Module 5: Developing Effective Team-Based Care
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Learning Objectives

- Describe the operational strategies in developing a medical home team to support the patient- and family-centered medical home in clinical practice.
- Assess a practice’s performance and the quality of its care as a team-based medical home.

Pretest

1. The difference between working in a group and working in a team is that a group is a collection of clinical and administrative personnel coming together to care for patients and families, while a team also requires interdependent and collaborative efforts on the part of all members of the group. True or false?

2. During team huddles, the pediatrician or lead clinician gathers only members of the clinical staff for a short meeting (5–15 minutes) to prepare for the day’s patients. True or false?

3. Which of the following indicators should be included when a medical home team decides to evaluate its performance?
   a. Patient outcomes.
   b. Patient care processes.
   c. Patient and family satisfaction.
   d. All of the above.

4. Which of the following characteristics of team-based care is important?
   a. Open communication among all members of the team.
   b. Strong leadership from the pediatrician or lead clinician.
   c. Clear goals and measurable objectives.
   d. All of the above.

Overview

“Optimal pediatric care is best delivered in a team-based approach that is led by a primary physician, ideally a pediatrician, who assumes responsibility for managing the patient’s care,” according to a policy statement from the American Academy of Pediatrics. This statement explains that “[l]earning to work in teams should begin in pediatric residency training, where collaborative learning with non-physician clinicians can expose future pediatricians to the benefits of team-based care.” This educational module will discuss several of those benefits.

It is important to understand the critical differences between working in a group and working in a team. A pediatrician, nurse practitioner, medical assistant, front desk assistants, and anyone coming into contact with the patient and family who come together to care for patients are, by definition, a group. For that group to work as a team, all members must engage in interdependent and collaborative efforts. A sports analogy can illustrate the difference.

A football team is far more than a group of players who show up in the first quarter and start playing. They spend many hours practicing, getting to know one another, and developing an understanding of how
other members of the team think and perform. A sports team also works together to understand everyone’s strengths and responsibilities, as well as how they relate to one another.

Similarly, a medical home team works together before it actually offers direct patient care. Researchers who have studied the difference between groups and teams explain the issue in the following way: “It is ironic indeed to realize that a football team spends 40 hours a week practicing teamwork for the two hours on Sunday afternoon when their teamwork really counts. Teams in organizations seldom spend two hours per year practicing when their ability to function as a team counts 40 hours per week.”

Among the many characteristics that distinguish a team from a group are

- Clear goals, measurable objectives
- A well-defined division of labor among staff members
- Adequate training
- Well thought-out clinical and administrative systems
- Effective communication

Team goals should be shared among the entire team, including the patient and family members. A report from the Institute of Medicine explain that these goals should be “clearly articulated, understood, and supported by all team members.” The same report also emphasizes the importance of measurable processes and outcomes, mutual trust, and effective communication. Finally, the report lists the need for clear roles for each member of the medical home team, explaining that “[t]here are clear expectations for each team member’s functions, responsibilities, and accountabilities, which optimize the team’s efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.”

While the most important goal of a professional football team may be winning a Super Bowl, the goals of a patient- and family-centered medical home include providing accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective medical care.

There are various ways to help medical homes develop into effective teams. The first step is designating a pediatrician as the leader for the team. This leader can also put into place cross-training of certain team members so that the practice can function well when someone is on vacation and ill. Such cross-training must keep in mind, however, the scope of practice of each licensed professional so as not to violate state law.

It is also important to recognize patients and their families as integral parts of every medical home team. Including patients and families on the team provides them an opportunity to take part in shared decision making and demonstrates respect for their input.

Of course, team-based care includes more than patient and family involvement. It is also fostered by collaboration with community partners, including the youth’s school and any subspecialists she may be seeing. Team-based care also includes staff from home nursing agencies, case managers, physical therapists, and anyone else who provides or optimizes care for patients.

The following case study illustrates the principles of team-based care by describing a routine day in a medical practice that follows the medical home model of care.
Case Study

Janet Blackstone, MD, FAAP, recently finished a pediatric residency and has joined a pediatric practice that includes 2 pediatric nurse practitioners (NPs), a registered nurse, 2 medical assistants, and 2 front desk assistants. Dr Blackstone has been well trained to take on the overall responsibility of primary care pediatrics. However, she also realizes the complexities of medicine make it impossible for her to accomplish everything on her own. She is determined to build a successful team that can provide the high-quality patient care she was taught to deliver during residency. Her goal is fostering a medical home model and incorporating principles discussed in the educational modules in this series on patient- and family-centered medical homes, which highlight the importance of care coordination, the need for enhanced access to care, the critically important role of family in the decision-making process, and the value of care planning.

