

REPORT 6 OF THE COUNCIL ON MEDICAL SERVICE (A-14)
Development of Models/Guidelines for Medical Health Care Teams
Reference Committee G

EXECUTIVE SUMMARY

Physician-led health care teams hold the promise of addressing anticipated access problems due to an imbalance between the supply of health care professionals and the demand for health care. Yet, the definition of what comprises a “physician-led” team needs to be clearly articulated. Leadership on teams of highly-skilled health professionals doing complex or innovative work does not require physician leaders to have all the right answers for every task the team needs to accomplish; rather, it requires physicians to ask the right questions, invite participation, communicate clearly, promote a culture of respect, reward excellence, and ensure accountability, among other important leadership skills. With these concepts in mind, this report proposes a definition of “physician-led” in the context of health care teams.

A strategic focus of the American Medical Association (AMA) is to enhance physician satisfaction and practice sustainability by shaping delivery and payment models. The AMA continues to evaluate team-based care models as part of this focus area. Even so, the Council believes that the AMA is not likely to endorse specific models. A key factor to consider is that teams in different situations work differently so no one team-based model is appropriate for all physician practices or clinical situations. Each physician practice should design its team-based model according to its needs, the population served and relevant state laws. There are numerous elements that could comprise a team-based model. Physician practices of all sizes and specialties should implement the necessary elements, as identified by the practice, to operate as a unique team-based model.

Physician expertise and authority, patient safety, ethical considerations, and legal issues are elements of a team-based model that are addressed in this report. There are potentially dozens of other components that could be included in a team-based health care model depending on each specific practice. The Council believes that certain elements should be considered when planning a team-based health care model according to the needs of each physician practice. These elements fall under the categories of patient-centered care, teamwork, clinical roles and responsibilities, and practice management.

This report defines “physician-led” in the context of team-based health care, outlines components of team-based models and guidelines for health care teams, summarizes relevant AMA policy and advocacy, and presents policy recommendations.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-14

Subject: Development of Models/Guidelines for Medical Health Care Teams

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Referred to: Reference Committee G
(Craig A. Backs, MD, Chair)

1 At the 2013 Annual Meeting, the House of Delegates adopted amended Resolution 711 (Policy
2 D-160.935), which asked:

3
4 That our American Medical Association (AMA) study and report back on the definition of
5 leadership in physician-led medical teams and to propose acceptable models that value the
6 expertise of the physician and models that could be used by medical teams that address
7 specific issues such as patient safety, the nature of physician authority within the teams, and
8 the ethical and legal issues of the team model.
9

10 This report defines “physician-led” in the context of team-based health care, outlines components
11 of team-based models and guidelines for health care teams, summarizes relevant AMA policy and
12 advocacy, and presents policy recommendations.
13

14 BACKGROUND

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16 The requests in Resolution 711-A-13 were prompted by the Council on Medical Education and
17 Council on Medical Service Joint Report I-12 (Joint Report),¹ which addressed the structure and
18 function of inter-professional health care teams. The Joint Report defined “team-based health care”
19 as the provision of health care services by a physician-led team of at least two health care
20 professionals who work collaboratively with each other, the patient and family, to accomplish
21 shared goals within and across settings to achieve coordinated, high-quality, patient-centered care
22 (Policy H-160.912[1]). The Councils’ report also established a series of principles to guide
23 physician leaders of health care teams (Policy H-160.912[4]).
24

25 PHYSICIAN-LED MEDICAL TEAMS

26
27 Policy D-160.935[1] directs our AMA to study and report back on the definition of leadership in
28 physician-led medical teams. Extensive AMA communications and advocacy initiatives strongly
29 support physician-led, team-based care as an effective model of health care delivery. The
30 unwavering principle that clinical care teams should be physician-led helps guide the activities of
31 the AMA, as well as AMA initiatives such as the Scope of Practice Partnership (SOPP). As noted
32 in the Joint Report, physician-led health care teams hold the promise of addressing anticipated
33 access problems due to an imbalance between the supply of health care professionals and the
34 demand for health care. Yet, the definition of what comprises a “physician-led” team has not been
35 clearly articulated. The House of Delegates considered Board of Trustees Report 2-I-13,²
36 developed by a Board and Council task force convened to respond to Resolution 213-I-12, “Non-
37 Physician Practitioners Certifying Medicare Patients’ Need for Therapeutic Shoes and Inserts.”

1 Board Report 2-I-13 was referred, but included a definition of “physician-led” as “the consistent
2 use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage
3 and elicit from each team member the unique set of contributions needed to help each patient
4 achieve their care goals.”

