# Team-based Patient Care:
# Best Practices to Meet the Needs of CDCR's Patients

## Introduction

This paper describes an integrated care model based on the concept of team-based patient care, especially the role of team-based care in the seven new facilities, and their relationship to delivering medical, mental health, dental, rehabilitation and related treatment services to patients in California's prison system.

In incorporating this range of services, these facilities will be designed to:

- Provide efficient and appropriate health care; and,
- Be sustainable (i.e., operable by the State over the long term).

A team-based approach is intended to support a philosophy that is being "designed into" these facilities, which highlights:

- Patient-centered care that emphasizes a recovery and wellness-based treatment approach;
- Integrated care (medical, mental health, dental, rehabilitation and other health care services) using an Interdisciplinary Treatment Team model; and,
- A direct supervision approach.

The paper is divided into six sections. Part I provides background information on the concept of team-based care. Part II offers a range of types of team models, highlighting two in particular as most effective in supporting a patient-centered, integrated continuum of care. Part III lists the advantages and challenges of implementing team-based care. Part IV focuses on implementing teams in the seven new facilities. Part V describes organizational models that facilitate team-based care. Part VI lists questions for discussion.

## Part I. Teams

### A. Definition

Jon Katzenbach defined a team as a small number of people with complementary skills who are committed to a common purpose, performance goals, and an approach for which they hold themselves mutually accountable.[1]

Jo Manion refined Katzenbach's generic description in *Team-Based Healthcare Organizations*[2] for the health care field as follows:

> A team is a small number of consistent people committed to a shared purpose, with common performance goals, complementary and overlapping skills, and a common approach to their work. Team members hold themselves mutually accountable for the team's results and outcomes.

It should be noted that organizational culture or "context" has direct and indirect effects upon team functioning.[3] Also, teamwork is a measurable attribute of organizational functioning that extends beyond the boundaries of defined teams.

### B. Mission, Competencies and Activities of Teams

A team exists to meet specific **performance goals and outcomes** through a shared mission and common values. A good health care team has as its first priority the patient's needs, and the success of that team is measured by the achievement of the best health care outcomes possible for each patient, consistent with the patient's wishes, to the extent possible.

For example, an interdisciplinary treatment team (described in II. E. below) of mental health, physical health, and rehabilitation professionals may have as a **goal** the improved functioning and health of 80% of the patients served in Q1 of 2010, resulting in 70% of the 80% being prepared for discharge. To achieve this goal, the team might set an **objective** to address workflow design in order to reduce waste, eliminate rework, and provide for effective, efficient use of staff resources in order to achieve the goal.

Critical team member attributes include technical or functional expertise, problem-solving and decision-making skills, effective communication and interpersonal skills, flexibility, and commitment to the process and desired outcomes.

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[1] Katzenbach, Jon R., and D.K. Smith. 1993. *The Wisdom of Teams*. Boston, MA: Harvard Business School Press, Page 45.

[2] Manion, Jo, W. Lorimer, and W Leander. 1996. *Team-Based Healthcare Organizations*. Aspen, CO: Aspen Press. Page 5.

[3] Lemieux-Charles, *op.cit.*

Team members must be well-trained, coached and motivated to perform. Members are expected to help each other and to back each other up, to utilize team strengths to elevate any individual weaknesses and coordinate efforts for success. They must be able to analyze what went wrong, critique each other's work, and make the necessary corrections in team functioning as needed.

Successful teams set goals in order to solve problems, make, or recommend decisions. Members commit to:

- Measurable results
- Mutual accountability
- Focusing on outcomes
- Ensuring task completion and follow-through
- Collaborating
- Communicating within the team and to members of the organization
- Operating in a respectful manner
- Resolving conflicts through an agreed-upon mechanism

### C. Decision-making by a Team

The role of the team leader is key to effective functioning of the team. The leader can be appointed by management or elected by colleagues. Team leadership may rotate, too, among team members. In all cases, it is up to the leader to make sure the team stays focused, members assume appropriate tasks, and that decisions are made.

The team's decision-making authority must be clear as it addresses the following questions in developing a mechanism for making decisions:

- What needs to be decided?
- Who should be involved in the process?
- What decision-making process should be used?
- Who will be responsible for carrying out the decision?
- Who needs to be informed about the decision?
- What does success look like?

