Virtual Training: Care Team Activities

March 26, 2020

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Hello!

Jillian Bird **Emily Kane**

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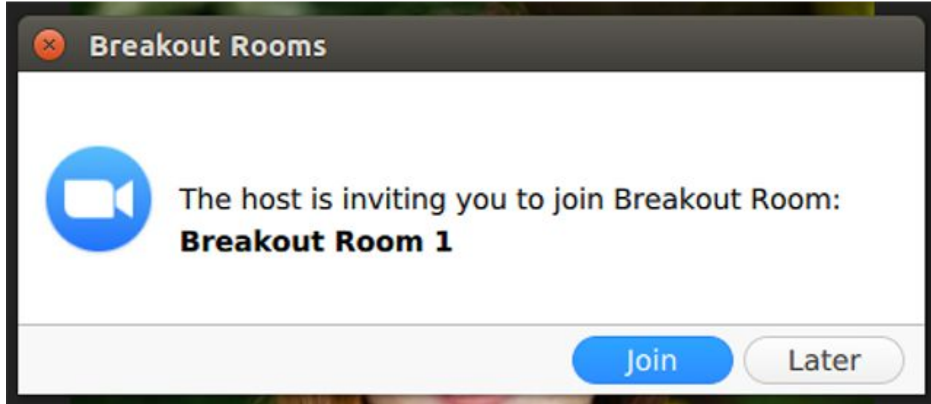
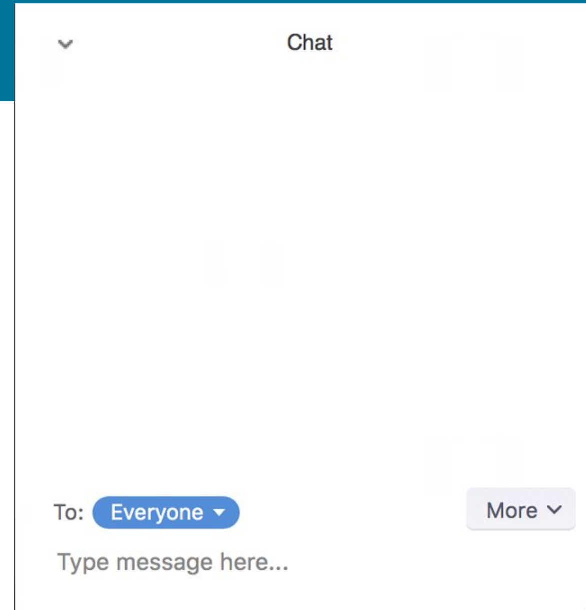
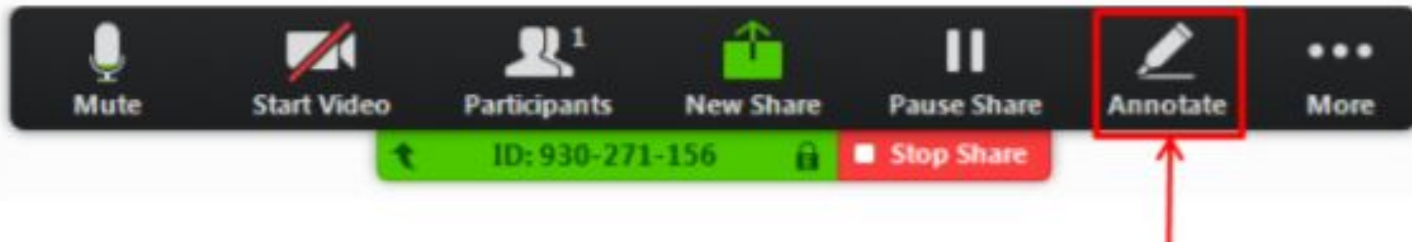
Using Zoom







Icebreaker Activity

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Getting to know you

In the chat…

1. Your name.
2. Your role.
3. Your organization.
4. One competency (#) you feel great about.
5. One competency (#) you need help with.

