

Promoting Patient-Centered Team-Based Health Care

Effective Date: 2016

Overview

The United States spends more on health care than any other country, and the outcomes are not representative of that investment. It is evident that the current health care infrastructure is insufficient to meet the needs of health care consumers today and in the future.

A fundamental change in health care delivery is needed to achieve what the Institute for Healthcare Improvement describes as the “Triple Aim”:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care (Berwick et al., 2008).

The high-performing team is now widely recognized as an essential tool for constructing a more patient-centered, coordinated, and effective system of health care delivery (Mitchell et al., 2012). The American Nurses Association (ANA) supports the use of patient-focused health care teams composed of various health care professionals with unique abilities, training, and expertise.

Defining Team-Based Health Care

The Institute of Medicine (IOM) defines team-based care as “the provision of health services to individuals, families, and/or communities by at least two healthcare providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated high-quality care” (Mitchell et al., 2012, p. 5).

Team-based care offers many potential advantages, including expanded access to care (more hours of coverage, shorter wait times); more effective and efficient delivery of additional services that are essential to high-quality care, such as patient education, behavioral health services, self-management support, and care coordination; increased job satisfaction; and an environment in which all medical and nonmedical professionals are encouraged to perform work that is matched to their abilities. Fundamental to this approach is the belief that when practices draw on the expertise of a variety of provider-team members, patients are more likely to get the care they need. A large provider team might also support continuous, data-driven quality improvement through effective intra-team communication and problem solving (AHRQ,

2016). Nursing has a particularly important role to play in defining “care coordination,” which has always been a primary duty of nursing (Lamb, 2014).

Shared Values and Principles

Each team is unique based on the setting or situation, but the IOM describes core shared values and principles that embody “teamness” and are critical to high-functioning teams (IOM, 2010, p. 6). In applying the core principles for true collaboration, team members’ values must align. Specific values reported include **honesty, discipline, humility, creativity, and curiosity**, and these values are interwoven through the principles of **shared goals, clear roles, mutual trust, effective communication, and measurable processes and outcomes**.

Shared goals: The team—including the patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities and can be clearly articulated, understood, and supported by all team members. Inherent in shared goals is **humility** among team members, as evidenced by accepting and celebrating the roles of the various other health care disciplines and the central role of the patient. Subscribing to this value demands that no team member fundamentally believes that he or she is superior to another.

Clear roles: Because professional responsibilities and duties may overlap, it is especially important that clear expectations be identified for each team member’s functions, responsibilities, and accountabilities, and that **discipline** be used in meeting these expectations, thus optimizing the team’s efficiency and effectiveness.

Mutual trust: When team members value **honesty**, trust can be earned. Thus, strong norms of collaboration and opportunities for shared achievement can be attained.

Effective communication: The team needs to prioritize and continuously refine its communication skills. The team should have consistent channels for candid and complete communication that are accessed and used by all team members across all settings.

Measurable processes and outcomes: **Creativity** and **curiosity** are paramount in team-based care, allowing team members to seek out new ways of solving problems, learn from poor outcomes, and commit to continual improvement of the team’s practice. The team must agree on and implement reliable and timely feedback on successes and failures in both the functioning of the team and the achievement of the team’s goals. These factors can be used to track and improve performance immediately and over time (Mitchell et al., 2012).

Team Composition

In an increasingly complex health care system, no single team member can perform every task that the patient needs. Access to a diverse team that maximizes the unique expertise and insights of team members fosters the delivery of optimal care. Therefore, the expanded health care team pulls from a variety of disciplines and may include registered nurses, advanced practice registered nurses (APRNs), physicians, physician assistants, pharmacists, physical therapists, occupational therapists, speech therapists, dieticians, certified nurses’ aides, social workers, psychologists, and even community support systems and other allied health disciplines.

Although it is sometimes easy to differentiate among health care professionals, occasionally the lines are blurred and duties overlap. This is often the situation with regard to physicians and APRNs. It is not realistic or cost effective to draw distinct lines between the duties of all health care professionals. As APRNs have grown in number and visibility, the legal and regulatory framework for nursing practice has developed and

evolved. In the case of advanced practice nursing, nurses are able to perform certain components of care that were traditionally the province of medicine, including diagnosis and pharmacotherapy.

When providers work together in a team, outcomes are much improved over the work of just one person (Mitchell et al., 2012). And as in any team, success can be largely attributed to the leadership. The leader embraces the team values and fosters coordination and collaboration among the team members with a continued focus on the patient-consumer. Although there is support for this new delivery model, it comes with challenges.

Challenges in Implementing Team-Based Care

In making sense of the current controversy, it is helpful to make a distinction between team-based care as a model for delivering care and individual licensure authority. Team-based care is a delivery model where patient care needs are addressed as coordinated efforts among multiple health care providers and across settings of care. Licensure is the legal recognition and permission of one individual to provide professional services to patients.

Patients

The most important team member is the patient. Not all patients are comfortable being much more active participants in health care decisions. This can be compounded by an orientation to the use of a single provider for multiple episodes of care. Although the situation is changing, that single provider has historically been a physician. APRNs are not interested in replacing physicians but rather in practicing in a manner consistent with their education and training, thus permitting physicians to focus on patients with more complex needs. When the knowledge and skill of all team members is used optimally, patients will find that their care is being delivered by the most appropriate team member.

Reimbursement

Team-based care is intended to provide the right care at the right time by the person with the most appropriate level of training, experience, and licensure, but reimbursement practices don't necessarily support this model. Traditionally, payments for services have been based on an encounter with an individual provider. Many payers reimburse only when a physician delivers certain services or reimburse members of another discipline for those same services at a fraction of what a physician would be paid.

