COMMENTARY

Share the Care™: Building Teams in Primary Care Practices

Amireh Ghorob, MPH and Thomas Bodenheimer, MD

Everyone agrees that health care is a team sport. But creating and nurturing successful teams has proven to be difficult.[1] Basketball enthusiasts and primary care team champions agree that forming a dream team is not as simple as thrusting individuals into a group. To engage all team members equally, everyone must agree on the old adage, "There is no 'I' in team."

For primary care practices to build great teams, we suggest a transformed team model and a list of key team characteristics. We call the new model "Share the Care."

Share the Care Paradigm

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, whose job is to assist the clinician. The language "delegating tasks from doctor to team" suggests that team building means less work for the doctor and more work for others. Nonclinician team members often resist such delegation.

Share the Care, the "we" paradigm, means reallocating responsibilities, not just tasks, so that all team members share responsibility for and contribute meaningfully to the health of their patient panel. The patient panel is the team's panel, not the clinician's panel.

Submitted 6 January 2012; revised 6 January 2012; accepted 6 January 2012.

From the Center for Excellence in Primary Care, University of California, San Francisco.

Funding: none.

Conflict of interest: none declared.

Corresponding author: Amireh Ghorob, MPH, Department of Family and Community Medicine, University of California, SF, Building 80–83, San Francisco General Hospital, 995 Potrero Avenue, San Francisco, CA 94110 (E-mail: ghoroba@fcm.ucsf.edu).

Concretely, what is the difference between delegation of tasks ("I with helpers") and Share the Care ("we")? The key team characteristics needed to implement Share the Care are colocation, concrete goals agreed on by all team members, mapping team workflows, training, regular team meetings, ground rules, and—most important of all—standing orders.

Colocation

Colocation means that all team members, including clinicians, work together in one space, allowing for easy minute-to-minute communication. Colocation is a test of the "I" to "we" paradigm shift because many clinicians resist giving up their separate offices. Clinicians in colocated practices learn to value working side by side with other team members.

Team Goals

Specific team-created goals allow nonclinician team members to take responsibility for the health of a patient panel. Examples of goals include "increasing the percent of appropriate patients receiving colorectal cancer screening from 25% to 75% by January 1, 2013," or "reducing the percent of diabetic patients with glycosylated hemoglobin >9 from 20% to 10% by July 1, 2012."

Mapping Team Workflow

Workflow mapping involves the entire team creating a step-by-step diagram of each primary care process, for example, refilling prescriptions or performing panel management (ensuring that all patients receive all evidence-based preventive and chronic care services). Mapping workflows determines the division of labor within the team and indicates how team members interact with each other. The exercise of mapping workflows is in itself a team-building process.

Team Training, Meetings, and Expectations

The need to train all team members to assume their responsibilities is evident. Following-up initial training with booster sessions plus mentoring and feedback keeps team members' skill sets sharp and up-to-date. Regular team meetings can provide opportunities for booster sessions, while daily huddles organize the day's work. For communication and decision making, teams need ground rules—for example, who makes decisions, what are the expectations for coming to meetings on time, and how is feedback given when a team member is uncooperative—to encourage team cohesion and team spirit.

Standing Orders

One cannot overemphasize the need for clinic leaders to create standing orders that empower nonclinician team members to assume patient care responsibilities. Without standing orders, all responsibility and all decisions remain with the clinician. Standing orders are the chief mechanism for moving from "I" to "we." In high-performing primary care practices, nurses have standing orders to treat—without clinician involvement—positive Streptococcus or Chlamydia cultures or urinary tract infections in uncomplicated patients. In some practices medical assistants use standing orders to give routine pediatric and adult immunizations without checking with the clinician. Other practices adopt standing orders that empower nurses or medical assistants to refill hypertensive or cholesterol medications for well-controlled patients without involving the clinician. Without standing orders, teams cannot share the care.

In This Issue

This issue of the *Journal* contains several articles on primary care teams. Share the Care teams will not succeed unless engaged team members derive satisfaction and joy from providing meaningful care. Roth and Markova[2] define "joy in work" as the satisfaction that comes with a job well done, in concert with team members and patients. The authors emphasize that joy can emerge from the synergy of 3 foundational processes of teamwork: trust among the team members, involving all team members in decision making, and dedicating time for communication.

