

Peer sharing & learning session (third Thursday of each month, 12-1:30 pm)
15 January 2026 – Team-based care: Role definition and working to scope of practice

A day in the life of team-based care:

Where the rubber of the health care system hits the road of care delivery

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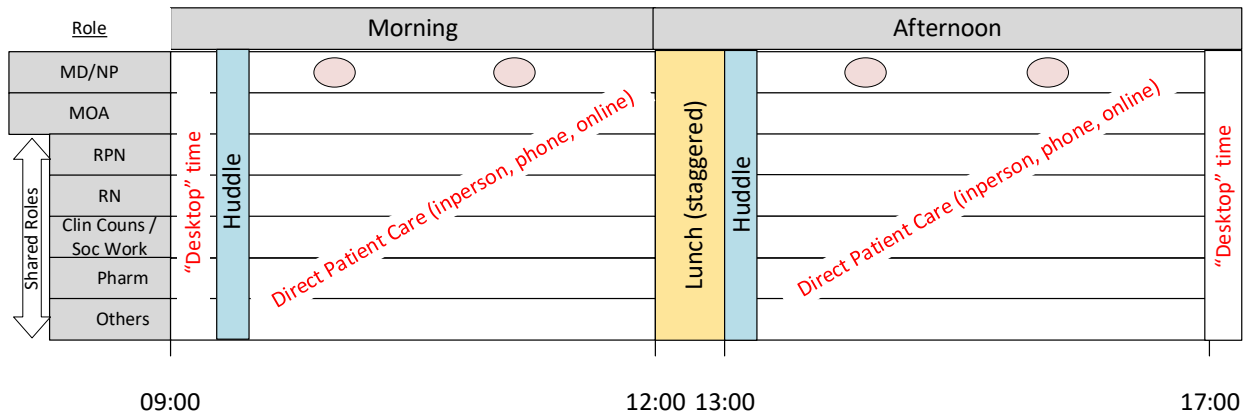
Context

First I want to mention a **'teamlet'** – the MD/NP (physician / nurse practitioner) and an MOA (medical office assistant, or sometimes a medical assistant), who work most closely together in the direct care of patients during the day. The MOA was the person I would interact with most frequently, and with most every patient.

Then the **'clinical team,'** typically a group of 5-7 MD/NPs with MOAs, and shared staff RPN/RNs (registered practical nurse / registered nurse), pharmacist, PT (physiotherapist), midwife, councillor and many more. This was considered a manageable size for a daily operational group. A typical MD/NP worked four days a week, so a minimum five-member MD/NP team was a great way to ensure that everyday coverage for the week would be even.

Sharing **resources** amongst multiple team members has its economy of scale:

- 1) space – exam rooms, a specialized procedure room if desired, and supplies
- 2) electronic data systems and hardware – just yesterday I got a message for some unused licenses available for software from my local OHT that were available, with organizational discount
- 3) personnel – difficult for a single MD to staff a full-time RPN/RN on their own
- 4) coverage concerns for smaller offices.



Preparatory time before seeing patients

The clinic opened a half-hour prior to the first appointment with time well-used prior as shown in the above image.

MDs, NPs and RNs are looking at **lab results** that have come in since the previous day, any electronic **messages** from patients from overnight, reports from ED (emergency department), UC (urgent care) and 24-hour nursing services, and preparing for day ahead.

The MOA had already started today's work the day before by doing preliminary reviews of the patient charts for the day ahead – this includes looking at any unmet care needs for the patient in addition to what they are there for, preparing equipment/rooms as needed. They were '**mining the schedule**' to look for opportunities to provide care.

As we all are aware, the moment a clinic opens is a time that a large number of patients start calling in and a high priority was to **answer the calls** and resolve them if possible as promptly as possible. Our phone system was programmed that everyone could sign in to the main trunk line to take incoming calls and we all were encouraged to do so. It was great to help a patient immediately and avoid adding an appointment later and delaying what could be done immediately.

Just before the start of seeing patients and this last minute prep was done.

Team huddle would be called by the team leader (typically an MD or NP but it could be anyone of the team who has been chosen/designated) would call all members of the team together for 5-10 minutes to discuss what they saw for the day ahead and plan who will do what – issues of access, resource needs amongst all members of the team, working to top of scope, and directing patients to the most-available person who could provide the service.

We would review our **tracking board and practice metrics** to flag issues for improvement – this included all practice metrics – access, used and unused appointments, patient satisfaction metrics, monthly PCER (patient care electronic report), which could be used [in the U.S.] to determine future work and practice quality, particularly chronic conditions and screening rates.

We would **review the prior day** for lessons learned and give out kudos – positive reinforcement for team members that built cohesion and support for any future change.

This was the most important part of the day, and often one of the most looked forward to because it allowed us to connect with colleagues.

Direct patient care time (both morning and afternoon)

Three personnel were key to my direct patient care time:

- **MOA** – they did the pre-visit work (checking to see external records / laboratory results, preventive care or chronic illness tasks that were needed) and set up the visit for the MD or NP (took vital signs, assessed patient readiness and pending orders, and set out needed equipment), did post-visit planning (follow-up appointments, referrals, lab requisitions, etc.), reviewed forms for completion, and made phone calls (triaging calls for service type).
- **physician/NP** – we conducted office, phone and online (virtual medicine) visits, led medical management, provided acute and chronic disease care, undertook preventive care tasks like tobacco cessation counselling and cancer screenings. A few open slots were held at the beginning of the day to deal with urgent visits/same-day access. And while I would have my contact with a patient, the MOA was already preparing the next person, as well as answering and making calls and doing registry management/outreach. Our EMR could provide us with the information on all of the patients in our panel, attached to us.

