

Function of the Medical Team Quarterback: Patient, Family, and Physician Perspectives on Team Care Coordination in Patient- and Family-Centered Primary Care

Marlaine Figueroa Gray, PhD¹; Jennifer Sweeney, MA²; Wendy Nickel, MPH³; Mary Minniti, BS, CPHQ⁴; Katie Coleman, MSPH^{1,5}; Karin Johnson, PhD⁶; Tracy Mroz, PhD⁷; Barb Forss⁸; Robert Reid, MD⁹; Dominick Frosch, PhD¹⁰; Clarissa Hsu, PhD¹

Perm J 2019;23:18.147

E-pub: 08/26/2019

<https://doi.org/10.7812/TPP/18.147>

ABSTRACT

Context: Patient- and family-centered care (PFCC) literature is growing, but few reports present patient, caregiver, and practitioner perspectives about care coordination in a team-based model.

Objective: To understand the patient's, caregiver's, and physician's ideal forms of PFCC, we investigated the function of the medical team quarterback, who coordinates and advocates for appropriate care, and probed to understand how the quarterback works with a team to contribute to ideal PFCC.

Design and Main Outcome Measures: Nine focus groups with 92 participants were held in 3 major cities. Patients (n = 35) and family members (n = 36) were recruited through market research groups. Physicians (n = 21) were recruited by the American College of Physicians. Focus group transcripts were analyzed and coded using inductive analysis.

Results: The quarterback emerged as an important function for addressing care gaps and improving the care experience. We identified 6 themes articulated by participants that defined the role of a medical team quarterback: Overseeing care; coordinating diagnoses, tests, and treatments; advocating for patients; identifying and respecting patient values; proactively communicating; and solving problems. Patients and family members in our sample were open to different members of the care team acting as quarterback in coordination with the physician.

Conclusion: Medical team quarterbacks were perceived as enhancing team-based care by facilitating the coordination/communication that is critical to PFCC. Patients and family members acknowledged that PFCC can be delivered by different members of the medical team if the care felt organized and coordinated with the primary care physician.

and competencies of multiple care team members to address the Quadruple Aim¹¹ of better care, better health, lower costs, and happier care practitioners.

As health systems continue to experiment with defining and supporting care teams, much has been done to clarify and expand the specific roles of each care team member individually and as part of the team.² For example, as the physician role changes, some authors have proposed physicians could function more like a quarterback.¹²⁻¹⁷ Others have proposed enhanced roles for nursing, clinical pharmacists, and medical assistants.^{13,18} Yet little research has focused on understanding health care practitioners' perceptions of team-based care that is patient and family centered, patients' and caregivers' views on practitioner roles, and how these perceptions shape a practice's approach to team-based care, including care coordination. Physician perspectives on this topic are especially salient because physicians may have substantial responsibility for team roles and responsibilities. Patient and caregiver perspectives are underrepresented in the literature and offer valuable insight into what patients and their caregivers think about receiving team-based care.

This article highlights findings from a collaboration of the American College of Physicians (ACP) in Philadelphia, PA; the Institute for Patient- and Family-Centered Care (IPFCC) in Bethesda, MD; the National Partnership for Women & Families in Washington, DC; and Kaiser Permanente (KP) Washington Health Research Institute in Seattle, WA. We used focus groups with physicians, patients, and family caregivers about patient- and family-centered care (PFCC) concepts to explore what ideal care looked like from their perspective. We focused specifically on

INTRODUCTION

In ambulatory care, the concept and function of medical teams and team-based care as a model to promote patient-centered care is receiving increasing attention.^{1,2} Team-based care is defined by the National Academy of Medicine (formerly the Institute of Medicine) as “the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care.”³ Evidence has shown that physicians do not have the time to provide patients with the array of preventive, chronic, and acute care they need.¹⁻⁴ Recent research and policy⁵⁻¹⁰ has aligned to point out the importance of including the skills

Author Affiliations

- ¹ Kaiser Permanente Washington Health Research Institute, Seattle, WA
- ² X4Health, Washington, DC
- ³ Centers for Quality and Patient Partnership in Healthcare, American College of Physicians, Philadelphia, PA
- ⁴ Institute for Patient- and Family-Centered Care, Washington, DC
- ⁵ MacColl Center for Health Care Innovation, Seattle, WA
- ⁶ IMPAQ International, Seattle, WA
- ⁷ Rehabilitation Medicine, University of Washington, Seattle
- ⁸ PeaceHealth St Joseph Medical Center, Bellingham, WA
- ⁹ Institute for Better Medicine, Trillium Health Partners, Mississauga, Ontario, Canada
- ¹⁰ Palo Alto Medical Foundation, Mountain View, CA

Corresponding Author

Marlaine Figueroa Gray, PhD (marlaine.s.figueroagray@kp.org)

Keywords: care coordination, focus groups, patient- and family-centered care, primary health care, team-based care

actions participants described as critical to care coordination, and how to address care gaps and improve the overall care experience. As discussed in the literature, the term *quarterback* has been used to describe the role of the primary care practitioner (PCP) as leader of a practice team.^{12,14,16,19} In our groups, the quarterback was a metaphor that arose organically from the respondent, not just to describe the role of the physician but also to describe how it feels when care is coordinated, organized, and accountability is clear—that is, when it is patient and family centered. This article provides a detailed exploration of the concept of the medical team quarterback and the actions and themes that are associated with that role.

