Hello!

Casey Alrich

Emily Kane
National Nurse-Led Care Consortium

The National Nurse-Led Care Consortium (NNCC) is a membership organization that supports nurse-led care and nurses at the front lines of care.

NNCC provides expertise to support comprehensive, community-based primary care.
  – Policy research and advocacy
  – Technical assistance and support
  – Direct, nurse-led healthcare services

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**Our Partners**

NNCC is thrilled to partner with the Tennessee Primary Care Association on a learning collaborative around team-based care.

This training is Part 3 of a 4-part series.

NNCC is supported in part by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) through a National Training and Technical Assistance Cooperative Agreement. The information presented in this webinar, or its content and conclusions, are those of the presenters and should not be construed as the official position or policy of HRSA, HHS or the U.S. Government. More information about can be found at our website, www.nurseledcare.org

**Housekeeping Items**

- Cell phones out of sight
- Restrooms
- Courteous of different view points
- Questions/clarifications at any time
- Breaks/refreshments
Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Module</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:30</td>
<td>Welcome and Introductions</td>
<td>• Orientation to the training focus, content, and process</td>
</tr>
<tr>
<td>9:30-11:30</td>
<td>Part 1: Enhancing Teams</td>
<td>• Defining your team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recognizing high-performing teams</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Communicating effectively: SBAR, Huddles</td>
</tr>
<tr>
<td>11:30-12:30</td>
<td>Lunch Break</td>
<td></td>
</tr>
<tr>
<td>12:30-1:30</td>
<td>Part 2: Clarifying &amp; Optimizing Team Roles</td>
<td>• Defining team roles and responsibilities: swim lanes, role maps</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Optimizing team roles</td>
</tr>
<tr>
<td>1:30-1:40</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>1:40-2:40</td>
<td>Part 3: Optimizing Continuity</td>
<td>• Building continuity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Shared care planning</td>
</tr>
<tr>
<td>2:40-3:00</td>
<td>Evaluation of Learners and Next Steps</td>
<td></td>
</tr>
</tbody>
</table>

Workshop Focus

- Building data-driven care teams and optimizing their use for patient-centered care.
- Clarifying team roles and responsibilities to optimize efficiency, outcomes, and accountability.
- Enhancing continuity of patient care through health IT so that patients, caregivers, and providers recognize each other as partners in care.
Train-the-Trainer Model

Within each module:

• Key content
• Examples of ready-to-use tools
• Practice tools
• How to recognize success
• Recommendations for facilitating learning and uptake in your settings

Teams and Teamwork in Primary Care
Teamwork  
Culture of Work  
Quality Outcomes

<table>
<thead>
<tr>
<th>Patient &amp; Family Outcomes</th>
<th>Team Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction</td>
<td>Satisfaction</td>
</tr>
<tr>
<td>Engagement</td>
<td>Productivity</td>
</tr>
<tr>
<td>Adherence</td>
<td>Accurate problem identification</td>
</tr>
<tr>
<td>Self-care</td>
<td>Fewer errors</td>
</tr>
<tr>
<td>Fewer missed visits</td>
<td>Less turnover</td>
</tr>
<tr>
<td>Clinical outcomes</td>
<td></td>
</tr>
</tbody>
</table>
“Teamwork is the predominant form of work organization in healthcare. Clinician occupational well-being and patient safety develop in a teamwork context and are dependent on each other.”

Welp & Manser (2016)
Getting to Know You

Icebreaker Activity
Getting to know you...

1. Your name.
2. Your role.
3. Your organization.
4. ACE-15 outcomes.

MODULE 1
ENHANCING TEAMS
### Module 1 Topics

- Defining your team
- Recognizing high-performing teams
- Communicating effectively  
  - SBAR  
  - Huddles

### Module 1 Objectives

- Use IPEC® competencies to guide quality coaching.
- Recognize role of IT on the care team
- Recognize characteristics of high performing teams.
- Identify outcomes of effective and ineffective team communication.
- Demonstrate effective communication and huddle strategies.
- Select at least 2 measures to evaluate team communication and huddles in your setting.
- Identify at least 1 teaching-learning strategy you might pursue with your enrolled practices (45 Day Commitment).
Defining Your Team

Patient Family Community

Primary Care Provider
Behavioral Health
?
?
Social Worker
Registered Nurse
Team Diagram Activity

