-care testing
- Giving an oral presentation about the patient to the physician
- Doing in-room documentation (scribe function)
- Implementing plan (pending orders)
- Updating problem list
- Providing educational resources
- Completing forms, letters, etc.
- Scheduling follow-up visits
- Giving after-visit summary, ensuring understanding
- Doing a warm handoff to next team member
- Handling charge entry

with available local and regional social services, able to assist with medication and transportation issues, and able to support patients and their families with complicated care decisions such as placement in a residential care facility. Primary care social work services are generally not billable, but there are some exceptions. For example, licensed social workers can bill for performing Medicare AWVs (under physician supervision) and for providing certain counseling services.

TEAM-BASED CARE RESOURCES

The basics

AMA STEPS Forward:

- General team-based care: https://edhub.ama-assn.org/steps-forward/module/2702513
- Expanded rooming and discharge protocols: https://edhub.ama-assn.org/steps-forward/module/2702600
- Team documentation: https://edhub.ama-assn.org/steps-forward/module/2702598
- Telemedicine and team-based care: https://edhub.ama-assn.org/steps-forward/module/2781279

Clinical pharmacists

- American College of Clinical Pharmacy, Comprehensive medication management in primary care study: https://careers.accp.com/article/comprehensive-medication-management-landmark-study-s-findings-and-future-directions
- AMA STEPS Forward, Embedding pharmacists into the practice: https://edhub.ama-assn.org/steps-forward/module/2702554

Behavioral health professionals

- FPM editorial, Integrating behavioral health into primary care: https://www.aafp.org/fpm/2021/0500/p3.html
- FPM article, Bringing behavioral health into your practice through a psychiatric collaborative care program: https://www.aafp.org/fpm/2019/1100/p11.html
- AMA STEPS Forward, Behavioral health integration into primary care: https://edhub.ama-assn.org/steps-forward/module/2782794

Team huddles:

- FPM article, Huddles: improve office efficiency in mere minutes: https://www.aafp.org/fpm/2007/0600/p27.html
- AMA STEPS Forward, Daily team huddles: https://edhub.ama-assn.org/steps-forward/module/2702506

Medicare annual wellness visits

- AAFP, Annual wellness visit: https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/annual-wellness-visits.html
- AMA STEPS Forward, Streamline workflow to perform a thorough AWV: https://edhub.ama-assn.org/steps-forward/module/2757861

Population health management training

- FPM article, Put your clinical data to work with a registry: https://www.aafp.org/fpm/2021/1100/p21.html
- AMA STEPS Forward, Patient care registries: https://edhub.ama-assn.org/steps-forward/module/2702745

Panel management meetings

- University of Washington School of Medicine, Panel management meeting workflow for panel managers: https://depts.washington.edu/uwmedptn/wp-content/uploads/Panel-Management-Meeting-Workflow-for-Panel-Managers.pdf
- FPM article, The right-sized patient panel: a practical way to make adjustments for acuity and complexity: https://www.aafp.org/fpm/2019/1100/p23.html
- AMA STEPS Forward, Panel management: https://edhub.ama-assn.org/steps-forward/module/2702192

Pre-visit planning

- FPM article, Putting pre-visit planning into practice: https://www.aafp.org/fpm/2015/1100/p34.html
- AMA STEPS Forward, Pre-visit planning: https://edhub.ama-assn.org/steps-forward/module/2702514
- AMA STEPS Forward, Pre-visit laboratory testing: https://edhub.ama-assn.org/steps-forward/module/2702697

Synchronized prescription renewal

- FPM article, A streamlined approach to prescription management: https://www.aafp.org/fpm/2012/1100/p11.html
- AMA STEPS Forward, Annual prescription renewal: https://edhub.ama-assn.org/steps-forward/module/2702751