METHODS

Focus Groups

We conducted 9 focus groups with 92 participants to understand how patients, family caregivers, and physicians in the US describe ideal PFCC. The description of the study design and data analysis that follows is closely aligned with the COnsolidated criteria for REporting Qualitative research.⁵

Sampling/Recruitment

The KP Washington Health Research Institute institutional review board determined the study was exempt. We took an

ethnographic approach to study design⁶ because we were interested in the emic, or insider, perspective⁷ of participants who had intimate experience with the topic (as described in the next paragraph on inclusion criteria). To increase regional and ethnic diversity in experiences and attitudes of respondents, we conducted focus groups in 3 metropolitan areas—Greater Seattle, WA; Greater Dallas, TX; and Greater Philadelphia, PA (which included Mount Laurel, NJ, where 1 set of focus groups was held). Sites were chosen using a combination of convenience and a desire to capture geographic diversity recognizing the strong evidence on geographic variation in health care.^{20,21} We recruited physicians through the ACP, a physician membership organization for internists. In each region, we conducted 1 focus group with each of the 3 respondent groups: Patients (n = 35), caregivers (n = 36), and physicians (n = 21).

To recruit patient and family caregivers, we contracted with local market research firms that used a screening questionnaire we designed to recruit groups representing a range of experiences. Inclusion criteria for patients were as follows: 1) age 18 years or older, 2) had a PCP, and 3) visited their PCP 2 or more times in the last year. Caregivers were recruited if they were 1) age 18 years or older, and 2) attended 2 or more in-person PCP visits with a friend or family member in the last year. Demographic variables collected included age, sex, insurance, race/ethnicity, and education level (Tables 1-3).

Table 1. Demographics of patient focus groups^a

Characteristic	Location 1 (Dallas, TX)	Location 2 (Seattle, WA)	Location 3 (Mount Laurel, NJ)	All locations combined
Number of participants	10	12	13	35
Sex, female	7 (70)	5 (42)	8 (62)	20 (57)
Age, y				
Range	40-73	20-72	21-69	20-73
Mean	54.2	46.4	47.4	49.0
Insurance type				
Out of pocket	0 (0)	0 (0)	4 (31)	4 (11)
Private	7 (70)	6 (50)	6 (46)	19 (54)
Private and Medicare	1 (10)	2 (17)	0 (0)	3 (9)
Medicare	2 (20)	0 (0)	1 (8)	3 (9)
Medicaid	0 (0)	2 (17)	1 (8)	3 (9)
TRICARE (military)	0 (0)	2 (17)	1 (8)	3 (9)
Race/ethnicity				
White	6 (60)	8 (67)	9 (69)	23 (66)
African American	2 (20)	3 (25)	2 (15)	7 (20)
Asian	0 (0)	1 (8)	1 (8)	2 (6)
American Indian	0 (0)	0 (0)	1 (8)	1 (3)
Hispanic ^b	2 (20)	0 (0)	0 (0)	2 (6)
Level of education				
High school	0 (0)	1 (8)	1 (8)	2 (6)
Trade school	0 (0)	1 (8)	0 (0)	1 (3)
Some college	1 (10)	4 (30)	4 (31)	9 (26)
Undergraduate degree	5 (50)	3 (25)	6 (46)	14 (40)
Professional degree	4 (20)	3 (25)	2 (15)	9 (26)

^a Data are shown as number (percent) except for age. Some percentages do not total to 100 because of rounding.

^b Hispanic ethnicity as collected by the market research firm was reported as a mutually exclusive category under race.

For physician groups, ACP staff sent email invitations to members on the basis of ZIP codes in a designated radius of each city. Emails contained a link to an online screening survey. Eligible physicians were approached via email from a research team member. Inclusion criteria for physicians were as follows: 1) out of residency or fellowship program for at least 1 year, 2) self-identification as a PCP, and 3) providing care in an outpatient setting.

Data Collection and Analysis

Two research team members who are PhD-level medical anthropologists with experience conducting qualitative research (MFG and CH) facilitated all focus groups. Focus groups were transcribed in real time by a professional transcriber who did not include names or demographic information in the transcript. Participants were given table tents with numbers that the transcriptionist used to ensure confidentiality. Patients and caregivers received a meal and \$100 cash incentive for participation; physician participants received a meal and \$150 cash incentive. The purpose of the study was explained to participants, and they were invited to ask questions before consenting to participation. Participants were asked a semistructured series of questions (See Sidebar: Focus Group Guide), with the facilitator drawing out topics of interest and encouraging clarification. Discussions were approximately 2 hours for patients and family caregivers and 90 minutes for physicians.

The 2 team members who facilitated the focus groups conducted the data analysis. The analysts reviewed transcripts, and the primary coder (MFG) drafted an initial code list using an inductive analysis approach.⁸ Both analyzers then coded a patient transcript using a draft code list. After comparison, the analysts discussed discrepancies and revised the code list, repeating the

process with caregiver and physician transcripts. After 3 rounds of iterative code development, consensus on codes and code meanings was reached. The primary coder coded all transcripts using the final code list with data analysis and research software (Atlas.ti, Berlin, Germany).

