With a little effort, your team can take its performance to new heights.

6 Characteristics of Effective Practice Teams

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In a 2005 study published in the *Annals of Family Medicine,* researchers estimated the number of hours a primary care physician would have to work each day to provide recommended chronic disease care to an average panel of 2,500 patients.[1] Looking at the 10 most common diseases only, they found that it would require 10.6 hours per day. In separate studies, researchers found that providing recommended preventive care would require 7.4 hours per day[2] while acute care would require 4.6 hours per day.[3] This amounts to 22.6 hours of work per day.

The moral is that physicians cannot do this work alone. They need a team. To quote Bruce Bagley, MD, medical director of quality improvement for the American Academy of Family Physicians, "Primary care is a team sport."

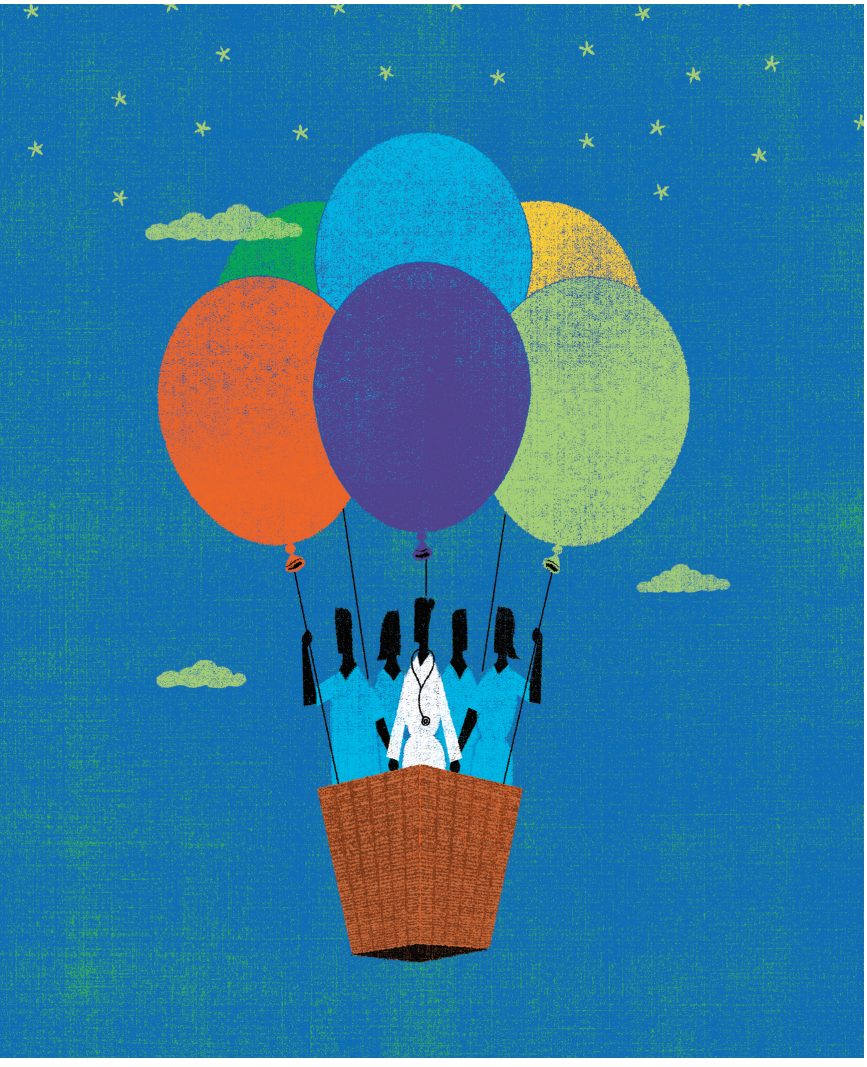
About 15 years ago, Ed Wagner, MD, and colleagues at Group Health Cooperative of Puget Sound first highlighted the importance of the practice team. They looked at sites all across the country that had the best outcomes for patients with chronic diseases and then designed a care model based on what they found.[4] Although their model involves multiple elements, they all funnel down through two main components: an informed, activated patient and a prepared, proactive practice team.

So what's the big deal? Isn't every practice already a team? The answer is both yes and no. Most practices are a team in the sense that their physicians and staff work alongside each other each day and generally get along, but true team-based care requires more than that, as this article will discuss.

