Kevin D. Hopkins, MD, and Christine A. Sinsky, MD

# TEAM-BASED CARE:
## Saving Time and Improving Efficiency

**Physicians can maximize their time — and their practice's income — by delegating more documentation tasks to well-trained staff.**

This used to be the start of a typical day in my (Dr. Hopkins') office: 18-25 patient visits on the schedule, 30 test results in my inbox, and 20 phone encounters that I didn't get to the day before. I also had office notes from two days ago still needing documentation, patients wondering when I would finish their Family Medical Leave Act forms, and an email from the information technology department about allowing patients to ask me questions through a secure computer portal, which I anticipated would further eat into my personal time. It frequently had me beginning the day in a bad mood and wondering how I was ever going to get all of this done by myself.

I often wondered, "Why can't I just focus on the things I'm uniquely allowed to do as a physician and let others do the rest?" I knew it was possible because I had experienced it.

At Cleveland Clinic, innovation is one of our core values. But three years out of residency in 2008, I was struck by the fact that, compared with the latest surgical techniques and inpatient procedures, the typical primary care outpatient visit had not seen a lot of innovation. In addition, as a poor typist, I was struggling with my first exposure to an electronic health record (EHR), which was further slowing me down.

I realized that I was going to need some help if I

© RON CHAN

**About the Authors**

Dr. Hopkins is medical director of the Cleveland Clinic Strongsville Family Health and Ambulatory Surgery Center in Strongsville, Ohio. Dr. Sinsky practices internal medicine in Dubuque, Iowa, is vice president of professional satisfaction for the American Medical Association, and serves on the American Board of Internal Medicine's board of directors. Author disclosures: no relevant financial affiliations disclosed.

**I often wondered, "Why can't I just focus on the things I'm uniquely allowed to do as a physician and let others do the rest?"**

wanted to practice medicine for the next 30 years.

Around that time, I was inspired by a *Family Practice Management* article co-authored by Peter Anderson, MD, who had implemented a new type of practice in Newport News, Virginia, and achieved dramatic improvements in key metrics.[1] Sometimes referred to as "collaborative care," "turbo practice," "shared care," or "team care," this high-efficiency alternative to the traditional medical practice model is designed to reduce patient waiting times and increase quality of care, accessibility, and the satisfaction of physicians, clinical employees, and patients. Practice management journals have published articles about similar practice models over the past several years.[2] In April 2010, as I began writing a business plan to apply this model across multiple outpatient service lines in our organization, my medical assistant (MA) and I spent two days at Anderson's practice to see this innovative practice style first-hand. I quickly became convinced that this was how primary care, and primary care physicians, could survive.

The team-based care model allows physicians to focus on medical tasks only they are trained to do.

Improper delegation of tasks can limit a physician's efficiency and hurt the practice's income.

Clinical assistants handle much of the data collection for visits, while the physician performs the exam and develops the care plan.

## Rethinking – and delegating – documentation

The model uses a team approach to care for patients. Each individual performs at the highest level of his or her qualifications. The physician performs the functions that only he or she is qualified to do and delegates the other tasks to well-trained clinical assistants. These clinical assistants could be registered nurses (RNs), licensed practice nurses, or very capable and experienced MAs. In a traditional practice model, failure to delegate often limits efficiency. The physician is typically the only person in the office who can generate revenue. If the physician is spending time entering data in an EHR or filling out forms that do not require his or her expertise, that is time *not* spent seeing patients and generating income for the practice.

The majority of outpatient office visits can be divided into four distinct stages:

- Stage 1: Gathering data,
- Stage 2: Physical examination and synthesis of data,
- Stage 3: Medical decision-making,
- Stage 4: Patient education and plan-of-care implementation.

In a traditional practice model, the physician is solely responsible for most, if not all, of these four stages. With a "team care" model, however, the physician and clinical assistant share these responsibilities. The clinical assistant handles much of the data gathering, including documenting the patient's complaints and gaining additional detail through questioning. The physician can develop protocols and templates based on specific patient complaints and chronic conditions that direct the clinical assistant's questioning. My MAs and I constantly revise and update these templates, and we have also developed standardized text that the MA can drop into a note for "oh, by the way" complaints that invariably come up. The assistant also reviews and makes necessary updates to the patient's medical, surgical, social, and family histories; reviews approaching or overdue health maintenance topics and pending orders for tests or procedures the patient is willing to pursue; and reviews the patient's medication list and upcoming refills.