The full research team discussed the distribution of codes to prioritize and organize the final stage of analysis. Extracted data were used to draft and refine a coding memo through several iterations with team feedback. This memo was used to structure our findings. Quotes were edited for readability.

RESULTS

Our 9 focus groups included 35 patients, 36 family members, and 21 physicians (Tables 1, 2, and 3). The quarterback concept was identified by the analysis team as a recurring theme across participant groups, with specific mention of the term *quarterback* by a physician and a family caregiver from different regions. Therefore, we focused our analysis on how participants used this term. We used both the data from participants who specifically referenced the term *quarterback* and supporting data based on the research team's understanding of how the quarterback function was used. We chose to analyze codes related to understanding and taking responsibility for the big picture of patient care, advocating for patients, respecting patient values, communicating with other practitioners and with patients, and closing the loop in care coordination.

Themes Regarding the Medical Team Quarterback

The focus groups examined patient, caregiver, and physician perspectives of ideal care, building on the IPFCC definition and core concepts of PFCC: Respect and dignity, information sharing, participation, and collaboration.^{22,23} As an example of ideal

Table 2. Demographics of family groups^a

Characteristic	Location 1 (Dallas, TX)	Location 2 (Seattle, WA)	Location 3 (Mount Laurel, NJ)	All locations combined
Number of participants	12	12	12	36
Sex, female	5 (42)	6 (50)	5 (42)	16 (44)
Age, y				
Range	31-70	27-69	39-65	27-70
Mean	50.1	50.3	51.2	50.5
Race/ethnicity				
White	4 (33)	7 (58)	6 (50)	17 (47)
African American	4 (33)	2 (17)	4 (33)	10 (28)
Asian	2 (17)	1 (8)	1 (8)	4 (11)
Hispanic ^b	2 (17)	2 (17)	1 (8)	5 (14)
Level of education				
High school	0 (0)	0 (0)	1 (8)	1 (3)
Trade school	0 (0)	0 (0)	1 (8)	1 (3)
Some college	3 (25)	5 (42)	5 (42)	13 (36)
Undergraduate degree	3 (25)	4 (33)	2 (17)	9 (25)
Professional degree	6 (50)	3 (25)	3 (25)	12 (33)

^a Data are shown as number (percent) except for age. Some percentages do not total to 100 because of rounding.

^b Hispanic ethnicity as collected by the market research firm was reported as a mutually exclusive category under race.

care, participants often described an individual as serving in a quarterback role by coordinating overall care and advocating for patient needs. We looked at segments of text that were coded with both statements that referenced the term *quarterback* and with other codes via double-coding or co-occurrence coding,²⁴ a process that reveals the multiple nuances of meaning in a quotation. The emergent concept of a team quarterback was associated with 6 major themes: 1) takes responsibility for overseeing the big picture of a patient’s care, 2) coordinates care, 3) advocates for the patient, 4) knows and respects patients and their values, 5) practices proactive communication, and 6) engages in proactive and persistent problem solving (Figure 1). In the examples participants shared, perhaps unsurprisingly the need for care coordination and the use of the quarterback metaphor was most often linked to the context of acute or chronic illness that required complex diagnosis and treatment. These findings are exemplified in comments from focus group participants below.

Takes Responsibility for Overseeing the Big Picture

When participants discussed what good PFCC looked like, they described being certain that someone on the care team understood the “big picture” of the patient’s care. Participants described a medical team quarterback as the person who takes responsibility for the logistics of care communication and responsibility for understanding the overall picture of a patient’s care.

My general practitioner was not the doctor that was supposed to be handling my back case, but he said, “Come here, I’m going to be your quarterback. I may not know how to handle this, but we’re going to figure it out.” While I felt that I was just a number to everybody, this doctor has stood by me through this entire time and helped me figure all these medical issues out when he could have sent me to a specialist. —Patient

It’s not just coordinating, though, it’s taking responsibility to find out what’s wrong with you when everybody else kind of just blows

Table 3. Demographics of physician groups^a

Characteristic	Location 1 (Dallas, TX)	Location 2 (Seattle, WA) ^b	Location 3 (Mount Laurel, NJ)	All locations combined
Number of participants	8	8	5	21
Sex, female, no. (%)	4 (50)	6 (75)	2 (40)	12 (57)
Age, y				
Range	38-56	37-69	45-69	37-69
Mean	47.6	36.8	56.6	50.8
Race and ethnicity, no. (%)				
White	5 (63)	2 (25)	3 (60)	10 (48)
African American	0 (0)	0 (0)	2 (40)	2 (10)
Asian	1 (13)	5 (63)	0 (0)	6 (29)
Unknown	2 (25)	1 (13)	0 (0)	3 (14)
Hispanic	1/8 (13)	0/7 (0)	0/5 (0)	1/20 (5)
Years in practice				
Range	9-27	8-39	20-27	8-39
Mean	15.9	17.2	23.4	18.3
Number (%) of providers in participant’s practice, including participant				
1	2/8 (25)	1/5 (20)	0/5 (0)	3/18 (17)
2-5	1/8 (13)	1/5 (20)	4/5 (80)	6/18 (33)
6-9	4/8 (50)	2/5 (40)	0/5 (0)	6/18 (33)
≥ 10	1/8 (13)	1/5 (20)	1/5 (20)	3/18 (17)
Percentage of time per week spent: In direct patient care in an outpatient setting				
Range	40-95	20-100	50-95	20-100
Mean	66.1	72.2	71.1	69.2
Percentage of time per week spent: In direct patient care in a hospital setting				
Range	0-60	0-0	0-31	0-60
Mean	18.4	0.0	5.2	9.6
Percentage of time per week spent: Doing administrative work				
Range	0-27	0-80	5-50	0-80
Mean	15.5	27.8	23.7	21.2

