Management Lessons for High-Functioning Primary Care Teams

Erin E. Sullivan, PhD, research director, Harvard Medical School Center for Primary Care, and lecturer, Department of Global Health and Social Medicine, Harvard Medical School, Boston, Massachusetts; Zara Ibrahim, researcher, Harvard Medical School Center for Primary Care; Andrew L. Ellner, MD, co-director, Center for Primary Care, Harvard Medical School, director, Program in Global Primary Care and Social Change, Harvard Medical School, assistant professor of medicine, Harvard Medical School, and associate physician, Division of Global Health Equity, Brigham and Women’s Hospital, Boston; and Lindsay J. Giesen, intern, Harvard Medical School Center for Primary Care

EXECUTIVE SUMMARY

Healthcare leaders and managers have only an emerging understanding of how to create high-functioning primary care teams. Management scholars have researched and debated the fundamentals of high-functioning teams over the past few decades in a variety of industries, and it is critical that the primary care providers adopt management teachings to deliver better interprofessional care. This semistructured literature review, grounded in the management and healthcare literature, summarizes and applies relevant team frameworks and best practices from the past 35 years to the current primary care landscape. Relevant management strategies for primary care teams include teaming, working with existing teams, and customer-based teams. The management literature presents a number of recommendations for building successful professional teams, such as re-envisioning goals, promoting shared decision making, communicating effectively and interprofessionally, clarifying roles, learning from failure, and using organizational structures to support multidisciplinary teams. Common barriers include systems-level obstacles to communication and efficiency, hierarchies, lack of time and financial incentives, information and interest asymmetry, and the complexity of working with people from diverse backgrounds. Early adopters of team-based care also offer recommendations. The strategies identified offer healthcare managers insights on common but important primary care topics, such as time-sensitive and interprofessional care, workforce shortages and constraints, and patient-centered care. In addition, this article offers healthcare managers key recommendations on building teams, deconstructing current practice hierarchy, promoting culture change, creating role clarity for healthcare managers and team members, and incentivizing team-based care.

For more information about the concepts in this article, contact Dr. Sullivan at Erin_Sullivan@hms.harvard.edu.
INTRODUCTION
The need for accessible, efficient, cost-effective, and quality primary care is a recurring theme in the literature. The 15-minute physician visit model fails to provide acute, chronic, and preventive care and does not enable providers to build lasting relationships with patients or manage multiple diagnoses in line with evidence-based recommendations (Bodenheimer & Laing, 2007). These problems have caused a resurgence of interest in team-based primary care among key stakeholders, including government officials, providers, policy analysts, and researchers (Institute of Medicine, 2011; Iglehart, 2009). The rise of integrated models, such as accountable care organizations and patient-centered medical homes (PCMHs), the critical shortage of primary care physicians, the increasing number of patients covered by insurance since passage of the Affordable Care Act, the prioritization of interprofessional training, and the call for payment reform all suggest a solution that includes implementation of team-based primary care (Iglehart, 2009). By incorporating team-based frameworks and lessons from management, stakeholders can create innovative and holistic solutions for primary care that enable teams to achieve goals (Hackman, 1990). The purpose of this literature review is to examine the extensive management literature on this topic, as well as current trends and recommendations in the healthcare literature. This review focuses on applying this knowledge to primary care and considers the preliminary research conducted on primary care teams.

METHODS
Study Design
We conducted an extensive, semistructured review of management and healthcare literature to identify research on teams. We identified articles in the Business Source Complete (Premier, Elite, and Main Edition), Academic Search Complete (Premier, Elite, and Main Edition), Google Scholar, and PubMed databases, and we also identified relevant reports and white papers on prominent healthcare websites, including—but not limited to—The Commonwealth Fund, The Robert Wood Johnson Foundation, and The Johns Hopkins Primary Care Consortium. In addition, we examined cited works and references to discover additional publications. The following key search terms, as well as stems, variants, and synonyms, were used in combination across the databases: “management,” “teams,” “teamwork,” “interprofessional teams,” “cross-functional teams,” “high-functioning,” “high-performing,” “health care,” and “primary care.” Additionally, the MeSH (Medical Subject Headings) headings “primary health care” and “patient care team” were used in PubMed to focus results. We queried databases and collected articles dating from 1979 to 2015.

