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Examining the Healthcare Administrator's Perspective on "Teamness" in Primary Care

Bianca K. Frogner, PhD [associate professor and director],

Center for Health Workforce Studies, Department of Family Medicine, School of Medicine,
University of Washington, Seattle, Washington;

Cyndy R. Snyder, PhD [research assistant professor],

Center for Health Workforce Studies, Department of Family Medicine, School of Medicine,
University of Washington;

Jaime R. Hornecker, PharmD, BCPS, CDE, DPLA [clinical professor]

Pharmacy Practice, University of Wyoming School of Pharmacy, University of Wyoming Family
Medicine Residency Program, Casper, Wyoming

EXECUTIVE SUMMARY

Team-based care has been identified as an important element of effective primary care practice. While there is a growing body of literature supporting the value of team-based care, research on best practices in team-based care has suffered from the lack of a widely accepted framework with common definitions. We used qualitative interviews to explore healthcare administrators' perspectives regarding team-based care descriptions, their decisions regarding composition of a team, and how they identify characteristics of a well-functioning team. Interviewees discussed six broad themes: (1) definitions of team-based care, (2) team structure and roles, (3) team goals, (4) monitoring team effectiveness, (5) challenges to implementing team-based care, and (6) the influence of healthcare policy on team-based care. The study findings can be used to identify further ways to assess the notion of "teamness."

INTRODUCTION

I think that a lot of team-based care kind of happens without thinking about it. ... I think when you actually do consciously think about it and assign roles and use the concepts of having folks work to the top of their license, it makes a lot of sense. At first it may seem like it's more work, but in the long run I think it does work and makes [care] better.

—Clinic leader

Team-based care has been identified as one of the four foundational elements of a high-performing primary care practice (Bodenheimer, Ghorob, Willard-Grace,& Grumbach, 2014). Despite a growing body of literature supporting the value of team-based care,

For more information about the concepts in this article, contact Dr. Frogner at bfrogner@uw.edu.

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research to evaluate and disseminate best practices in team-based care has suffered from the lack of a widely accepted framework with common definitions (Mitchell et al., 2012). Researchers need a common framework to assess the impact of emerging practice transformation activities—including adoption of patient-centered medical home (PCMH) models, accountable care organizations, and electronic health records (EHRs)—on the effectiveness of the team and, ultimately, on patient outcomes. To create a common framework, Shoemaker and colleagues (2016) conducted a literature review, which resulted in a catalog of survey instruments hosted by the Agency for Healthcare Research and Quality (AHRQ, n.d.-a) that can be adapted to measure various dimensions of team-based primary care. A key perspective missing from this catalog is that of the healthcare administrator in primary care settings who makes hiring and staffing decisions, which affect the team configurations. In this study, we examine how healthcare administrators conceptualize “teamness” in primary care settings and discuss how their views fit the currently available frameworks.

A common definition of team-based care is “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” (Mitchell et al., 2012, p. 5; Naylor, Coburn, & Kurtzman, 2010; Schottenfeld et al., 2016, p. 2). Shoemaker and colleagues’ (2016) review of the literature revealed 44 survey instruments and four observational checklists potentially relevant to measuring team-based primary care, though more than half needed modifications to make them relevant to primary care. These instruments often summarized the *effectiveness*, *functionality*, or *teamness* (terms used somewhat interchangeably) of a team as a single index. The index can then be used to quantify the relationship between teamness and various process and outcome measures related to patient safety and quality of care. Only eight instruments directly addressed primary care, and nine included healthcare administrators among the respondents. In our review of the instruments, none explicitly looked at how healthcare administrators conceptualized team-based care within primary care. Yet leadership, which generally includes healthcare administrators, was identified by Shoemaker and colleagues (2016) as an important input and a mediator in team-based care.

In Shoemaker and colleagues’ (2016) conceptual framework (also adopted by AHRQ), teamwork is a mediator between inputs (internal organization factors including leadership, team composition, patient population needs, “built” environment, and quality improvement infrastructure, and external organization factors including local context, financing/payment models, and health policy environment) and outputs (team-based primary care, including patient centricity, defined and agreed-upon roles, measures of process and outcomes, continuous improvement, practice care, link to teams and resources, and longitudinal continuity relationship) (AHRQ, n.d.-b). Teamwork is defined by three domains: (1) cognitive (i.e., sense-making, continuous learning, shared explicit goals and accountability, and evolving mental models of roles), (2) affective/relational (i.e., trust, respectful interactions, heedful interrelating, and commitment), and (3) behavioral (i.e., conflict resolution, adaptable to context and needs, and communication). Leadership is an input to the model, but it is also the central connector of these three domains.