Communicating Effectively
Effective Team Communication

CLEAR CONSISTENT COMMUNICATION

Satisfaction
Quality and Outcomes
Care Gaps
Medical Errors

Ineffective Team Communication

COMMUNICATION ERRORS

Increased employee turnover and absenteeism
Project failures and failed change management
80% of serious medical errors during transfer

35-40% malpractice claims (1.7 billion healthcare malpractice costs)
5th leading cause of death in U.S.
Attributes of Communication

- Frequency
- Timing
- Accuracy
- Focus

Effective Communication for Team Based Care

- Organized
- Concise
- Easy to understand
- Respectful
S = Situation

A brief and focused description of the problem or need

Presentation of the situation usually includes:
- Name and location of the patient.
- Description of the problem:
  - What’s the problem?
  - When did it start?
  - How severe is it?

Description of the situation is usually 1-3 sentences
B = Background

Essential information related to the problem/need.

**Presentation of background may include:**
- Brief demographic information (e.g. age)
- Diagnoses related to the problem or need
- Brief history
- Current medications, allergies
- Most recent vital signs
- Relevant test results including date and time; results of previous tests for comparison
- Other team members and community services

A = Assessment

Your focused assessment of what is happening.

Your assessment will be based on the situation and background, your role, scope of practice, and may include:
- Significant change in an ongoing problem.
- Preliminary diagnosis or concern regarding acute problem.
- Issue with medication taking, adherence, and/or interaction.
- Inadequate community supports.
R = Recommendation

Your recommendation of what should be done to address the problem or need.

Your recommendation should be consistent with your role and scope of practice and may address:

- Appointment scheduling
- Tests or procedures
- Treatment or medications
- Interventions and action planning
- Referral needs

Preparing to Use SBAR

Assess the situation, scenario, and gather information

- What is going on?
- How is the patient experiencing the problem or need?
- Current medications, labs, functional assessments, and related dates?

Review the health record for information relevant to the problem or need

- What are the physical and behavioral health problems/diagnoses?
- What has happened recently?

Ask team members for information relevant to the problem or need

- What can they contribute to defining or understanding the problem?

Identify who you plan to contact/invoke in the patient’s care

- What information will they need?
Ineffective Communication

https://www.youtube.com/watch?v=CtdNQ-sfKg8

Effective Communication

https://www.youtube.com/watch?v=fsazEArBy2g
SBAR Role Play Activity

SBAR Group Activity

1. Review your scenario

2. Develop SBAR
   • **Situation:** A brief and focused description of the problem or need in the moment
   • **Background:** Essential information related to the problem/need
   • **Assessment:** Focused assessment of what is happening, **based on your role**
   • **Recommendation:** What should be done to address problem or need, **based on your role**

3. Practice

   SBAR script should be no more than 1-2 minutes in length
Recognizing Success

In order to improve communication within the clinic (co-workers, patients, referral partners), consider setting your own goal:

*Example: “Establish a SBAR template for messaging within the EMR. Pilot usage with 1 care team.”*
Measure goal success using a SBAR Competency Check List

**Example Goal:** Care team members will demonstrate use of SBAR through role-play activity meeting minimum score of 80%

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Recognizing Success: Communication

<table>
<thead>
<tr>
<th>Patient Outcomes</th>
<th>Team Outcomes</th>
<th>Assessment</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement</td>
<td>Reduced medical errors</td>
<td>SBAR competency</td>
<td>Efficiency</td>
</tr>
<tr>
<td>Adherence to plan of care</td>
<td>Improved satisfaction</td>
<td></td>
<td>Effectiveness</td>
</tr>
<tr>
<td>Decreased no-show rates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved understanding &amp; commitment</td>
<td></td>
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</tr>
</tbody>
</table>
Communication Tool #2: Huddle

Huddles are short, daily meetings in which a “teamlet” or pod (a Primary Care Provider/Clinician and a Medical Assistant and other support staff) reviews their patient list for the day for coordination, continuity, and efficiency.