Inclusion Criteria and Articles Identified
All articles identified in the preliminary searches were selected because of their interdisciplinarity and potential applicability to healthcare. “Management” searches yielded results from the fields of general management, service management, operations management, crisis
management, organizational behavior, and strategy. We excluded articles from the field of information services because we determined that their technology-focused team structure was too narrow and did not directly apply to healthcare. Our search for “teams” and “teamwork” included, but was not limited to, literature detailing members of a team and their behavior, planning, and execution of teamwork, situations requiring teams, and benefits and challenges of teams. We also included seminal literature on “interprofessional” and “cross-functional” teams. For the terms “high functioning and high performing,” we included literature pertaining to the distinction between successful and unsuccessful teams. When searching for the term “health care,” we included only literature relevant to the field in general; with the exception of primary care, subspecialties were excluded. Within primary care, we included existing models and evidence of team-based care for adults from internal medicine, family medicine, pediatrics, and geriatrics; literature focusing on mental health was excluded because of its lack of integration with primary care.

After the preliminary search, we assessed article abstracts individually for their relevance to teamwork, team-based frameworks, and best practices in the field of management or healthcare. Special attention was paid to articles with potential applicability to primary care settings. We collected white papers on a case-by-case basis from prominent healthcare websites if they pertained to identified themes. For the articles and reports that met the inclusion criteria, a full-text review was conducted. We categorized articles according to the date of publication (1979–2015), publication in peer-reviewed journals, publication in high-impact journals, and frequency of citations. A single reviewer (Z. I.) conducted all searches and reviewed abstracts and reports for inclusion.

Analysis
We conducted the analysis by creating lists of emerging themes and trends from the articles and categorizing the findings accordingly. The same reviewer (Z. I.) conducted the analysis, though input and feedback were obtained from the other authors. Preliminary search results yielded approximately 300 items, and of these, 97 were selected for an in-depth review based on relevance. An additional 11 white papers were added, and 22 articles were acquired after a review of references.

RESULTS
Defining Teams
No consensus exists regarding a definition for team. For the purposes of this review, we use Katzenbach and Smith’s (2005, p. 165) definition; a team is “a small number of people with complementary skills who are committed to a common purpose, set of performance goals, and approach for which they hold themselves mutually accountable.” Grumbach and Bodenheimer (2004) analyzed primary care sites with team-based care and concluded that the key characteristics of cohesive healthcare teams include clear goals with measurable outcomes, clinical and administrative systems that enable teamwork,
division of labor, training for all team members, and effective communication strategies. Table 1 summarizes key principles that were identified repeatedly in management and healthcare literature or highlighted in seminal literature. To establish the relevance to primary care specifically, we match each principle with an example from the primary care literature. With these core principles in mind, we turn to the management literature to gain clarity on the transition from group to team, as well as on effective team strategies applicable to primary care.

**Mobilizing Teams**
The mobilization period is the team-building stage. Decisions and actions during this period influence team development and performance (Cohen & Bailey, 1997). Hackman (1990) believes this phase is a major opportunity for leaders to create enabling conditions that should lead to desired outcomes. These conditions are

- appropriate team designs, including defined boundaries and levels of authority;

