

**Optimizing the Care Team: Lessons Learned**  
*Best Practices, Critical Issues, and Site Examples*

# I Introduction

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Healthcare delivery has been moving towards a quality based model since the Institute of Medicine 2001 report: Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century<sup>i</sup>. As people live longer with co-morbidities, health care management becomes more complex across the spectrum of life and requires a more coordinated, patient centered health care delivery system. To maintain good health outcomes and improve population health among persons living with HIV, the HIV primary care model has begun to reflect principles related to the chronic care and patient-centered medical home models. Each of these models emphasizes multidisciplinary primary care teams, coordination of patient care, promotion of active patient participation and application of clinical practice guidelines. These models aim to improve efficiency and effectiveness of the health care delivery system and place central importance on the relationship between a patient and her care team and holding the relationship accountable to ensure accessibility, continuity of care, comprehension of services and care coordination.<sup>ii</sup>

In the HRSA/SPNS Workforce Initiative focusing on HIV practice transformation, over half of the 15 demonstration sites designed, implemented, and are integrating into their practice various collaborative Care Teams. Each Care Team has been designed to meet the sites' unique patient population needs and organizational contexts.

In the Fall of 2016, representatives from the SPNS Workforce Initiative demonstration sites formed a workgroup with the goal of extracting cross-cutting themes and exemplar case studies from a diversity of site environments and experiences. In this document, the Optimizing the Care Team workgroup presents a constellation of lessons learned at the project mid-point, including best practices, critical issues, and site-specific examples that highlight how broader operational themes look in real clinical context.

The best practices were compiled and refined by committee, representing invaluable lessons learned. In some cases, these lessons were based on rich existing knowledge of organizational development and the diverse needs of regional HIV patient populations, confirmed through experience with Care Team implementation. In other cases, they were based on real struggles, missteps, and adaptation – in other words, lessons learned the hard way.

Critical issues, meanwhile, were similarly compiled and refined, and represent core components of Care Team implementation that sites recognize as complex challenges, presenting in various ways, about which best practices have not yet been identified.

These issues tap into some of the most challenging underlying constructs of practice transformation, grant-based initiatives, program integration, and implementation science. As a workgroup, we are excited to present these Critical Issues as a contribution to a deepening academic and clinical discourse around practice transformation; it is rare that dynamic challenges, resistant to concrete or generalizable solutions, can be aired out for discussion and analysis.

This guidance tool is meant to be used by program teams looking to either design and implement or optimize their collaborative Care Teams. More broadly, this document is intended to contribute to the collective knowledge of a growing community of organizations interested in practice transformation, and agencies providing comprehensive HIV care and services.

# II Overview

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## Who needs this information?

This document was written with the following types of provider groups in mind:

- HIV service providers looking to improve patient outcomes by streamlining care
- HIV service providers managing changes in practice
- Provider groups or practices looking to implement a collaborative Care Team
- Existing collaborative Care Teams looking to optimize their operation
- Practices looking to implement a PCMH model
- Practices dealing with changes in Case Management credentialing

## What is a Care Team?

Broadly defined, a Care Team is a multidisciplinary group of providers who work as a team to meet multiple patient needs, with the goal of improving patient care, streamlining the patient experience, and improving patient outcomes. In addition to providers, a Care Team will also typically include patient-focused staff whose role it is to view each patient's care through a wide angle lens, coordinate care, track patient engagement and progress, address needs as they arise, and connect the patient to additional resources. Such team members may include Care Coordinators, Case Managers, Social Workers, and Peer Navigators.

A Care Team in operation will typically consist of four main components: task shifting/revised workflows; huddles; case conferences; community resources.

**Task shifting / revised workflows.** Redistribution of tasks from one care team member to another, usually from members with higher credentials to members with lesser credentials. Revising workflow and task shifting are deployed to create greater efficiencies among the healthcare workforce.

**Huddles.** Typically occur prior to start of clinic and includes a 5-10 minute gathering to discuss the patient care issues of the day.

**Case conferences.** When two or more staff persons from same or different units / organizations meet to discuss client (client may or may not be present). During the case conference, patient cases with specific needs are brought to the group for evaluation, discussion and plan of action to tackle their needs and find the best solution to their care. This can also be used to terminate services to individuals whom the organization cannot meet their needs and offer appropriate referral to other entities more qualified to provide the type of services needed.

**Community resources / extension of your team.** Creating partnerships with entities that provide specialized care, beyond the capacity of the organization. Mission-aligned organizations that provide a component, extension or enhancement to another unit's / organization's Care Team, usually through a Memorandum of Understanding / Linkage Agreement or other mutual contractual agreement. Organizations may also form or be members of a Consortium of providers that share patients and coordinate care.

## Why is a Care Team important?

Care Teams can further streamline the provider experience by redistributing patient care activities across providers and staff such that each team member operates at the top of his or her license, and the scope of each team member's role is clearly defined. Care Teams place patients at the center of clinical practice, and provide a formal structure that supports an integrated understanding of a patient's health concerns, goals, resources, and barriers. ***Particularly with respect to HIV, a chronic and often complex disease that affects and is affected by many areas of a patient's life, coordinated care is essential; an optimized care team provides well-coordinated care.***

## What do we mean by "optimization" of the Care Team?

Implementing the components of a Care Team can be a labor- and resource-intensive endeavor, and a sub-optimal implementation may result in added work and confusion for all involved, without a noticeable yield in patient care experience or quality improvement. We present best practices and critical issues with the goal of aiding in the optimization of Care Teams, such that programs are built in a methodical and sustainable way, effort is invested into high-impact outputs, possible barriers and complicating factors are anticipatable and built into program conception, and ultimately, that quality of care improves while provider effort is streamlined.