### D. Successful Teams

A team is not a "working group." Working groups come together to share information, solve problems and help individuals do their job better. Members do not take responsibility for results other than their own, as they do when they are members of a successful team.

For a team to work, member participation and each member's role must be defined and agreed upon by management. The team member is accountable in two directions: to his or her colleagues on the team and also "upward."

According to Thomas Bodenheimer, MD:

> The factors identified with better performance (of health care teams) include good leadership, a clear division of labor, training of team members in their personal roles and in team functioning, and team supporting policies of the organization within which the team is working. Considerable and ongoing investment is required to create and sustain team cohesion. This investment includes training, the creation of protocols that define tasks and those who will perform them, the adoption of team rules including decision-making and communication, and the granting of some protected, non patient-care time for team meetings of a larger team.[4]

## Part II. Types of Teams

There are five types of teams described in the section below with a particular emphasis on two team frameworks that appear to be best suited to meet the goals of the Federal Receivership for the seven new health care facilities. Interdisciplinary treatment teams and primary work teams are described in detail below with further discussion about implementation of these team models in Part III.

### A. Ad Hoc Teams

The ad hoc team is created to implement a short-term project, such as putting on an employee recognition event. It lasts for a relatively limited period of time and is disbanded when the project is completed**.**

### B. Leadership Teams

A leadership team is formed by the chief executive who selects top managers as team members. The leadership team can play a range of roles within an organization from advising the CEO to solving institution-wide problems.

### C. Primary Work Team (PWT)

Members of primary work teams have similar duty statements and responsibilities, such as a group of recreational therapists, LVN's, certified nursing assistants, etc.

For example, Lead Nurses on Shift II in a health care facility can comprise a primary work team. This team is made up of a specific classification of nurses who, through supervising other nursing staff, focus on improving practices that lead to better patient-centered care.

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[4] Bodenheimer, Thomas, M.D. July 2007. Building teams in primary care: lessons learned. California HealthCare Foundation.

The design of the PWT is fundamental for success:[5]

- Its size must be tailored to accomplish its purpose.
- The right combination of shared responsibility and individual expertise must exist.
- The team must have the ability to shift its activities and priorities as needed.

### D. Multi-disciplinary Team (MDT)

Professionals who make up a multi-disciplinary team come from diverse disciplines. Following a one-stop assessment, MDT members consult one another and use sequential problem solving to develop and plan implementation of a care plan. The patient is the center of the MDT. Meetings of team members, including the patient, generally occur monthly or quarterly. Differences in opinion or approach are discussed and resolved when the entire group meets.[6]

### E. Interdisciplinary Treatment Team (IDTT)

Interdisciplinary treatment teams are becoming an increasingly common way to organize work groups. IDTTs are most prevalent in primary care practice, practices that care for those with chronic conditions, critical acute care, geriatrics, mental health settings, and care at the end of life.[7] As in multi-disciplinary teams, *the patient is at the center of the team and participates in the IDTT process.*

Interdisciplinary treatment teams include members from different professions and occupations. Using a collaborative model, they work together closely and communicate frequently to optimize care for the patient. Each member contributes his/her knowledge, skill set, and experience to support and augment the contributions of other team members.[8] According to Theresa Drinka:

> Team members determine the team's mission and common goals. They work *interdependently* to define and treat patient problems, learn to accept and capitalize on disciplinary differences, differential power and overlapping roles. To accomplish these, they share leadership that is appropriate to the presenting problem and promote the use of differences for confrontation and collaboration.[9]

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[5] Manion, Jo, W. Lorimer, and W Leander. 1996. *Team-Based Healthcare Organizations*. Aspen, CO: Aspen Press. Page 22.

[6] www.associatedcontent.com/article/291553/the_multidisciplinary_team_approach.html. June 29, 2007.

[7] Institute of Medicine. 2001. *Quality Chasm Series*. National Academies Press.

[8] Hall P., and L. Weaver. 2001. Interdisciplinary education and teamwork: a long and winding road. Med Educ 35(9):867-75.

[9] Drinka, T.J.K. and P.G. Clark. 2000. *Healthcare Teamwork: Interdisciplinary Practice and Teaching*. Westport, CT: Greenwood Publishing Group.

