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Building Teams in Primary Care: A Practical Guide

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Introduction: Primary care is changing to a team-based model. A number of high-performing primary-care practices in the United States have succeeded in making the transition to team-based care. ***Method:*** Site visits were conducted to 29 high-performing primary-care practices. Observations made in these practices were summarized for common elements exhibited by care teams. A limited literature search was done to review corroborating evidence. ***Results:*** Teams observed in the 29 practices were found to exhibit 9 elements: a stable team structure, colocation, a culture shift in progress from physician-driven to team-based care, defined roles with training and skill checks to reinforce those roles, standing orders and protocols, defined workflows and workflow mapping, staffing ratios adequate to facilitate new roles, ground rules, and modes of communication, including team meetings, huddles, and minute-to-minute interaction. ***Discussion:*** These 9 elements may be helpful to practices making the transition to team-based care.

Keywords: primary care, team care, high-performing teams

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OldWay Clinic: The clinic has a staff of four clinicians, four medical assistants (MAs), 1 registered nurse (RN) and two receptionists. The clinic recently created Teams A and B, each with two clinicians and two medical assistants. The RN and receptionists support both teams. On Mondays and Wednesdays, Team A has only one clinician working, pushing one Team A medical assistant to Team B which is very busy those days. Although patients are empaneled to a clinician, when the clinic is busy and the staff is stretched thin, patients are seen by any available clinician and MA. Hence, patients are not aware of the clinic's teams. Between patients, clinicians are charting in their private offices. MAs are busy but find their jobs boring and unchallenging.

NewWay Clinic: The clinic takes a different approach to creating and nurturing teams, although the staff makeup is identical to the OldWay clinic. Both Team Ruby and Team Emerald—each with two clinicians, two MAs, and a receptionist—are divided into stable teamlets. The same MA works with the same clinician every day. The receptionist belongs to one team while the RN supports both teams. Ruby team members are never switched to Emerald Team and vice versa. All patients are empaneled to a teamlet. Patients know their team gemstone and receive a business card featuring their teamlet members. Team pictures are displayed in the waiting room. Clinic walls are color-coded to distinguish Ruby and Emerald workspaces and exam rooms. Each team is colocated with its members working together in the same open space. During sessions when clinicians are not seeing patients, MAs are receiving training, scrubbing charts to prepare for huddles, or providing panel management and health coaching. Each teamlet holds a 6-min huddle each morning and afternoon led by the MA. MAs are busy and find their jobs interesting and challenging.

A patient-care team is a group of diverse clinicians who communicate with each other regularly about the care of a defined group of patients and participate in that care (Wagner, 2000). Primary health care is transforming into a team sport, with the fictional OldWay and NewWay clinics at opposite ends of a team-development spectrum. Research on teams in primary care attests to the difficulties encountered in forging teams that are more effective than individuals acting independently (Hysong, Knox, & Haidet, 2014; Ladebue et al., 2014). Yet a growing number of primary-care practices are successfully creating high-functioning teams. In this paper, we explore nine elements we observed in high-performing primary-care practices—elements that underlie the differences between OldWay and NewWay clinics.

Method

Over 4 years, six members of the Center for Excellence in Primary Care at the University of California, San Francisco plus three col-

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leagues from other institutions, using a detailed checklist, visited 29 highly regarded primary-care practices to uncover features these practices have in common. Of the nine people visiting practices, six were primary-care physicians with a range of 3 to 32 years in full-time primary-care practice, one a physician assistant with 25 years in primary-care practice, and two master of public health practice coaches averaging 3 years of practice improvement work. Our observations led to the building blocks of high-performing primary-care model offering a detailed vision of primary-care transformation (Bodenheimer, Ghorob, Willard-Grace, & Grumbach, 2014). This paper takes one building block—team-based care—and drills down in detail how high-performing practices organize their teams.

