

CONTINUOUS AND TEAM-BASED HEALING RELATIONSHIPS

Improving Patient Care Through Teams

December 2010 Transforming Safety Net Clinics into Patient-Centered Medical Homes

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Introduction

Today, healthcare is fragmented with patients receiving care from a wide variety of care providers who often work in different places. Yet research and patient experience attest that a strong patient-provider relationship is central to good health and satisfaction with care. Key to becoming a medical home is building partnerships between patients and providers and teams who can coordinate care among the array of medical and non-medical partners that patients need to be healthy. In this implementation guide, we address ways to build an effective provider team and the steps a practice can take to ensure teams are meeting patient needs and expectations.

Change Concepts

The following eight Change Concepts for Practice Transformation (Change Concepts) comprise the operational definition of a Patient-centered Medical Home for the “Transforming Safety Net Clinics into Patient-Centered Medical Homes” Initiative. They were derived from reviews of the literature and also from discussions with leaders in primary care and quality improvement. Over the course of the “Transforming Safety Net Clinics into Patient-Centered Medical Homes” Initiative, we will cover each of these change concepts in turn. An implementation guide will be prepared and made available for each concept.

The goal of the Safety Net Medical Home Initiative (SNMHI) is to help practices redesign their clinical and administrative systems to improve patient health by supporting effective and continuous relationships between patients and their care teams. In addition, SNMHI seeks to sustain practice transformation by helping practices coordinate community resources and build capacity to advocate for improved reimbursement. The SNMHI is sponsored by The Commonwealth Fund and is administered by Qualis Health and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute.



MacColl Institute at
Group Health Cooperative

This implementation guide is focused on the Change Concept Continuous and Team-based Healing Relationships.

1. Empanelment
2. **Continuous and Team-based Healing Relationships**
3. Patient-centered Interactions
4. Engaged Leadership
5. Quality Improvement (QI) Strategy
6. Enhanced Access
7. Care Coordination
8. Organized, Evidence-based Care

Elements of Continuous and Team-Based Healing Relationships

The Safety Net Medical Home Initiative has identified five core elements of team-based care that any practice undertaking PCMH transformation must adopt. These elements are:

- Establish and support care delivery teams.
- Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
- Assure that patients are able to see their provider or care team whenever possible.
- Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.
- Cross-train care team members to maximize flexibility and ensure that patients' needs are met.



Message to Readers

SNMHI implementation guides are living documents. Updates will be issued as additional tools, resources, and best-practices are identified. This implementation guide provides an introduction to the elements of the Change Concept "Continuous and Team-based Healing Relationships:"

- Establish and support care delivery teams.
- Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care.
- Assure that patients are able to see their provider or care team whenever possible.
- Define roles and distribute tasks among care team members to reflect the skills, abilities, and credentials of team members.
- Cross-train care team members to maximize flexibility and ensure that patients' needs are met.

Transformative change relies upon knowledge sharing and transfer. The partner clinics and Regional Coordinating Centers participating in the SNMHI are members of a learning community working towards the shared goal of PCMH transformation. This learning community produces and tests ideas and actions for change. The Initiative celebrates the contributions and accomplishments of all its partner clinics and Regional Coordinating Centers and, in the spirit of collaborative learning, implementation guides often highlight their work. This guide includes resources from Multnomah County Health Department (Oregon).

Background: Preserving Continuity of Care Through the Team

Building long-term relationships between patients and providers is often referred to as improving the continuity of care. “Continuity of care” refers to the degree to which patients experience discrete components of healthcare as coherent, organized, and connected and consistent with their needs.¹ Experts have defined three types of continuity that bridge one element of care to another over time.

1. **Relational continuity** refers to ongoing caring relationships where a patient is known by his or her provider so that past care is linked with current care, usually with an expectation that the relationships will continue in the future.
2. **Informational continuity** refers to the transfer of information from one episode of care to another, and the notion that relevant information is taken up and acted upon over time.
3. **Managerial continuity** refers to the notion that care is coherently organized and planned and that today’s care decisions take into account yesterday’s care experiences.

Strong patient-provider relationships foster improved communication, trust, and knowledge of patient contexts and preferences.

