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Transforming Care Teams to Provide the Best Possible Patient-Centered, Collaborative Care

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Abstract: Patient experience of care is now a crucial parameter in assessing the quality of healthcare delivered in the United States. Continuity, patient-driven access to care, and being "known" by a provider or practice, particularly for patients with chronic diseases, have been shown to enhance patient satisfaction with care and health outcomes. Healthcare systems are challenged to effectively meet the wants and needs of patients by tailoring interventions based on each person's unique set factors—his or her strengths, preferences, and personal and social context. Creating care teams, a coordinated multidisciplinary group of healthcare professionals, enables a practice to take advantage of the skill sets represented and redesign care delivery with the patient and community as the focal point. This article describes the attributes of highly functioning care teams, how to measure them, and guidance on creating them. A case example illustrates how these ideas work in practice. **Key words:** *care team*, *patient centered*, *planned care*, *primary care*

IT USED TO BE that patients saw the physician when they had an acute need. They received a diagnosis, a targeted intervention, and left the physician's office in short order. Over time, the nature of primary care has changed dramatically. The typical primary care practice today manages many more patients with 1 or more chronic conditions, many with mental and behavioral health needs, and all with preventive screening needs. In one study, 45% of Americans 65 years or older had 2 or more chronic conditions (Wolff et al., 2002). Helping people manage and prevent chronic conditions requires more than a diagnosis and a prescription. Patients with chronic conditions spend little of their time in the medical office and, in effect, all are self-managing their conditions.

Patient-centered, collaborative care requires new ways of delivering care. Office practices, and the healthcare system as a whole, must be designed to reliably collaborate with patients and respond to an individual's strengths and challenges in managing his or her care, including the psychosocial context, available financial and support resources, ability to self-manage, and barriers to self-care (Epstein et al., 1993; Epstein et al., 2005). Working with a person and tailoring healthcare to better fit the context of the individual is called "patient-centered" care and has been described in the medical literature (Maes & Karoly, 2005; Wasson et al., 1999). An article in this series on patient activation describes how clinical practice improvement teams are working to address patients' preferences in the context of their own settings.

One analysis of a typical primary care practice with 2500 patients documented more than 7 hours of work per day to attend to that

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day's patients with chronic conditions; add to that more than 10 hours per day of preventive and acute care (Ostbye et al., 2005). This example makes it strikingly obvious that the traditional 15-minute office visit is no longer sufficient to fulfill patients' care needs. Many practices have implemented advanced access principles—such as simplifying appointment types and times and delegating work to others in a coordinated team effort—to better meet patient needs (see the article titled "Accessing patient-centered care" in this series).

Most practices have tried to meet patient needs by adding staff trained in social work, behavioral health, medication adherence, nutrition, and other disciplines and skills. This article focuses on 10 years of experience working with office practices that have developed a "care team"—a coordinated group of individuals in the practice who actively participate in meeting the needs of individual patient and the population served by the practice. The attributes of a high-performing clinical care team are measurable and can be successfully implemented in primary care practices.

DEFINING A "CARE TEAM"

"A team is a small number of people with complementary skills who are committed to a common purpose, set of performance goals, and approach for which they hold themselves mutually accountable" (Katzenbach & Smith, 1993).

Any group of people working together for a defined population of patients is a de facto team, but we will follow Bodenheimer's lead and only use the term "care team" when referring to highly functional teams and not to unplanned groupings of individuals who do not exhibit the attributes and outcomes of a highly functional team (Bodenheimer, 2007, p. 6). The goal of the care team is to deliver patient-centered, collaborative, evidence-based care both to individuals and the patient populations the team serves (Wasson et al., 2008).

Patient-centered, collaborative care is made possible through an intentional service orientation and tailoring of the work to meet the needs of the population(s) and individuals served. An intentional service orientation eliminates barriers to care by improving access to the team (eg, implementing advanced access principles, providing e-mail and phone care) and embeds continuity of care so that the patient is "known" and long-term trusting relationships can be established. For example, a pediatric practice in a high-income area will need a different care team configuration than a practice with a high volume of low-income patients with chronic disease. Providing tailored, patient-centered care relies on recognizing and addressing the wants and needs of the individual patient by working within the individual's psychosocial context, available financial and support resources, ability to self-manage, and address barriers to self-care (Epstein et al., 1993; Epstein et al., 2005).

For more than a decade, improvement teams and faculty participating in the Institute for Healthcare Improvement (IHI) Learning and Innovation Community on Redesigning the Clinical Office Practice have tested team function strategies as a means to improve quality of care, patient and staff satisfaction, and office efficiency. Although there is much yet to learn, this collective experience provides some insight to those behaviors and attributes that differentiate highly functioning care teams from ever-larger groups of clinicians and practice staff working together to provide care.

