Chapter 2
From a Squad to a Team: Creating Team-Based Care

2.1 Understanding the Change

The changes represented by the implementation of the PCMH model that make a positive difference for the experience of patients include receiving team-based care, seeing the same team members consistently, and having access to case management [1]. Certainly, a commitment to patient-centered care would require an understanding and implementation of team-based care.

"Team-based care" is a concept that is applied broadly within and across healthcare settings. A "high-functioning team" could describe care in an inpatient setting, in which case it would describe an improvement in the sequential care given by different shifts of clinicians and staff. Another use of "team" might represent clinicians and staff that a patient would encounter across different healthcare settings who work to achieve continuity of care plans and to share information. For our purposes, "team-based care" represents care from a group of people who work together in real time to serve a shared panel of patients in a primary care setting.

In an Institute of Medicine discussion paper on the principles and values of team-based care [2], the principles of successful team-based care are identified as shared goals, clear roles, mutual trust, effective communication, and effective process and outcomes. These represent a good list for assessing the functioning of a care team in primary care. They also represent a challenge. Creating a team that exhibits these qualities requires a substantial process of evolution for most practices, one that can be stressful on clinicians, staff, and patients.

In Chap. 1 we discussed the fact that the practice change elements of the patient-centered medical home have been studied extensively, whereas the fundamental change in the relationship of the doctor to the patient and how to create that change have been much less well outlined. Looking at the guidance for developing a PCMH, one could assume that a better organized practice that is easier on the doctor and that delivers better care more smoothly will create the core change in the doctor-patient relationship such as the IOM calls for in the "rules" for patient-centered care. The

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evaluators of the National Demonstration Project *did not* find that to be the case. The change in the doctor's role, from being the creator of a treatment plan which the patient should follow to being a facilitative guide to better health who offers whatever type of leadership is needed by each patient, constitutes a challenge, in skills and in identity, for many doctors.

A similar situation exists in the realm of team-based care. Ways of getting to the routines of interaction that characterize high-functioning teams have been described at some length. How to do a huddle and how to develop workflows that involve other members of the team more substantively in the care process and that take pressure off the doctor have been described in detail [3]. There are good examples of tools for making this transition on the web. One particularly well-worked-out example is the Steps Forward program offered by the American Medical Association (www.Stepsforward.org). The change in the role of the doctor in relation to the rest of the team, from the creator of the treatment with a supporting cast to a facilitative leader enabling the self-organizing energy of the same group, has been much less extensively described. For many doctors that change is the most challenging aspect of the transition. The ways to effect this change need to be outlined in much better detail.

Reorganizing the practice, in itself, does not bring about the wanted change in doctor-patient relationship, and reorganizing the team, in itself, does not bring about the wanted change in doctor-team relationships. It was the assumption at the start of the National Demonstration Project that if the whole team, physicians, and support staff met regularly, communicated more intensively, and worked together to improve the quality of the care based on meaningful data, the transi- tion in roles and in the experience of team members would happen. The authors of the NDP evaluation did not find this to be true [4]. They reported a finding that was unexpected, the necessity for new "mental models of care" that go along with a team-based practice organization as well as those that are needed for patient-centered care. Specifically referring to the relationship of the people and their roles on the practice team, they offer an account of the difficulties that were discovered.

> Nevertheless, as the NDP unfolded, it was observed that the effect of integrating NDP model components required roles of practice participants to transition in ways that met unexpected resistance. Becoming a PCMH requires more than just implementing sophisti- cated office systems: it involves adopting substantially different approaches to patient care that require moving away from a physician-centered approach and toward a team approach shared with prepared office staff. (Crabtree et al. [4], p. 586)

This move to team-based care changes the roles of staff and physicians, with the most immediately noticeable change demanded of the physician who previously had been the only leader.

Some people who were part of the practices in the National Demonstration Project expressed concerns about the possibility that the patients' experience of the team members' enhanced roles would be a loss of the focal relationship with the physician. The centrality of the physician-patient relationship was asserted in the initial definitions promulgated by the primary care physician guild organizations for

the PCMH model which required a "physician-led team." Crabtree and his colleagues on the NDP evaluation project, two thirds of whom were physicians, felt this definition of the physician-led team could be a disservice to physicians, staff, and, in the long run, patients.

