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Leveraging Interprofessional Team-Based Care Toward Case Management Excellence

Part 1, History, Fundamentals, Evidence

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ABSTRACT

Health care teams continue to be a constructive way to approach, assess, coordinate, plan, and facilitate the care of clients and populations. Independent of practice setting, some type of team is in place, engaging different professionals and specialists. There has been considerable evolution of these teams over the years, with a heritage of terms to frame each one, including "multidisciplinary," "interdisciplinary," and "transdisciplinary." However, these long-standing framings have been replaced by a timelier model that shifts both focus and aim of the team effort. Interprofessional team-based care (IPTBC) sets the tone for how students entering the industry are educated and empowers the workforce to a more intentional means to the care end. This is the first in a 2-part series focusing on the evolution and implementation of IPTBC across the industry. Part 1 focuses on the history and fundamental concepts of interprofessional models. Evidence and outcomes to promote the value proposition for IPTBC implementation are also provided.

Purpose/Objectives:
This article:

1. Reviews the evolution of health care teams;
2. Defines IPTBC;
3. Discusses the challenges to implementation of IPTBC; and
4. Identifies the implications for professional case management.

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

Findings/Conclusions: Interprofessional team-based care models demonstrate a successful means to achieve client-driven, quality, and cost-effective care across disease states and practice settings.

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. Poor team collaboration contributes to unsuccessful outcomes for clients, increased costs, and concerning quality and risk management issues for the organization. The latest generation of value-based care initiatives and complex population health needs (e.g., social determinants of health, co-occurring physical and behavioral health) translates to greater pressures on case managers to maximize financial risk and attain their share of financial incentives (e.g., bonuses, shared savings) by avoiding readmissions, preventable complications, and duplicate services.

Key words: *case management, health and human services, interdisciplinary, interprofessional, medicine, multidisciplinary, nursing, population health, social determinants of health, social work, team-based care, transdisciplinary, value-based care*

Case managers involved on the front lines of health and behavioral health care face overwhelming pressures to facilitate effective treatment processes for their populations. The latest generation of value-based care initiatives and complex population health needs (e.g., social determinants of health, co-occurring physical and behavioral health) forces case managers to maximize financial risk as a means to attain their employer's share of financial incentives (e.g., bonuses, shared savings). Avoiding readmissions and preventable complications have become daily mantras for care teams, all while ensuring efficient and effective processes that

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minimize redundancies in care. The mandate exists for health and behavioral health organizations to approach treatment from the broadest perspective possible. Although the health care industry clearly benefits from having degreed professionals uniquely educated and trained in their respective disciplines, a team approach ensures a more wholistic lens that is client-driven and cost-effective. Herein lies the opportunity for interprofessional team-based care (IPTBC).

Interprofessional team-based care sets the tone for how students entering the industry are educated and empowers the workforce to a more intentional means to the care end. Organizations often present as understanding the interprofessional team concept, though the reality yields a different picture, one interprofessional in name only. Instead of the care process being an intentional collaborative effort with shared responsibility for action, case managers become tagged to facilitate tasks identified by other team members. It is one thing to own a care coordination, treatment, or discharge planning process, yet another thing entirely to be left holding the heavy bag of actions necessary to efficiently move these processes along. The true essence of an IPTBC effort is grossly misunderstood, with frustration and burnout contributing to workplace retention challenges for case management departments across the industry.

This article is the first in a two-part series focused on the evolution and implementation of IPTBC across the industry. Part 1 addresses the history and fundamental concepts of interprofessional models. Evidence and outcomes to promote the value proposition for IPTBC implementation are also discussed. Part 2 will tackle emerging IPTBC models across population health and practice settings, plus dedicated tactics to evolve successful teams across the industry landscape.

The Team-Based Care Revolution

The concept of teams and the structure of those teams have been a constant conversation in health care for well over five decades. The term, interprofessional may be the latest buzzword to describe a health care team, but it is part of an enduring legacy of other models and approaches, as shown in Figure 1.

Multidisciplinary

Multidisciplinary approaches were more models than actual teams. They involved various disciplines (e.g., physicians, nurses, social workers, rehabilitation professionals, nutrition, respiratory) working with a client and caregivers, though staff members functioned independently of each other (Gordon et al., 2014). Each professional brought the unique expertise of his or her discipline to the table, documenting his or her views of the client accordingly in the client record. None of the expertise engaged was intended to overlap. Instead, the unique skill sets were poised to complement each other, contribute to the treatment process and, ultimately, improve the client's care experience.