CREATING HIGHLY FUNCTIONING PATIENT-CENTERED, COLLABORATIVE HEALTHCARE TEAMS

Becoming a high-performing clinical team—that is, one able to provide truly patient-centered, collaborative care—does not just "happen." It takes intent, hard work, willingness to change, and measurement to assess improvement. To promote a patient-centered focus that meets the needs of both individual patient and the community, it is necessary to change the roles and the work of individuals in office practices and the organizations in which they operate. "The

Sidebar. Advantages of Care Teams

- Improved ability to address the expanded scope of work of patient-centered and evidence-based care (Wagner, 2000).
- A highly functioning care team may improve efficiency and increase the number of patients seen per unit time, thus increasing revenue and/or access to care (Medical Group Management Association data and experience of Institute for Healthcare Improvement faculty working with practices over the past decade).
- Improved patient and population experience of care and outcomes:
  - Nurses, other healthcare professionals and, at times, lay healthcare providers are skilled in patient self-management support and education, prevention and chronic disease management, care coordination, and population management (Bodenheimer, 2007; Wagner, 2000).
  - The likelihood of patient follow-through on preventive and chronic disease care improves with improved experience of care (Lacy et al., 2004; Ling et al., 2006; Wasson et al., 2008).
- Teams can offer different perspectives and a complement of knowledge and skills for the benefit of a particular individual patient's or a population's care (Bodenheimer, 2007; Wagner, 2000).
- Increased satisfaction of physicians, nurses, medical assistants, and other healthcare professionals is related to being able to work at the top of their licensure, leading to greater staff retention (experience of Institute for Healthcare Improvement faculty).
- A strong care team supports the ability to "max pack" the visit, meaning, when appropriate, the patient and provider can decide on performing a number of needed services in 1 visit. This process ultimately increases patient satisfaction, increases effective clinical approaches and outcomes, and increases access for additional patients. (See the article titled "Accessing patient-centered care" in this series.)

factors identified with better performance include good leadership, a clear division of labor, training of team members in their personal roles and in team functioning, and team-supporting policies of the organization within which the team is working" (Bodenheimer, 2007, p. 6). Bodenheimer notes the need for a significant and ongoing investment in training, the creation of protocols that define tasks and who will perform them, adoption of team rules, including decision making and communication, and protected nonpatient care time for team meetings.

The care team can be an effective engine to reach the goals of patient-centered, collaborative care and improved outcomes; however, team care can also result in fragmentation of communication, continuity, and accountability. This fragmentation can result in a degraded experience of care and worse outcomes for the patients served (Wasson, 2008).

What has to happen so that healthcare professionals can and do perform their work, daily and over time, to provide care that is focused both on the clinical conditions and "what matters" from the patient perspective? What attributes do patients say are important?

In the authors' work with practices over the last decade, surveys of office practice staff demonstrate a high correlation of the following attributes with positive patient experience and improved outcomes (see the article titled "Balanced measures for patient-centered care" in this series).

- It is clear what is expected of each person at work and he or she has the materials and equipment that are needed to accomplish the role in his or her job. It is easy for care team members to understand and discuss processes of care.
- Information for and about the patient's health and wellness is available to the care team when needed (history, diagnoses, laboratory and test results, etc).
- Everyone on the staff is valued, and there is respect and sharing.

- Feedback of performance is routine, and there are professional growth opportunities.
- Care team members have positive attitudes.

These attributes are more likely to be present when practices and organizations intentionally take them into account when forming care teams and when the care teams engage in certain behaviors discussed below.

For care teams to function at a high level and achieve the desired patient-centered, collaborative care goals, organizational leadership must view the care team model as "the way we do business." That is, the care team model is the means for achieving strategic, long-term goals; business plans are based on care team resource needs; and the model is "hard-wired" into the system through training, job descriptions, and perhaps team incentives.

Office practice improvement teams working with IHI have tested the following strategies to create patient-centered, collaborative care teams.