> Perhaps from the patient's perspective there will need to be a physician-led team, but from the practice's perspective, this concept needs to transform into one wherein the physician is part of a team, and not even necessarily the team leader. (Crabtree et al. [4], p. S86)

They recognized that this is a challenge for most physicians. It is a "change in their professional identity, and the ways in which they have been trained to deliver primary care. Training programs are not set up for future practice models as they are currently envisioned" (Crabtree et al. [4], p. S86).

The basics of teamwork or leadership are rarely topics in coursework in the training of medical students [4]. When leadership is mentioned, it is with an emphasis on the physician being responsible for what happens in the practice and on the team. For a doctor trained in this way, the sort of "change of identity" described by the NDP evaluators is often experienced as making them vulnerable. "My license is at risk here," and similar statements have been heard numerous times as practices attempt to make the transition to team-based care. Having one more thing to feel stressed about would seem to make this sort of transition an non-starter for many physicians.

These are not trivial concerns, yet for many sites, they are not taken as concerns that stop the development of teams.

> The issue of team leadership has sometimes been contentious, especially when approached in the political or legal arenas, where questions about team leadership often become entangled in professional "scope of practice" issues. In particular, arguments have arisen around "independent practice" versus team-based care and, where care is team-based, whether all team functions must be "physician-led," and what this would imply for other health professionals with regard to care management decision-making… . While the teams we interviewed acknowledged that physicians are clinically and often legally accountable for many team actions, the physicians on the teams we interviewed were not micromanagers; instead, they were collaborators who did not seek or exercise authority to override decisions best made by other team members with particular expertise, whether in social work, chaplaincy, or care coordination, etc. (Mitchel et al. [2], pp. 11–12)

Being realistic about the challenges is important in a developing a successful team. Team size can be an issue with 4–8 seeming ideal and over 12 being too big to work [3]. Using a process in which everyone's input is needed on every decision likely takes too much time and is unrealistic in areas in which the expertise of the physician or nurse needs to prevail. Finally, in fee-for-service payment systems, there are some functions that are compensated when performed or adequately overseen by a physician or nurse, but not when performed independently by another team member. Keep in mind, however, that in many practices there are divisions of labor based on understandings of payment regulations that are out of date. These have been used as reasons not to expand the roles of team members based on unrealistic fears of risk and consequences. The development of a team requires efforts

on the part of administration to seek and exploit flexibility in regulations in addition to the work to seek and exploit flexibility in care routines on the part of clinical staff.

2.2 From a Squad to a Team

One way of understanding the difference in leadership styles that the IOM [2] and the NDP evaluation team [4] describe between poorly functioning and well-functioning teams may be thought of as the difference between a squad and a team. A squad is a small group of people with a clear leader and a shared purpose, often associated with the military. The leader does not change because of the context or the task. Leadership is permanently designated by the hierarchy of rank.

A team is different. "A team is a group with a specific task, the accomplishment of which requires the *interdependent* and *collaborative* efforts of its members" (Wise et al. [5], quoted in Bodenheimer [3], emphasis added). A team may have a clear leader, but the implication of the inflexible hierarchy of a squad is gone. Teams can have situational leaders. Each member of the team can be the eyes and ears of the whole team. Each can make discoveries that will influence everyone's functioning with a given patient. Each can make suggestions about improvements in clinical routines, suggestions that may become the usual practice of the whole team after a team discussion.

The transition from a squad to a team is a reorientation for all members. The expectation in a squad is that each member knows their job and carries it out under the continual direction of the squad leader. In specialty medical settings, this is sometimes possible. The array of situations that are presented to the practice may be reasonably narrow and fairly predictable. Each member's job, therefore, can be predictable. Roles and routines can meet the definition of a squad and still be very functional. In an acute setting such as the operating room or intensive care unit, a squad organization is necessary. In most primary care practices, a squad organization is not optimal. The array of problems and situations presented to the practice team is extremely broad. When you consider the complexity of diagnoses, complaints, and demands patients present as they are receiving preventive care, chronic care, and urgent care, it is necessary that team members display more flexibility of approach. Though primary care can be informed by protocols, a protocol that was developed for "patients like this one" (e.g., patients with type 2 diabetes) is often not a fit for "this patient" (patient with type 2 diabetes, congestive heart failure, anxiety, and substance use disorder) [6]. A team in which each member is trained and enfranchised to adapt their approach based on the needs of an individual patient and that maintains adequate communication in the flow of care to include a helpful adaptation or a new piece of information into the work of all its members will do better for most of its patients.