Below, we provide a snapshot of a day in the life of a medical home team as it strives to provide high-quality patient- and family-centered care.

8:15 am. The team gathers for the first meeting of the day, where they discuss how they will care for patients on the day’s schedule. All 8 members of the practice attend to review each patient’s needs. Many pediatric practices start their day by immediately seeing patients. However, Dr Blackstone has learned that setting aside 15 minutes makes the entire day go smoother and empowers all practice team members to work to their highest potential.

On this particular day, Dr Blackstone sets the tone at the meeting, asking for suggestions on how to manage the heavy patient load for the day. Because one of the NPs has to unexpectedly leave early, Dr Blackstone asks if anyone else on the team is available to help care for the NP’s patients. Also, one of the front office staff mentions that a child from their practice was admitted to the hospital, and she volunteers to obtain the discharge summary from the hospital.

8:30 am. The pediatrician sees Mr and Mrs Milstein to discuss their son’s hiatal hernia. Surgical repair is one option, but Dr Blackstone also mentions watchful waiting, since the infant’s gastrointestinal symptoms are relatively mild. The practice strives to include families on the team and encourages shared decision making. During the 8:15 am meeting, the medical home team had identified previously documented concerns about difficulties the Milsteins have in understanding medical jargon. To address this, they had identified appropriate patient education materials for Dr Blackstone to use to help support the Milsteins in making decisions related to their child’s condition.

The next patient that Dr Blackstone sees, Michelle Nelson, age 12, has just been diagnosed with type 2 diabetes, and the pediatrician helps her and her family develop a care plan. Dr Blackstone explains the basics on how to manage Michelle’s diabetes at home and then asks the nurse to follow up with the Nelsons to provide more in-depth patient education. The nurse asks the family’s permission to reach out to Michelle’s school nurse to help coordinate her diabetes care and contribute to the care plan. The National Diabetes Education Program, which is a joint venture between the National Institutes of Health and Centers for Disease Control and Prevention, recommends that each student with diabetes have a written individualized care plan that incorporates the physician’s orders and parents’ requests and is tailored to the child’s specific developmental, physical, and cognitive abilities. The parents agree to this arrangement, so the NP gives them a copy of the care plan to take to the school.
Jasmine Smith presents for her 9-month-old health maintenance visit with an NP. However, since the NP is tied up with another patient, Dr Blackstone plans to see this child for her. To manage clinical flow, the team decided to have a medical assistant administer Jasmine’s immunizations prior to the pediatrician coming into the examination room. But the medical assistant had recalled that Jasmine’s mother usually prefers discussion with the pediatrician regarding all interventions, so the team’s plan would not work. Fortunately, Dr Blackstone’s leadership and communication style have encouraged other members of the team to freely express themselves. This openness had allowed the medical assistant to challenge the team’s decision and request that Dr Blackstone alter the plan.

Dr Blackstone is pleased that the medical assistant feels comfortable enough to make the suggestion and wants to do all she can to empower him. She first meets with Ms Smith, who agrees to the plan regarding administration of immunizations; then the medical assistant administers the immunizations while Dr Blackstone sees her other patient. Then Dr Blackstone returns to Jasmine to finish her visit. This approach addresses the needs of the patients while facilitating clinic flow.

Dr Blackstone finishes her health maintenance visit with Jennifer Morales. She explains to Mr and Mrs Morales the importance of obtaining family feedback on how well the medical home is doing in accomplishing its goals of providing comprehensive, holistic care. In the past, patients were directed to the front desk staff to complete a patient satisfaction survey. Surveys like this are among the many tools that patient- and family-centered medical home teams can use to assess their performance and continually strive for quality improvement. Practice performance evaluation and a quality improvement initiatives are important components of any team effort. In fact, a team-based approach to medical care is only effective if improvements are measurable and demonstrated.

During the earlier team meeting, the team had noted a recent decline in survey participation. For today, they had decided on a trial of placing copies of the surveys in the patient rooms. The Morales family is directed to the survey in the room and completes it prior to leaving.

Patient and family satisfaction surveys are only one of many practice evaluation tools. Dr Blackstone has heard about a variety of other assessment tools in residency and is considering bringing them to the practice team to explore possibly implementing them as a strategy for improving team-based care.