Primary care practices emphasize relational continuity by promoting open-ended, ongoing healing relationships that bridge the range of patient needs including preventive, acute illness, chronic disease, and end of life care. Strong patient-provider relationships foster improved communication, trust, and knowledge of patient contexts and preferences. Not only does a strong patient-provider relationship lead to improved patient satisfaction,² but it has also been consistently linked with improved health behaviors,³ better health outcomes,⁴ and less emergency department and hospital use.^{4,5} Furthermore, providers also prefer strong long-term relationships with their patients as these relationships give their work more meaning.⁶

Although building strong personal relationships is a fundamental goal in primary care, there are many practical challenges to building and sustaining these relationships. Research has shown that providing all of the evidence-based preventive and chronic illness care to an average panel of patients would take a primary care provider 18 hours a day.^{7,8} A provider cannot provide this level of care on their own; many burn out trying. Other healthcare providers, including nurses and pharmacists, can appropriately share in this work, but when they are disconnected from the primary care practice they can detract from the patient-provider relationship. Many providers also work part-time and are not available when patient needs arise, requiring a more team-based approach if continuity is to be preserved.

Improving Care and Strengthening Relationships Requires Teamwork

Providers want to provide the highest quality of care and develop deep personal relationships with each patient, but there simply aren’t enough hours in a day to do both. One option is to reduce the size of patient panels. Another is to develop a highly functioning, well-integrated clinical team. In order to address the full complement of patient needs – preventive, chronic, and acute—practices can draw on the expertise of a variety of clinical and non-clinical skills. Reorganizing care so it is provided to patients by a team of professionals with diverse skills and talents, rather than by a single provider (MD, NP, PA), can help to ensure patients get all the education and support they need and improve clinical quality as well. In fact, a meta-analysis published in the *Journal of the American Medical Association (JAMA)* found that among a dozen quality improvement interventions, using teams was the most effective intervention at reducing hemoglobin A1C values for patients with diabetes.⁹

Healthcare teams must organize their work to foster trusting relationships between patients and providers and allocate tasks to ensure they are completed, of high quality, and provided efficiently. Attention must be placed on appropriately structuring the team, defining roles and responsibilities, fostering team collaboration, and providing feedback.

Who is on a Clinical Team?

Teams can be designed in a variety of ways depending on the size and needs of the patient population and the resources of the practice. Ideally, primary care practices should be structured to respond to all common problems for which their patients seek care. Since patient populations can vary substantially in age, gender, illness patterns, and social circumstances, the composition of primary care teams must also vary. For instance, social issues may be more prevalent in some practices than others, indicating the need for a social worker be an every-day team member. However, there are some general principles which can be applied broadly.

Most successful practices are organized around an accountable clinician (usually a physician or advanced registered nurse practitioner or physician assistant) and a medical assistant dyad who interact continuously throughout the day. The medical assistant is generally responsible for preparing the visit (e.g., making sure that external medical records are available if care has been received elsewhere), checking in and rooming patients, and ensuring post-visit tasks are completed and patients understand the follow-up plan. Other team members are usually responsible for providing self-management support (e.g., nurse or clinical pharmacist, or health educator) or arranging other resources (e.g., social worker). Tom Bodenheimer, a primary care doctor who works at the University of California San Francisco, uses “teamlets” made up of a provider and a nurse or medical assistant who is specially trained to coach patients to manage their illnesses and to reach out to patients who need to come in for chronic or preventive care.¹⁰ The goal is that this two-person team is able to address most routine primary care needs when structured and trained properly. Physician assistants are also often key primary care

team members. In some practices, they carry their own practice panels and serve as the responsible clinician. In other practices, they have specific roles and responsibilities, such as supporting patients with chronic illness, or providing acute care “overflow” for a practice panel. Some organizations, like Group Health Cooperative, include clinical pharmacists and nurse care managers on their teams in a one to four ratio – one pharmacist/nurse for every four provider panels.¹¹ Regardless of team composition, care must be taken to keep the team size relatively small (fewer than five to seven members) because team functioning breaks down as teams grow. Other clinic staff members, including billing staff, receptionists, computer technicians, and laboratory personnel, complement the primary care teams. Each of these staff members can play important roles in engendering strong trusting relationships between patients and their care team. For instance, receptionists can help ensure that patients see their chosen team, reach out to them when follow-up care is needed, and remind them to bring in medications.

