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Leveraging Interprofessional Team-Based Care Toward Case Management Excellence

Part 2, Team Development, Interprofessional Team Activation, and Sustainability

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ABSTRACT

Health care teams are constructive and efficient ways to approach, assess, coordinate, plan, and facilitate the client-centric and population-based care. Some iteration of team is in place across most practice settings, comprising different professionals and specialists, from multidisciplinary, interdisciplinary, and transdisciplinary to the most recent interprofessional model. This 2-part article series sets the tone for how interprofessional team-based care (IPTBC) empowers the care process. Part 1 focused on the history and fundamental concepts of interprofessional models, with outcomes to promote the value proposition for IPTBC implementation. This Part 2 article focuses on the identification of seminal group development and team processes. An original model, the Interprofessional Team Activation Cycle (ITAC), is presented, as well as defined tactics for professional case managers to promote successful implementation of IPTBC in their organizations.

Purpose/Objectives:
This article:

1. Identifies deterrents to implementing IPTBC;
2. Explores timely and successful IPTBC models across the industry;
3. Discusses models of group and team development;
4. Explores the ITAC for professional case management; and
5. Identifies 10 tactics for case managers to sustain successful IPTBC.

Primary Practice Setting(s): Applicable to all health and behavioral health settings where case management is practiced.

Findings/Conclusions: Shifts in reimbursement models, organizational cultures, and client populations have yielded emphasis on the swift IPTBC implementation. In addition, the recognition of team development as a fluid process endemic to achieve client-centric outcomes and organizational return on investment mandates a keen eye to the phases of a team implementation, especially those that are interprofessional in scope.

Implications for Case Management Practice: With case management so closely linked to the fiscal imperatives of organizations, engagement in IPTBC is a necessity for every practice setting yet not always implemented properly or successfully. Poor team collaboration contributes to unsuccessful outcomes for clients, increased costs, and concerning quality and risk management issues for the organization. Models focused on group development serve to support how health and behavioral health organizations consider and implement interprofessional teams.

Key words: *case management, health care, interdisciplinary, interprofessional, Interprofessional Team Activation Cycle, multidisciplinary, nursing, population health, social determinants of health, social work, transdisciplinary, value-based care*

Interprofessional team-based care (IPTBC) incorporates distinctly educated members of the workforce to leverage the most inclusive perspective to achieve client-centric care. Although IPTBC has presented as a long accepted reality for the health care industry, not all organizations have fully embraced or integrated the model as intended. Models can easily morph to iterations and alterations defined by the cultural minutiae of each entity. As a result, what starts as an IPTBC product can easily turn into a siloed, multidisciplinary effort, far from the intended vision.

Interprofessional teamwork is viewed as a main element of client-centered treatment across the industry. The practice has become especially popular in specialty sectors and programs across rehabilitation, palliative

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care, intensive care units, and emergency departments (Becker et al., 2017). These unique teams have equally become adapted as a mainstay of behavioral health programs, particularly the newest iterations focused on integrated and collaborative care. In the world of the social determinants of health (SDoH), the incorporation of all disciplines and expertise is viewed as a "must" to ensure appropriate attention to clients and communities (e.g., case management, social work, behavioral health medicine, nutrition, pharmacy).

Yet, despite being recognized as an optimal mode to deliver safe and effective care for clients and communities, IPTBC implementation continues to be slow across practice settings. Although accreditation entities and subject matter experts believed that first setting an academic framework would allow for successful implementation and expansion of IPTBC, this action has been a daunting effort.

Part 1 (Fink-Samnick, 2019a) of this article series set the critical foundation for IPTBC comprehension by providing the historical context and value proposition for interprofessional teams including their components, progression within academia, and integration across the industry. Part 2 of this article series further explores successful IPTBC programs and foundational group development processes for case managers to consider in evolving their own teams. Attention is placed on the industry drivers and deterrents that can influence model advancement. The Interprofessional Team Activation Cycle (IPTAC) is introduced, an original model for professional case managers to phase in and approach interprofessional team-based efforts. Finally, 10 tactics are provided for the workforce to leverage their efforts to build sound and enduring interprofessional teams and accompanying processes.

Industry Drivers

The value proposition and successful outcomes demonstrated by IPTBC across disease states and chronic health conditions have a majority of organizations working to employ iterations of the model. As identified in Part 1 (Fink-Samnick, 2019a), these teams have been successfully implemented in management of chronic disease and populations with more complex health and behavioral health needs (e.g., diabetes, heart failure, respiratory illnesses, co-occurring physical and behavioral health manifestations). Yet, deterrents interfere with both a more abundant use of IPTBC and consistent implementation. This section first explores further industry drivers to IPTBC and then expands on the factors that limit putting the model into more common practice.

IPTBC and the Social Determinants of Health

The merit and popularity of IPTBC are being leveraged in response to the SDoH. The costs associated with the SDoH have the industry riveted, with a majority of payers, health systems, and organizations stepping up to evolve reflective initiatives. New numbers and outcomes continue to drain the financial reserves of every provider, mandating a shift in care practices and access to that care, reimbursement methods, and resource availability:

- National health expenditures of $3.5 trillion for 2017 (Centers for Medicare & Medicaid Services, 2019);
- More than 50% of readmissions caused by the SDoH alone (Gooch, 2018);
- $1.7 trillion spent on 5% of the population (Sullivan, 2017); and
- For Medicaid patients, health systems paid on average 36 cents on the dollar, roughly one third of Medicaid patients visiting the emergency department at least four times a year (AVIA, 2018).