Evidence suggests that IDTTs enhance quality and lower costs.[10] For example, the Institute of Healthcare Improvement brought together IDTTs from numerous health care organizations over several years to work on specific health issues. In the case of asthma care, interdisciplinary treatment teams from twelve medical centers came together. Within fifteen months, nine teams had achieved positive results including sizeable reductions in hospital and emergency room visits.

Recently, Kaiser Permanente's Georgia region studied the outcomes of their interdisciplinary treatment teams. They found that teams with "higher collaborative clinical culture" had higher measurable patient outcomes.[11] Furthermore, in a national, multi-site controlled trial at the Veteran's Administration to assess the effectiveness of comprehensive team delivery of care on care delivery outcomes, the geriatric evaluation and management (GEM) interdisciplinary treatment team interventions positively affected physical functioning and general health, pain, activities of daily living, and physical performance for inpatients at discharge.[12]

In summary, the interdisciplinary treatment team approach can provide good, comprehensive, patient-centered care. It holds the promise of offering truly "holistic" care, something out of the reach of solo practitioners or even facility-based working groups. Indeed, interdisciplinary teams can be viewed as a specific form of collaboration within the workplace.[13]

## Part III Advantages and Challenges of Team-based Care

### A. Advantages to IDTT-based Patient Care and Primary Work Teams

The team-based approach to patient care and operations offers some key advantages:

#### 1. Patient care

- Patients are at the center of interdisciplinary treatment teams. They participate in the IDTT process, making their needs and wishes known. IDTT-based care therefore offers a means to deliver patient-centered care.
- IDTTs form the backbone of an integrated service delivery model[14], as described in the paper on *Patient-centered Care.*

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[10] McDonough, Randal P., and William R. Doucette, 2001. Dynamics of pharmaceutical care: developing collaborative working relationships between pharmacists and physicians. 682-692. NLNAC. 2002. www.lnnac.org.

[11] Roblin, D.W., Kaplan, S.H., Greenfiled, S.,et al. Collaborative clinical culture and primary care outcomes. Washington, DC, program and abstracts of the annual meeting of the Academy for Health Services Research and Quality. June 2002.

[12] Page, A., Editor, Committee on the Work Environment for Nurses and Patient Safety. Keeping Patients Safe: Transforming the Work Environment of Nurses.
National Academies Press, Appendix B. Envirhttp://www.nap.edu/catalog/10851.htmlNational

[13] Page, *op. cit.*

[14] See Integrated, Patient-Centered Care, prepared by Amy Rassen at Steve Cambra and Dr. Terry Hill's request and distributed in October 2008.

- Staff members working in teams are more likely to develop higher levels of knowledge, skills, expertise and experience, thus ensuring higher quality diagnosis, treatment and care for patients.
- Work can be assigned to people with less training but more specific expertise than the physician or nurse. For example, while a physician signs the orders for treatment, the therapist is generally more knowledgeable about the specific treatment plan. Optimum use of staff skills will yield a better-crafted care plan with more efficiency.

**2. Operations**

- Teams outperform individuals acting alone or in larger organizational groupings, especially when performance requires multiple skills, judgments, and experiences.[15]
- Being part of the decision-making process, members buy in to the ensuring measurable outcomes set by leadership.
- Teams are the most practical way to develop a shared sense of direction and ownership among people throughout an organization.[16]
- Using teams offers the possibility for organizational improvement and increased satisfaction for employees.

## B. Challenges of Using Team-based Approaches

Many have asked, "If teams are such a good idea, why aren't they more prevalent?" Some of the challenges surrounding a team-based approach include the following:

- There is a growing literature on factors that facilitate and inhibit team success.[17,18] The use of teams does not guarantee either success or efficiency. Ideally teams develop an internal culture of accountability that will drive effectiveness, but the dysfunctional tendencies of teams are well known and need to be mitigated to ensure success.
- Ongoing training in team communication, facilitation, decision-making, conflict resolution, and individualized care planning are critical, as is senior management commitment to a team-based approach.
- Clear expectations and support needs to be developed for middle managers, for whom team autonomy may represent a loss of power and control.

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[15] Katzenbach, Jon R., and D.K. Smith. 1993. *The Wisdom of Teams*. Boston, MA: Harvard Business School Press, Page 9.

[16] Katzenbach, Jon R., and D.K. Smith. 1993. *The Wisdom of Teams*. Boston, MA: Harvard Business School Press, Page 19.