Reorganizing care so it is provided to patients by a team of professionals with diverse skills and talents, rather than by a single provider (MD, NP, PA), can help ensure that patients get all the education and support they need and improve clinical quality as well.

In addition to strong caring relationships between patients and their primary care clinician, the development and fostering of relationships with other team members is important. While it is true that patients may not form deep relationships with all team members, patient feedback suggests that consistency in personnel and their roles is important to promote trust, communication, a clear expectations for care. It is also important that team members support the relationships that each have with their patients, particularly the relationship with the primary care clinician.

Who Leads the Team?

Like an orchestra, teams need leaders so that members don't work at cross-purposes and activities are staged so the right care is given at the right time by the right person. The primary care clinician (physician, advanced registered nurse practitioner, physician assistant) is generally responsible for leading the team to jointly accomplish the necessary tasks. Clinicians aren't always natural leaders and it is often important to assist them in delegating tasks that can be accomplished by other team members. Strong team managers can be helpful in this regard. Leadership skills are often not taught in medical or nursing programs, and additional training and mentoring may be required.¹²

Finally, patients may have other care providers or family members that they consider essential parts of their care team. Honoring the relationships that patients feel are important can build trust and lay the foundation for improved patient-provider communication.

How do Practices Form Teams?

Highly functioning clinical teams are not just an amalgamation of different providers with different skill sets all talking to the same patients. Without close communication and partnership, external resources like care managers or others have the potential to fragment care. However, well-organized teams—those that are identified both by the care team members themselves and, most importantly, by their patients as a unit—can provide improved capacity to deliver care without sacrificing continuity.^{13,14}

Leadership

Making teams work both for patients and for staff requires much more than co-locating a group and giving them a name like "Team 1" or "the Red Pod." It requires changes to daily operations, like scheduling and visit planning. And, it requires changes in human resources policies, job descriptions, and performance expectations. It requires access to basic health information technology so that team members can truly share in the care for an established panel of patients. In short, choosing to organize a practice into teams requires senior leadership, buy-in, and real resources.

Roles & Responsibilities

It is important that team member roles and responsibilities be clearly defined and delineated so that key tasks are neither duplicated nor neglected, and so they are delivered by the person with the right skill set. Several principles characterize the most successful primary care teams.

