

# DFMCH Team Based Care Taskforce

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## **Proposal**

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## **Team Members**

**John Hawkins, MD**

**Magnolia Larson, DO**

**Linda Kiefer, RN**

**Sara Johnson**

**Mona Mathews**

**Ken Kushner PhD**

## Taskforce Development

The Team Based Care Task Force was developed as part of the strategic planning initiatives called DFMCH ReCHARGED. Activities conducted on behalf of DFMCH ReCHARGED group have included planning, forming a steering group, gathering data and holding conferences in order to gain outside perspectives to expand the department's knowledge of best practices and innovation. In June of 2015, an opportunities conference was held. The Team Based Care Task Force (task force) was one of several task forces that emerged from that conference in order to address barriers to optimal practices.

## Description of the Issue Background

Decreasing numbers of primary care physicians and the increase in older and more complex patients contribute to the need to implement team based care within primary care. Medical school graduates selecting to go into primary care have dropped significantly in recent decades. According to the U.S Department of Health and Human Services, the demand for primary care physicians is projected to grow by 28,700 FTEs or 14 percent by 2020. Without changes in how primary care is delivered, The U.S Department of Health and Human Services projects a shortage of 20,400 primary care physicians by 2020.

The reality of increased primary care demand and decreased supply of primary care physicians has prompted many systems—including UW Health—to re-examine the delivery model for primary care. Panel sizes for primary care physicians vary and estimating the optimal panel size is difficult. In a 2013 article by Ghorob and Bodenheimer cited past studies that estimated the average primary care panel size to be 2300 patients. It was further estimated that it would take a physician 18 hours a day to accomplish the necessary work for these patients.

UW Health began working on primary care redesign (PCR) in 2008 as part of its strategic plan. PCR was driven by: sub-optimal health outcomes, primary care and workforce attrition, and outdated care models and payment incentives. Many local and national healthcare organizations have implemented redesign programs over the past several years and have had very positive outcomes. Achieving the triple aim, better health and better care at lower costs, required UW Health to redesign our care delivery system.

UW Health has gone through an extensive PCR effort to streamline processes and meet the goals for primary care. The UW Health PCR goals found on UConnect Workspaces are as follows.

- Work Environment and Satisfaction
  - Reduce turnover and increase physician and staff satisfaction
- Access
  - Increase patient satisfaction with access, while decreasing use of urgent care
- Care Experience

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- Increase patient satisfaction with sensitivity to patient needs and patient involvement in decision making
- Clinical Outcomes
  - Improve UW Health rank in publicly reported metrics
- Academic Mission
  - Increase interest in primary care residency
  - Increase medical school student interest in family medicine
  - Increase scholarly activities around primary care redesign

Metrics for process measures and clinical outcomes have improved after the implementation of centralized outreach to address care gaps and through the use of chronic disease registries within Healthlink. The data reported to WCHQ showed that about 56 percent of UW Health diabetic patients had good control in 2010. The same measure increased to nearly 72 percent in 2014 (the most recent reported data). Similar improvements have been made in preventive screening. In 2010 UW Health reported 80 percent of their patients were screened for osteoporosis and in 2014 they reported 85 percent. Colorectal screening increased from 67 percent in 2010 to 81 percent in 2014. Other measures also increased and can be found at [www.wchq.org](http://www.wchq.org). PCR has standardized the rooming process and has leveraged the functionality of Healthlink to address care gaps during patient visits. The results of this effort have been positive and the organization has improved many quality indicators for preventive and chronic care.

### The Problem

Despite the work of PCR, some of the primary care goals have not been achieved. There is still a level of dissatisfaction with the work environment; due to numerous factors including less time spent in direct patient care, and spending too much time on administrative tasks including data entry.

While it has been a number of years since UW has surveyed its physicians, the Wisconsin Medical Society surveyed 1016 Wisconsin physicians in 2014. Coleman and Nankivil published the data 2015. As reported, “Almost one out of four respondents reported they were either totally or significantly burned out. Approximately 25% more said they were moderately burned out. Over one third said they were somewhat burned out. Together 82% of respondents reported some level of professional burn out” (p.138). In addition, rates of burnout were higher in primary care compared to other specialties. Staff burnout is associated with lower patient satisfaction, lower adherence to treatment plans, and lower levels of empathy.

Another study conducted by Mayo clinic compared the burnout of physicians to the general US working population. The study was originally conducted in 2011 and a follow up study was conducted in 2014. This study revealed an increase in the burnout among physicians while the general working population stayed the same. The study reported that in 2011 45.5 percent of physicians reported at least one symptom of burnout and in 2014 the percentage was 54.4. Family medicine experienced higher than average burnout rates (51.3% in 2011 and 63.0% in

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2014). The general population was 28.4 in 2011 and 28.6 percent. The authors of the study pointed out that their study had some limitations. One of which was that emails were sent to a sample of physicians using the AMA Physician Master File. The vast majority of emails sent to invite physicians to participate were never opened. The participation rate of those opening the email was only 19 percent. In addition changes over time were not assessed because the survey was random. Lastly, the survey of the general population had a higher number of females than that of the physician surveys. Despite the studies recognized weaknesses, the authors point out that the same validated instruments were used to study the physicians in 2011 and 2014. (Shanafelt, T, et al 2015).

Anecdotally, the reasons for increased burnout are multifactorial. Some physicians say that one of the biggest factors for physicians feeling unsatisfied is due to the time spent in direct patient care versus other duties. Many physicians feel that they spend too much time on administrative and data entry tasks and feel that the EHR has increased this burden. Other factors contributing to burnout are ongoing time constraints throughout the day, sicker and more complicated patients, a chaotic work environment, and regulatory burdens.