The evidence related to high-functioning teams reveals the benefits to everyone on the team when physicians take the facilitative rather than the directing approach. Rachael Willard-Grace and her colleagues [7] looked at the relationship of team

structure and culture to burnout or emotional exhaustion for both primary care clinicians and support staff. "Team structure" in their study indicated the consistency with which the same primary care clinicians and support staff worked together. They called a small group that worked together on a regular basis a "teamlet." They used the term "team culture" to describe what might be called the cohesion of the team built on elements such as communication, participation, effort, social support, respect, and shared objectives (essentially the IOM list of the elements of a good team). The study was done in 16 primary care practices, ten serving primarily low-income or uninsured patients, and six serving more commercially insured and Medicare patients, in total encompassing 264,000 visits in the year before the study. They found that a strong team culture seemed to protect against emotional exhaustion for both clinicians and support staff. Tight team structure, consistency of working as a team, helped to promote team culture particularly for the clinicians. Where there was a lack of team culture, consistency of working together did not help to lower burnout.

One way to help doctors make the transition to a different sort of leadership and to a team vs. squad organization is to make it possible for them to practice with the same group of support staff and other clinicians regularly. Consistency of working as a team also helps the support staff members to keep from getting the message that they are interchangeable, as can happen when they work with different doctors on different days without a pattern that relates to their particular preference or skills. People who know they are going to be regularly working together tend to invest more attention to getting to know each other personally, to working together smoothly, and to solving problems amicably. They are more likely to attend to elements that Willard-Grace and her colleagues called team culture.

At first glance, organizing a practice in consistent teams is not the most convenient or efficient way for administrators. Some people want to work part-time. That complicates scheduling. Sometimes people are out for one reason or another. If a doctor is at a conference, does the rest of the team stay home? These are not trivial questions to people who are trying to keep the practice organized and who are watching the budget. When the longer-term effects of promoting teams that are cohesive are considered, the equation changes. Consistent team structure contributes to better team culture for doctors, who contribute to a team culture for everyone, culture that reduces emotional exhaustion or "burnout." Burnout of clinicians or staff is associated with higher errors, poorer communication with patients, and lower patient satisfaction. Lower patient satisfaction is associated with poorer patient adherence to care plans and poorer health outcomes [7].

Job satisfaction, when studied as an aggregate measure of the whole team, correlates with higher-quality metrics [8]. One knowledgeable interpretation of this data attributes the finding to the "flattening of the current knowledge-based hierarchy" and "more efficient matches between individual team member knowledge and skills and the actual work that they do" (Kimberly [9], p. 8). A team that can promote the importance and involvement of support staff in the core services of the patient visit also promotes higher-quality care, better patient satisfaction, stronger team culture, better job satisfaction, and lower burnout for clinicians and staff.

It might help to think of the change in the leadership role of the physician and the change from squad leader to team leader, from directive to facilitative, and from setting the tasks to developing the mission and the culture, as being a version of the same change that is called for by the IOM relationship rules for the doctor-patient relationship. The change is isomorphic (of the same form) as the change in the clinician-patient relationship identified as true patient-centered care. The transition of the squad to a team is preparing the doctor for a second transition, the transition from "delivering care to" patients to "partnering with" patients to achieve better health. This allows the challenge of team-based care to be seen in a new light. Attending to a different form of leadership for the doctors is an intervention in quality and sustainability of the practice as a whole by developing the skills for patient-centered care.

Getting to a new approach to leadership can go wrong. Team leaders sometimes make an effort to enfranchise other team members to participate by exerting less leadership, allowing things to rock along hoping that the leadership vacuum will be filled by other team members. It is a strategy that aims to be egalitarian, but that usually fails. In an undefined situation, historical patterns of hierarchy based on job title, race, gender, and socioeconomic and educational status are likely to exert unbidden influence on team members expectation about leadership. People, who are supposed to feel enfranchised or empowered by this approach, instead can feel anxious when they are unclear about what they are supposed to do. It makes people feel vulnerable if the person, whom they expect to be providing leadership and who will have an impact on their evaluation, retention, and promotion decisions, denies his or her own role in guiding of the team process. It tends to make people more likely to work from a "CYA" mindset as they go through the day.