However, a few clear pitfalls were identified for the multidisciplinary approach to care. First, although beneficial to involve the appropriate consultants, there was no imperative (e.g., fiscal, regulatory) for these individuals to actually communicate directly with each other. Particularly, given the lack of electronic health records and integrated documentation for the times, this led to a tedious and often labor-intensive effort for the involved staff (e.g., social workers, charge nurses, discharge planners, utilization review nurses). Within an inpatient setting, the order for the consultation would be written in the medical record. Once the client was evaluated, there would be a handwritten consultation by the provider, which was hopefully legible. A final dictated copy of the report was then sent to the referring physician but might not be received for weeks. Time frames for completion of these needed consultations were challenging, particularly prior to the implementation of diagnostic related groups (DRGs). Any case managers working in the industry at that time most likely recall having to chase down one, if not more specialists, to complete the requested consult.

A second challenge of the multidisciplinary model involved the hierarchical structure of these "teams" and who was in charge. Leadership responsibility was most often delegated to the highest ranking professional, usually the physician. Although this power structure was thought to ensure oversight of the meeting's flow and built-in accountability for conflict resolution, there was an important downside. When a client's treatment mandated consultations by

FIGURE 1
Evolution of team-based care. From Interprofessional Education Collaborative Expert Panel (2011); Treiger and Fink-Samnick (2016).

multiple specialists, the challenge of who was tasked to coordinate the care process became a frequent challenge; herding cats was easier. Those involved in the early models of acute care case management recall these dynamics intimately. Each professional only felt responsible for the clinical scope of his or her discipline and shared little sense of responsibility for the client's clinical outcome (Treiger & Fink-Samnick, 2016). Other specialists involved in the client's care felt no vested interest in the overall process. Consider the client admitted to the hospital for a routine and elective joint replacement. During the surgery, the client experienced a complication, codes, and is postoperatively admitted to the intensive care unit. When the case manager asks the surgeon about the client's status, the response is focused only on the surgery, such as "the joint replacement surgery was a success"; the evidence points to the contrary.

Multidisciplinary models did little to foster a cohesive, organized care effort but rather maintained the silos that had been long-standing across the industry. With no formal mechanism to clarify or address the various and often conflicting viewpoints of professionals, this approach led to contradictory treatment expectations and goals that were potentially confusing for all stakeholders of the team effort, clients, caregivers, colleagues, community resources, and partners alike.

Multidisciplinary processes were not conducive to the high level of team interaction and communication that case managers rely on. This was a "team" in name only and functioned as the name implied, multiple disciplines that have been asked to consult on a certain client. Unfortunately, misunderstanding of the true intent of team-based care processes continues to present across practice settings. To this day, colleagues frequently share experiences of what they perceive as model multidisciplinary teams, viewing their care approach as a far more evolved rendering of team-based care than reality portrays.

Interdisciplinary

By the late 1980s DRGs were established in the practice landscape, with a higher degree of collaboration and communication understood across the industry. In addition, evolving technology, rapidly expanding treatment options, and range of care settings meant greater need to implement more intentional care dialogues and decision making. The race was on for

organizations to stay fiscally focused, quality-driven, and clinically competitive. Reimbursement shifts (e.g., managed care, capitation) called for care needing to be rendered more promptly, with minimal margin for error. Increased emphasis on utilization and resource management led to the birth of clinical pathways, variances to care, enhanced quality initiatives, and quicker transitions across health care systems.

Several population-specific challenges also pushed the directive for a more integrated approach to care, including:

1. An aging population with frail older people and larger numbers of clients with more complex needs associated with chronic diseases;
2. The increasing complexity of skills and knowledge required to provide comprehensive care to populations;
3. Increasing specialization within health professions and a corresponding fragmentation of disciplinary knowledge resulting in no single health care professional being able to meet all the complex needs of his or her clients;
4. Increasing emphasis and research across the globe of the benefits of multiprofessional teamwork and development of shared learning; and
5. The pursuit of continuity of care within the move toward continuous quality improvement.

