

A NEW APPROACH TO MAKING YOUR DOCTOR-NURSE TEAM MORE PRODUCTIVE

With proper training and delegation, your team can see more patients, deliver better care and feel more satisfied at work.



Myriad factors are challenging the financial viability of physician practices in general and primary care practices in particular. Downward pressure on reimbursement combined with increasing costs have ratcheted up the pressure on physicians to see more patients each day just to stay even. The increasing administrative burden on physicians and their clinical staff has heightened frustration, reduced productivity and career satisfaction, and increased the potential for clinical errors. None of this is news, of course; the situation has been worsening for years. But new ways of surmounting the problems are continually appearing.

A key part of responding to the current threats to medical practice viability is what we call “highest and best use staffing”; that is, structuring work processes to ensure that 1) the physician does only what he or she is trained to do, with appropriate delegation of all lesser tasks, and 2) clinical staff members do only what *they* are trained to do, with appropriate delegation of all lesser tasks. In a typical practice, the failure to delegate hampers efficiency, which in turn hampers practice finances.

In a new approach to the clinical visit called *family team care*, one of the authors

THE FAILURE TO DELEGATE HAMPERS EFFICIENCY, WHICH IN TURN HAMPERS PRACTICE FINANCES.

■ The team care model can improve productivity, staff satisfaction, quality of care and practice finances.

■ When fully implemented, it involves a physician and two clinical assistants who partner closely to provide patient visits.

(Peter Anderson, MD) has created a practice that epitomizes highest and best use staffing. The results have been extraordinary. The team care approach has improved professional satisfaction with practice, quality of care, documentation and financial performance. It has increased patient visit volume while raising patient satisfaction. It has even increased job satisfaction for the nurses. Here's how it works.

What is team care?

The team care concept is relatively simple. It involves a physician and a well-trained clinical assistant – or, ideally, two assistants – working closely together to provide a high-quality patient encounter. Most patient visits can be broken down into four distinct components:

Part 1: Data gathering,

Part 2: Analysis of data and pertinent physical exam,

Part 3: Decision making and development of a plan,

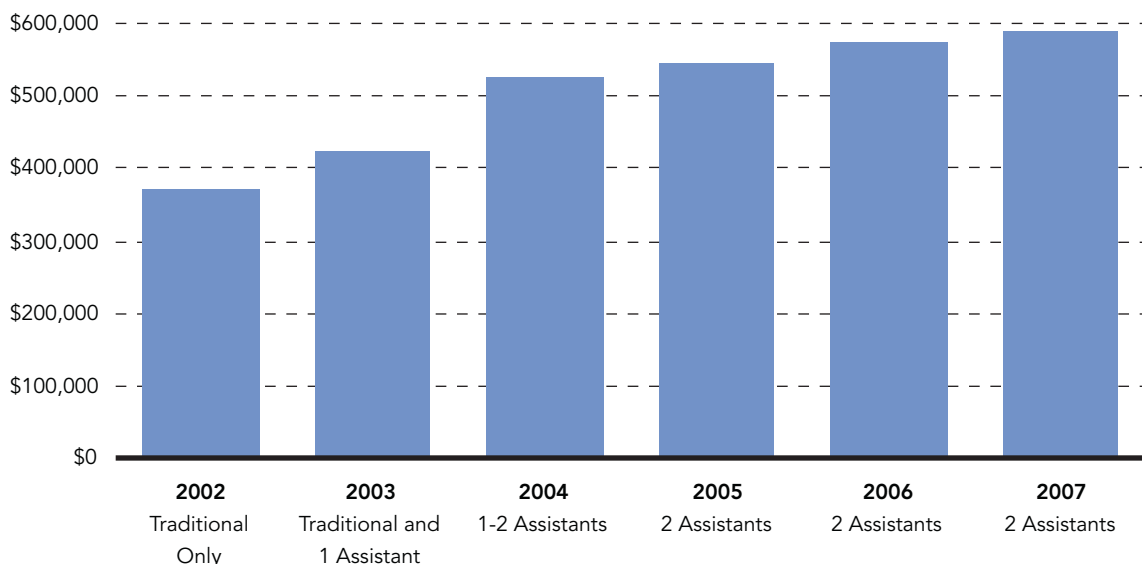
Part 4: Implementation of the plan and patient education.