- Invite patient and family representatives to participate in the care team to provide feedback and advice on the redesign of care processes. For example, patient and/or family representatives fully participate in a care team's regular data review and quality improvement work.
- Promote excellent team communication daily and ongoing. For example, conduct daily or twice daily care team huddles in which the provider, nurse, secretary, and other team members meet for 5 to 20 minutes.
- Proactively plan care for individuals and for the panel of patients by anticipating fluctuations in demand for care and planning needed care. For example, the nurse and nurse practitioner huddle once or twice daily to review the day's appointment schedule to determine in advance which patients need updated vaccines or require blood tests for their conditions. (For more on huddles, search "Huddles" on www.IHI.org.)
- The care team meets weekly to review processes of care and fine-tune roles and functions. For example, as part of its daily huddles, the care team discovers that several patients have to schedule return visits to have blood work completed. The team devises a protocol for identifying patients flagged for "blood work follow-up" prior to the scheduled office visit.
- Provide regular feedback on process and outcome measures to the care team. For example, on reviewing data, the care team notes that its patients with chronic conditions are less confident in managing their conditions. The team investigates and begins to pilot group visits to enhance patient self-management skills.
- Improve minute-to-minute communication by moving care team members into physical proximity. For example, locate the scheduler next to the nurse or provide team members with real-time 2-way communication devices (eg, walkie-talkies).
- Optimize each person's role on the team based on the scope of practice, experience, skills, and abilities. For example, each team member performs a subjective analysis of his or her own work. When this information is shared in the team huddle, the team elects to shift some clerical work from a nurse to a secretary.
- Collaborate with community resources to improve the health of people in that community. For example, the practice identifies and evaluates programs offered by the local community center and refers patients with diabetes to healthy cooking and water fitness classes.
- Use the clinical information system (CIS) to proactively query, manage, and plan for both individual patient and the population of patients. For example, a team member runs a CIS query for all patients recently prescribed an antihypertensive medication who are still not achieving adequate blood pressure control. Those patients receive proactive follow-up and support (population management). Or, the receptionist runs a CIS report for

each patient visit, identifies preventive and chronic condition needs for those patients, and responsibility to follow-up on identified needs is assigned in the team huddle.

CASE STUDY: CLINICA CAMPESINA

Clinica Campesina, a community health center in Northwest Denver, began caring for underserved and medically vulnerable people in the 1970s as a small practice with 1 nurse practitioner. As the health center grew over time, leadership recognized that its ability to maintain patient and population care focus—to "be big but feel small to patients and staff"—would be better served by using miniclinics or care teams.

Over time, Clinica Campesina created service delivery options to meet the complex needs of its patients. Starting with existing staff, staff roles were optimized and *teams* focused on specific panels of patients were created. This enabled the staff to learn what processes and tools were needed to support the care team's delivery of patient-centered care. Eventually, partnerships with other important services such as integrated behavioral health and group visits were strategically added to meet the many different needs of their patients.

The formation of Clinica's care teams was guided by research and continual feedback from their own patients. It is worth noting that their journey started 10 years ago and they continue to improve their care delivery.

Clinica Campesina's approach to developing care teams was to create "pods" of providers and care team members, supported to reliably deliver patient centered, collaborative care:

- *Service orientation—continuity*: A primary care provider's (PCP's) patients know that they are part of the "purple pod" or the "orange pod" in the clinic. When the PCP is not available, his or her patients see one of the other 2 providers in the pod, limiting the number of possible providers with whom the patients must interact.
- *Service orientation—access*: Clinica employs the principles of advanced access to "meet today's demand today."
- *Service orientation—efficiency*: A well thought-out electronic health record (EHR) provides instantaneous messaging to the care team, identifying patients who need an appointment and when; patient preferences or needs (eg, no gas money or a question about a new medication); and needs that can be met without a face-to-face office visit. Given the care team's focus on meeting patient needs, team members are tuned into their electronic tasks and act on the messages in a timely manner. The EHR also provides key clinical and patient information at the point of any interaction, giving care team members access to key current clinical information (eg, laboratories, self-management activity, barriers to self-care, or referral information). It is important to note that most of these processes were designed well before the implementation of the EHR, which meant that Clinica was clear on how the EHR should support the work of the care team.
- *Service orientation—efficiency*: A PCP's care team is located in its own "pod," or physical space, designed to support great teamwork, efficiency for staff and patients, and a vital work environment. The team is colocated, meaning all desks are in an area together, have line of sight, meaning every care team member can see patient flow from registration to checkout, and continuous flow of work. For example, the examination rooms are built larger than many so that all tasks to complete the visit, such as drawing blood, can happen in the examination room. On a very busy day, the area is fairly quiet because patients and staff are only moving in and out of examination rooms. A simple visual flag system lets care team members know what the patient needs next.
- *Care team tasks and roles are defined and planned*: Patients become more

familiar with the entire care team over time as they begin to receive assistance and care from these team members. Patients are greeted by care team members at the front desk; medical assistants and nurses know the patient and the patient knows them; a medical records team member may provide assistance with health information; and a case manager or social worker can assist with referrals, care coordination, self-management, or behavioral health issues. Increasingly, patients gain confidence in all care team members, not just their PCP, giving patients access to a variety of people who know and respect them and provide a variety of skills, knowledge, and styles. The care team also includes a small number of members, functioning at their highest level of skill and licensure, who are committed to the common purpose of caring for the panel of patients and share in the team's performance goals for which all team members hold themselves mutually accountable.

