Journal of the American College of Cardiology
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Published by Elsevier Inc.

Vol. 57, No. 9, 2011
ISSN 0735-1097/$36.00
doi:10.1016/j.jacc.2011.02.003

ACC NEWS

President's Page: Team-Based Care: A Solution for Our Health Care Delivery Challenges

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Health care is a team sport, and today's health care challenges are making it even more so.

Over the past year we have seen dramatic changes in the clinical practice landscape, and these changes are only expected to continue. One of the biggest changes has been the transition from private practice groups to hospital employment. The American College of Cardiology's (ACC's) 2010 Practice Census found that nearly 40% of private group practices are currently integrating with hospitals or merging with other practices. Furthermore, an additional 13% of all cardiovascular practices are considering hospital integration or a merger in the next 3 years to help ease the financial burden (unpublished data, American College of Cardiology 2010 Practice Census, May 5 to August 9, 2010).

Workforce issues also continue to pose very real challenges. An ACC Workforce Task Force study found that an additional 3,000 to 4,000 general cardiologists will be needed in the near future to adequately address the needs of the aging "Baby Boomer" population and an ever-increasing number of people with, or at risk of, cardiovascular disease (1). Meanwhile, a recent Lewin Group study found that the shortage in cardiologists will increase from 1,700 in 2008 to roughly 16,000 by 2025 (2).

These profound changes, while forcing all of us to literally re-evaluate business as usual, also present opportunities to improve the way we provide care to cardiovascular patients. One of the biggest opportunities is a movement toward team-based care. Team-based care not only offers solutions to the workforce shortage, it also has the potential to enhance patient care in terms of quality and safety, expanded physician productivity, and improved job satisfaction by reducing workloads and preventing burnout.

In Canada, patient-centered care teams have proven over the last several years to successfully improve health outcomes when it comes to managing blood pressure, diabetes, and other chronic illnesses. Patients and health care providers have also reported greater satisfaction and more positive experiences, likely as a result of organizational improvements in terms of "more efficient resource utilization, better access to services, shorter wait times, increased coordination of care, and more comprehensive care" (3).

The ACC's Practice Census supported these results. Of the practices operating in a team-based care environment, increased efficiency (63%), improved quality of care (53%), and increased patient satisfaction (50%) were the primary improvements cited. Other benefits of the team approach included increased staff satisfaction (36%) and improved financial outcomes (19%). According to the survey, team-based care providers were most likely to implement patient education (69%) and internal communications (63%) as a part of their care protocol. Performance improvement (56%) and data monitoring (56%) were also popular practices, followed by patient adherence (50%), objective feedback (47%), and clearly defined roles (41%).

However, despite these benefits, implementing team-based care in practice can be challenging, particularly in smaller private practices. The ACC Practice Census found that solo practitioners were less likely to employ a team-based care model compared with hospital-based, multi-specialty, and academic practices, which were more likely to

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March 1, 2011:1123–5

use physician extenders in their care delivery. Of the 43% not using team-based care, reimbursement and the inability to break the more traditional views of practicing medicine held by patients and providers were the primary reasons cited.

Overcoming these barriers is certainly feasible. For example, Dan Caldwell, MBA, CMPE, a member of the ACC's Team Curriculum Planning Committee, credits team-based care as the reason his 16-person practice in Little Rock, Arkansas, is busier than practices twice its size. The practice uses 20 nurse practitioners (NPs) in various roles. These NPs are assigned to each of the physicians as part of the physician's care team. According to Caldwell, the greatest return on investment is the ability for the physician to move up in complexity of his or her activities, thereby increasing the revenue from the physician. "The practice makes the best use of each provider's time, so that the team can see more patients," he said. "The team's revenue is the unit of analysis: when you supplement the physicians with the NP, then the financial value of the team increases."

In an effort to help other cardiovascular care providers realize similar benefits, the ACC's Team Curriculum Planning Committee is working to identify various team-based practice models that would work in both practice and hospital settings, while also developing educational programs to foster greater understanding of roles and responsibilities within a team. In addition, the committee is also looking to identify and reduce—if not eliminate—the financial restrictions that pose very real barriers to team-based care. Given current efforts to reform physician payment and to move away from fee-for-service and toward a system that rewards quality, cost-effective care, the time is right to ensure that team-based care models are promoted in any new payment system.

At the present time, it is uncertain how practice teams will be integrated into the hospital environment. The function of teams in the hospital setting will be contingent on the contracts negotiated between practices and/or physicians and the hospitals. Given that many practice groups maintain control over their own employees, the hospital is less involved in managing a team-based process. Providing practice teams with a greater understanding of the contract process and the know-how to best ensure the cohesiveness of their "team" is an important part of the education process.

The ACC Practice Census showed that cardiovascular professionals in hospital or academic settings are more likely to engage in quality improvement types of team-based care (i.e., registry participation, data monitoring, and performance improvement activities like Hospital to Home [H2H]). Providing opportunities for all team members to share best practices related to these activities while also continuing to update registry and data monitoring tools to better meet the needs of physicians, nurses, NPs, and hospital administrators are key to elevating the success of these programs and resources.

The ACC's Annual Scientific Session (ACC.11) in New Orleans will showcase several ways that the College is working to provide these opportunities. For example, the ACC is partnering with Philips Healthcare on a new H2H Learning Destination to be featured as part of the ACC.11 Expo. The H2H Learning Destination will showcase the ways that collaboration, better communication, and the innovative use of technology can improve the patient transition from inpatient to outpatient status and reduce costly readmissions. The exhibit will spotlight a variety of companies' technologies and services and showcase best practices for reducing hospital readmissions as well as improving the quality of life for cardiac patients and their caregivers through engagement of providers, patients, and caregivers at each point along the care continuum.

Another barrier to the effective use of nonphysician cardiac care professionals is a lack of knowledge about the potential role they may play in the practice. Practices continue to look for guidance on how best to use these care extenders. Practice managers must have a definitive belief supported by data that the expanded use of nurses, NPs, and physician assistants (which will increase their overhead) will result in a return on investment. If a practice has more patients than it can care for, then the use of care extenders can be well justified. Even if the practice might feel they have the right patient-physician balance, the development of a team-based care model can lead to higher quality care and greater patient satisfaction, and can enhance the ability of that practice to expand its patient base.

Developing a "best practices" model for team-based care will go a long way toward providing the guidance needed. While this will take some time given the fluidity of discussions taking place regarding payment reform and the early stages of hospital integration, preliminary efforts to share strategies, test new models, and identify team roles are already taking place. In addition, several sessions as part of the ACC.11 "Practice Management Track" are designed to generate debate and discussion about these issues, while programs such as the Cardiovascular Leadership Institute and the PINNACLE Network are working to ensure that team-based care resources and programs are available as part of their offerings moving forward.

Health care is a team sport, and today's health care challenges are making it even more so. By working together as an integrated team, we have a unique opportunity to successfully address the workforce issues we face

and to change the way we practice cardiovascular medicine for the better.

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