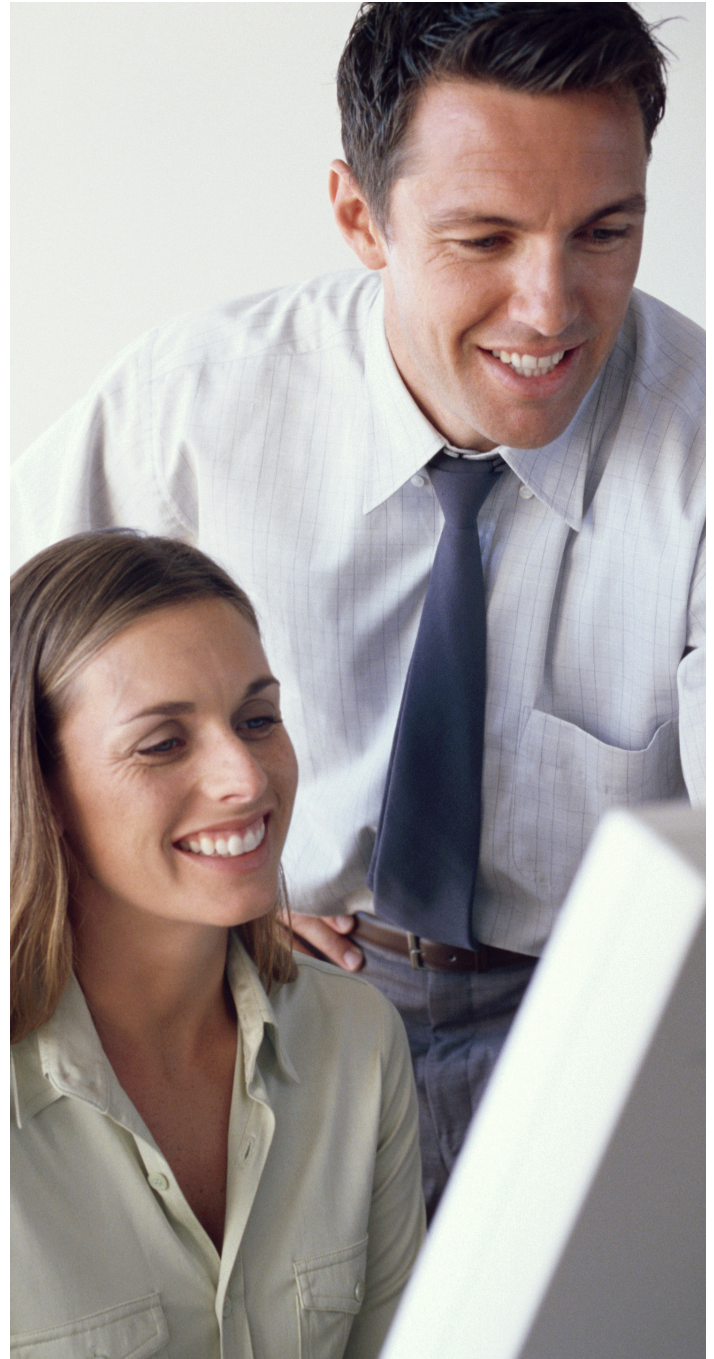
- First, teams generally function best (and care is delivered most efficiently) when team members function at the maximum of their licensure, skill-set, and abilities. Team members need to recognize the roles that others on the team can and do play; for example, how clinical pharmacists can assist patients in managing their complex medication regimens. Medical assistants in particular can play major roles in critical functions like population management—developing and monitoring reports of sub-populations of patients like people with diabetes, identifying gaps in treatment, and inviting them in for a planned visit—and self-management support. Practices with limited resources can assess the strengths, interests, and skills of their medical assistants and match them with practice needs. See the [St. Peter Family Medicine story](#) for an example of how this works.
- Second, team members function best when they are given both authority and responsibility for performing those tasks. This may require a change in thinking, particularly on the part of physicians who are often used to doing all the tasks themselves. Delegation of activities requires trust among team members—something that often has to be built overtime as teams develop. One tool that teams can use to clarify delegated tasks is standing orders. An example of standing orders is available [here](#).
- Finally, because teams are usually small, it is important to cross-train staff so that tasks are not dropped because of staffing shortages, unpredictable changes in demand, or expected absences. In clearly defining responsibilities and roles, training gaps are often identified.

Time for Teamwork

Effective medical practices allocate specific time for teams to interact and plan their activities. Short mandatory team huddles, that occur daily or even several times per day, are often used for teams to review their schedules, make staffing adjustments to accommodate demands, identify patient needs, and plan the care activities in advance. These huddles also allow tasks to be clearly delegated, and problem-solving to occur. Using visual display systems to list and distribute tasks and activities is often very helpful in ensuring that tasks are not duplicated or omitted, and that patient flow is efficient and timely. Medical assistants are often assigned to “scrub” the charts ahead of time using pre-visit checklists to clarify visit expectations, identify unmet needs, make sure test and referral results are available, and prep the visit accordingly with supplies, patient education materials, and pended orders. If the patients’ visit expectations are unclear, or follow-up tests are outstanding, medical assistants should reach out to patients via phone or email to clarify expectations and have needed tests performed before the visit. In addition to devoted time to plan daily activities, teams need dedicated and protected time for quality improvement activities.

Effective medical practices allocate specific time for teams to interact and plan their activities.

Successful teams lead a variety of quality improvement initiatives by allocating time to review metrics, celebrating successes, identifying trouble spots, brainstorming improvements, and testing changes made. This dedicated time also allows roles and responsibilities to be adjusted to make more effective and efficient use of various team member skills and abilities. The most successful meetings deliberately elicit input from all participants and do not allow individuals to dominate, jeopardizing teamwork.



Case Study: Moving to Team-based Care in a Large Provider Setting with Diverse Populations

Santa Clara Valley Medical Center in densely populated Santa Clara County, California, is a large public health system with eight health centers and one 553-bed hospital serving over 200,000 patients in 750,000 visits per year. Moving towards proactive, continuous, team-based care in such a vast system is challenging, says Margo Maida, MSW, Program Director of Medical Home and Leadership Development for the health system.