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<th>TABLE 1</th>
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<td>Principles of a Team-Based Framework for Application in Primary Care</td>
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<tr>
<td><strong>Team Principle (Management)</strong></td>
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<td>Leader’s inclusiveness (words and deeds that invite member contributions); the leader encourages team members to speak up and offer different perspectives, clarifications, and feedback (Nembhard &amp; Edmondson, 2006).</td>
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<td>Leaders must repeatedly present their vision of the performance goal to recharge team members’ efforts (Katzenbach &amp; Smith, 2005; Rashid, Edmondson, &amp; Leonard, 2013).</td>
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<td>Reshaped reality calls for re-envisioning goals and establishing new paths to success (Rashid et al., 2013).</td>
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<td>Leaders in chaotic environments need to draw boundaries and turn away people whose efforts are no longer helpful (Rashid et al., 2013).</td>
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<td>Teams need members with essential competencies and skills (Hackman, 1987).</td>
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<td>Team Principle (Management)</td>
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<tr>
<td>Assign clinical and coordination responsibilities for a patient’s care based on who is</td>
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<td>the most effective, qualified, and available team member, while maintaining mutual</td>
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<td>accountability (Doherty &amp; Crowley, 2013).</td>
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<td>Teams should be dynamic and flexible based on roles determined by patients’ needs and</td>
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<td>team members’ competencies (Doherty &amp; Crowley, 2013).</td>
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<td>Multidisciplinary teams bring together health professionals with distinct training,</td>
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<td>skills, knowledge, competencies, and patient care experiences to respond in a patient-</td>
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<td>and family-centered manner (Doherty &amp; Crowley, 2013).</td>
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<td>Collaborate, have shared commitment, and avoid excessive hierarchy (Katzenbach &amp; Smith,</td>
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<td>2005).</td>
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<td>Learn from failure as opposed to blaming individuals (Rashid et al., 2013).</td>
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<td>Promote interprofessional communication to increase workplace morale and minimize patient</td>
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<td>harm. Key elements of communication are energy, engagement, and exploration (Parikh, 2013;</td>
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<td>Pentland, 2012).</td>
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<td>Promote interprofessional education (WHO, 2010).</td>
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<td>Provide organizational structures and systems to support teamwork (key supports: rewards</td>
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<td>system recognizing excellent team performance, an educational system/training to</td>
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<td>supplement knowledge and expertise, and so forth) (Parikh, 2013).</td>
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• structure with tasks, team composition, and norms that foster full use of members’ knowledge and skills;
• goals that are defined, compelling, and engaging;
• reinforcement in an organizational context through support and resources; and
• availability of expert team coaching throughout the team’s life cycle.

Ericksen and Dyer (2004) examined whether high- and low-performing project teams differ in how their team members assemble and launch projects and the extent to which any differences become apparent during team performance. Comparisons of three high-performing and three low-performing teams in a field study of five major corporations showed that high performers build teams relatively quickly, plan thorough and detailed strategies, and hold kickoff meetings with shared decision making and participation as opposed to receiving top-down direction from leaders. In addition, high-performing teams effectively use the resources of time, tasks, and talent in tandem (Ericksen & Dyer, 2004). According to these authors, these strategies allow teams to work efficiently, define key competencies to finish tasks, and successfully complete projects by following an agreed-upon strategy.

**Strategies**

**Primary Care Teams in Practice**

A variety of practices, community health centers, and networks across the United States have implemented different models of team-based care. The Robert Wood Johnson Foundation (LEAP Project) and The California HealthCare Foundation published preliminary findings regarding the key elements and innovations of successful teams, some of which are the following (Ladden et al., 2013; Sinsky et al., 2013):

• Proactive planned care, such as previsit laboratory tests and review of patient records by medical assistants to identify care gaps
• Shared clinical care and clerical tasks, with more clinical support staff per physician
• Team members practicing at the top of their license (e.g., nurses focusing on uncomplicated, preventive, acute, and chronic care)
• Frequent forums for communication, such as weekly team huddles
• Work-flow mapping and physical co-location of team members to encourage immediate consultations, brief interventions, and collaboration

Furthermore, a literature review by Xyrichis and Lowton (2008) offers best practices on interprofessional teams in the primary care setting. Two main factors that affect interprofessional teamwork are team structure (e.g., team members should be co-located, and the team should be small in size, occupationally diverse, have a leader, and be supported by the practice or organization) and team processes (e.g., team meetings, clear goals and objectives, and audits to evaluate team effectiveness) (Xyrichis & Lowton, 2008). The Primary Care Workforce Commission (2015), which advises the National Health Services in the United Kingdom, also offers recommendations informed by a
literature review, site visits, evidence, and panel meetings. The solutions offered vary from local to national levels and include encouraging a stronger population focus, increasing information technology services for patient communication, and expanding the workforce with new and redefined professional and staff roles. Although primary care practices are ultimately responsible for the care of their patients, teams will also include and work with community pharmacies, hospitals, and social service agencies (Primary Care Workforce Commission, 2015).