(Nancarrow et al., 2013)

Interdisciplinary teams addressed these directives while expanding on the seminal work of the then Institute of Medicine ([IOM]; 2003). The concept of working in interdisciplinary teams was identified by the IOM as one of its initial five core competencies. The other four being:

1. Provide patient-centered care;
2. Employ evidence-based practice;
3. Apply quality improvement; and
4. Utilize informatics.

The IOM competencies set a foundation for the team trajectory, with interdisciplinary teams viewed as the remedy for a system fraught with medical errors and quality challenges (IOM, 2003). Involving team members from different professions with varied and specialized knowledge, skills, and methods was a logical solution to the identified problems (e.g., poor communication, fixable medical errors, challenges to patient safety, and care quality). The engaged professionals would integrate their observations and expertise to coordinate and communicate in a concerted effort that optimized care for target populations. It was expected that team members would dialogue more consistently over the duration of their engagement with their assigned client(s) or population(s). This approach represented a dramatic difference from the multidisciplinary efforts in place heretofore.

It became common to see the staff assigned to an interdisciplinary team who shared the primary assignment of a particular program, unit, or population. The experience an individual had as the member of an interdisciplinary team became as important a qualification in hiring as the person's clinical expertise. Although a number of interdisciplinary team examples and competencies were developed across the industry, there remains no clear synthesis of exactly what defines a model interdisciplinary team. Box 1 displays the 10 team competencies developed to promote interdisciplinary team sustainability.

Transdisciplinary

Although interdisciplinary teams appeared across the industry, another model took flight courtesy of the industry's attention to end-of-life care. Rapidly emerging chronic and acute care populations using hospice and palliative care (e.g., AIDS, cancers, end-stage renal disease, chronic obstructive pulmonary disease, congestive heart failure) gave rise to an innovative team-based model that allowed for fluid boundaries among the members. The consummate attention of these programs to person-centered care and shared decision-making led to a new culture of health care team that was now transdisciplinary in scope.

BOX 1
Ten Competencies of an Interdisciplinary Team

1. Identifies a leader who establishes a clear direction and vision for the team, while listening and providing support and supervision to the team members.
2. Incorporates a set of values that clearly provide direction for the team's service provision; these values should be visible and consistently portrayed.
3. Demonstrates a team culture and interdisciplinary atmosphere of trust where contributions are valued and consensus is fostered.
4. Ensures appropriate processes and infrastructures are in place to uphold the vision of the service (e.g., referral criteria, communications infrastructure).
5. Provides quality patient-focused services with documented outcomes; utilizes feedback to improve the quality of care.
6. Utilizes communication strategies that promote intrateam communication, collaborative decision-making, and effective team processes.
7. Provides sufficient team staffing to integrate an appropriate mix of skills, competencies, and personalities to meet the needs of patients and enhance smooth functioning.
8. Facilitates recruitment of staff members who demonstrate interdisciplinary competencies including team functioning, collaborative leadership, communication, and sufficient professional knowledge and experience.
9. Promotes role interdependence while respecting individual roles and autonomy.
10. Facilitates personal development through appropriate training, rewards, recognition, and opportunities for career development.

Note. From Nancarrow et al. (2013).

These transdisciplinary teams comprised members of several distinct professions who cooperated across disciplines to enhance the care of dedicated populations. By virtue of its definition, transdisciplinary teams integrated the natural, social, and health sciences (Choi & Pak, 2006). Their daily practice used established team-focused tools to assess, develop treatment plans and critical pathways, document, discuss, and intervene collectively. The involved practitioners (e.g., physician, case management, nursing, social work, pharmacy, rehabilitation, nutrition, respiratory) would implement a unified and integrated treatment plan, with all team members responsible for the same client-centric goals (Daly & Matzel, 2013; Gordon et al., 2014).

The model was further leveraged by the consummate expertise of those directly involved in the care process, becoming as vital as any clinical treatment. It was as if this type of team functioned with one brain, with successful outcomes driven by the sum of the parts and not attributed to any single team member. As a result, high levels of professional identity and competence were coveted strengths for those chosen to participate in this particular model. Other hallmarks of this approach included mutual respect and trust, which facilitated more consistent communication, interaction, and cooperation among team members. Programs known to use transdisciplinary teams include hospice and palliative care, pain management, Alzheimer's disease and dementia, rehabilitation (adults and pediatric), and patient-centered medical homes ([PCMHs]; Aubin & Mortenson, 2015; Daly & Matzel, 2013; Leasure et al., 2013; Treiger & Fink-Samnick, 2016).

