Redesigning the Care Team Holistically

Build a more sustainable care team to maximize ROI

While most organizations are piloting changes to their care team design, these changes have had limited impact on physician burnout or cost savings. Often, as leaders offload tasks from the physician's plate, they inadvertently set a trickle-down effect in motion, passing tasks on to other team members and resulting in broader care team burnout and turnover.

To build a model that's sustainable for the future, organizations must redesign the ambulatory care team holistically, redefining the roles of all team members at once.

❯❯ Advisory
Board

Table of contents

The conventional wisdom

Almost every organization is piloting some change to their care team model. Since the primary goal of most of these changes is to prevent physician burnout, groups often take a physician-centric approach to the redesign process. As a result, care team redesign often looks like what you see below: Leaders offload tasks from the physician's plate onto advanced practice providers (APPs). Then, when APPs start feeling burnt out too, they do the same to nurses, and this task shifting continues down the line, setting a trickle-down effect in motion.

Trickle-down care team redesign

Physician

APP[1]

RN[2]

MA[3]

Front desk staff
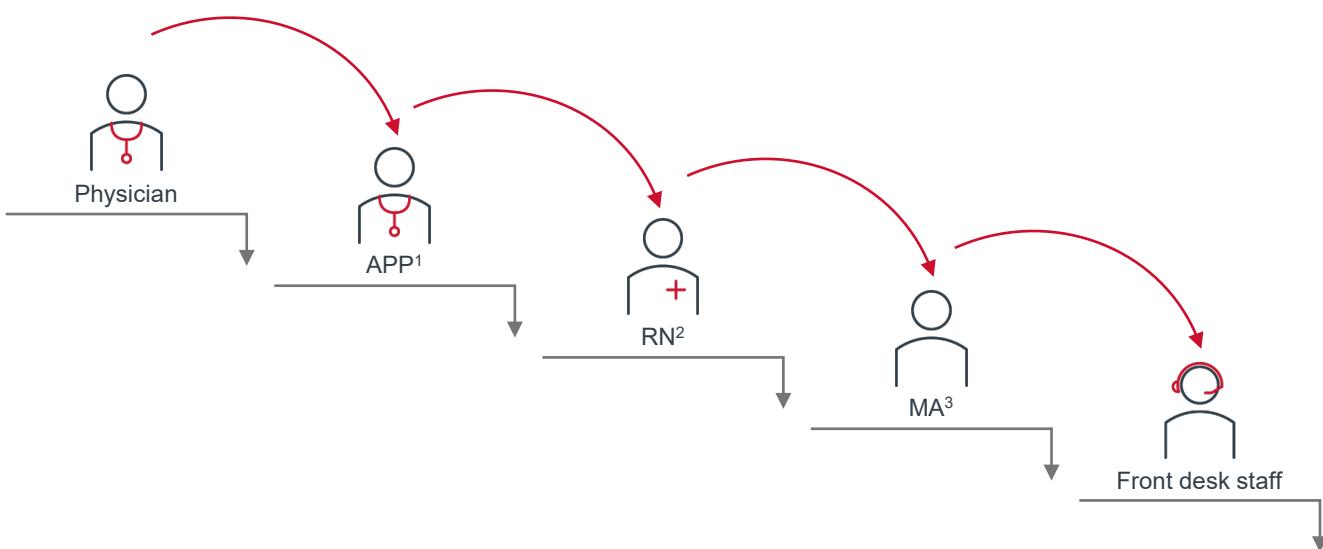
1. Advanced practice provider.
2. Registered nurse.
3. Medical assistant.

Using this approach, physician leaders could historically offset turnover by hiring more staff. But this trickle-down approach is unsustainable for three reasons:

Care team members are still working below top-of-license: Shifting tasks in response to physician burnout means that team members are too often given the tasks that physicians do not want or have time to take on, as opposed to those that are top-of-license. This inadvertently builds gaps and redundancies into the model—and this can be costly even in small doses. For example, even when an RN spends just 15% of their time on tasks that are below top-of-license, that's still $6,000 worth of work that the RN does that could've gone to an MA.[1]

Physicians are an increasingly smaller subset of the workforce: From 2018 to 2028, physician jobs are expected to grow 7%—which is *less* than the 10-year projected growth rate for other non-physician roles, such as RNs (12%), MAs (23%), NPs[2] (26%), and PAs[3] (31%). As groups employ more non-physician team members, the total percentage of the workforce—and associated labor costs—made up by physicians will shrink. Therefore, basing care team redesign on the physician at the expense of other team members has diminishing returns.