In addition, three comprehensive models in geriatrics—GRACE model, Guided Care, and PACE—are aimed at improving quality of care and quality of life while avoiding increased costs for older patients with complex needs (Boult & Wieland, 2010). All three models are based on care delivered by teams of primary care physicians, registered nurses, and other healthcare professionals in the primary care setting. They all incorporate the following:

- Comprehensive assessment
- Development of and adherence to an evidence-based, comprehensive care plan
- Proactive monitoring of patients
- Coordination of services in primary care, specialty care, hospitals, emergency departments, skilled nursing facilities, other medical institutions, and community agencies
- Facilitation of patient transitions from hospitals to post-acute care settings and access to community resources (e.g., meal programs and support groups)

Team-based care is not the norm in pediatrics, but it is becoming a more prevalent strategy to treat children with special healthcare needs (CSHCN). These children and youth require a spectrum of medical, mental health, social, and academic assistance that is coordinated in a single place and time (Antonelli, McAllister, & Popp, 2009). Parents also have a role on the team as advocates for their children who help develop their care plans. The Commonwealth Fund proposed the following set of functions for high-performing pediatric care teams to address the interrelated needs of the CSHCN population (Antonelli, McAllister, & Popp, 2009):

- Manages continuous communications and integrates critical care information
- Coaches and develops care plans with families
- Analyzes assessments and tracks tests, referrals, and outcomes
- Supports care transitions
- Facilitates team meetings
- Uses health information technology

**Teaming**

“Teaming” is one management strategy to build teams, and it is relevant to multidisciplinary primary care teams under pressure to perform. Teaming happens in almost every industry outside of healthcare (Edmondson, 2012). According to Edmondson (2012), Novartis Professor of Leadership and Management at the Harvard Business School, teaming is flexible teamwork and a way to bring together a group of people temporarily to identify and solve
problems. Implementing a teaming approach requires the combination of project management tasks (e.g., scoping out the project, structuring the group, and sorting tasks by level of interdependence) and team leadership (e.g., emphasizing purpose, building psychological safety, and embracing failure or conflict) to quickly address new challenges. This strategy allows team members to develop their knowledge, skills, and networks while accelerating the delivery of services. In short, “teaming is a way to get work done while figuring out how to do it better,” and it can be incorporated in a setting in which needs and staff resources are constantly changing (Edmondson, 2012, p. 74).

Rashid et al. (2013) examine teaming in their analysis of the 2010 rescue mission of 33 Chilean mine workers. During a time of uncertainty (the probability of rescuing the mine workers was less than 1%), André Sougarret, a mining engineer leading the rescue efforts, enlisted a diverse group of highly skilled people and asked them to leave behind preconceived notions and prepackaged solutions. People on the rescue mission had to work in fluid, shifting arrangements and enlist or dismiss people as the situation required. This incident shows that excluding unhelpful people may be just as important as including helpful people, and demands what Rashid et al. (2013) call “high-stakes leadership.” High-stakes leadership is needed in time-pressured, make-or-break situations, which also occur in primary care.

Eisenhardt (1989) builds on the topic of high-stakes leadership by looking at teams with different functional perspectives. In executive management teams composed of a CEO and heads of major functions, such as sales, finance, and engineering, she explores how teams can make fast decisions in high-velocity environments that result in high performance. In such environments, fast decision makers use more information and develop more alternatives than do slow decision makers, seek advice from all team members but focus on the advice from a few experienced members, and integrate decisions with an overall tactical plan. Fast decision making allows decision makers to keep pace with the constantly changing primary care landscape in the United States.

**Bounded Teams**

In cases in which teams are limited or confined to working with existing team members—or bounded teams—metrics help companies objectively identify unproductive team members without demoralizing other employees (Reichheld & Rogers, 2005). More specifically, team leaders can motivate employees by applying metrics to compensation, promotions, and career transitions. They accomplish this by rewarding exceptional hires and tapping that extra 10%, thus inspiring the best employees to stay and give their best (Reichheld & Rogers, 2005). Because of workforce shortages in primary care, it is necessary to explore strategies for bounded teams.

