Is Team-Based Care the Key to Successful Population Management?

*By **Erika Pabo** | Wednesday, February 21, 2018*

Erika Pabo, MD, MBA, is Associate Director and Medical Director for Population Health for Primary Care at Brigham and Women's Hospital. She specializes in helping practices redesign their care and reshape their culture to deliver Triple Aim outcomes. IHI recently spoke with Pabo about the keys to successful team-based care, and how it can benefit both patients and care providers.

How can team-based care help with population management?

I don’t know how you care for a population and pursue the Triple Aim or the Quadruple Aim — higher quality care, better patient experience, and increased joy in work, while maintaining or reducing costs — without a team. To provide high-quality care, it’s essential to have a range of skills and expertise to care for a patient’s whole continuum of needs.

Health care has changed so much over the last five years for primary care doctors — from pharmaceutical developments in how we treat anticoagulation or hepatitis c to the delivery system challenges of moving from taking care of the patient in front of us to caring for a population. There's so much to know and so much new work to do for our patients. One person can't know or do it all. In my world, a team includes primary care doctors, nurses, medical assistants, community health workers, social workers, and pharmacists.

How can team-based care help patients with complex needs?

Teams are critical to giving our patients the tools to address social inequities. For example, I have a patient who has poorly controlled diabetes. He's also sometimes homeless and struggling with substance use and depression. It would be overwhelming to care for him alone. I'm well-trained to treat his medical problems, but I'm not particularly well-equipped to deal with the other challenges he faces.

My relationship with him as his primary care doctor is central to the care we provide, but so is his relationship with the social worker on our team. When he's feeling depressed, or when he's having a crisis, he can reach out to her or to me. When he's been homeless, he works with a community resource specialist to help identify short-term and then longer-term housing options. Recovery coaches and addiction psychiatrists have also played critical roles on his care team to support his substance use recovery.

It would be very hard for one individual to help with the multiple factors contributing to his poor health, but — as a team — we can work together to connect him with the resources he needs to support his own health.

How can effective team-based care help address burnout?

If we look nationally, approximately 50 percent of primary care physicians in the country are experiencing burnout. It's a crisis. Teams are a critical piece of addressing that.

In my day job we focus on three strategies to address burnout and wellness: 1) developing personal resilience; 2) creating a culture of wellness; and 3) redesigning who and how we provide care to patients.

I think the last one is particularly important. It means stepping back to understand the work that a given system or microsystem (a primary care

practice, for example) needs to do for a patient. Most of this might fall onto the physician today, but if you give careful thought to who should be on that team — from a primary care physician to a pharmacist to a community resource specialist — you can reconsider who should do what for each patient. Done right, this can take a tremendous burden of work off the physician's plate while simultaneously empowering and building the capacity of other members of the care team.

In primary care, there are a lot of screenings. Do you find it easier to address something like depression, for example, as part of a team?

Absolutely. It doesn't feel good to ask patients questions when you can't support them when the answer is yes. A lot of PCPs in our system were initially resistant to screening for depression until we provided team-based resources to care for patients who screened in. We've implemented the IMPACT model, which is a team-based care model for patients with depression. Our PCPs now work with a population health coordinator, a social worker and consultant psychiatrist to manage their patients with depression.

Some physicians have trouble adapting to a team-based model. What are some common challenges?

It's a different way of working, so it's only natural that some individuals would struggle. It starts with our training systems. Medical schools, nursing schools, and post-graduate training programs are typically designed to teach people how to be high-functioning individual contributors to care, but they haven't all shifted to teaching people how to work in teams. Health care is traditionally very hierarchical. Providing care in teams is a big cultural shift.

For example, sometimes you'll hear physicians talking about "my medical assistant" or "my nurse." That kind of hierarchical language does not contribute to a supportive environment for a team. Even simple changes like ones we have enacted in my own primary care practice — like saying "the nurse on our team" or referring to "the medical assistant I work with" — signals that all the members of the team are equally valuable.

What can help physicians successfully transition to team-based care?

Part of successfully transitioning to team-based care is a mindset shift. Part of it is understanding and respecting the training and expertise of the individuals that you work with.

We do an exercise in my practice called “Walk a Mile in My Shoes.” Each guild — social workers, community health workers, community resources specialists, nurses, and physicians — go around and share different kinds of information about their role: what they do for patients, something that others might be surprised to learn, the reasons I should refer patients to them, and common (false) assumptions about their work. This kind of simple exercise can be a great way to get to know each other as professionals and learn how we each contribute to the care of our patients.

Are you saying that successfully adapting to team-based care requires some humility on the part of physicians?

Yes. I think there’s often a sense in medical training that you as the doctor should always have the answers, but I need humility to understand and respect that others on the team have as much — and in many situations more — to contribute to care. For example, I don’t know how to do cognitive behavioral therapy, but the social worker on my team does. The pharmacist on my team is better at managing diabetes than I am because that is the core of what she does every day.

Physicians have traditionally seen themselves on top of some sort of hierarchy, so we have a powerful role to play in making clear that each of us is an equally valued member of the team.

What is the future of team-based care?

The biggest challenge is figuring out how to pay for team-based care. Health care systems across the country — unless you’re the VA or Kaiser — are somewhere in the transition from fee-for-service to a fee-for-value system. Even within an organization, there can be disconnects between how the organization is paid and how individual physicians or team members within the organization are paid.

For example, at the Brigham, which is a part of Partners Healthcare where I work, we have many value-based contracts with our external payers. However, until now, our primary care physicians have been paid on a fee-for-service basis. When we’re trying to provide population

health, which our external contracts require us to do, it's been just layered on the work that our PCPs are already doing in a fee-for-service world. In other words, we've been asking them to do more with the same resources, and we need to get away from that. We're in the process internally of restructuring how we compensate our physicians and renegotiating with the hospital how they compensate primary care, so that we can better support the robust teams we need to care for our patients.

Is there a story you can share that helps illustrate the benefits of team-based care for physicians?

One of the physicians in our organization is what you'd call "a doctor's doctor." When you think of who you would want as your PCP, he's the one you would choose. He's one of our more senior physicians, and he was trained to do everything himself. He always worked incredibly hard, dawn to dusk.

It's been interesting to watch his practice evolve. Initially, we implemented a dyad model in which a medical assistant and a PCP work together to care for a patient. At first, he didn't think there was a lot the medical assistant could contribute. But he started to see how much they can help with pre-visit preparation. Before he even sees his patient, the medical assistant can determine that they need a mammography or a colon cancer screening or is overdue for their A1C to screen for diabetes.

More recently, as we've rolled out a behavioral health program to support patients with depression across our practices. He was initially one of the biggest skeptics. We listened to his feedback and said, "Why don't you just send this one patient [to the behavioral health program] and see what happens?" And he did.

The patient got support, therapy, and connected to a psychiatry resource. He then referred another patient, and another patient. Just a couple of weeks ago, I was at their practice, and he had become one of the biggest proponents of our behavioral health program. He was extolling the virtues of working with the social worker. Sometimes you just need to convince a skeptic to try a team-based model for them to see its value.

What have you personally seen as the benefits of team-based care?

The team that I get to work with is my second family. Instead of feeling burned out or overwhelmed by the challenges in front of me, I feel energized by them because our team has the tools to provide the care that my patients want, need, and deserve.