Team-Based Primary Care: Convergence of Improving Engagement, Safety, and Enhanced Joy in Practice

Executive Summary

Summary

The physician leadership in the primary care practices of Bellin Health in Green Bay, Wisconsin, knew that they needed to make some changes in how they delivered care. Their goal was to provide better, safer, and more efficient care to their patients and health care community while improving work-life balance for providers and staff.

Select practices embarked on a pilot program to transform their delivery of primary care by emphasizing teamwork and team-based care—with the patient and family at the center of the care team. The result was improved professional satisfaction for providers, improved care outcomes for patients, and enhanced teamwork and communication. All of these factors led to improved patient and provider engagement as well as improved patient safety and team culture.

Evidence Rating

Suggestive: The evidence consists primarily of qualitative reports of the individual practices' improved outcomes for patients, providers, and the practice. The pilot within selected primary care practices was so successful that Bellin Health is now launching their program systemwide.

Use by Other Organizations

Bellin Health's work is featured as part of the American Medical Association's STEPS Forward™ practice transformation program, allowing practices across the country to benefit from their pioneering work.

Date First Implemented

The initial pilot program began in June 2014.

Case Study

Problem Addressed

A typical primary care visit is not always a satisfying encounter for either the provider or the patient. Providers feel stressed by the need for efficiency and the demands of electronic documentation. Patients feel that their provider is hidden behind the computer, typing instead of actively engaging with them.

- **Professional satisfaction in primary care is low:** Up to 80 percent of nurse and physician work output is waste, not from ordering tests or treatments, but from doing work that does not add value for the patient.[1,2] Leading factors contributing to dissatisfaction among providers include the practice environment, work-life balance, and income.[2]
- **Time spent on direct patient care is perceived to have declined:** Despite the need to provide comprehensive holistic care, primary care practitioners are spending less and less time in direct contact with their patients. Reports indicate that approximately 55 percent of the primary care provider's time is direct contact with patients while in the office, and 23 to 33 percent of time is spent engaged in patient-related activities for documentation, followup, and other activities often considered nonreimbursed time.[3,4] Even when providers are in direct contact with patients, patients may not feel that the providers are fully engaged

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with them, particularly if a provider spends much of the visit documenting in the electronic health record.

- **Lack of patient engagement affects patient outcomes:** Engaging patients in their care is the cornerstone of health reform, leading to improved patient outcomes and experience.5 Primary care practice reform can yield improved outcomes, experience, and engagement.[6,7]

Description of the Innovative Activity

The goal of the Bellin Health primary care practice transformation was to overcome physician burnout and improve patient outcomes and experience. One provider commented, "Our initial focus was on provider burnout, but it wasn't long before we realized the most important function was achieving population health through team-based care." Their effort included a novel approach to team-based care that required practice infrastructure change, along with provider and practice behavior change. They established core teams that included a provider, two care team coordinators (CTCs), a registered nurse, and a patient access representative. The CTCs are certified medical assistants or licensed practical nurses.

Key elements of the Bellin team-based care model include:

- **Planned care principles:** Bellin implemented core constructs such as previsit planning, previsit labs, and advanced access to care (e.g., same day appointments). Previsit planning and labs require the patient to become engaged before his or her visit, in order to complete labs and other previsit activities.
- **Expanded standard rooming processes:** In addition to standard rooming practices such as vital signs and exam room preparation, the CTC spends more time with the patient conducting a series of enhanced processes, including functional and behavioral health screenings, agenda setting, coaching, and medication reconciliation. This helps forge a strong bond between the patient and the CTC and increases patient engagement with care planning and adherence to recommended therapies. Further, the CTC eases the burden on the provider by choosing documentation templates for the visit based on the patient's chief complaints and initiating the documentation.
- **Co-location:** The core team works together in a space that fosters collaboration and continuous communication among team members. Co-location has been identified as a vital part of the transformation process and essential functioning of the team-based care model. It resulted in a significant decrease in electronic messaging between care team members.
- **Daily huddles:** The core team performs a daily huddle to:
  - Review the schedule,
  - Anticipate the needs of the different patients they will see,
  - Ensure that all needed documents, labs, and other records have been reviewed to foster shared decisionmaking,
  - Review options for same-day appointments, and
  - Build a culture of teamwork, communication, and trust.
- **Regular care team meetings:** The core team and the extended care team meet on a weekly or biweekly basis to review the needs of complex or high-risk patients, focus on the care gaps of all patients, and encourage communication.
- **Use of warm handoffs:** Communication between providers and extended care team members should be in the presence of the patients to engage them in the process. In a warm handoff, the patient handoff is conducted in front of the patient so the patient can hear exactly what is being said and to whom it is being said.
- **Team documentation:** Implementing team documentation removes the documentation burden from the provider and allows the provider to spend more time engaging directly with patients during the visit. This approach allows the provider to actively engage the patient in decisionmaking, identification of challenges to recommended therapies, or other factors that may limit a patient's ability to achieve expected health outcomes. As one provider said, "I don't spend all my time trying to figure out where to find something in the electronic health record. I spend it with my patient, talking to them about what is important to them, seeing what they aren't willing

to tell me, and engaging them in decisions about their health."