Gouillart and Billings (2013, p. 72) developed a team-based strategy for bounded teams called co-creation, which invites all involved “constituencies to collectively solve problems and exploit opportunities” for teamwork.
Leaders begin with the people they already have relationships with and then enlist their help to persuade more people to join them. These leaders effectively act as community organizers as they engage customers, suppliers, employees, partners, citizens, and regulators. This community-powered problem solving is a way to fuel continual innovation and value for both the organization and stakeholders. Co-creation is applicable to the dynamic setting of primary care in which clinicians and staff members must continuously adapt and solve problems while experiencing workforce constraints.

**Cross-Functional Teams**

The benefits of cross-functional teams in the field of product development have been demonstrated (Brown & Eisenhardt, 1995). For example, a team developing new software products may include a team leader or an executive sponsor, a marketing manager, a product owner, a technical writer, a database manager, and software developers. These team members bring their unique skill sets to the group and are all involved in building the new product. In traditional siloed environments, the integration, expansion, and recombination of knowledge are challenging. Cross-functional teams offer an effective approach to address these challenges. Defined as project groups with members from more than one functional area, such as engineering, manufacturing, or marketing, successful cross-functional teams hinge on integrated problem solving to maximize the breadth and depth of functional knowledge. Team members bring expertise to a problem, integrating and expanding on potential solutions. Moreover, because of overlapping development phases, cross-functional teams can offer a productive and efficient process, thus leading to lower costs, lower prices, and greater product success. Primary care could benefit immensely from a cross-functional team approach. Primary care teams must retire the professional, siloed model and encourage cross-functional teams to capitalize on the collective knowledge, backgrounds, and experiences of professional and nonprofessional staff.

A key factor for success is the ability of cross-functional teams to communicate internally and externally. For example, because cross-functional teams bring together individuals across the spectrum of product development, team members are prone to interpret the same information differently (Brown & Eisenhardt, 1995). Similarly, the ability to communicate and incorporate information and expertise from outside the team or organization directly affects success. To promote clear communication internally, Brown and Eisenhardt (1995) recommend combining perspectives in a highly interactive and iterative fashion. To promote clear communication externally, they propose using a “gatekeeper,” or a high-performing individual who communicates with people outside the team and specialty to gather, translate, and communicate external information.

Once communicated, information needs to be incorporated or turned into knowledge, which requires additional pathways. Although many such information pathways exist, both formally and informally, Grant (1996) recommends
two mechanisms for integrating knowledge in an organization: (1) direction in the form of directives, policies, or procedures; and (2) organizational routines, which involve codifying tacit knowledge into explicit rules and instructions so that choice is simplified into fixed responses. The literature on cross-functional teams in management offers insights on communication practices in primary care. The cross-functional team approach suggests that having defined pathways and protected systems for recombining knowledge, receiving knowledge, and incorporating knowledge is key to success (Grant, 1996). As team-based care becomes more common in primary care, clear communication channels between primary care teams, specialty care providers, and patients are crucial.

**Customer-Based Teams**

According to management literature, teams may be customer-centric and change on the basis of customers’ needs, desires, and experiences. To create a customer-based model, Madsbjerg and Rasmussen (2014) assert that customers must be observed in their natural habitats to better understand their decisions. The authors discuss “sense-making,” which, at its core, is studying how people experience life (i.e., phenomenology) and analyzing their motivations (Madsbjerg & Rasmussen, 2014). Standard market research tools such as market data analytics, conjoint analysis, surveys, and focus groups fall short in this endeavor. Lego researchers, for example, garnered insight by collecting data for months, interviewing parents and children, creating photographs and video diaries, shopping with families, and studying toy shops (Wittenberg-Cox, 2014). This concept of sensemaking parallels the patient-centered approach in primary care and the changing—and often unpredictable—needs and choices of patients that affect team structure and dynamics.