In addition, access to care continues to be an issue at many of the primary care clinics. Despite efforts to allow more same day appointments and expanding visits through midlevel providers such as nurse practitioners and physician assistants, efforts to increase access have been only marginally successful. Ghorob and Bodenheimer( 2013) note in a review article that “a study of six primary care practices found that five of the six improved access but none achieved same-day access, and the improvements were often not sustainable over time. A systematic review of the literature on advanced access concluded that most practices can reduce waiting times but few accomplish same-day or next-day access. Moreover, patient satisfaction did not increase and in some cases decreased even when access improved”(Ghorob and Bodenheimer, 2013 p. 12).

Traditional limits on scope of practice and reimbursement have also limited expanded access to care and to team based care solutions that may allow improve access to care. Although the UW has been progressive in expanding its compensation plans to take into account non face-to-face services, the previously existing fee-for-service compensation system relied primarily on in-person visits with physicians.

### **Understanding the Problem**

In order to more clearly understand teams within the DFMCH, the task force members interviewed managers at each of the clinics. Each manager was asked questions about the size of their clinic, team members and how many teams were at their clinic. In addition, the managers were asked to describe the people on their teams and how effective they thought their teams functioned. All teams had physicians, registered nurses, and medical assistants; however, there was considerable variability in how these roles interacted with each other. Some clinics had consistent medical assistant and physician teams while others rotated staff on a regular basis. The roles and existence of lab and X-Ray were variable, based on clinic site and

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volume. Clinic managers were asked to rank the effectiveness of their teams on a scale of 1-7. The range of effectiveness was from 3-6 with an average of 4.7. The results of these interviews can be found in Appendix A.

The task force also conducted a root cause analysis to identify root causes related to difficulty in implementing a standardized team based care in Family Medicine (Appendix B)

Through a root cause analysis the taskforce identified the following challenges to the implementation of a department wide team based care

- Lack of common definition of team based care
- Dissatisfaction of team members
- Burnout of providers and staff
- Increased cost to the department due to recruitment and training of new staff

### **Problem Statement**

The DFMCH lacks a consistent vision or definition for team based care which has resulted in dissatisfied team members, increased turnover, and staff and physicians not working up to their level of training. The use of scribes and enhancing the role of the medical assistants were explored as options to address this problem.

### **Goals and Objectives**

The taskforce aimed to develop a patient centered model that allowed all team members to work up to their scope of practice by building on the work that PCR had done with defining clinical roles and making the various roles function more collaboratively as a team. The task force developed this proposal for a team based care model utilizing knowledgeable and skilled team members, to accomplish the IHI triple aim, and Bodenheimer's (2014) Quadruple Aim

#### Triple Aim

1. Improving the patient experience of care (including quality and satisfaction)
2. Improving the health of populations
3. Reducing per capita cost of health care

#### Quadruple Aim

1. Improving the patient experience of care
2. Improving the health of populations
3. Reducing per capita cost of health care
4. Improving the life of health care providers

The basic principles that were applied to team based were as follows:

1. Put the patient first
2. Build team culture
3. Empower staff
4. Encourage critical thinking
5. Know our populations

## Best and Current Practices Literature Review

Team based care has been a proposed solution to physician and staff burnout as well as successfully caring for patients with complex needs. The implementation of team based care is not as simple as putting a group of people together and asking them to work together as a team. In a “Journal of the American Board of Family Medicine”, Roth et.al (2012) stressed the importance of trust, diversity, and communication within effect teams. This culture needs to be developed within the teams by focusing not only on what needs to be done but also how tasks are to be completed. Roth et.al, stresses the importance of teaching teams how to work together and allowing time for teams to get to know one another. Bodenheimer (2012) also supports the notion that teams need to learn to work together and suggests that team based care is more than just a doctor with helpers. Team based care requires not only reallocating tasks but also reallocating the responsibility for the tasks.

As reported in *In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices* (Sinsky, et.al 2013), shifting from a physician centric model to a shared care model can result in high functioning teams, improved professional satisfaction, and greater joy in practice.

Sinsky et al (2013), specifically found that although no practice is likely to solve every issue surrounding ideal primary care delivery, certain themes make a practice more likely to be effective in delivering team based care. “Practices that build stable, well-trained teams which work together every day and meet regularly to improve their work can create efficient work flows and rewarding practice environments. Standardized work flows with higher levels of clinical support personnel can make practices less chaotic, save time, and meet patients’ needs more quickly. Teamwork is facilitated by proximity of workstations and frequent forums for interaction. Thoughtful physical layout with co-location of staff and line of sight enhances communication. Face-to-face verbal communication is often more effective, efficient, and enjoyable than circulating asynchronous electronic messaging” (p. 277).

Johnson (2013) suggests that “High-performing teams share several characteristics, including recognition of member contributions, effective communication, shared decision making, and shared vision and values. Attaining these characteristics suggest that there is trust and flexibility among the team members with regard to who will take responsibility for what aspect of the practice” with the “purpose of working to achieve a high-functioning team to provide high-quality care to patients” (p. 241).

There are multiple articles regarding how to show how true team based care is financially viable, and even how it makes good financial sense. This was best summarized by Kevin Hopkins from the Cleveland Clinic in Strongsville, Ohio (Hopkins and Sinsky 2014). In a model similar to the others outlined previously, they clearly showed how the increased efficiency allowed them and others implementing team based care to see more patients during the regular clinic schedule. This obviously resulted in increased access and greater revenue generated. Thus, as we move towards value based care, the gains will still remain as the quality of care improves, at

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a lower cost. Patient satisfaction indicators that improved with team based care included: likelihood of recommending practice, ability to get desired appointment, time spent moving through visit.