The Emergence of Interprofessional Practice

Interdisciplinary and transdisciplinary teams thrived across health care organizations. Regulatory entities looked for polished models and processes, with standards developed. Many case managers can share at least one story of being informed of an assignment and team model change, often in response to an upcoming regulatory visit (e.g., The Joint Commission, Commission on the Accreditation for Acute Rehabilitation Facilities). Although the team concept across practice settings continued to advance, the training of the professionals on the front lines did not keep pace. More seasoned professionals especially continued to practice as they always did not always embracing the newer models. An inverse relationship developed between the education of health care professionals and actual needs and realities of their practice, as well as those settings where their practice was engaged.

The Canadian Interprofessional Health Collaborative ([CIHC]; 2010) took a strong step to define next generation of team practice, or interprofessional collaboration, as "a partnership between a team of health providers and a client in a participatory collaborative and coordinated approach to shared decision making around health and social issues."

Using established academic and industry research, the CIHC mobilized an effort mandating the cooperation, collaboration, communication, and integration of care in teams. These elements were viewed as necessary actions to ensure the care and treatment rendered would be continuous and reliable. The World Health Organization ([WHO]; 2010) further emphasized the necessity of a more comprehensive and intentional education of the next generation of the health care workforce. The WHO developed a report with strong messaging and validation, that the theme of interprofessional practice should begin at the gateway of professional academic education: "Interprofessional education occurs when students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes." Only when students understand how to work interprofessionally can they be ready to enter the workplace as a member of any collaborative practice team. The WHO saw this team evolution as a key step to move health systems from fragmentation to a more cohesive, organized, and collective endeavor.

Ultimately, the Interprofessional Education Collaborative (IPEC) formed, comprising academic and professional accreditation organizations and associations across the industry. Its goal was to further leverage this competency-based methodology to both education and patient care. The focus used a collaborative approach toward developing future generations of health care students to be interprofessional team members. The work was supported and endorsed by the IOM, as well as the majority of academic and professional accreditation entities. A current listing of the 20 IPEC supporting members appears in Box 2. Although not an exhaustive compilation of every discipline and specialty, the listing provides a preliminary

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BOX 2
The Interprofessional Education Collaborative

Supporting Members

- Academy of Nutrition and Dietetics (ACEND): https://www.eatrightpro.org/acend
- American Association of Colleges of Nursing (AACN): https://www.aacnnursing.org
- American Association of Colleges of Osteopathic Medicine (AACOM): https://www.aacom.org
- American Association of Colleges of Pharmacy (AACP): https://www.aacp.org
- American Association of Colleges of Podiatric Medicine (AACPM): https://www.aacpm.org
- American Council of Academic Physical Therapy (ACAPT): https://www.acapt.org
- American Dental Education Association (ADEA): https://www.adea.org
- American Occupational Therapy Association (AOTA): https://www.aota.org
- American Psychological Association (APA): https://www.apa.org
- American Speech-Language Hearing Association (ASHA): https://www.asha.org
- Association of Academic Health Sciences Libraries (AAHSL): https://www.aahsl.org
- Association of American Medical Colleges (AAMC): https://www.aamc.org
- Association of American Veterinary Medical Colleges (AAVMC): http://www.aavmc.org
- Association of Chiropractic Colleges: http://www.chirocolleges.org
- Association of Schools and Colleges of Optometry (ASCO): https://optometriceducation.org
- Association of Schools and Programs of Public Health (ASPPH): https://www.aspph.org
- Association of Schools of Allied Health Professions (ASAHP): http://www.asahp.org
- Council on Social Work Education (CSWE): https://www.cswe.org
- National League for Nursing (NLN): http://www.nln.org
- Physician Assistant Education Association (PAEA): https://paeaonline.org

understanding of those individual disciplines involved in IPTBC. There is no doubt that clients and their support systems are integral members of any IPTBC approach. The model embeds the concept of client, or patient-centric, care.

To coalesce the practice foundation, IPEC defined four competency domains:

1. Teams and teamwork
2. Values/ethics
3. Interprofessional communication
4. Roles/responsibilities

FIGURE 2
Interprofessional competency domains. From Interprofessional Education Collaborative Expert Panel (2011). Adapted with permission.

Each domain is shown in Figure 2. These domains would also set the structure for the progression of current education and degree programs, plus development of new training and credentialing. In addition, a number of foundational definitions were presented for the industry to align their thinking and process, shown in Table 1.