In addition, John Chambers, then CEO of Cisco Systems, explained that Cisco learned early on to listen to customers to identify market transitions and “build collaboration into their DNA” (Fryer & Stewart, 2008). To capture the processes, technology, and culture for a market transition, Cisco is organized into cross-functional, collaborative boards and councils, which are the equivalent of social networking groups that work together in real time using technology. To incentivize this collaboration, Chambers based his employees’ compensation on their collaborative abilities as opposed to their individual performance, forcing employees to work with each other and customers. Those who were unable to make this transition left the company. Components of Cisco’s customer-based team model carry implications for incentivizing patient-centric, team-based primary care.

**Barriers to High-Functioning Teams**

Identifying and avoiding common barriers to productive teamwork are important considerations. Patrick Lencioni (2002), founder of the Table Group, lists five dysfunctions of a team that build on each other in the following order: absence of trust, fear of conflict, lack of commitment, avoidance...
of accountability, and inattention to results. As Eisenhardt, Kahwajy, and Bourgeois (1997) explained, conflict is commonplace in strategic decision making. However, if the conflict is interpersonal, such that negative emotions take over, the conflict can impede the decision-making process. When managing interpersonal conflict, skillful decision makers focus on issues, not people, by means of facts, references to common goals, humor, and a sense of fairness exhibited through balanced power structures and consensus.

As discussed earlier, situations may arise in which teams do not have the freedom to add or remove members, which is a concern if unhelpful group members are present. According to Felps, Mitchell, and Byington (2006), the impact of negative group members can be minimized by withholding leadership positions and by monitoring or punishing consistent negative behavior. Felps et al. (2006) define negative group members as those who withhold effort from the group, express negative affect, or violate interpersonal norms. Alternatively, groups can empower positive members by reinforcing relationships or through use of tools, such as the 360-degree feedback approach that allows peers to comment on each other’s behavior. Positive members generally work toward group goals with intensity and persistence, regulating their expression of feelings to facilitate comfortable interactions among group members. In any case, a quick response is critical to minimize any negative effects of poor behavior.

In some team-based primary care models, such as PCMHs, physicians bring the highest level of training and preparation to lead integrated and multidisciplinary teams (American Academy of Family Physicians, 2012). Ghorob and Bodenheimer (2015) explained that because of their extensive medical training and legal liability, some physicians find it difficult to share responsibility for a patient panel. Table 2 summarizes common barriers to team formation and performance in primary care, as well as potential solutions from both the healthcare and primary care literature.

**DISCUSSION**

A consensus is emerging that effective teamwork is crucial in primary care. Teams take a variety of shapes and forms. However, key principles and strategies are gleaned from decades of robust research in the management literature.