2.3 Communication in the Team[1]

Successful transition to a highly functioning team is based on a significantly richer exchange of information both at regular meetings and through brief exchanges of information to keep each other up to date in the flow of care. It is a fair generalization that primary care practices, and medical services in general, commonly try to have as little time in meetings as possible. This often leads to a practice having barely enough communication to keep things moving and not nearly enough communication to effect any meaningful changes. Lack of adequate communication means a lack of coordination of action and to team members feeling unsupported and alone, even with colleagues all around. In this situation team members are more likely to feel overwhelmed.

[1] Some of the ideas in this section appeared previously in a chapter: Blount, A. (2018). Building your team. In Gold, S. & Green, L. (Eds.) *Your Patients are Waiting: Integrating Behavioral Health for the Primary Care Physician*. Springer, New York.

The idea that more communication is needed to plan changes in workflows, to evaluate the results, to do brief targeted training, or to talk about mission or values and that the investment in more communication could leave everyone less stressed and help the practice provide better care more efficiently can be very hard for administrators to translate into quantitative value. It is also true that time spent in meetings which is not productive in the experience of team members, or in conversations that don't relate to the jobs the team has accomplish will lead to meetings losing the engagement of team members.

There are a number of approaches possible to address the need for more communication in the team. One health system that has done an exemplary job in building primary care teams, including behavioral health clinicians and multiple "health coaches" supporting each doctor, expects that teams will meet for a 45-minute huddle at the beginning of each day and use an additional 3 hours per week for team meetings and training [10]. This health system considers team functioning in the architecture of practice facilities. Team members work stations are designed so that they can't help seeing each other. The unscheduled exchange of information that is facilitated improves group cohesion and patient care.

For regular meetings, some practices have one meeting a week to address a range of matters. Other practices have more than one kind of meeting and address different sorts of issues at different times. Some have longer meetings to get it all done, while some have briefer meetings because those are more efficient for them. It is very hard to say what schedule and organization works for a practice.

Examples of topics for regularly occurring meetings:

1. One or two patients that team members feel the team could engage or manage better, e.g., nonadherent patients, scary patients, dissatisfied patients, patients who aren't getting better, and patients with complex lives or family situations that need to be understood better.
2. How can we improve? The team looks at data, something that is being counted and sees where the numbers look good and where there might be a place to try something different. They remember together one or two specific instances when things didn't go smoothly and think about how those specific situations could be handled better in the future. Before spending too much time looking for a fix, it is important to spend some time looking for instances when that same process or task went well. They see what various team members did in those instances that made things work. Whatever the sequence, the work in the successful case is something they already know how to do and could be the basis for making that success more frequent.
3. Highlight excellence. The team takes a moment to let team members recite things that other members did that were noticeably helpful or insightful or caring or courageous. They make sure they describe very specifically what their teammate did that they appreciated.

Some have a weekly meeting time with rotating topics so that the time is always interesting and useful.

Perhaps the most useful regular meeting, in terms of value per minute spent, is the huddle before each session of patient care. A huddle is commonly a 10- to 15-minute meeting in which all of the people who will be providing or assisting in patient care during the session exchange information that will help everyone work in a coordinated and efficient way. When the decision is made to hold huddles, there will likely be pushback. "We could use this time better to each get ready for our individual roles." The clinical and administrative leadership in the practice is wise not to give in. Once team members see how much better the half-day goes, how much less stressed everyone is, and how much less follow-up work there is, they will come around.

2.4 Team Roles

In the medical group that we have been calling a squad, roles and the functions that go with each role are often determined by discipline. The person who can give injections, the person who can take vital signs, the person who can instruct the patient to temporarily increase or discontinue a medication, or the person who can assess the acuity of a patient's complaint and dispense medical advice over the phone, each of these tends to be determined by the discipline and training level of the squad member. In the move from squad to team, team members are likely to take on additional functions that are not identified with a particular discipline. A team member who is helping a patient articulate their health goals, who is teaching sleep hygiene, or who is scoring a depression screen might be from any of a number of disciplines or have any of a number of different levels of training. This team member might be in a role with any of a number of different names.