“It’s very difficult in a large public hospital system to move to innovation, team-based care, or care coordination,” says Maida. “Teams are in very different phases in a sometimes-damaged system. But we are committed to the medical home model so we find ways to make it work.”

Santa Clara is rolling Patient-centered Medical Home transformation across their system: selecting teams at some sites and providing the resources for them to meet regularly, helping remove barriers, challenging them to share best practices, and moving towards more efficient team meetings with data.

“Each team is in a different place,” says Maida. “In our system, we’re beginning to move the teams towards population management, proactive and team-based care. We’ve also staffed up our teams,” she adds, by changing some roles, and creating different ratios of medical assistant to physician to physician assistants, for example.

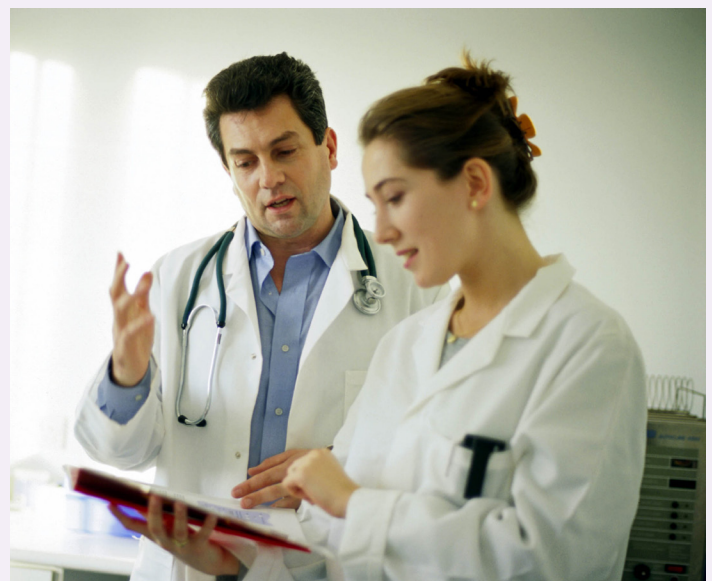
“Team-based care is a huge paradigm shift for teams and for patients. How ready the team is becomes important to how this unfolds for patients. And patients want care to be there when they want it and they want a care plan to revolve around their needs,” says Maida. “So there are really two variables for success: how ready is the team to make changes, and how ready is the patient to see a member of the team and not the doctor.”

Santa Clara also effectively uses coaches who are on-site and who can “move mountains.” “We develop strong coaches within organizations that perpetuate this. There is training for the coaches such as meeting management training. Coaching is very important to moving team-based care forward,” says Maida.

This system-wide commitment to staffing, coaching, collaborating, and providing resources to plan for improvements is making the difference in transforming care in a sometimes broken system.

Important payoffs to implementing team-based care are patient satisfaction and provider satisfaction. “Medical home teams always fare better in patient satisfaction than non-medical home teams,” says Maida. “Also, what is consistent among all teams is team satisfaction—they are happier with the work they are doing. We’re a unionized county health system, and the unions are saying that their members in medical home are happier at work.”

The example of Santa Clara Valley Medical Center illustrates how, even in a very large system, with diverse patient populations such as migrant workers, homeless, non-English speaking, and high mental health need patients, continuous and team-based care is working for patients and providers.



Where to Start? Relational Continuity

☑ **Step 1: Empanel patients.** Empanelling patients is a bi-directional activity – patients choose a provider and team and care teams understand who they are accountable for over time. The patient and provider team should recognize each other as partners in care.¹⁵ Often this linking begins with practices making a tentative assignment based on historical utilization patterns. Prioritizing continuity can be a real shift in emphasis for practices that have prioritized getting patients in to see any available provider. They will now need to think about how to develop and strengthen a consistent patient-provider/team relationship. Refer to the [Empanelment Implementation Guide](#) for guidance on how to empanel your patients.