- **Standard documentation and communication:** Standard templates for messaging, smart order sets, and other templates were developed for consistent and accurate communication and health record documentation. These reduce the likelihood of errors and improve quality of care.
- **Effective use of the extended care team:** An extended care team, including pharmacists, diabetes educators, centralized care managers, case managers, and care coordinators, plays a key role in engaging with complex and high-risk patients, leading to improved health outcomes and patient safety.
- **Team approach to "in-between visit" work:** Patient needs between visits, such as followup on test results, triage issues, patient questions, medication refills, and referrals and forms, are addressed in a team approach. The CTC and patient have jointly set expectations for followup on test results, and the CTC serves as the first line of contact for the patient, further strengthening the relationship and encouraging patient activation.
- **On-time starts:** Starting each half-day on time minimizes stress on the core team, respects team members' time, and supports practice resilience to respond to emergencies or unexpected changes to the day. It also enhances patient satisfaction as appointments start and end on time, establishing a culture of mutual respect.
- **Consistent messaging to patients to reinforce the team:** As one provider noted, "The office visit has radically changed in our system. From the moment of check-in, patients hear the word team. 'This is team-based care… Our team will take care of this…' It is very loud, so the patients know they have an entire team supporting them."

Context of the Innovation

Bellin Health is a health care system in Green Bay, Wisconsin. The Bellin primary care practice that piloted the team-based care model is composed of 11 family practice physicians, 2 nurse practitioners, and 1 physician assistant. They have been using the team-based care model for 2 years and are now spreading the work that they have pioneered to all ambulatory practices in the Bellin Health system.

Impact

The team-based approaches to care instituted by Bellin Health have achieved the following successes:

- **Improved provider and care team satisfaction:** As described by providers, practice staff, and administrators, transforming primary care using a team-based approach has resulted in higher levels of work-life balance.
- I**mproved team communication:** Bellin's team-based care approach is grounded in strong team communication, respect, and trust. Handoffs include the patient as a team member so that he or she can hear what is discussed about the clinical problem and current status. Bellin has experienced similar benefits to huddles and other structured communication approaches as those achieved during the Department of Veterans Affairs' patient-centered medical home transformation.8
- **Improved patient safety:** According to one team-based care leader and physician at Bellin Health, the model builds in a "backup safety measure." Engaging the team and the patient together in care gives more people a chance to prevent or catch issues with care, such as medication prescribing errors, missed followup testing, or changes in a patient's social situation that could impede the achievement of optimal health outcomes.
- **Improved patient and family engagement in care:** Patients also have responded to the transformation. One Bellin physician observed, "The reactions of the patients are great. They feel that they've gotten their doctor back. Their doctor isn't in the computer the whole time." Patients know that they have not just a physician caring for them, but a whole team. Patients appreciate that the physician spends more time with them and less time documenting the visit.

Evidence Rating

Suggestive: The evidence consists primarily of qualitative reports of the individual practices' improved outcomes for patients, providers, and the practice. The pilot within selected primary care practices was so successful that Bellin Health is now launching their program systemwide.

Planning and Development Process

To implement team-based care, practices must design their own care models. The American Medical Association provides guidance for establishing team-based care models through their STEPS Forward program (https://www.stepsforward.org/). Important decisions include:

- **Team roles and responsibilities:** The composition of the team and the roles and responsibilities of each team member should be established. Bellin chose a team structure that includes a provider, nurse, and multiple CTCs, and they found that it is key that everyone on the team work to their skill and licensure level. Tasks should be analyzed to ensure that the right person is completing the task. Any task that could be performed by someone with a lower level of licensure, skill, or competency should be completed at the lower level.
- **Co-location:** Co-location is an important feature for the success of team-based care. Co-location may require significant advance planning, as the physical space may have to be modified.
- **Communication practices:** Team-based communication practices, such as daily huddles, warm handoffs, and regular care meetings, should be established and standardized.
- **Planned care principles:** Planned care principles such as previsit planning, previsit labs, and advanced access to care should be considered for inclusion in the care model.