During a traditional office visit, the physician completes the majority of all four components. By contrast, in a fully implemented team care model the clinical assistant gathers data according to specific protocols and communicates that information to the physician, in the presence of the patient, when the physician enters the exam room (Part 1). The physician then analyzes the data, conducts the exam, determines the diagnosis and develops the treatment plan (Parts 2 and 3). The clinical assistant documents the findings and additional information elicited by the doctor during the exam. The physician discusses the treatment plan with the patient and the clinical assistant and exits the room. The clinical assistant then closes the visit with the patient, reiterating the physician's

IMPROVED FINANCES

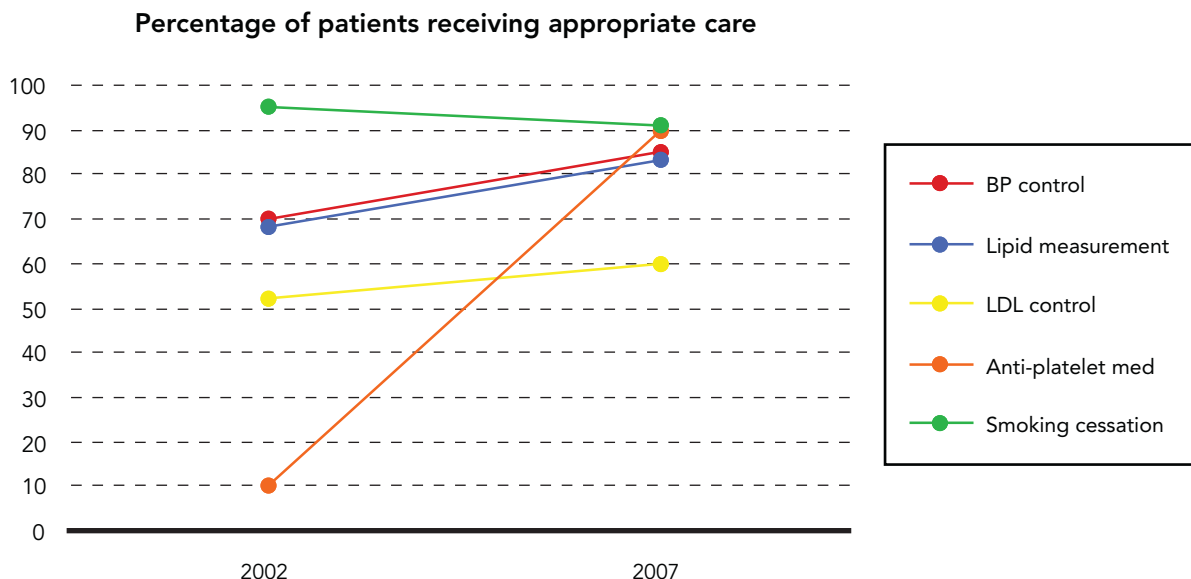
Dr. Anderson's collections have increased from \$370,000 in 2002, before he implemented team care, to \$590,000 in 2007, with a fully implemented team care model. His income and benefits equal approximately 40 percent of his collections. He sees 540 patients per month, on average, and spends 40 to 44 hours in practice per week, with five weeks paid time off per year.

Collections 2002-2007



IMPROVED QUALITY OF CARE

Based on measures used for the National Committee for Quality Assurance (NCQA) Heart Stroke Recognition Program, Dr. Anderson's quality of care, as well as his documentation, has improved since his implementation of team care in 2003. He made improvements in all measures except smoking cessation, where a 4 percent decrease resulted from one chart lacking documentation of smoking cessation counseling. The vast difference in the use of anti-platelet medications is due in part to poor documentation in 2002. While Dr. Anderson would have fallen far short of the NCQA criteria in 2002, he received 50 out of 50 points in 2007. This is just one example of his improved quality of care.



instructions and providing prescriptions, referral information and patient education materials as directed by the physician (Part 4). When fully implemented, the team care model partners two well-trained clinical assistants with one physician and requires three to five exam rooms. As the physician exits one exam room, he enters the next room where the second clinical assistant has gathered information and is prepared to start the communication process again.