Interprofessional practice promotes the ability of students to grasp and understand their own individual professional identity, while also gaining keen understanding of other professional roles on the health care team. Anyone involved these days on the front lines of care, whether health or behavioral health, knows the merits of having the unique expertise of colleagues available when they need it. Our populations are far too complex and benefit greatly from the knowledge that each one of us brings to the table. Teamwork and attention to shared values promote the breaking down of barriers and silos, converting fragmented care into integrated care (Nester, 2016).

The core goal of IPTBC is to build relationships, interconnections, and interdependencies in order to manage complex problems (Nester, 2016). This concept aligns with case management, whose workforce comprises many disciplines and thus interprofessional by design. Moving forward, it will take the collective expertise of every member of the workforce to ensure

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TABLE 1
Interprofessional Foundational Terms and Definitions

Term	Definition
Interprofessional teamwork	The levels of cooperation, coordination, and collaboration characterizing the relationships between professions in delivering patient-centered care
Interprofessional team-based care	Care delivered by intentionally created, usually relatively small work groups in health care that are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or group of patients, e.g., rapid response team, palliative care team, primary care team, operating room team
Professional competencies in health care	Integrated enactment of knowledge, skills, and values/attitudes that define the domains of work of a particular health profession applied in specific care contexts
Interprofessional competencies in health care	Integrated enactment of knowledge, skills, and values/attitudes that define working together across the professions, with other health care workers, and with patients, along with families and communities, as appropriate to improve health outcomes in specific care contexts
Interprofessional competency domain	A generally identified cluster of more specific interprofessional competencies that are conceptually linked and serve as theoretical constructs

Note. From Interprofessional Education Collaborative Expert Panel (2011).

quality-driven, cost-effective, and ethical care for the industry (Fink-Samnick, 2019).

Evidence and Value Proposition of Interprofessional Team-Based Care

General Evidence and Costs

Working on an interprofessional team is a unique experience. There is something about taking your own practice scope and merging it with the expertise of a respected colleague: an aligned effort that has the potential to achieve an optimal client outcome. The moral imperative to deliver care through a collaborative effort of this type is of clear benefit to all industry stakeholders. Over time, it becomes second nature to reach out to the dietician, wound care nurse, and pharmacist to co-develop treatment goals that promote wound healing. The client with a severe exacerbation of emphysema who experiences profound anxiety during efforts to wean off a ventilator receives co-occurring treatment from the respiratory therapist and the clinical social worker, ultimately able to advance to nighttime ventilation only.

The latest challenges across the transitions of care demonstrate a clear value proposition of health care organizations implementing IPTBC. Successful team handoffs across the transitions of care are driven by high levels of interprofessional collaboration. When done well, they are poetry in motion, though the opposite has become the industry norm. Close to 70% of handoffs in hospitals were identified as flawed (e.g., medical errors, medication reconciliation challenges, unclear orders). The cost of inadequate care coordination, including inadequate management of care transitions by care teams and providers, was responsible for $25 billion to $45 billion in wasteful spending. Eighty percent of the most serious medical errors are linked to less than optimal communication among the care team (Brunken, 2013; Fink-Samnick, 2019).

With an industry continuing to place strong emphasis on readmissions to hospitals, staggering numbers and costs are associated with disorganized and fragmented communications and care. More than 75% of readmissions cost roughly $12 billion and were considered potentially preventable through more coordinated transitions. For fiscal year 2019, more than 50% of hospitals in the United States will have payments docked, with $566 million in penalties for readmissions. Lack of IPTBC negatively affects the delivery of health services and care process, with penalties and high costs impacting every organization (Fink-Samnick, 2019; Rau, 2018).

Populations and Programs

Use of IPTBC has led to positive outcomes across disease states and chronic health conditions, including diabetes, heart failure, obesity, and co-occurring physical and behavioral health diagnoses (Aboueid, Pouliot, Bourgeault, & Giroux, 2018; Nagelkerk et al., 2018; van Dongen et al., 2016; Walter, Schall, DeWitt, Arnold, & Feudtner, 2018). The need for an IPTBC approach has been especially noted for chronic heart failure and chronic obstructive pulmonary disease,

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particularly to address the accompanying anxiety and depression (Yohannes, Kaplan, & Hanania, 2018).