☑ **Step 2: Educate and communicate with patients about their team.** Communicate with patients about who their team is and the main role and purpose of each team member. Assumptions are often made that patients and clinical staff have a shared understanding about appointments, the differences between medical assistants, nurses, and physician assistants, and how team members interact. These assumptions, however, are often faulty, leading to miscommunication, confusion, and mistrust. Communication strategies that can help bind patients to teams include: provider introductions to individual team members, letters for new patients introducing the team, new patient orientation, team business cards, waiting room pamphlets with team member names and descriptions, and bulletin boards describing the PCMH model and team-based care. Color-coded badges can help patients visually link members of their care team.

☑ **Step 3: Revise scheduling.** Revise scheduling practices to help support continuity and relationships. In addition to communication, real operational changes must be made to ensure patients and provider teams are linked. Appointment systems should be designed to preferentially book patients with their own team, and staff should routinely ask patients if they would prefer to see their own physician even if means foregoing speedier access to a non-team provider.

When patients are seen by other care providers, coordination strategies are essential to ensure patients get organized care and are systematically connected back to their team for

follow-up. One helpful tool for ensuring that care is organized even when relational continuity is disrupted is a shared care plan. These plans outline the patient and provider's shared goals for treatment and enable new providers to fit into the established approach, understanding the historical challenges and future goals. With a shared care plan, a new provider can say "I see you and your doctor are working on X, here is how I might help to make X successful." This simple acknowledgement of the patient's existing relationship and goals can reduce confusion and rework. More information on shared care plans is available [here](#).

In clinical settings where continuity has not historically been a priority, patients and staff both need to be included in and committed to the culture shift towards emphasizing patient-team partnership.

In clinical settings where continuity has not historically been a priority, patients and staff both need to be included in and committed to the culture shift towards emphasizing patient-team partnership. For those patients who continue to bounce around the system, it may take encouragement from a provider to say "one of the most important things you can do for your health is to establish a relationship with a provider and team who you trust."

☑ **Step 4: Use technology to support continuity.** Secure email messaging and telephone visits are often very helpful to connect with patients when they have concerns or questions, and as follow-up to in-person visits. Practices that integrate telephone and email into their everyday workflows often find efficiencies, allowing them to connect with more of their patients more often and facilitating pre-work. However, redesigning phone systems or investing in IT is a tremendous undertaking, and one that is most effective when built around a team with strong care processes already in place. For more information about expanded modes of communication, please see the [Enhanced Access Implementation Guide](#).

How do Practices Sustain These Changes?

Establishing patient panels and organizing care teams is a lot of work, but is the first step in a long-term commitment to a new way of doing business. Sustaining these changes requires on-going investment in at least three areas.

1. Monitoring metrics and adjusting work. Successfully linking patients and providers as partners in care is not an activity, but an opportunity that presents itself with every visit and phone call. Providers must have reasonable patient loads so that patients can access their care team without extended waits or delays, so a commitment to constantly assessing supply and demand is essential. For more information refer to the [Empanelment Implementation Guide](#).¹⁴

In addition to managing supply and demand, organizations like the Multnomah County Health Department measure how often patients see their preferred care teams to ensure that continuity is actually happening. When patients are not regularly receiving care from their preferred care team, action needs to be taken to understand why and changes need to be made. Often it is seemingly mundane operational issues that stand in the way of continuity – vacations, part-time providers, or scheduling policies that place availability over continuity. Understanding and managing the potential downsides of continuity on patient access is important. Strong leadership and a commitment to addressing challenges when they arise are essential to ensure that the patient-provider relationship is weighted against competing demands. A robust and active quality improvement program (regular team meetings, staff support) can help to improve continuity if/when problems arise by leading teams through iterative tests of change.

2. Ongoing training and team assessment. Strong clinical teams rely on trust, good communication, clear roles, and available, actionable data to do their work. Especially when new teams are formed or new hires are introduced, training can prove a worthwhile investment. More and more organizations are looking seriously at the clinical and staff initial training and orientation session as an opportunity to clarify specific roles and tasks for staff and offer training in team communication. Listed in the tools section are trainings for staff and assessments

of team functioning that can help your group run smoothly. Sometimes personalities, licensure, or employment contracts may initially limit your ability to create high-functioning teams. See the Santa Clara Valley Medical Center case study for an example of how radical team redesign led to improvement in patient care, on page 7.

