Equity Minded Team-Based Care

Part 1: The Shift to Team-Based Care

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KEYWORDS

- Collaboration
- Teamwork
- Culture Transformation
- Multidisciplinary
- Interdisciplinary
- Transdisciplinary
- Team-based Care
- Leadership
- High Need Patients
- Vulnerable Patients
- Health Disparities
- Health Care Disparities
- Health Equity
- Health Care Equity
- Social Determinants of Health
- Social Needs

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Healthcare Organization Structure

Current Healthcare Organizations

- Generally designed from the top down
  - Hierarchical
  - Provider Focused
  - Reactive
- As a result, Leadership has generally been tailored around supporting those structures **or** working successfully around and within them

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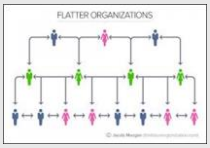
ACA requires a shift in how organizations are structured and function

- "Delayering" to a flatter, more decentralized structure
  - Work reorganization – time, resources, communication
- Collaborative, team based
  - Complex, high need patients require more
- Patient centered
  - Patient engagement, activation and support
- Shift from Reactive to Proactive
  - Population Health Management
  - Chronic Disease Care



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Teamwork and Collaboration

- **Collaboration** is defined as working jointly with others toward a common goal in relationships characterized by mutual trust, respect and power

- Some use the words **teamwork and collaboration** interchangeably to stress cooperation between interprofessional groups

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Attributes that Foster Collaboration

- Autonomy
- Assertiveness
- Cooperation
- Knowledge
- Openness to Learning
- Emotional Maturity
- Communication
- Shared Decision Making
- Mutual Respect
- Trust
- Responsibility

Requires Cultural Transformation

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What Is Culture Transformation?

- **Culture transformation** is a shift that can take place throughout an entire organization or in individual departments and teams
- A **transformation** is the process whereby, over time, people behave differently, and the organization benefits in some fashion as a result

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Teams in Practice

Multiple Studies - using staff at higher levels in team approach increases:

- Patient satisfaction
- Staff and clinician satisfaction
- Quality and efficiency of care

Goal of highly effective teams is everyone working at the top of their license and skills

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Cultural Transformation for Clinicians and Patients

Requires Team Members to:

- Know and understand their scope of practice
- Be able to articulate their role and expertise
- Empower patients to be active in their own healthcare, self-management

All require knowledge, communication skills and confidence in your role

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Benefits of Collaboration Between Healthcare Professionals

Evidence indicates that collaboration results in high functioning teams that demonstrate:

- Controlled costs and improved quality of care
- Positive effect on reducing length of hospital stays, readmissions and ED visits
- Increased staff/team member recruitment and retention
- Increased team members knowledge about team members role and contribution to improved health outcomes

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High Functioning Teams

- Demonstrate cooperation between disciplines
- Share responsibility for problem solving
- Make decisions related to patient care together
- Share ownership and responsibility for both decisions and outcomes

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Levels of Teams

- **Multidisciplinary** – each discipline independently contributes its expertise – work in parallel
- **Interdisciplinary** – team members work together closely, communicate frequently to optimize care – each contributes skill and expertise to support the work
- **Transdisciplinary** – roles appropriately blur as functions overlap, interchange

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Who Is the Team?

Everyone who plays a role in ensuring the health of the patient and their caregivers

- Teams expand and contract based on the healthcare needs of patients
- Robust primary care that includes front staff, MAs, RNs, APRNs, MDs, SW
- Includes Specialty providers and Community Services

Patients and Families are at the center of all teams at all levels

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Crucial Elements of Teamwork

- Mutual respect and trust
- Willingness to abandon assumptions
- Understanding of the distinct roles of each team member
- A willingness to blur roles *when appropriate*
- Flexibility
- Communication
- Relationships

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Effective Teams Need

- Clear purpose – vision
- Coordination, time to meet
- Patience – it takes time to get there
- Protocols and procedures
- Conflict resolution skills (and willingness)
- Active participation by everyone
- Collective and individual accountability

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Better Relationships Better Results
8 Pillars of Trust

1. Clarity in Communications
2. Compassion for Others
3. Character in doing what is right over what is easy
4. Competency in one's leadership responsibilities
5. Commitment during times of adversity
6. Connection to others
7. Contributions to the work of the organization
8. Consistency in leadership approach

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Effective Team Members

- Are open and transparent in their interactions
- Listens to understand
- Shows vulnerability and admits mistakes
- Do what you say you'll do
- Is a giver, not a taker
- Sustains hope

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Barriers to Teamwork

- Traditional hierarchical leadership
- Reluctance to question "the leader" or "the expert"
- Cultural differences – "cognitive maps"
- Unwillingness to take on new roles
- Communication styles
- Lack of supportive organizational structure
- Exclusion of team members
- Reimbursement

Barriers to teamwork are also barriers to effective team-based care

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Defining Team-Based Care

"the provision of health services to individuals, families, and/or communities by at least two healthcare providers who work collaboratively with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across setting to achieve coordinated high-quality care" – Institute of Medicine

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Advantages to Team-Based Care

- Expanded access to care
- More effective and efficient delivery of additional services essential to high-quality care
- Increased job satisfaction
- An environment in which all medical and nonmedical professionals are encouraged to perform work that is matched to their abilities and licensure

When practices draw on the expertise of a variety of provider-team members, patients are more likely to get the care they need

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Team-based Care: A Match for Complex Care

- Complex care is a person-centered approach to care that brings together patients and their families, the community, and the healthcare system to collaboratively improve health outcomes and well-being for people with complex health and social needs.