### Best Practice Observations

#### *Conferences and Site Visits*

In November of 2015 members from the task force attended a conference on team based care sponsored by the Wisconsin Council on Medical Education and Workforce. One of the presenters at the conference was Kathy Kerscher, from Bellin Health Care. Ms. Kerscher, outlined Bellin Health's journey with redesigning primary care. Driving factors for their redesign efforts were very similar to UW Health's Primary Care Redesign. After the presentation, the UW Health team based care task force scheduled a visit to Bellin Health and in February of 2016, a subgroup of the committee visited the Ashwaubenon clinic, a family practice clinic that is part of the Bellin Health System in Green Bay area. Like UW Health, Bellin Health Care System had a diverse set of clinics in rural and urban settings with clinicians and staff experiencing burnout due to the complexity of a primary care practice and difficulty in successfully caring for patients with increasingly complex needs. Bellin Health implemented a team based care model to address the challenges in primary care.

Bellin Health took a similar approach to UW Health to redesign primary care with planned care principles, standardized rooming process and the use of daily huddles. Their redesign efforts achieved significant results, but like UW Health, they just did not adequately address some of the driving factors behind the need to change the delivery model. Even after the redesigning and standardizing many of the processes at the clinic, physicians and staff were overwhelmed with the complexity of the patients and meeting the needs of the patients. Physicians were still spending time documenting visits and following up with patients. In addition, the physicians and patients felt that the interaction with the computer system was a distraction to patient care.

There were many similarities in the Bellin Health and UW Health's primary care redesign. Both organizations standardized the rooming process, expanded the roll of the Medical Assistants and implemented disease registries. Bellin Health went beyond redesigning the workflows and also focused on how teams worked together to meet the needs of the patients. They developed a triple win as a goal for their redesign efforts. Their triple win was "a win for the patient, a win for the care team and a win for the system. Ms Kerschner from Bellin noted that they made the decision to go all in on implementing team based care in their clinics which meant the organization needed to commit to additional resources. Most of the additional resources were in the form of additional medical assistants to work with the physicians. The Bellin Health care team model subsequently has been implemented at the Ashwaubenon Clinic; their implementation strategy was one care team at a time. As can be imagined, the roll out has been slow.

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### Observations of Bellin Health’s Care Team Model

The team spent an afternoon at the Ashwaubenon Clinic observing patient visits. The layout of the clinic was not much different than many of the UW Health Clinics. One thing that the team noticed was that teams were co-located and the medical assistants had an active role at the patient visit and served as a care team coordinator. Based on observation, it was clear that the Ashwaubenon Clinic was not designed for co-location of the care team, but the teams were making it work to better serve the patients. Care team members had enough space for a computer and one stack of papers at their work stations. They felt that, although they had to work in tight conditions, it was well worth it because it facilitated communication among team members, which resulted in better care to the patients and a more efficient clinic. The role of the medical assistant at Bellin was much different than the UW Health model. In addition to standard rooming process, the Bellin medical assistants stayed in the exam room to complete documentation for the visit and complete any follow up after the visit. The office visit is described in the box below.

#### **Office visit process:**

The medical assistants worked as a care team coordinator and followed standard rooming process. During the rooming process, the visit diagnoses were pulled from the problem list, refills were set up, visit agendas were set, care gaps were identified and addressed. The care team coordinator would then start the visit documentation prior to the physician entering the room, start appropriate templates start documenting the visit. When the medical provider came into the room they were able to focus on the patient instead of the computer. The care team coordinator served as chaperon for sensitive exams and completed any follow up care or instructions after the exam allowing the the medical provider to go to the next patient room with a second patient care coordinator.

Bellin Health tracked outcome and process measures prior and after the implementation of Team based care at their clinics. The results in the chart below was reproduced from November 12, 2015 compare the baseline data to data one year after implementation of team based care. Bellin Health refers to this as “a win for the patient, care team and system”.

Measure	Baseline 2014	Actual 2015	Percent Improvement
Breast	55.37%	64.01%	8.64%
Cervical	69.61%	77.57%	8.26%
Colorectal	79.71%	84.38%	7.97%
LDL @ Target (<100)	65.79%	65.43%	.36%

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Blood Pressure @ Target (<140/80)	50%	50.53%	.53%
A1C @ Target	48.95%	57.98%	9.03%
A1C Poor Control (>9%)	6.11%	4.37%	1.74%
Renal Protection	62.11%	68.62%	7.40%
Foot Exam	21.05%	73.94%	52.89%
Retinal Exam	32.63%	38.30%	5.67%
Pneumovax Completed	54.21%	64.89%	10.68%
Hep B Completed	6.32%	7.45%	1.13%

Reproduced from November 12, 2015 Presentation to Wisconsin Council on Medical Education and Workforce Conference.

In addition to the outcome and process measures, Bellin completed a financial analysis for each care team prior to implementation and again after go live. The results of this can be found in the chart below.

Care Team	Operating Margin prior to Go-Live	Operating Margin Target	Operating Margin Actual
1	-2.2	3.3	5.7
2	10.5	10.4	17
3	7.9	8.4	18.1
4	9.5	4.8	-11.1
5	-9.5	-1.2	-4.6
6	49.2	50.3	46.1

Reproduced from November 12, 2015 Presentation to Wisconsin Council on Medical Education and Workforce Conference.