With the SDoH an industry priority, a majority of health systems and organizations are dedicating their fiscal and human capital to developing population-based programs and initiatives. For the past several years, the industry has experienced a rising number of mergers and acquisitions, the highest numbers to date. Insurers, providers, and related stakeholders are forging their resources to ensure financial sustainability that allows them to render care for their clients and communities with both, costly and more complex health and behavioral health needs. Many of these related transactions target the rapidly expanding numbers of medically underserved areas (MUAs) and populations (MUPs) across the United States. The MUAs have a shortage of primary health services for residents within a particular geographic area, whereas the MUPs experience the shortage for a defined group of people. More than 6,600 communities around the United States carry the MUA designation, which is defined by the Health Resources and Services Administration (HRSA). With these areas facing economic, cultural, and/or linguistic barriers to health care, they are closely associated with the SDoH (Fink-Samnick, 2019b; HRSA.gov, 2019). Despite the clear benefits of engaging interprofessional teams for persons and populations either facing, or at risk of, the SDoH, challenges abound.

The Camden Coalition Core Model

A number of successful examples of IPTBC can be found across the collaborative endeavors of providers, payers, practitioners, and their communities. The Camden Coalition is one of the most successful interprofessional nonprofits in the industry. Camden, NJ, received critical attention in the media several years ago when it was identified that as high as 42% of the region lived below the poverty level. Using a client-centered focus, the program renders care for

An interprofessional team of nurses, social workers, and community health workers visits participants in the community to reconcile their medications, accompany them to doctor's visits, and link them to social and legal services.

people with complex health and social needs in and around Camden. The program's successful programming and outcomes in addressing chronic illness and social barriers to care have prompted adoption of the model across the country (Camden Coalition of Healthcare Providers, 2019a; Guy, 2013).

The Coalition has successfully embedded IPTBC amid target populations through use of its Core Model. An interprofessional team of nurses, social workers, and community health workers visits participants in the community to reconcile their medications, accompany them to doctor's visits, and link them to social and legal services. They employ a unique care management intervention that embraces the COACH framework, shown in Figure 1. The framework supports the team's ability to build authentic healing relationships that advance client self-efficacy. Clients receive a customized care plan centered on their distinct goals and wishes, which help them realize their highest level of health and well-being (Camden Coalition of Healthcare Providers, 2019b). The COACH manual and reference guide are accessible on the Camden Coalition website (www.camdenhealth.org).

Industry Deterrents

One would think that the promising outcomes and evidence attributed to IPTBC would secure the model's place across the industry. Yet, a number of factors impede this reality, while grossly impacting the quality of care process.

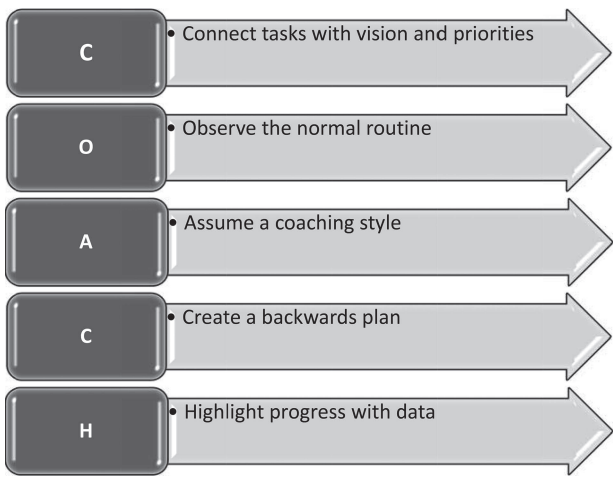

FIGURE 1
The COACH framework. COACH program elements from Camden Coalition of Healthcare Providers (2019b).

Workforce Retention

First, the current high level of workforce retention difficulties across health and behavioral health practice settings is one of the top challenges faced by the industry. This dynamic makes for fluid staffing patterns, as well as interprofessional team members. A variety of disrupters contribute to this dynamic, notwithstanding the maneuvering of complex and overwhelming demands of electronic health records, and the sharp uptick of workplace violence directed at frontline professionals, whether perpetrated by clients or fellow staff. Rampant stressors emerge from dealing with factors as the constant balancing between client life and death, the intense emotions of client and caregiver coping, not to mention frequent dysfunctional family reactions. A revolving door of reimbursement and regulations has professionals functioning on overdrive. As a result of these issues, burnout of today's health care workforce is at an all-time high, prompting a critical look at frontline care processes.

Workplace violence has taken an equally heavy toll on frontline professionals. News stories appear daily across media outlets detailing the reality of violent actions toward practitioners. Recent outcomes from the Occupational Safety and Health Administration show as high as 75% of the nearly 25,000 assaults and other workplace violence reported annually in the United States occur in a health care setting. Health care workers are also four times more likely to be the victim of a violent workplace event than any other private sector employee (Lasky, 2019).

Those persons who were victims of violent incidents warranted considerable time off, on average 112.8 hr per year of sick, disability, and leave time (excluding short- and long-term disability). This amount is 60.6 hr more annually than colleagues who had not experienced a workplace violence incident (American Society of Hematology, 2018).