We initially identified practices using reputational sampling, eliciting site-visit candidates from knowledgeable primary-care leaders. We defined those highly regarded practices that could demonstrate excellent performance on triple aim measures as high-performing practices. We prepared detailed reports on all site visits; for the first few visits, three members of the project team independently made lists of common elements present in care teams. These preliminary lists were discussed and an initial agreed-upon list was created. Using an iterative process, we looked for these elements in the next round of site visits and made changes in the list of team elements. This process was repeated with new site visits until no further elements were observed. After the initial site visits, detailed reports on each practice were organized according to the then-current list of team elements. We did not apply formal qualitative methods to develop the elements characterizing teams in high-performing practices.

To look for research evidence that might bolster our observations, we conducted a limited literature review involving PubMed and Google searches using the search phrase "teams in primary care" for English-language studies published in 2014. We reviewed pertinent references found in the articles, websites, and reports identified in these searches. This limited search uncovered 35 peer-reviewed articles examining primary-care team issues.

Results

Twenty-nine site visits were conducted at high-performing practices, including nine hospital-based clinics, seven integrated delivery system sites, 11 federally qualified health centers, and two independent private practices. The practices were located throughout the United States, varied in size from two to 115 physicians, and nine were residency-teaching practices. Seven practices had five or fewer physicians.

We found that high-performing practices demonstrated nine elements or features of team-based care (see Table 1). The first element, a stable team structure, can be considered the anatomy of team formation—how the teams are organized, how they look. The other eight elements make up the physiology, the functions that take place within the structure. We will now proceed step by step to describe these elements of team-based care.

A Stable Team Structure

Some primary-care practices create a team structure on paper, but in reality, team members often work on other teams due to scheduling concerns (see Figure 1A). In the high-performing practices visited, teams are stable: team members always work together unless pressing scheduling issues require team members to work on other teams. While a variety of team structures exist in primary care, the majority of practices visited created a small teamlet (see Figure 1B) as the core of a larger team (Bodenheimer & Laing, 2007).

Teamlets pair up a clinician (physician, nurse practitioner, or physician assistant) with one or

Table 1
The Elements of High-Performing Team-Based Care

Characteristic
1. A stable team structure
2. Colocation
3. Culture shift: Share the care
4. Defined roles with training and skills checks
5. Standing orders/protocols
6. Defined workflows and workflow mapping
7. Staffing ratios adequate to facilitate new roles
8. Ground rules
9. Communication: team meetings, huddles, and minute-to-minute interaction