The heart of the team care innovation is having an assistant who is trained and capable of soliciting and documenting a complete patient history for the visit. Taking a thorough history and updating medication lists and other important details is often the most time-consuming part of the visit. However,

because this initial gathering of information requires little medical decision making, it is not essential that the physician participate in it. Once the physician enters the exam room, he or she can hear the clinical assistant's summary of pertinent facts, with the potential for clarification by the patient, and can solicit additional information as needed. This step allows the physician to confirm and become owner of the HPI, in a sense, which ensures compliance with documentation guidelines.

Implementing team care

Implementing team care requires starting with at least one clinical assistant, whether part time or full time. This person would gener-

The assistants, usually RNs or LPNs, are trained to solicit and document a complete patient history, among other duties.

Upon entering the exam room, the physician is briefed on the patient and gathers additional data as needed.

About the Authors

Dr. Anderson, a family physician, practices at Hilton Family Practice in Newport News, Va. The practice is part of Riverside Medical Group, one of the largest multispecialty groups in the state of Virginia. He is also a visiting assistant professor of family medicine at the University of Virginia Medical School. Marc Halley is president and CEO of The Halley Consulting Group in Columbus, Ohio. He has provided practice management and consulting services to medical practices for more than 20 years. Author disclosure: nothing to disclose.

THE TEAM CARE MODEL PARTNERS TWO WELL-TRAINED CLINICAL ASSISTANTS WITH ONE PHYSICIAN AND REQUIRES THREE TO FIVE EXAMINATION ROOMS.

■ With a few hours of training, a clinical assistant can learn to gather the majority of information needed.

■ While the model can work with just one assistant, involving two assistants maximizes the benefits of the team care model.

ally be an RN or LPN (or a capable MA) who has exhibited dependability, has the skill and capacity to accommodate a changing role, and can commit the time for training. The physician must be able to work closely with the selected clinical assistant since the overlap of functions depends on effective interaction.

The training is primarily focused on Part 1 of the patient encounter and usually requires a few hours of discussion between the physician and the clinical assistant after both have reviewed and studied the training tools (see the resource on page 39; a detailed handbook¹ and training DVD are also available at <http://www.familyteamcare.org>). The assistant must be taught the different areas of information needed for a high-quality patient visit, including key questions the clinical assistant can use to uncover symptoms or illnesses.

After the initial training, the physician should continue to meet weekly with the clinical assistant to review questions on selected

disease states, discuss specific medical problems, improve their communication skills and streamline the team care process. This ongoing training enhances the working relationship between the physician and the assistant, which is essential to the success of team care.

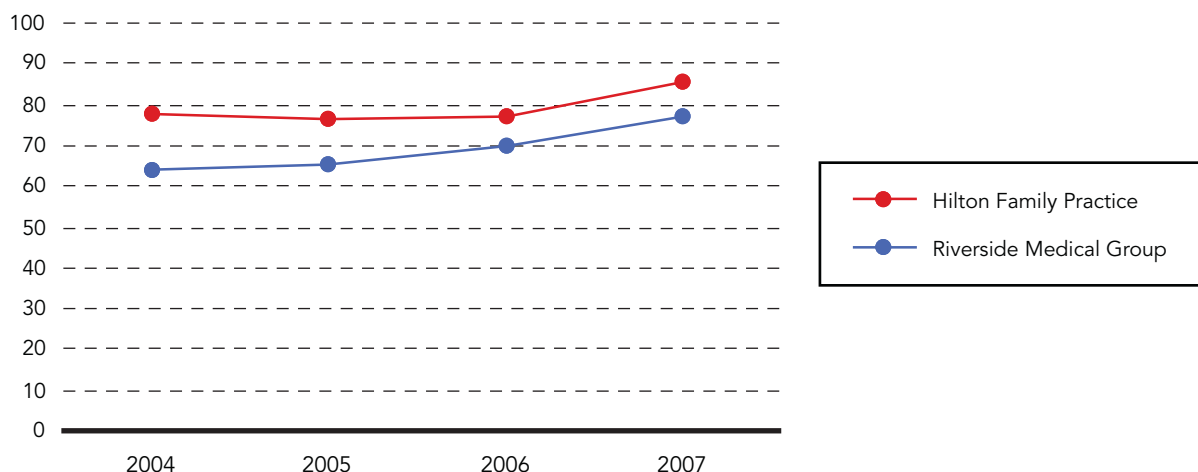
A physician may choose to implement the team care approach with one clinical assistant or two. If only one assistant is involved, the assistant leaves the first exam room after finishing Part 1 and moves to the next patient, leaving the physician to review the first patient's chart and complete the remainder of the visit on his or her own.