The overall impact of employee retention affects every discipline, practice setting, and thus dimension of client care. Retention challenges also mean little to no ability for a stable workforce, let alone interprofessional team composition:

- *Behavioral health*: Roughly 59.5% of organizations had clinical staffing levels below their

threshold, with only 38.2% noting their staffing was adequate (Miller, 2018).

- *Medicine*: Average national burnout rate for physicians is 54%, with costs between $500,000 and $1 million to replace one practitioner (Rosenbaum, 2018).
- *Nursing*: 43% of new hires leave their jobs within 3 years; turnover for a bedside registered nurse resulted in the average hospital losing up to $8.1 million annually (Streamline Verify, 2016).
- *Social work*: 30%–45% of the workforce leave within 2 years, with turnover rates 215% higher than other roles (Public Consulting Group, 2018).

An unstable and fluid workforce translates to inability for organizations and their programs to develop the high level of cohesion mandated by interprofessional teams.

Workplace Bullying

Second, workplace bullying's presence in health care impedes team collaboration, especially the development of optimally functioning interprofessional teams. Record levels of workplace stress contribute to the health care sector having among the highest incidence of workplace bullying among every workplace (Farouque & Burgio, 2013). Frustration with routine, on-the-job pressures becomes misdirected at colleagues. This action, in turn, manifests as unhealthy and often volatile communications and interactions between members of the workforce. Bullying is an interprofessional sport that no discipline gets to sit out.

The power hierarchy of health care organizations further enables bullying to be embedded in staffing patterns. Talking down to, devaluing, and sabotaging staff become regular occurrences across organizations. Antagonism, disrespect, and avoidance become acceptable behaviors. These behaviors create a negative atmosphere, though become the organizational norm. Misused power among care team members is enabled by an organizational hierarchy that promotes insolent communication patterns. Members of the C-suite (e.g., leadership, physicians) bully clinical professionals (e.g., case management, interprofessional team members), who then become empowered to bully those perceived below them in the pecking order (e.g., nonclinical staff, paraprofessionals, housekeeping staff) (Neckar as cited in Nesbitt, 2012).

The impact of bullying on interprofessional dialogues, and thus client quality and safety, has been the focus of a number of recent studies. Data show that 75% of workers are affected by workplace bullying, whether they experience the dynamic as a direct target or as a witness (Comaford, 2016). Intimidating and unruly behaviors of all disciplines fuel medical errors and lead to preventable adverse outcomes. Disruptive physicians have 14% more complications in the month postsurgery than clients who are treated by surgeons with better bedside manners (Cooper et al., 2017). This is a scenario many case managers can unfortunately relate to. Imagine, a hospital case manager (HCM) is working with a client scheduled to be discharged to a skilled nursing facility for continued care. The HCM is approached by the client's spouse, who shares that her partner is in extreme and uncontrollable pain, feels hot to the touch, and appears to have new darkly colored fluid weeping from the surgical site. The HCM pages the attending physician who yells in the phone, "You know the partner is a worrier and overreacts. I saw that lady earlier and all was fine. Get her transferred today." Visions of readmission penalties dance through the HCM's head. The physician advisor is busy with another emergency, with the ambulance that is on the unit. The client is transferred, though readmitted within 36 hr for a rampant infection. Those often present organizational stressors to discharge the client can easily outweigh best ethical case management practice. The HCM's primary obligation to advocate for client's safety first and foremost is dismissed.

Time as Luxury Versus Reality

Finally, change is a constant in health and behavioral health settings. Yet, the successful advancement of any organizational change takes time, including the execution of innovative teams. As most case managers know, time is a luxury that escapes most, if not all, organizations. Return on investment (ROI) of any fiscal or human capital is traditionally expected within 3–6 months. One might as well break out a magic wand to accomplish the task. As a result, the speed at which successful outcomes are expected is equally swift. Organizations too often have a reactive, as opposed to proactive, mind-set, going full steam ahead to resolve a presenting problem. Cookie-cutter implementation is trialed, though one reality is usually dismissed; success of an effort in one organization will not guarantee that same success in another environment. The wide range of cultural nuances that exist across each organization does not simply allow for it. Examples of these nuances are displayed in Box 1.

Ask any seasoned case manager about the value of starting any change effort with a pilot project or gradually phasing in a new initiative. This type of intentional effort may involve a more concerted and timely front end effort but will take far less time on back end when done methodically. Unfortunately, the time commitment required for proper trial and error is not traditionally on an organization's radar. However, the industry must shift this mind-set to ensure meaningful, effective, and efficient interprofessional team efforts.

BOX 1
Examples of Organizational Cultural Nuances That Impact Change Management Processes

- Size and scope of the organization
- Target populations served
- Payer mix
- Value-based care mind-set and operationalization
- Workforce composition
- Organizational hierarchy, and
- Cultural factors (e.g., faith-based, military, rural community, inner-city, retention challenges)
- Leadership styles (e.g., autocratic or top-down, authentic, servant)
- Financial status (e.g., profit, non-for-profit, safety-net).
- Case management operations (e.g., reporting matrix, department staffing composition, staffing model, roles, and functions)
- Support for, and
- Realistic understanding of change management processes
- Unique interpretations and applications of IPTBC

Group Development Models

A number of successful models have been developed to support and advance both group and team processes. Their intent is to allow for the normal maturational processes required by any work group of diverse-minded persons to facilitate a task at hand. New iterations of these models occur daily to account for a wave of innovation shifts as the new generation of virtual teams. However, there must still be attention to the foundational processes that occur, from engagement and choosing of group/team members to successful completion of the assigned work/task.