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Linking IPEC® to Specific Teamwork Tools & Strategies

IPEC®	Teamwork Tools & Strategies
• Teams and Teamwork (TT10) • Interprofessional Communication (CC1, CC2, CC8)	• Recognizing high-performing teams • SBAR Communication • Huddles
• Roles/Responsibilities (RR1, RR4, RR9)	• Swim Lanes • Role Maps • Role Redesign
• Teams and Teamwork (TT3, TT4)	• Shared Care Planning

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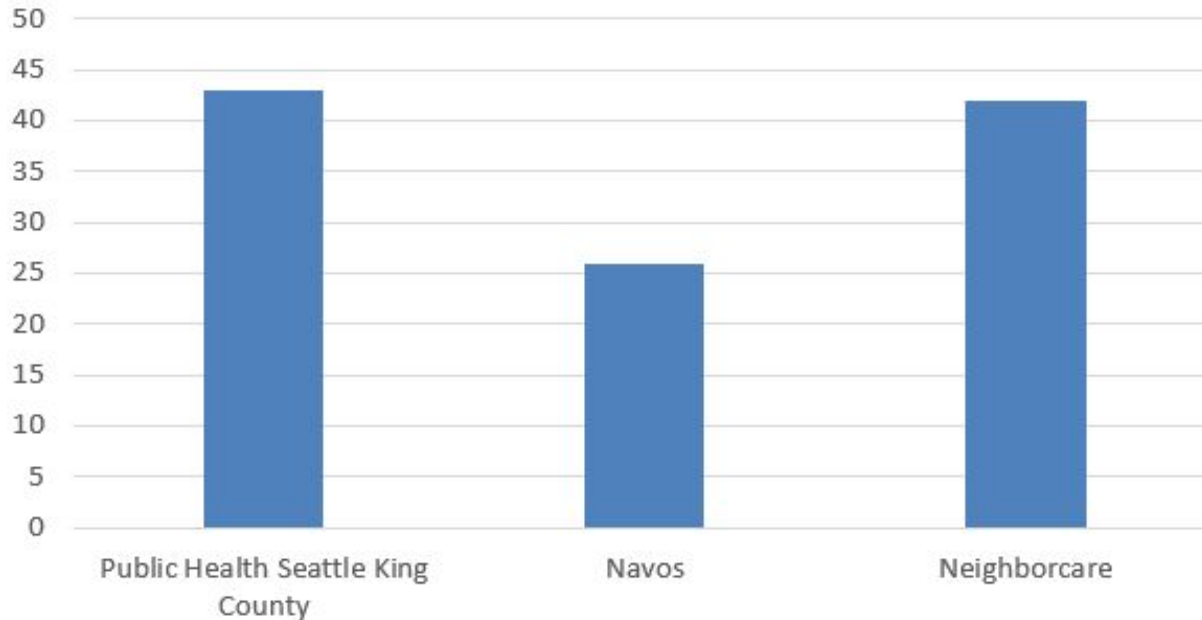
ACE-15 Scores



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ACE-15 Scores (cont.)

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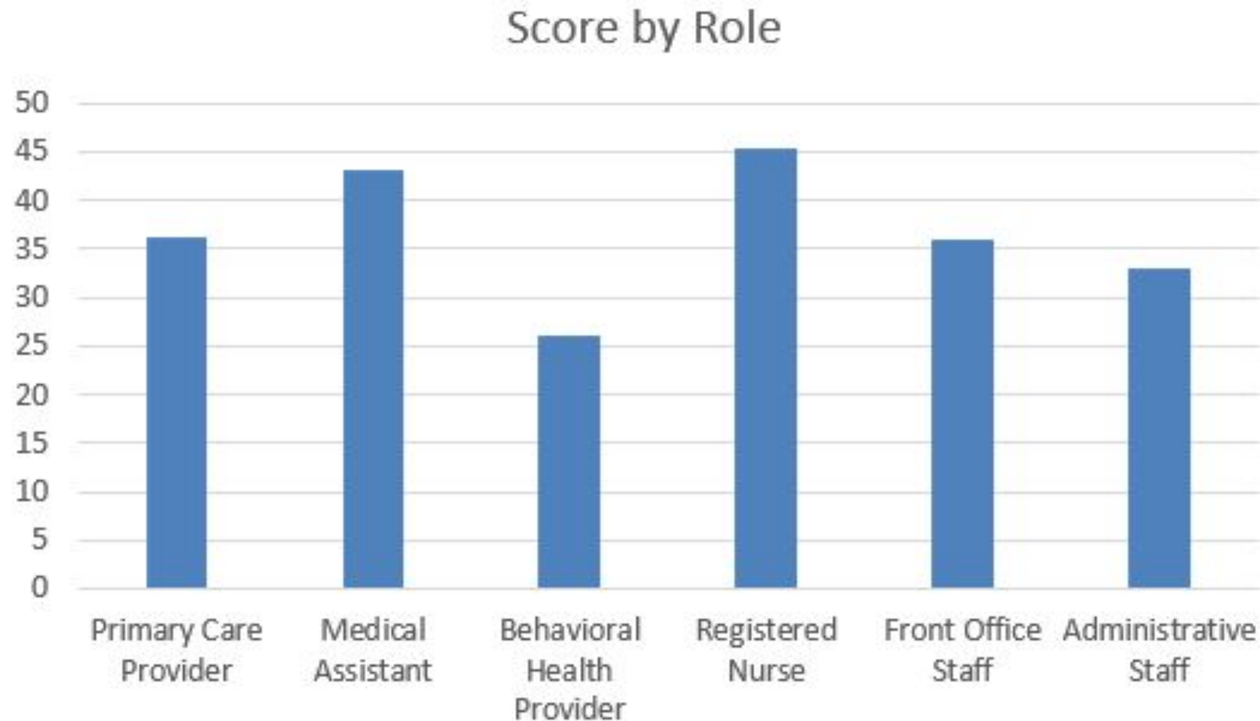