Although having one assistant working on Part 1 of the patient encounter is sufficient to enhance productivity, two full-time assistants are required to maximize the benefits of the team care approach. Once a second assistant is available and trained, the assistants can effectively manage parts 1 and 4 of the encounter, allowing the physician to focus on parts 2

IMPROVED SATISFACTION

Satisfied employees contribute to satisfied patients. In Dr. Anderson's practice, employee satisfaction is consistently above the 75-percent range and higher than the overall rate achieved within their parent organization.

Percentage of employees who are satisfied



CLINICAL ASSISTANT RESPONSIBILITIES IN A ROUTINE VISIT

The following description of responsibilities relates to routine follow-up visits, such as a routine diabetes check up. The responsibilities vary for other visit types. For example, physicals include greater emphasis on preventive services, while responsibilities for follow-up visits for minor illnesses and acute visits are much more abbreviated.

PART I. ASSISTANT ONLY

A. HPI

Welcome patient and confirm patient's statement of current problems or symptoms.

Ask appropriate questions for the problems or symptoms, using the "ODD IF HAPPY" mnemonic. (Note: The handbook¹ provides specific questions in this format for 116 symptoms and diseases.)

O: Onset of symptoms – When did this episode start?

D: Description of symptoms – Constant vs. intermittent, detail of the sensation, character of the pain, location of the pain, radiation of the pain, etc.

D: Duration – How long does the symptom last?

I: Intensity – Is it mild, moderate, severe, etc.?

F: Frequency – Does it occur daily, weekly, etc.?

H: History – Is this the first episode, or has it occurred before?

A: Accompanying signs and symptoms – Do any other symptoms/signs accompany this symptom?

P: Precipitating/alleviating factors – What makes it better or worse?

P: Progression of the symptom – Is it getting better or worse?

Y: You have finished the questions for this symptom.

Review "plan" from previous two visits.

Review any appended notes or recent phone notes since previous two visits.

Collect the results of any recently completed diagnostic tests, lab results or emergency department visits.

Review problem list and get patient's update on recent problems.

Update the problem list with dates of important completed tests (colonoscopy, mammogram, etc.).

B. PAST MEDICAL HISTORY

Review and update medication list, removing completed medications.

Determine if patient is compliant with medication schedule.

Determine if patient needs refills.

Ask about side effects from medications.

Encourage patient to bring all current medications to each visit.

C. FAMILY HISTORY, SOCIAL HISTORY AND ALLERGIES

Review and update family history and social history.

Review and update allergy list.

D. REVIEW OF SYSTEMS

Review all appropriate systems. (Note: The handbook¹ can

serve as a guide about which system to review depending on the problems or symptoms that necessitated the visit.)

E. PREVENTIVE CARE UPDATE

Ask briefly about last physical, well-woman exam, mammogram, lipids, etc.

Recommend and document appropriate preventive care plan.

F. POSSIBLE PROCEDURES AND QUESTIONNAIRES

Administer pulse ox, peak flow, UA, etc., when appropriate.

Administer MMSE, Epworth sleepiness scale, Zung scale, bipolar questionnaire, etc., when necessary.

PART II. ASSISTANT AND PHYSICIAN

Physician enters room, greets patient and, in the presence of the patient, obtains verbally from the assistant all the information already gathered.

Physician adds to information as necessary, and assistant records this additional information.

Physician performs pertinent physical exam and communicates findings for documentation by the assistant.

PART III. ASSISTANT AND PHYSICIAN

Physician writes down impressions and plan.

Physician updates problem list if paper charts are used or communicates to assistant, in writing, problem list changes, which the assistant records in the electronic medical record. The problem list must contain information about pertinent tests and when they are needed.

Physician reviews the impressions and plans with the patient and then politely exits, leaving the hard copy of the impressions and plan with the assistant.