5
6 Policy D-160.935[2] directs our AMA to propose acceptable medical team models, but the Council
7 strongly encourages physician choice of practice rather than endorsing specific “acceptable”
8 models. Effective physician-led teams can involve many types of models. Following are some
9 examples.

10
11 *Mayo Clinic*

12
13 The Mayo Clinic’s physician-led structure³ supports integrated, multidisciplinary, physician-led
14 teamwork within subsets of the overall organization, such as in Mayo’s diabetes care teams. These
15 teams are led by an endocrinologist who depends on the expertise of primary care physicians,
16 nurses, and diabetes educators who, together with patients, develop, share, and implement care
17 plans to achieve patient goals. They rely on team members taking on some non-traditional roles,
18 such as nurses, who conduct outreach and pre-visit planning, and receptionists, who act as diabetes
19 registry coordinators. The teams are also supported by a primary care council of physicians
20 including internists, family physicians, pediatricians, and urgent care physicians, who identify and
21 share best practices, and design care models. Mayo’s use of physician-led teams in this way, with
22 emphasis on each team member’s unique capabilities, has led to improved diabetes care and
23 metabolic outcomes. Similarly, organizations including Virginia Mason, Kaiser Permanente and
24 Intermountain Medical Group are built upon the use of physician-led teams that challenge each
25 member of the team to achieve their fullest potential, all in the interest of quality, affordable,
26 patient-centered care.

27
28 *El Rio Community Health Center*

29
30 Physician-led teams recognize that health care is dynamic, and they must organize the
31 responsibilities of each team member to align with the patient’s best interests. With shared goals
32 and clear roles, various members of the team can take lead responsibility for specific tasks or
33 domains of care commensurate with their skill, training, education, and demonstrated competency.
34 While certain tasks must be directly led by physicians to ensure patient care and safety, other tasks
35 are more appropriately led by non-physician health care professionals. This is a reflection of the
36 nuanced nature of “leadership” within teams carrying out complex or innovative work, in which
37 there is an expectation of some degree of leadership from all members of the team.

38
39 El Rio Community Health Center in Tucson, Arizona is instructive in this regard. At El Rio, using
40 a medical staff-approved collaborative practice agreement, the clinical pharmacist serves as the
41 primary care provider for patients with diabetes and comorbid conditions, such as hypertension and
42 hyperlipidemia, requiring complex medication management. Pursuant to the collaborative practice
43 agreement, and with physician oversight, the pharmacist provides appropriate diagnostic,
44 educational, and therapeutic management services, including prescribing medications and ordering
45 laboratory tests, based on national standards of care for diabetes. This physician-led arrangement
46 is focused on patient needs while maximizing the use of all the clinic’s health professionals.

1 *Duke Heart Center*

2
3 Physician-led, team-based care can improve specialty care as well. At Duke Heart Center, a new
4 “parallel model” leverages inter-professional teams by using health professionals working at the
5 “top of their competency and licensure.” Physicians develop care plans for new patients, nurse
6 practitioners (NPs) and physician assistants see returning or acutely ill patients, and registered
7 nurses coordinate follow-up care, schedule procedures, and respond to triage calls. Team members
8 consult each other as necessary and appropriate.

9
10 *Massachusetts General Hospital*

11
12 At the Massachusetts General Hospital (MGH), physician-led inter-professional care teams
13 established a “spine line” service through which NPs assist patients and referring physicians who
14 request guidance in navigating to the right professional at the right time for back pain. This process
15 helps save patient time and money. It decreases confusion and frustration among patients and
16 referring professionals alike, while increasing the appropriateness of specialist consultations. For
17 example, the “spine line” NP helps patients get urgent access when indicated, thereby decreasing
18 emergency department visits for back pain. MGH and Duke Heart Center represent physician-led
19 teams that use all of their members to increase access to care and improve patient satisfaction.

20
21 **MODELS/GUIDELINES FOR MEDICAL TEAMS**

22
23 Policy D-160.935[2] directs our AMA to propose models that could be used by medical teams that
24 address specific issues such as patient safety, the nature of physician authority within the teams,
25 and the ethical and legal issues of the team model. As noted, the Council strongly encourages
26 physician choice of practice rather than endorsing specific models. Nevertheless, the Council
27 reviewed AMA policy, advocacy and ethical opinions in response to this request.