Leadership

Large physician groups have resisted acknowledging that other health professionals, such as nurses, are equipped to lead a team and have launched a campaign focused on "Physician-led Team Based Care" (AMA, 2014). In partnership with other health care professionals, registered nurses have long demonstrated leadership and innovation in the design, implementation, and evaluation of successful team-based care-coordination processes and models.

The team member guiding patient care and decision-making should be the patient. In partnering with the patient, team leaders will need to be fluid and adapt over time for a given situation. In a statement regarding team-based health care, the American College of Cardiology notes:

Front-line practitioners usually have no trouble figuring out who is the logical leader of the team. Leadership of healthcare teams can be situational, clinical, or managerial, depending on the charge and the task that the team is undertaking.... It is our position that leadership should be flexible, reflecting the special needs of the patient at a particular time and setting. For example, a chaplain or a social worker may lead a team meeting to discuss transition to palliative care; a nurse or a pharmacist may lead a team that organizes a chronic anticoagulation clinic; and an APRN or PA may

lead a team that coordinates transitions of care. The leader should be the team member with the greatest knowledge and experience and the best qualifications for the leadership task at hand (Brush et al., 2015, p. 2123).

Regulatory Barriers

The current controversy over the leadership of health care teams is rooted in scope of practice laws. Almost all members of the health care team have experienced, or are now experiencing, unnecessary restrictions in practice as a result of outdated scope of practice laws (AAPA, 2016). There is, however, one exception: physicians. Physicians have the oldest and most broadly defined scope of practice. Many of the health professions have scope of practice laws that are seemingly “carved out” of the practice of physicians, and state laws dictate that physicians must supervise the practice of these health care professionals in order to give adequate health care (Safriet, 2002). The literature simply does not support this notion. Decades of research have established the safety and effectiveness of care by APRNs (Martínez-González et al., 2014), and that body of evidence has led institutions and organizations from the Institute of Medicine to the National Governor’s Association to AARP to call for the lifting of barriers to APRN practice (ANA, 2015b).

Although many organizations and individual physicians have embraced the APRN role, it has not been without controversy. Unfortunately, some physician groups have resisted recognizing the capacity of APRNs, arguing that they are insufficiently prepared and thereby require supervision by a physician. APRNs are prepared at the graduate or post-graduate level and are deemed competent clinicians upon graduation and passage of a national certification examination. There is no evidence to support the need for additional post-licensure supervision of APRN practice beyond current educational and certification standards.

The Federal Trade Commission and the Bay Area Council Economic Institute have noted that unsubstantiated supervision increases health care costs and may exacerbate existing and projected shortages in the health care workforce. Each APRN is personally accountable for his or her practice—to patients, licensing boards, the nursing profession, and society. The notion that physicians should supervise care provided by APRNs or that written collaborative agreements are needed is outdated. APRNs use their professional judgment and responsibility to assess and treat patients within the bounds of their legally authorized scope of practice. Individual accountability extends to legal liability. It is inappropriate to expect physicians, or any other provider, to accept responsibility or liability for care in which they have not been directly involved (ANA, 2015a, p. 5). **This role competence and professional accountability holds true for all health care providers.** Members of the health care team, specifically APRNs, have demonstrated safe, effective, and high-quality care. Regulatory supervision requirements prohibit these team members from functioning fully and can result in reduced or delayed access to care.

Representatives of six national health care organizations, including the Federation of State Medical Board of the United States, collaborated on a document intended to help policy makers decide when a profession’s scope of practice should be modified (NCSBN, 2012). The document emphasizes that scope of practice laws are meant to protect the public. They state that “the argument for scope of practice changes should have a foundational basis within four areas: 1) an established history of the practice scope within the profession, 2) education and training, 3) supporting evidence, and 4) appropriate regulatory environment” (NCSBN, 2012, p. 3). When a profession can speak to these four areas and provide evidence within each of them, changes to scope of practice are “in the public’s best interest” (NCSBN, 2012, p. 3).

Government regulation’s sole purpose is to protect the public, and this should guide scope of practice reform, not safeguard the self-interests of professional groups. Scope of practice reform is necessary as a profession’s practice evolves. Many things contribute to the evolution of a profession, including technology, patient demographics, and evidence-based advancement in the practice of medicine, among others (NCSBN, 2012). **The group stressed the importance that changes in a profession’s scope of practice would not result in independent practice. Collaboration among health care providers is not only encouraged, it is essential**

to effectively practice in today's health care environment. Collaboration should be enhanced through reformed scope of practice, not the opposite. Currently, there exists an overlap of responsibilities between health care professionals that will only increase given the ongoing transformation in health care. This is not a negative result of scope of practice reform: overlap of practice is necessary and vital to promoting optimal patient care. (NCSBN, 2012).

ANA's Position

The ANA supports patient-centered, team-based health care that values each and every team member for his or her own unique abilities, training, and expertise. Formulation of health care teams based on the individual needs of patients requires unencumbered, highly functioning team members to coordinate care and improve the nation's system of health care delivery. To foster effective health care teams, all health care professionals need to practice to the full extent of their education and training, unburdened by outdated, baseless, and costly restrictions.

Solutions

- **Encourage policy makers, the nursing community, and other stakeholders to work together with consumers to reform outdated scope of practice laws.**
- **Support the collection of data and application of evidence to advocate for payment models that are consistent with team-based care and acknowledge that the most qualified leader may not be a physician, depending on the specific situation.**
Although further research on the safety and effectiveness of APRNs is unnecessary, ANA welcomes well-designed research studies to better understand the APRN workforce, the impact of restrictions on APRN practice, and how best to increase access to effective patient-centered care.
- **Educate patients about team-based care and about team members' unique qualifications and roles** while exercising sensitivity to the care recipients' perceptions and concerns about this shift in delivery. Assist patients in becoming active participants in managing their care.

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