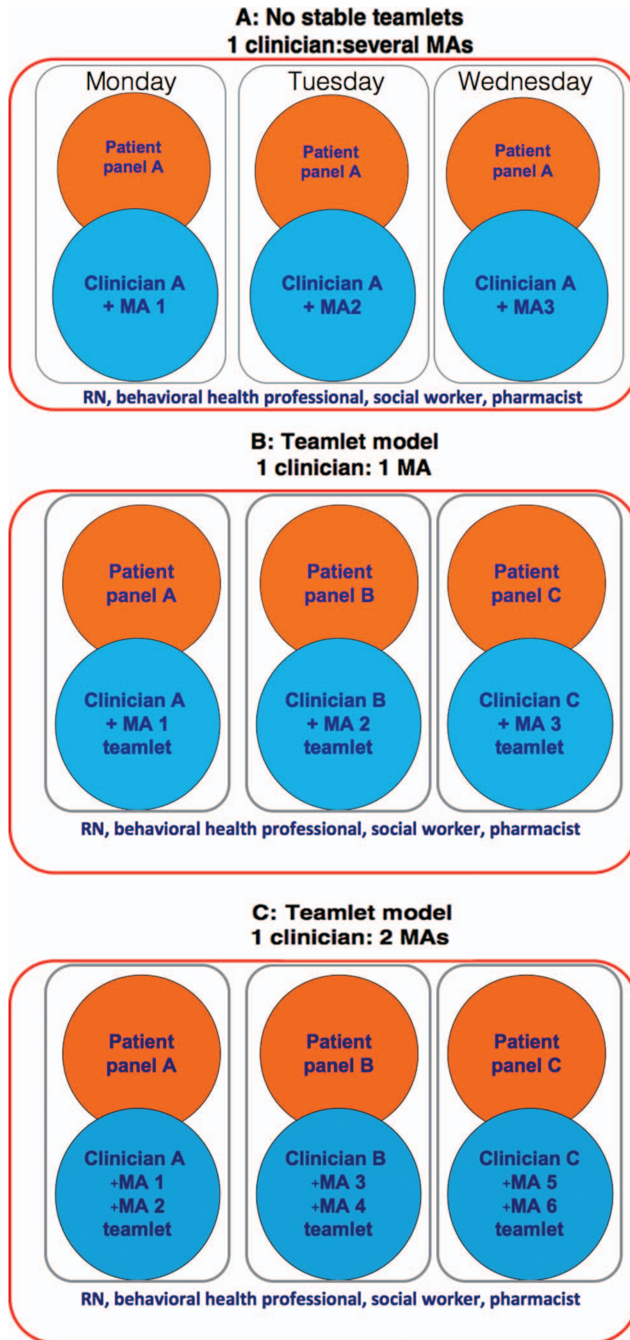

Figure 1. Team and teamlet structures. See the online article for the color version of this figure.

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more support staff—usually medical assistants (MAs)—who work together daily (see Figure 1C). Other team members, for example, a registered nurse, behavioral health provider, or health coach, support a few teamlets. In these practices, patients are empaneled to the teamlet so that both the clinician and MA know and feel responsible for their patient panel and patients know both teamlet members. Teamlets are modified in residency-teaching practices and other practices with part-time physicians.

The teamlet model has several advantages: (a) Patients prefer small practices over large ones (Rubin et al., 1993), and teamlets allow patients of large practices to feel as though they are cared for in a small practice; (b) clinicians working in stable, collaborative teamlets experience less burnout than those working in nonstable team structures (Willard-Grace et al., 2014); (c) in some practices visited, teamlets provide a structure within which MAs assume responsibility for some aspects of their panel's health, for example preventive services (Willard & Bodenheimer, 2012). However, while some physicians and medical assistants paired into teamlets develop trusting relationships, others exhibit contentious behavior (Elder et al., 2014).

High-performing practices usually make their teams visible to patients through business cards listing team or teamlet members and through team member photos. Teams visible to patients, with team members knowing their patients, are associated with improved patient experience of care (Rodriguez, Rogers, Marshall, & Safran, 2007).

Implementing team models is challenging until leadership prioritizes team and teamlet members always working together without derailment by staffing issues. Another challenge is pairing clinicians and MAs, which requires consideration of schedules, language concordance with the patient panel, and compatibility of work styles (Elder et al., 2014). We observed some leaders garnering buy-in for teamlet pairings during staff meetings, in conversations with individual clinicians and MAs, and adjusting dysfunctional teamlet pairings.

Colocation

About half of practices visited have colocated their teams; these practices reported that colocation dramatically improves team cohesion and communication among team members. Rather than locating MAs and nurses in a central island and clinicians in private offices, teamlet partners work side by side at adjacent work stations and the entire team shares a common space (i.e., a pod; Willard & Bodenheimer, 2012). Because colocation can require expensive architectural remodeling, some practices have found alternative ways of relocating team members in their existing architecture. Colocated practices have reported that some physicians initially resisted colocation but embraced it when finding that it saved them time. In three studies, colocation was associated with improved team collaboration and coordination (MacNaughton, Chreim, & Bourgeault, 2013; O'Malley, Gourevitch, Draper, Bond, & Tirodkar, 2015; Sims, Hewitt, & Harris, 2015); however, one study added that small shared spaces can lead to feelings of crowding and having one's privacy invaded (MacNaughton et al., 2013).

