Leveraging team-based care to accelerate transition from volume to value and return joy in practice

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THE PROBLEM

- Teamwork in care delivery is foundational to healthcare’s shift to value. However, ambulatory practices have historically worked in silos where clinical and administrative staff operate independently.
- The Mount Sinai Doctors Faculty Practice (MSDFP) at 1090 Amsterdam Avenue is an urban community based primary care office located in Morningside Heights, New York.
- Current state: MSDFP at 1090 Amsterdam Avenue was a physician driven practice with rudimentary teamlets consisting of a physician (MD), a medical assistant (MA) and a front desk (FD) receptionist, with a larger circle of care including a pharmacist, nutritionist, and a care manager. The MA and FD serve as the clinical and administrative staff for the MD, but this system was not standardized, nor sufficient. This was further compounded by the lack of standardized workflows among providers and staff, and a lack of clarity around the roles and responsibilities of each team member.

CULTURE CHANGE THRU CO-DESIGN

- Weekly Meetings: We engaged our MAs in co-design sprints over a series of weekly meetings. Our goal was to encourage a culture change to continuous improvement and staff engagement in the evolving role of MAs in clinical care delivery.
- Sample Project – Previsit planning: The first project we worked on together was previsit planning, something all the MAs had done previously but had not sustained. The key to success this time around was designing a solution with input from all the MAs. As the experts in their daily work, each MA had figured out what worked best for their workflows. As each of them made suggestions, they were able to course correct each other. At the end of our session, we developed a unified plan, with contributions from each of them. When we asked the MAs to sign-off on the expectations, there was very little reluctance since each of them had taken part in building the workflow.

THE SOLUTION

- Co creation of future state: The practice leadership and staff co-designed a series of changes to inspire increased integration and teamwork. These changes included: co-location of MA:MD pairings, cross-functional role coverage, and proactive collaborative team based care initiatives. These improvements resulted in enhanced patient care and work satisfaction alike.
- Flow Stations: In a conscious effort to promote teamwork and efficiency, the classic physician consult room was transformed into a flow station where MDs and MAs were co-located side-by-side. This brought the MA:MD teams into continuous contact and fostered collaboration and a move towards safety culture.
- Huddle Sheets: Point-of-care huddle sheets designed to highlight preventive care gaps and key quality metrics were integrated into daily workflows. MAs and MDs reviewed the huddle sheets together at the beginning of the clinic session identifying outstanding care gaps and ways to engage the care team in managing high risk patients. Referrals were made to a clinical pharmacist embedded in the practice to educate and engage patients in improving their blood pressure and glucose control.
- Previsit Planning: Those same huddle sheets were used to perform previsit planning. A week in advance, MAs reviewed charts to ensure that all laboratory testing, diagnostic imaging, and consultation notes were accounted for in preparation of the patients’ scheduled appointment. The goal was to encourage MAs to have co-ownership of their MD’s patient panel.
- Cross-Functional Role Coverage: MAs were trained in FD functions, and asked to cover the FD during administrative sessions. This cross-training improved staff understanding of each team members role.

TEAM FEEDBACK

PATIENT FEEDBACK: A CASE STUDY

79 year-old woman with a history of hypertension, hyperlipidemia, chronic kidney disease, and knee arthritis, presented for pre-op medical clearance for total knee repair. At first glance, the EKG appeared to be normal, except something just did not look right to the MD. The patient for the most part was asymptomatic, although she described a “strange vibration” in her chest every time she lay down.

After several EKGs, confirmation of lead placement, and consulting a colleague, the MD concluded that the patient was experiencing a paroxysmal junctional tachycardia. Having witnessed all the interchanges, and the MD’s growing concern, the MA asked, “Should we send her to the ER?”

The MD was hesitant to send the patient to the ER since she was asymptomatic and would likely get admitted unnecessarily. She asked, “How difficult would it be to get an urgent cardiology appointment and an echocardiogram?”

The MA called our front desk supervisor who was covering our cardiology group, and scheduled the patient urgently for both an echo and a cardiology consultation.

An EP study and ablation later, the patient came in for follow-up and thanked the 1090 Amsterdam team for ”saving her life.” She even brought the MD flowers.

CONCLUSIONS

Team based care requires a conscious culture change:
- Co-location improves communication and fosters collaboration that translates into safer patient care
- Cross-functional role coverage enhances the understanding of team members roles and stimulates creative problem solving
- Quality improvement and co-design sprints engage teams to focus on a problem together, build consensus, and develop sustainable changes
- Staff engagement in quality improvement and co-design enhances buy-in and overcomes the challenges of change management