

# Newport News Family Practice

## The Family Team Care Model

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Watching Dr. Peter Anderson's Family Team Care Model in action is watching medicine being practiced as many of us hoped it would be when we chose primary care as a vocation.

For the past 8 years Anderson has been able to spend his days working as a doctor, listening and caring for patients, rather than as a data entry clerk. His two nurses and medical assistant (MA) and Anderson form a well orchestrated team. The key innovations are collaborative visits and the extensive role the nurses play in patient preparation, real-time visit note documentation, order entry, patient education and between visit care. One of his clinical assistants remains with him in the room with patients, documenting the note, preparing an after visit summary and then after he is finished, reviewing with the patient for in-depth patient understanding. His two nurses and MA make meaningful contributions to patient care while he is able to spend his time applying his skills as a physician

### **Origins of Innovation: "Ghost to my family"**

The revitalization of Anderson's practice model was born out of desperation. In 2003 he realized that he could not continue the traditional model of care. The economic trajectory of his practice was not sustainable. Nor was the lifestyle: "I was becoming a ghost to my family."

Anderson developed and tested his model, demonstrating that it provided improved quality, efficiency, compensation, and job satisfaction for himself, his staff and his patients. (see <http://www.aafp.org/fpm/2008/0700/p35.html> ).

### **The Care Team.**

Anderson's core care team consists of the physician, two nurses and one MA. With 4 other physicians he also shares one referral clerk, 2-3 front desk receptionists and 1-2 schedulers who manage the patient departure as the patient leaves the clinic. Two additional receptionists triage phone messages.

## **Real teamwork**

Of the many practices I have visited, Anderson's provides the truest example of real teamwork. Anderson has invested heavily in training his nurses and MAs, explaining "In the old model, the doctor and the nurse each went on in their separate ways. In the Family Team Care Model the tasks of the nurse and doctor are tightly woven together, like a single cord, moving toward the same goal of excellent patient care."

### **The Model in action:**

A patient arrives and checks in with the front desk receptionist.

The MA brings the patient back to the clinical area. She charts the reason for the visit, vital signs, updates allergy history and asks questions about smoking, alcohol and exercise and enters the data into the EMR. She exits the room, prints up a lab summary sheet and places it in a holder on the exam room door. This component of the care may take 3-4 minutes.

One of the two RN's then enters the room. She further explores the patient's agenda for the visit and documents all of the patient's current and relevant medical data. She performs medication reconciliation reviewing the current list in the EMR and making any changes as guided by her interview with the patient.

The nurse then performs a specific review of systems appropriate for that patient's problems, or, a more general review of systems if the visit is for an annual physical. She enters this information into the EMR using structured templates which Anderson has developed. The nurse reviews the last few visit notes in the EMR to be sure that issues from previous visits are addressed during this visit. She also collects any consult notes, emergency room notes, outside labs etc that have entered the patient's chart since their last visit to Anderson. In the Family Team Care Model "chart prep" is done by the nurse while in the room with the patient before the doctor enters the room. The nurse exits the room. This component may take 8-12 minutes.

The nurse then assembles the three hard copy information sheets which Anderson will use during his time with the patient:

1. A printed flow sheet of pertinent labs. This allows Anderson to see at a glance which labs are up to date and which might need to be ordered at the end of today's visit.
2. A charge ticket. Anderson indicates the appropriate code and diagnoses, and any lab to be performed at the end of the visit. After the visit the patient presents this charge ticket to the front desk scheduler who uploads the information into their electronic billing software. These schedulers are trained in coding and audit 10

charts per week for each physician to provide feedback and ensure that documentation and billing remain complete and accurate.

3. The hard copy of today's EMR developing note. This includes the patient's personal data, vitals, smoking, alcohol and exercise history (entered by the MA.) the reason for today's visit, the reconciled medication list, the review of systems (entered by the nurse), and the patient's imported problem list.