Once stage 1 of the visit is complete, the assistant presents the case to the physician, who reviews the patient's chart. The two then enter the exam room together, and the physician greets the patient for the first time. The assistant remains in the exam room during the visit, sitting at the computer and serving as a scribe for the physician. The physician checks with the patient regarding the accuracy and completeness of the information gathered by the assistant, asks more directed, specific questions of the patient, and performs the physical exam. The assistant documents and immediately enters into the EHR any additional

data, including pertinent exam findings. The physician then formulates a diagnosis and care plan with the patient and the clinical assistant. The assistant records all diagnoses for the visit as well as any orders needing the physician's approval. If directed by the physician, the assistant may also maintain the problem list.

The patient is given an opportunity to ask questions, to make sure he or she understands the results of the visit, and then the physician exits the exam room to review and file the orders for the encounter.

The clinical assistant remains with the patient to end the visit by reinforcing the

## TEAM CARE FREQUENTLY ASKED QUESTIONS

**Question:** Do patients mind discussing private issues with the assistant in the room?

**Answer:** We have found that if the physician explains the assistant's role (i.e., ensuring accurate documentation and handling the computer so the physician can remain concentrated and focused on the patient), most patients accept and welcome the additional medical professional helping with their visit. Many patients even see it as an opportunity to have another advocate for their health care. When introducing the team care process, it may be reassuring to let patients know that it is no problem if they want to be alone with their physician. In addition, if the physician or assistant senses that the patient is uncomfortable – for example, during certain sensitive parts of the visit – the assistant may leave the room. Exam rooms may also be fitted with curtains or screens that can provide a level of patient privacy.

**Question:** Does the extra person interfere with the physician-patient relationship?

**Answer:** We find that the extra person actually improves the physician-patient relationship because the physician is able to provide his or her full attention to the patient and is not distracted by data entry.

**Question:** Who is best to help with documentation?

**Answer:** There are a variety of models for providing "team documentation," which is preferred to the term "scribe," a label that doesn't cover the breadth of activities that assistants do and could be considered offensive. The full "team care" model involves a trained *clinical* assistant, such as a medical assistant (MA), licensed practical nurse, registered nurse, nurse practitioner, or, in the case of orthopedic practices, a physical trainer. These staff members not only record the visit but also contribute to the clinical care of the patient. In one organization, medical transcriptionists were subsequently trained as MAs and, with their combination of skills, were able to function as "super MAs."

Other models involve a trained *clerical* assistant, whose duties are more limited but often include administrative tasks, such as documenting visit notes and making sure the visit is properly billed. In some settings, such as university settings, pre-health-care-professional students may be hired for this role.

**Question:** What are the qualities or skills that you look for in an assistant in the team-care model?

**Answer:** The most important skills are being personable, putting the patient at ease, and eliciting the preliminary history. It is also important to have good keyboarding skills and electronic health record navigating skills. A minimum typing competency and timed typing test may be a good idea. An understanding of billing requirements also helps individuals document accurately.

**Question:** How do you position assistants in the exam room so they aren't intrusive?

**Answer:** In a full team-care model, the assistant helps interact with the patient during the visit and does not need to "disappear." In Dr. Sinsky's practice, the nurse and physician position themselves according to the care needs. When the patient is seated at the desk, the physician is also at the desk, and the nurse stands at the counter. When the patient is on the exam table, the physician stands at his or her side at the counter, and the nurse is at the desk. There is subtle choreography, and the providers switch places automatically now, depending on how they need to interact with the patient. Positioning also depends on the available technology infrastructure and hardware. Some practices use tablets for better mobility, but this can certainly be done with laptops or desktop computers as well.

**Question:** Is using an assistant more likely to result in documentation errors than doing it yourself?

**Answer:** Accuracy and completeness of the documentation depends on the training and the close working relationship between the physician and the assistant. In some ways, the documentation is likely to be more accurate because the assistant is focused primarily on documentation while the physician is focused primarily on providing care. In addition, the documentation is done in real time, so there is less chance for details to be misremembered or confused between different patients. Some teams adopt a hybrid approach – the assistant does most of the documentation, especially those elements that are most suited to structured text entries, while the physician types or dictates a few additional lines explaining the medical thinking and more complicated details of the care plan.

physician's instructions, providing prescriptions and referral information, delivering patient education, answering questions, and arranging appropriate follow-up, such as scheduling future visits. This allows the physician to move on to the next patient with whom another clinical assistant has performed stage 1 of the office visit, and the process repeats. The interaction between the physician, assistant, and patient, when it works well, is like a well-choreographed dance.

Making the physician more efficient can allow him or her to see more patients.

## Selling the change to those in charge

Convincing administrators to support a practice transformation like this isn't easy. Our organization, like most, is constantly tracking head count, full-time equivalents (FTEs), and the all-important bottom line. However, when you describe the plan in terms that are easy to understand, it just makes sense. (See "Team care frequently asked questions," page 25.)

Training clinical assistants in the team model is essential.