Patient portal message delegation

- FPM article, Practical ways to manage your EHR inbox: https://www.aafp.org/fpm/2021/0700/p27.html
- AMA STEPS Forward, Patient portal optimization: https://edhub.ama-assn.org/steps-forward/module/2767762

Behavioral health specialists are another optional resource, ideally co-located within a primary care practice to provide access to traditional behavioral health office visits as well as real-time in-office and informal consults.[9] This team member could be a psychiatrist, psychologist, behavioral health nurse practitioner or physician assistant, counselor, health coach, or social worker. The best option for each practice depends on the patients' needs and the availability of each type of behavioral health professional. Depending on their training, these providers can help with mood disorder treatment, substance use disorder treatment, attention-deficit/hyperactivity disorder assessments, sleep disturbance counseling, weight loss and exercise coaching, triaging patients to the appropriate level of care, and even coordinating inpatient psychiatric care. These services are billable, depending on provider credentials and type of care.

Advanced practice RNs (APRNs) and physician assistants (PAs) are becoming increasingly common in primary care practice. APRNs and PAs can increase patient access for scheduled wellness and chronic care visits, as well as acute and walk-in care. In some practices, physicians work in formal pairs with APRNs or PAs, sharing a patient panel, in-basket work, and panel management. An APRN or PA may have dedicated time to manage the inbox, complete administrative tasks, and see patients.

OPTIMIZING THE TEAM: SEVEN STRATEGIES

Adding team members helps, and equally important to practice transformation is workflow innovation and redesign. Goals for clinical outcomes are rising. Regulatory compliance standards are advancing. Demand for telemedicine remains strong.[10] We cannot expect to meet these moving targets without transforming the model in which we deliver care. No physician, practice, or health care system can hire or implement the full scope of the care team described above. Recognizing the current challenges with workforce availability, it may be more feasible to start with making changes that optimize your existing team. The best predictor of a change being successfully implemented is whether it is mutually beneficial to patients, care teams, and systems.[4] Here are some strategies to consider.

Team huddles are used in sports for frequent, brief communication between team members and can serve the same purpose for a clinical team. When and where they take place and who attends may differ by practice, but huddles often take just 5-10 minutes at the beginning of the clinic day. They are most effective when there is a shared purpose and agenda. Which team members are in or out today? What opportunities and challenges might we expect with today's patients? What does each team member need to know, and what do they need to share with the others? Answering these questions ahead of time with a huddle makes the day go more smoothly.

Medicare annual wellness visits (AWV) do not need to be performed by physicians, according to Medicare rules. Physician assistants, nurse practitioners, or clinical nurse specialists may perform them. They may also be performed by other licensed medical professionals (e.g., nurses, health educators, registered dietitians, or nutritionists) working under the direct supervision of a physician.[11] Developing a standard documentation template to ensure the AWV includes all of the required components and having a nurse, MA, or other staff member complete the template frees physicians to provide more undivided attention to their patients. While some practices bring the patient in for an additional appointment with staff to complete the AWV, a "co-visit" model with staff and physician can also be effective. Under this model, nursing staff completes the required data collection, documentation, and preventive-care scheduling during the rooming process of a physician visit. This reduces redundancy and patient inconvenience. Using a registry to identify eligible patients who are not scheduled for future AWVs provides an opportunity for patients who may not have been active with the practice recently to reestablish care and could improve patient retention.

Population health management training is a process of educating and empowering each team member to take care of the whole patient. When everyone on the team understands the importance and impact of specific interventions on overall patient

health, they are more likely to be active participants in this valuable work. Clinical decision-making should remain with the team's physicians, while others on the care team work through patient lists, reach out to those who are overdue for care, schedule follow-ups, and confirm patient status and record accuracy.

Some primary care teams and health systems have incorporated point-of-care lab tests into pre-visit planning.

