

# Primary Care Practice Facilitation Curriculum

Module 30: Building Teams in Primary Care



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# Primary Care Practice Facilitation Curriculum

## Module 30. Building Teams in Primary Care

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# Module 30. Building Teams in Primary Care

## Instructor's Guide

Practice facilitator (PF) competencies addressed in this module:

- Meeting management
- Leadership coaching
- Basic quality improvement skills
- Change management

### Time

- Pre-session preparation for learners: 1-2 hours
- Session: 1 hour

### Objectives

After completing this module, learners will be able to:

1. Describe the role of the practice facilitator in optimizing teams in primary care practices.
2. Discuss how this work may differ based on the size of the practice and the type of team (clinical vs. nonclinical).
3. Discuss the five characteristics of effective teams and the relevance of each to primary care practices.
4. Use the Waterline Model to engage practice team members in self-assessment and reflection.
5. Deliver a short training on the characteristics of high-functioning care teams and common problems faced by these teams.
6. Access select online resources that are appropriate for helping a care team optimize its functioning.

### Exercises and Activities To Complete Before and During the Session

**Pre-session preparation.** Ask the learners to read, review, or watch the following items. (1-2 hours)

1. The content of this module.
2. [Module 29](#), Implementing Care Teams, which should be reviewed for the principles and processes of team-based care as a core element of the patient-centered medical home.
3. Video on the Waterline Model. Available at:  
[https://www.youtube.com/watch?v=XTIBvQh3\\_zQ](https://www.youtube.com/watch?v=XTIBvQh3_zQ).
4. TED video on the marshmallow teambuilding exercise and lessons learned. Available at:  
[https://www.ted.com/talks/tom\\_wujec\\_build\\_a\\_tower?language=en](https://www.ted.com/talks/tom_wujec_build_a_tower?language=en)
5. Mitchell P, Wynia M, Golden R, et al. Core Principles & Values of Effective Team-based Health Care. Washington, DC: Institute of Medicine; 2012. Available at:  
<https://nam.edu/wp-content/uploads/2015/06/VSRT-Team-Based-Care-Principles-Values.pdf>.

**During the session.** Presentation (15 minutes)

1. Present key concepts from the module.

**Activity for learners.** (45 minutes)

1. Divide into groups of three or four. Assign roles: Practice Facilitator and Participants.
2. Have members of each group share details about a team they have been part of.
3. Have one member of each group lead a conversation about whether or not these teams were effective and why, using the “five features of effective teams” model.
4. Have Practice Facilitator report out findings to the larger group for discussion of common findings.

## Module 30.

Teams and teamwork are a vital part of every primary care practice, no matter how small or large the practice. The functioning of these teams plays a large role in the quality of care and patient experience with care, as well as the morale and job satisfaction of clinicians and other staff in the practice. Moreover, the increased focus on team-based care in the past several years means that teams are more important than ever in primary care.

One of your roles as a practice facilitator (PF) is to help these teams improve how they function and work together to accomplish their goals. This module will introduce the information you will need to help these practice teams work well together. In this module, you will learn:

- The basics of team formation and functioning.
- The types of problems that prevent teams from accomplishing their goals.
- Some basic methods for helping teams improve their effectiveness.

Moreover, this module provides additional information and resources that you can use with your practices to optimize this essential team. This module is a companion to [Module 29](#), Implementing Care Teams, which you should complete before beginning this module.

### Ways That PFs Can Help Practices Improve Their Teams and Teamwork

You will find many types of teams within a primary care practice. The most obvious and relevant to the patient centered medical home are *patient care teams*, which are often made up of a clinician and a medical assistant but can include a variety of additional members, such as pharmacists, health educators, community health workers, and, of course, the patients themselves. Other teams found in primary care practices include *practice leadership*, *finance*, *health information technology (HIT)*, *quality improvement (QI)*, and *risk management teams*, as well as teams built around specific types of patients or specific patient services, such as women's health, diabetes care, or pediatrics. You will probably find yourself working most often with the practice's QI team, leadership team, or one or more of their patient care teams.

As a PF, you can help your practices improve the effectiveness of their teams in a number of ways. You can:

- Help practice leaders design and support effective teams (see [Module 21](#): Working With and Supporting Practice Leaders, for techniques on how to engage these leaders).
- Train practice members on characteristics of teams and what makes them effective.
- Help teams assess their performance and functioning and use this information to identify changes that can improve their functioning.