# III Best Practices

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The workgroup identified Care Team implementation best practices across five cross-cutting categories: Preparation; Staffing; Buy-in; Formalization; and Adaptability.

## 1. Preparation

While “implementation” suggests active building and changing, some of the most important Care Team implementation work happens during the initial preparation stage or the pre-implementation phase.

**Vision.** Have a clear and articulated understanding of what you want the Care Team to look like (i.e., team composition), how you want it to function, and what patient outcomes are anticipated as a result. Make sure your vision is aligned with industry requirements and service standards around you, including Medicaid and Ryan White. Maintain focus on this vision even as unexpected challenges and delays cross your path. Challenges may slow progress, but will not derail progress.

**Collaborative development.** Consult personnel whose roles will be impacted by Care Team operation, particularly those who are client-facing and those who liaise between providers or departments. This will strengthen the content of the program by maximizing resources, targeting needs, and addressing operation gaps from the beginning, and it organically promotes buy-in.

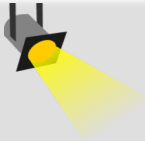
**Formative assessment.** Perform an in-depth assessment of current activities and workflows at the foundation of implementation. Prior to making concrete, understandable changes, there must be an articulated understanding of how current practice operates. This practice clarifies and communicates the scope and content of planned changes. This practice can be resource-intensive and requires skills.

**Workflow mapping.** Following a formative assessment of current activities, take the time to perform workflow mapping of, at minimum, the processes associated with Care Team operation, and ideally, all clinical operations. Workflow mapping is maximally valuable on multiple levels. It communicates processes in a clear, unambiguous, visual way that all personnel can refer to. It will often uncover gaps, inefficiencies, bottlenecks, or barriers that had been previously felt, but not identified. Workflow mapping is an aid to change management, because it anchors the often fraught ethos of change in discrete and observable activities. It is also of particular importance because it informs all Care Team participants – leadership, providers, and support staff – how to

get where they are trying to go from a variety of starting points, with a variety of organizational structures.

**Preparatory staffing.** Involve Human Resources in the Care Team practice transformation from the beginning. If there are new positions to be created and/or changes made to existing positions, official job descriptions will need to be generated and amended, as will the job descriptions of personnel who may not be involved in the Care Team specifically, but whose roles will change as a result of adapting to a new workflow. HR is a critical resource that should be used to its full potential in support of this effort.

Be on the lookout for executive, provider, and other Care Team support **champions**. These are individuals who independently believe in the value of a Care Team as a vehicle for practice transformation, and can advocate for it both within and outside the organization. Depending on the position and vociferousness of the champion, these individuals can enhance cultural acceptance of the workflow change, affect time, space, and funding resources directed towards the effort, and establish contacts that connect their home program with external resources and networks. ***A champion cannot be designated, they emerge.*** A champion who doesn't want to be a champion isn't really a champion.



**Coastal Bend Wellness Foundation** took a systemic approach to work flow mapping because not only would the Interdisciplinary Care Team Meetings be crucial to the intervention, it would also prove to be paramount to the success of the patient. Work flows were mapped by a team of core individuals who understood the goals of the intervention, and were also very familiar with the existing operating policies and procedures. It was important that the workflows reflected the standard operating procedures. Once workflows were mapped a larger group came together to review the them to evaluate the practicality and utility of the processes set forth. Understanding that both the workflows and SOP's were living documents the team amended and redrafted them until a usable product had emerged. As the participants to the Interdisciplinary Care Team Meeting were identified, the team at CBWF recognized that not only were the Providers, MA,'s and Case Managers an integral part of the meetings, but so were receptionists, patient navigators, behavioral health specialists and Pharmacy. In many instances we found that the latter also had insights to the patient that the patient had not shared with the care team, information that usually helped to put the puzzle together and give the team a better picture of what was going on with the patient from a global perspective.

The Cook County Health and Hospitals System (CCHHS) **Ruth M. Rothstein CORE Center (CORE Center)** embarked on the path to implement the Patient Centered Medical Home (PCMH) model in 2012. Workflow mapping was used as a tool to identify processes within the organization/systems to facilitate and enhance the implementation of a PCMH model. The overall goal was to improve the patient experience. CORE staff conducted 18 workflows with diagrams/narratives focused on eight points of patient entry into care as well as sub-processes. This involved over 25 different disciplines and 50 multi-disciplinary participants. Staff identified opportunities to provide more efficient patient care e.g., new patient appointments (NPO) processes resulted were split into two visits. In addition, the NPO appointment slot structure became staggered appointment times to more accurately represent when the patient would be seen by the provider. Patients access to care and registration processes were centralized via an ACCESS Line and Central Registration resulting in enhanced patient access, improved patient experience and minimizing disruption. All agents were cross-trained in the following departments: Central Appointments, Medical Records, Benefits and Registration. The process in which patients were seen during a clinic session was also revamped. The clinic flow was changed from a provider-centered to a patient-centered process whereby a patient was "roomed in" and the clinic team members went to the patient. This decreased patient movements from 8 to 2.3 times per clinic session. The workflow mapping process resulted in many organizational changes that not everyone was prepared to implement but that gave everyone an opportunity for growth to improve not only patient satisfaction but also staff satisfaction.