Making the critical jump from a group of coworkers to a high-functioning care team brings challenges that need to be confronted by practice and systems leaders. When possible, the momentum to create a primary care team should begin in the mobilization period, which could be during the creation phase of a patient panel, for example, or during the launch of an effort to promote team-based care. In addition, the management strategy of teaming could prove useful when fast and appropriate care is required in a multidisciplinary setting. Achieving high-functioning teams through teaming might involve the difficult and painful process of removing team members who do not contribute to the overall goal or do not work well as team players. Removing team members
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<th>Barriers to Primary Care Teams</th>
<th>Potential Solutions</th>
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<td>Risk aversion to experiment with a new model of care because human life is at risk, as well as legal liability (Nembhard &amp; Edmondson, 2006).</td>
<td>Engaging healthcare professionals is difficult in a seemingly chaotic and uncertain landscape of team experimentation (Nembhard &amp; Edmondson, 2006). Build psychological safety and improvement efforts to create the willingness to change habits and promote enthusiasm for change and engagement (Nembhard &amp; Edmondson, 2006).</td>
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<td>Information is not shared (also known as information and interest asymmetry). Multidisciplinary teamwork that integrates knowledge and expertise from different sources is difficult to carry out in practice (Edmondson, Roberto, &amp; Watkins, 2003).</td>
<td>Primary care physicians possess specialized medical expertise, whereas nurses and other healthcare workers have greater knowledge of daily patient interaction processes (Tucker &amp; Edmondson, 2003). Regular team huddles offer a designated time and space to discuss patient cases (Bodenheimer, 2011).</td>
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<td>Collaborative learning does not occur naturally in primary care because of an imposed hierarchy (Edmondson et al., 2003). Patient outcomes are correlated with the degree of hierarchy in healthcare team interactions (Feiger &amp; Schmitt, 1979).</td>
<td>Although nurses witness and experience a variety of problems and use a creative solutions to resolve emergent issues, they do not communicate their ideas across professional boundaries because of a well-entrenched status hierarchy in medicine (Edmondson et al., 2003). Incentivize clinicians and staff members to work in teams (Schoen et al., 2006).</td>
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<td>&quot;Hamster healthcare&quot; in which clinicians frequently find themselves in a constant state of mental exhaustion (Edmondson et al., 2003).</td>
<td>Finding the time to participate in team development is difficult for physicians, which hampers planning and cooperation (Edmondson et al., 2003). Hamster healthcare has its origins in increasing complexity of care, payment models, and patient expectations. The delivery system should address these factors (Morrison &amp; Smith, 2000).</td>
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<td><strong>Barriers to Primary Care Teams</strong></td>
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<td>Frequent transitions between caregivers in the continuity of care (Haggerty et al., 2003).</td>
<td>Shift changes, patient transfers, and academic hospital scheduling constraints complicate coordination and teamwork (Haggerty et al., 2003). Create an online patient portal system through which patients can connect with the care team (Katz &amp; Moyer, 2004).</td>
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<tr>
<td>Organizational complexity stemming from relationships and personalities, the challenge of team structure when compared with a hierarchical structure (Grumbach &amp; Bodenheimer, 2004).</td>
<td>As team size increases, interpersonal communication increases exponentially and may overtake the benefits of teamwork. Some team members may shine as initiators, clarifiers, or encouragers, while others may play negative roles as dominators, blockers, evaders, and recognition seekers (Grumbach &amp; Bodenheimer, 2004). Use improvement processes informed by complexity science: Multimethod Assessment Process (MAP) and Reflective Adaptive Process (RAP) (Stroebel et al., 2005). Focus on task conflict, and differences in opinion rather than personality differences and interpersonal tensions (Smith &amp; Edmondson, 2006).</td>
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<td>Financial incentives: under the current fee-for-service payment model, no incentives for team-based care (Grumbach &amp; Bodenheimer, 2004).</td>
<td>Practices set their panel primarily on the basis of profitability (Grumbach &amp; Bodenheimer, 2004). The incentive to avoid focusing on profitability may be to move from a fee-for-service model to other forms of global payment or shared-savings models, which are being incorporated in pilot medical homes (Auerbach et al., 2013).</td>
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<td>Systems-level obstacles to communication and efficiency (e.g., not enough time allotted to schedule appointments, complete treatment authorization requests, or conduct follow-up phone calls) (Saba, Tache, Ward, Chen, &amp; Hammer, 2011).</td>
<td>Health coaches need time for medication reconciliation, creation of an action plan, patient education, patient follow-up, and review of the patient panel with physicians (Saba et al., 2011). Locate all team members in a central, open area to conduct clinical activity and interact easily with each other (Bodenheimer, 2011).</td>
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is an unfamiliar and uncomfortable task for many healthcare leaders, but it is crucial to create a culture of accountability and trust as well as to provide the level of service that patients deserve. Interpersonal conflict and Lencioni’s (2002) five dysfunctions are other common barriers to team-based care, as discussed earlier. The hiring process offers a key opportunity to bring in the right people and reset the practice’s culture and expectations.

The strategies of using metrics and co-creation to work with bounded teams are also relevant to primary care practices that may be limited by physician shortages or budgetary constraints. In these scenarios, team leaders, physicians, or others need to adopt the role of coach and incentivize team members to engage in team-based care, as well as engage the community to identify and achieve goals (Gottlieb, Sylvester, & Eby, 2008). For example, at Southcentral Foundation (SCF), a primary care–based health system in Alaska, physician salaries are driven by team performance to incentivize team-based care. Also, similar to a co-creation strategy, SCF engages the American Indian and Alaska Native communities in designing a system that achieves wellness through health and related services.