^a Some percentages do not total to 100 because of rounding.

^b We have incomplete data, because forms were filled out for only 5 of 8 participants in the Seattle, WA, group. Data are presented for all 8 when the item can be imputed (eg, sex) or for only 5 when imputation was not possible. Similarly, 1 participant with a completed form left the age blank. Data for age are reported for only 4 Seattle participants. Hispanic ethnicity was unknown for 1 of the 8 physicians in Seattle.

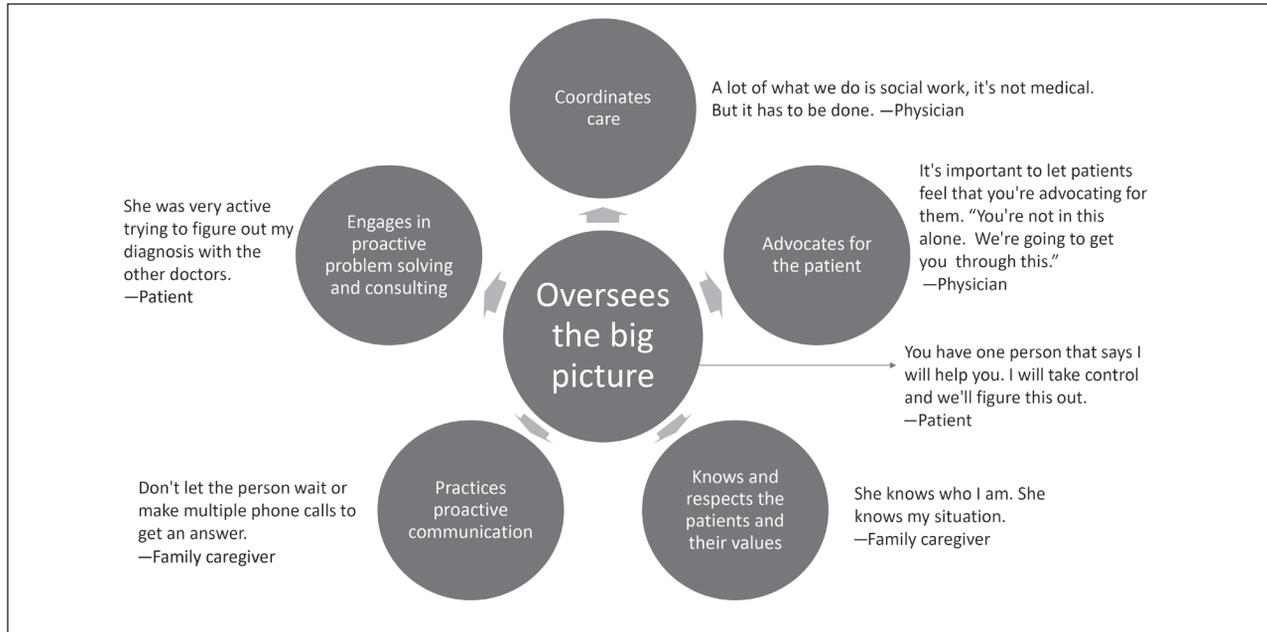


Figure 1. Functions of a medical care team quarterback.

you off. They get so busy they don't really take the time to care, and you have one person that says, "I will help you. I will take control and we'll figure this out." —Patient

Coordinates Care and Advocates for the Patient

Overseeing the big picture of a patient's care often leads to knowledge about gaps in care that call for care coordination or patient advocacy. Advocacy may also involve the practitioner or care team member spending time with patients who need special attention to get them whatever they need—medical care, access to specialists, social services, or prescriptions.

A lot of what we [physicians] do is social work; it's not medical. But it has to be done. Getting Meals on Wheels and getting home aides to the house. If it's a medication that works, we get the meds. We might have to contact the pharmaceutical company and get the samples. —Physician

[M]y sister's primary care physician, even though she didn't know what her illness was, did research on her own spare time about the disease and looked up support groups and other resources.

I've never gotten any of that with my health care. To be able to have people advocating for you—that is huge. —Family caregiver

I think it's important to let patients feel that you're advocating for them in the system. To let them know that you're on their side and you're going to see them through what's going on. Sometimes I will say, "You're not in this alone. We're going to get you through this." —Physician

[When my patient] was referred for a CT [computed tomography] scan, they were not able to reach the person who was in their network. So my team again called the people she was referred to, got the right numbers for her, made the appointments for her. And now she's having her first CT [scan] next week. —Physician

A medical team quarterback recommends quality care and advocates with insurance companies when needed to ensure patients receive coverage.