Bodenheimer [11] summarizes a study of 15 sites with teams that exhibited some or many aspects of what could be called "high functioning" in a paper called "lessons learned." It is a product of 112 interviews with team members representing the variety of the team roles. The study found that a number of functions that physicians had been performing could be distributed to other team members, especially in the care of chronic illnesses, using protocols, standing orders, oversight, and training. When the "care enhancers" (my term for the different roles and job descriptions that are part of the care team but not licensed clinicians) were used more broadly in chronic illness care, the quality of the practices' care of chronic illnesses improved, especially in the areas of monitoring and patient teaching. Attention to team cohesion and shared decision-making led to team input on defining and refining the roles of team members which led to improved care metrics and more efficient use of the time of the most expensive team members, physicians, and RNs.

Using the structure of the usual primary care interaction, pre-visit, visit, post-visit, and between visits [3] can be helpful in delineating functions that should be added or that can be passed to different team members. The structure helps in developing protocols for various chronic illnesses or common presentations. Pre-visit care can be done by team members who have been taught specific routines for preparation or for handling aspects of care that can be checked by the doctor in the visit.

In the visit there can be clinical support roles and, more recently, the role of scribe, a person who creates the documentation of the visit and who accesses information and resources during the visit under the direction of the doctor. In some models this scribe is a person who accompanies the patient through all of the stages of the visit [3].

Post-visit can be a time for clarifying or extending information offered in the visit and for setting up monitoring or other contacts in the between visit periods. This period can encompass programs of chronic illness teaching, monitoring, or care. It can include visits with subgroups of the team or outreach by team members. It can include time spent connecting the practice and the patient with resources for the individual patient or for a population. A good deal of the creativity being shown by high-functioning teams in enfranchising team members to providing excellent care without using the direct contact time of the doctor is occurring in this space.

In designing the roles, teams try to make a balance between adding functions for "care enhancers" and limiting the number to handoffs in the process. Though roles are evolving over time, at any one point all of the team members ought to be able to describe the roles of each member involved in a patient's care to the patient. These descriptions should allow the patient to know why the person is participating in their care and what they are contributing to the treatment. It helps when these explanations are made to the patient as part of the introduction of a team member, either by the team member themselves or by another team member. When one team member introduces another in terms of their role in the care, the skill set they bring, and the contribution they are making to the treatment plan, and when this introduction is followed by an introduction of the patient to the team member in terms of the reason for their visit today and the efforts they have made to promote their own health, the relationship of the first team member with the patient is partially passed to the second. This is especially true when the introducing team member is the doctor, the person with the clearest reason for relating to the patient. When patients have the experience of working with the same team members repeatedly, this introduction can be modified, but there could be reasons to go back to introductions of a sort depending on the reason for the visit on a given day.

Team-based care is often part of a larger reorganization of primary care practices that is going forward around the country. In some settings the goal of the reorganization is to better serve patients with complex health needs who tend to require a great deal of medical services from a healthcare system while failing to obtain the benefit the services are designed to provide (see the Union Square model below). In these instances, the team increases the intensity and variety of services the doctor can offer. This is designed to promote, in the long run, better health and lower cost. In other settings, the reason for creating team-based care is to increase doctors' work satisfaction and lower their burnout rate (the APEX model). In primary care, attending to the problem of physician burnout is important for the quality of patient care as well as for maintaining the workforce. In Chap. 1 we saw that physician burnout is associated with twofold increased odds for unsafe care, unprofessional behaviors, and low patient satisfaction [12]. If we consider the RAND finding that the way to counter burnout is to reduce the administrative complexity that gets

between the doctor and the patient (e.g., the EHR) and to enable the doctor to feel that he or she is providing high-quality care to their patients [13], both of the approaches to reorganization below are likely to serve both the goals of improved patient care and lowered burnout. They differ in the degree to which they are designed to support or change the physician-led team approach.