Culture Shift: Share the Care

"Share the care" is both a paradigm shift and a concrete implementation strategy. The paradigm (culture) shift transforms the practice from "I" to "We." "I" refers to the lone doctor-with-helpers model, in which the clinician assumes all responsibility, makes all decisions, and delegates tasks to other team members. Share the care ("We") means reallocated responsibilities, not only tasks, so that all team members contribute meaningfully to the health of their patient panel (Ghorob & Bodenheimer, 2012). This culture shift is not easy; Veterans Health Administration teams often fail to distribute patient responsibilities to nonphysician team members (Hysong et al., 2014). More skilled team members are reluctant to delegate to lesser trained teammates because they do not trust their skill level (Solimeo, Ono, Lampman, Paez, & Stewart, 2015).

In our site visits, we found that practice teams embracing the culture shift consider that the patient panel is the team or teamlet's panel, not the clinician's panel. Some teams engaged in activities to create a team identity and build camaraderie, for example, drawing a picture of their existing team and of their dream

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team, and creating a team name. Some teams wrote statements of the team's values and agreed on concrete team goals such as "By June 2015, all our patients will know they belong to the Blue Team."

On some visits, we facilitated two exercises to help teams redistribute activities based on licensure and skill. These exercises, "Share the care: Who does it now?" and "Share the care: Who could do it?" were popular among participants and are displayed in Figures 2 and 3.

Some research studies support the culture shift. Medical assistants taking responsibility to ensure that all patients have received appropriate cancer screening improved screening rates (Bodenheimer, Willard-Grace, & Ghorob, 2014). Medical assistants providing health coaching for patients with chronic conditions improved diabetes and lipid outcomes compared with clinician-only care (Willard-Grace et al., 2015). Nonclinician team members acting as scribes saved physician time by 75 minutes per 4-hr clinic session while increasing patient satisfaction (Reuben, Knudsen, Senelick, Glazier, & Koritz, 2014). Teams with a collaborative team climate were associated with better diabetes management, patient satisfaction, and patient activation (Becker & Roblin, 2008; Bower, Campbell, Bojke, & Sibbald, 2003). An observational study of 27 practices found that moving toward a "share the care" culture increases physician and staff satisfaction (O'Malley et al., 2015). Team members working to the top of their competency level was associated with lower burnout among team members. However, understaffed teams and teams facing a stressful, fast-moving environment had higher burnout scores (Helfrich et al., 2014).

On our visits, we found that high-performing practices have made major strides in sharing the care among team members, but that some clinicians find it difficult to share responsibility for a patient panel because the clinician has superior medical training and retains legal liability. Nonclinical staff may oppose expanded roles due to lack of training and concern about having sufficient time for new responsibilities. In addition, many practices do not receive payment for services performed by nonclinicians.

Defined Roles With Training and Skills Checks

We found that once there is a commitment to sharing the care, practice leadership, consulting with staff, defines roles for team members. Some practices—mostly larger ones—committed substantial time, money, and resources into training, mentorship, and observation and feedback of team members' competence for new roles.

Standing Orders/Protocols

Many practices visited have created physician-approved standing orders that empower nurses, medical assistants, and other nonclinician team members to provide routine services to patients on their panel with minimal or no clinician time required. Standing orders, which must conform to scope of practice laws, allow teams to provide more services to more patients, which can add capacity and thereby improve access (Bodenheimer & Smith, 2013). An effective standing order specifies the conditions under which a particular staff member can provide care to patients, using nationally accepted guidelines (see Figure 4).

Defined Workflows and Workflow Mapping

Primary-care practices perform hundreds of complex, intersecting workflows, for example, how MAs room patients, how receptionists handle different phone calls, how prescriptions are refilled, and how patients are informed of their lab results. Workflows in many high-performing practices are clearly mapped so team members understand who performs which functions, in what order, and how handoffs are made among team members. In some, but not all practices visited, workflows were mapped as a team activity.