In this article, we take a closer look at how primary care leaders conceptualize team-based care, which is a perspective largely missing from the literature. Specifically, we target healthcare administrators to understand how they describe team-based care, their decisions regarding composition of a team, and how they identify characteristics of a well-functioning team. We also focus on multiple smaller clinics, including some in rural areas that are not well-represented in the literature. In addition, we focus on how external factors such as healthcare policies impact administrators' decisions, a gap identified by Shoemaker and colleagues (2016). We evaluate how healthcare administrators' responses fit within current frameworks. The study findings can be used to identify further ways to assess the notion of teamness.

METHODS

Sample

To identify participants for this study, we worked with the WWAMI region Practice and Research Network (WPRN), which is a network of primary care practices across the region's five states (Washington, Wyoming, Alaska, Montana, and Idaho) that are committed to research and practice improvement. Participation was open to any administrator who met the following criteria: (1) involved in either hiring or staffing of the clinic, (2) held a title of director or manager, and (3) at the time of the interview, worked in a clinic that delivers care or direct services to patients. We sought two administrators per clinic to enable us to compare and contrast perspectives within the same clinic.

With the help of the WPRN Coordinating Center, we identified five clinics that represented a heterogeneous set of primary care practices in the WWAMI region with regard to level of PCMH implementation, geographic location, and payer mix. We identified 10 administrators in these clinics and completed interviews with nine of them; one administrator could not be reached during the study period. Interviewees included clinic managers and directors, medical directors and executives, and residency program managers. The sample was one of convenience rather than a random sample given the number of available clinics in WPRN and the fact that the WPRN solicits participation, on behalf of the investigators, based on interest from the clinics.

Data Collection

Informed by literature on team-based care, the interview protocol was refined by experts in health workforce and health systems research, qualitative research, physicians and team-based practitioners, and representatives from WPRN. The open-ended protocol included questions about (1) how team-based care was defined; (2) types of clinicians and non-clinicians included on teams; (3) how clinics decided on staffing and team composition; (4) team goals and monitoring of team effectiveness; (5) team-based care challenges; and (6) the impact of health policy changes on team-based healthcare design and delivery. Each administrator was interviewed by telephone, with one study investigator conducting the interview and a second taking notes. All interviews were recorded and transcribed with participant consent. This study was considered exempt by the institutional review board.

Data Analysis

We analyzed data inductively using a grounded theory approach, identifying themes that emerged from the data (Charmaz, 2006; Strauss & Corbin, 1990). Our analysis followed an interpretive, multiphased approach (Tolman & Brydon-Miller, 2001). The first step involved open coding initial interviews to identify preliminary conceptual themes that emerged from the transcripts. The second step consisted of a reflexive process to identify exceptions or contradictions in the data and initial conceptual themes (Crabtree & Miller, 1999). Once themes and codes were developed, each transcript was coded and analyzed using ATLAS.ti.

RESULTS

We organized interview findings around six broad areas: (1) definitions of team-based care, (2) team structure and roles, (3) team goals, (4) monitoring team effectiveness, (5) challenges to implementing team-based care, and (6) the influence of healthcare policy on team-based care.

Definitions of Team-Based Care

To begin, we asked interviewees to share their definition of team-based care. In responding to the question, the majority of respondents focused on what they viewed as the purpose of team-based care. Most interviewees discussed team-based care as a way to more effectively and efficiently provide care to patients, followed by providing a multidisciplinary approach to patient care. One interviewee described team-based care as a way to tackle complex medical and social issues. Additionally, while most interviewees viewed team-based care as a way to provide care to the patient, only one interviewee explicitly included the patient in the definition of the team. Table 1 presents some of the ways in which interviewees defined team-based care.

Team Structure and Roles

When interviewees described the structure and members of their team, all mentioned residents, physicians (including faculty members), and nurse practitioners, and some mentioned physician assistants and registered nurses. Interviewees also described the concept of a big team (larger clinic staff and resources) versus a little team (immediate care team members) whereby the little team is a conduit to the larger team. The additional multidisciplinary team members mentioned included medical or nursing assistant (6); behavioral health provider, including psychiatrists (5); pharmacists (4); social workers (4); care managers (2); nutritionists or dietitians (2); admitting staff or schedulers (2); and community health workers (2). Other positions mentioned by one or two interviewees included lab technician, X-ray technician, group visit coordinator, quality project manager, and referral coordinators. Only one interviewee mentioned patients as being part of the team.