Six key characteristics

From our experience both in practice and as part of quality-improvement programs sponsored by groups such as the Institute for Healthcare Improvement and the Robert Wood Johnson Foundation, we have learned that effective practice teams embody the following characteristics.

1. Shared goals. If asked to identify their goal at work, most staff members would probably say that it is to provide high-quality, patient-centered care. However, their unspoken, even unconscious goal is



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probably to please the doctor. Why? Because the doctor is usually the boss, or at least is someone with authority over staff. When pleasing the doctor supersedes working for the patient as the overall goal, it can hamper the practice's ability to improve and to grow. For example, staff members may not tell a physician when his or her actions make their lives unnecessarily hard, or they may be too afraid to discuss mistakes or ask questions. At the same time, because physicians usually want their staff to like them too, they aren't always honest about problems either. This kind of culture may seem polite, but it actually interferes with what should be the shared goal: working for the patient.

Once a practice gets to the point where everyone agrees that they are working for the patient and are comfortable having tough conversations with one another about improving processes and systems, they need to go one step further: Everyone on the team must know what the individual patient's goal is. That is the true shared goal. For example, a practice might have a patient who is overweight, does not exercise, smokes, has diabetes, has a wife with Alzheimer's, etc. This patient could have myriad goals, but the people interacting with him need to know the one thing that is currently most important to him. Without that knowledge, they won't know what to focus on and they cannot be good team members.

2. Clearly defined roles. As practices move from a culture in which the doctor is at the center of everything to a culture in which staff members are engaged in accomplishing the shared goal, it is vitally important to be clear about who is going to do what. If you fail here, things are going to fall between the cracks, and then the typical physician's response will be to swoop everything back into his or her lap.

Recently, Family Care Network [Dr. Safford's group] was working on improving care for patients with hypertension. One of the interventions being introduced was that if a patient had elevated blood pressure when vital signs were taken, someone was supposed to take the measurement five minutes later to see whether it had come down. The question, of course, was who is going to do this work? Although the clinical assistants roomed the patient and took the vitals initially, they weren't always available five minutes later for the repeat measurement, so the task was often left for the doctor. However, when the task was left for the doctor, it was completed only about 40 percent of the time. In the hustle and bustle of a typical office visit, the physician simply could not remember to do it. So the team clearly needed to make this one person's responsibility, and the best choice was the clinical assistant. Initially, one of the doctors was adamant that he was not going to hand off this task to the clinical assistant because, it turns out, he did not trust her to take blood pressure well. He soon realized, however, that he either needed to train his clinical assistant or hire someone new. Trying to do everything yourself because you don't trust others to do the task as well as you do is not a workable solution.

Standing orders can be a helpful tool for clarifying roles. The clinical assistants in Family Care Network are delegated responsibility for preventive care, and they follow standing orders that communicate what preventive care is appropriate and what tasks they can take care of on their own. For example, if a patient needs a tetanus or

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Effective practice teams have shared goals that focus on the patient and have clearly defined roles.

They also share knowledge and skills so that every team member can contribute to his or her fullest potential.

pneumococcal immunization, he or she will have already gotten it from the clinical assistant by the time the physician walks into the exam room.

The clinical assistants follow protocols for prescription refills as well. For example, if a patient needs a refill of atenolol or hydrochlorothiazide for high blood pressure, the clinical assistant can consult the protocol. If the patient has been seen within the last six months for hypertension, if his or her blood pressure was at target, and if he or she has had the appropriate lab work done (a metabolic panel every six months), then the clinical assistant can approve the refill for another six months. With these protocols in place, the practices have actually done a better job identifying patients who need checkups or lab work than when the physicians were trying to manage all of this by themselves.

One word of caution: While practices need roles to be clearly delineated, be careful that you do not create silos in the process, where team member A does one thing, team member B does the next thing, and so on with long waits and no communication between steps. Staff members cannot simply sit back and say, "That's so-and-so's job, so I'm not going to help out." Yes, everyone has core roles, but teams need fluidity. They must talk to each other, their work may need to overlap at times, and they must make it work for the patient's best interest.

