Care Team Integration: 421 Fallsway

Team-based care—Where we've been and where we're going

January 2019

In 2016, we officially set out to become a health home. A health home delivers *person-centered* care that is *evidence based* and uses *data* to *continuously improve* the care we deliver. A health home has five clinical areas:

1. Access
2. *Team-based care*
3. Care management
4. Care coordination
5. Population health

Care teams are the most critical component to team-based care, and to achieving health home status as a whole. By bringing together a wide range of expertise and acting as a cohesive unit, care teams provide clients with integrated, whole-person care that feels comfortable, easy and safe.

Team-based care helps provide the right care at the right time by the person with the most appropriate level of training, experience and licensure.

- Cindy Hupke, Director, Institute for Healthcare Improvement (IHI)

Launching care teams in January 2016 was a big move towards making us a health home. As an agency, we held care team trainings, and together learned how team-based care can improve the health of our clients.

Almost three years later, care teams have become a big part of our work and have helped us greatly increase our care coordination. Looking back at that journey reminds us about what we set out to do—and how far we've come.

Why care teams?

Simple: For our clients. Since the 1990s, health care providers have been moving toward team-based care as a model proven to increase quality of care.

Since we opened our doors over thirty years ago, we've known that integrated, interdisciplinary care is the only way to help our clients navigate a range of physical, behavioral and societal challenges. To overcome homelessness, clients need a team that treats the *whole-person*.

Step by step, year by year, we've increased our ability to provide whole-person care. In 2016 that meant creating care teams. The care team model has been proven to improve client care in a number of ways:

"I like that everything is under one roof. If I had to run around to different people around the city to get what I needed, I couldn't have done it. I wouldn't have had the money or the ability."

—Armstead Hetherington, Advocate and client

- **More time with clients.** The more efficient the care, the more time providers have to spend with their clients, making for more meaningful interactions and increasing client access.

- **Better care.** Assembling a range of expertise around clients ensures that the care is customized and comprehensive, with providers who have different skill sets acting together to address the health needs of the whole person.

- **Increased self-management.** Putting a client at the center focuses providers on helping the client to manage their own care to the greatest extent possible.

Care team values

A successful care team relies on team members working well together. To this end, we adopted five principles to guide our work together in teams:

1. **Shared goals**

   The team—including the client and, where appropriate, family members or other support persons—works to establish client goals that reflect client priorities, that can be clearly articulated and that are understood and supported by all team members.

2. **Clear roles**

   There are clear expectations for each team member's functions, responsibilities, and overall team role. Together, these maximize efficiency, making it possible for the team to divvy up—and not duplicate—work and do more for clients.

3. **Mutual trust**

   Trust among team members results in a spirit of reciprocity and shared achievement.

4. **Effective communication**

   The team prioritizes communication and establishes channels and norms for clear, complete and candid communication.

5. **Measurable outcomes**

   To track success and failure, team members set measurable goals and track progress toward meeting those goals over time. The team continually strives to improve performance.

Checklist for effective team communication:

- ✓ *Systems integration*
- ✓ *Team meetings*
- ✓ *Shared space*
- ✓ *Coordinated workflows*
- ✓ *Shared reports and metrics*

Building an integrated, team-based practice

Developing a high-functioning care team model doesn't happen overnight, and it certainly couldn't be accomplished with a one-time launch. It takes careful planning, experimentation and time for the team

to fully develop. And even then, continuous improvement is key for long-lasting and efficient team-based care.

Integrated care teams fall on a spectrum of six levels of care coordination. On one end is *minimal collaboration*. Team members operate independently, with separate systems and little communication. On the other end is *full collaboration*. Team members communicate regularly—and so do the systems they use. During care team training in 2016, we read about this spectrum in A Standard Framework for Levels of Integrated Healthcare:

Before launching care teams, we fit somewhere around level three: *Basic collaboration onsite*. Staff members coordinated care, shared a facility (but not necessarily space), used separate systems, and had occasional formal meeting times. We've since taken steps to increase care coordination, including:

- Investing time and energy into clean and consistent EHR data entry and report development/visualization
- Forming multi-disciplinary care teams and monthly meetings
- Clarifying team member roles and responsibilities
- Introducing client panels and refining the empanelment process
- Developing a population health program, metrics, and goals

Next stage: Physical Team Integration at 421 Fallsway

To meet the needs of our clients, we're steadily improving care teams. Effective communication is the lynchpin in keeping the care team model together.

Creating shared systems and scheduling routine meetings have improved communication, but informal, in-the-moment communication between providers and across disciplines remains a challenge. Care teams meet only twice a month, and EHR notes and flags can be missed. What's more, traversing floors and wandering halls to deliver time-sensitive information to other providers takes a lot of time and resources and, sometimes, simply isn't doable. We're too big—and our time too valuable—to operate in this model.

The next step is for all care teams to sit and work together.

Why share space?

Shared space increases team communication—and team communication improves integrated health care. Having care team members sit together will improve care coordination for clients by:

- Increasing informal and spontaneous communication for in-the-moment problem solving and information sharing (cutting back on emails!)
- Reducing time spent trying to find and then traveling from one staff member to another
- Developing stronger relationships and a deepened sense of trust among team members
- Promoting the team to clients as one, cohesive unit working (and sitting!) together

Shared offices: Coming together around clients

We often talk about putting clients at the center of the care team—and positioning the care team around their needs. Shared office space helps us physically organize ourselves in that way. When not with a client, providers will sit together, rather than in individual offices organized by disciplines. Everyone has a "home base" that includes their own workstation, with a computer, phone and storage space, but the space is communal and collaborative. Team members come together for daily huddles, and when urgent needs arise, providers can share that information and adjust care plans accordingly.

Exam rooms: Meeting clients where they are

We meet our clients where they are. That's why we have community health workers, a mobile clinic and multiple locations throughout greater Baltimore. Shared space is a continuation of that work.

Each care team will have exam and interview rooms where they see clients. Use of rooms will be coordinated so that providers and clients always have a private space to meet. Providers will meet clients in a scheduled exam room. If needs arise that require additional support, providers can quickly communicate with their nearby colleagues. This will increase warm hand-offs, and decrease time and effort needed for clients to navigate referrals. In other words, *providers move—clients don't.*

Where we go from here

Integrating care teams is a big change. We won't make the transition all at once. Instead, we'll start by moving one team (the Yellow Team) into a shared space at 421 Fallsway on January 14, 2019. Together with those team members, we'll learn what works best for our clients and our staff. Yellow Team staff members will give feedback through weekly meetings and weekly "rapid surveys," designed to address immediate workflow and space issues, as well as a monthly survey. Yellow team clients will also be asked for feedback through regular surveys and during meetings with the Consumer Relations Committee.

The Magenta (West Baltimore), Jade (Baltimore County) and Orange (family and pediatrics) teams will experience some change, but they are already primarily integrated. Some staff at 421 Fallsway who are not on care teams may also move to accommodate the changes to the building's floorplan.

In the first half of 2019, we will identify and work with a construction consultant to map out the needs for future phases. With this information, we can begin to build the timeline for integrating the other three adult care teams in the 421 Fallsway building: Green, Purple, and Steel.

Throughout the process, we will post news, videos, timelines, quality measures, and more on the portal at www.hchmd.org/team-based-care. Staff and clients will also have the opportunity to give feedback through anonymous surveys, and staff will be able to discuss the move during All-Staff Meetings, In-Service Trainings and Brown Bag Luncheons.

References

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Videos

- Leap Doing the Work
- Collaboration in Health Care
- Health care should be a team sport