**FoundCare, Inc.** involved team members at all levels including front desk staff, medical assistants, providers, and case managers in conducting workflow mapping. Through this process, the team was able to identify many areas for improvement, Participants in the workflow mapping process frequently uncovered "misconceptions" or practices that were in place that didn't follow written policy or protocol, but that had somehow crept into the system and been passed along to new staff members when they came on board. FoundCare did the workflow mapping process prior to focusing on creating the interdisciplinary care team, and found it to be extremely valuable. One of the biggest identified needs was for cross-department and cross-site training, and a renewed focus on orientation and onboarding of new staff so that protocols and written policies are implemented as intended.





In addition to workflow mapping, **La Clinica** conducted interviews with all care team members to obtain perspectives on communication and collaboration within and across teams. This formative assessment guided training informed not only our understanding of what activities each role performed, but also what areas of strength as well as tension already existing within current and prospective team members, and how various roles communicated with each other.

**SHRT** advocated for continuous training and cross-training of personnel to prevent disruption in providing services due to staff absence (particularly in rural setting where it may not be as easy to find skilled personnel or to be in compliance with state/federal requirements).

## 2. Staffing

Staffing, whether by way of creating new positions, modifying existing roles, or formalizing task-shifting, is central to any change strategy. For the implementation of collaborative Care Teams within the context of HIV practice transformation, best practices include:

**Engage managers and department directors to help assess when it is appropriate to recruit from within, versus hiring new personnel to work in a project-specific role.**

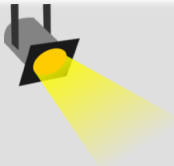
Identifying key talent within the organization and recruiting their involvement can contribute to buy-in and staff engagement, and it also can facilitate communication and collaboration amongst colleagues already familiar with one another. However, depending on existing relationships and/or inter-departmental dynamics, this can also at times work against the goal of collaboration, if territoriality or existing tensions are a problem. We have learned that frank consultation with managers at the outset can prevent disruptive Care Team dynamics during project implementation and operation. Transparency around the staffing goals and the hiring process can offset tensions among existing staff.

**Assign a Care Coordinator.** A Care Coordinator is a high-impact role. This person coordinates huddles and team meetings, liaises between departments and providers, fills communication gaps, and oversees individual care. Ideally, a full FTE is given to this role.

**Plan the structure of the Care Team with defined roles, and a defined scope for each role.** The Care Team should be comprised of specific individuals (rather than a generalized “representative from each participating department”), and each of these individuals should understand the contents, and limits, of their role on the team. The importance of this is partly in its instructive capacity for team members, and partly to avoid a situation in which one person does the job of 3 people, or is tasked with inappropriate responsibilities because it would seem to flow naturally from their designated duties. A common example of this is Care Coordinators taking on Case Management responsibilities which, depending on the case load, may be neither reasonable nor sustainable.

**Cultural and interpersonal tensions:** This is a difficult area to generalize or pin down, but it needs to be addressed. It is not uncommon for there to be tensions between staff/providers/institutions born out of the Ryan White/HIV world and staff/providers/institutions that come from the health center/FQHC world (at all levels – administration, facilities, Care Teams, etc.). Additionally, interpersonal tensions may already exist within teams, cultural issues may exist in which staff in one department

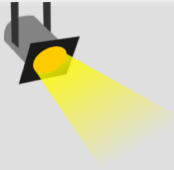
don't trust or hold hostility towards staff from another department, there may be territoriality particularly if any staff feel threatened by proposed changes. It is tempting to ignore or downplay the importance of these issues, since they can be subtle, convoluted, and/or emotionally-charged. We have learned from experience during this process, however, that these issues need to be addressed directly. At best, they can be worked through and resolved, and at minimum, they must be effectively worked around.



**FoundCare** has a long history as an AIDS Services Organization (ASO) and has provided medical case management through Ryan White funds for many years. It was a newer FQHC and integrating HIV care into the primary care setting created a number of challenges, including identifying staff for the new care coordination project. Initially, FoundCare had two Ryan White case managers who were co-located in the health center and served as a liaison between the medical providers and the rest of the case management team (the agency employs nearly 30 case managers). These two individuals helped obtain labs, reminded clients of appointments, and contacted patients' case managers as needed to coordinate specialty care. They also worked closely with the medical providers as social services needs arose. Between the two of them, they touched more than 800 people living with HIV/AIDS during their visits at the health center each year. One of them left the agency, leaving only case manager in this role.