Characteristics of Successful Team Huddles (1)

- Huddles typically last no more than 10 minutes.
- Scheduled time and place.
- Identified team members are present (start/stop on time).
- No interruptions rule: This rule reduces distractions of phone calls, emails, or other items.
Characteristics of Successful Team Huddles (2)

- Close proximity
- Time and communication efficiency: SBAR
- Formatted for your clinic practice-patient needs
- Routine and roles assigned (facilitator, timekeeper)
- All inclusive: team-based, everyone contributes
- Formatted for your team

Characteristics of Successful Team Huddles (3)

- Pre-work completed/use of tools (SBAR, checklists, agenda, shared documents, chart review)
- Addresses whole person interprofessional care
- Assess, adapt, and adopt
- Practice, practice, practice
Huddle Role Play Activity

Recognizing Success
Example Goal: Care team members will demonstrate use of Huddle through role-play activity meeting minimum score of 80%.

Recognizing Success: Huddles

<table>
<thead>
<tr>
<th>Patient Outcomes</th>
<th>Team Outcomes</th>
<th>Assessment</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Continuity of care</td>
<td>• Reduced medical errors</td>
<td>• Huddle use and/or competency</td>
<td>• Efficiency</td>
</tr>
<tr>
<td>• Improved access</td>
<td>• Improved satisfaction</td>
<td></td>
<td>• Effectiveness</td>
</tr>
<tr>
<td>• Manage population health</td>
<td>• Improved teamwork and engagement</td>
<td></td>
<td>• Visit preparation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Clinic preparation</td>
</tr>
</tbody>
</table>
Recognizing Success: Teams

• Objective: Measuring Interprofessional “Teamness”
• Tool: Assessment for Collaborative Environments (ACE-15)
• Measures:
  - Effective communication
  - Clear roles
  - Shared goals
  - Mutual trust
  - Measureable process and outcomes
  - Organizational support

(15 questions, 5 minutes)

Recognizing Success: Teams

• Objective: Measuring strengths and weakness in clinical teams
• Tool: The Collaborative Practice Assessment Tool (CPAT)
• Measures:
  - Purpose/goals
  - Relationships
  - Team leadership
  - Roles
  - Communication
  - Community linkages and coordination
  - Decision-making
  - Patient involvement

(56 questions, 15 minutes)
Facilitation

Interactive Training Methods

- Demonstration / Consensus Building
  - E.g., experiment with huddle forms and huddle times.
- Video Checklist
  - E.g., show our SBAR videos.
- Case Studies
  - E.g., share SBAR medical studies.
- Self-Appraisal / Reflective Practice
  - E.g., use our SBAR activity and grade scripts.
- Role Play Scenarios
  - E.g., use our huddle activity in staff meeting.
Opportunities for continuous learning and improvement

Resources

- SBAR worksheets and tools
- SBAR evaluation tool
- Videos of SBAR and huddles (ineffective vs. effective)
- Huddle worksheets and tools
- Huddle evaluation tool
- Assessment tools
- Quality improvement and assurance
Characteristics of high performing teams are well defined in research & competencies.

Ready-to-use tools are available to improve team communication and planning including SBAR, huddles, team meetings.

There is research connecting teamwork competencies, team performance and important clinical outcomes.

You can be creative (and time efficient) in facilitating learning using a variety of teaching-learning strategies.

Recap: Enhancing Teams

Lunch Break
MODULE 2
CLARIFYING AND OPTIMIZING TEAM ROLES

Module 2 Topics

Defining team roles and responsibilities
  – Role maps
  – Data stewardship

Optimizing team roles
  – Examples
• Define care team member roles, functions and responsibilities.
• Identify the role of patients and families on the primary care team.
• Assess current team role functions and opportunity for role redesign and optimization.
• Select at least 2 measures to evaluate role clarity and optimization in your setting.
• Identify at least 1 teaching-learning strategy you might pursue with your enrolled practices (45 Day Commitment).

Defining Team Roles and Responsibilities
Roles and Responsibilities for Effective Teamwork

- All roles are understood and respected
- Scope and responsibilities of each role are explicit
- Each team member understands how his/her role fits in the work of the team
- Roles standardized across the EHR

THE PATIENT’S ROLE ON PATIENT-CENTERED PRIMARY CARE TEAMS

Patient

- Provide information about own health and experience
- Describe and report changes in health status
- Share response to self-care and treatments
- Identify factors that help and hinder engagement and achieving health goals
Role Clarity

- Competencies
- Scope of practice
- Licensure
- Values and ethics
- Education / accreditation standards
- EHR-mandated access levels