[17] Lemieux-Charles L; McGuire WL. 2006. What do we know about health care team effectiveness? A review of the literature. *Medical Care Research and Review*.2006;63(3):263.

[18] Page, A. (Editor). 2004. *Keeping Patients Safe: Transforming the Work Environment of Nurses.* National Academies Press: Institute of Medicine.

- Building teams requires careful planning, organizational commitment, and nurturing -- lots of up-front time and people resources. Once on a team, dividing up work and identifying spheres of competence is arduous, as are establishing the team's mission, goals, etc.
- Implementing teams requires formalized and ongoing training, which are time-consuming and costly. Most health care professionals are skilled in their specific work, but are not trained in team skills.
- Members move from individual accountability to mutual accountability, which can be a substantial "culture change."
- A team structure is not easy to implement in any environment. It is especially challenging in top-down organizations.
- Teams have some inherent drawbacks related to their added organizational complexity. For example, as team size increases, the transaction costs -- that is, the number of handoffs between caregivers, the time these take, and the potential for error -- of interpersonal communication increase and may overtake the benefits of teamwork.

## Part IV. Implementing Team-based Care in the Seven

The mission of the Receivership is to reduce avoidable morbidity and mortality and protect public health by providing patient-inmates timely access to *safe, effective and efficient medical care, and coordinate the delivery of medical care with mental health, dental and disability programs*.

Members of the Integrated Care Team (formally TAO Champions and members) believe that team-based care will enable staff in the seven new facilities to provide a system "in which (patient) encounters are: proactive, planned, informed, patient-centered, and professional," as described in Federal Receiver's Draft Strategic Plan (2.0) dated April 21, 2008 objectives.

Two types of teams are recommended for implementation in the seven new health care facilities: interdisciplinary treatment teams (IDTT) and primary work teams (PWT).

### A. Interdisciplinary Treatment Teams in Action

The building block of the clinical delivery system is the interdisciplinary team. Just as direct supervision drives design and program for custody, collaboration and teams drive design and program clinically.

With the IDTT as the primary approach to managing care, the patient experiences that he or she is dealing with a single unified entity. Communication among team members is close and ongoing. The goals, treatment plans, and hoped-for outcomes are shared by all

members of the team, including the patient.[19] There is one medical record; an evidence-based patient assessment tool and joint treatment planning ensure that all members are on the same page.

Team composition varies depending on the level of care and whether mental health or medical is the predominant focus. Composition of the core team versus the extended team varies as well. Nurses are core members of every interdisciplinary team. Given the medical and behavioral complexity of the population, both medical providers and mental health professionals are core members of most teams. Dietitians and physical therapists are more often members of the extended team rather than the core team. The participation of custody officers, both those who provide counseling and those who provide direct supervision, varies from team to team. Social workers may or may not be members of the core team. Pharmacists and medical specialists may not be members of the team per se. All patients are served by an integrated case management system.

### 1. Pre-Admission

Upon arrival at the health care facility, a physician examines the patient, his vital signs and medical history are taken, property processed, and mental health status assessed. His bed assignment is confirmed or changed based on this beginning assessment.[20] The rehabilitation case manager and assigned custody rehabilitation correctional counselor escort the patient to his housing unit.

### 2. Post-Admission

Post admission, the IDTT team meets to continue the assessment process. Goals for recovery or maintenance are identified, depending on the patient's diagnosis(es). When patients have dental problems or need an assessment by physical, occupational, or speech therapy, additional professionals may participate in the IDTT process. A care plan is developed identifying interventions, activities, goals, timelines, and anticipated outcomes. All members of the team sign off on the care plan, including the patient, if he or she is willing.

The team, working with the patient, then ensures that the care plan is implemented. Discussion among team members, medical/mental health questions, problems, and appropriate and necessary modifications of the care plan take place as needed. The patient has regular access to the members of his team. A formal review of the care plan based on the patient's level of care takes place during IDTT meetings. The treatment plan is then modified as appropriate during the patient's stay as treatment goals are met and/or new goals develop.