At about the same time, the remaining case manager was selected to be the Care Coordinator for the new SPNS project. Since the project was new, his role wasn't clearly defined, and as he remained in the same co-located position, he continued to perform his previous function (for all HIV/AIDS patients in the health center) while trying to start up and facilitate the interdisciplinary care team and implement care planning. While that was happening, the local Ryan White funder indicated that he had to maintain a personal caseload of no fewer than 60 clients, following the established medical case management standards. Trying to complete the tasks of four full-time jobs can make anyone stressed out. Due to the "can do" personality of the Care Coordinator, he attempted to balance and do as much as he could. Fortunately, the overload was recognized relatively quickly, and his job duties were shifted to clearly focus his efforts on providing care coordination. All medical case managers were tasked with serving as the liaison between patients and providers (instead of relying on just one or two case managers to do this) and the Care Coordinator position was moved outside of the Ryan White funding so that the caseload standards didn't apply.

Now, the care coordinator has a "right sized" job to do with clear expectations and a realistic workload. The providers and other case managers still attempt to task him with things he used to do in the past, however, he has support from his supervisor to gently decline and refer those tasks on to the appropriate team members.



At **La Clinica**, careful and intentional care team optimization had to change course midway through our PTM due to changes in our funding environment from Ryan White and Medicaid. New licensing requirements for medical case managers accelerated changes in our teams, moving La Clinica's PTM to transform the Ryan White medical case manager role traditionally housed and supervised by social work, to a care coordinator role working within a nursing model. While this change was partially driven by external funding requirements, it was also consistent with an internal direction including a greater leadership role for nursing. Nevertheless, this was a difficult transition for our team, particularly for those that had been working with distinction for years as case managers, despite being unlicensed. Transition to this new model was further complicated by the health systems delays in implementing the new standards. This created much uncertainty, as staff were aware that changes "were coming", yet a firm start date was not clear from the external partners. Once La Clinica decided to move forth with the staffing changes based on its own timeline, program leadership met several times with staff most impacted by these changes to explain the changes and their rationale as well as to outline the steps La Clinica would take to make this transition over several months, and to discuss staff concerns and choices. As the transition also included development of new job descriptions and new supervision lines, program leadership worked with the HR Director to develop an appropriate process for this change. Including a senior level HR individual in this process was critical to ensuring a change that was in keeping with the organization's policies and procedures, addressed staff concerns regarding salaries and benefits, and allowed staff impacted by these changes to make informed decisions regarding the new positions. HR was perceived as a neutral party, with whom staff whose positions were changing could raise questions and concerns they did not feel comfortable asking in group settings. Program leadership also devoted time to have one-on-one meeting with staff to motivate, provide information, or hear concerns. Managing this change was difficult, but ultimately successful in that staff who chose to go through the change in roles felt committed to the new model, and those that decided to leave the organization by and large gave generously of their time to support the transition before moving on

At **SHRT** new staff recruited to provide primary care, had to be trained on HIV care and management. It was very important to address the care for HIV positive patients during the interviewing process to dismiss potential employees that would not be comfortable serving this patient population. One of the most important aspects to building a successful treatment plan and optimizing quality of life for people living with HIV, is a good relationship with the clinic staff. Unfortunately, lack of education and HIV-related discrimination still are prevalent in rural areas.

### 3. Buy-in

Participant buy-in is essential at the operations level of Care Team implementation, and extremely valuable at the leadership level. From our cumulative experience, we have identified the following approaches and insights as best practices for generating and promoting buy-in:

**Integrate grassroots feedback into program design and adjustment.** Particularly in an environment where changes are either directive and handed down from leadership, or largely manager-driven, integrating the needs and perspectives of front-line staff into the creation or adjustment of Care Team workflows is essential to generating and maintaining buy-in. As a general rule, if you define something, you support it.

**Institutionalize a buy-in model.** Formalize practices that can elicit and support buy-in, such as iterative feedback rounds, opportunities for participating providers and staff to publicize their work, established chains of command for resource requests, etc.

**Buy-in is an iterative process.** Buy-in up front does not guarantee continued buy-in. It is an evolving process, and requires patience and on-going attention.

**Identify provider and staff champions.** There are bound to be individuals who both believe in the concept of collaborative Care Teams, and approach change with a positive attitude. Keep an eye out for these individuals at every level of operation, and engage them as champions. Ambassadors within the personnel groups whose actual workflows are going to be changing can be invaluable in generating buy-in, affecting culture, and changing hearts and minds.

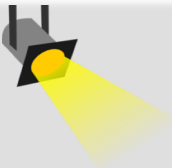
**Leadership support sets the tone for staff engagement.** If staff see that they are supported at the leadership level, that the initiative is seen and understood, they are more likely to be engaged. Further, when staff are able to trust that their operational needs will be listened to, taken seriously, and addressed by leadership, they are more likely to buy in because they feel supported and safe.

**An optimal buy-in strategy is one that is appropriate for the management structure of the organization.** Some organizations tend to develop programs from the bottom-up, which is to say that most operational procedures are developed close to the front lines, by staff and managers heavily involved with day-to-day operations, and leadership's role is to support, provide resources, and evaluate. Bottom-up strategies are appropriate for very large organizations, or organizations that have a tall management structure, in which those in leadership are widely distanced from the providers and staff executing interventions and working directly with patients. A bottom-up, or grassroots approach

tends to garner a lot of buy-in, because the people executing the implementation are also the ones planning it.