2.5 The APEX Model

A model of team-based care specifically designed to lower physician burnout and improve their experience of providing healthcare is called the APEX model (standing for "ambulatory process excellence" or "awesome patient experience") [14] which was piloted first in the University of Colorado health system. Building on the "team-let" as the central unit of care [3], the APEX model is designed to reduce burnout by adding substantial support for doctors in each patient visit. This is done by greatly expanding the role of the medical assistant (MA) and more than doubling the number of MAs supporting each doctor, from <1:1 to 2.5:1. In addition managing the flow of patients into and out of exam rooms and taking vital measurements, the MAs' role in the visit is expanded to spend added time before each visit to do the following:

- Elicit a comprehensive patient agenda.
- Collect or update elements of the patient's past medical, surgical, social and family history in the EHR.
- Conduct detailed medication reconciliation …
- Use templates to document the history of the illness or complaint that was the reason for the visit (History of Present Illness) and ask standard questions covering other aspects of the patient's health (Review of Systems).
- Using protocols, initiate certain clinical tasks such as rapid strep or urinalysis.
- Review preventive care gaps such as screenings or immunizations and either arrange for them or mark the gaps for the physician's review. (Paraphrased from Lyon et al. [14], pp. 7–8)

The MA remains in the visit when the doctor comes in. They provide "documentation support," writing in the EHR, thereby freeing the doctor from the having to look at a computer screen rather than the patient during the visit. The doctor reviews the information gathered by the MA, finalizes the agenda for the visit, conducts the conversation, performs any examinations, makes diagnoses, and makes the recommendations needed for ongoing treatment. When the visit is over, the MA remains with the patient, to reinforce the patient's understanding of the information and advice offered in the visit, to add additional protocol-based teaching, to carry out any orders from the visit such as lab draws or immunizations, and to arrange follow-up. Finally, the MA escorts the patient back to the waiting room.

Early outcomes have been very promising. The expanded participation by the MA has allowed attention to preventive health elements that might not have been able to be addressed in the physician visit. Colon cancer screening, hypertension

control, and diabetes care such as foot exams and retinal exams increased modestly, and breast cancer screening increased by almost 50%. The largest measured improvement has been in the work life of the doctors. Measurements of burnout symptoms decreased by half. Doctors willingness to take on additional clinical hours increased. Doctors spending extra time logged into the EHR after hours dropped. Scores improved in all measured domains, including overall doctors' satisfaction, efficiency, documentation, and actions defined as patient-centered or as improving patient engagement. Perhaps the most telling outcome for administrators has been the greatly improved success in recruiting new doctors.

Patients' experience improved in the areas of better communication with their health professionals on the team, particularly in the area of feeling their concerns were listened to. Their willingness to recommend the practice to others went up as well.

In its impact on provider stress and potential burnout, the APEX model seems to be having the results seen in other implementations of team-based care. Because it was explicitly designed and studied as an intervention on provider burnout, the results of its effect on burnout may be somewhat more robust than other studies. An unintended result of the program is its usefulness as an example of a transition from a squad to a team organization. Lyon, English, and Smith have done us a favor by including brief descriptions of the organizational challenges that accompanied the APEX implementation.

The increased involvement of MAs and the extra support of doctors set off a cascade of other organizational changes, changes that probably should be expected as part of a plan to move from a squad to a team organization. There were challenges in the health system and in the relationships in the team itself. The increasing importance of the MA's role to the success of the model required increased organizational attention to their training and their needs. They needed ongoing training and support equal to about 40 hours of additional classroom training as well as time to observe doctors' visits with patients and do simulated practice in their new roles with the physicians. Several meetings about the purpose of the change were held with all concerned, and ultimately a transition facilitator was hired to help in the process. With the increased responsibility and increased training came an expectation from MAs for increased salaries, which had to be met before the recruiting of the additional MAs could be successful and the existing workforce could be stable. If there was any belief that MAs would be happy with receiving just the "professional development" the program offered, especially in a medical setting where the difference in levels of payment between doctors and staff can be so stark, that proved to be wishful thinking. The changes in roles and salaries in the pilot practice encountered the sort of pushback within its large health system that is common when exceptions to usual job descriptions and pay levels are requested. To keep the program going, budgetary and human resources administrators had to be brought on board by the support of top administrators.

The evolution of roles within the team was a challenge. In the previous organization as a squad, the role of the MA was much narrower and better defined. In the expanded role, no matter how clear the protocols that were developed, the increased

complexity of the role created the need for increased use of judgment by the MAs and gave opportunities for increased variance between their actions and doctors' expectations. For their part, MAs needed to understand and to participate in developing the overall vision and mission of the program. Doctors found they needed to treat MAs more as team members who required personal support for their learning and participation in planning. The "squad" approach of offering gentle corrections if an MA made a mistake was not workable, because they felt more vulnerable when doing tasks that were new to them. The "flattening" of the leadership structure of the teams occurred to some degree even though it does not appear to have been a goal of the program.