When respondents explained how team structures were determined, three approaches emerged. First, many noted that their facilities went through a process of trial and error and experimentation with different configurations until they found something that seemed to work. As one interviewee put it, “We start piloting things. In one clinic, it works. And then we spread it out to some of the other clinics.”

A second approach involved setting up teams in ways that facilitated a balance of workflow and resources. Accomplishing this often included making sure teams had an appropriate balance of skills represented to enable them to handle a variety of patient needs. For example, one administrator shared his organization's process and the importance of team balance:

What we try to do is make sure that the teams are relatively equal in terms of the numbers of pediatric patients and the numbers of elderly patients and/or the numbers of patients with really very, very complex medical conditions. If you don't pay attention to those things, you can wind up with one or two teams having by far the heaviest load in terms of complexity. ... It [is] imperative that we have the team huddles in the morning, for example.

Another administrator mentioned ensuring a balance of bilingual abilities as part of the decision-making process in structuring teams:

So we try and make the teams more even as far as their strengths, whether it be a foreign language, whether it be the type of care that they do. But [obstetrics] is huge here and so we try and make [sure] that everybody does OB.

About half of the interviewees stated that decisions on structuring their teams were informed by literature and exploring best practices at other sites. It is important to point out that some interviewees also noted that the decision to structure teams was not in their purview or had been made by clinical (rather than administrative) leadership, most often physicians and medical staff. Thus, the individuals with whom we spoke may have been unaware of the explicit processes undertaken by clinical leadership when deciding on team structures.

Team Goals

We asked interviewees about their teams' goals. The majority noted that the goal of team-based care was to improve patients' care, experience, and satisfaction. For example, one interviewee said, "The goal for the team is the same as the goal for the facility. It's to provide patient care. I don't know how to say that any differently."

Another goal was to improve staff satisfaction. One respondent said, "The whole focus is to try to improve the efficiency and to make this process better, not only for the patient but also for all of the staff members."

Three interviewees mentioned the goal of improving clinic workflow and operations. Such efforts were most often described in the context of trying to streamline the process for the patient, contributing to improved patient and staff experiences. One interviewee commented,

So the goal was to achieve the patient-centered medical home recognition. And I think when that first started out we kind of thought it was just a box to mark and didn't really understand the transformation that it meant. And now we've caught that bug of quality improvement in workflows and doing things in a systematic way to really [achieve] the best experience for the patient rather than having all these individual workflows and preferences by providers.

Given that most of the individuals interviewed worked in academic medicine facilities, many discussed the goal of training residents and the importance of interprofessional education to facilitate team-based care. As one administrator remarked,

This idea of teams and working in teams is so important that it's really critical to have that process happening for the residents during their training. ... We're training family doctors to go out into the world and it seems like they are not going to be well-trained if they're not getting exposure during residency to working with other members of the team.

Monitoring Team Effectiveness

When asked about monitoring goals and team effectiveness, interviewees mentioned metrics related to the external impact of the team as well as those related to the internal functionality of the team. For external factors, interviewees often cited tracking and monitoring patient satisfaction as a way to gauge effectiveness. One administrator described how the organization incorporated patient satisfaction ratings into monitoring activities:

We also have our willingness-to-recommend scores from our [Clinician & Group Survey Consumer Assessment of Healthcare Providers and Systems] CG-CAHPS that we look at. ... We look at [them] from month to month, and we see the feedback from patients. We also do monthly rounding where the managers round and meet with the patients, and we check in with patients to see how their experience is.

Interviewees also discussed how they regularly monitored federal standards and meaningful use criteria as a means of assessing the team's performance. This assessment included tracking and monitoring PCMH and National Committee for Quality Assurance metrics. In terms of internal measures, interviewees most often discussed more subjective aspects of teamwork, including staff members' feeling respected and being motivated, and assessing the general morale of the staff and feel of the environment. For example: "I think some of that is you see if people feel respected and engaged and if they feel ownership with what's happening with the patients—then I think you have a good team."

Respondents also mentioned the need to "keep a finger on the pulse" of the team to determine how well staff members were working and what, if any, adjustments needed to be made. The following comment illustrates this point:

We also round with all of our staff every month and check in with them to see what's working well, what's not working well, and what are some of the things that are driving them crazy that we can improve. And so, keeping our finger on the pulse of the clinic to see how things are going from the patient's perspective, the staff's perspective, and the provider's perspective gives us a good idea of that.