Staffing Ratios Adequate to Facilitate New Roles

Some site-visited practices added nonclinician team members to allow for sharing the care. Because the additional staff members represent costs without revenue, other practices were reluctant to increase their staff/clinician ratio. Some practices that added MA, RN, and/or health coaches were able to increase the number or intensity of clinician visits, thereby

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Directions: Place a tick mark in the Role column that matches who is currently charged with doing the task in Column 1. If more than one person, you can place a tick mark in more than one Role column. Then, add up the tick marks vertically and place the total number of tick marks in the totals row. Note: Clinician = MD, NP or PA

	Who does it now?				
Tasks	Clinician	RN	LVN	Medical assistant	Pharmacist
Orders mammograms for healthy women between 50 and 75 years old					
Refills high blood pressure medications for patients with well-controlled hypertension					
Performs diabetes foot exams					
Reviews lab tests to separate normals from abnormals					
Cares for patients with uncomplicated urinary tract infections					
Finds patients who are overdue for LDL and orders lipid panel					
Prescribes statins for patients with elevated LDL					
Does medication reconciliation					
Screens patients for depression using PHQ 2 and PHQ 9					
Follows up by phone with patients treated for depression					
Totals					

Figure 2. Share the care: Who does it now?

generating additional revenue while improving outcomes and clinician satisfaction (Anderson & Halley, 2008; Blash, Dower, & Chapman, 2011). Adding more highly paid RNs, pharmacists, or behaviorists often requires that their visits be reimbursed, which some practices have achieved with brief clinician involvement in these visits. To implement a successful patient-

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Directions: Place a check mark in the column that matches who you think could do this task **in the future in an ideal primary care practice**. Only one check mark per task, please. Note: Clinician = MD, NP or PA.

	Who could do it?				
Tasks	**Clinician**	**RN**	**Front desk**	**Medical assistant**	**Pharmacist**
Take initial patient history using EMR template					
Order mammograms for healthy women between 50 and 75 years old					
Refill high blood pressure medications for patients with well-controlled hypertension					
Decide whether to refill narcotics for chronic pain patients					
Use protocols to squeeze in patients wanting same-day appointments					
Perform diabetes foot exams					
Review lab tests to separate normals from abnormals					
Inform patients of normal lab results					
Manage warfarin doses for patients needing anti-coagulation					

Figure 3. Share the care: Who could do it?

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centered medical home, primary-care practices need 4.25 staffing personnel for each full-time clinician, a 59% increase from current average staffing ratios (Patel et al., 2013). In the U.S. Department of Veterans Affairs system, respondents who reported being on a team staffed to the recommended 3.1 ratio had significantly lower odds of burnout (Helfrich et al., 2014).

Ground Rules

A number of practices have created ground rules in two areas: to ensure productive, respectful meetings, and to guarantee high-functioning teamwork for patient care. Some of these practices have initiated discussions of the ground rules among team members. For example, if

	Clinician	RN	Front desk	Medical assistant	Pharmacist
Order and give routine immunizations					
Do medication reconciliation for patients taking 9 medications					
Screen patients for depression using PHQ 2 and PHQ 9					
Keep track of how long it takes for patients to get appointments					
Treat patients with routine urinary tract infections					
Discuss colorectal cancer screening options with patients					
Prescribe statins for patients with elevated LDL					
Do phone follow up for patients treated for depression					
Find patients overdue for LDL and order labs					
Prescribe statins for patients with elevated LDL					
Lead daily huddles					
Management of most patients with hypertension					

Figure 3 (continued).

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everyone—including clinicians—agrees that clinicians are expected to come to clinic on time, there is a basis on which to hold clinicians accountable.

Meetings without ground rules may result in a few people doing most of the talking while others are disengaged. We observed meetings in practices with ground rules in which team members dominating the conversation were asked to "step back" while those participating little were encouraged to "step up." Other ground rules for effective meetings include agenda preparation, facilitation, note taking, time keeping, and the process for making decisions.