- Help teams implement changes in the way they operate, such as:
  - Creating a clear definition of the team’s purpose and goals
  - Clarifying members’ roles
  - Adopting effective group norms and processes
  - Improving methods and skills in communication and addressing conflict
- Connect team leaders to resources on effective team leadership and coaching them in these areas.
- Help teams modify workflows to support better teamwork.

## What Makes for an Effective Team?

The teams you work with will typically be focused on accomplishing specific tasks or objectives. For such teams, effectiveness requires the following five features (Hackman, 2002).

1. The team is a **real team**. A real team must have: a task for which the members are collectively responsible, a clear definition of who is on the team, a clear definition of what things the team (as individuals and a group) is accountable for, and a stable membership over time so that the team can develop a shared approach to the task they have been assigned.
2. The team has a **compelling direction**. Teams need a purpose that is compelling, challenging, and important. Once practice leaders have determined the purpose of a specific team, the team can focus on achieving specified objectives related to their purpose. For example, a team could be given the clear direction from practice leaders to ensure that a member of the clinical team follows up with patients who have been recently discharged from a hospital stay within four days to improve care and reduce unnecessary re-visits to the hospital. A practice leader who provides motivation to the team about followup is needed after hospital discharge can make the task even more compelling to team members.
3. The team must have an **enabling structure** to make it possible for them to accomplish their objectives. Specifically, teams should be diverse enough to offer different potential approaches to solving problems. You should advise practice leaders of this and help to ensure that they select team members with care. For example, having someone with data analysis skills on a QI team is essential for monitoring care improvements; having a clinician on the team is also essential for identifying clinically meaningful improvement targets. However, a team with lots of members often runs into difficulties completing the assigned tasks. Research on teams shows that the coordination required within the team goes up dramatically when a team has more than six members. For a large practice taking on a complex project, it likely will have to organize a large team into sub teams responsible for certain portions of the work to ensure that work gets completed and team members feel accountable for it.



4. The team also needs a **supportive environment** to be effective. You can work with practice leaders to set up effective recognition systems to reinforce good team performance. Some things you can do to help make an environment supportive include:
  - Advise the team on ways to gather information needed to make and monitor the changes they are working on.
  - Direct team members to technical assistance or training when needed (e.g., learning about specific techniques to engage patients or improve chronic illness care).
  - Help with or advise on securing the resources needed to make change (e.g., technologies, staff).
1. **Competent coaching** is an important resource that you can provide to the teams you work with. Your coaching should change in approach as the team develops over time. At the beginning, your coaching will largely be *motivational*, focusing on getting all members of the team to put forth the effort needed to solve the problem they are working on. Once the team is up and running, your efforts will be more *consultative*, focusing on getting the team to consider its work so far and to think about strategies for its upcoming work. You can be a resource for change strategies. Once a team has completed its assigned task, your coaching should be *educational*, focusing on facilitating a conversation about the lessons learned from the task they have successfully completed.

Practice leaders play a key role in making sure that the teams in their practice include these features, and you can play an important role in helping practice leaders understand the importance of these features of a successful team. Helping practices ensure their teams are well designed—for example, they are real teams that have a compelling direction, enabling structure, and a supportive environment—is an important place to start when you are working with a practice to optimize a team’s functioning. For more information on the five features of effective teams, see Hackman (2004).

## Assessing Teams

As a PF, you will need to become skilled at observing and assessing teams in your practices.

**Common problems of teams and how to identify them.** Teams get stuck or become dysfunctional for many reasons. They may run into problems because they lack the content knowledge or technical skills to accomplish the goals they have been charged with. Or the roles of individual team members may not be well defined, leading to confusion about how each member should participate on the team. A team might fail to value the input of all its members, perhaps dismissing input from lower-status members, or fail to elicit input from quieter members. Teams can also run into difficulties because of interpersonal conflicts among its members that are ineffectively handled. The Waterline Model, described below, offers a good approach to identifying these types of problems and working through them to help a team be more productive.