Management is involved in sanctioning the IDTT structure, supporting members with

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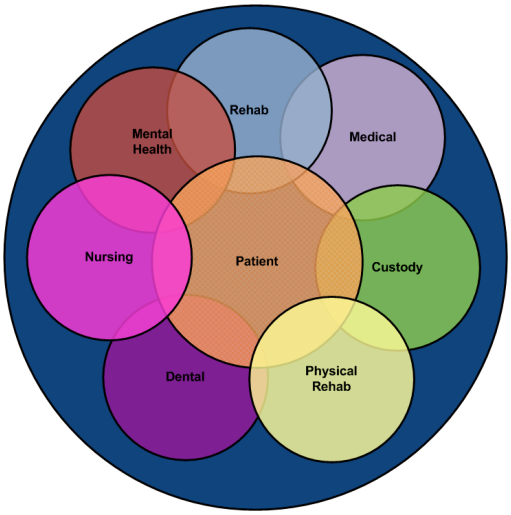
[19] The patient participates in the IDTT meetings whenever he or she is able to do so, based on the medical condition and active problems.

[20] A custody classification is sent to the healthcare facility prior to transfer.

training and time, and reviewing patient outcomes. Management may also appoint the IDTT leader and request reports from the team. Members are accountable to each other, the patient, and management for efficient and effective use of their time as well as for patient-specific, measurable outcomes.

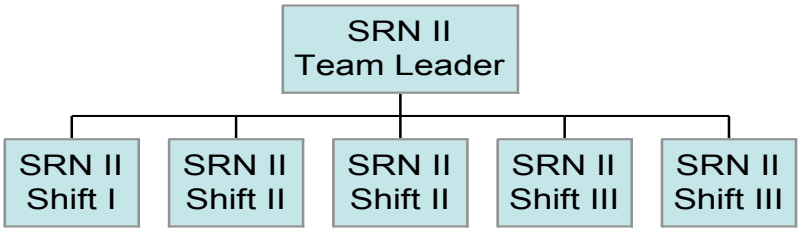
The diagram below is a visual representation of a patient-centered IDTT.




## B. Primary Work Teams (PWT) in Action

Primary *work groups* are very common in health care settings. For example, nurses on Shift I generally meet as a group to "hand off" patients to Shift II. Or, recreational therapists in acute psychiatry settings meet together to go over the treatment plans of patients who benefit from art therapy. Management generally mandates these practices.

Primary work *teams* as defined in Parts I and II of this document, are rare, even though a team-based structure provides a level of accountability that is the foundation of patient care and smooth functioning of the facility. PWTs offer an opportunity to "flatten" the facility's hierarchy, depending on the authority delegated by management to the PWTs. The diagram below depicts a potential PWT.



For example, the above diagram of a PWT is comprised of SRN II's on all shifts. Through the PWT, SRN II's identify their training needs, meet regularly to discuss staffing, organizational and patient issues and, understanding their decision-making authority, resolve identified problems, or escalate the issue "upward."

## Part V. Organizational Team Models in Action

As noted above, teams can only exist with the permission of management and with the support of the person at the top of the organizational chart. The organizational culture should match the team culture: it should be collaborative, open, appreciative of staff's strengths, and respectful of patients. Expectations should be clear. Information should flow smoothly up and down the organizational hierarchy. New ideas should be welcomed and errors should be considered learning opportunities. Management should be thin and the organization as flat as is reasonable to achieve desired outcomes.

All teams are held accountable for their performance by means of standardized performance measures as well as more traditional management oversight. While team members have formal supervision from managers in their disciplines, team leaders and other team members also inform that supervision.

Just as the interdisciplinary treatment teams are organized to support the needs of patients, managerial and governance structures should be organized to support the needs of the teams. Managers need to set goals and expectations, allow for team autonomy, provide teams with resources and opportunities to learn appropriate skills, provide problem-solving support, and provide feedback on performance. There is evidence that a benevolent ethical climate and leadership commitment to quality improvement can improvement teamwork.[21]

The facility can also benefit from specific, dedicated teams, several types of which are described below.

### A. Leadership Team

For example, all executive managers might be on a leadership team, led by the Health Care Administrator. Within this type of team, the Medical Director, Nursing Director, Rehabilitation Director, Custody Director, Administrative Director, Facilities Director, Mental Health Director and Dental Director would work together to identify and solve institutional problems, both large and small. They would be accountable to each other for results and also to the Health Care Administrator. Each member would be responsible for specific functional areas. (See Page 32.)