Other organizations tend to operate in a more top-down direction, in which changes are conceived of and designed at the leadership and senior manager levels, then rolled out as a directive to staff. Groups with top-down implementation garner buy-in with strong leadership and leader engagement (i.e., COO attending grantees' meetings and collaborating in small groups with providers). Part of top-down success is trust. Failure to deliver on promises from leadership results in lost trust and buy-in from project staff. Accounting for this from the beginning is important; set realistic goals with the amount of people that you have, with the resources that you have.

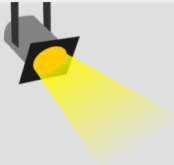
Buy-in at all levels is sometimes possible. Some sites have leadership support, provider-led initiatives, and patient involvement.



**University of Miami** used frontline staff as consultants when creating program plan. By dynamically incorporating input from stakeholders involved in the workflows, the program plan reflected a collective ownership of the PTM. In this way, input from those involved in the workflows and those who would ultimately be impacted by the implementation of the initiative reflected a reality-based and experience-driven product, versus one based on theoretical principles that lack firsthand patient interaction.

**One Stop Career Center of Puerto Rico** has instituted Transitional Care Coordinators (TCC) who facilitate linkages to community care and services after incarceration for HIV patients identified in PR Correctional facilities and facilitate and enhance access to care after incarceration.

**SHRT** involved members of the community advisory board in developing the PTM. The members of the Consumer Advisory Board receive patient feedback, both positive and negative comments. At the same time, the CAB members can interact with other clients to assess community needs in response to changes in the organization. Their input is crucial when working on policies that directly affect the provision of services.



From the beginning, **CBWF** understood that Buy-In from the staff working on the initiative would be crucial to the overall success of the intervention. This meant that staff from all levels of the organizational hierarchy would have to “believe” in what we were trying to accomplish and we felt we had those staff on board.

Sadly, very soon into the intervention we found that our current Medical Director, a maverick in his own right, was not truly onboard with the rest of team or the goals of initiative. In discussions and case conferences it was very apparent that he didn't solicit or want input from the rest of the team because in his mind he was the ultimate factor in the patient's successful health outcome.

At this point it became painfully obvious that we would need to identify another key provider to be a part of the intervention if we were going to be successful, and did so. Unfortunately, the Medical Director took the addition of the new provider as affront and saw her as a competitor. Consequently, he left rather abruptly essentially abandoning us and his patients.

Fortunately, because of the insight we gained by monitoring the individual buy-in from the start of the initiative paired with frequent discussions during the formation of the intervention we were able to be proactive in hiring additional Providers who were willing to be more collaborative in their approach to patient care and the intervention.

**La Clinica** employed a qualitative process to evaluate how changes to our care teams were experienced by staff. This process, called Most Significant Change, involved meeting with care teams every six months to obtain examples and “stories” from them that represented the most significant changes in the previous period. The groups then selected and ranked the most important stories, providing further context for the changes selected. Through this process, La Clinica was able to hear perspectives, both negative and positive, from staff. For example, the first major change made in our PTM, consisted of assigning specific medical case managers to work with a subset of medical providers. In the past medical case managers worked with all providers, so there was concern among managers that this change would be resisted. Through the MSC process, we heard from case managers that the change had made them feel greater clarity on who would cover them in their absence, as well as greater clarity from the medical team on who to call for patient needs.

While verbal feedback, and having an ongoing, systematic process for obtaining feedback, has been very useful, it's also been important to recognize the non-verbal communication. In our experience, buy-in must be developed on an ongoing basis, as new issues emerge, context changes, and new staff comes on board. We learned that although our management team sometimes said they agreed with changes, their behavior showed that they were not ready or committed to the change. We were more successful when we acknowledge that a change was taking us further than we wanted to go and taking smaller bites. Resistance is not something to overcome; it's something to learn from.

## 4. Formalization

A best practice that threads through all activities is formalizing processes, including policies, protocols, workplans, job descriptions, program/evaluation tools (i.e., logic models, theoretical frameworks), etc.

**Create formal policies and procedures that detail changes to workflow, staff involved, and training content and schedule.** Existing staff must be trained on new policies and procedures, and new staff will be on-boarded with the expectation of adherence to these policies and procedures. Performance evaluations and disciplinary steps must be able to rely on these documented policy and procedure changes as a baseline expectation, against which staff and provider performance is assessed.

**Formalize routine communication.** Care team meetings and huddles are of paramount importance to optimizing care team. ***Attendance and agenda structure should not be left to chance and availability.***

**Document and track evolution of partnerships and collaborations, both within and external to the organization.** Workforce capacity building, maximizing resources, networking – many aspects of Care Team implementation and operation are enhanced by partnerships and collaborations. These connections are sometimes counterintuitive, sometimes temporary or transient, and may therefore be lost to organizational history if they are not recorded and accessible. Including a living document in policies and procedures that captures these collaborations preserves these pathways of learning as part of the building blocks of the intervention. It also enhances the sustainability and replicability of the program.





**Foundcare** has formalized Care Team processes in the form of daily huddles and weekly care conferences, inclusive of specific member individuals, without each of whom the team would not function optimally. The main work product of the case conferences, and a key component of Care Team process formalization, is the Care Plan.