Resources Used and Skills Needed

Staffing: Bellin Health added CTCs to each care team. The primary roles of the CTC are to identify and close care gaps and to serve as the primary point of contact for the patient and family.

Costs: Bellin Health invested approximately $250,000 in a robust staffing model, infrastructure changes for care team co-location, administrative costs such as marketing and travel expenses, and provider productivity for meeting attendance. From Bellin Health's perspective, team-based care has been worth the investment. The practice has seen an increase in reimbursement even in a fee-for-service environment, which comes from a combination of factors, including higher daily patient volume and higher complexity of care for high-risk patients. They are now investing an additional $40 million in capital funds to expand the team-based care approach, including co-location, to all their ambulatory practice environments.

Infrastructure: Bellin Health invested in practice reorganization and redesign of the physical space to enable the care teams to be co-located.

Funding Sources

Bellin Health internally funded the development and implementation process as part of their practice transformation initiatives; there was no external funding.

Getting Started With This Innovation

- **Make the case to your institution:** Before developing a team-based care model, it is important to obtain support from institutional stakeholders. Stakeholders should understand the benefits of team-based care and the resulting improved care experience and increased patient safety. It will be necessary to have leadership buy-in for such changes as staffing increases and modifications to the physical space to accomplish co-location.
- **Form a development team:** A working group should be formed to design the team-based care model, establish the policies that will govern the model, and develop the processes and procedures that will be used to implement the model. A physician at Bellin Health stressed the value of visiting other practices already engaged in team-based care.
- **Provide strong messaging:** The concepts of teamwork and collaboration should be promoted to providers, practice staff, and patients to emphasize the team culture, partnership between the practice and patients, and patient engagement.

Bellin Health spent 9 months developing their team-based care model and 6 months in pilot implementation, before starting a more extensive implementation.

Sustaining This Innovation

A transformation to team-based care requires some initial investment—in the time to develop new practices and establish a new culture, in increased or changed staffing, and in modifications required for co-location. However, once the initial investment is complete, the benefits of team-based care ensure its sustainability. When physicians at Bellin were asked if they would ever go back to the old

system of care, the response was "a resounding no! Team-based care puts the joy back in practice. It has restored a work-life balance, and we are using it as a recruiting tool, to attract students to primary care."

Use by Other Organizations

Bellin Health's work is featured as part of the American Medical Association's STEPS Forward™ practice transformation program, allowing practices across the country to benefit from their pioneering work.

Spreading This Innovation

Bellin Health continues to share their lessons learned with other practices across the country. They are currently working to spread the team-based care model across all ambulatory care practices associated with Bellin Health.

Contact the Innovator

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Innovator Disclosures

All work presented here is attributed to Bellin Health.

References and Related Articles

1. Sinsky CA. Dissatification among Wisconsin physicians is part of serious national trend. WMJ. 2015;114(4):132-3. https://www.wisconsinmedicalsociety.org/_WMS/publications/wmj/pdf/114/4/132.pdf. Accessed May 2, 2016.
2. Coleman M, Dexter D, Nankivill N. Factors affecting physician satisfaction and Wisconsin Medical Society strategies to drive change. WMJ 2015;114(4):135-42. https://www.wisconsinmedicalsociety.org/_WMS/publications/wmj/pdf/114/4/135.pdf. Accessed May 2, 2016.
3. Gottschalk A, Flocke SA. Time spent in face-to-face patient care and work outside the examination room. Ann Fam Med 2005;3(6):488-93. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1466945/. Accessed May 2, 2016.
4. Chen MA, Hollenberg JP, Michelen W, et al. Patient care outside of office visits: a primary care physician time study. J Gen Intern Med 2011;26(1):58-63. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3024108/. Accessed May 2, 2016.
5. Hibbard JH, Greene J, Overton V. Patients with lower activation associated with higher costs; delivery systems should know their patients' "scores." Health Aff (Millwood) 2013;32(2):216-22. http://content.healthaffairs.org/content/32/2/216.long. Accessed May 2, 2016.
6. Friedberg MW, Hussey PS, Schneider EC. Primary care: a critical review of the evidence on quality and costs of health care. Health Aff (Millwood) 2010;29(5):766-72. http://content.healthaffairs.org/content/29/5/766.long. Accessed May 2, 2016.
7. Shahian DM, Normand S-LT, Friedberg MW, et al. Rating the raters: the inconsistent quality of health care performance measurement. Ann Surg 2016 Jan 7 [Epub ahead of print]. PMID:26756770..
8. Rodriguez HP, Meredith LS, Hamilton AB, et al. Huddle up!: The adoption and use of structured team communication for VA medical home implementation. Health Care Manage Rev 2015;40(4):286-99. PMID:25029511.

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