### Discussion with Watertown Regional Medical Center

A subgroup of the taskforce met with Jim Milford, MD who practices with the Watertown Regional Medical Center (WRMC), at the Lake Mills and Johnson Creek clinics. Dr. Milford described the changes made at their clinics. The clinic launched a pilot, which increased the ratio of medical assistants to physicians, from 1:1, to 2:1 initially and to 3:2 later. During the pilot, the role of the medical assistants was expanded. The medical assistants had expanded duties when rooming and discharging patients. Medical assistants also served as scribes during the visits. The piloted changes resulted in decreased cycle time, and added to face to face time. Increased satisfaction among patients, staff and physicians was also noted.

Our team hoped to set up a site visit but was unable. Unfortunately, Dr. Milford reported that it is unpredictable when they would be practicing team based care. It varied by the week and day. Dr. Milford's practice was bought out by a national for profit system, which did not agree with the staffing models that they had previously established.

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The Universities of Utah and Colorado instituted similar models to those mentioned previously and have experienced gains in provider and patient satisfaction as well as improved patient access. The University of Utah implemented a team-based care model that increased the ratio of medical assistants (MAs) per provider to 5:2 ratio. In the University of Utah model, there are five medical assistants working with two physicians. In this model the medical assistants greet the patients when they arrive and the same MA stays with the patient throughout their entire time at the clinic. Medical Assistants are with each patient for 30-35 minutes and the physician is with the patient for 15-20 minutes. The MAs work in teams but are not paired with an individual provider. Through team based care, the University of Utah enhanced the organizations clinical and financial outcomes, and improved staff, provider and patient satisfaction and improved patient access to the clinics. (Blash et. al. 2014).

### Options

#### Overview of Options

This proposal contains three options for team based care in the =DFMCH. As mentioned above, the taskforce used several methods to evaluate various models for team based care including those described below and some that were not included in the proposed options. One model that is not part of the options below is integrating behavioral health into family medicine. The taskforce thought that this was an important part of team based care in family medicine however, did not include it in the proposal because there is a separate UWMF initiative on the integration of behavioral health. Our taskforce chose to focus on the interaction between the physician, medical assistant, nurse and business office staff during the office visit.

#### Utilization of Scribes in Family Medicine

To build upon the work already done by Primary Care Redesign, one option would be to implement the use of medical scribes. UW health is currently looking at the use of the vendor model, or using an outside company to provide this service. The medical scribes model has been piloted in the past at UW, and in the right setting could have multiple benefits. Medical scribes could be implemented with no changes to current workflows other than informing the patient that a medical scribe will be present in the room during the exam.

After informing the patient, the medical scribe would accompany the physician into the room. The physician would complete the history and exam as normal with the scribe in the room. During the exam, scribes would assist in transcribing and after visit summary or letters that are needed, such as work notes. Although the physician would still need to review the notes and edit as needed, the use of scribes can significantly reduce the time spent documenting visits.

The key to using the scribe model is that it is implemented in the appropriate setting. In the current environment, time spent documenting visits varies greatly between physician. Some physicians are already very efficient in documenting visits and these physicians may not gain any efficiency by utilizing a scribe. Others spend more time documenting and may become

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more efficient by having a scribe in the room during the visit. The task force recommends that physicians are given a choice as to whether or not to use a scribe. This is similar to physicians having the choice of dictating, using Dragon software, or typing notes. In addition to the difference in physician documentation style, there are also differences in the documentation requirements based on visit type. The task force also recommends that further exploration of visit types may be needed to identify the visits that may benefit the greatest by having scribes in the room.

A major advantage of using scribes is that the physician is allowed to focus on the patient rather than typing during the encounter. During certain clinical visits this can be quite distracting to the physician and patient. The medical scribe model has been shown to increase patient and physician satisfaction due to the decreased time the physician spends typing or documenting which may free up time to see additional patients. This would improve access, which is an ongoing problem. Another advantage is an increase number of charts closed the same days as the visit. Utilizing scribes also could potentially increase the accuracy of documentation because it is being done in real time.

### Enhanced Role of the Medical Assistant

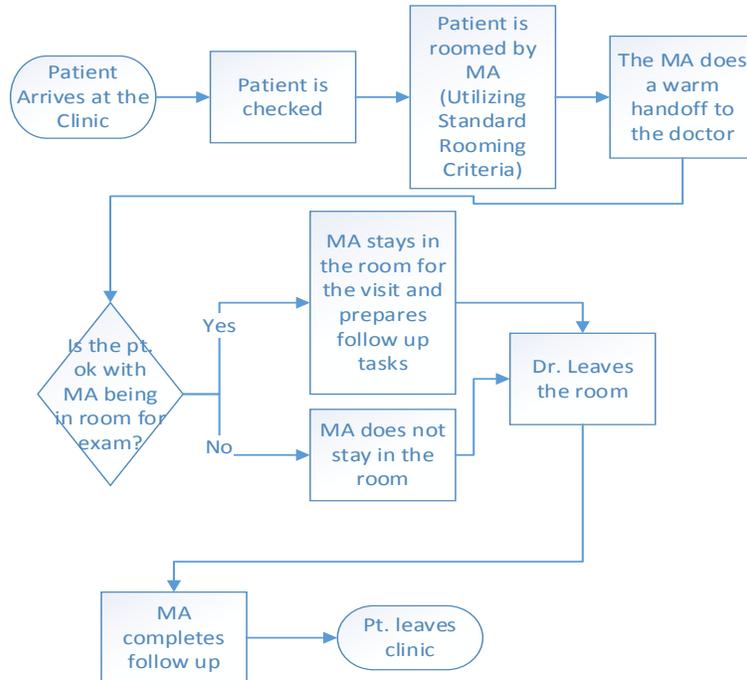
The second option the taskforce explored was increasing the responsibility of the Medical Assistant to include being in the room during the visit and completing follow up appointments and explanations after the patient visit. This option would also build upon the work of PCR and make the medical assistant a more active member of the care team.