3. Shared knowledge and skills. Once you've embraced the idea that your staff can take on more responsibility, don't neglect to train them well in the details of these new tasks, or you will be setting them up for failure. For example, when Family Care Network decided to let its staff be responsible for preventive care, the clinical assistants had to be trained in how to have the preventive care conversation with patients. Immunization rates can vary significantly depending simply on the way the clinical assistant broaches the subject – "So, would you like to have a tetanus shot today?" versus " I can see you are overdue for your tetanus shot. It's really important to all of us on your team, and especially Dr. Safford, that you stay up to date on your immunizations, so we're going to give one today, okay?" Spending a little bit of time up front training your staff to do things the right way will more than pay for itself down the road.

Another point to remember is that if team members are going to be expected to take on new tasks and do them well, you have to give them both the information and the time they need to do the work. This is perhaps the biggest culture change for doctors. For example, if you delegate diabetic foot exams to your clinical assistant, then you need to give that person enough time to complete the task before you start knocking on the exam room door.

4. Effective, timely communication. There are two pieces to effective communication. First, you need effective communication among team members when the patient is in the office. Larry Mauksch, MEd, from the Department of Family Medicine at the University of Washington, has observed that most

WHAT COULD YOU DELEGATE?

Many employees are capable of taking on more responsibility than they currently have and would actually appreciate being entrusted with higher level tasks, within reason. Here are just a few ideas of tasks physicians could delegate. Although the list might be different for your practice, the point is to re-examine roles and consider how each team member can contribute the most value to the patient care process.

To your front desk:

- Notifying patients of normal test results
- Entering orders for labs, X-rays, and referrals

To your clinical assistant:

- Performing diabetic foot exams
- Approving prescription refill requests (with the assistance of protocols)
- Administering immunizations
- Gathering portions of the history

About the Authors

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patients, when they come to their doctor's office, will tell their most pressing concern to only one member of the team. Some patients will tell it to the scheduler, others will tell a nurse, and others will tell the physician, but they rarely repeat it. So, team members need to be deliberate about finding a system for sharing that information with one another. In the old days, practices used sticky notes. Today, many practices use computerized notes to communicate with each other when the patient is in the office. For example, an elderly person coming to your office for a routine checkup might have told the scheduler that she was feeling fine, but the receptionist may observe that the patient could barely stand up to get to the bathroom. These observations are important and need to be shared so that the entire care team can work together to meet the patient's needs and reinforce his or her goals.

The other part of effective and timely communication is how you and your team members talk to one another about performance. Ideally, when a team member learns something new, he or she should get a chance to practice it, receive feedback, practice it some more, receive more feedback, and so on. But that doesn't always happen in a busy office. Instead, physicians tend to give instructions once and then never discuss the issue again. Particularly for newer physicians who don't typically have experience managing staff, performance conversations can be uncomfortable, but they need to be able to provide constructive feedback to staff, and vice versa. For example, when Family Care Network first implemented an electronic health record, the staff realized that physicians could send test results straight to a front-desk person who actually had time to notify patients via standardized letters about their results instead of sending test results to the nurses. They asked the physicians to follow this new process, but the majority of the time the physicians were still sending the requests to the nurses. Instead of going back to the doctors and reminding them of the new process, the nurses were simply forwarding those messages to the front desk. When this was finally pointed out and nurses were given explicit permission to send these requests back to the physicians, communication vastly improved.

5. Mutual respect. Building a culture of mutual respect may seem like a touchy-feely issue, but it is foundational to having an effective team. If we don't give people a chance to do their job, if we complain about others behind their back, if we are quick to point out others' failures, and so on, we are not really respecting them or being good team members. While your practice may never perfect this trait, the important thing is that you value it, strive for it, and encourage your physicians to lead the way by modeling respectful speech and behavior.

6. An optimistic, can-do attitude. There's an old saying that "Nothing shares better than a bad mood." Often, it's the leaders in an organization who set the mood. In a medical practice, this responsibility usually falls to the doctors. So, for example, if a physician rushes into the office late after a stressful hospital meeting or a long night of being on call, doesn't say hello to staff, and starts issuing orders, that physician has just set a certain tone for the day. A better approach would be to pause, take a deep breath, project an

UPCOMING ONLINE SEMINAR

On May 30 at 1 p.m. CDT, Dr. Safford will present a one-hour online seminar on team-based care sponsored by TransforMED and the American Academy of Family Physicians. AAFP members can register at http://www.aafp.org/d-exchange, where you'll be invited to join Delta Exchange, an online community hosted by TransforMED with free membership for AAFP members.