Non-physician team members are disengaged and burned out: Downshifting tasks to APPs, RNs, and MAs without getting them to top-of-license leads to costly turnover. As one example, 56% of MAs, who are usually at the end of the trickle-down process, plan to leave for another job in health care in the next five years—and worse, 21% plan to leave health care altogether.

1. Calculated by taking the difference in salary between an RN in an outpatient clinic and an MA in family medicine and multiplying by 15%.
2. Nurse practitioner.
3. Physician assistant.

Source: Stokowski L, "Medscape RN/LPN Compensation Report, 2019," *Medscape*, October 9, 2019; Integrated Medical Group Benchmark Generator, Medical Group Strategy Council, Advisory Board; "Occupational Outlook Handbook," US Bureau of Labor Statistics; Skillman S et al, "Frontline Workers' Career Pathways: A Detailed Look at Washington State's Medical Assistant Workforce," *Center for Health Workforce Studies*, December 2018.
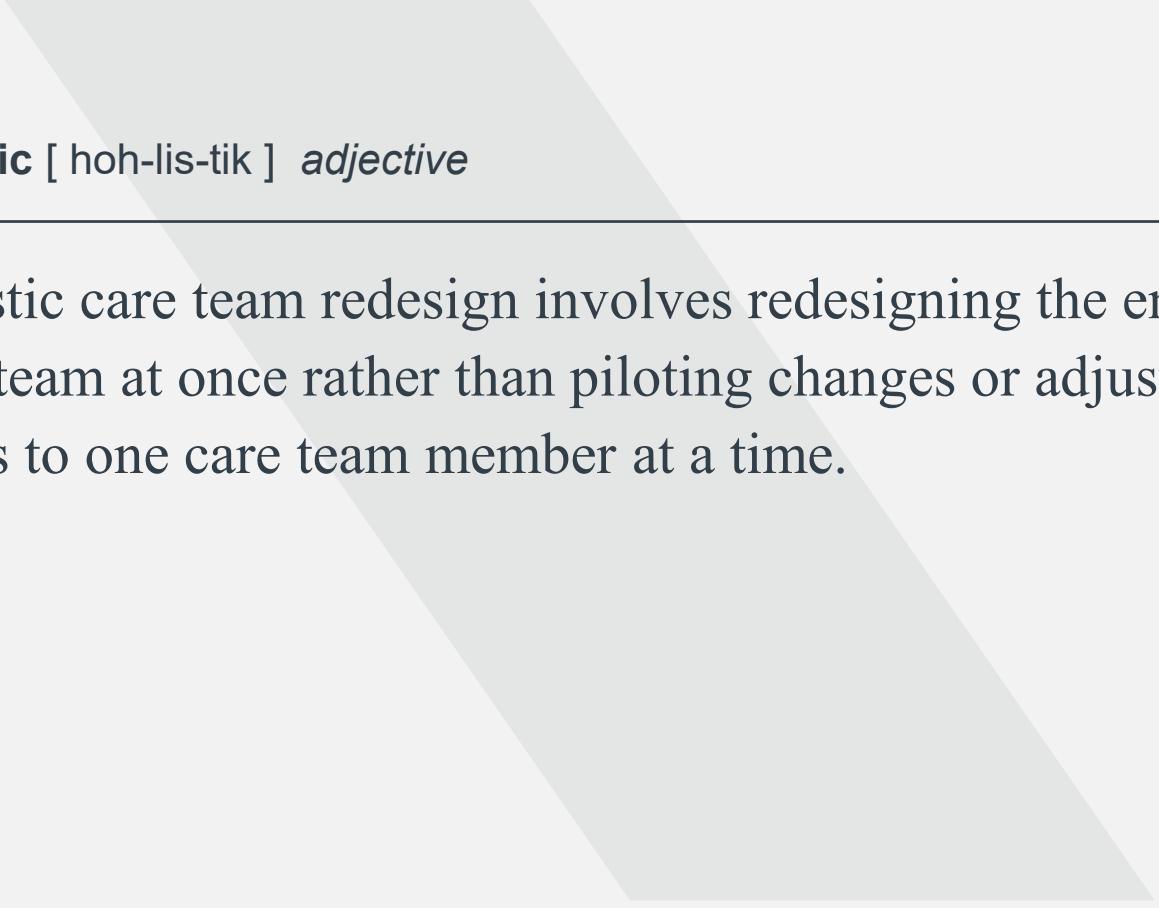
Holistic [hoh-lis-tik] *adjective*