Both before and after the transition to the APEX model, behavioral health clinicians were part of the practice. Their contribution was more as specialty services available within the practice space than as members of the "teamlet." Both the report on the APEX model and on the "Union Square" model assume the presence and importance of behavioral health services. They are not the focus in the transformations that are reported.

2.6 The "Union Square" Model

This model was developed at Union Square Family Health Center (USFHC) in Somerville, Massachusetts. It was designed to provide effective care to a particularly challenging patient population, to serve the complex health needs of low-income immigrant families in an urban setting. The model involves segmenting the patients of a large health center into smaller practices within the clinic called "pods." Each pod has 4000–5000 patients, 2–4 primary care physicians, 1.5 physician assistants (PAs), 1.5 nurses, 1 receptionist, and 3–4 MAs. Patients are assigned to pods without regard to their diagnoses or risk profiles. Every attempt is made to have continuity between patients and providers within the pod. For the PAs, the continuity is about 90%. The continuity with the pod is almost 100%.

In their reorganization of the roles in the multidisciplinary team, USFHC has gone farther away from the physician-led team and has distributed functions more broadly than simply enhancing the MA's role. Here is how they describe the roles they developed:

- Medical receptionist: Frontline staff represents the local community and serve as cultural ambassadors for the clinic, helping bridge language barriers. Receptionists are familiar with each team's patients and can schedule immunizations and appointment for the whole family. They help ensure consistent follow-up, leveraging mobile technology like secure texting to contact patients.
- Medical assistant (MA): Considered the "boss" during clinic sessions, MAs manage clinic flow and guide patients through blood pressure checks, immunization and other activities. Before a clinic session, the MA coordinates with the physician around care needs for patients visiting that day. The MA also has a panel of patients to outreach for screening and prevention.

- Registered nurse: Nurses facilitate chronic disease management, developing relationship with patient through longitudinal educational visits. They also undertake outreach to complex patients and manage transitions of care, following patients after discharge from the hospital.
- Physician: Because other team members handle many of the screening, prevention, education, and administrative efforts that often consume physician time in primary care practices, physicians at Union Square focus on the work of diagnosing, treating, and developing relationships with patients.
- Physician assistant: Physician assistants share a panel of patients with physicians. Patients can choose the kind of provider they want to see, and many receive care solely from PAs. For example, Haitian patients on one physician’s team may opt to see a PA who is fluent in Haitian-Creole (Jain et al. [15]).

“The multi-disciplinary team employed innovative workflows to be able to address many different types of needs with different intensities of contact at the same time. In a three-hour period, the team of one physician, one nurse practitioner, two medical assistants and one nurse would have contact with 30 patients. All would huddle at the beginning of the session. Two patients with complex needs could get visits with increased physician time. Patients with acute needs could be seen quickly by the NP, both physician and NP supported by an MA. In addition, the nurse could do 2 hours of care management outreach calls, the physician did a half hour of e-visits and phone visits and half hour of coordination with specialists and hospitalists.

The physician, NP and nurse could meet, and the medical assistants had significant time for panel management or patient health coaching (see Jain et al. [15]). Over the course of 3 years of implementation, the average number of visits per year was cut in half, reducing wait times. This does not mean that the average number of contacts with patients by the practice fell. These increased.”

In addition to the pod organization, USFHC tracks 20 chronic conditions using registries. Each registry has a group of staff that meets weekly to discuss the patients they are tracking. There is a team especially set up to provide care management for complex patients, and behavioral health clinicians are available to work with any team and any patient. Communication about patients is enhanced by placing the workspace of all providers in a common area. This facilitates unscheduled exchange of information in real time rather than asynchronous communication using the EHR. The success of the model is continually monitored by 20 measures used by the health system, Cambridge Health Alliance, of which USFHC is a part. In 2016, USFHC met or exceeded 15 out of those measures.