> Trying to do everything yourself because you don't trust others to do the task as well as you do is not a workable solution.

Effective teams communicate with one another in a timely way for the good of the patient.

They also have tough conversations with one another about their performance.

A positive attitude, particularly in a physician, can set the tone for the entire team.

optimistic attitude, and greet your staff by name when you arrive in the morning. This may sound like a little thing, but it will ripple throughout your practice.

A team will be more likely to change its behavior if there is a compelling reason for doing so.

How to get there

If your practice doesn't already embody these six characteristics – and most practices don't – the question is how do you get everyone to change? There are several ways. First, because change is difficult, you need to identify a reason for change – something that compels people to do something difficult. Maybe the reason is saving time, reducing frustration, or even feeling more empowered or competent at work. At first, people will only be willing to try a few simple things, so start with the easiest changes and build from there. If you're meeting a complete wall of resistance, try piloting a change in your own little sphere of the practice and do it so well that everyone else wants to take part in it. Another option, if you have a team member who is particularly resistant, is to find out who that person trusts in the practice and get that person on board. (For more help in this area, see "The Key to Implementing Change In Your Practice," *FPM,* September/October 2008, http://www.aafp.org/fpm/2008/0900/pa5.html, and "Implementing Change: From Ideas to Reality," *FPM,* January 2003, http://www.aafp.org/fpm/2003/0100/p57.html.)

Piloting team-based care in one sphere of the practice can help others see its benefits and buy into the concept.

As more and more staff members catch a vision for team-based care and become willing to participate, the culture will change throughout your practice. FPM

Send comments to **fpmedit@aafp.org.**

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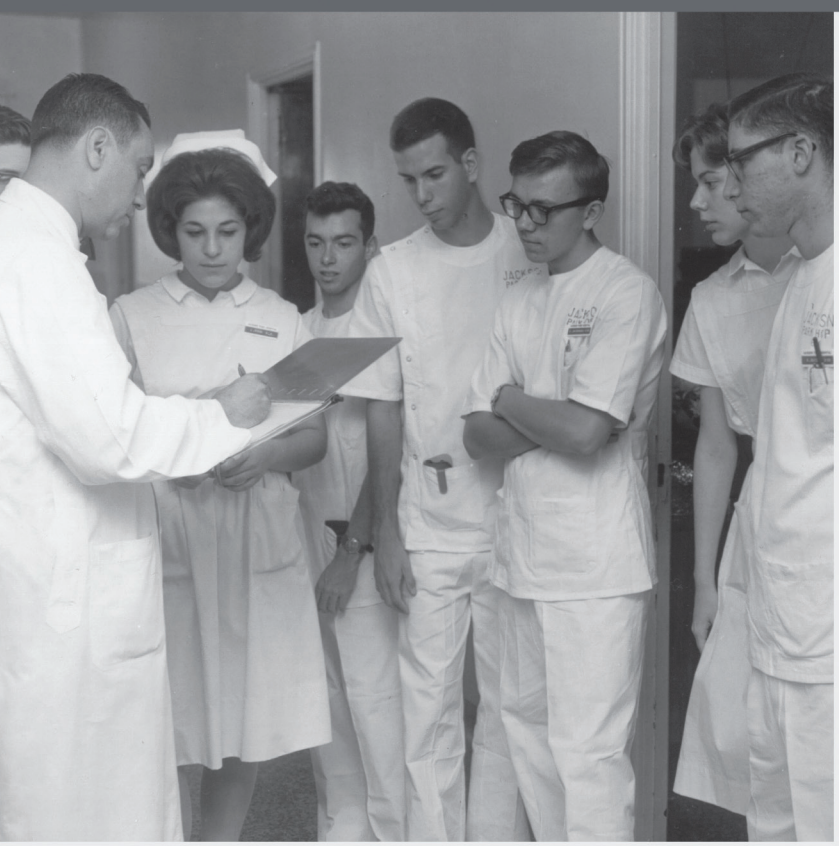

Dr. Maynard Shapiro (AAFP President, 1968-1969) with medical trainees (part of a special program to acquaint college-bound students with medicine) at Chicago's Jackson Park Hospital, 1963, from CHFM photograph collections.