This section includes four influential models that have been widely acknowledged across every industry and sector. An original model for professional case management appears at the end of the section. That model draws on the foundational elements of its predecessors to support interprofessional team processes across health care. Table 1 includes all five models detailed in this section and compares their stages/phases.

Tuckman's Stages of Group Development

Those who have studied productive teams are usually familiar with Bruce Tuckman's seminal stages of group development (Tuckman, 1965). His research into the theory of group dynamics set the foundation for group and team development used across a variety of sectors, with the primary stages of:

- Forming
- Storming
- Norming
- Performing

An additional stage, "adjourning" was added over time to acknowledge that the team goals have been accomplished (Tuckman & Jensen, 1977). The stage also afforded an opportunity for the group to transition from its work, whether to end its processes or potentially redefine new goals for the future. Given the grief that can be associated with the ending, or termination of any process, the adjourning stage has also appeared in the literature as mourning.

Further model enhancements recommended a distinct stage be created to acknowledge the value of addressing any unfinished work and reflect the proactive intent that comes with this effort. The stage has been identified as "outperforming" and also may address succession planning toward leadership (Manges, Scott-Cawiezell, & Ward, 2017). A rendering of Tuckman's original model and the added elements appear in Figure 2.

Tubbs' Systems Model

Stewart Tubbs had an interest in systems and how they played out through small group interactions. This lens facilitated the birth of Tubbs' basic four-phase Systems Model (Tubbs, 2012). Like Fisher's and Tuckman's works, the Systems Model is linear and has four separate phases:

- Orientation
- Conflict
- Consensus
- Closure

Tubbs provided a front end descriptor of a small group being limited from between three to approximately 20 people. However, Tubbs was clear that small groups could be deceptive, as their size alone does not necessarily make for easier and less complex efforts. He identified a number of other factors with potential to impact how a small group moves through its four stages. Of major significance to Tubbs were member interactions and dynamics, including all verbal and nonverbal communications, gestures, glances, and any behavior to which people assign meaning (Tubbs, 2012, p. 6). Think of how the tone a person conveys in his or her voice or the expression on his or her face can shift the meaning or intent of the messaging. In these times of reliance on electronic communication, it can be especially difficult to read sarcasm, let alone the semantics of a text, unless emojis or acronyms are used (e.g., OMG, LOL). Tubbs' definition of member interactions becomes a vital element and underpinning of how to consider the actions that occur in any small group, as well as team.

Fisher's Theory of Decision Emergence

Like Tuckman and Tubbs, Fisher developed four stages to reflect those task groups that move through when engaged in any decision-making processes:

- Orientation,
- Conflict,
- Emergence, and
- Reinforcement.

TABLE 1
Models of Group Development: Compare and Contrast

Fink-Samnick's Interprofessional Team Activation Cycle	Fisher's Theory of Decision Emergence	Poole's Multiple Sequences Model	Tubbs' Systems Model	Tuckman's Stages of Group Development
Focus: Set team purpose and priority: • Ensure team intent and organizational expectation: ◦ Client selection and ◦ Team composition. • Acknowledge foundation of a shared experience marked by: ◦ Mutual acceptance, value, and respect with ◦ Agreement to disagree. • Accept the depersonalization that comes with participation on all teams. • Accountability (both individual and team members) measured by: ◦ Completion of performance metrics, and ◦ Meaningful team outcomes.	**Orientation:** Group members get to know each other and experience a primary tension: • Awkward feelings experienced before communication rules and expectations are established. • Groups must take time to learn about each other and achieve comfort in communicating around new people.	**Task Track:** Process by which the group accomplishes its goals: • Dealing, • Doing problem analysis, and • Designing solutions.	**Orientation:** Group members get to know each other, they start to talk about the problem, and they examine the limitations and opportunities of the project.	**Forming:** • Purposefully pick group and individual members. • Facilitate group to identify goals. • Ensure group development of shared consensus.
Commit: Ensure commitment by members. • Define team rules and processes: ◦ Frequency/duration of meetings, ◦ Format, ◦ Leadership, ◦ Privacy and confidentiality, ◦ Meaningful outcomes, and ◦ Team performance metrics. • Accept reality of disagreement and how to manage. • That all contributions are valued and subject to group consensus.	**Conflict:** Secondary tension or tension surrounding the task at hand: • Group members will disagree with each other and debate ideas. • Conflict is viewed as positive, as it helps the group achieve positive results.	**Relation Track:** Deals with interpersonal relationships between group members: • Group may stop its work on the task and work instead on its relationships. • Members share personal information, engage in joking, and camaraderie building.	**Conflict:** Viewed as a necessary part of group development that: • Allows the group to evaluate ideas and • Helps the group avoid conformity and groupthink.	**Storming:** Group members get to know each other and the honeymoon is over. The politeness barrier disappears: • Group strives to resolve conflict and tension and • Works to develop mutual trust among individual members.
Discourse: Engage in effective communication processes that: • Allow for dialogues, debates, and differing perspectives; • Promote attention to verbal and nonverbal communication; and • End with defined actions plans, marked by: ◦ Goals and objectives, with ◦ Ownership for each action, and ◦ Accommodate need to revise and revisit any element.	**Emergence:** Outcome of group's task and social structure become apparent. • Members soften positions and • Undergo attitudinal change to decrease defensiveness in expressing individual viewpoints.	**Topic Track:** Includes a series of issues or concerns the group have over time.	**Consensus:** Group members end conflict and start to: • Compromise, • Select ideas, and • Agree on alternatives.	**Norming:** Group consensus emerges, with a commitment to the efforts at hand: • Group members freely elicit feedback from each other. • The group actively devotes time for planning/engaging in all goals.