In a 2012 article Naughton et.al explored roles of medical assistants in patient centered medical homes. There are many ways that medical assistants can contribute to the improvement of patient care. UW Health PCR has implemented some of the roles suggested in this article, such as utilizing medical assistants in population health and chronic disease management. Other than following the UW Health standard rooming process while rooming patients for visits and giving needed immunizations, the medical assistants at UW Health have limited interaction during the patient visit.

After researching and visiting other clinics, the task force suggests that there may be benefit to having medical assistant in the room during patient visits and staying in the room after the clinician leaves the room at the conclusion of the exam. This expanded role for the medical assistant would allow for the patient to get questions answered and to review the after visit summary and complete any after visit follow up. The medical assistant would be in a better position to answer patient questions because they were in the room for the visit. A high level flow chart is found below.

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### High Level Process Map "Enhanced MA"



The taskforce anticipates that this model would increase patient understanding of physician instructions, which would result in increased patient compliance. It would also allow the physician to see more patients and increase access to primary care. In addition, if patients have questions or concerns immediately or days after the visit this model puts the medical assistant in a better position to address concerns and questions. Having the medical assistant actively involved in the visit could increase the compliance of chronic disease management during the visit. For example, assessing if labs are needed for hypertension or diabetes care at acute and chronic visits.

This model would require further research and study to determine the best staffing ratio. An increase in the number of medical assistants is anticipated in this model.

### Enhance Medical Assistants and Scribes (Bellin Model)

The Bellin model which utilizes Care Team Coordinators to facilitate office visits and reduce the amount of time spent on visits. This model is combines the use of scribes and enhancing the medical assisting role by having the medical assistant in the room for visits serving as scribe as well as assisting in the visit. The medical assistant would prepare follow up tasks during the visit and stay after the exam was complete to answer any questions. The task force

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recommends that teams would be co-located in this model. Co-locating care teams should be trialed at a clinic.

The recommendations for this model were derived from a visit to the Bellin Health Ashwaubenon Clinic. As already mentioned, the Ashwaubenon clinic was not designed for co-location but the care team has found the benefits of co-location far outweigh the inconvenience of a small work area.

Huddles played an important part in the team care provided at the Ashwaubenon clinic. UW has also focused on using huddles to optimize access and anticipate issue that may come up during the clinic session. The taskforce also recommends team meetings to discuss more complex patients this will build upon the work that is already being done by the RN care coordinators.

This model would require a change in the staffing ratio of medical assistants to clinicians. The Ashwaubenon clinic utilized LPNs and Medical Assistants as clinical team coordinators. The work flows required a ratio of 2 LPNs or MAS per provider in an enhanced role called "care team coordinators." The proposed model would require additional staff at the clinics. As "care team coordinators" the individuals would follow the standard rooming criteria implemented in phase one of PCR and stay in the exam room during the patient visit to document relevant information and hear the patient story. After the visit, the clinical team coordinator would remain in the room and review the AVS and make arrangements for any follow up visits or appointments. While one "clinical team coordinator" is in the room with the provider, the other "clinical team coordinator" rooms the next patient.

### **Short and Long Term Plan**

Implementation of medical scribes, the enhanced medical assistant model or a combination of the two will need to be tested and piloted. Careful consideration of testing pilot sites will be critical to successful implementation.

As mentioned previously, not every practice would necessarily benefit from the use of medical scribes. The task force recommends identifying practices that would have the most to gain by utilizing medical scribes. Considerations to identify practices that would benefit include, time to close charts and utilization and time spent dictating after the visits and willingness to test a new process. Test and pilot sites need to be willing to trial the changes and work with an implementation team to determine the best process.

Once test and pilot practices are identified, the taskforce recommends an assessment of the clinic and practice site, as well as equipment and current practices. Exam room layouts need to accommodate the extra person in the room and a determination of where to place the extra person will need to be made. Additional tablets or computers may be needed depending on current equipment. It will be important to understand how test and pilot providers currently

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document visits and how long the documentation takes. Understanding and being familiar with provider templates, smart- phrases, and preferences for charting will be important to review prior to testing or piloting.

Enhancing the medical assistant role will take careful planning and assessment. The taskforce recommends that testing, piloting and implementation is done at the provider (microsystem) level rather than an entire clinic. This will allow for the selection of physician/provider champions that are enthusiastic about testing the model and the selection of teams that may benefit the most. The physician/provider champion and staff will need to be willing to take on the challenge to expand the role of the medical assistant. Teams will need to be flexible as they develops, accepts, and works toward a common goals. Current medical assistants are familiar with what is need for most chronic disease management and will be able use those skills in real time as an active participant during the patient visit. Protocols will need to be reviewed, including the use of the follow up section, order entry, and the use of smartsets. Other metrics as outlined in the “Summary of Models” chart (found on pages 17 and 18) will need to be monitored at baseline and as the model is tested. The taskforce strongly recommends continuing and possibly enhancing huddles that were implemented as part of primary care redesign. Weekly team meetings to monitor change, evaluate improvements, and make necessary changes in work flow are also suggested. As additional teams are being implemented, this information can be disseminated across multiple practices for ongoing improvement.