Markova et al[3] highlight the challenges of shifting the culture from the old paradigm to a team-based approach in a family medicine residency training clinic. Their recipe for effective and sustainable teams calls for ingredients such as setting clear performance expectations (defining roles) for each team member, daily huddles, and training leaders to utilize nonauthoritarian techniques.

Tapp et al[4] implement a multidisciplinary team in a community clinic to provide integrated care for poorly controlled diabetic patients with comorbid depression. The team was comprised of physicians, nurses, behavioral medicine interns, pharmacists, social workers, information technology specialists, and office schedulers, each with a clearly defined role. The interns coached patients to develop behavior change action plans, the pharmacists coached patients about timely medication titrations, and the information technology specialists served as panel managers to identify patients overdue for procedures or those with clinical values above goal.

Kaferle and Wimsatt[5] utilize nurses to increase the number of patients with asthma who use evidence-based asthma action plans. Margolius et al[6] examine how physicians react to team-based management of patients with hypertension, in which health coaches were empowered to up-titrate medications for patients with poorly controlled blood pressures using patient-specific, physician-created algorithms.

The practices described in these articles have made progress in delegating tasks from clinicians to other team members, but overall have not yet achieved the paradigm shift to Share the Care by empowering the team through colocation, team-determined goals, workflow mapping, and—most importantly—standing orders.

Why Have Teams?

If team-based care is so difficult, why have teams at all? Two compelling reasons come to mind. First, given the large panels of most primary care practices, inevitable because of the primary care clinician shortage, clinicians cannot do everything expected of them. It would consume 18 hours per day for a primary care physician without a team to provide high-quality chronic and preventive care to a panel of 2500 patients, which is close to the average panel size for US primary care.[7,8] A team is needed to share chronic and preventive care because the physician cannot do it alone. As the articles in this issue demonstrate, a great

deal of chronic and preventive can be performed with high quality by nonclinician team members. Second, the team is needed to increase capacity for patient encounters for a primary care practice to deliver patient-centered access. With a well-functioning team, nurses, pharmacists, and medical assistants trained as health coaches and panel managers can substantially increase the capacity to provide chronic and preventive care, thereby improving access.

Finally, sharing the care requires change on the part of clinicians. Some resist sharing the care for four reasons, three of which are valid. First, nonclinician staff may not have the proper training to take on new responsibilities; second, they may not feel accountable for providing high-quality care; and third, they may not have time to assume new roles. The fourth, nonvalid reason is that some physicians believe that "only I can do it." The fourth reason is best addressed by solving the first 3: making sure nonclinician staff are well-trained in new roles, building in accountability by arranging that clinicians always work with the same nonclinician team members (teamlets), and analyzing workflows to ensure that everyone has the time and resources needed to do their new jobs well. If these barriers are overcome, many clinicians will come to enjoy sharing the care.

References

1. Bodenheimer T, California HealthCare Foundation. Building teams in primary care: lessons from 15 case studies. July 2007. Available at http://www.chcf.org/publications/2007/07/building-teams-in-primary-care-lessons-from-15-case-studies. Accessed January 19, 2012.
2. Roth L, Markova T. Essentials for Great Teams: Trust, Diversity, Communication…and Joy. J Am Board Fam Med 2012;25:146–8.
3. Markova T, Mateo M, Roth LM. Implementing teams in a patient-centered medical home residency practice: lessons learned. J Am Board Fam Med 2012;25:224–31.
4. Tapp H, Phillips SE, Waxman D, Alexander M, Brown R, Hall M. Multidisciplinary team approach to improved chronic care management for diabetic patients in an urban safety net ambulatory care clinic. J Am Board Fam Med 2012;25:245–6.
5. Kaferle A, Wimsatt L. A team-based approach to providing asthma action plans. J Am Board Fam Med 2012;25:247–9.
6. Margolius D, Wong J, Goldman ML, Rouse-Iniguez J, Bodenheimer T. Delegating responsibility from clinicians to nonprofessional personnel: the example of hypertension control. J Am Board Fam Med 2012; 25:209–15.
7. Yarnall KSH, Pollak KI, Ostbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention? Am J Public Health 2003;93:635–41.
8. Ostbye T, Yarnall KSH, Krause KM, Pollak KI, Gradison M, Michener JL. Is there time for management of patients with chronic diseases in primary care? Ann Fam Med 2005;3:209–14.