(*continues*)

TABLE 1
Models of Group Development: Compare and Contrast (*Continued*)

Fink-Samnick's Interprofessional Team Activation Cycle	Fisher's Theory of Decision Emergence	Poole's Multiple Sequences Model	Tubbs' Systems Model	Tuckman's Stages of Group Development
Activate: Operationalize team within site (e.g., units, divisions): • Engage in a pilot, as necessary. • Allow for reassignment of/or onboard new members. • Affirm and complete meaningful outcomes: ◦ Measuring, ◦ Monitoring, ◦ Completion, and ◦ Reporting.	**Reinforcement:** Group members bolster their final decision: • Via use of supportive verbal and nonverbal communications.	**Breakpoints:** Group switches from one track to another: • Shift conversation vs. adjournment, or postponement.	**Closure:** Final group result announced: • Members reaffirm support of the decision.	**Performing:** The group successfully gels: • Implements objectives toward goals and • Works consistently to sustain the project.
Debrief: Accept that all experiences yield opportunities to enhance team interactions/interventions for the future: • Routine review of processes. • Identify lessons learned, • Develop action plans to address, with accountability and ownership for implementation. • Define opportunities to promote team outcomes via: ◦ Evidence-based publications and ◦ Organizational meetings, conference presentations (e.g., formal, posters). • Explore team opportunities: ◦ Expand to other sites, system facilities, programs, and organizations. ◦ Seek grant opportunities.				**Outperforming**[a]**:** The group is proactive in its efforts, allowing them to: • Expand initiatives, • Add new team members, and • Build leadership succession planning.
				Adjourning/Mourning[b]**:** The group acknowledges completion of the group's goals, plus addresses: • Breaking up the team, • Mourning for the group process, plus • Consider and recommend strategic foci for the future.

Note. Content from Fisher (1970); Manges et al. (2017); Poole (1983); Tubbs (2012); Tuckman (1965); and Tuckman and Jensen (1977).
[a]Manges et al. (2017).
[b]Tuckman and Jensen (1977).

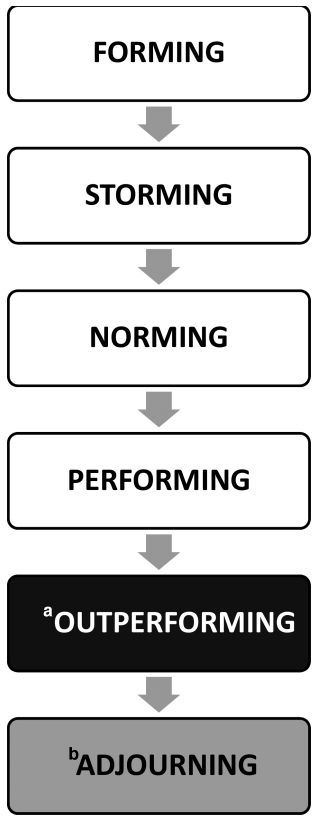

FIGURE 2
Tuckman's stages of group development, Advanced. Included content from Manges et al. (2017); Tuckman (1965); and Tuckman and Jensen (1977). [a]Manges et al. (2017). [b]Tuckman and Jensen (1977).

Fisher's (1970) theory of decision emergence reflected his interest in how interactions changed as group decisions were formulated and solidified. Fisher's unique emphasis was on the distribution of what he referred to as "interacts." This construct is understood as dyads of act–response pairs that are merged together across different moments of the group decision-making processes. Each pair supports the intent and functions of each stage (Fisher, 1970). For example, in Fisher's Stage 2, Conflict, engaged group members begin to dig in and discuss a specific problem. High levels of group discussion and participation (the Act) are prompted by increased member comfort, decreased nervousness to participate, and the beginning of group cohesion (the Response). The interacts propel each stage and are critical to understanding the group process.

Fisher also observed that group decision-making processes were more cyclical in nature than had been observed by other experts, as well as somewhat erratic. He hypothesized that breaks from the task at hand were often required by group members to address the interpersonal demands of discussion. These breaks also served to explain some of the decision paths that groups would need to take, always allowing for contingencies such as building in extra time for the detour of a phase (Fisher, 1970). For example, a group venturing off on a path of group think could be a pitfall. Although many individuals associate the concept of, group think as a positive action, it is far from what is implied. In group think, the group loses objectivity, getting so caught up in the discussion and one possible course of action that it fails to see how the facts leads to another more correct result.

Poole's Multiple Sequences Model

Marshall Scott Poole took a rare and alternative focus in considering his Multiple Sequences Model (Poole, 1983). The model reflected Poole's stance that different groups utilized different sequences to make decisions. In contrast to the unitary sequence models that was developed by Tuckman, Poole's multiple sequences accounted for the natural evolution of decision making as a function of several contingency, if not individual variables:

- Task structure,
- Group composition, and
- Conflict management strategies.