Anderson emphasizes the importance of the hard copy and points out that a hybrid system of paper and paperless communication and documentation is more efficient and effective than a totally paperless system, which forces the physician to keep his head buried in the computer rather than interacting with the patient during the visit.

Anderson and the nurse enter the patient room together. The nurse sits at a desk with the computer and scribes the visit, and accesses any additional information needed as the visit progresses. Dr. Anderson sits at a stool by a counter or stands during the appointment. He does not sign into the EMR. Anderson relates, "My goal is to never sit down, never look at the computer during the visit." *A great way to increase the joy in practice!*

Anderson greets the patient and family members. He then looks at the hard copy of the visit note while the nurse verbally relays the reason for the visit, all initial medical data collected, and review of systems, similar to the manner in which a resident physician presents to an attending. Anderson asks clarifying questions of the nurse or the patient during this review. The nurse types in any additions or corrections to the review of systems as directed by the physician. Anderson uses his hard copy to make any brief comments that he wishes to use later in his review of the scribed visit note.

Anderson then performs the exam calling out any abnormalities which the nurse documents in the EMR.

Anderson then spends the rest of the visit talking directly with the patient and family. He scrutinizes the patient's problem list as printed on his hard copy and tells the nurse to record specific notes (e.g. "COPD, CT scan 5/08-CXR Due 9/08), adding a new diagnosis from this visit or deleting a problem that is no longer active. The nurse can rearrange the problem list by organizing according to organ system. This close attention to accuracy and utility of the problem list is essential to managing patients with multiple chronic illnesses.

The nurse records the doctor's recommendations into the visit note, which will become part of the visit summary the patient receives as he leaves the room. When Anderson changes or orders new medications, the nurse performs the order entry and sends off the prescription. Anderson informs the nurse of any lab, the appropriate diagnosis for billing and the interval for the next follow-up appointment, which she enters into the EMR.

He finishes his conversation with the patient, leaves the room and immediately moves on to another exam room with the other nurse who has prepared the next patient.

After the physician leaves the room, the nurse reviews the plan with the patient, answers any questions, and prints and reviews the visit summary with the patient. She then escorts the patient across the hall to the lab area where the MA will draw blood if necessary, otherwise the patient proceeds to the check out desk where the staff receives any co-pays, schedules the next visit and uses the charge ticket to enter charges and diagnosis codes into the EMR.

### **Scheduling, Access and Continuity**

The Family Team Care Model allows Anderson to see 30-32 patients during a 8:30-5:00 schedule. A typical day's schedule will include 3-6 annual physicals, 12-15 acute visits, and 12-15 follow-up visits. The nurses usually arrive at 8:20 AM and go home between 5:30 and 6:00 PM.

Anderson schedules acute visit slots at the end of the morning and the end of the afternoon. Patients are educated that these visits must be limited to one problem only. The history taking is less extensive during these visits and Anderson and his nurses can move very rapidly from one patient to the next. This allows him to provide consistent continuity and access for his patient panel of 3500 patients. Anderson explains, "We hold the acute visit to the symptom for which the patient called us. We protect these slots until day of service, but occasionally will use them the day before service if the patient cannot come in the day they call us. These are actually a relief in spite of the number since we can focus on only one problem. We all LOVE acutes and protect the protocol, since this allows us to see all our patients on their schedule instead of referring out.

I do not do email visits and try my best to not make decisions over the phone. I have always felt too vulnerable by phone medicine and never was convinced email visits were any better. We communicate all normal labs by secure email and patients can access their charts and communicate with us by email. I really enjoy this form of communication and access, but I have never accepted it as a way to replace visits.