Panel management meetings are longer, more specialized huddles that bring the care team together to collaboratively review certain groups of patients and develop action steps for each patient. These meetings might be weekly, monthly, or on a different cadence, and they might include different team members depending on the type of patients being reviewed. Teams can use data from the EHR or other sources to select groups of patients to focus on at each meeting — e.g., patients with frequent emergency department visits, patients who haven't been seen in the previous 36 months, patients enrolled in care coordination, or patients who have a high risk score. Teams can then discuss how to improve the health of these patients, leveraging all resources at their disposal, and assign responsibility for putting the plan into action. This type of panel management is valuable in any payment model, but particularly in a risk-based or capitated model.

Pre-visit planning is a strategy to help scheduled appointments go smoothly and productively. It entails creating protocols for basic or in-depth tasks that can be shared across a care team to prep patients and practices for the visit. Pre-visit planning begins with using the end of each visit to prepare for the patient's next visit. The physician communicates the timing of the next appointment and outlines any tests that will be needed. For patients with a chronic disease like diabetes or hypertension, staff can ensure proper lab tests are ordered and results are available at the next visit.

Some primary care teams and health systems have incorporated point-of-care lab tests into pre-visit planning, an arrangement popular with patients.[12] Others have implemented evidence-based pre-visit protocols for patients with certain chronic diseases to monitor medications and to ensure patients are receiving screening/preventive care on schedule. Technology can increasingly automate this process and individualize it for each patient.

Pre-visit planning also can include identifying care gaps the day before or the morning of an appointment so that staff are prepared to give needed immunizations or schedule any overdue screenings. For more complex patients, staff may conduct a pre-visit phone call to identify any new issues patients may want to discuss. This can help visit efficiency and allows for a medication review while patients are at home and able to look at their medication bottles.

The final step in pre-visit planning is a very brief (1-2 minute) mini-huddle between the nurse/MA and the physician just before the physician greets the patient. This allows staff members to share key social or medical issues they identified during rooming to help the physician focus the visit.

Synchronized prescription renewal is a process improvement for renewing all chronic medication prescriptions for a patient at the same time, once a year, with slightly more than a year's supply of refills. Ideally, each prescription is written for a 90-day supply with four refills (providing 15 months of medication authorization). This improves medication adherence and can save a typical primary care practice hundreds of hours of work annually.

Patient portal message delegation is essential to helping patients, physicians, and care teams stay connected. Without the support of the care team, portal messages can become just one more task that consumes physicians' limited time.

Patient portals store messages in the EHR as an encounter type, usually with the same functionality as other encounter

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types such as telephone or in-person visits. This allows the care team to respond to the patient, place orders, and update the chart within the same screen.

The volume of patient portal messages for the typical practice has increased steadily over the past decade, and particularly dramatically during the COVID-19 pandemic. Data from one large EHR vendor showed a 157% increase in incoming patient messages during the pandemic's first year, with each message requiring physicians to spend an average of 2.32 additional minutes in the EHR.[13] Physicians cannot absorb all of that time.[14] All incoming patient messages should first be reviewed by members of the care team, who handle those that they can adequately address. The small number of messages that require the physician's attention can be prepped to the extent possible, then routed to the physician for review and action.

PUTTING IT ALL TOGETHER

A 2014 article in *Annals of Family Medicine* described the "Quadruple Aim" of medicine, taking the "Triple Aim" (better patient outcomes, lower cost, and better patient experience) and adding a fourth, equally important priority: care team well-being.[15] Supporting wellness among health care workers is a critical tenet of significant and sustainable care model innovation and improvement. Caregivers who are well physically, emotionally, and spiritually will naturally provide better care and experiences for the patients they treat than caregivers who are unhealthy, exhausted, or burned out.[16]

Over the past decade, more individuals, health systems, and advocacy organizations have embraced taking care of the care team as essential to delivering the highest quality patient care. The team-based protocols outlined above can help your practice increase caregiver wellness and decrease burnout, as well as improve patient outcomes. Starting, and then advancing, a team-based care model can be a win for everyone. FPM

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