

# Building Powerful Primary Care Teams



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Primary care practices face chronic problems: their panels/calendars are full, making it difficult to add new patients; their capacity is insufficient to meet patient demand for appointments, resulting in poor access to care; and clinicians (physicians and advanced practice providers) are working too hard and spending too much time on electronic medical records and desk work, thereby creating dissatisfaction and burnout. Teams are offered as a solution to these problems. However, to add value, teams need to increase the capacity of the practice to see more patients promptly while reducing the workload and nonclinical responsibilities of clinicians. At first glance, these objectives seem challenging and even contradictory, thereby leading to the following question: Is it possible to build teams that increase capacity and improve patient access while unburdening clinicians from excessive work and frustrating administrative tasks?

To explore this question we first introduce the 2 elements of a primary care team and list the functions they perform. Primary care teams are often composed of a core team or teamlet (a clinician working with a medical assistant) and an extended care team (ideally a nurse care manager, a pharmacist, a social worker, a behaviorist, and a physical therapist) that supports several core teams. In the best case, teams are stable, that is, members of the team always work together and patients on the team's panel receive all care from their team so that patients know their team members and the team knows their patients.<sup>1</sup> Perfect team stability is not possible but is an important goal to strive for.

Patients are empaneled to a core team, which is responsible for all patients on its panel. In contrast, extended care team members care for some of the patients empaneled to the 3 or 4 core teams they support. Nurse care managers and pharmacists may care for patients with diabetes and

hypertension, behaviorists manage patients with psychosocial issues, and physical therapists are experts in musculoskeletal problems.

The functions of core teams include building longitudinal relationships with their patients, being available for routine and acute care visits, ensuring that all patients on their panel have received evidence-based chronic and preventive services (ie, that care gaps are closed for standard diabetes services, immunizations, and cancer screenings), and coordinating the care of their patients with extended care team members and with outside services.

The functions of extended care teams are to provide care for appropriate patients and to be available for referrals or warm handoffs from the core teams they support. The article by Mitchell et al<sup>2</sup> in this issue of *Mayo Clinic Proceedings* describes a robust extended care team.

## Core Teams

Examples of primary care practices that have built core teams that increase capacity while unburdening clinicians from excessive work include Bellin Health in Wisconsin and the University of Colorado Health System. The fundamental change in these practices is an increase in medical assistant (MA) staffing, with 2 or 3 MAs for each clinician, intensive MA training, and conversion of the clinician visit into a team visit that includes both clinician and MA.

Before the clinician enters the room the MA negotiates the agenda, takes and documents the history, makes sure all chronic and preventive care gaps are taken care of, and performs medication reconciliation. When the clinician joins, the MA assumes the scribe role so that the clinician gives undivided attention to the patient. When the clinician leaves to join the visit initiated by the second MA, the first MA makes sure that the patient understands the care plan, arranges follow-up services, helps with

navigation, and performs as-needed behavior-change health coaching. Because the MA is in the room participating in all the care, the MA's work life becomes more interesting and enjoyable. The MA knows the patients and can be more helpful with patients' phone calls and electronic messages. Both at Bellin and the University of Colorado, clinical performance improved, patient and staff satisfaction increased, clinician satisfaction doubled, and burnout decreased by half. Revenues increased as clinicians provided more patient visits because they no longer spent time on documentation, which more than paid for the additional MA staff.<sup>3-6</sup>

### Extended Care Teams

As research studies demonstrate, nurse care managers, pharmacists, behaviorists, and physical therapists working with protocols or standing orders can care for most patients with diabetes, hypertension, depression, and uncomplicated musculoskeletal problems with only rare clinician input. Because this small group of clinical conditions composes a substantial proportion of an average primary care panel, a robust extended care team can greatly increase primary care capacity while reducing clinician work.

Registered nurse or pharmacist care managers with the authority to make medication changes independently can significantly improve hemoglobin A<sub>1c</sub> levels in patients with diabetes compared with usual care plus patient education.<sup>7</sup> In a randomized controlled trial, patients with diabetes and elevated blood pressure cared for by registered nurses, including initiating medications and titrating doses, were 3 times more likely to reach their blood pressure goal than those managed by conventional primary care.<sup>8</sup>

Outpatient diabetes care provided by pharmacists who perform medication adjustments and patient education results in significant reductions in hemoglobin A<sub>1c</sub> level, systolic blood pressure, and low-density lipoprotein cholesterol level compared with care without a pharmacist.<sup>9</sup> Management of cardiovascular risk exclusively by pharmacists

is associated with improved blood pressure, low-density lipoprotein cholesterol level, and smoking risk compared with care not including a pharmacist.<sup>10</sup> In a randomized controlled trial, pharmacist management of hypertension (including medication prescribing) achieved 72% blood pressure control compared with 57% with usual care.<sup>11</sup>

Behaviorists working as depression care managers in primary care improve depression outcomes compared with physician-only care and can reduce the number of physician visits.<sup>12</sup>

A systematic review comparing patients with direct access to physical therapy (seeing the physical therapist first) vs physician referral to physical therapy found that patients in the direct-access group had better outcomes (more fully achieved goals, less average pain at discharge from care, and fewer missed days from work), higher satisfaction, fewer imaging studies, and lower health care costs.<sup>13</sup>

### Improving Access While Reducing Clinician Work

Let us envision the work of a hypothetical primary care team. A clinician has a panel of 2000 patients who come an average of 3 times a year, creating a patient demand of 6000 visits per year. If the clinician works 200 days per year and sees 20 patients per day, her or his capacity is 4000 visits per year. Demand exceeds capacity, and patient access is poor.

Now assume that 1000 of the visits are for diabetes, 1000 for hypertension, and another 1000 for uncomplicated low-back, knee, and shoulder pain. Imagine that registered nurses, pharmacists, and physical therapists can independently care for two-thirds of these visits, for a total of 2000 nonclinician visits. Now capacity is 4000 plus 2000, access has improved, and clinicians are not working harder. Moreover, with the core team model described previously herein, clinicians are seeing more patients but shedding much electronic medical record and administrative work. Such a scenario envisions a team (core and extended care) that increases capacity,

improves access, and improves the work life of clinicians.

Realizing such a vision means excellent training and mentoring, physician-written protocols and standing orders, conversations with regulators about scope of practice, and financial viability. The barriers are substantial but surmountable over time. For those who embrace the vision of a powerful primary care team, the first step is to consider how such a team might function in your practice.

The article by Mitchell et al<sup>2</sup> in the current issue of the *Proceedings* is an important one because it describes a novel team-based primary care delivery model in Rochester, Minnesota, that emphasizes the integration, collaboration, and collocation of relevant expertise. In addition, preliminary assessment of this model revealed that such objectives as quality of and satisfaction with care, access, and health care costs were favorably met. There are certain general principles, as outlined in this editorial, that are broadly applicable to team-based care irrespective of where such team-based care is located; in addition, there may be considerations specific for the locale where the team-based care is delivered. Incorporating both perspectives, the extended care model introduced by Mitchell et al<sup>2</sup> shows how envisioning the appropriate team-based primary care model can become a reality in clinical practice.

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