**Value.** With a nationwide shift to value-based care, primary care physicians have a responsibility to do whatever we can to increase value by improving quality and lowering costs.

**Access.** Many primary care groups are functioning at capacity, so access is already a problem. As more and more people gain insurance coverage, primary care groups will have to absorb more volume or refer patients to emergency rooms, urgent care centers, or other sources of care, resulting in lost opportunities to create revenue and provide higher-quality care. At the same time, the health care system is moving more acute care out of the inpatient setting and into primary care offices to reduce costs, meaning the patients we see are sicker than in the past. Team-based care has taken place in hospitals and extended care facilities for years, and patients consider it normal to have a team of doctors, nurses, technicians, pharmacists, and assistants care for them during a hospital admission. Why should it be different in the outpatient office?

The physician can explain better documentation, complaint protocols, and SOAP notes.

**Training.** When my two MAs and I first started out, we had no formal training but instead relied on trial and error and on-the-fly instruction and coaching. We set aside an hour per week for additional training and to discuss what was going well and what needed to be done differently. I spent a lot of time editing the MAs' notes and giving them feedback on how to improve their documentation. I taught them how I went about collecting a history of present illness and a review of systems. We discussed effective oral presenta-

### AVERAGE ANNUAL RVUs PER PHYSICIAN FTE

Dr. Hopkins' practice has gradually expanded the team-care model, from one physician in 2011 to three physicians in 2012 and six physicians in 2013. Over that time, the practice's productivity, measured as RVUs (relative value units) per full-time-equivalent (FTE) physician, has increased by approximately 20 percent.

### IN THE AUTHOR'S OWN WORDS

Dr. Hopkins provides additional perspective on how his practice improved its efficiency by using the team-based care model in a video available with the online version of this article (http://www.aafp.org/fpm/2014/1100/p23.html). The video can also be viewed on a mobile device by scanning this QR code.

**The model uses a team approach to care for patients. Each individual performs at the highest level of his or her qualifications.**

tions and the essential components of a good subjective, objective, assessment, and plan (SOAP) note. They learned why we do certain things, such as the importance of checking the urine microalbumin for patients with diabetes. Ultimately, we developed a training manual so that future training of clinical staff would be more formalized and we could reproduce the model elsewhere.

Honestly, retraining the physicians – who can be set in their ways and uncomfortable giving up even a little control – has often been more difficult than training the assistants. The physicians needed to learn how best to communicate with MAs about physical exam findings, diagnoses, orders, patient education materials, and so on, and had to understand that the MAs could not read their minds. As time passed, though, the MAs did learn the physicians' patterns and began to anticipate what we would say and do in particular circumstances.

## Results

We didn't initially try to see more patients using this model; instead, we focused on getting the workflow right. After about two months, we felt comfortable enough to add a single patient per half-day session. As we continued to gain efficiency and expertise, we eventually were able to add four patients per half-day session compared with the old model. As an example, when we schedule a 40-minute patient physical and a 20-minute acute-care visit, we can easily double-book them. By the time one MA has finished the data collection and documentation for the physical, I am usually finished with the acute visit with the other MA. I can then enter the next exam room and conduct my portion of the physical – complete the exam, develop a treatment or diagnostic plan, and provide patient education. Once I'm through in that exam room, we've completed essentially 60 minutes of patient care in 40 minutes. My productivity has increased by 40 percent since 2010, and as we've expanded this model to six of the seven physicians in our group, our total productivity has increased by approximately 20 percent. (See "Average annual RVUs per physician FTE," page 26.)

In our experience, moving to team-based care made good financial sense, and the initial financial investment wasn't as great as we originally thought it might be. Using historical visit and financial data from my practice,

### ANNUAL GROSS PATIENT REVENUE

Gross patient revenue increased 23 percent from 2010, before the practice implemented the team-care model, to 2013, when six of the practice's seven physicians were using the model.

Physicians must also be trained to better communicate with assistants.

Effective coordination of the team model allowed the author to see four additional patients per half-day session.

The initial investment of moving to a team care model may be less than expected, and additional volume can pay for those investments in time.

### COMPARISON OF REVENUE AND COSTS PER ENCOUNTER

| Indicator | Baseline (5/10-4/11) | 2012 Q3 | 2012 Q4 | 2013 Q1 | Percent change |
|---|---|---|---|---|---|
| Net revenue | $276 | $304 | $308 | $305 | 10.5 |
| Direct costs | $118 | $109 | $111 | $108 | -8.5 |
| Operating profit | $158 | $195 | $197 | $198 | 25.3 |
| Encounters/day | 26 | 36 | 27 | 29 | 11.5 |

Note: The realization rate is kept constant for comparison sake.