Swim Lane Diagramming

A swim lane diagram assists with role clarification and efficiency.
Example: Swim Lane Diagram for a Physician Assistant Office Visit

Adapted from “Physician Assistant (PA) Office Visit” available at:

RACI Matrix

- Responsible, Accountable, Consulted, Informed
- Defining these roles for a task improves clarity, ownership and communication
- Identify functional roles (e.g., front desk, RN, etc.)
- Identify activities or decisions
- Good for QI projects or introducing new EBIs
RACI Matrix Example

<table>
<thead>
<tr>
<th>Task</th>
<th>Medical Director</th>
<th>RN</th>
<th>MA</th>
<th>Clinic Director</th>
<th>Student Intern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research new Type 2 diabetes screening tool</td>
<td>R</td>
<td>I</td>
<td></td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Arrange for training for Type 2 diabetes screening work flows</td>
<td>R</td>
<td></td>
<td></td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Create new screening protocols</td>
<td>R</td>
<td></td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify patients in need of screening in the EHR</td>
<td>I</td>
<td>R</td>
<td>I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educate patients and provide Type 2 diabetes screening cards</td>
<td>R</td>
<td></td>
<td>I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Run weekly reports to see how many returned cards</td>
<td></td>
<td></td>
<td></td>
<td>I</td>
<td>R</td>
</tr>
<tr>
<td>Call patients to remind them to return cards or discuss follow-up</td>
<td></td>
<td>C</td>
<td>R</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Roles and Responsibilities: It Takes a Team!
http://links.asu.edu/fm3
Optimizing Team Roles

Demand → Team composition
Visit scheduling
Workflows
Optimization Principles

• All team members work to their highest level of expertise, skill and licensure

• Team composition driven by:
  – Patient/family/population needs and
  – Characteristics of practice.

• Look for potential for cross-training to maximize flexibility and flow

Team Redesign

<table>
<thead>
<tr>
<th>Primary care team members</th>
<th>Health IT redesign examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurse</td>
<td>• Data stewardship for client records</td>
</tr>
<tr>
<td></td>
<td>• Tele-triage for shelter-based patients</td>
</tr>
<tr>
<td>Medical assistant</td>
<td>• Execute EHR standing orders</td>
</tr>
<tr>
<td></td>
<td>• Chart prep for huddles</td>
</tr>
<tr>
<td>Data analyst</td>
<td>• Running population health registries</td>
</tr>
<tr>
<td></td>
<td>• Custom queries for CQI projects</td>
</tr>
</tbody>
</table>
For additional reference on role re-design

https://www.niddk.nih.gov

For additional reference on Primary Care Team Re-design:
Project LEAP: Learning from Effective Ambulatory Practices

http://improvingprimarycare.org/
Care Team Redesign

https://www.youtube.com/watch?v=6u6xFutnBy8

Clarifying/Optimizing Roles Activity
Care Team Role Here

Patient Education

Data Capture

Care Coordination

Patient Health

Recognizing Success
Enhance existing job description with added roles and responsibilities central to care team functioning:
- Patient engagement,
- Population health management, etc.

**Outcomes of Role Clarity and Optimization**

<table>
<thead>
<tr>
<th>Practice Outcomes</th>
<th>How to Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Realistic expectations of team members</td>
<td>• Enhanced job description with defined roles.</td>
</tr>
<tr>
<td>• Efficient workflow</td>
<td>• Wait times, time spent rooming, etc.</td>
</tr>
<tr>
<td>• Improved decision-making</td>
<td>• Use of standing orders</td>
</tr>
<tr>
<td>• Team member satisfaction, perception of being valued</td>
<td>• Satisfaction surveys, assessment</td>
</tr>
<tr>
<td>• Less conflict</td>
<td>• Portal engagement – patients/providers</td>
</tr>
<tr>
<td></td>
<td>• # of open charts</td>
</tr>
</tbody>
</table>
Strategies and Tools to Engage Patients and Families

- Patient portal
- Welcome center
- Secure texting
- Engaging health apps
- Scripts
- Display patient feedback and success stories

Strategies and Tools to Engage Patients and Families

**Bio-Card**

**Letter from Office Manager**
Facilitation

- **Demonstration / Consensus Building**: E.g., develop standard EHR user roles based on positions.
- **Case Studies**: E.g., NIH case study scenarios.
- **Role Play Scenarios**: E.g., practice intro scripts at staff meetings.
- **Self-Appraisal / Reflective Practice**: E.g., fill in role worksheets for one another.
- **Video Checklist**: E.g., “Roles and Responsibilities” e-learning module.