Customer-based team models, such as sensemaking and Cisco System’s collaboration with customers, also draw critical parallels to the patient-centered approach of primary care practices. Compelling examples exist of the deconstruction of the current practice hierarchy—with the primary care physician at the top, professional staff in the middle, and nonprofessional staff at the bottom—to promote patient-centered care. Several leading organizations have made significant progress toward achieving this cultural change (Chen et al., 2010). We should also note that physicians must learn to be managers and team players, but depending on team composition, constraints, and needs, the physician may not be the best team leader (Bodenheimer, 2011).

Study Limitations and Potential Areas of Future Investigation
As efforts are made to transition to team-based care in the primary care setting, it is critical to continuously assess the value of teamwork and opportunities for improvement. Instruments and tools for measuring team function are available in the management and healthcare literature, yet few are available in the primary care space. Also, this article focuses on literature pertaining to internal medicine, family medicine, geriatrics, and pediatrics, but we also acknowledge that specialties such as surgery and mental health contribute to advancements in team-based care. Although this review focuses on management principles, other industries, such as sports, also offer valuable insights on teams and should be considered for future research. Finally, the integration of information services and technology in the primary care team setting is also critical to consider.

CONCLUSION
Applying team-based care strategies from the management and healthcare literature to primary care teams can foster innovative and holistic solutions to challenges in primary care. The
management literature on teams is robust and extensive, offering a wealth of information and multidisciplinary recommendations for primary care teams. Because the model of primary care teams is relatively nascent, it is important that we continue to learn about teams inside and outside primary care and improve on existing models.

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PRACTITIONER APPLICATION

Daniel A. Handel, MD, chief medical officer/executive medical director, Medical University of South Carolina Medical Center, Charleston, South Carolina

As the drive to maximize value in healthcare continues, we look at how to optimize our delivery care models. At the center of the value equation is the primary care provider whose team leads care coordination and navigation. The days of sole practitioners are quickly disappearing, replaced by complex teams with complementary skill sets. Every member of a high-functioning team serves a specific purpose in maximizing the quality of care. Healthcare is now a team effort, and the best teams will deliver the best care. Good teamwork will lead not only to higher-quality care, but also to lower employee turnover. Do both of these functions well, and the cost of care decreases.

Given the complexity of work we do, and the impact we can have on patients’ lives, creating a highly reliable and resilient healthcare team is a must. Healthcare

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providers and leaders must be preoccupied with failure, the first principle of highly reliable organizations, and that starts at the team level (Weick & Sutcliffe, 2007). Good teams make sure that no one fails in the mission to provide high-quality care every day for every patient. General Stanley McChrystal (2015) emphasizes the importance of teams in Team of Teams and the importance of creating teams that are empowered to make the right decisions in the field, adjusting and improvising when necessary. This skill set is also needed in healthcare to meet the changing and increasingly complex needs of our patients (McChrystal, 2015). Sullivan et al. explore the literature to identify best practices with respect to creating effective primary care teams.

Healthcare leaders must assemble the right teams—whether in a primary care setting or inpatient areas—but we also must be able to monitor how well they function over time. Employee engagement surveys are a good proxy for this, but they typically look at an entire organization or specific disciplines (e.g., physicians, nurses). Rarely is a measurement tool deployed specifically for use with an interdisciplinary team, as the one described in this study.

The TeamSTEPPS Teamwork Perceptions Questionnaire (Agency for Healthcare Research and Quality, 2016) is a tool that can be used to meet this need. After the high-functioning team has been assembled according to the principles set forth in this study, the survey can be used to track the team’s performance over time. A baseline survey should be administered on formation of the team; it then should be administered on a regular basis, no less than annually.

The challenge with surveys is that they are retrospective in nature—they only tell you how a team has performed in the past. These lag metrics do not help leaders manage their teams on a daily basis. Metrics need to be developed that continuously monitor the effectiveness of the team, allowing the leader to intervene in real time to correct issues that may disrupt the team’s dynamic. Surveys, such as the one discussed earlier, then serve to confirm that the team is on course.

Even in the best healthcare systems, patients most remember their individual encounters. We must ensure that the teams we create sustain our common goal of providing high-value care for every patient, every time.

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