Anderson does not employ nurse practitioners or PA's as many practices do to see these acute visits. He feels these visits are important for building and maintaining the relationship with the patient. Also, in the current payment environment, these visits are well reimbursed and provide much of the increased productivity for the practice. Anderson and his nurses also report that these visits provide "emotional relief" after hours spent with the more complex regular visits. The patients are very grateful to be seen immediately, the problems are usually straight forward and "fixable". Part of the joy of practice is fixing simple problems for grateful patients. *Many practices eliminate this aspect of joy from the primary care physician by sending the patient off to a non-*

*physician provider or acute care center. The physician is left with only complex, often unsolvable problems.*

### **Staffing and Cross coverage:**

Anderson has invested heavily in his staff because they are crucial to the care model. Some physicians may be reluctant to invest this much in their staff, because of the concern, “what if my nurse is sick or on vacation or maternity leave? Does the entire system break down?” Anderson’s answer: although on any given day in clinic he has three staff working with him, there are five persons trained in the model. Everyone is part time and thus scheduling for vacations, maternity leave, illness etc. is possible. The practice is not crippled if one staff member cannot work on a particular day.

Although Anderson began his model with two nurses, he has trained an MA to do all of the scribing tasks performed by the nurses. Anderson believes well-trained nurses are the best fit for this model, yet he has demonstrated that in areas where nursing salaries are prohibitive, a well-trained MA can do the work.

### **Messaging**

Phone messages into the clinic are handled by the front desk phone staff who send e-mail messages to the appropriate nurse or MA if further clinical information is required. The nurses and MA handle these messages between rooming patients. Anderson and his staff utilize e-mail to send messages to one another throughout the day. Forty percent of lab results are communicated to patients by e-mail; however many times patients do not look at their e-mail and call in for results anyway.

### **Lab Results**

Between visits and at the end of the day Anderson reviews all lab results and then emails a note to the MA to call the patient that day or the following day. On long days with large number of lab results Anderson may spend 45 minutes at home reviewing the lab and e-mailing the MA. *This is one of the few areas of Family Team Care that seems inefficient and would benefit from obtaining lab prior to, rather than at the end of each appointment.*

### **Patient Education and other Ancillary Services.**

Resource intense patient education, such as diabetic education, is done outside the practice, at a separate hospital site, although the nurses will do some simple updating and reminders at the time of the visit.

The practice does not employ pharmacists, social workers or behavioralists.

## **Physical Space**

Anderson works out of 3-5 exam rooms. The nurses' station and MA/lab station are located along the opposite side of the same hallway. This co-location allows for ease of communication throughout the day among the team members. The nurses and MA have clear line of site to all of the exam rooms. Plastic markers of various colors indicate which person or persons are in each room.

## **Financials**

Anderson's model has been financially successful even in the present climate of low reimbursement for primary care. He advised: "Financial success without quality is irrelevant. Quality without financial success is unsustainable." In 2009, working 40-45 hours/week the practice brought in \$660,000 in production. 40% of production went to physician income. Anderson's practice is 55% private payers, 40% Medicare, 5% Medicaid or uninsured.

## **Spread**

Anderson is now working to help others transform their practices. He has produced a DVD/ handbook tool which describes his model and the change process necessary to bring the model to life in a traditional practice. More than 50 physicians have spent time shadowing Dr. Anderson to observe in person the success of the Family Team Care model.

Most recently, Anderson has been hired by the U.S. Army to transform their primary care system. This year he and his nurses are organizing and supervising intensive 20 hour training workshops for 26 new Army outpatient clinic sites around the nation.

(Anderson is also a faculty member for one of the two medical schools in Afghanistan. He provides weekly conferences for the students and residents via Skype, and visits Afghanistan several times a year to train students, residents and faculty, as they rebuild their medical education infrastructure.)

## **A Legacy of Healing Relationships: what every medical student and resident should experience**

I was privileged to shadow Anderson during his last months of practice as he was preparing to move on to his work for the U.S. Army. I witnessed the heartfelt gratitude expressed by his patients as they wished him well in his new endeavors. It is obvious that he has built thousands of "healing relationships" during his 30 years of service. A day spent with Anderson and his Family Care team is what every medical student and resident should experience if we are to inspire them to a vocation of primary care.