Communication: Team Meetings, Huddles, and Minute-to-Minute Interaction

For the larger team, regular meetings are typically scheduled monthly to discuss team-

Prescription Refill Standing Orders for RNs			
Hypertension			
Appointment last 6 months	**Systolic BP = 140/90 or below**	**Normal creatinine and potassium in last 6 months**	**How to renew**
Yes	Yes	Yes	3 month supply + 1 refill
	Yes or No	No[a]	1 month supply + order labs, give appt, no refill
	No	Yes	1 month supply + give appt, no refill
No	Yes	Yes	3 month supply + give appt, no refill
	No	Yes or No[a]	1 month supply + give appt, no refill

[a] The standing order would specify seriously abnormal levels that would trigger urgent clinician review.

Figure 4. Sample medication refill standing order.

related issues. Teamlet-level communication takes place at daily huddles and during minute-to-minute interactions. Practices with colocated teams reported that real-time communication is greatly enhanced by colocation.

Huddles allow teamlets to meet briefly to discuss that day's patients—what tasks need to get done by whom. Prior to the huddle, MAs typically review ("scrub") patient charts to identify care gaps, care coordination needs, and other information that guides the visit. Although no evidence associates huddles with improved clinical outcomes (Shunk, Dulay, Chou, Janson, & O'Brien, 2014), a study of huddles among Veterans Health Administration teamlets found that staff participating in huddles, compared with those not attending huddles, reported better practice climate and work satisfaction (Rodriguez, Meredith, Hamilton, Yano, & Rubenstein, 2014).

Barriers to Team-Based Care

All practices we visited faced significant barriers to team formation. Payment methods that fail to reward nonclinicians to meaningfully contribute to patient care is a universal barrier. Difficulty financing adequate staff ratios results from dysfunctional payment. Time for training and mentoring is hard to find. Practice schedules undermine stable teams in which team members always work together. Clinician and staff resistance to change is understandable in the hurried atmosphere of primary care; when rushed and stressed, it is easier to do what one is used to doing. Although these challenges are daunting, we found many practices with determined and thoughtful leaders who have succeeded in implementing and sustaining high-performing teams.

Discussion

Based on detailed observations of care teams at 29 high-performing primary-care practices, we compiled a list of nine elements commonly found in the teams of these practices. A nascent research literature on primary-care teams suggests that some of these elements are associated with improved care, better patient experience, and greater staff satisfaction, but that practices have difficulty implementing these elements.

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Of these nine elements, two stand out as foundational: (a) a stable team structure, visible to patients, in which team members are not shuffled from one team to another, and (b) a team culture that moves toward all team members, not only clinicians, viewing a defined panel of patients as their responsibility and meaningfully sharing the care of those patients. It is these elements that underlie the difference between OldWay and NewWay clinics.

Studies of primary-care teams conclude that the transformation from an OldWay to a NewWay clinic is difficult, and that team members must work collaboratively with one another for the team to prosper (Bower, Campbell, Bojke, & Sibbald, 2003; Hysong et al., 2014; Ladebue et al., 2014; O'Malley et al., 2015; Sims, Hewitt, & Harris, 2015). However, practices trying to improve cannot operationalize the advice that team members need to get along with each other. The nine elements proposed here may provide more concrete ideas on building teams.

The framework provided here has important limitations. It was formulated based on observations of practices that are not a representative sample of high-performing practices and used a nonspecific definition of "high-performing practice." The nine elements of high-performing teams were generated without employing standard qualitative research methods. Moreover, other frameworks for team formation have been proposed, e.g., *TeamSTEPPS* (Agency for Healthcare Research and Quality, 2013), lean management (Institute for Healthcare Improvement, 2015), Change Concepts (Safety Net Medical Home Initiative, 2015), and others.

The team-building guide proposed here suggests some practical elements that primary-care practices may wish to consider in implementing care teams. Practitioners can learn from high performers and succeed in (a) reorganizing themselves into stable teams, perhaps with a teamlet core, to which a defined group of patients is empaneled; (b) creating standing orders and training nonclinicians to expand the scope of their responsibilities; (c) colocating teams to enhance communication; and (d) agreeing on ground rules that assist team members to work cooperatively.

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