The doctor should take the extra steps when needed. Sometimes you have to fight the insurance companies. I was supposed to have surgery, and my insurance company denied me. So the doctor's office appealed it, and the insurance company denied it again, and then it took, like, 2 or 3 months and the doctor actually had a phone conversation with the insurance company, and then they finally approved it. —Patient

We needed to do an MRI [magnetic resonance image] and get things moving very quickly. . . . We had to basically call the hospital, ask to speak to the nurse, explain the situation. But that was an experience that really stood out in my mind, because the patient appreciated it, his daughter appreciated it, and they sent us emails, thanking us. And basically, we were trying to save the patient from going to the ER [emergency room]. . . . It was one instance that stands in my mind, because we spent a lot of time facilitating, coordinating, and getting the care that the patient needed that day. —Physician

Knows and Respects Patients and their Values

Knowing patient values helps the medical team quarterback know how to best provide care in line with patient preferences. Participants described the lead practitioner of ideal PFCC as someone who listens to the patient, comes to know the patient over time, and respects the patient's values.

She [my family member's primary care provider] knows who I am. She knows my situation. —Family caregiver

He showed an interest in me, not just for the particular reason for my visit. He wanted to know a little bit more about me, wanted to know what I have encountered and the things I look forward to,

what type of work I'm involved in, and upcoming goals in life and everything. It shows a sincere interest in me, not just as a patient. ... I enjoyed knowing that he had an interest [in me]. —Patient
Patients felt that learning about the practitioner fostered the care relationship.

He actually sat down and talked with me and discussed some things he encountered in life, and it brought us together. —Patient

I wanted someone to know me and get to know me and if I needed to improve my physical well-being, that would be appreciated. ... He sat down and started talking with me. He's not one to just run in and run out. —Patient

A lead practitioner partners with patients and families to elicit and support health care goals.

[I had] a 75-year-old patient who came in with her daughter. She moved here from out of town. They came in and established care with me. And she had very poor quality of life because she had really terrible arthritis in her knees. She couldn't walk, couldn't make it to the bathroom on time. Eventually, she ended up getting a knee replacement. And her life just turned around. I think it was because I had her daughter there as well, and we had discussions about what was important to them in terms of what her quality of life was like. —Physician

Proactively Communicates with Patients and Family Caregivers

Taking responsibility for a patient's care means proactively communicating with patients and family caregivers to keep them informed and to learn about potential health problems that the

Focus Group Guides

Guide for patients

I would like to have you describe a time when you felt your primary care practitioner or the practitioner's team partnered with you to deliver really great care (we are trying to avoid experiences you may have had in the hospital).

Let's go around and have you each share your example. We really want to have you be specific about what exactly your practitioner or your practitioner's team did that you felt made this experience particularly good.

What were some common themes we heard across your examples regarding what makes care really great?

There is a term that is being used now, called *patient- and family-centered care*. Patient- and family-centered care means that patients and families are treated with dignity and respect; they are provided with useful information in a helpful manner; they are encouraged and supported in participating in care and decision making; and they have opportunities to collaborate in making changes and improvement in health care organizations.

Now we'd like you to think about this definition in light of the list of specific attributes of great care and partnership you generated. How do you see your list and the key aspects of this definition fitting together? (*List items*).

To what extent do you feel the health center or practice where you currently get your care is providing patient- and family-centered care? What do they do that makes you feel this way?

Now we are going to focus on your thoughts about your role as a patient. What are the different roles and responsibilities that you feel you have as a patient in health center or practice settings?

How would you feel about getting your care from a team of people that included other clinicians—nurses and other staff—rather than only your practitioner?

As we think about making care more patient centered, what is one thing you would change? Why?

Guide for family members

I would like to have you describe a time when you felt your primary care practitioner or the practitioner's team partnered with you to deliver really great care to a family member (we are trying to avoid experiences you may have had in the hospital).

Let's go around and have you each share your example. We really want to have you be specific about what exactly your doctor or your practitioner's team did that you felt made this experience particularly good.

What were some common themes we heard across your examples regarding what makes care really great?

There is a term that is being used now, called *patient- and family-centered care*. Patient- and family-centered care means that patients and families are treated with dignity and respect; they are provided with useful information in a helpful manner; they are encouraged and supported in participating in care and decision making; and they have opportunities to collaborate in making changes and improvement in health care organizations.

Now we'd like you to think about this definition in light of the list of specific attributes of great care and partnership you generated. We would like you to talk about what your family member's doctor or doctor's office does that demonstrates these concepts to you. Let's go through each of these concepts. ... What does your family member's doctor/doctor's office do that demonstrates ... (*list items*).

What are some other ways that you might expect/want your family member's practitioner/practitioner's office to show that they are providing patient- and family-centered care?

Now we are going to focus on your thoughts about your role as a patient's family member. What are the different roles and responsibilities that you feel you have as a family member in health center or practice settings?

How would you feel about your family member getting care from a team of people that included other clinicians—nurses and other staff—rather than only your practitioner?