Lora Council [16], Senior Medical Director for Primary Care of Cambridge Health Alliance, makes the point the additional members of the primary care team are not just relieving doctors and nurses of some tasks so that their jobs will be more managed. There is a new dimension to the care introduced because of the way these other members relate to patients. It is important to consider the idea that the care enhancers do not just take on task but they may take on aspects of the therapeutic relationship. The patient benefits from having a relationship with someone who may more directly support them rather than instruct them. In a heterogenous large patient

panel, the doctor or the nurse may not be the best people to serve the therapeutic relationship needs of every patient. It is both threatening to professional identity and immensely relieving simultaneously if a care enhancer on the team is the primary "owner" of some of the emotional relationships of the 2500 patient panel.

The examples detailed here are but two of many reorganizations to team-based care that are happening around the nation. Whatever the emphasis or goal of these reorganizations, all involve increasing the involvement in and responsibility for important aspects of patient care by non-physician team members. With these changes come increased need for training, additional exchange of information among team members, flexibility in the types of services offered, and increased involvement, support, and flexibility on the part of administration to keep the transformation from stalling.

2.7 Team Training

The training a team will need to create or to find will depend on the approach it takes to adding functions for its members. Faster transitions call for more extensive training, usually from an outside sources, though the results are less reliable (see Chap. 11). More evolutionary changes may be achieved with training developed by the team itself. Many of the functions done by the doctor or a nurse could be done by someone with lesser training if the team member who has the skills can take the time to develop a training experience for other team members. This will include time given to overseeing the development of the team member in using the new skill.

One way that mutual skill improvement can be done is to have a regular routine of mutual observation and feedback on the team. It takes some planning to schedule mutual observation in a way that does not take too much of the team's time. Some teams do mutual observation during the visit of the first patient of the day. In this approach each team member joins the team member who works with the patient before or after themselves, observing the work of that member. This is done with the permission of the patient, who usually is happy to be part of the self-improvement that this represents for the team. Each member notices specific behaviors that the team member whom they observe does well in addition to noticing opportunities for improvement. As each team member completes their role in the care of the first patient, they return to their usual routines. The team shares observations when they get together for a planned lunch meeting at the end of the morning patient care. Substitutions in who observes whom can be made based on trainer or mentor and trainee relationships on the team (see Chap. 11).

2.8 Conclusion

The benefits of high-functioning teams are many. A high-functioning team allows tasks that do not need a doctor's level of training to be performed by other members

of the team. The evidence indicates that working in a high-functioning team increases job satisfaction and reduces burnout for doctors and staff. Team-based care increases patient satisfaction. Having participation by team members in monitoring care and addressing problems allows for patients to feel more constant support and for the team to care for a patient's needs without needing to have the patient come for a visit each time.

Sustaining team-based care is hard in a fee-for-service payment environment. Union Square calculated that its model lost money in fee-for-service because of the many types of service it offered for which there was no payment code. When the center had 63% of its patients covered by capitation, the model showed financial gains [15]. Some very innovative team-based care has been developed by for-profit health systems who only work with patients covered by capitated payments, such as in the Medicare Advantage program [10]. On one hand, payment transformation allows this flexibility for team-based care, and on the other, it appears that having a high-functioning team in a practice makes moving to an alternate payment approach a safer bet for payers.

The dedication of additional time to regular meetings, meetings in the flow of care each day or by the week or month, does not in itself lead to the change from a squad to a team. It is perfectly possible for these meetings to become opportunities for the squad leader to give more detailed directions to the squad members without creating any new ways of relating. The transition comes when the patterns of exchange of information are transformed. Some accounts suggest that additional meetings could lead to increased coordination and effectiveness of care and that could lead to better satisfaction and esprit de corps for team members. Yet, at the point that a practice decides to take on this transition, what does the current squad leader say or do to create successful team process? It is unreasonable to expect that doctors or other team members will create a method that fosters the transformation on their own. Having a method that can be used to build engagement with patients and with fellow team members, such as the T.E.A.M. Way, can make the entire transformation easier (see Chap. 11). Finally, adding a team member with expertise in group processes and in mental and behavioral health can be a way to help all team members to be more successful in their additional levels of responsibility for overall patient care. However it is achieved, team-based care, when it includes the changes in relationship and communication patterns described here, and when it is supported by data on its performance with its particular panel of patients, seems to be a necessary foundation block for patient-centered care.

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Resources

Getting to team-based care: https://www.stepsforward.org/modules/team-based-care