### Financial Requirements

Any of the plans outlined in this document will require a financial commitment. Starting with test and pilot sites will help to discover potential problems and mitigate financial costs to implement team based care in the DFMCH. Potential revenue increases are anticipated with each model however it is important to realize that it is unlikely that efficiencies will be gained immediately. It will take time for provider teams to realize the efficiencies that are anticipated by the taskforce. The testing phase can be used to determine the amount of time for efficiencies to be realized.

Each of the plans outlined project an increase in efficiency at the office visit, especially for the physician or provider. As a physician or mid-level provider becomes more efficient with patient flow and spending less time dictating or documenting, additional clinic visits should be manageable. The taskforce anticipates this will partially address access issues. Whether using the medical scribe or enhanced medical assistant model, it would take approximately two to three additional level three office visits per day to offset the anticipated cost for each plan.

The enhanced medical assistant model will result in an increased amount of patient care being provided by team members other than the physician or provider. The taskforce anticipates a potential increase in panel size if more care is provided by the team members.

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The taskforce anticipates that the scribe model will result in quicker times to close encounters and possibly more robust and active charting which may support increased level of service billing. Other possible sources of revenue, at least initially, may include research funding such as AHRQ funding through the National Center for Excellence and Primary Care Research (NCEPCR).

### **Conclusion**

Team based care has the potential to improve patient care and improve patient, staff and provider satisfaction. It may be necessary to test and pilot the models outlined in this document to develop a common definition and understanding of team based care.

During the testing and piloting phase of the project it will be important to collect data on patient, staff, and physician satisfaction, appointment access, and time to complete charts. This data will be collected prior to the start of the test or pilot, during and after the pilot. Methods for collecting this data are varied. A summary of the methods can be found in Appendix D of this document.

## Summary of Models

	<b>Scribes</b>	<b>Enhanced Medical Assistant</b>	<b>Combined</b>
Pros	<p>Allows physicians to focus on patient rather than computer.</p> <p>Possible increase in patient satisfaction.</p> <p>Improved access by allowing physicians to see more patients and spend less time documenting.</p> <p>Relatively easy to implement.</p> <p>Increased number of charts closed at the end of the day.</p>	<p>Improved patient understanding of and compliance with instructions.</p> <p>Improved access because clinicians could see more patients.</p> <p>Improved staff satisfaction.</p> <p>Medical Assistant can better answer patient question or concerns because they were part of the visit.</p>	<p>Improved patient understanding of and compliance with instructions.</p> <p>Improved access because clinicians could see more patients.</p> <p>Improved staff satisfaction.</p> <p>Medical Assistant can better answer patient question or concerns because they were part of the visit.</p> <p>Allows physicians to focus on patient rather than computer.</p> <p>Increased number of charts closed at the end of the day.</p> <p>Addresses some of the provider concerns/workload with labs, phone calls, and order entry.</p>
Cons	<p>Not all providers would benefit</p> <p>Doesn't address other work such as labs, phone calls, order entry.</p> <p>Vendor scribes may not be seen as part of the team by patient and other team members.</p>	<p>Doesn't help with documentation during the visit.</p> <p>The provider will need to interact with the computer during visit.</p>	<p>Difficult/impossible to implement in current environment. (Explanation of this can be found in Appendix C)</p>

## Care Team Proposal

	<b>Scribes</b>	<b>Enhanced Medical Assistant</b>	<b>Combined</b>
Metrics	Patient access Patient satisfaction	Patient Satisfaction survey “Medications and care at home were explained to me in a way I could understand.”  Staff satisfaction survey.	Patient Satisfaction survey “Medications and care at home were explained to me in a way I could understand.”  Staff satisfaction survey.
Implementation considerations	All of the options will need careful consideration prior to implementation. A process to select and evaluate of test and pilot practices will need to be developed. Considerations to select include, eagerness/interest in testing or piloting, how the provider works in the current environment, and clinic layout.		
Expenses/Additional FTE Requirements	The taskforce used the assumption that medical assistant to provider ratio is currently 1:1 and in the proposed models that ratio would change to 2:1. The increase staff (scribe/medical assistant) cost was estimated at \$47,840 annually for salary and benefits.		
Plan to off-set additional costs	To offset the cost of the additional staff providers would need to add an additional three level three visits per day assuming a 50% collection rate.		