For us, the introduction of a multi-disciplinary Care Plan is a main key to success for this project. Previously, there was a medical treatment plan, a behavioral health problem list and treatment plan, an oral health treatment plan, and a case management care plan. Each team worked in a silo to meet the patient's needs. Having an interdisciplinary Care Plan helps focus the team on the "whole person" aspect of serving the patient, and helps team members understand the "bigger picture" that the patient is dealing with – which can help remove barriers to care and facilitate better adherence.

Attached to this document as an Appendix is a Care Plan template.

**One Stop Career Center of Puerto Rico** employs Transitional Care Coordination, a nationally recognized evidence informed intervention (Alison O. Jordan, October 2013). This model includes formalized case conferencing at two key phases:

- 1) First transitional care coordinator reaches out from the jail to community care coordinators / providers and schedules in-person or telephone or tele-conferences including the patient as practicable, to inform the jail-based services and discharge plan for after incarceration.
- 2) After incarceration, the transitional care coordinator reaches out to community HIV primary care provider and case manager to facilitate transition to the standard of care within 90 days after incarceration.

Case conferences facilitate transitional care coordination, connecting the client and the service team on behalf of and / or with the participation of the client during and after incarceration. Facilitating a dialogue and coordinating care helps foster a connection between the client, the transitional care coordinator and the community provider, setting the stage for a warm transition that provides social supports focused on addressing basic survival needs and other barriers to accessing care and treatment client after incarceration. Case conferences are augmented by the transitional care coordinator accompanying clients to healthcare and other services providers acting as surrogate family for this vulnerable population at a high-risk high need time after incarceration.

**SHRT:** As an FQHC, we entered into collaborations with different entities and medical services. One of our collaborations is with the University of Texas at Tyler, in which the School of Nursing, particularly the MSN-FNP program provides faculty members overseeing FNP-students providing primary care in a community clinic setting. Thanks to this, the organization and the university have identified the need to develop more detailed protocols to ensure that the students are provided with the appropriate knowledge of the population served, their needs and the typical clinic workflow. Both entities are working on it. The incorporation of OB-GYN services with an established Women's health clinic has provided the organization with the appropriate protocols for this specialty care, saving several hours of research and development; making it less stressful for providers.

## 5. Adaptability

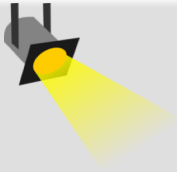
While it is difficult to prescribe specific activities that amount to “adaptability,” our experiences implementing and operating our collaborative Care Teams has taught us that the *ability* to adapt to change and unexpected circumstances is essential.

Practice transformation initiatives are occurring in a time of fast-paced change in the health care environment. Clinics open, clinics close, clinics become FQHCs, clinics change model due to external funding requirements, public and private insurance processes change, etc. Particularly for a project that is built to coordinate multiple positions across multiple departments, the only guarantee is that there will be change and movement. The ability to keep moving forward when met with unexpected challenges will determine the success or failure of Care Team operation.

**Find ways to break down barriers, overcome barriers, or work around barriers.** The only guarantee in this whole process is that barriers will arise. There is no singular way to address them, and it’s important to keep in mind that just because a barrier can’t be eradicated doesn’t mean that it will halt progress. Some barriers can indeed be eradicated or broken down, but other issues may be intractable and must be leapt over or worked around. An imperfect pathway, as long as it leads to where you want to go, is perfectly fine.

**Balance adaptability with dedication to core program components.** Staying adaptable while maintaining the core elements of the implementation and/or maintaining fidelity to the original model is a challenge. It requires attention and intention.

**Actively seek out elements of Care Team operation that need adjustment.** After so much planning and implementation effort, so much selling the idea of the project to leadership and staff who may be resistant, so much assuring funders that your plan is sound and backed by evidence that promises success, it can be very difficult to acknowledge weaknesses or elements that need adjusting. The reality is that no matter how perfect a plan is, there will always be tailoring that needs to be done in order to optimize fit. This tailoring is an iterative process, and is best sought out proactively, rather than engaged in reactively.



At the **University of Miami**, project activities have been refined over time. Through examining our processes using workflows, the processes described in them were dynamically reviewed and updated. Workflow efficiency and streamlining improved over time in that the practical day-to-day use of the workflow after PTM implementation highlighted areas that could be improved and optimized. Additionally, by using workflows to train staff, other areas of improvement and editing were recognized.

At **La Clinica del Pueblo**, we transformed our monthly care team meetings from a place to review patient cases, which became unwieldy and not productive with the entire team present, into a setting for discussion of population level data, strategies for quality improvement, suggestions for workflows, and trainings. For us, this change provided a needed forum for this level of Care Team engagement, which didn't exist previously. We are still working on how to further maximize this time.

Adaptability has always been one of the strengths of the **CBWF**, we understand that despite all the planning, workflow mapping and policy formation, things will change; unseen challenges will inevitably present themselves forcing us to adjust our course to a specific set of goals. While we planned a very measured introduction of patients into the initiative, our plan changed quickly after the abrupt closure of the only other HIV provider in the area. We were suddenly faced with an influx of over 300 patients instead of the 50 we planned for in the first year of the intervention. Shortly after our Medical Director, left deciding he didn't want to be a part of the PTM, however in true fashion we regrouped, re-staffed and continued the journey onward to what we have seen to be a very successful implementation. It's important to understand that no one person holds the keys to success in the implementation of the PTM, but that it is a concerted effort. Individuals, processes, workflows and policies all have to be adaptable if you expect to have any sort of true success.