Holistic care team redesign involves redesigning the entire care team at once rather than piloting changes or adjusting ratios to one care team member at a time.

Our take

To build a care team model that's sustainable for the future, organizations need to design an ambulatory care team that maximizes the ROI and reduces the burnout of every team member—not just physicians. This requires a shift in mindset from seeing the care team as individual roles to viewing it holistically: looking at how individual care team members come together to work as a single cohesive unit. Rather than piloting changes to one team member at a time, leaders must redesign the entire care team at once to ensure everyone is working at top-of-license and as one high-performing team.

Holistic care team redesign
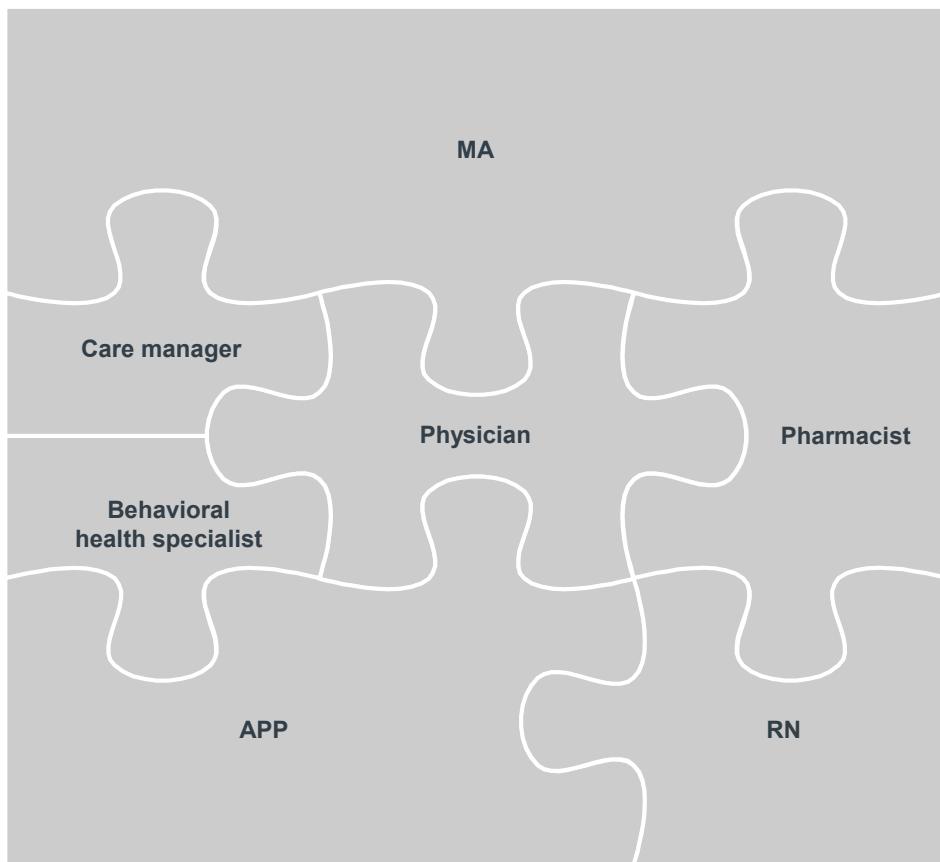
In practice, this means evaluating all tasks the care team needs to perform, and then matching those tasks to the appropriate team member. In other words, rather than starting with the physician and shifting tasks down the line, begin with the tasks and assign them to the right role. The key is completing this exercise for the entire team at once and then rolling out the new roles—again, all at once.