Challenges to Team-Based Care

We asked the healthcare administrators to discuss some of the challenges to implementing team-based care at their facilities. Responses centered on maintaining continuity of care, recruitment, culture change within and beyond the organization for both patients and

providers, restrictive or insufficient payment and funding models, and using EHRs (Table 2). One interviewee emphasized the importance of communication as a way to overcome challenges:

This is a huge culture change for everyone. Nobody in the traditional model of medicine is naturally very comfortable with this new way of doing things. So, people have to meet frequently, and they have to [discuss] meaningful topics, they have to be able to have free and open communication, they have to have conflict.

Influence of Healthcare Policy on Team-Based Care

Our final questions focused on the impact of healthcare policies, such as the Affordable Care Act (ACA), on team-based care. All clinics held or were in the process of obtaining the PCMH certification. While a few interviewees discussed how the ACA increased the number of patients with insurance and changed the payer mix, many said it did not have a direct impact on how they define or structure team-based care for a variety of reasons. As one interviewee stated,

I don't think it [the ACA] has really changed the way that we've structured team-based care. Now, I mean, it's definitely changed the landscape of our clinic and our payer mix, but it hasn't changed the way that we've provided care here.

Another administrator described the changes in healthcare policy as a way to legitimize existing activities and efforts:

[The changes to healthcare policy] legitimize what clinics were doing before, which is relying on other people to provide care for the patient and to wrap around services. There are a lot of different terms that we use for [team-based care], but it legitimizes [existing activities]. It says, this is what we're doing here.

One limiting factor described by interviewees in states where Medicaid was not expanded is that the changes in healthcare policies did not affect their service base or structure because they still had a large population of uninsured patients.

I don't know that we have a lot more people with insurance, even with Obamacare there's so many people here who fall in the hole who just don't qualify. Unless they extend Medicaid, these people are going to be uninsured.

Although EMRs and EHRs were a point of some contention, with some interviewees describing them as cumbersome and problematic, others felt they were useful in helping them better monitor team functions and care outcomes. As one interviewee described,

[Through] EMRs and PCMHs, I'm providing better care to my patients, especially preventive healthcare, because I'm actually tracking what we're doing and what I'm doing. And I have the tools that help lead me to ask the right questions and to be able to see if folks have had their colonoscopy or whatever and then get it set up if they haven't.

DISCUSSION

The perspectives on teamness provided by healthcare administrators across a regional set of primary care settings overlap the conceptual framework of Shoemaker and colleagues (2016). Furthermore, many of the complexities of primary care teams identified by interviewees parallel the broader management and healthcare literature on high-functioning teams, particularly with respect to the challenges of communication, funding models, culture change, and team structure (Sullivan, Zara, Andrew, & Lindsay, 2016). Although our study consisted of a small sample of administrators, the findings highlight areas for future focus, including the need to better understand patient perspectives, staff perspectives, and the more subjective aspects of team functioning, such as organizational climate and the complexities of academic medical settings.

The overarching goal of team-based care in primary care is to improve quality for patients, while reducing costs and increasing access (Bodenheimer et al., 2014; Coleman, Wagner, Schaefer, Reid, & LeRoy, 2016; Mitchell et al., 2012; Schottenfeld et al., 2016). Despite acknowledging the importance of patient care, healthcare administrators rarely mentioned patients in their definition of team-based care or as part of the care team. This gap mirrors that identified by other researchers, who stressed the need to develop survey instruments from the patient's perspective or better understand the role of patients (and caregivers) as part of the care team (Okun et al., 2014; Shoemaker et al., 2016).

Although improving patient health outcomes was among the important goals across clinics, staff and patient satisfaction and experience were the high-priority goals, as well as the metrics of team effectiveness. Many of the domains of teamwork identified by Shoemaker and colleagues (2016) speak to the relationship between staff members and workflow, but further work is needed to understand how these concepts link to staff satisfaction. The healthcare administrators interviewed in this study pointed to subjective and nontangible aspects of teamness—climate, motivation, and a feeling of being welcomed—that also are related to Shoemaker and colleagues' (2016) concepts of conflict resolution, adaptability to context, and sense-making, which often are not measured.

More attention is needed on how issues pertaining to training and skills of healthcare personnel (particularly in academic medical settings with residents) and staffing configuration decisions relate to teamness, constructs that are not well-identified in Shoemaker and colleagues' framework, but were identified in our study as important challenges in implementing team-based care. Similarly, although there are many output measures of teamwork, including patient care process and outcome measures, more research is needed to understand how these metrics are prioritized and how they relate to patient satisfaction (Manary, Boulding, Staelin, & Glickman, 2013).