# IV Critical Issues

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As we have been reflecting at this midpoint on best practices and lessons learned, we have also identified some key areas of practice that have been the most difficult to address in any generalizable way, but which have played defining roles in our implementation experiences. The value of identifying, considering, and articulating these critical issues is to raise a flag of warning for other groups that these issues – often complex, sometimes subtle or mired in larger unmovable constructs - may arise and require special attention. Troubleshooting will need to be an individualized effort based on the unique environment of each agency and the political, social, administrative, and financial context in which it operates.

We recommend that groups interested in implementing a collaborative Care Team, or working to optimize their current Care Team, take some time to review the following critical issues and examples, discuss whether any of them resonate, and if so, begin brainstorming problem-solving approaches. It is never too early to fold these concepts into your framework and develop language around concerns and challenges.

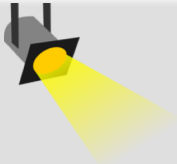
## 1. Provider/staff resistance

In general, structural issues tend to be more straightforward to address than organizational culture or personality issues. When it comes to acceptability and buy-in, regardless of engagement strategies employed, we have found that there are sometimes either individual personalities involved, or pockets of organizational culture, that make resistance and conflict seem intractable. The following examples reflect different ways that resistance can show up in Care Team operation.

**Words vs. action: when people say “yes,” but their behavior says “no.”** Occasionally, someone involved with activity change will express willingness to take on new practices, but their behavior suggests resistance. This behavior can come in the form of negative attitude, simply not adhering to new practices, or even performing behavior that obstructs new practices from operating.

**The “nay-sayer” /opposite of a champion:** We have had a few instances in which a key player is known to not be on board with Care Team implementation, or is even bad-mouthing the program to others. This is tremendously difficult to address. A provider or staff member central to Care Team operation who is not aligned with the mission of the project can sway culture, and even prevent the practice transformation entirely.

**Territorial departments or staff groups:** As mentioned earlier, adjustments to workflow and task shifting can raise anxieties and insecurities, which can breed territoriality and an unwillingness to let go of some areas of responsibility. Animosity or resentment across departments or staff groups can also slow progress considerably.



- Approval from the top does not mean buy in at the intervention level and cultural challenges include race, ethnicity and class as well as bureaucratic hierarchy. Take some time to assess the landscape and identify supporters as well as detractors. Detractors that are converted may become your strongest supporters. In NYC, one community case manager thought the proposed approach replicated what they were already doing – absent any documented outcomes. By focusing on documented health outcomes, the intervention was nationally recognized. Before that the biggest critic had already become the strongest supporter.
- In Puerto Rico, those who signed Linkage Agreement were skeptical about joining a Consortium. What's in it for me? Who will pay for the space and refreshments? Became an openness to share meeting space and clients once the benefits of working as a collaborative were realized - fewer missed appointments, shared patient navigators and emergency contacts were only a few of the shared benefits.

## 2. Staffing

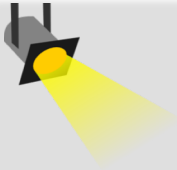
Staffing presented one of the most protracted and ongoing challenges to our Care Teams. Whether one needs to add staff, retain staff, or ensure proper licensing for staff, a complex and changing regulatory landscape intersects with funding limitations, specialized skill set requirements, and high work loads to create a perfect staffing storm.

**Difficulty hiring.** The hiring process can take time, and the more specialized the skill set required, the more difficult this step can be. A Care Team that does not have representation from key collaborative areas is not fully operational, but finding the right team member is also of utmost importance.

**Attrition.** Some turnover is a natural part of any clinic environment, but high turnover can be a sign of acute problems, burnout, or low morale. Losing key players in a Care Team workflow can also present a significant obstacle at any point in implementation or operation. Retention efforts, particularly identification and acknowledgement of underlying drivers of attrition, need to be a priority focus.

**Core competencies vs. licensure requirements.** Particularly within the constellation of mental health service providers for HIV clientele, there can be a conflict between the core competencies that you need to fill a position and the licensure requirements for the individual to fill that job title. The licensure requirement is essential because it allows for reimbursement coding for services provided, but it can be very difficult to find a candidate with the required licensure, who is also appropriate for the work content and able to accept the salary offered.

**Job descriptions in a union environment.** For unionized staff, adding or amending existing job descriptions can be a tortuous path. Furthermore, in a union environment, depending on the collective bargaining agreement in place, when a team member leaves, there can be an automatic internal placement provision in place based on seniority, rather than competencies specific to the Care Team workflow.



At **CORE Center**, workflow redesign was a challenge to navigate within a union staff environment. Through the workflow mapping process, we were able to identify several gaps in service. A key redesign in organizational procedures was the centralization of the Access Line and Central Registration. This organizational transformation required the redeployment of existing staff and redefining of union positions in order to provide a streamlined, centralized and efficient delivery of services to our patients. Staff came from two Human Resource departments (based on funding) and two different unions. The Executive Director and the PTM Project Manager held discussions with the staff and union leaders. It was crucial that the redeployment of the positions were within the core construct of the job descriptions and that they continued to remain as union members. The transformation process was facilitated by the Cook County Health and Hospitals System leadership since as a whole since the system was implementing the changes necessary to improve access to care, efficiency and the patients' experience.