PART IV. ASSISTANT ONLY

Document the impressions and plan of the physician. The plan includes tests and labs ordered, referrals initiated, new medications added, medications discontinued, suggested lifestyle changes, work notes with dates given and date expected to return to clinic.

Document any treatments or tests refused by the patient, along with the patient's acknowledgement of possible poor outcome.

Provide patient education concerning disease process, medications, tests ordered or lifestyle changes.

Explain matters of referral process or obtaining further tests at other facilities.

Provide all scripts and review them with patient.

Obtain medication samples and review dosage schedule.

Remind patient to call if necessary and to schedule any recommended return visits.

Close the visit kindly or take the patient to appropriate area of the practice for further in-office testing.

USING TWO ASSISTANTS CAN INCREASE PATIENT VISIT VOLUMES BY 60 PERCENT OR MORE OVER TRADITIONAL PATIENT ENCOUNTERS.

■ After finishing with one patient, the physician leaves the first assistant to close the visit and joins the second, who has gathered the history on a second patient.

■ It can take several months to transition to a fully functioning team care process.

■ This approach allows the clinical team to see more patients each day, which boosts collections, among other benefits.

and 3. Here's how the process works: The first assistant completes Part 1 of the encounter and then is joined by the physician, who completes parts 2 and 3. When the physician exits, the assistant remains in the exam room to implement the care plan, which is Part 4. When the physician enters the next room, the second clinical assistant has completed Part 1. After completing parts 2 and 3 and leaving the assistant to complete Part 4, the physician rejoins the first assistant, who has finished with the first patient, completed Part 1 of another encounter and is ready to share the information he or she has just gathered.

Developing a fully functioning team care process can take several months. The transition is greatly facilitated by breaking the process into a series of small, sequential changes. Team care can work well with either paper charts or an EMR, but it dramatically enhances productivity of an EMR system.

The benefits of team care

The team care approach offers a variety of important benefits for family medicine offices:

1. Improved productivity and finances. In our experience, one assistant managing Part 1 of the patient encounter can increase visit volumes by 30 percent or more over the traditional approach. Two assistants can increase visit volumes by 60 percent or more. This results in increased income as well. The higher patient volume more than offsets the cost of an additional assistant. In Dr. Anderson's practice, collections increased from \$370,000 in 2002 (prior to implementation of team care) to \$590,000 in 2007. (See the graph on page 36.)

2. Improved documentation and quality of care. With a well-trained RN or LPN doing most of parts 1 and 4, data can be collected and recorded with less pressure and fewer time restrictions. The clinical assistant continues the documentation process while the physician performs the exam. With most of the documentation completed during the visit, the physician does not have to take time

between patients or after hours to dictate. The improved documentation greatly reduces liability risk and makes it easier for physicians to demonstrate their quality of care. In Dr. Anderson's practice, performance on key quality of care measures improved greatly between 2002 and 2007 (see the graph on page 37).

3. Improved patient and staff satisfaction. Patients are delighted by the additional attention to detail and the opportunity to hear the clinical assistant reiterate their issues to the physician (and to contribute to that communication, if necessary). In Dr. Anderson's practice, 96 percent of patients say they are likely to return to the practice and 94.5 percent say they are satisfied with the manner of treatment by their physician. The fact that the practice provides same-day service for all acute visits plays a big part in patient satisfaction. The practice starts every day with 10 to 14 acute slots open for patients' medical needs that day.

Staff members who are trained to do more than move patients and take vital signs also express greater satisfaction with team care.

An approach worth trying

From a business perspective, the success of a medical practice is driven by the revenue side of the income statement. Many medical groups have had to extend their hours and reduce the time they spend with patients to remain viable. These changes have sometimes strained patient relationships and have added to physicians' frustrations. The team care approach dramatically enhances a family physician's ability to see additional patients while improving quality of care, increasing patient satisfaction, enhancing clinical documentation and improving the quality of work life for both physicians and their clinical assistants. **FPM**

Send comments to fpmedit@aafp.org.

1. Anderson PB. *Liberating the Family Physician: The Handbook of Team Care for 21st Century Family Medicine*. Newport News, Va: Riverside Health System; 2005 (<http://www.familyteamcare.org>).