The Center for Medical Home Improvement, for example, offers a tool to help evaluate practice performance. *The Medical Home Index: Pediatric* measures organization and delivery of pediatric care for children, youth, and families and is located on the CMHI Web site (www.medicalhomeimprovement.org/pdf/CMHI-MHI-Pediatric_Full-Version.pdf). The assessment tool allows medical homes to evaluate organizational capacity, care coordination, community outreach, data management, quality improvement, and their ability to manage chronic conditions.

**Summary**

Although Dr Blackstone has been out of residency for only a short time, she is already seeing the benefits of a team-based approach to patient care. Through her openness and willingness to listen to suggestions from her entire staff, along with many hours of training and the implementation of well thought-out clinical and administrative systems, the medical home is developing into a well-trained team that is on its way to accomplishing the overall goals of providing accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective medical care.
Posttest

1. The difference between working in a group and working in a team is that a group is a collection of clinical and administrative personnel coming together to care for patients, while a team also requires interdependent and collaborative efforts on the part of all members of the group. True or false?

Explanation:
A sports team is more than a group of players who show up on the field to start playing. They require many hours practicing, getting to know one another, and developing an understanding of how other members of the team think and perform. Similarly, a pediatric medical home team needs a great deal of preparation and planning before they can successfully begin offering direct patient care.

2. During team huddles, the pediatrician or lead clinician gathers only members of the clinical staff for a short meeting (5–15 minutes) to prepare for the day’s patients. True or false?

Explanation:
Team huddles need to include all members of the practice, not just the clinical staff but all administrative personnel as well. All members of a medical home team have something to contribute. Similarly, the purpose of a team huddle goes beyond just preparing the team for the day's patients and can include a wide variety of practice issues, including discussing ways in which team members can share responsibilities or fill in for one another in an emergency.

3. Which of the following indicators should be included when a medical home team decides to evaluate its performance?
   a. Patient outcomes.
   b. Patient care processes.
   c. Patient and family satisfaction.
   d. All of the above.

Explanation:
To provide comprehensive, team-based patient care, a medical home needs to perform a comprehensive analysis of its performance. All 3 of the above issues need to be addressed using one or more self-assessment tools.

4. Which of the following characteristics of team-based care is important?
   a. Open communication among staff members.
   b. Strong leadership from the pediatrician.
   c. Clear goals and measurable objectives.
   d. All of the above.

Explanation:
Open communication starts with a pediatrician who serves as a strong leader as well as a role model, showing respect for other members of the team, encouraging others to speak up, and providing them with a safe environment in which to express their opinions. Clear goals and measurable objectives are 2 additional elements that distinguish a group from a team. It also helps to achieve the triple aim of health care—improving patient experience, improving patient health, and reducing the cost of care—and to foster patient- and family-centered care.
Reflections to Consider

The following questions are meant to prompt thought and discussion either individually or in a small group. There are no right or wrong answers.

- Think about the members of your care team in your practice. In your experience, how does working in a team differ from group work? How might you foster team building and buy-in for the medical home model?
- Have you participated in a team huddle in practice? How did it go? What could be done differently? If you have not been part of a team huddle, what do you feel the value of a huddle could be in your practice?
- How would you approach a parent/caregiver to become part of your medical home team?
- What are ways to maintain a medical home team and foster sustained quality improvement?

References


Resources


Institute for Patient- and Family-Centered Care

- Advancing the Practice of Patient- and Family-Centered in Primary Care and Other Ambulatory Settings: How to Get Started handout (http://www.ipfcc.org/pdf/GettingStarted-AmbulatoryCare.pdf)
- Partnering with Patients and Families to Design a Patient- and Family-Centered Health Care
System: A Roadmap for the Future; A Work in Progress

- Patients and Families as Advisors in Primary Care: Broadening Our Vision handout (http://www.ipfcc.org/pdf/pc-vision.pdf)

National Center for Medical Home Implementation

- “Practice Management Measurement” Web page (www.medicalhomeinfo.org/how/performance_management.aspx#tools)
- “Preparing the Office” Web page (www.medicalhomeinfo.org/how/care_delivery/#office)

National Institute for Children’s Health Quality

- Family Engagement Guide: The Role of Family Health Partners in Quality Improvement Within a Pediatric Medical Home handout (http://medicalhome.nichq.org/resources/family-engagement-guide)
- Powerful Partnerships: A Handbook for Families and Providers Working Together to Improve Care (www.nichq.org/how%20we%20improve/resources/powerful%20partnerships)