- **a shared RPN/RN** – they worked in a shared role with me and other MDs, which included providing vaccinations, supporting chronic-disease management (CDM), enabling care transitions (e.g., to a long-term care), conducting ED/UC follow-ups (all patients who were discharged or seen in ER were tracked and contacted), undertaking post-visit counselling (e.g., wound care), and doing phone consults for patients with medical issues under medical directives.

Other personnel included:

- social worker/clinical councillor – helping particularly with patients with SES (socioeconomic status-related) challenges – who supported intake, point-of-care visits, referrals to and from outside agencies, worked with patients to solve family issues, and worked on financial and legal supports.
- pharmacists – helping with high-risk complex medication management, medication reconciliation, direct prescribing advice for physicians (e.g., drug interactions), direct counseling for patients on issues related to side effects and adherence, and direct patient care for minor issues (as their scope has widened)
- other personnel who were available when needed included midwives, PTs/OTs (physiotherapists and occupational therapists), dieticians, and CDEs (certified diabetes educators).

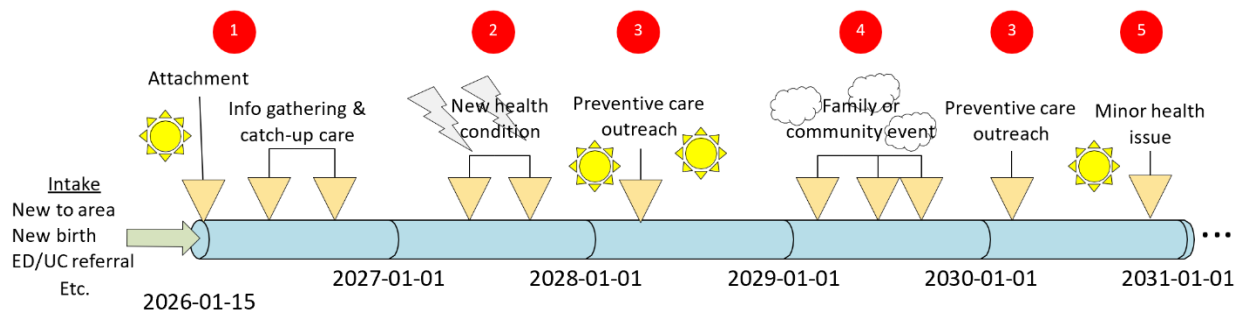
We considered any patient contact as a **comprehensive contact** – e.g., if a PT sees a vaccine/lab work/screening is due when a chart is open for care, they inform the patient.

Lunch (staggered to keep the utilization of services and for patient convenience) was followed by a **mini-huddle** to review the morning and look to the afternoon. These were mostly at the teamlet level.

At the end of the day, the MOA was already **getting started for the next day** by reviewing the schedule and reviewing/mining the charts for the next day. The doctor would finish with patient care in the office, and review any final messages from other team members about patient care, as well as review additional labwork/reports/patient information that came in through the day. And the doctor would **thank the team** members for their efforts for the day.

Phones were forwarded to the 24 hour service line and the doors closed.

A life in the system



The above image is from the patient's perspective and how they experience the team.

Remember that primary care is all about lifetime care for the patient – in happy times, challenging times, boring times, ongoing times. Consider these five example touchpoints:

- 1) **Attachment to primary care** – consider this a first date, starting a relationship between patients and members of the care team; this can include information gathering (demographics, medical and social determinants of health needs), sharing online resources, identifying current health needs (including preventive and chronic illness care), and getting up to date. This is where the line ‘thickens’ into the cylinder, which is the team and other surrounding supports the patients will be able to access through their life and needs in medical care.
- 2) **Major health condition** – primary care MD, NP and/or RN will provide follow-up as necessary, possibly complemented by other people on the care team (e.g., pharmacist might help with medication issues) as well as other health care professionals/specialists.
- 3) **Nothing (outreach)** – MOA will provide outreach on a regular basis and at least annually, with all needed services including cancer screening, well-child care and immunizations, chronic conditions management, monitoring medication use, and frailty support (for seniors)
- 4) **Family or community event** – we see people at extreme moments in their lives in a family crisis – like death of a loved one, or a major new illness like cancer – with many repeated visits; patients would see many people on the team during these periods (councillor, RN, MD) and we would coordinate with many external specialists (with primary care always considered the back stop for all care)
- 5) **Minor health issue** – team pharmacist, RN, NP, MD could all help out here, and this has been a welcome development in Ontario that allowed me to focus more on applying my unique expertise.

Conclusion: My thoughts on team-based care

I was able to provide **higher quality** care and feel **professionally rewarded** knowing my skills were used efficiently, in a more expedited way. I could do the things that were unique for my team, and provide mentorship to other members on the team also.

My patients much happier from their experience. They appreciated that all members of the team could meet with them and participate in their care, and knew what was happening. More ‘brains’ involved in a person’s care is a good feeling. **Patient satisfaction** surveys were regularly done within the organization and reported and it was great seeing numbers go up over time.

Other team members and myself all had higher **job/organizational satisfaction**, both with the care we were providing to others, but also with each other, becoming some of my best friends that I still am connected with 10 years later. Again, staff satisfaction surveys were routinely done and metrics showed improvement amongst all members of the team.

I could go home at the end of the day, knowing that work for today was done, my MOA had already gotten a start on tomorrow and I could return tomorrow to **face new challenges, together**.



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