**SHRT:** Complying with the State or Ryan White Administrative Agencies can make it difficult to find staff to comply with the requirements for certain positions. i.e. Medical Case Managers are required to have a Bachelor's degree on certain areas, while a Registered Nurse or a Licensed Vocational Nurse with a Associates Degree are not eligible to apply for that position.

### 3. Change Management

Many of the challenging themes shared by sites had less to do with the content of the proposed activities, and more to do with the act of making workflow and cultural changes in general. We have found that it is the act of change itself, on a collective and organizational level that is difficult, regardless of the merits or promise of the new state.

**Workflow changes.** To implement any effective change, staffing and workflow changes were necessary across sites. Implementing new processes into an existing framework was a challenge. These changes required buy-in from existing personnel, engaged leadership, and an overall culture shift.

**Culture shift.** Some of the largest issues we experienced involved ongoing efforts to change culture and engage leadership. Cultural change was described by one workgroup member as being like an ocean tide, and clinical practice is a ship. Tides are invisible, but undeniably powerful. There is no direct act that can change a tide, but a ship trying to sail against it will be constantly battling and not making much progress. Similarly, organizational culture is difficult to redirect, partly because it's ephemeral and intangible, and partly because it is a product of myriad unknown but real components.

**Implementing new positions and changes in supervisors.** Moving around responsibilities, introducing new staff, and changing an individual's supervisor are delicate maneuvers, and every individual is going to react differently. In our experience, common responses to these changes included an underlying fear of job security (i.e., "If someone new is coming in to do some of what I'm currently doing, will my job be made obsolete?"), reluctance to work in cooperation with people or departments that are unfamiliar, and a general resistance to learning new processes in an environment where many staff feel they are already working at capacity with too few resources at too little pay.



## Next steps / pros and cons of optimization

While optimization would ideally happen quickly, systems change takes time. Balance the competing demands of successful implementation with a sustainability integrated approach requires patience and communication. Building trust and demonstrated process improvements are key building blocks along the way.

**SHRT:** Always include your staff, at all levels to improve buy-in. We have promoted the creation of educational videos by our staff. This not only boosted morale, but encouraged staff to participate and get in compliance with requirements at local, state and federal level.

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Appendix A



Date:

EPIC CARE PLAN

Patient Name:		Age:	Patient Language:		Patient ID:
Address:					
Education Level:			Phone:		NOE Expiration:
Completed By: Roosevelt Charles			Next NOE Appt:		
Provider: Pascal Gedeon		Case Manager:		Peer: Sheila Evens	
Last Lab:	CD4:		Viral Load:		
Last Medical Apptmnt:		Next Lab	Apptmnt:		
Last Dental Apptmnt:		Next Dental	Apptmnt:		
Last CM Appointment:		Next CM	Apptmnt:		
HAART Regimen:					
Other Medications:					
Pharmacy:					
Allergies:					
Status of Chronic Conditions:					
Vital Signs:	Assessment	Result		Assessment	Result
	Skin/Appendage			Ostomy Bag	
	Height			Foley Catheter and Bag	
	Weight			Nephrostomy Tube and Bag	
	BMI			Walker	
	Ideal Weight			Wheelchair	
Lab Results:	Date	CD4	Viral Load	eGFR	
Active Problems:					
Preventive Services Due:					
Specialists/Other Providers:					
Hospitalizations/ER/ Urgent Care:					
Date Met:					

Screening/Identify Problem:	Assessment	Screened	Needed
	Behavioral Health	X	X
	Oral Care	X	
	Food Panty	X	
	Legal Aid Assistance	X	
	Substance Abuse Treatment	X	
	Transportation	X	
	Other: _____		
Biggest issues:			
Risk Factors:			
Barriers:			
Strengths:			
Goals:			
Timeline:			
<i>Notes</i>			
<i>Strategy (Include Advance Care Planning)</i>			
<b>Case Management:</b>			
Biggest issues:			
Risk Factors:			
Barriers:			
Strengths:			
Goals			
<b>Behavioral Health:</b>			
Biggest issues:			
Risk Factors:			
Barriers:			
Strengths:			
Goals			

<b>Peer Advocate:</b>	
<b>Biggest issues:</b>	
<b>Risk Factors:</b>	
<b>Barriers:</b>	
<b>Strengths:</b>	
<b>Goals</b>	
<b>Patient Input:</b>	
<b>Case Manager Signature:</b>	
<b>Provider Signature:</b>	
<b>Patient Signature:</b>	

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<sup>i</sup> Institute of Medicine. Crossing the Quality Chasm: A new Health system for 21<sup>st</sup> Century. March 2001. Available at [Http://www.nap.edu/books/0309072808/html/](http://www.nap.edu/books/0309072808/html/)

<sup>ii</sup> Beal, A. C., Doty, M. M.; Hernandez, K.K. S. and Davis, K. Closing the divide: how medical homes promote equity in health care. Results from the Commonwealth Fund: 2006 Health Care Quality Survey. June 2007.