*Interactive Training Methods*
Opportunities for continuous learning and improvement

Resources

- Roles and responsibility tools
- Roles and responsibility examples
- Value and ethics tools
- Videos
- Online resources
- Quality improvement and assurance
- Strategies and tools to engage patients and families
Supplemental Teamwork Training Ideas

- Running team meetings
- Value and ethics exploration in interprofessional teams
- Lean six sigma training/certification
- Kaizen/PDSA cycle training

Recap: Clarifying and Optimizing Team Roles

Understanding roles and responsibilities of each team member is integral to successful performance.

Role clarity entails being clear on the scope of each person’s responsibilities, what each person can or cannot do based on regulations, education, and experience.

Many primary care settings are experimenting with redesigning the roles of team members – lots of examples available.
Break Time

MODULE 3
OPTIMIZING CONTINUITY
Module 3 Topics

• Building in continuity
• Shared care planning

Module 3 Objectives

• Identify outcomes associated with effective and ineffective continuity and coordination
• Design a shared care plan to enhance continuity of care
• Demonstrate writing measureable goals for patient-centered continuous care
• Select at least 2 measures to evaluate success in continuity and coordination in your setting
• Identify at least 1 teaching-learning strategy you might pursue with your enrolled practices (45 Day Commitment)
Building Continuity

What’s Your Script?
Introducing Team Members to Patients and Families

- Greet and introduce by name
- State role on team
- Explain purpose/focus of interaction

Introducing Team Members to Each Other

- Introduce by name and role:
  - “I am a medical assistant, nurse, pharmacist…”
- Describe focus of work and contribution to team:
  - “I support the work of the team by…”
- Share information about specialized education, certification that relate to work with patients and families as useful:
  - “I have specialized education in diabetes care.”
“Care Coordination is the deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients’ and families’ needs and preferences for healthcare and community services are met over time.”

National Quality Forum (2014)
Care Coordination and Continuity of Care

Provider Experience

Managing referrals, appointments, EHR notes, transportation, CCDs, consult reports, etc.

Patient Experience

Continuity of Care

Incorporating Continuity of Care in Shared Care Planning

Characteristics of care continuity success:

- Essential to quality care
- Core value to primary care
- Patient and their family are part of the healthcare team
- Shared goals and monitoring
- Early identification
- Whole person perspective
- Coordination with healthcare team and broader healthcare community
Shared Care Planning

Shared Care Planning with Health IT Support

1. Introduce the patient to the full care team
2. Discuss goals and priorities with the patient and their family/support
3. Address the patient’s whole health needs – integrated care
4. Acknowledge needs
5. Prioritize needs
6. Set clear and achievable goals
7. Determine strengths, facilitators, and barriers
8. Identify evidence based interventions
9. Address need for community supports and services
10. Establish plan for monitoring goals and outcomes
## Example

### EMR Shared Plan of Care

<table>
<thead>
<tr>
<th>Patient Goal: Find Housing inopro 2 days</th>
<th>Health Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Need</td>
<td></td>
</tr>
<tr>
<td>Interventions</td>
<td></td>
</tr>
<tr>
<td>• Making housing or renewing on housing list</td>
<td></td>
</tr>
<tr>
<td>Recommendations &amp; Outcomes</td>
<td></td>
</tr>
<tr>
<td>• Goal is to ensure safety</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Goal: Stay with Transportation

- Goal is to ensure safety
- Interventions: Make transportation arrangements

### Care Plan Assessment - NY (transitions aged include community)

<table>
<thead>
<tr>
<th>Health Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Arthritis</td>
</tr>
<tr>
<td>• Asthma Medicine</td>
</tr>
<tr>
<td>• Diabetes Type 2</td>
</tr>
<tr>
<td>• Drug-related Center</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clinical Social Work Counseling for Hendoness, Abuse issues within the home, DPT NY report</td>
</tr>
<tr>
<td>• Care Plan Assessment, Transportation/Social Issues, Due to providing, legislators paperlessipment</td>
</tr>
<tr>
<td>• Follow-up Contact, Religious groups needed, Access Housing, Seeking location to the area where you can still to your spiritual connection</td>
</tr>
<tr>
<td>• Related to Adult Primary Care Physician</td>
</tr>
<tr>
<td>• Patient Education - Drug Abuse</td>
</tr>
<tr>
<td>• Patient Education - Diabetes</td>
</tr>
<tr>
<td>• TZ PT Intensive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendations &amp; Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Need Care Plan Assessment</td>
</tr>
</tbody>
</table>