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ACE-15 Scores (cont.)

- 12 participants completed the survey from 3 health centers
- Scored on 4-point scale: strongly disagree (1), disagree (2), agree (3) and strongly agree (4)
    - Range of possible total scores is 15 to 60
    - Higher the score the higher the perception of teamness
    - Mean score was 41, ranged from 26-56
- Scores stratified by:
    - Time at health center
    - Team role

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ACE-15 Scores (cont.)

Lowest scoring domain:

The team constructively manages disagreements among team members.

Highest scoring domain:

The team is well supported by the overall organization (e.g., practice improvement is encouraged; team training is supported).

SBAR Role Play Activity

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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

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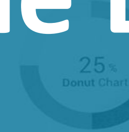
Huddle Discussion



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Videos + Resources

- Example of a small huddle b/w provider and MA/RN
    - https://youtu.be/fG9aB7TB27E
- PCMH huddle
    - https://youtu.be/rFSbguDv2sg
- Huddles acted out
    - https://youtu.be/dJrORZEiXpo
- Cambridge Health Alliance Model of Team-Based Care Implementation Guide and Toolkit:
    - https://www.integration.samhsa.gov/workforce/team-members/cambridge_health_alliance_team-based_care_toolkit.pdf

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Break Time

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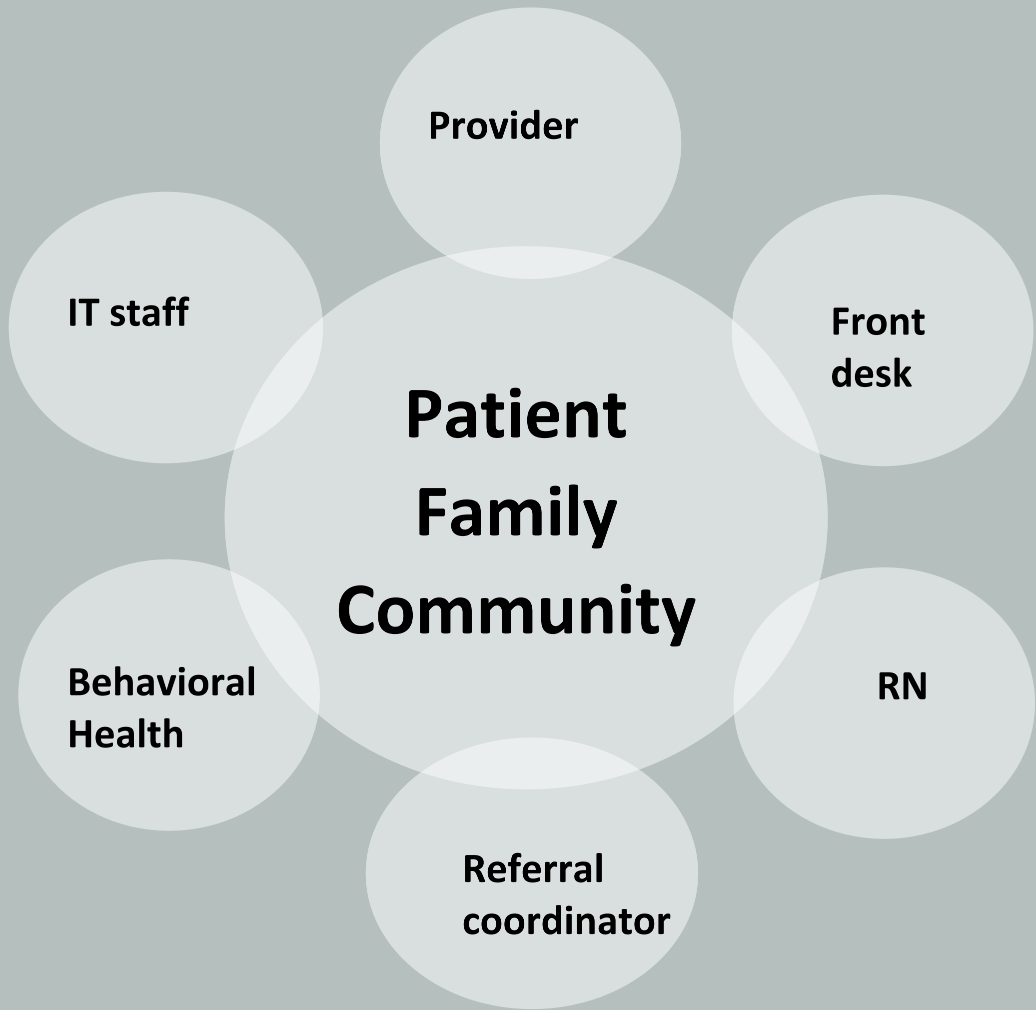
Team Diagram Activity