28
29 *Physician Expertise and Authority*

30
31 Physician expertise is widely recognized in the delivery of medical care in the United States.
32 Physicians have acquired seven years or more of postgraduate education and more than 10,000
33 hours (average for a three year residency) of clinical experience through training. While team-
34 based care is a group effort, physicians, due to their education, training and expertise, are the
35 natural leaders in overall care delivery.⁴ Policy H-450.955 supports educating our society on the
36 differences between physician and non-physician providers of clinical services regarding their
37 unique training, experience, broad based knowledge, ability and expertise, which impacts their
38 ability to provide high quality clinical care.

39
40 The AMA advocates that physicians maintain authority for patient care in any team care
41 arrangement to assure patient safety and quality of care. The AMA believes that the ultimate
42 responsibility for the individual patient’s medical care rests with the physician. Physicians must be
43 responsible and have authority for initiating and implementing quality-control programs for non-
44 physicians delivering medical care in integrated practices. To assure quality patient care, the
45 physicians and non-physician practitioners should have continuing dialogue on patient care
46 functions that may be delegated to allied health professionals consistent with their education,
47 experience and competency (Policies H-360.987[1,2,6], H-200.994 and D-35.985[5,6]). The
48 patient-centered medical home model is an example that respects physician expertise and authority.

1 *Patient Safety*

2
 3 In some areas of clinical practice, such as surgery and critical care management in intensive care
 4 units, medical professionals have already developed team-based approaches and methods for
 5 quality improvement. In these settings, one team model that has been identified and adopted from
 6 the aviation industry is Crew Resource Management (CRM), which is a management method to
 7 increase safety by focusing on teamwork, challenges to successful outcomes, error management
 8 and blame-free discussions of human mistakes.⁵ A key element of CRM is the use of a brief
 9 checklist to ensure that all team members have the same knowledge of a particular clinical case and
 10 are prepared to work as a cohesive unit. When applied to the practice of medicine, CRM has the
 11 potential to reduce errors. A study of 106 simulated surgical-crisis scenarios found that when a
 12 checklist was not used, 23 percent of lifesaving procedures were not performed compared to 6
 13 percent when a checklist was used.⁶

14
 15 *Ethical Considerations*

16
 17 The Council on Ethical and Judicial Affairs has developed ethical opinions relevant to team-based
 18 care. Opinion E-3.05 states that a physician’s relationship with non-physician practitioners must be
 19 based on mutual respect and trust as well as their shared commitment to patient well-being. Given
 20 their comprehensive training and broad scope of practice, physicians have a professional
 21 responsibility for the quality of overall care that patients receive, even when aspects of that care are
 22 delivered by non-physician clinicians. Furthermore, when non-physicians employ physicians to
 23 supervise the employer’s clinical practice, conditions are created that can lead to ethical dilemmas
 24 for the physician. Physicians in such arrangements must give precedence to their ethical obligation
 25 to act in the patient’s best interest by always exercising independent professional judgment, even if
 26 that puts the physician at odds with the employer/supervisee. In addition, Opinions E-8.05 and
 27 E-8.051 state that in any contractual relationship, physicians should be free from outside
 28 interference in professional medical matters and should not enter into any arrangement that
 29 undermines the physician’s ethical obligation to advocate for patient welfare.

30
 31 *Legal Issues*

32
 33 Legal aspects of collaboration between physicians and non-physicians fall largely under state laws,
 34 which outline physician supervision of non-physician practitioners and also delineate the terms of
 35 such supervision. The AMA has developed model state legislation entitled “An Act to Support
 36 Physician-Led Team Based Health Care,”⁷ which is based on landmark legislation adopted in
 37 Virginia in 2012,⁸ and outlines how physicians and nurse practitioners will partner to provide
 38 physician-led, team-based care. When enacted in a state, this model legislation empowers physician
 39 leaders of health care teams to require that a nurse practitioner be covered by a professional
 40 liability insurance policy with limits equal to the current limitation on damages as set forth by that
 41 state’s laws. In addition, the model state legislation established that a practitioner’s service on a
 42 physician-led patient care team shall not, by the existence of such service alone, establish or create
 43 liability for the actions or inactions of other team members. The model state legislation is the
 44 foundation of the AMA’s new state advocacy campaign, “Physician-led Health Care Teams,”
 45 which encourages flexible, innovative health care teams under a framework of physician
 46 leadership.⁹

47
 48 **AMA POLICY AND ADVOCACY**

49
 50 AMA policy encourages independent physician practices and small group practices to consider
 51 opportunities to form health care teams, such as through independent practice associations, virtual

1 networks or other networks of independent providers (Policy H-160.912[5]). The AMA will
 2 continue to identify, publicize and promote physician-led delivery and payment reform programs
 3 that can serve as models to improve patient care and lower costs, and to provide resources to help
 4 physicians understand and participate in these initiatives (Policy D-385.963[4, 5]). Council on
 5 Medical Service Report 1-I-13¹⁰ highlights case studies of various team-based models and their
 6 respective payment systems in order to identify, publicize, and promote physician-led payment and
 7 delivery reform programs that can serve as models for physician practices working to improve
 8 patient care and lower costs.