Although Shoemaker and colleagues (2016) identified the need for a metric that can assess changes in the healthcare delivery system, major policies, such as the ACA, did not appear to greatly affect the decisions made by healthcare administrators in this study. However, when probed further, interviewees deconstructed policies into issues related to local market factors (e.g., identifying local talent), financing/reimbursement models, and adoption of

EHRs. Previous studies have shown that primary care settings, specifically community health centers, have had to adjust their staffing to adapt to local market factors and to adopt EHRs (Frogner, Wu, Ku, Pittman, & Masselink, 2017; Frogner, Wu, Park, & Pittman, 2017; Ku, Frogner, & Pittman, 2014). Understanding how these changes affect team effectiveness, and thus patient and staff satisfaction, warrants further study.

CONCLUSION

Identifying one index representing teamness that works across heterogeneous primary care settings and across team members remains a challenge for researchers. One reason health workforce researchers desire a quantitative metric is to begin a systematic data collection approach regarding team-based care that can be linked to other administrative and survey data to identify how internal and external organizational factors impact teamwork and, thus, patient outcomes. Qualitative research continues to be important, however, to fully understand the “team” in primary care. Despite having a conceptual framework on the “who,” “what,” and “where” of team-based care (Mitchell et al., 2012), more research is needed to understand the “how” of team-based care, including how decisions are made in configuration of the team. Without a solid understanding of how team-based care is operationalized, widespread replicability of team-based care is nearly impossible. Also, researchers are unable to monitor the impact of innovations on the effectiveness of a team and, hence, the impact on health outcomes. Through this qualitative study, we begin to understand the “how” from the perspective of the healthcare administrator who makes hiring and staffing decisions that affect the configuration of the team.

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TABLE 1

Themes and Illustrative Quotes Defining Team-Based Care

Definition and Purpose	Illustrative Quotes
Providing patient care	We have people who have different roles and different responsibilities, but all of the roles have patient care as their focus. It doesn't matter whether you're in billing or at the reception desk or you're a case manager or a nurse. Whatever your position, the focus and the reason we're here is to take care of people.
Providing a multidisciplinary approach to patient care	Team-based care—how I think of it in the family medicine clinic—is a multidisciplinary approach to patient care that includes the patient.
Providing wraparound services	Basically, to wrap ourselves around the patient as best as possible, or to wrap services around the patient as best as possible to deliver good care.
Expanding access to care	Under the team-based model, a large, dispersed team or a diverse team of professionals are taking a lot of the direct patient care off the physicians' shoulders and actually expanding the direct patient services that can be provided.

TABLE 2

Themes and Illustrative Quotes on Challenges to Implementing Team-Based Care

Challenge	Illustrative Quotes
Continuity of care ($n = 6$)	It's difficult because you don't have as many continuity [of care] providers. For the patients [who] need to come in three times a week or routinely, the continuity often is more with the nursing and the MA [medical assistant] staff than it is with the provider. And that can be difficult when you're looking at team-based care.
Staff recruitment ($n = 5$)	There's two different pieces to it. One is the level of competence of the people we hire. Sometimes that's not been quite up to what I would consider par. The other piece of it is just the personality of the people involved. Sometimes we have had the experience where we hire people into positions for which they are just not well-suited from a personality standpoint.
Culture change ($n = 4$)	Some of our older patients have a hard time if they don't get to see the provider they've seen for the last 20 years. [This has been our experience] even if we say, you know, this is a team-based concept. Everybody who will be taking care of you has access to your chart. They'll communicate with your [primary care provider], I think that's probably been one of the harder things. Team-based care is a huge cultural transformation. This is not something that anyone can do in a short period of time. Our experience took 5 years, with a bunch of trial and error and stutter steps. We probably lost six faculty physicians during this time, partly due to the cultural changes needed to transform.
Funding/reimbursement models ($n = 4$)	But in a setting where visits are the widget, churning patients through is what gets you paid. If the work of the other people on the team is not billable and not compensated by insurance, then it's pretty hard to set up a system in which the doctor isn't just churning patients through in order to make income to support the practice. So I think reimbursement is probably the biggest hurdle.
Electronic health and medical records ($n = 3$)	I've never seen an EMR like this. It's more like a hospital EMR. The thing is, because we have to report so many measures, it's very robust, but it is just very difficult to use because the physicians go to private practices and use their [systems]. And they have their charts done by the time they go home. Not here. It's just very difficult.