Poole developed a complex system for studying multiple sequences. The perspective included 36 clusters of group activities for coding group interactions and four cluster sets to organize the data into:

- Proposal development,
- Socioemotional concerns,
- Conflict, and
- Expressions of ambiguity.

Poole ultimately rejected models of group development that used phases. He felt any model to explain group processes had to account for the organic and developing threads of activity, a tough process at best. From Poole's lens, group discussions could not optimally be characterized by sequential phases but, instead, by intertwining tracks of activity and interaction. Case managers can especially appreciate a view that accounts for the fluid nature of a care process and the infinite moving parts that comprise any client, patient, member, or consumer experience.

Interprofessional Team Activation Cycle

In exploring the previously mentioned group development models, it was identified that none were written exclusively for health care teams, let alone an interprofessional endeavor. Tuckman's original research and meta-analysis focused primarily on psychoanalytical studies of therapy and laboratory training groups (Cassidy, 2007). The universal appeal of Tuckman's model and its variations has it associated with group program design and facilitation by managers, team leaders, and team members in business operations,

supervision, and therapy groups, as well as health care teams. The Outperforming stage (Manges et al., 2017) morphed Tuckman's model for nursing leadership, which was a vital progression to evolve. Although the merit of each of four models is clearly acknowledged by this author, activating effective and efficient IPTBC should be informed by the evidence-based practices and processes of the health care industry's workforce.

In the spirit of its ancestors, the ITAC incorporates a series of five distinct phases as shown in Figure 3. The phases appear in a circular design to promote the multisequential flow that is endemic to the realities faced by health care teams. The number of moving parts comprising any care effort does not allow for anything linear or rigid in presentation. Each of the ITAC's five phases reflects the naturally occurring organic processes required for interprofessional teams to form, engage in, and intervene with intentionality toward quality-driven practices.

Focus

Organization is the mantra for the initial Focus phase, as it is in other group development models. In this way, the team's purpose and priorities are explicitly defined, setting a firm tone for the phases to follow. Most professionals do better when they possess clear direction, understanding of the work scope, and corresponding expectations, particularly case managers. Team discussions set the foundational pillars of an activity that is a mandate. The concept of mutual respect and valuing each member's input is another essential topic for exploration, especially with so many disciplines, perspectives, and potentially competing egos involved on the team. In tandem, the

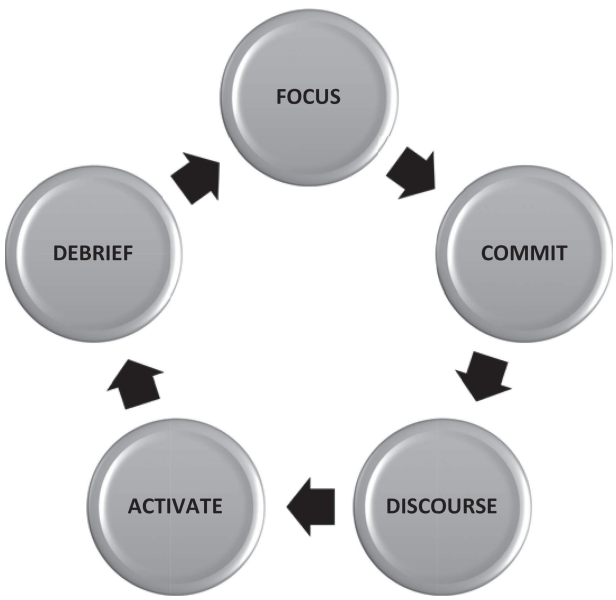

FIGURE 3
Stages of the Interprofessional Team Activation Cycle.

Each of the ITAC's five phases reflects the naturally occurring organic processes required for interprofessional teams to form, engage in, and intervene with intentionality toward quality-driven practices.

depersonalization often associated with group work must be discussed. This construct can be especially difficult for individuals who are not as experienced or familiar with a true interprofessional mind-set. In the end, working through depersonalization promotes team efficiency by reducing competition between members, building camaraderie, and fostering an interprofessional team identity. Ultimate solidification of the collective effort is spurred by the definition of team outcomes with clear accountability.

There is one reality of any sector that bears mentioning at this juncture and that is especially prevalent in health care. Earlier in this article, impatience with time during change management was discussed. The speed with which change is often expected can translate to "pop-up" team implementation. The danger of these teams is that they can become interprofessional in name only, lacking the formality and aim intended. Ensuring the team intent, as well as any organizational expectations, is a theme that requires explicit attention on the front end. Those concepts are positioned on the front end of the process in the Focus phase.

Commit

In contrast to other models (Fisher, 1970; Poole, 1983; Tubbs, 2012; Tuckman, 1965) that move directly to addressing the expected conflict among members in their second stage, the ITAC adds a step to first ensure commitment by all intended personnel. These actions should not occur in tandem with the other organizational processes defined in the previous, first phase. A person's eagerness to participate in any innovative effort can easily impact his or her objectivity with the obligations and responsibilities required. Case managers are frequently enticed with new initiatives to maintain interest, if not retention. A moment of pause is always recommended on the front end to allow for potential members to consider the reality and prospective enormity of the task before them. Only once an objective review of the facts and expectations is done can then team members fully commit to the IPTBC approach.