As we think about making care more patient centered, what is one thing you would change? Why?

care team can address. A medical team quarterback prioritizes answering patients' and family caregivers' care questions and regularly checks in.

I mean, just being a little more sensitive to patients and their family and be available. If [patients] have questions or a concern, call back as soon as possible. Don't let the person wait or make multiple phone calls to get an answer. —Family caregiver

One of the other things that my sister's doctor does for her is regular check-ins. So, she'll call, or somebody from her office will call in and say, "Hey, I know you've got a lot going on. I know you've got all these other appointments going on. How are you doing? Are you able to make them? Is there anything we can do to help?" You know, this is a rarity. —Family caregiver

Guide for practitioners

I would like to have you think about a time when you felt you and/or your team partnered with a patient and/or the family in a way that resulted in really great care. Take a few minutes to jot down some notes about that experience. We are looking for an experience that goes beyond making a difficult diagnosis, but one that might have been difficult but that you handled particularly well.

Underline the specific actions you took to better partner with the patient and his/her family.

Let's go around and have you each share your example. We really want to have you highlight the things that happened that you felt made this experience particularly good.

Now that you have had a chance to think about experiences that were great, I'd like to have us brainstorm some of the common themes that emerged around what it looks like when you really partner with patients to provide them great care. What are some of things that—from your perspective—you and your team do to make the care provided really great?

There is a term that is being used now, called *patient- and family-centered care*. Patient- and family-centered care means that patients and families are treated with dignity and respect; they are provided with useful information in a helpful manner; they are encouraged and supported in participating in care and decision making; and they have opportunities to collaborate in making changes and improvement in health care organizations.

We would like you to talk about what you do that demonstrates these concepts to your patients and their families. There may be some overlap with our list, or you might think of other things you would add. Let's go through each of these concepts . . . What are some very specific actions you and/or your team carry out that demonstrate . . . (list each item).

What are some of the different ways that your health care center or office has patients and family members involved in improving the care your health care center or office provides? For example, do you have a patient advisory group?

What are some other ways—some specific actions—that you might consider making your care more patient and family centered?

To what extent have you implemented a team-based model of care in your practice?

As we think about making care more patient centered, what is one thing you would change? Why?

A medical team quarterback follows up with patients as part of ongoing communication and partnership.

[A patient's husband had unexpected eye surgery.] The very next day, I got a call from the doctor to see how he was. Then I got a call from the eye doctor to see how he was and also from the eye center. All of them called to check up on him. Every time we go to the doctor now, the doctors always ask me how is your husband, is his eye okay, like, [being] right on top of it. That's what all doctors need to do, they need to follow through and get you to the right doctors right away. —Family caregiver

People are . . . extremely grateful for just listening to them and [for] follow-up and coordination of care. So anytime that I'm making the phone call to make something happen, they're extra grateful for that, or when my nurse follows up with them by phone a couple of days later, they say, "Thank you so much for the call." —Physician

Engages in Proactive and Persistent Problem Solving

The medical team quarterback takes responsibility for helping the patient resolve issues that might be difficult to diagnose or that require persistence over time.

I had a physician patient who had years of summertime distress, and her doctor couldn't figure it out. And she honestly had 15 to 20 years of this issue . . . Ultimately, I got her a CT scan. And she had diverticulitis. . . . She just said she was floored by the experience of going through that process, getting the CT scan so quickly, getting the result within 2 hours. Solving something that was a mystery to her for years, decades. —Physician

The medical team quarterback practices proactive consulting with medical colleagues to ensure high-quality care, acting as the central care hub.

Five years ago, I had all these conditions. And I had a rare disease. We couldn't figure out what it was, and it took us a couple of years to diagnose it. And my primary care [practitioner], she was like, she was like the glue . . . She made a point to contact all these different doctors, and they were all in different networks. And she was doing her own research. She always made time for me, and she was very active trying to figure out my diagnosis with the other doctors. —Patient

I got to a point that I couldn't handle it, and he just said you come here. I will have all the doctors send everything to me. I will decipher it, put you on your medications, send you to this doctor, and that doctor will report back to me, and he started doing it. He [called] the infectious disease [specialist] for my MRSA [methicillin-resistant Staphylococcus aureus], the back doctor, so he knew what was going on. These other doctors, they don't talk. He knew and he took care of me; he got me well. —Patient

Several participants stated that team-based care can be problematic when there is no quarterback. They described the need for a role that is responsible for overseeing the myriad details of patient care.

My only concern [with receiving care from a team of people] would be having too many people dealing with one person, and one hand not knowing what the other hand was doing. —Patient

Barriers to Patient- and Family-Centered Care

In addition to the identified themes, physician participants raised concerns about barriers to providing PFCC. These barriers

included the pressurized practice environment, structural components of the current environment that are not conducive to the quarterback function, and limited reimbursement processes that support performing this function effectively. For example, a physician participant suggested reimbursement codes, such as CPT [Current Procedural Technology] codes, for care coordination.

One concrete way of doing it, which I keep reading in ACP Internist that could be coming down the pike is new CPT codes for care coordination. I think that would be just a huge step in the right direction. I think that's a very concrete thing that could happen. Because right now, nobody is the quarterback. —Physician

Other practitioners built on one another's comments as they suggested structural changes that would help them provide PFCC.