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Clarifying/Optimizing Roles Activity

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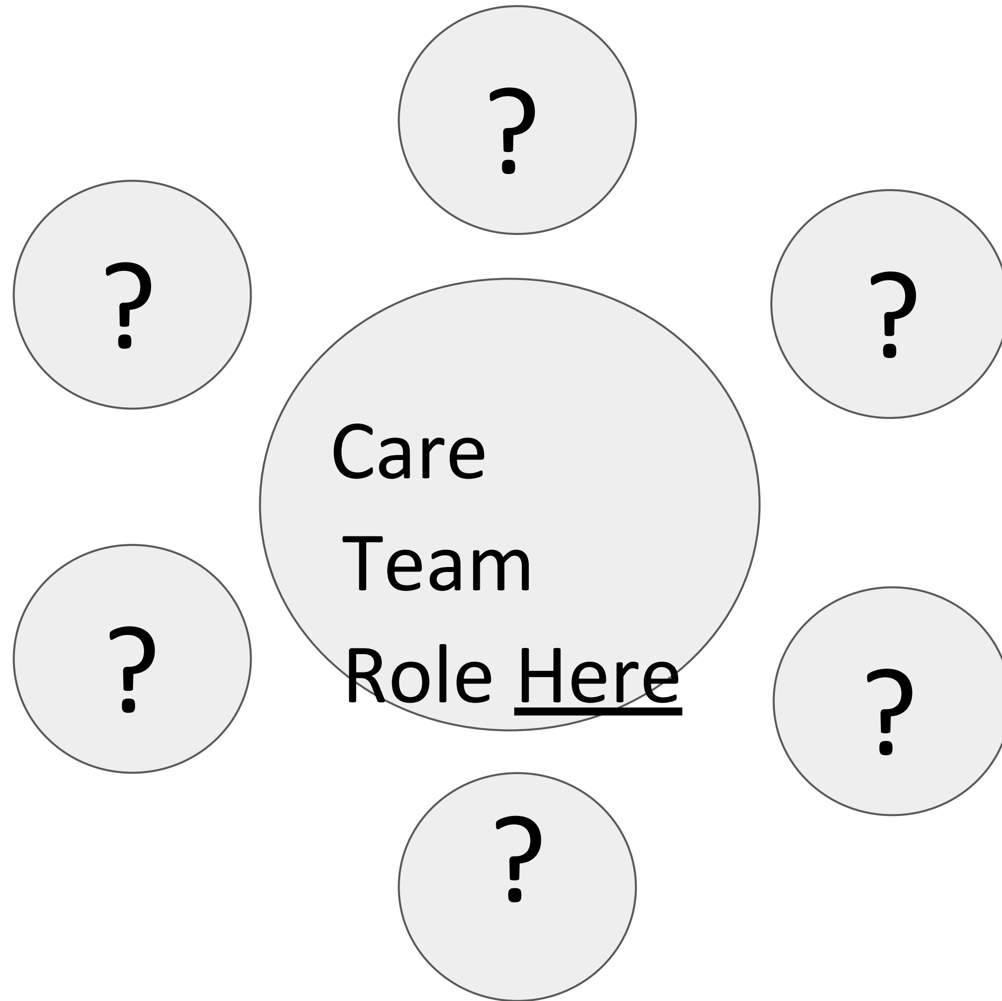

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Swim Lane Diagramming

A swim lane diagram assists with role clarification and efficiency.

