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PRACTICE PROFILE

'Core Teams': Nurse-Physician Partnerships Provide Patient-Centered Care At An Iowa Practice

PRACTICE Department of Internal Medicine, Medical Associates Clinic and Health Plans.

WHO AND WHERE General internists and nurses at a large, multispecialty group practice providing 540,000 clinic visits in Dubuque, Iowa, a town of 60,000 people.

CORE INNOVATION The “core team,” in which nurses are paired with a physician as integral partners in patient care.

KEY RESULTS Core teams enhance communication and continuity of care. Nurses' attention to preventive care and disease management tasks enables physicians to focus on active problems and patients' concerns.

CHALLENGES Staffing for core teams requires a ratio of 1.5–2 nurses per physician. A nurse's skills and training are desirable for the optimal functioning of a core team. However, not all practices can afford or recruit nurses. Other pilot projects have used a similar model with medical assistants instead of nurses.

Teamwork is considered central to primary care reform and the patient-centered medical home. But what will that teamwork look like? Our nurse-physician partnerships are one model. In what we call the “core team,” one physician works with 1.5–2 nurse full-time equivalents to care for patients, assuming roles of care coordination, prevention management, health coaching, information organization, and practice improvement. The majority of patient contact and management occurs within this team, which minimizes handoffs, redundancy of effort, loss of information, and conflicting communication.

The core team model has evolved over many years in our practice, which under the guidelines developed by the National Committee for Quality Assurance (NCQA) is a designated level three patient-centered medical home. The model con-

tinues to evolve as we face the daily challenges associated with the breadth and complexities of primary care. Our work has been informed by direct observation of multiple practices across the United States.

Given the widening gap between primary care workforce supply and demand, improving the practice model of primary care has become imperative. We view core teams as one possible solution. To understand how such a team works, consider the following vignette.

Core Teams In Action

Mr. Z is a sixty-one-year-old smoker who comes in for his annual comprehensive care visit, which includes management of diabetes, high cholesterol, and hypertension; and evaluations of a sleep disturbance that has come on recently, pain in the upper middle abdomen, and fatigue.

DOI: 10.1377/hlthaff.2010.0356
HEALTH AFFAIRS 29,
NO. 5 (2010): -
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Foundation, Inc.

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Christine A. Sinsky, right, is a physician with Medical Associates Clinic and Health Plans in Dubuque, Iowa. Their “core team” approach to the patient-centered medical home assigns one physician and up to two nurses to provide patient care coordination, prevention management, health coaching, information organization, and practice improvement.

After he is shown into the examination room, his nurse explains the results of his laboratory tests obtained two days earlier, as arranged at his previous visit. They note that his hemoglobin A1c (blood sugar) level has risen, to which he responds that he has stopped exercising lately.

Using self-management strategies, the nurse helps Mr. Z set goals for exercise. She also reviews his body mass index, inquires about home blood sugar and blood pressure readings, and obtains a preliminary history regarding the new complaints. She asks if he is interested in quitting smoking and describes a cessation program offered by the clinic. She administers a tetanus shot and schedules a screening colonoscopy.

While reviewing Mr. Z’s medications, the nurse learns that he forgets to take his evening blood pressure medications about half the time. Briefing the physician, the nurse shares the history, including the patient’s difficulty with his medications and his priorities. The physician is thus able to focus her attention on engaging the patient in his chronic illness care, performing a contextualized evaluation of his new symptoms, and strengthening the physician-patient relationship.

After the visit, the nurse provides Mr. Z. with an updated list of his medications, arranges for him to call back in three weeks with his home blood pressure readings and his response to life-

style changes for acid reflux, and ensures that he understands the management plan. Before leaving, he is scheduled for a follow-up visit in four months, with the laboratory tests selected by his physician to be conducted a few days in advance.

Healing Relationships

Healing relationships are the foundation of patient-centered care. Continuity with the same small group of people strengthens these relationships. Instead of distributing the tasks of primary care across a wide array of staff, each with narrow areas of responsibility and spread across several physician practices, core team members are trained in a broad range of competencies and apply them to a single practice. This allows the practice to meet the inherent variability and unpredictability of patients’ needs.

The nurses on a core team can alternate between non-visit-based work—such as care coordination, population management, and practice organization—and hands-on clinic work as service demands ebb and flow throughout the day. With this consolidation of functions comes greater contact between the patient and family and the core team and, we believe, better integration and safety in the care of the patient’s multiple medical problems.

Lab Results

Our use of core teams also allows us to review and respond to laboratory test results efficiently. Primary care physicians typically review several hundred test results per week. With some electronic health record implementations, every bit of this information automatically loops back to the physician. As a result, primary care physicians commonly face several hours of “in-box management” daily.

In our practice, most laboratory tests are obtained before the appointment, so that the patient and physician have up-to-date data upon which to base their discussion and decisions. We accomplish this by planning the next visit at the conclusion of the current one. This system supports efficiency and reduces redundancy, as the physician views the majority of data only once, at the time of shared decision making with the patient.

All lab, x-ray, and consultation reports are first directed to the nurse, who filters and organizes this information, presenting any critical issues to the physician for immediate response. This work flow minimizes information gaps, information overload, and information chaos—all conditions that contribute to burnout and errors

in medical decision making. The system also decreases a practice's workload, as there are fewer follow-up letters to generate, and fewer callbacks from patients in response to care-management instructions by phone or letter.

Time For Follow-Up

At the annual comprehensive care visit, the nurses have extra time to follow through with the patient on any prevention and chronic care issues—for example, providing immunizations, scheduling colonoscopies, and offering counseling regarding calcium supplements and weight control. This work is consistently and reliably done before the physician component of the visit. Thus, the physician can be more relaxed and focused on the patient's main concerns.

In the core team model, disease management is "built in" at the practice level rather than "carved out" to a health care worker not closely connected to the patient's personal physician. For example, the nurse who coordinates home care services is the same nurse who assists with the patient's planned care appointments. She speaks frequently with family members and with the home care nurse, and shares that information with the physician.

A typical day for a physician-nurse team in our practice includes six to eight annual comprehensive care appointments, ten to twelve planned care appointments, three to six same-day call-in appointments, and thirty to sixty minutes of non-visit-based care and practice organization. This framework allows each physician to manage a panel of 1,800–2,000 patients.

Strengthened Primary Care

It is widely accepted that health care reform in the United States must include increasing the primary care workforce and strengthening the primary care infrastructure. The emphasis has been on strengthening the health information technology infrastructure through the adoption of electronic health records. We believe that a similar focus on the personnel infrastructure will result in a practice model that draws physicians to the primary care specialties.

Without changes, the primary care physician workforce is at risk. Burnout and dissatisfaction



Thomas A. Sinsky is a physician with Medical Associates Clinic and Health Plans, where patient-centered medical home practices continue to evolve to meet daily challenges.

are widespread, and many physicians have stated that they intend to leave practice. In our multi-specialty group practice, 60 percent of primary care internists rank their overall satisfaction as excellent, compared with a specialty norm of 28 percent. In addition to optimizing patient care, our use of core teams has reduced stress and promoted collegiality in the practice environment. ■