A number of Patient-Centered Medical Homes (PCMH) have yielded powerful outcomes in using IPTBC models. These clients experience multidimensional needs across the physical, social, economic, behavioral health, and community domains of care, many impacted by the social determinants of health. With the majority of PCMH programs targeting the most vulnerable populations, the pressure is on to further expand these models as possible. One study demonstrated how PCMHs and the involved IPTBC approach were instrumental in cutting down outpatient emergency department visits by 11% (Pines, Keyes, van Hasselt, & McCall, 2015). Another study demonstrated improved medication adherence, along with decreased costs and utilization of health systems. Extensive attention compared 6 years of client claims data to current outcomes through PCMH and IPTBC implementation (David, Saynisch, Luster, Smith-McLallen, & Chawla, 2018).

City Health Works in the New York Metropolitan Area found increased treatment adherence for those persons with co-occurring diabetes and major depression. Seventy-eight percent of clients had a decrease in their HbA1c, with 50% identifying a medical issue that was otherwise unknown to the medical provider. Ongoing IPTBC intervention for this community-based program bridges the gap between the physician's office and the client's home, while engaging a global view of care. The program has consistently demonstrated successful quality and cost outcomes across a number of other disease states, including hypertension and asthma, besides diabetes. Program expansion will add attention to congestive heart failure, chronic obstructive pulmonary disease, and chronic kidney disease (City Health Works, 2018).

The Challenges to Interprofessional Team-Based Care

Professional Practice Culture

The literature validates that practitioners simply do not play well together, with the disparities among professional cultures cited frequently in the literature as a causal factor (Gittell, Godfrey, & Thistlethwaite; 2013; Hall, 2005). Each distinct health care discipline embodies a unique culture that includes values, beliefs, attitudes, customs, and behaviors. Hall (2005) speaks to how professional cultures evolved for each discipline over time, each reflecting historic considerations as well as social class and gender issues. For example, social workers traditionally were viewed as "helpers," engaging society's most vulnerable, at-risk, and disenfranchised individuals. Their ethical code mandates attention to the core values of service, social justice, worth of the person, human relationships, integrity, and competence (National Association of Social Workers, 2017). Like social work, nursing puts the client and community first, ensuring compassion and respect for dignity and attributes of each person. For close to the past two decades, nursing has topped the Gallup poll as the most trustworthy profession, with physicians and pharmacists in the fourth and fifth positions, respectively (Marotta, 2018).

The heritage of physicians places them as the undisputed leaders of the overall care process, a view that challenges the thought of shared team accountability, as well as an IPTBC mind-set. The culture of physician education and training has emphasized action, outcomes, and cure as opposed to caring, nurturing, and the building of relationships (Hall, 2005). Until recently, new physicians were not taught how to work in teams or communicate with colleagues or the general public about what is going on in health care and medicine (Fink-Samnick, 2016; Rovner, 2015). It takes a high level of mutual respect and trust for the traditional physician to step back from that conventional leadership role and either defer or share it with other team members.

Communication and relationship patterns of practitioners become embedded in professional identities and cultures and are not easily altered. Health care professionals have long struggled to define their boundaries, if not the scope of their care; each profession assuming accountability for its requisite actions. The changes in industry culture wrought by shifting regulations and reimbursement structures have found the industry's professionals constantly struggling to define and redefine their identity, values, sphere of practice, and role in the care process. Despite the benefits of building relationships across areas of professional expertise, practitioners have often maintained silos for self-preservation. In this way, their respective members are ensured common values, approaches to problem solving, and language for professional interventions. However, too discipline-focused a perspective during education and training further emphasizes the silo mind-set. This reason enforces why any meaningful change in how the industry approaches treatment teams must engage an interprofessional perspective that begins at the gateway of learning.

Professional Communication and Collaboration at Risk

The workforce must move quickly these days, contributing to a feeling that people talk "at" as opposed "to" each other. Is it frustration run amuck with insufficient time to get all the work done, ineffective communications, or the interweave of both? This is far from discipline-specific but reflective of a more universal dilemma across the industry. I would also argue that the reliance on technology-driven communications (e.g., texting, e-mail) has impacted the quality of conversations, including use of the written and spoken words. What results is rapid-fire messaging, in the moment, with no subjective content or way to address the emotionality of a situation.