**The Waterline Model.** A tool that many PFs find particularly useful and practical in their work with practices is the Waterline Model (Harrison et al., 2001). This model is an interactive approach to identifying the source of problems in a team, which can help you and the team take steps to resolve the problems. It can also be used to help a team reflect on its functioning and look for ways to further enhance that functioning. As a PF, you can use the Waterline Model to help teams diagnose the reasons they are having problems attaining their goals and then use this information to take steps to resolve these problems (Harrison et al., 2001). A video that presents a good overview of this approach is available at: [https://www.youtube.com/watch?v=XTIBvQh3\\_zQ](https://www.youtube.com/watch?v=XTIBvQh3_zQ).

## Optimizing Patient Care Teams

Patient care teams are central to the PCMH. [Module 29](#) in this curriculum discusses the initial implementation of care teams and provides you with a variety of related resources. This module deals with what comes next. Just because a practice implements care teams does not mean that the team members work together well or even at all. Sometimes clinicians and staff have fully bought into the idea of team-based care. In other instances, they are reluctant participants and are doing so only because it has been forced on them by their practice leaders.

Regardless of the level of buy-in, most care teams—just like members of a sports team—need training, support, and practice to hit their stride.

Some of the things you can do as a PF to help practices optimize the functioning of their patient care teams include:

- Helping team members more clearly define each member’s role.
- Helping team members improve communication with each other about patient care.
- Helping team members improve their huddling process.
- Helping teams decide on and implement standing orders.
- Helping teams (and practices) modify workflows to better support teamwork.
- Helping practices better use their electronic health record (EHR) and other IT resources to support teamwork.
- Helping practices incorporate patients as members of the team.
- Helping teams gather feedback from patients about the experience of team-based care and using this information to improve processes.
- Helping teams develop scripts for explaining team-based care to patients.

An emerging approach in care team formation is the **teamlet plus expanded team member model**. Teamlets consist of a clinician (physician, nurse practitioner, or physician assistant) and one or more medical assistants that work together daily. Both the clinician and the medical assistants feel responsible for the panel of patients assigned to them. The teamlet forms the core of a larger team—the expanded team member model—that includes other practice members such as a registered nurse, a health coach, and a behavioral health clinician.

- Helping teams to expand their membership to include community health workers, pharmacists, nutritionists, patient advocates, and others important to patient care.
- Helping practices train their medical assistants, clerks, nurses, and other members of the team in the skills needed for their new expanded roles.

## Characteristics of High-Performing Primary Care Teams

High-functioning care teams in primary care practices share a number of characteristics, as described in Table 30.1.

**Table 30.1. Nine characteristics of high-functioning primary care teams**

Characteristic	Description
Stable team structure	Team membership is consistent; the same people always work together. Schedules, language, and compatibility of work styles are considered when forming teams.
Co-location	Team members have adjacent workstations and spaces that enable them to share information in real-time about patients.
“Share the care” culture	The practice and care team have transitioned from the traditional “lone physician with helpers” or “I” model of care to a “share the care” or “we” approach. This involves reallocating responsibilities, not just tasks, and meaningful participation. It also means the patient panel is seen not just as the clinician’s panel but the entire team’s.
Defined roles with training and skills checks	Team members’ roles are clearly defined, and they are provided with training to enable them to fill these roles. Each member’s competencies in required skills are evaluated and additional training is provided to remediate skills deficits.
Use of standing orders and protocols	Clinicians (physicians, nurse practitioners, physician assistants) approve standing orders that enable nurses, medical assistants, and other nonclinician team members to provide routine services without taking up clinician time. Conditions under which staff can provide care are clearly spelled out.
Use of workflow mapping to clearly define workflows	Team members are clear on who does what tasks and functions, in what order, and how handoffs occur. The team maps its workflows and works together to improve them to ensure this clarity.
Staffing ratios are adequate for new roles	Sufficient nonclinician staff are available to assume additional responsibilities. Optimal staffing can be supported through revenue generated by reallocating work, thus enabling clinicians to see more patients per day, or through other payment arrangements, such as shared savings, care management fees, or per-member per-month payments (see <a href="#">Module 3</a> , The Primary Care Landscape and Context, for additional information).

