Team-Based Care Coordination: Is it real?

According to a recent Agency for Healthcare Research and Quality (AHRQ) publication:

"Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient"[1].

This excellent publication then mentions "Teamwork" as a key care coordination approach, and lists specific care coordination/teamwork activities that include:

Establishing accountability and agreeing on responsibility.

Communicating/sharing knowledge.

Helping with transitions of care.

Assessing patient needs and goals.

Creating a proactive care plan.

Monitoring and follow-up, including responding to changes in patients' needs.

Supporting patients' self-management goals.

It is well established that the following are all fundamental to the concept of high functioning care teams[2]:

Team commitment to a unifying patient goal

Shared accountability towards achievement of aligned patient results

Team actions guided by both an integrated plan and influential leadership

Ability to make coordinated/timely adjustments in delivered care required to meet both expected and unanticipated changes.

As in any team dealing with a dynamically changing environment, shared "situational awareness" is critical to effective team performance. In complex care delivery, shared awareness must address key questions:

What is the current state of the patient, the current "integrated" plan and relevant history?

Is the current plan working? If not, how do we best adjust the plan to achieve goal?

Are all team members "on the same page"? Is the current plan the best our team can deliver? How can the combined experience/expertise of team members be best used to leverage the power of the entire team?

The answers to these questions dynamically change, so the whole team needs to maintain an accurate, current, unified perspective with shared situational awareness of both changes in status and of the impact of change to each person on the team. This can only be achieved with the support of a coordinating team plan.

What is a care plan? For our purposes in discussing teamwork-based care coordination we adopt the following HL7 definition[3]:

"The Care Plan represents the synthesis and reconciliation of the multiple plans of care produced by each provider to address specific health concerns. It serves as a blueprint shared by all participants to guide the individual's care. As such, it provides the structure required to coordinate care across multiple sites, providers and episodes of care."

These principles must guide the organization's decisions on how to build a team culture that includes dynamic leadership for care coordination and the technology tools for timely data collection and effective communication.

[1] https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

[2] https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-Values.pdf

[3] http://wiki.hl7.org/index.php?title=Care_Plan