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Manager Interviews

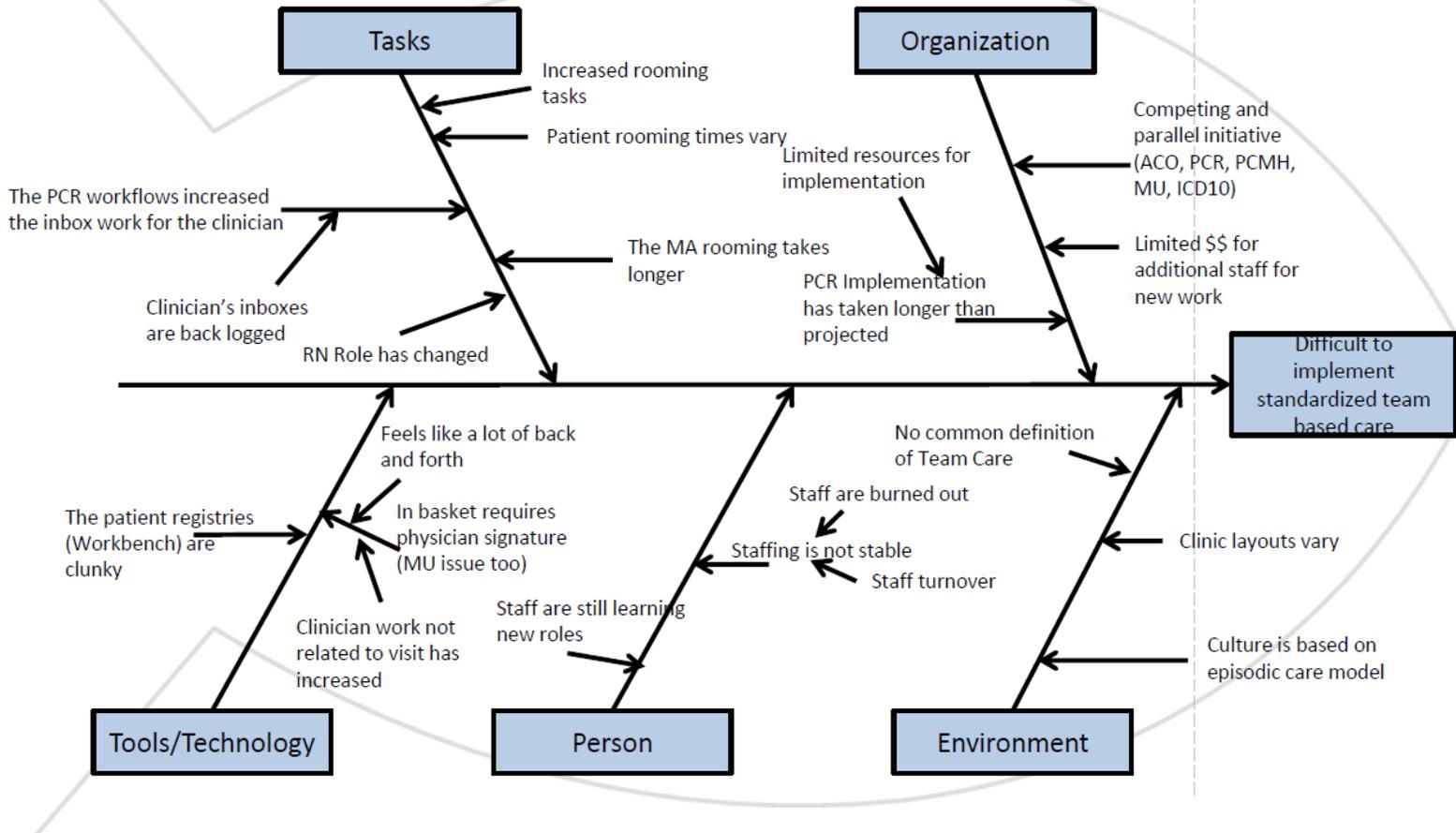
Manager Name	Peggy Belleville	Nancy Ford Sun Prairie	Jennifer LeClaire Sun Prairie RN	Lynette Fort Atkinson	Nicole Oregon	Nicole Fitchburg	Cheryl Blaskowski Yahara	Mark Shapleigh Verona	Jerry Barton Eau Claire	Jerry Barton Augusta	Kristin Bisch Portage	Beaver Dam	Columbus
Q1 Physician FTE	4.62	5.85	Unsure	3	2.7	3	2	3.73	2.7	3	2.4	3.8	2
Q2A How many Physicians	8	7	10	4	3	3	3	10	9	3	3	5	2
Q2B Residents? Yes (physician number includes residents)	No	No	No	No	No	No	No	.4 FTE Residents 12 Residents	Yes (14)	Yes (1)			
Q3 Mid-Level FTE	1	1.9		1.6	1	None		2.4	2.8	No	No	2	1.6
Q3A Number of Mid-	1	3	3	3	2	1	None	4	4	None	None	2	2
Q4 Behavioral health professionals (Yes/No)	Yes	No	No	No	No	No	No	Yes	Yes		No	No	No
Q4A Behavioral Health FTE	0.6	None	None	None	None	None	None	0.9	0.7	0.1			
Q4B Number Behavioral	1	None	None	None	None	None	None	1	1	1			
Q5 Care Team "Look"	One team on each side of the nurse's station	Four care teams - Pod A-D in three areas Pod BC is larger pod	Three care teams - 2 small and one large	Two teams all in one area until we move to new building	Each team has a doctor and MA on it. The RNs work for all providers	Each team has a doctor and MA on it. The RNs work for all providers	WE have three pods and in each pod there is room for four providers and they have three rooms assigned to them to use for a total of 12 rooms per pod (36 exam rooms total). The CMA sits next to the provider and there is an RN Team Nurse assigned to each pod. We also have three RN Care coordinators (all part-time) that are assigned to a	Recently changed care teams so they are not as functional as they will be in the future. Four team layout with 10-12 individuals on each team. Two of the care teams work on each "side" of the clinic.	RN, MA, Module Coordinator, Resident and Faculty Physician	One RN, MA and Resident and Faculty physician	No	No	No
Q6 Number of Care Teams	2	4	3	2	3	3	3	3	4	2	1	Unknown?	1
Q6B Who is on the care team?	Each team is made up of providers, 2 medical assistants, 1LPN, 1 Xray tech and 1 RN	Per physician - Medical Assistant, Team RN, Clinical support person	One RN, Provider, MA/LPN, Clinical Support person.	One Medical Assistant on each team with a shared RN. Triage nurses are not on assigned to a team.	Each team has a doctor and MA on it. The RNs work for all providers	Each team has a doctor and MA on it. The RNs work for all providers	See above	Faculty physicians (the number varies usually 2-3), PA, 3 residents (one from each year), Team Lead RN, Two receptionists assigned to each team and their goal is to preview schedules for the clinicians on the team. They do the background work for the team. The assigned receptionists are not located with the team. There are 13 medical assistants in the clinic and each is assigned to one of the four care teams and paired up with clinicians in a way to even out their work load. Three medical assistants per team with one extra. Medical assistants	See Above	See Above	See Above	We have a total of 7 MAs that make up 5.5 FTE, 3 RNs that make up 2.2 FTE which includes .3 FTE for RN supervisor and .5 FTE RN care coordinator	There is one care team. It includes physicians, PA, MA/LPN, Lab and X-ray, reception. (this makes up the whole clinic)
Q7 Onsite Xray/Lab (Yes/No)	Xray Yes Lab No	NO	No	Yes they are part of the workflows.	Yes	Yes	Yes	Yes	Yes	No	Yes	Xray No Lab Yes	Yes
Q7A How are Xray/Lab Used?	Xray techs act as MA and room patients.	None	None	Part of workflows	Not mentioned	Not mentioned	With scheduling and huddling we try to remind patients that they are due for specific health maintenance topics, which include labs and mammography. We also have INR POC here so the	Do not have a role for Lab or Xray within the care teams.		No	Xray performs medical records responsibility but otherwise not utilized in the care team.	Do not have Xray on site. Onsite lab doesn't go in on huddles, etc. Lab is not considered on teams.	Part of care team. The X-ray tech doubles as an MA; the lab tech doubles as a receptionist
Q7B Number of Xray/Lab	2	None	None							None	Unknown?		
Q7C FTE of Lab/Xray	1.6	None	None							None	Unknown?		
Q8 How are learners utilized	Residents are on teams - Split by teams	No	Not often	First and second year med students, NP and PA students, Medical Assistant students. They are part of the care teams.	No residents Do have med students but they are not on the teams	No residents Do have med students but they are not on the teams	If asking about students, we currently have 1st and 2nd year medical students, an x-ray student, a medical assistant student and a lab student here. We are stressing the importance of lab and x-ray taking on students since there was some reluctance to do so, especially with lab but they are coming around. We are missing out on	Residency clinic. The residents are part of the care team. Other learners such as medical students rotate through and work with a care team.	We have MA learners, Medical Students both MD and Do which are supervised by each discipline in the clinic. We use the department of Family medicine policy on students	We have MA learners, Medical Students both MD and Do which are supervised by each discipline in the clinic. We use the department of Family medicine policy on students	We do utilize learners. We currently have a PA student with one of our mid-levels. In the past we have had MA students.	Have medical students; first year medical students just shadow, may do brief introductory interview. Take on local tech college, CMAs	The manager does not know how they are utilized
Q9 Do teams stay the same each day?	Yes for continuity they stay the same.	Yes to some degree, pull clinical staff in	Generally, but will vary when clinical staff is out, some crossing over.	Teams stay the same and do not rotate.	Yes	Yes	No	No	Teams stay the same with clinic personnel but residents and faculty physicians change.	Teams stay the same with clinic personnel but residents and faculty physicians	No - There is some variability. We do not always have a clinical support	Have to vary because of day's work and timeout of the clinic	The teams vary due to the large number of part-time employees
Q10 Scale of 1-7 how effective are your teams?	6	6	5	5	5	5	5	5	4	5	5	5	3
Other comments		Extended hours - no care team structure in evenings, two providers here in evenings, two clinical support, one RN	The clinic support person is not attached to the provider.	Feels the teams will be more effective once they is a new building. Location is key She would be on the task force if we			having RN students in the clinics. I wish organization would work more with the schools and have the RN students come into the clinics to learn.	The team concept is new at Verona and Mark feels that they will be more effective in the future as the teams work together more. Would be willing to have the team look at their clinic.		Note the Manager submitted the answers. No manager interview conducted.	Note the Manager submitted the answers. No manager interview conducted.	Manager feels that the reason for the low score is the MDs don't know how to optimally utilize APPS	