Physician 1: *Take out the whole insurance thing. All of those barriers that always face you, I know every day. It's really hard.*

Physician 2: *More time with patients.*

Physician 3: *More time.*

Physician 4: *More staff.*

DISCUSSION

Our focus groups asked physicians, patients, and family caregivers about their conceptions of ideal PFCC. Our patient and family caregiver participants clearly correlated highly satisfying care with knowing which individual oversaw and coordinated their care. Patients and families used a quarterback to personify care-coordination functions. To our participants, a medical team quarterback was responsible for overall patient care, knew and respected patients and their values, advocated for patients, persistently solved problems and effectively communicated with patients and families. Other studies have also found that care accountability, patient support, and patient communication are important elements of team-based primary care, and have used the term quarterback to describe this leadership role.^{9,10}

All our focus groups agreed that the function of a quarterback is to be responsible for overseeing a patient's care and that it was important to designate that person within a care team and introduce him/her to the patient as the team leader. In some practices, this role is an individual physician coordinating the many small tasks associated with the care of one patient. In other practices, the quarterback is a health professional who works behind the scenes as the leader of several teams to resolve patient concerns or manage care.

Each of our participant groups stated that an important quarterback activity is proactively communicating with patients about their values and adjusting care as values change, especially for patients with chronic or complex conditions. Medical philosopher Annemarie Mol²⁵ found that physician attention to patient goals over time, even or especially if these goals shift, is an essential component of quality care. Practitioner and care alignment with patient and family caregiver goals is a hallmark of PFCC. Team-based care encourages patient care goals to be shared across the team, including with the patient.^{17,18} This approach also supports a more active role for patients on their health care team, which was endorsed by a 2012 National Academy of Medicine working group report on team-based and patient-centered care.¹²

Despite concordance of patient, family, and physician views about ideal care, physicians in this study said being able to support the function of the medical team quarterback in their pressurized practice environment, which has barriers to providing coordinated PFCC,¹³ was difficult. In a study that examined the gap between best practice and actual clinical care, physicians described heavy workload and lack of necessary staff as barriers to achieving best practices.¹⁵ Patients with chronic conditions also present care challenges.¹⁴ Given strong evidence of increasing time pressures in ambulatory care settings,¹⁶ care teams have limited time for quarterback activities such as overseeing, coordinating, and advocating for a patient's care; engaging in proactive problem solving; and consulting with patients and caregivers.

Our results highlight the tension between a common perception for the PCP to serve as the quarterback and yet the challenge for PCPs to serve this function on their own. Our findings add support to previous assertions that individual actions by physicians, patients, and family caregivers toward PFCC must be paired with structural changes in the practice environment and a reimbursement process that supports the time and effort required for PFCC.

The concept of the medical team quarterback can help articulate and illustrate how care teams can more effectively work together in a challenging environment. Each team member has a defined role with effective and ongoing communication among members. Practices that have adopted team-based care report improved patient and practitioner satisfaction, increased office efficiency, and better financial outcomes.^{19,20} In turn, team-based care may improve clinical outcomes, for example, glucose levels, cholesterol concentrations, and blood pressure in patients with diabetes.^{21,22} Such complex teams, performing multiple tasks, need a leader for guidance—thus the need for the quarterback.

This study has several limitations. By its nature, qualitative work is not expected to be generalizable to larger populations.²³ This study might also be limited by a relatively small number of participants. Our sample may not reflect the experiences of patients, family members, and physicians from all regions of the US. Even though geography is a key driver of differences, we recognize that our findings may not generalize to all patients and families, in particular, those in underserved areas (eg, rural), and that is an area for future research. Nonetheless, the consistency between our findings and those of previously published work suggests that themes we identified may prove useful for many practices for conceptualizing the role of a clinical quarterback in team-based care.

CONCLUSION

Navigating the health care system can be confusing and overwhelming for patients and family caregivers, especially when multiple practitioners are involved in diagnosis and treatment. When PCPs and care team members guide, advocate, and organize information and services in understandable ways, patients and families experience relief and confidence that their concerns will be addressed effectively. Patients and families endorsed a facilitator of the PFCC experience, likening this role to a

quarterback who organizes team efforts and leverages skills and contributions from all team members. Without a medical team quarterback, patients and family caregivers referred to care situations that were difficult to navigate alone because of the many handoffs among practitioners, with poor communication about patient needs. When referring to how care was different with a medical team quarterback, patients and caregivers reportedly felt their participation was valued and they were part of a team that cared about them and their goals. ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

Acknowledgments

We thank the American College of Physicians, the Institute for Patient- and Family-Centered Care, and the National Partnership for Women and Families for their partnership. Funding was from the Gordon and Betty Moore Foundation in Palo Alto, CA.

Kathleen Loudon, ELS, of Loudon Health Communications performed a primary copy edit.