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Partnering with High Need Patients

"People who have three or more chronic diseases and a functional limitation in their ability to care for themselves or perform routine daily tasks" (NAM, 2022)

In the U.S. about 12 million people meet this high need definition

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Chronic Disease & the Health of U.S. Populations

1. Percent of population with **fair or poor health**:
   All ages — **10.4 percent**
   65 years and older — **24.7 percent**
2. Percent of population with **heart disease**:
   18 years and over — **11.6 percent**
   65 years and over — **30.5 percent**
3. Percent of population with **cancer**:
   18 years and over — **6.3 percent**
   65 years and over — **18.5 percent**
4. Percent of population with **hypertension**:
   20 years and over — **31.9 percent**
5. Percent of population with **high cholesterol**:
   20 years and over — **13.6 percent**
6. Percent of population categorized as **obese**:
   20 years and over — **35.9 percent**
7. Percent of population who **smoke cigarettes**:
   18 years and over —**19 percent**

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Vulnerable Populations

Refers to

"those who have poor access to health care, receive poor-quality care, and experience poor outcomes – often resulting from societal injustices related to race, ethnicity, poverty, gender, sexual orientation, age, first language or physical or mental condition."

- The Commonwealth Fund

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Health Disparities

The differences in incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific populations.

Health Care Disparities

The difference in the preventive, diagnostic or treatment services offered to people with similar health conditions

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Team-based Care & Health Equity

Health Equity

Everyone has a fair and just opportunity to be as healthy as possible.

- Requires removing obstacles to health
  - Poverty
  - Discrimination and related consequences including powerlessness
  - Lack of access to good jobs with fair pay
  - Quality education
  - Housing
  - Safe environments
  - Health care

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Health Care Equity

Providing care that does not vary in quality by personal characteristics such as ethnicity, race, gender, geographic location, socioeconomic status and other identity

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One Size Does Not Fit All

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Social Determinants of Health

"Social determinants of health include the conditions in the environments in which people live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality of life outcomes and risks." – Kaiser Family Foundation

"The conditions in which people are born, work, live and age and the wider set of forces and systems shaping the conditions of daily life including economic policies and systems, development agendas, social norms, social policies and political systems."
– The World Health Organization

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Social Needs (NASEM, 2019)

"Individual level nonmedical acute resource needs related to SDoH such as housing, reliable transportation, strong support system at home, that must be met for individuals to achieve good health outcomes and for communities to achieve better health."

"Person centered concept that incorporates each person's perceptions of his or her own health-related needs, which therefore vary among individuals."

Unmet social needs describe factors that prevent people from experiencing positive health outcomes

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Figure 1
Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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Redefining Health

Social Determinants of Health

- SDoH have been described as "the causes of the causes"
- Provide a framework for understanding root causes that contribute to an individual's health, the reasons health disparities exist and how health equity is achieved by all people regardless of socioeconomic status
- Reflect a commitment to advocate for social justice and health equity
- Moves beyond defining health in terms of medical care

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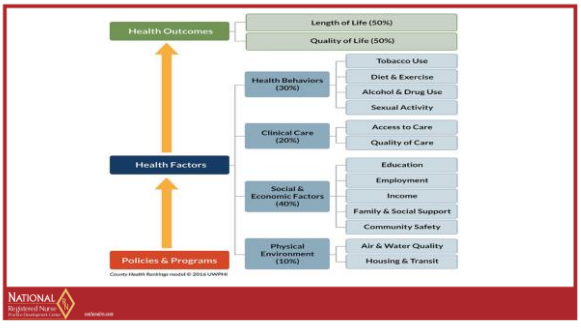

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In Closing
Leadership Tips to Achieving Equity Minded Team-Based Care

Lead Where You Stand

With the Patient and Family

- Serve as a patient advocate
- Initiate family, team meetings
- Demonstrate evidence-based practice
- Model
  - Positive health behaviors
  - Effective problem solving
  - Self-management support

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Lead Where You Stand

Within the Team

- Know and understand your role and the role of other team members; Be able to clearly articulate
- Represent the patient and their plan of care
- Engage in effective problem solving
- Communicate in a timely manner patient progress, changes in condition and plan of care

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Lead Where You Stand

Within the Healthcare Organization/Practice

- Engage in patient centered care strategies
- Apply principles of population health including matching patients with team-based care
- Support continuous data-driven quality improvement

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Making the transition to Equity Minded Team-based Care can be challenging but we can and must get there!

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Questions? Let me know:

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