However, even the best teams often stray from productive work during their huddles, rendering them less impactful than they could be. Groups start discussing important but tangential issues, like vacation time or the break room, rather than preparing for the day, evaluating the results of a Plan – Do – Study – Act (PDSA) test or following up on patient issues. Leadership check-ins can help keep precious team time on track. AN example of a PDSA test is available [here](#).

3. Developing and implementing policies and procedures, especially around part-time providers, is critical. Vacation requests, patient scheduling, and front-desk responsibilities are just a few of the many policies that need to be updated when you implement team-based care. As continuity and team-work become priorities, other operational systems may need to be readjusted.

One common barrier to continuity in practice today is the near total reliance on part-time providers. Very few providers offer clinical care in the office five days a week; so finding ways to ensure patients get their needs met can be a challenge. Several models for how to deal with this issue exist. At Group Health Cooperative, for example, clinicians who are in practice less than 50% time do not have their own patient panel, but are assigned to a locum pool that provides “substitute” care when others are temporarily out of the office for a period of time due to vacation or needed family/medical leave. Those clinicians who practice more than 50% time but less than 100% time have their own panels, but are paired together with other part-time providers so that coverage arrangements are clear. For this pairing to work, providers cannot both be out of the office on the same day (say Fridays or Mondays) and they do need to be in the office at least occasionally at the same time to facilitate information sharing. Refer to Part-time Providers webinar for more information, available [here](#).

Conclusion

A continuous healing relationship benefits both patients and providers, and is an essential component of primary care and the PCMH model. Yet achieving these benefits requires a substantial commitment to organizing teams, communicating differently with patients, and continually monitoring teamwork, health outcomes, and supply and demand. Though there is no quick fix to achieve continuity, below are studies, tools, and stories to help you along the way.

Related Change Concepts

Redesigning your clinical practice to provide team-based care to a regular population of patients is central to building a medical home. Because it impacts the way you structure your practice and deliver care to your patients, linking patients to established care teams impacts all other change concepts. Strong, engaged leadership, a well-defined quality improvement strategy, and patient panels need to be established before beginning this work in earnest.

Engaged Leadership is essential to prioritizing continuity in patient/team relationships and for ensuring the on-going operational supports are in place. Ongoing training is needed for clinical and non-clinical staff as they take on different roles and responsibilities as members of a consistent team. Time for huddles and communication, as well as investments in information technology are required to ensure the daily success of your initial redesign efforts.

Resources will need to be devoted to develop and track continuity metrics like percentage of patients seeing the team of their choice. And, an established quality improvement strategy must be in place to ensure teams can act on these data.

Of course, to provide continuous care, patients need to know who their provider is and providers need to know their patients. Empanelling patients and providers is an essential first step in establishing continuous team-based healing relationships.

Other Change Concepts impacted by Continuous, Team-based Healing Relationships include:

- Patient-centered Interactions
- Care Coordination
- Organized, Evidence-based Care
- Enhanced Access

Additional Resources

Tools

[Clinical Microsystems](#)

The Dartmouth-Hitchcock Medical Center offers free tools, including a great quick team assessment, to help pinpoint areas of improvement in team functioning.

[Improving Chronic Illness Care](#)

ICIC developed a free, step-by-step toolkit called "Integrating Chronic Care and Business Strategies in the Safety Net" that provides tools for practices as they work to improve quality.

[Institute for Healthcare Improvement](#)

IHI provides free guidance and tools around forming the team and using team huddles to improve communication.

[Iowa Chronic Care Consortium](#)

This group offers training for health professionals interested in becoming leaders in improving chronic illness care in their practice. Training focuses on self-management support and panel management skills among others.

[Integrating Chronic Care and Business Strategies in the Safety Net](#)

Group Health's MacColl Institute for Healthcare Innovation, RAND and the California Health Care Safety Net Institute have published a toolkit which provides a step-by-step practical approach to guide teams through quality improvement, focused on the chronically ill in safety net populations.

Team STEPPS

Strategies and tools developed by AHRQ to improve team communication and functioning

Patient Centered Primary Care Collaborative

PCPCC offers a PowerPoint presentation from leading national experts on developing teams and continuity, among other elements of the medical home.

Transformed.

A program of the American Academy of Family Practice, this website offers online assessments, tools and working papers focused on medical home transformation. Tools may be especially relevant for small practices.

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Safety Net Medical Home Initiative

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