Discourse

The extra phase allowed to secure a more authentic level of team member commitment moves the needed

dialogues and debates to the third phase. Verbal and nonverbal communications are key elements to group development, especially affirmed by Tubbs' work. His focus on the dynamics, gestures, and energy generated by the interactions that occur between individual members and the collective group emphasizes the importance of the Discourse phase. The phase name is intentional, given the various definitions of discourse, which account for written or spoken communication or debate, interchange of ideas, to express oneself (Cambridge Academic Content Dictionary, n.d.; Merriam-Webster Dictionary, n.d.).

Promoting an atmosphere that allows team members to agree to disagree is a pivotal theme of a quality interprofessional team effort. An atmosphere removing inhibitions allows for freer discussion that leads to defined goals and objectives and subsequent ownership for necessary action. Case management's force lies in the consummate attention to accountability for planning, monitoring, facilitation, coordination, and collaboration of processes (Case Management Society of America, 2016). The practice of case management relies on collective practices that use communication, among other available resources, to promote health, quality, and cost-effective outcomes to achieve the Triple Aim (Commission for Case Manager Certification, 2015). The efficient progression of these standards of professional case management is all fostered by the quality of discussions that occur, lending further credence to the value of this phase.

Activate

Some interprofessional teams may be fully operationalized at this point, whereas others may first need to be piloted on specific units or population-based programs. To this end, the Activate phase accounts for any need to engage and further advance the IPTBC focus. Remember, what works in one organization will not work in all, as well-intended or successful as the effort might present. Perhaps, a hospital thinks it has been doing IPTBC when a new consultant identifies his or her team model never moved beyond a multidisciplinary effort. This may sound familiar to many readers of this article, who are most likely actively nodding their heads in acknowledgement. As a result, the C-suite may need convincing of the need for an IPTBC shift, traditionally achieved by a solid pilot. Pledging the completion of meaningful outcomes factors heavily in this phase. Case managers are aware that the one thing most organizations respond to is successful outcomes, whether through demonstration of an initiative or program's effort to meet organization goals or potentially ROI. Here is where interprofessional teams can shine, by providing outcomes that speak to the fruits of the team's labor. Measuring, completion, and reporting out of carefully chosen outcomes ensure sustainability for many model efforts. Consistent IPTBC will be incumbent on reporting out meaningful outcomes to ensure thresholds are met.

Some organizations may be at a more advanced position at this point, where successful implementation across units and programs has already occurred. These interprofessional teams will be ready to consider whether or not to identify and onboard new members. There are positions to support both opposing sides of this discussion, whether permanent team assignment as opposed to rotation onto and off the team. Experts have argued that reassignment is counter to the intent of the interprofessional focus, which has long been grounded on the intentionality of a consistent team of experts (Interprofessional Education Collaborative, 2011). Team-based care has also been seen as optimal means to reduce clinician burnout and enhance the patient experience (Smith et al., 2018). Others may equally challenge that longer term team members can contribute to both members and the team feeling stagnant. All are considerations for each team to define for itself.

Debrief

The final stage of any team effort must provide the opportunity for all involved parties to review their experiences, plus any lessons learned. The value of this particular undertaking cannot be overstated. All experiences have occurrences that went well and others that did not go as expected. To that end, surprises or unexpected outcomes may have emerged. Perhaps, the team was able to identify more efficient ways to facilitate team meetings that targeted key client issues. That needed attention may ultimately maximize client handoffs and transitions and reduce length of stay and readmissions.

Systematic debriefing allows the interprofessional team to not only reflect on past opportunities, but also look toward the future. What further

Systematic debriefing allows the interprofessional team to not only reflect on past opportunities but also look toward the future. What further methods can the team engage in to expand its IPTBC vision? What other outcomes should the team collect? Where can its outcomes be published or presented? Are there grant opportunities to finance expanding the team to other sites or even organizations?