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[21] Rathert C, Fleming DA. 2008. Hospital ethical climate and teamwork in acute care: the moderating role of leaders. *Health Care Management Review*; 33 (4): 323.

### B. Clinical Directors' Team

One subset of the leadership team might be the Clinical Directors' Team, which would include the Medical Director, Nursing Director, Rehabilitation Director, and Mental Health Director. This team would focus on patient care issues, ensuring that the IDTT process is effective, patients are satisfied with their care, and that problems related to patient care are solved. (See Page 33.)

### C. Operations Team

A second subset of the leadership team might be the Operations Team, which would include the Custody Director, Health Care Administrator, and Facilities Director. These team members would focus on operations, such as use of space, problems with equipment, plant services, and more. (See Page 33.)

## Part VI. Questions for Discussion

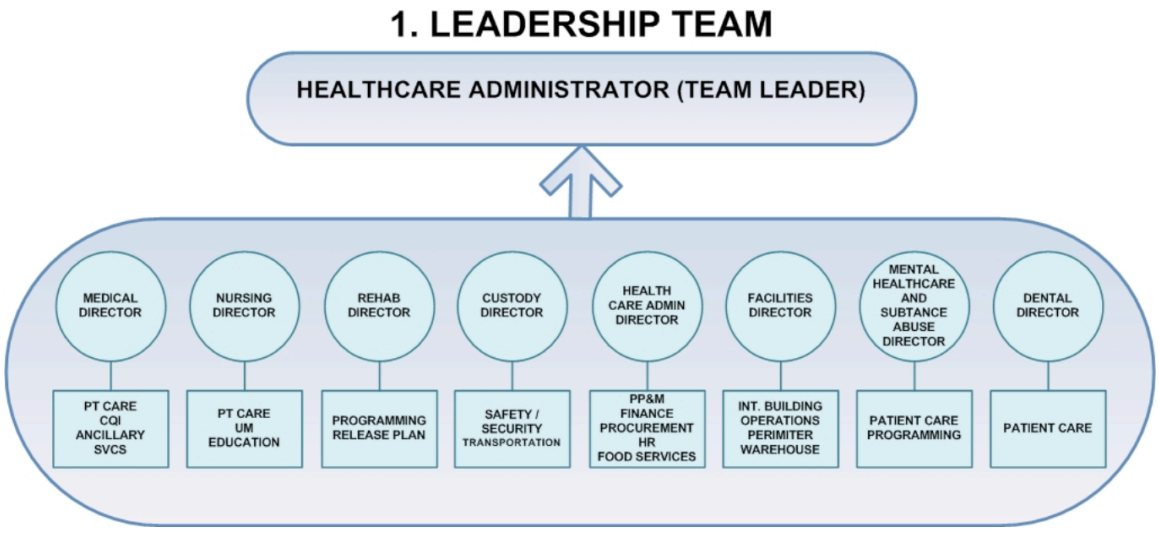
1. Will IDTTs and clinical PWTs lead to integrated, patient-centered care that is efficient and cost/resource effective?

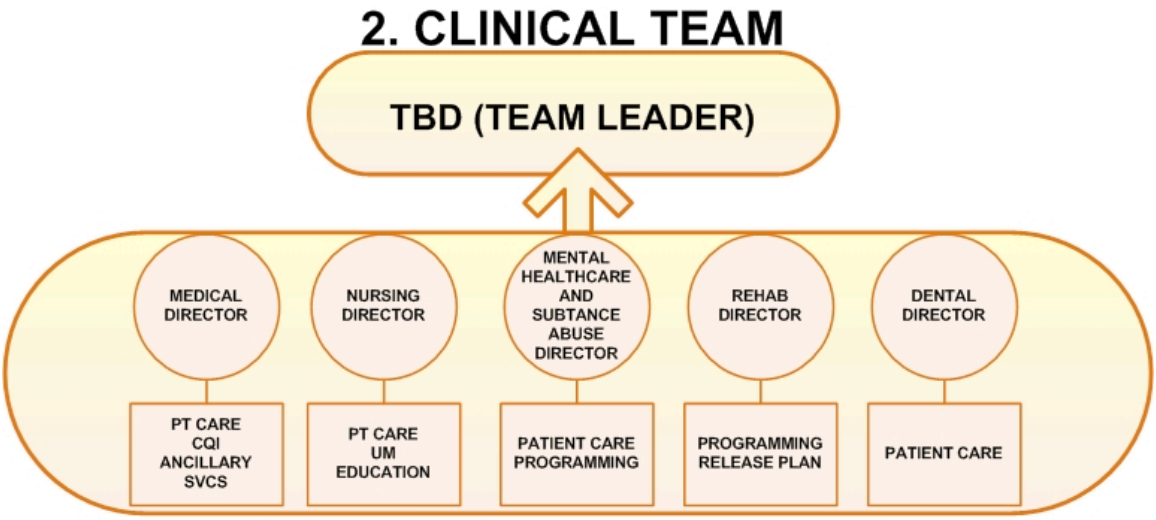
2. Will a team-based approach to leadership enable the smooth functioning of the facilities?