Characteristic	Description
Ground rules	Two sets of teamwork ground rules are needed: first, to enable productive team meetings that are respectful of all participants; second, to enable effective teamwork on patient care. Developing effective ground rules for teamwork may require addressing and overriding existing norms and work patterns that undermine teamwork.
Defined methods for communication	The team holds regular meetings of all its members to discuss issues. Daily huddles are held and used to coordinate how the team will work together to provide care for the patients being seen that day. Minute-by-minute communications are facilitated by co-location, clear roles, trust, and workflows.

**Source:** Adapted from Bodenheimer T, personal communication, November 2014.

As a PF, you can use these characteristics to help you evaluate the care teams you work with. You can also train primary care teams on these factors and help them reflect on the degree to which their team contains each of these characteristics. You can then work with them to plan and implement interventions to better align their structure and processes with these characteristics.

## Common Challenges Faced by Primary Care Teams

As a PF, you should be familiar with the types of problems that can affect the effectiveness of care teams. Even if the practice has not engaged you specifically to address these issues, it is important for you to keep aware of them, given how central teams are to all aspects of the PCMH and practice functioning. In fact, they affect almost every aspect of the practice from who is hired, to staff training, workflow, IT, and patient experience.

Primary care teams face a number of common challenges.

The first is the **complexity of primary care itself**.

The sheer scope of care and range of patient issues that care teams need to be able to address can make it challenging to define a manageable list of tasks and roles. Different workflows, processes, and teamwork can be required for different types of patients (pediatric, adult, elderly) and visits (wellness, acute, chronic).

**What payers will allow practices to bill for** can create another barrier to teamwork. For example, in some instances, visits with physicians, nurse practitioners, and physician assistants are billable, but visits with other types of professionals on the team may not be. This can create a disincentive to “share the care” and offset any gains in physician time that result from the team-based approach. Practices may need to think creatively about how to address these barriers.

### Example of Care Team Principles from the Cambridge Health Alliance

Every patient is assigned to a care team that, at the very least, includes a primary care clinician, nurse, medical assistant, and receptionist.

The team huddles daily to care for patients in a proactive way.

The teams meet at least monthly to proactively manage the work of population health and to discuss high-risk patients. At most sites, teams meet weekly or biweekly.

The usual care team interfaces seamlessly with the complex care management team.

**The history of medicine and the power structure** within it can be another barrier. Team members, especially physicians who are often the leaders of their care teams, must learn to balance their degree and credentials with the need for all members to participate fully on the team for it to function well (Bodenheimer, 2007). Similarly, nonphysicians that may have been acculturated to wait for direction from the MD or DO must learn to form new relationships with physicians (and patients) and navigate the patient care process in a different way. The issue of power and its effects on communication and teamwork is pervasive in all areas of medicine—not just primary care—and has important implications not only for quality of care but also for patient safety. The Agency for Healthcare Research and Quality has developed some outstanding resources to improve communication around patient care issues called TeamSTEPPS (available at: <https://www.ahrq.gov/teamstepps/index.html>). As a PF, you should become familiar with this program and its resources so you can draw on them as needed with your practices.

**Issues with a practice’s IT** also can create additional barriers. The EHR used by a practice may create its own set of obstacles to team care. The system may not be configured to support team-based care or key functionalities may be missing or not enabled. For example, a small practice using a web-based system may have set up individual accounts for each clinician; this would make it difficult for others to view the patient’s medical record. Another practice may not have enabled capabilities like tasking that could support communication among members of care teams.

A number of **other factors** can affect care team functioning. Unpleasant tasks may be “dumped” on nursing staff or medical assistants. Staff may resist expanded roles if they are already feeling overworked. Physicians may endorse the team approach intellectually but resist “sharing the care.” Turf battles may occur between different staff members who fear that their role is being replaced. For example, medical assistants might feel threatened by inclusion of community health workers on the care team. Other common challenges include: unclear role definitions; insufficient time for teams to meet, reflect, and understand the meaning of their work together; inadequate training or skill development to perform tasks needed for team-based care; and reluctance to delegate tasks to team members because of concerns about competence.