Added pressures exist for a moving target of disrupters faced by the workforce and every interprofessional team member. A brief dialogue with any discipline reinforces the common challenges faced in rendering care today; untangling social determinants of health, managing treatment plan adherence, addressing symptoms of increased length of stay (e.g., poor team communications, bullying behaviors), dealing with disparate electronic health records and technology interoperability, coping with stringent reimbursement and regulatory issues, plus ensuring cost and quality jive. Outcomes must reflect return on investment for any program.

Implications for Professional Case Management

The profession of case management is quite interprofessional in scope. Although a clear majority of the case management workforce continues to be nurses, a growing number comprises social workers and other valued members of the allied health professions (e.g., physicians, pharmacists, physical therapists, occupational therapists). The standards of practice that underlie each professional discipline and the Case Management Society of America all speak to mutual respect among professional colleagues as a vehicle to achieve quality and safe client-driven care. A number of professions have recently updated their standards and codes to reflect use of the term "interprofessional," including the American Medical Association and the American Nurses Association. Examples of the relevant standards of practice and professional codes are displayed in Table 2.

My experiences of case managing patients with valued colleagues across disciplines have biased how I engage the case management process. When care is approached from an interprofessional lens, the critical dialogues which drive that care have a special energy of their own. All those individuals involved are granted the opportunity to share their clinical acumen and perspective. Communication is organic and quite fluid. I speak as candidly to my physician peers as I do to those in case management, social work, nursing, pharmacy, and respiratory therapy, to name a few.

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With case management so closely linked to the fiscal imperatives of their organizations, the engagement in solid IPTBC is a necessity for the workforce. Many of the latest programs that developed courtesy of the Affordable Care Act rely on interprofessional collaboration, such as PCMHs and Accountable Care Organizations (ACOs). Case management plays a paramount role in facilitating and coordinating the involved elements of care, whether assessment, treatment planning, or resource referral, negotiation, and coordination. In addition, the payment programs associated with value-based care (e.g., bundles) demand high levels of interprofessional effort to ensure appropriate client handoffs and transitions. An increasing and ever-changing face of clients with insurmountable and complicated needs dictates that case managers and their interprofessional partners engage fresh team models toward implementing creative treatment planning, as those using IPTBC (Fink-Samnick, 2019; Nester, 2016).

A number of organizational resources are available to support the development and implementation of interprofessional teams across the industry. Although Part 2 of this article series will take a deeper dive into this domain, I wanted to offer case managers some grounding of how to proceed. Box 3 provides a listing of organizations that provide guidance and information on IPTBC, plus academic institutions with interprofessional approaches to education. A full listing of interprofessional education programs in the United States appears on the website for the American Interprofessional Health Collaborative, also provided in Box 3. Most colleges and universities that offer degrees across the health and human services and allied health fields are transitioning their programming and focus. Some schools have transitioned from individual and often siloed professional departments and schools to a single health and human services building, such as the Peterson Family Health Sciences Hall at George

TABLE 2
Professional Standards of Practice and Codes of Conduct Relative to Interprofessional Practice for Case Management

American Medical Association (2017) Code of Medical Ethics	American Nurses Association (2015) Scope and Standards of Practice	Case Management Society of America (2016) Standards of Practice for Case Management	National Association of Social Workers (2017) Code of Ethics
Principle IV A physician shall respect the rights of patients, colleagues, and other health care professionals and safeguard patient confidences and privacy within the constraints of the law. **Chapter 10 Interprofessional Relationships** *Opinions*: • E10.1: Ethics guidance for physicians in nonclinical roles • E10.1.1: Ethical obligations of medical directors • E10.2: Physician employment by a nonphysician supervisee • E10.3: Peers as patients • E10.4: Nurses • E10.5: Allied health professionals • E10.6: Industry representatives in clinical settings • E10.8: Collaborative care	**Standard 5A: Coordination of Care** *The registered nurse*: Communicates with the health care consumer, interprofessional team, and community-based resources to effect safe transitions in continuity of care Additional competencies for the graduate-level prepared registered nurse: • Provides leadership in the coordination of interprofessional health care for integrated delivery of health care consumer services to achieve safe, effective, efficient, timely, patient-centered, and equitable care **Standard 7: Ethics** *The registered nurse*: Collaborates with other health care professionals and the public to protect human rights, promote health diplomacy, enhance cultural sensitivity and congruence, and reduce health disparities. **Standard 9: Communication** *The registered nurse*: Maintains communication with interprofessional team and others to facilitate safe transitions and continuity in care delivery.	**Standard K: Ethics** The professional case manager should behave and practice ethically and adhere to the tenets of the code of ethics that underlie his or her professional credentials. *How demonstrated*: – Awareness of the five ethical tenets and how they are applied: • Beneficence • Nonmaleficence • Autonomy • Justice • Fidelity *Recognition that*: – A primary obligation is to the client cared for, with – A secondary obligation engagement in and maintenance of respectful relationships with coworkers, employers, and other professionals	**Standard 2: Ethical Responsibilities to Colleagues** *2.01: Respect: Social workers should* (a) Treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues. (c) Cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the well-being of clients. *2.03: Interdisciplinary collaboration: Social workers* (a) Who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established. *2.04: Disputes with colleagues* (a) Social workers should not take advantage of a dispute between a colleague and an employer to obtain a position or otherwise advance the social workers' own interests.