9
 10 In addition, the Joint Council Report from I-12¹¹ highlighted the movement toward inter-
 11 professional medical education as the culture of team-based care is now starting in medical school.
 12 In 2013, the AMA launched its “Accelerating Change in Medical Education Initiative,”¹² which
 13 aims to bring innovative changes to medical education. This five-year initiative is one of the
 14 AMA’s strategic focus areas and includes promoting exemplary methods to achieve patient safety,
 15 performance improvement and patient-centered team care. Through this initiative, the AMA has
 16 awarded grants to 11 medical schools with innovative proposals to transform medical education.
 17 The majority of these schools have plans to incorporate learning experiences in inter-professional
 18 teams, instruction by various health care professionals, and development of leadership and change
 19 management skills. At the end of this initiative, these undergraduate medical educational
 20 improvements will have been tested, refined and adopted as mainstream options.

21
 22 Council on Medical Education Report 7-A-14,¹³ also being considered at this meeting, calls on the
 23 AMA to encourage the Accreditation Council for Graduate Medical Education and the American
 24 Osteopathic Association to develop and disseminate innovative methods of training physicians
 25 efficiently that foster the skills and inclinations to practice in a health care system that rewards
 26 team-based care and social accountability.

27
 28 **DISCUSSION**

29
 30 The AMA believes that all members of a physician-led health care team should be enabled to
 31 perform medical interventions that they are capable of performing according to their education,
 32 training, licensure, and experience to most effectively provide quality patient care (Policy
 33 H-160.912[3]). Similarly, the AMA recognizes that physicians working in high-functioning health
 34 care teams are both more reliant on others and more empowered to spend their time focused on
 35 carrying out the medical tasks that they are best trained to perform.

36
 37 Leadership on teams of highly-skilled health professionals doing complex or innovative work does
 38 not require physician leaders to have all the right answers for every task the team needs to
 39 accomplish; rather, it requires physicians to ask the right questions, invite participation,
 40 communicate clearly, promote a culture of respect, reward excellence, and ensure accountability,
 41 among other important leadership skills. With these concepts in mind, the Council proposes that
 42 in the context of health care teams, “physician-led,” should be defined as “the consistent use by a
 43 physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit
 44 from each team member the unique set of contributions needed to help patients achieve their care
 45 goals,” as recommended in referred Board of Trustees Report 2-I-13. The response to that referred
 46 report appears at this meeting in Board of Trustees Report 23-A-14.

47
 48 A strategic focus of the AMA is to enhance physician satisfaction and practice sustainability by
 49 shaping delivery and payment models. The AMA continues to evaluate team-based care models as
 50 part of this focus area. Even so, the Council believes that the AMA is not likely to endorse specific
 51 models. A key factor to consider is that teams in different situations work differently so no one

1 team-based model is appropriate for all physician practices or clinical situations. Each physician
2 practice should design its team-based model according to its needs, the population served and
3 relevant state laws. There are numerous elements that could comprise a team-based model.
4 Physician practices of all sizes and specialties should implement the necessary elements, as
5 identified by the practice, to operate as a unique team-based model.

6
7 Physician expertise and authority, patient safety, ethical considerations, and legal issues are
8 elements of a team-based model that are identified in Policy D-160.935[2], and addressed in this
9 report. There are potentially dozens of other components that could be included in a team-based
10 health care model depending on each specific practice. The Council believes that certain elements
11 should be considered when planning a team-based health care model according to the needs of each
12 physician practice. These elements fall under the categories of patient-centered care, teamwork,
13 clinical roles and responsibilities, and practice management.

14
15 The Council believes that patient-centered team care should establish a patient-physician
16 relationship at the onset of care, with each team member's role clearly explained to the patient;
17 include a health care team that involves the patient and family; adhere to best practice protocols;
18 strive to improve health outcomes by focusing on health as well as medical care; provide twenty-
19 four hours a day, seven days a week access to the team; and follow patient safety protocols.