The goal isn't to create one uniform care team across all providers, but rather, design a blueprint that practices and specialties can adapt depending on their staffing resources, patient populations, and strategic goals. Generally, organizations should strive for a consistent care team model at the practice or specialty level.

This holistic approach to care team redesign often surfaces redundancies and inefficiencies in the care team that you would not have identified using a trickle-down approach. For example, one organization who used this holistic approach was able to hire a new scheduler in place of a new RN, resulting in about $35,000 in labor savings.

Specialty and inpatient considerations

Most leaders begin care team redesign in primary care. However, progressive organizations are beginning to refine their approach to team-based care in specialty and inpatient care as well. While roles and responsibilities will likely look different across specialties and sites of care, leaders should consider applying the same holistic redesign principles and process to other care teams.

Population health considerations

Many organizations roll out team-based care with more universally deployed roles first, which is why you'll see us refer to physicians, APPs, RNs, and MAs frequently throughout this document. However, as organizations hire and deploy more population health-focused roles, such as pharmacists, care managers, and behavioral health specialists, leaders should take a similar holistic approach to integrating them into the care team—or deploying them across several care teams—rather than piloting these roles one-off.

Two leadership roles in holistic redesign

In the past, team-based care pilots were limited to a few practices at a time. Because holistic redesign affects all care teams at once, it requires organization-wide commitment and leadership.

In the following pages, we'll look at the role that you as a physician leader play in holistic care team redesign and the responsibilities you should allocate to others. We'll also discuss a critical element of securing buy-in: involving frontline care team members throughout the entire process.

01

ROLE 1

Executive leadership: Convene planning team led by frontline staff

02

ROLE 2

Planning team: Perform task reallocation and ensure sustainability

01 Executive leadership: Convene planning team led by frontline staff

Holistic redesign involves more simultaneous changes to the care team than ever before, making buy-in even more critical than in past pilots. Executives must set the right tone for their organization and begin cultivating buy-in from day one. This starts with convening a planning team to lead holistic redesign.

It's essential to build a diverse planning team that represents the roles, backgrounds, and skillsets that make up the care team. Importantly, the majority of these team members should be frontline staff. For example, at one progressive organization, 15 of the 20 people on the team leading this work were clinical care team members themselves, including physicians, APPs, RNs, MAs, and patient service representatives.

Involving frontline staff in the process helps confirm that you have a complete inventory of what each team member is currently doing and that those tasks are reassigned appropriately. After all, these are the people who do the work on a day-to-day basis and are best equipped to re-evaluate the team's roles.

More importantly, however, giving frontline staff a seat at the table reassures other care team members that their views were taken into account. Holistic redesign results in unprecedented changes to the care team at all levels. To secure buy-in, it's critical that frontline staff feel like these recommendations came from their peers, rather than top-down mandates from administrators.

EXECUTIVE LEADERSHIP: CONVENE PLANNING TEAM LED BY FRONTLINE STAFF

Below, we've outlined some important guiding principles for this planning team:

- **Representative:** Include team members from across the organization at all roles and levels. At minimum, involve the roles currently on most care teams. Make sure that your planning team reflects your organization's diversity, including diversity in background, practice location, and patient population.

- **Small:** Limit your team to 10-15 people so that it's efficient and agile. This ensures that you can make decisions quickly and productively without removing too many care team members from their day jobs.

- **High-performing:** Ensure all team members excel in their respective roles. Review performance evaluations and ask managers for recommendations to identify top performers. Not only is this important for gathering input on what is truly top-of-license for each role, but it also ensures that team members working below expectations remain in the clinic to improve their performance.

- **Respected:** Though hard to quantify, selecting respected and trusted representatives is essential for solidifying buy-in across the organization. These may be people who already serve in leadership positions or are tenured in their roles.