How to Cite This Article

Gray MF, Sweeney J, Nickel W, et al. Function of the medical team quarterback: Patient, family, and physician perspectives on team care coordination in patient- and family-centered primary care. *Perm J* 2019;23:18.147. DOI: <https://doi.org/10.7812/TPP/18.147>

References

- Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: A time and motion study in 4 specialties. *Ann Intern Med* 2016 Dec 6;165(11):753-60. DOI: <https://doi.org/10.7326/M16-0961>.
- Crompton D, Hsu C, Coleman K, et al. Barriers and facilitators to team-based care in the context of primary care transformation. *J Ambul Care Manage* 2015 Apr-Jun;38(2):125-33. DOI: <https://doi.org/10.1097/JAC.0000000000000056>.
- Arndt BG, Beasley JW, Watkinson MD, et al. Tethered to the EHR: Primary care physician workload assessment using EHR event log data and time-motion observations. *Ann Fam Med* 2017 Sep;15(5):419-26. DOI: <https://doi.org/10.1370/afm.2121>.
- Young RA, Burge SK, Kumar KA, Wilson JM, Ortiz DF. A time-motion study of primary care physicians' work in the electronic health record era. *Fam Med* 2018 Feb;50(2):91-9. DOI: <https://doi.org/10.22454/FamMed.2018.184803>.
- Bodenheimer T. Building teams in primary care: 15 case studies. Oakland, CA: California Health Care Foundation; 2007.
- Coleman K, Reid R. Continuous and team-based healing relationships: Improving patient care through teams. Seattle, WA: Group Health Research Institute; 2013.
- Daniel DM, Wagner EH, Coleman K, et al. Assessing progress toward becoming a patient-centered medical home: An assessment tool for practice transformation. *Health Services Res* 2013 Dec;48(6, Pt 1):1879-97. DOI: <https://doi.org/10.1111/1475-6773.12111>.
- Mickan SM. Evaluating the effectiveness of health care teams. *Aust Health Rev* 2005 May;29(2):211-7. DOI: <https://doi.org/https://doi.org/10.1071/AH050211>.
- Wagner EH. The role of patient care teams in chronic disease management. *BMJ* 2000 Feb;320(7234):569-72.
- Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. The 10 building blocks of high-performing primary care. *Ann Fam Med* 2014 Mar-Apr;12(2):166-71. DOI: <https://doi.org/10.1370/afm.1616>.
- What is the Quadruple Aim? [Internet]. Bay City, MI: Michigan Health Improvement Alliance Inc; 2011. Updated 2016 [cited 2019 Feb 22]. Available from: www.mihia.org/quad-aim.
- Kushner SJ. Team-based health care: The physician as quarterback. *Del Med J* 2013 Feb;85(2):41-2.
- Marbury D. Delegating tasks staff enhances team-based care. *Med Econ* 2014 Aug 10;91(15):49-51.
- Marbury D. Transition of care calls for primary care quarterback. While coordination between providers is critical to quality outcomes, the question remains if incentives for practices are realistic. *Med Econ* 2014 Jan 25;91(2):77-80.
- O'Brien EO, Schmidt U. Monday morning quarterback: The story of extubation failure. *Crit Care Med* 2015 Mar;43(3):711-2. DOI: <https://doi.org/10.1097/CCM.0000000000000793>.
- Press MJ. Instant replay—A quarterback's view of care coordination. *N Engl J Med* 2014 Aug 7;371(6):489-91. DOI: <https://doi.org/10.1056/NEJMp1406033>.
- Rice S. Quality quarterback. Hospital's chief experience officer faces challenges in opening up communication. *Mod Healthc* 2014 Dec 15;44(50):27-9.
- Ritten A, Waldrop J, Kitson J. Fit living in progress—Fighting lifelong obesity patterns (FLIP-FLOP): A nurse practitioner delivered intervention. *Appl Nurs Res* 2016 May;30:119-24. DOI: <https://doi.org/10.1016/j.apnr.2015.09.006>.
- Morrissey J. The cost of value-based care. *Trustee* 2015 Sep;68(8):13-6, 1.
- Medicare data for the Geographic Variation Public Use File: A methodological overview [Internet]. Baltimore, MD: Centers for Medicare & Medicaid Services; 2018. Updated 2019 Jan [cited 24 Feb 2019]. Available from: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/Downloads/Geo_Var_PUF_Methods_Paper.pdf.
- 2016 Employer Health Benefits Survey [Internet]. Menlo Park, CA: Kaiser Family Foundation 2016 [cited 24 Feb 2019]. Available from: www.kff.org/health-costs/report/2016-employer-health-benefits-survey/.
- Fact sheet: PFCC [Patient- and family-centered care] in daily practice [Internet]. Washington, DC: National Partnership for Women & Families; 2014 [cited 24 Feb 2019]. Available from: www.nationalpartnership.org/our-work/resources/campaigns/campaign-for-better-care/pfcc-in-daily-practice.pdf.
- Advancing the practice of patient and family-centered care in hospitals: How to get started ... [Internet]. Bethesda, MD: Institute for Patient- and Family-Centered Care; updated 2017 Jan [cited 24 Feb 2019]. Available from: www.ipfcc.org/resources/getting_started.pdf.
- Saldana J. The coding manual for qualitative researchers. 3rd ed. Los Angeles, CA: London, UK: SAGE Publications; 2016.
- Mol A. The logic of care: Health and the problem of patient choice. Oxford, UK; New York, NY: Routledge; 2008.