#### **Resources for Helping Care Teams Optimize Functioning**

Improving Primary Care: Team Guide is available at:

<https://improvingprimarycare.org/>

TeamSTEPPS for Office-Based Care:

<https://www.ahrq.gov/teamstepps/officebasedcare/index.html>

TeamSTEPPS videos

<https://www.ahrq.gov/teamstepps/officebasedcare/videos.html>

In small family-run practices, there may be an unwillingness to replace ineffective staff because these staff often have both a professional and a personal relationship (for example, a nurse at a practice who is also the wife of the solo physician). There is sometimes less professionalism in small practices, such as a lack of meetings, job descriptions, performance reviews, merit pay, basic policies and procedures, and so on. Finally, and not surprisingly, people often resist change. Staff and clinicians may be comfortable with existing roles and resist changes.

## Getting To Know the Care Teams in Your Practices

If assessing the functioning of a practice’s care teams is going to be a major focus of your work, you may want to conduct a more in-depth assessment of its teams. There are a variety of tools available for formally assessing care teams, including:

**The *Building Blocks Team Function Survey***, based on the 10 Building Blocks of High-Performing Primary Care model, provides a series of questions for assessing care team functioning. The Building Blocks survey is modeled after the Assessment of Chronic Illness Care.<sup>1</sup> It also assesses other areas of practice functioning beyond care teams (Bodenheimer, 2014).

**Traditional performance reports** can also be useful in getting a feel for how effective a care team is. You can work with the QI team at the practice to generate reports on care teams’ performance on important quality metrics that you review with care team members and help them use to assess how well they are functioning as a team. These metrics should also include assessments of member morale and “joy at work.” You can work with them to use tools like **The 5 Whys** (NHS Institute for Innovation and Improvement, 2008) and **fishbone diagrams** (Centers for Medicare & Medicaid Services, 2014) to identify root causes for problems they are encountering or—if you are taking a strengths-based approach—root causes for areas in which they are functioning particularly well (see [Module 11](#) for details). Then you can help them use this information to develop and test interventions to improve their functioning using Plan Do Study Act cycles or a similar process.

## Working With Care Teams To Engage Patients as Partners

Patients are an essential part of any care team. Clinicians and staff work collaboratively with patients to jointly attain defined health goals and outcomes. Both patients and their caregivers are members of the care team, each with their own areas of expertise. While clinicians and staff members are experts in medical treatments, patients are experts on their own lives and health care goals. You can work with clinicians and staff to ensure that the necessary conditions exist

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<sup>1</sup> Assessment of Chronic Illness Care (ACIC). Copyright 2000, The MacColl Center for Health Care Innovation, Group Health Cooperative.

for effectively partnering with patients. According to the Institute of Medicine (2012), these conditions include:

- clarifying the role of patients on care teams with clinicians, staff, and patients;
- supporting shared and individualized decision making about health goals and care, and
- supporting effective communication among clinicians, staff, and patient care team members.

As a PF, you can support care teams as they work to create these conditions by helping them gather feedback and ideas from their patients; directing them to resources, including exemplar care teams; and helping them select and implement specific changes. Table 30.2 contains some resources that other PFs have found helpful for supporting this work.

**Table 30.2 Resources for practices to use in engaging patients**

<p><i>Shared decision making</i></p> <p>AHRQ’s Shared Decision Making Toolkit, available at: <a href="https://www.ahrq.gov/health-literacy/professional-training/shared-decision/index.html">https://www.ahrq.gov/health-literacy/professional-training/shared-decision/index.html</a>.</p> <p><i>Engaging effectively with low literacy and low health literacy patients</i></p> <p>AHRQ’s Health Literacy Universal Precautions Toolkit, available at: <a href="https://www.ahrq.gov/health-literacy/improve/precautions/index.html">https://www.ahrq.gov/health-literacy/improve/precautions/index.html</a>.</p> <p><i>Engaging patients in redesigning care delivery</i></p> <p>Partnering with patients to redesign care, see: <a href="https://www.hipxchange.org/patientengagement">https://www.hipxchange.org/patientengagement</a>.</p> <p>Experienced-based co-design toolkit, see: <a href="https://www.kingsfund.org.uk/projects/ebcd">https://www.kingsfund.org.uk/projects/ebcd</a>.</p>
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## Summary

Teamwork is essential to effective practice operations and practice improvement, and to the PCMH. As a PF, you can help practices improve their teams and teamwork by helping teams learn about the process of becoming a team, evaluating their functioning, and designing and testing interventions to improve the effectiveness of all their teams.

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