02 Planning team: Perform task reallocation and ensure sustainability

After executives convene the planning team, it's time for this group to begin the holistic redesign process. Leaders should expect to take the frontline staff on this team offline for the equivalent of one full work week. Some organizations choose to spread this work out across several months, while others opt to complete it all at once in a one-week sprint.

Ask care team members themselves to re-evaluate task list

Start by asking the frontline staff on this team to list out all the tasks they perform on a day-to-day basis. Then, after collecting this inventory, go task-by-task, reallocating each one to the care team member who *should* perform it based on skillset, licensure, business goals, or other criteria.

It's important that the team use agreed upon filters when making these tradeoffs so that this process doesn't devolve into team members shifting less engaging tasks onto others. First, take into account practical considerations like who has the skills, training, and licensure for each task. Then, layer on additional considerations like who would find the work engaging.

We've seen teams complete this exercise using spreadsheets, sticky notes, and start-stop-continue frameworks. Regardless of the approach, the key is completing this work for the entire care team at once—and involving frontline staff throughout the process.

Save time (and money) with our tool

Redesigning the care team in this way can be a time-consuming process, so we created a tool to save you time and money as you reassign tasks across the team.

NEW TOOL

Primary Care Team Task Allocation Guide

The Primary Care Team Task Allocation Guide covers 8 roles and over 60 tasks with Advisory Board's recommendations for who should perform each one. Use this Excel-based tool to identify opportunities to reallocate tasks and get more value from your care teams.

To download the tool, visit **advisory.com/ppr/careteamtool**

Don't disband planning team after task reallocation

However, the planning team's work isn't done after the initial redesign process. This group should also be tasked with developing a strategy for rolling out these changes—and sustaining them on an ongoing basis.

Many organizations tap administrators with figuring out the details involved in the rollout process, but it's important that the planning team stay involved to provide the frontline perspective and act as change champions. The planning team also plays an important role in maintaining buy-in, sustaining momentum, and surfacing candid feedback from the frontlines. To help manage change during the care team redesign process, download our new toolkit.

Parting thoughts

Holistic redesign requires a greater upfront investment than care team pilots. Your biggest investment will be in human capital: taking the necessary frontline care team members offline to serve on the planning team and spearhead this work.

However, this investment is one worth making.

Pulling frontline care team members from the clinic for a week has a price tag. According to Advisory Board estimates, it costs about $30,000 to take the planning team offline to reallocate tasks and design new roles. It's a significant upfront investment—but the ROI is worth it when you consider the downstream impact on turnover and team sustainability. In fact, it only takes retaining one MA to break even on your investment.

<table>
<tr><td>$30K

Cost of taking **4 physicians**, **2 APPs**, **2 RNs**, **3 MAs**, and **2 receptionists** offline for one week</td><td>=</td><td>$34K

Cost of **1 MA** turning over[1]</td></tr>
</table>

We've tried to minimize this upfront investment with our new tool the Primary Care Team Task Allocation Guide. For additional support on your care team redesign strategy, please reach out to your Advisory Board membership advisor.

---

1. Advisory Board analysis suggests the cost to replace an employee that has turned over is 50-150% of annual salary. The cost of one MA turning over represents 100% of average MA salary in family medicine according to Advisory Board benchmarks.

Related content

◥ TOOL
Primary Care Team Task Allocation Guide
Download now

◥ RESEARCH REPORT
How to Scale Team-Based Primary
Care According to Financial Risk
Read now

◥ TOOLKIT
Three Steps to Incorporate Pharmacy
Services Into Primary Care
Download now

◥ TOOLKIT
Tools to Manage Change
During Care Team Redesign
Download now

◥ TOOLKIT
Four Keys to Maximizing APP ROI
Download now

◥ TOOLKIT
Four Steps to Increase MA
Productivity and Retention
Download now

◥ TOOLKIT
Integrated Behavioral Health
Implementation Toolkit
Download now

◥ TOOLKIT
Three Steps to Advance Care Management
Download now

Physician Executive Council

Project directors

Sarah Hostetter

hostetts@advisory.com
202-909-4162

Eliza Campbell

campbele@advisory.com
202-568-7908

Program leadership

Megan Clark