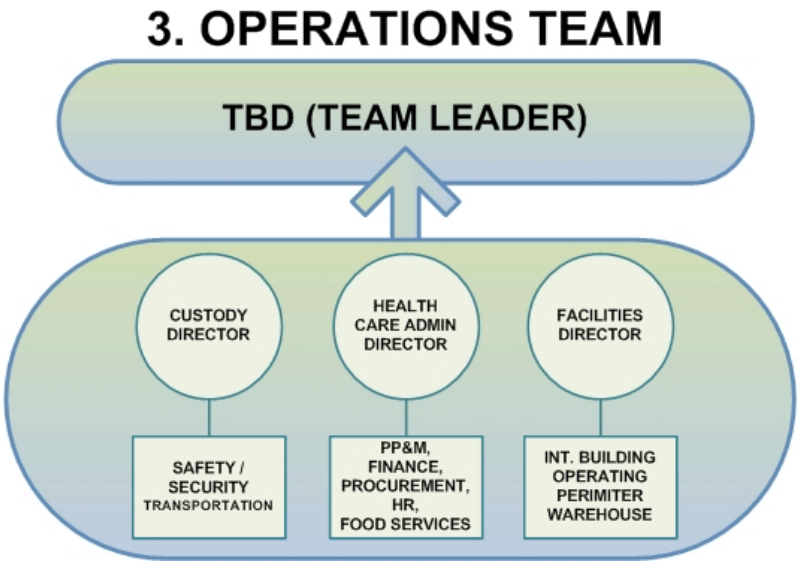
3. Is a flattened hierarchy possible in a state run health care facility?

4. What would the reporting structures look like for members of a facility's leadership team?

5. Are assignments of functional areas for leadership team members a good idea and also possible?


1. LEADERSHIP TEAM
HEALTHCARE ADMINISTRATOR (TEAM LEADER)
MEDICAL DIRECTOR
NURSING DIRECTOR
REHAB DIRECTOR
CUSTODY DIRECTOR
HEALTH CARE ADMIN DIRECTOR
FACILITIES DIRECTOR
MENTAL HEALTHCARE AND SUBTANCE ABUSE DIRECTOR
DENTAL DIRECTOR
PT CARE
CQI
ANCILLARY SVCS
PT CARE
UM
EDUCATION
PROGRAMMING
RELEASE PLAN
SAFETY / SECURITY
TRANSPORTATION
PP&M
FINANCE
PROCUREMENT
HR
FOOD SERVICES
INT. BUILDING
OPERATIONS
PERIMITER
WAREHOUSE
PATIENT CARE
PROGRAMMING
PATIENT CARE


2. CLINICAL TEAM
TBD (TEAM LEADER)
MEDICAL DIRECTOR
NURSING DIRECTOR
MENTAL HEALTHCARE AND SUBTANCE ABUSE DIRECTOR
REHAB DIRECTOR
DENTAL DIRECTOR
PT CARE CQI ANCILLARY SVCS
PT CARE UM EDUCATION
PATIENT CARE PROGRAMMING
PROGRAMMING RELEASE PLAN
PATIENT CARE


3. OPERATIONS TEAM
TBD (TEAM LEADER)
CUSTODY DIRECTOR
HEALTH CARE ADMIN DIRECTOR
FACILITIES DIRECTOR
SAFETY / SECURITY TRANSPORTATION
PP&M, FINANCE, PROCUREMENT, HR, FOOD SERVICES
INT. BUILDING OPERATING PERIMITER WAREHOUSE