**I feel less bogged down by details and busy work, and my MAs do a better job taking care of forms and paperwork than I ever did.**

we determined that hiring an additional MA for each physician would pay for itself if each physician was able to see just one additional patient per half-day clinical session. An additional RN would require two additional patients per half-day session. We set a target for our group that each team would see three additional patients per half-day session in order to offset the additional expenses and improve our margin. With increased volume comes increased revenue. From 2010 to 2013, our group's gross patient revenue has increased 23 percent, or almost $2 million a year. This is almost as much as we would expect to see by adding two new full-time physicians to our practice. (See "Annual gross patient revenue," page 27.)

By adding volume, we have been able to take the modest increase in overhead and spread it out over more patient visits. By also reducing unnecessary variation in the practice, such as when certain lab tests should be ordered, we have been able to show reductions in the direct cost per encounter. (See "Comparison of revenue and costs per encounter," page 27.)

We've also noted significant increases in our patient satisfaction scores as we've adopted this new model of care. (See "Patient satisfaction indicators.") One thing that surprised me was the relationships my patients developed with my MAs, sometimes telling my MAs things they won't tell me. Patients consider the MAs as additional advocates to whom they can go with problems or questions. I thought more patients would object to having another person in the exam room, but that has not been the case. As our clinical support staff has taken more initiative and taken on more responsibility, we've also noticed modest improvements in several key quality metrics. For example, in the third quarter of 2012, 78 percent of the clinic's patients had their blood pressure under control and 93 percent had been screened for diabetes. This is an increase from 74 percent and 89 percent, respectively, in the first quarter of 2011.

At Cleveland Clinic, we have rolled out team-based care across the organization's primary care practices. We currently have 15 to 20 primary care physicians using this model and hope to have up to 40 in the next year. Training more MAs will also make it easier to provide cross-coverage for vacations or illnesses. We are beginning to move the team model into specialty areas as well.

We have also added other support staff into our practices, including care coordinators, clinical pharmacists, and MAs who do previsit planning for our upcoming appoint-

Team care can also improve patient satisfaction scores.

Patients begin to view MAs as additional advocates they can go to with problems or questions.

Training more assistants in the model helps with cross-coverage during illnesses or vacations.

### PATIENT SATISFACTION INDICATORS

Below are patient satisfaction metrics collected during Dr. Hopkins' transition to team-based care.

| | 2011 | 2012 | |
|---|---|---|---|
| Indicator | % top performance | % top performance | Percent change |
| Wait time in exam room to see provider | 66.3 | 73.4 | +10.7 |
| Time spent moving through visit | 49.1 | 61.1 | +24.4 |
| Likelihood of recommending practice | 79.4 | 84.1 | +5.9 |
| Wait time at clinic | 48.6 | 59.7 | +22.8 |
| Time care provider spent with patient | 72.2 | 78.6 | +8.9 |
| Ability to get desired appointment | 57.1 | 62.3 | +9.1 |

ments. Medical assistants are now helping with scheduling patients for follow-up visits while they are in the office or on the phone. With the additional staff, we've had to use more shared office space, but we've realized the benefits of co-location (that is, putting employees who depend on one another in close proximity to one another), including improved communication within the team.

I can say that I am much more satisfied with my work today than I was a few years ago. I feel less bogged down by details and busy work, and my MAs do a better job taking care of forms and paperwork than I ever did. They help me navigate through my day and address issues sooner than I might have otherwise gotten to them. My MAs also say they are more satisfied and feel their work is more fulfilling because they have become an integral part of the care team.

On a typical day, I now see 29 patients and leave the office by 5:15 p.m. All of my notes are closed, and my laptop remains in its case at night. Patients appreciate that we are able to see them when they need to be seen, and I don't feel like I have to rush when "oh, by the way" conversations come up as I'm leaving the exam room. I can knock out refill requests pretty quickly because my MAs have prepared all of my orders for me and limited my messages to only the ones that I really need to address. One of my MAs will hand me a few forms, already completed, and just require my review and signature. I love my job. It doesn't always work perfectly. Sometimes in this dance, we step on each other's toes or the music comes to an abrupt unexpected stop, but it sure beats dancing alone. FPM

1. Anderson P, Halley MD. A new approach to making your doctor-nurse team more productive. *Fam Pract Manag.* 2008;15(7):35-40.

2. Anderson RJ. Optimizing the role of nursing staff to enhance physician productivity: one physician's journey. *Fam Pract Manag.* 2013;20(4):18-22.

- Physicians will likely feel more satisfied with their work under this model.
- Assistants can benefit from the model because they feel more integral to the patient's care team.

Send comments to **fpmedit@aafp.org**, or add your comments to the article at **http://www.aafp.org/fpm/2014/1100/p23.html**.