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[http://links.asu.edu/pcm3](http://links.asu.edu/pcm3)
Health IT Shared Care Planning Tips & Tricks

✓ Integration of Services

• Behavioral health charting directly in the EMR
• Flag alerts across disciplines
• Disease, risk factor, and population specific screening tools live in the EMR (PHQ-2, SBIRT, etc.)
• Consult reports stored as structured data
• Preferred lists of referral partners

✓ Secure Interoperability

• Limit access to sensitive patient chart information by user role
• Opt-out status for secure data sharing and data warehousing
• Standard referral format for external providers
• Allow patient-generated information to flow into EMR (upon review)

Teaching-Learning Plan: Shared Plan of Care Activity
Recognizing Success

• Improved effectiveness in patient advocacy
• Improved patient confidence in healthcare team/system
• Improved trust
• Improved health outcomes
• Improved handoffs
• Decreased costs of care
• Improved patient safety
• Enhanced coordination with healthcare team and broader healthcare community
Results-Oriented

Identify your outcomes and needs:

– Create Measureable Goals (SMART)
– Tie to medical outcomes and metrics (i.e., PQRS, HEDIS, UDS, NQF, PCMH)
– Patient needs / satisfaction
– Team based concerns
– Functional concerns
– Evidence based interventions
– Metrics – organizational / reportable
– Standardize across sites
– Referral focus

Recognizing Success: How to Measure

• Improved team, patient, and family satisfaction
• Improved health outcomes
• Improved team based care
• Improved quality care
• Increased patient and team satisfaction
• Reduced overuse and underuse of healthcare services
• Decreased length of hospital stay
• Decreased hospital readmission
• Decreased medical and medication errors
• Reduced duplication or gaps in services
Facilitation

- **Interactive Training Methods**
  - Demonstration / Consensus Building: E.g., edit work flows as a team to maximize care plan tool.
  - Video Checklist
  - Self-Appraisal / Reflective Practice: E.g., chart review of current care plans use.
  - Case Studies: E.g., SNMHI case studies on care coordination.
  - Role Play Scenarios: E.g., role play creating SMART goals with patients.

E.g., “Developing Plan of Care” e-learning module.
Opportunities for continuous learning and improvement

Resources

- Primary care team brochures/flyers
- SMART goal sheets and examples
- PDSA sheets
- Patient continuity of care cards
- Quality improvement and assurance
Supplemental Teamwork Training Ideas

- Shared decision making
- Shared goal setting and monitoring
- Quality improvement and assurance
- Motivational interviewing
- Certified educator status (diabetes or nutrition)

Recap: Optimizing Continuity

- Shared care plans enhance continuity within and across providers and settings
- Achieving continuity requires integration of multiple teamwork skills including communication and coordination
- Expanding continuity and coordination measures is a national priority
Preparing to adjourn...

Evaluation and Wrap-up
Collecting 45 Day Commitments

(e.g. Huddles, Risk Stratification, Shared Care Planning)

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
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</thead>
<tbody>
<tr>
<td>I will develop a Huddle pilot study at Main Street Health Center.</td>
<td>Members of our pilot huddle program will achieve a score of 80% on the huddle assessment during training before “going live”.</td>
</tr>
<tr>
<td>I will identify and train 3-4 care team members for this pilot program, inclusive of a Provider, MA, and RN.</td>
<td></td>
</tr>
<tr>
<td>In training this pilot group, we will introduce SBAR and Huddle techniques learned today and test competency through role play activities and learner assessment.</td>
<td></td>
</tr>
<tr>
<td>I will work with my counterpart at Main Street Health Center and identify a provider champion to support the huddle performance improvement objective outlined here.</td>
<td>My pilot group will be identified and trained by April, 2018.</td>
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Final Questions

Thank You!
Thank You!

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