Note. From American Medical Association (2017); American Nurses Association (2015); Case Management Society of America (2016); and National Association of Social Workers (2017).

Mason University (GMU) in Fairfax, VA. The home of the College of Health and Human Services houses a number of academic programs in one space:

- School of Nursing
- Department of Social Work
- Department of Rehabilitation Science
- The Health Informatics Program
- Department of Health Administration and Policy,
- Nutrition and Food Study
- Department of Global and Community Health

The Center for Health Policy, Research, and Ethics, the Center for Study of Chronic Illness, and the Center for Discovery Science and Health Informatics are also located in the building. Classrooms and collaboration spaces are available to promote team discussions and interaction across disciplines. Further information about GMU's interprofessional scope can be found on the College of Health and Human Services website (www2.gmu.edu).

Moving Toward Interprofessional Implementation

Although the industry clearly benefits from having degreed professionals uniquely educated and trained in their discipline, great gains come from these individuals

Although the industry clearly benefits from having degreed professionals uniquely educated and trained in their discipline, great gains come from these individuals joining forces to ensure patient-centered treatment goals. Even the act of agreeing to disagree becomes poetry in motion for the committed interprofessional team.

BOX 3
Interprofessional Resources

Interprofessional Education and Team-Based Resources

- AHRQ PCMH Resource Center: https://pcmh.ahrq.gov
- American Interprofessional Health Collaborative: https://aihc-us.org
- Canadian Foundation for Healthcare Improvement: https://www.cfhi-fcass.ca/AboutUs.aspx
- Centre for the Advancement of Interprofessional Education: https://www.caipe.org
- The Inteprofessional Education Collaborative (IPEC): https://www.ipecollaborative.org
- The National Committee for Quality Assurance (NCQA): https://www.ncqa.org

Centers for Interprofessional Education

- Philadelphia University and Thomas Jefferson University, Jefferson Center for Interprofessional Education and Practice: https://www.jefferson.edu/university/interprofessional_education.html
- University of Alabama, Center for Interprofessional Education and Simulation: https://www.uab.edu/cipes/
- University of California, San Francisco, Program for Interprofessional Practice and Education: https://interprofessional.ucsf.edu
- University of Kansas, Center for Interprofessional Education: http://www.kumc.edu/center-for-interprofessional-practice-education-and-research.html
- University of Michigan: https://interprofessional.umich.edu
- University of Minnesota, National Center for Interprofessional Practice and Education: https://nexusipe.org
- University of New England, Interprofessional Education Collaborative: https://www.une.edu/wchp/ipec
- University of Washington, Center for Health Sciences Interprofessional Education, Research, and Practice: https://collaborate.uw.edu
- University of Washington, Psychiatry and Behavioral Sciences, Division of Population Health: Advancing Integrated Mental Health Solutions (AIMS Center): http://aims.uw.edu

joining forces to ensure patient-centered treatment goals. Even the act of agreeing to disagree becomes poetry in motion for the committed interprofessional team. As Kenneth Blanchard stated, "None of us is as smart as all of us." Interprofessional team-based care is the vehicle allowing solid response to the complex and multidimensional issues experienced by the current generation of health care consumers.

What tactics move IPTBC forward? Join me in Part 2 for an in-depth exploration of current interprofessional models across health and behavioral health, with application across practice settings and populations, as well as defined tactics to promote successful implementation.

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