20
21 Teamwork in a health care setting includes physicians and non-physician practitioners working
22 together, sharing decisions and information, for the benefit of the patient. Physicians, nurse
23 practitioners, physician assistants, nurses and other professionals should work together, drawing on
24 the specific strengths of each team member. The Council believes that teamwork in a health care
25 setting should include a physician leader; practitioners committed to working in a team-based care
26 model; a variety of practitioners that reflect the needs of the practice; practitioners trained
27 according to their unique function in the team; interdependence among team members; routine
28 communication about patient care; and autonomous task completion. Specifically, AMA policy
29 advocates that the leader of a physician-led inter-professional health care team should be
30 empowered to perform the full range of medical interventions that she or he is trained to perform
31 and that all team members should be enabled to perform medical interventions that they are capable
32 of performing according to their education, training and licensure and the discretion of the
33 physician team leader in order to most effectively provide quality patient care (Policy
34 H-160.912[2,3]).

35
36 Accordingly, the Council believes that the clinical roles and responsibilities of a health care team
37 should include physician leaders who are focused on patient care, including the diagnosis of
38 illnesses and on complex cases; non-physician practitioners who are focused on routine, preventive
39 and follow-up care; care coordination and case management that are integral to the team's practice;
40 and population management that monitors the cost and utilization of care, and includes registry
41 development for most medical conditions.

42
43 Practice management tools are essential to the successful functioning of a medical practice and are
44 integral to the quality and efficiency of the health care that is provided. The Council believes that
45 practice management elements that should be considered when developing a health care team
46 model include the use of electronic medical records to the fullest capacity; quality improvement
47 processes that evolve according to improved interventions; data analytics that include statistical
48 and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling;
49 and streamlined prior authorization and precertification processes.

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51 The Council recommends rescinding Policy D-160.935, which was accomplished with this report.

1 RECOMMENDATIONS

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The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) define “physician-led” in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills. (New HOD Policy)
2. That our AMA support the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

Patient-Centered:

- a. The patient is an integral member of the team.
- b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
- b. Patient and family-centered care is prioritized by the team and approved by the physician team leader.
- c. Team members are expected to adhere to agreed upon practice protocols.
- d. Improving health outcomes is emphasized by focusing on health as well as medical care.
- e. Patients’ access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
- f. Safety protocols are developed and followed by all team members.

Teamwork:

- a. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
- b. All practitioners commit to working in a team-based care model.
- c. The number and variety of practitioners reflects the needs of the practice.
- d. Practitioners are trained according to their unique function in the team.
- e. Interdependence among team members is expected and relied upon.
- f. Communication about patient care between team members is a routine practice.
- g. Team members complete tasks according to agreed upon protocols as directed by the physician leader.

Clinical Roles and Responsibilities:

- a. Physician leaders are focused on individualized patient care and the development of treatment plans.
- b. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
- c. Care coordination and case management are integral to the team’s practice.
- d. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

Practice Management:

- a. Electronic medical records are used to the fullest capacity.

- 1 b. Quality improvement processes are used and continuously evolve according to
2 physician-led team-based practice assessments.
3 c. Data analytics include statistical and qualitative analysis on cost and utilization, and
4 provide explanatory and predictive modeling.
5 d. Prior authorization and recertification processes are streamlined through the adoption
6 of electronic transactions. (New HOD Policy)
7
8 3. That our AMA rescind Policy D-160.935, which requested this report on physician-led team-
9 based care. (Rescind HOD Policy)

Fiscal Note: Less than \$500

REFERENCES

- ¹ American Medical Association. Council on Medical Education and Council on Medical Service Report I-12. 2012. Available at: www.ama-assn.org/resources/doc/cms/i12-cmecms-jointreport.pdf
- ² American Medical Association. Board of Trustees Report 2-I-13. 2013. Available at: www.ama-assn.org/assets/meeting/2013i/i13-bot2.pdf
- ³ The Mayo Clinic is physician-led at all levels and operates through physician committees and a shared governance philosophy in which physician leaders work with administrative partners in a horizontal, consensus driven structure. Physicians serve in rotating assignments on committees and in leadership roles to promote broad participation and development of the workforce.
- ⁴ Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation; Final Rule. Centers for Medicare and Medicaid Services. Federal Register, Volume 77, No. 95. May 16, 2012. Available at: www.gpo.gov/fdsys/pkg/FR-2012-05-16/pdf/2012-11548.pdf
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- ¹³ American Medical Association. Council on Medical Education Report 7-A-14. 2014.