TABLE 2
Interprofessional Team Activation Cycle: Case Scenario Application

ITAC Phase	Application	Standards of Practice Alignment
Focus	Mara is the case manager for Bison Hospital, covering the Chronic Disease Clinic. Dr. Cooden is the clinic's newly hired medical director, who has expertise in collaborating interprofessional teams for populations with respiratory illness and co-occurring behavioral health issues (e.g., anxiety, depression, substance use). Dr. Cooden and Mara meet to define the key team members across disciplines to ensure the full scope of client needs is met. An orientation meeting is held with team appointments assigned to the clinic from Case Management; Documentation, Coding & Billing; Nutrition; Nursing; Pharmacy; Psychiatry; Rehabilitation (PT, OT, SLP); Respiratory; Revenue Cycle Management; and Social Work. The team will be called the CD-IPT Preliminary discussion around CD-IPT practices, organizational and group expectations, and potential outcomes to address readmissions for clients previously hospitalized with an *ICD-10-CM* code for 55-65 that reflect the SDoH.	CMSA • Client Selection Process for Professional Case Management Services; M. Cultural Competence; I. Qualifications for Professional Case Managers CCMC • Section 1—Client Advocate; • Section 2—Professional Responsibilities: S1–S3
Commit	Mara and Dr. Cooden facilitate discussion of CD-IPT rules and processes, with active input from team members. Plan to rotate leadership among team members to promote accountability among the group, with agreement by all group members to trial plan for 2 weeks. Discussion about weekly team meetings, with inclusion of clients, caregivers, and community stakeholders (e.g., power of attorney, payer case managers, community-based care managers, community resources, homecare agencies). The stigma of disagreement was discussed with rules to achieve team agreement amid differing perspectives defined.	CMSA • J. Legal; K. Ethics CCMC • Section 4—Confidentiality, Privacy, Security, and Recordkeeping: S12–S17
Discourse	The CD-IPT meets for weekly rounds to highlight clients at risk of rehospitalization. Robust team discussion around J., who had a recent hospitalization and intubation for emphysema and heart failure. Escalation in anxiety led to challenges extubating J., with the inpatient interprofessional team recommending discharge to a skilled nursing facility for short-term rehabilitation. J. refused and was discharged home on prehospitalization medications, O_2 via nasal cannula at 2 L, and prior services through a Patient Centered Medical Home. CD-IPT members want J. to be reported to adult protective services, due to safety in his community; factors include a rising crime rate and recent closure of the neighborhood's only supermarket. Concerns around readmission risk due to psychosocial factors presented. Eye rolling and team dissent lead Mara and the team social worker, Patti, to feel attacked for defending J.'s autonomy, with J.'s home plan meeting his current needs. Glenn, the coding team member, reviews current interprofessional documentation and *ICD-10* coding guidelines with the team in the event of J.'s admission.	CMSA • B. Client Assessment; C. Care Needs and Opportunities; D. Planning; H. Facilitation, Coordination, and Collaboration; L. Advocacy CCMC • Underlying values
Activate	J. thrives at home with current home plan and biweekly clinic visits. Dr. Cooden and Mara present CD-IPT's outcomes from the initial quarter of operations to Bison's Leadership Team. Mara discusses how the team promotes client wellness and ROI, showing the cost savings achieved by the team for the hospital in the past quarter. Readmissions for the same population decreased by 40% from the fiscal year prior. Current team members agree to continue in their roles for the rest of the year.	CMSA • E. Monitoring; F. Outcomes; N. Resource Management and Stewardship CCMC • Underlying values
Debrief	CD-IPT quarterly meeting held with full discussion of processes. All team members asked to prepare at least one lesson learned and one opportunity for both team and individual member improvement. After a second consecutive successful quarter, Mara obtains team permission to submit an article on the CD-IPT outcomes to an evidence-based journal. Following publication, the team is invited to present a poster at the annual Interprofessional Education Collaborative Meeting and a presentation at the annual case management conference. The CD-IPT becomes a model for interprofessional chronic disease teams, with the outcomes leveraging comparable team efforts across organizations and the nation.	CMSA • G. Closure of Professional Case Management Services; O. Professional Responsibilities and Scholarship CCMC • Section 5—Professional Relationships: S24–S25

Note. CCMC = Commission for Case Manager Certification; CD-IPT = chronic disease interprofessional team; CMSA = Case Management Society of America; ICD-10 = *International Classification of Diseases, Tenth Revision*; *ICD-10-CM* = *International Classification of Diseases, Tenth Revision, Clinical Modification*; ITAC = Interprofessional Team Activation Cycle; OT = occupational therapy, PT = physical therapy; ROI = return on investment; SDoH = social determinants of health; SLP = speech–language profession.

methods can the team engage in to expand its IPTBC vision? What other outcomes should the team collect? Where can its outcomes be published or presented? Are there grant opportunities to finance expanding the team to other sites or even organizations? The industry focus on the use of interprofessional teams to mitigate gaps in care for populations facing the SDoH means opportunities abound to evolve creative programming. A detailed rendering of each ITAC phase appears in Table 1.

Alignment With Established Resources of Guidance

The ITAC aligns with the industry's established resources of guidance, particularly those for professional case management. The premise of a case manager's practice as collaborative and interdisciplinary guides the Preamble of the Professional Code of Conduct (Commission for Case Manager Certification, 2015). The Standards of Practice (Case Management Society of America, 2016, p. 11) leverage the role of the professional case manager in the following definition:

> Case management is a collaborative processes assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individuals' and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes.

Case management's standards, rules, and values can be applied across each of ITAC's five phases, further supporting this model's use by case managers for the purposes of driving their interprofessional teams. A case scenario application appears in Table 2, which associates the requisite standards to each phase.

Inteprofessional Team Tactics

A case manager's time and efforts must be maximized to effectively manage the most complex client and support system dynamics to date. Although developing and implementing an ITAC is a start of the work, case managers must also focus on the long-term sustainability of their efforts. Ten Interprofessional Team Tactics appear in Box 2 to continue to leverage case management's efforts to this end. Consider each tactic a reminder of the behaviors that drive successful interprofessional teams. Remember, the sum of our strengths is far more valuable than a solo effort toward achieving successful outcomes for clients, their caregivers, communities, and consumers of the care process.

BOX 2
Interprofessional Team Tactics

1. Talk *to* each other as opposed to *at* or *down* to each other
2. Embrace mutual respect for expertise
3. Engage in team shared decision-making
4. Use collaborative treatment planning
5. Identify interprofessional champions to mentor other staff members
6. Develop coalitions to maximize team-focused actions
7. Collect interprofessional performance metrics
8. Model interprofessional efforts across the organization
9. Advance evidence-based interprofessional practice through presentations/publications
10. Engage in interprofessional initiatives across the industry

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