- *Organizational support for frontline work*: Clinica Campesina ensures that the support structures needed to provide patient-centered, collaborative care and to support the care team in its daily work are in place. Examples of important support structures include hiring staff who will thrive in the Clinica environment, a training program that develops and supports staff in providing patient-centered, collaborative care, information, and supply systems that ensure that the care teams have what they need, when they need it, to provide the care needed.
- *Work is organized to serve local population needs*: The care team is also supported in delivering care based on the needs of different subpopulations in the patient panel. Many of Clinica's patients have incomes at or below the poverty level, and they struggle with their health and getting care needs met. All care teams are familiar with the barriers to healthcare that poverty presents and they are trained to assist patients with referrals to community resources, access to programs for obtaining medications and other treatments, and low cost ways for patients to self-manage their care. Group visits, offered for people with chronic conditions and to deliver obstetrics and well care, provide alternative venues for patients who like and benefit from group support and socialization.
- *Feedback on performance*: Population-based care is reinforced with regular performance feedback to the pod and for each provider. Incentives are awarded on the basis of team performance rather than individual performance, and every staff receives an incentive when targets are met.

Care teams are composed of members with advanced academic degrees and those who have a high school general equivalency diploma. The care teams work so well together because of the shared goal of taking good care of their patients. Clinica care teams are successful because the health center makes care and information easy to access; decreases stress for staff and patients and provides a caring environment in which patients feel comfortable and confident in the care providers; and focuses on efficiently providing *what* is needed (eg, information, equipment, skills, and knowledge) *when* the patient needs it so that the patient's time is not wasted.

TENSIONS AND UNANSWERED QUESTIONS REGARDING CARE TEAMS

There are unknown factors and inherent tensions in the current US healthcare environment that pose barriers to developing care teams. First, the reimbursement model is focused on productivity, volume, and procedural care, and not necessarily on meeting the overall healthcare needs or preferences of the patient or the overall coordination of care.

Second, there is no fixed number of individuals who make up the perfect care team. Some high-performing teams are large and complex with representatives from multiple

disciplines, whereas other care teams are as small as 2 people (Wasson et al., 2008). The right size and composition of a care team is driven by the following factors.

- The needs of the patient population served.
- The complement of skills and capacity of the team members.
- The quality of the organizational support.
- The degree to which the needs of the population can be served outside the context of the team. If good external resources and good communication exist, it is possible to create a virtual care team and keep the size of the internal primary care team small. For instance, the practice might collaborate well with social work, behavioral health, community resources, and specialists outside their walls and, therefore, have a smaller primary care team. On the other hand, there may be few if any external resources available and the primary care team might need to grow to include social work, behavioral health, and other team members to meet the needs of the patient population.
- The degree to which leadership in the organization values the patient-centered care the team provides and can build a financial business plan that makes the care team model sustainable. If the work of the care team is not valued and goes uncompensated, or a sustainable business plan is not created, there are few organizations or practices that would be willing to staff the work.

Third, there is a tension between optimizing the role of each care team member and maintaining flexibility in roles to achieve smooth workflow. One extreme optimizes roles to such a degree that a team member might impede workflow by saying, "That is not my job." At the other extreme, team members perform work that should optimally be provided by another team member. Both can lead to bottlenecks. The middle ground is very fluid as it is based on the workflow of that moment. Cross-training of care team members is one strategy to address smooth flow of patient care. Most practices would benefit from a more careful consideration of roles and reorganizing the care team's work to better match each individual's licensure and scope of practice.

SUMMARY

Highly functioning care teams will play an increasingly important role as the healthcare delivery system makes necessary adjustments to meet the needs of patients and families today and in the future. Care teams can add value through improved efficiency, staff satisfaction, improved patient experience of care, and improved outcomes (Wagner, 2000, and experience of IHI faculty.) High-functioning teams require intention and support—they do not just happen when a group of people work together. Patient-centered, collaborative care takes intention and support. There continues to be a large gap between what we know and what we do to deliver the best evidence-based care as we reliably listen and adjust to the context of the patient's preferences, resources, family support, and self-management abilities.

Highly functioning care teams are more likely to occur when there is good leadership support in the organization and teams have specific training, protocols defining tasks and who does them, protected nonpatient time for meeting, and clear guidelines about decision making and communication. It is advisable to measure the attributes of a high-functioning team and work on those specific attributes that lead to improved team function.

How everyday work will be performed in an office, who is best suited to do what aspects of the work, and ongoing improvement to meet important patient-centered care goals are all informed by the local environment, including licensure, scope of practice, labor negotiations, and the individual strengths of team members. The Clinica Campesina case study is an example of how one organization, over the course of time, created highly functioning care teams that are focused on the needs, preferences, and context of its patients.

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