TEAM BASED CARE TASK FORCE



Causes

Effect



## Care Team Proposal

### Appendix C

#### UW Health Scribe Policy Summary

According to the UW Health Scribe Policy, scribing is only permitted by individuals with no role in patient care and no clinical license and records the words and/or activities of the provider during a visit so the provider can review the documentation at the end of the service. UW Health developed this policy based on thorough review of all pertinent regulations and guidance as well as numerous scribe policies from other Academic Medical Centers (AMCs).

A copy of the Scribe Policy can be downloaded on U-Connect at <https://uconnect.wisc.edu/depts/uwmf/compliance/compliance-dispatch/resources/name-79493-en.file>.

## Care Team Proposal

Appendix D
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### Data Collection Tools

Metric	Tool For Collecting the Data	Collection timeframe	Comments
Patient Satisfaction	Mailed Surveys – Press Gainey	Baseline Pilot	The organization will be switching from AVATAR to Press Gainey which will make it difficult to compare baseline and pilot.
	Surveys administered at the visit	Baseline Pilot	These surveys will need to be specifically developed. A simple survey will need to be developed to assess the patient's perception of the time that the physician spent interacting with the patient versus with the computer system. Some suggested methods include paperless surveys or using i-Pads to collect data.
Patient Access to Appointments	Organizational Access Reports (Perspective Template Availability Report)	Baseline, Pilot and Implementation	
Chronic Disease Metrics	Organizational Reports	Baseline, Pilot and Implementation	This data is already being collected through WCHQ reports. This will take little change.
Staff and Physician Satisfaction	There are some organizational reports that have been used in the past.	Baseline, Pilot and Implementation	

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