EXECUTIVE SUMMARY

CONTINUOUS AND TEAM-BASED HEALING RELATIONSHIPS

Improving Patient Care Through Teams

May 2013

For more information, see the Continuous and Team-Based Healing Relationships Implementation Guide.

What

A care team is a small group of clinical and non-clinical staff who, together with a provider, are responsible for the health and well-being of a panel of patients. Who is on the care team and their specific roles will vary based on patient needs and practice organization. A care team typically includes:

- **The patient** who is at the center of the care team.
- **A provider** (physician, nurse practitioner, physician assistant) who is responsible for leading the team.
- **Medical assistant(s)** who are responsible for preparing the visit, checking-in and rooming patients, ensuring that post-visit tasks are completed, and ensuring patients understand the follow-up plan.
- **Nurse(s), pharmacist(s), social worker(s), or health educator(s)** who provide self-management support, arrange other resources, and provide care coordination or other services.
- **Front desk staff** who help ensure patients see their team and conduct outreach to patients for preventive or follow-up care.

Why

Why continuity? Strong patient-provider relationships foster improved communication, trust, and knowledge of patient context and preference. Research and patient experience show that a strong, lasting patient-provider relationship is central to high patient satisfaction. Continuity of care has also been consistently linked with improved health behaviors, better health outcomes, and less emergency department and hospital use. Providers also prefer strong long-term relationships with patients as these relationships give their work more meaning.

Why team-based care? Well-functioning care teams have been shown to improve practice efficiency, quality of care, and staff satisfaction. Providers alone lack enough time to provide all needed care services to a full patient panel. Many services (e.g., self-management, education, care coordination) do not require a primary care provider and may be better performed by another care team member. Practices can draw on the expertise of a variety of clinical and non-clinical team members to ensure that patients get the care they want and need.

Implementation Overview

Prerequisite: Empanel Patients

Create patient panels so the patient, provider, and care team recognize each other as partners in care. To learn more, see the Empanelment Implementation Guide.

Meet Together

This is the first step for care teams to start working together.

- Ensure that time and space is available for teams to meet in quick daily huddles and longer weekly quality improvement meetings.

Redesign Care Team Roles

Once teams start meeting regularly, care team members may see areas of inefficiency or opportunities for improvement. Examine how to better use the skills and abilities of care team members and structure care teams to respond to all common problems for which patients seek care.

- Secure high-level leadership commitment to redefining staff roles.
- Carefully select and support the representatives of the improvement team you want to lead this work.
- Understand state regulations for scope of practice. Structure care teams so that members function at the maximum of training, skill-set, and abilities.
- Foster a culture of curiosity to help uncover core issues.
- Set up a process to formally and regularly reevaluate how things are working.
- Be willing to "peel the onion" and explore how redesigning one role affects others.
- Address staff concerns about their and others to perform more advanced tasks.
- Have a plan for spread and sustainability at the start.
- Explain new staffing roles to patients.
- Celebrate the returns and find the joy in work.

Facilitate Teamwork

After redesigning care team roles, make sure the infrastructure and skills are in place to keep the care teams functioning.

- Ensure relevant patient information is available to those who need it.
- Improve communication.
- Consider co-location.
- Get real about part-time providers and other policies.
- Examine scheduling practices.

Continuously Monitor and Adjust

Select and monitor metrics, such as continuity and access to care, to guide improvement efforts and to monitor how quality improvement changes affect patients and staff.

What Progress Looks Like: PCMH-A Level A

The PCMH-A is a self-assessment tool to help practices understand their current level of "medical homeness," identify opportunities for improvement, and track their progress toward practice transformation. It is also a learning tool that can help start conversations within a practice about patient-centered care. The PCMH-A is scored on a 1–12 scale, which is divided into four levels (D, C, B, and A). A "Level A" item score indicates that most or all of the critical aspects of the key change addressed by the item are well established in the practice. An overall Level A score indicates that the practice has achieved considerable success in implementing the key design features of the PCMH.

Level A PCMH-A Items

For more information, see the Patient-Centered Medical Home Assessment (PCMH-A).

13. **Patients are encouraged to see their paneled provider and practice team…**by the practice team, [this] is a priority in appointment scheduling, and patients usually see their own provider or practice team.

14. **Non-physician practice team members…**perform key clinical service roles that match their abilities and credentials.

15. **The practice…**routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides cross training to ensure that patient needs are consistently met.

Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

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