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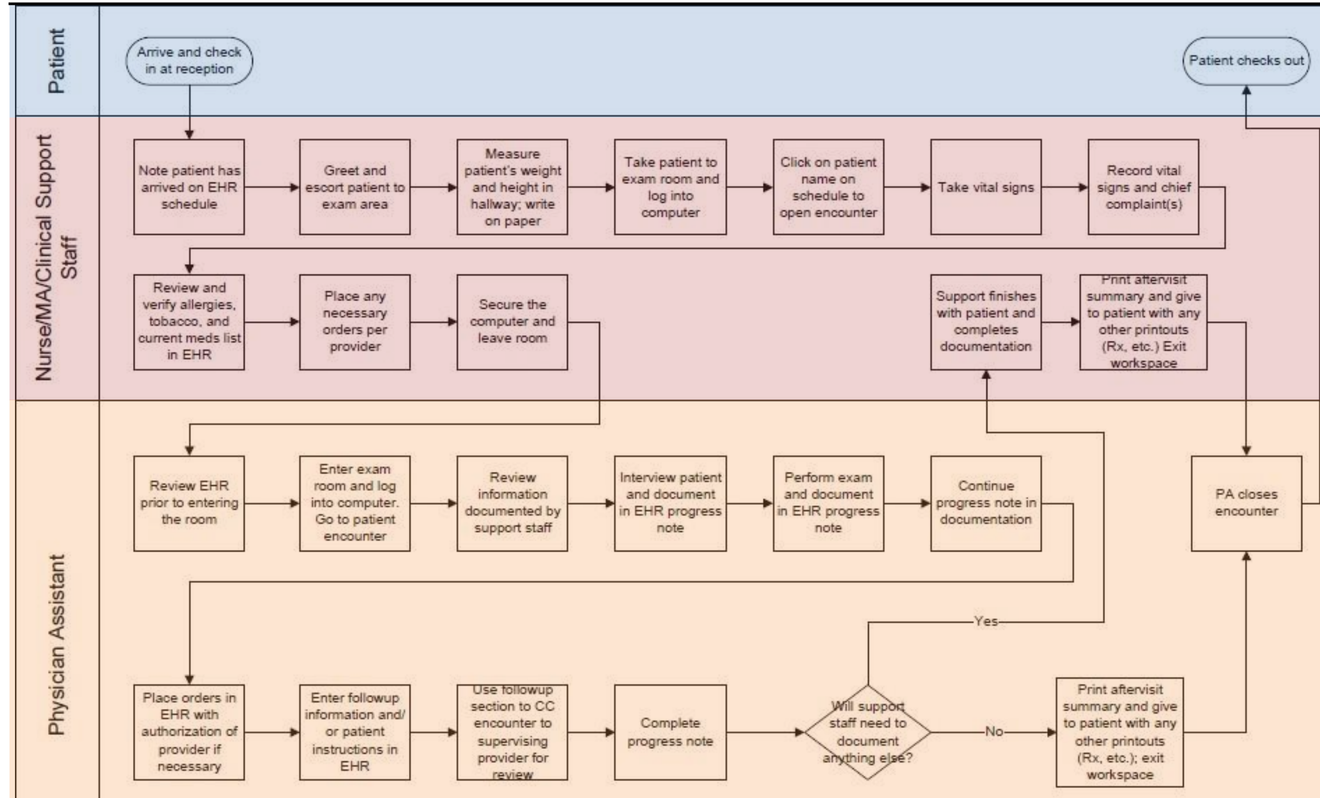
Example: Swim Lane Diagram for a Physician Assistant Office Visit



Adapted from "Physician Assistant (PA) Office Visit" available at: http://www.hrsa.gov/publichealth/business/healthit/toolbox/HealthITAdoptiontoolbox/index.html

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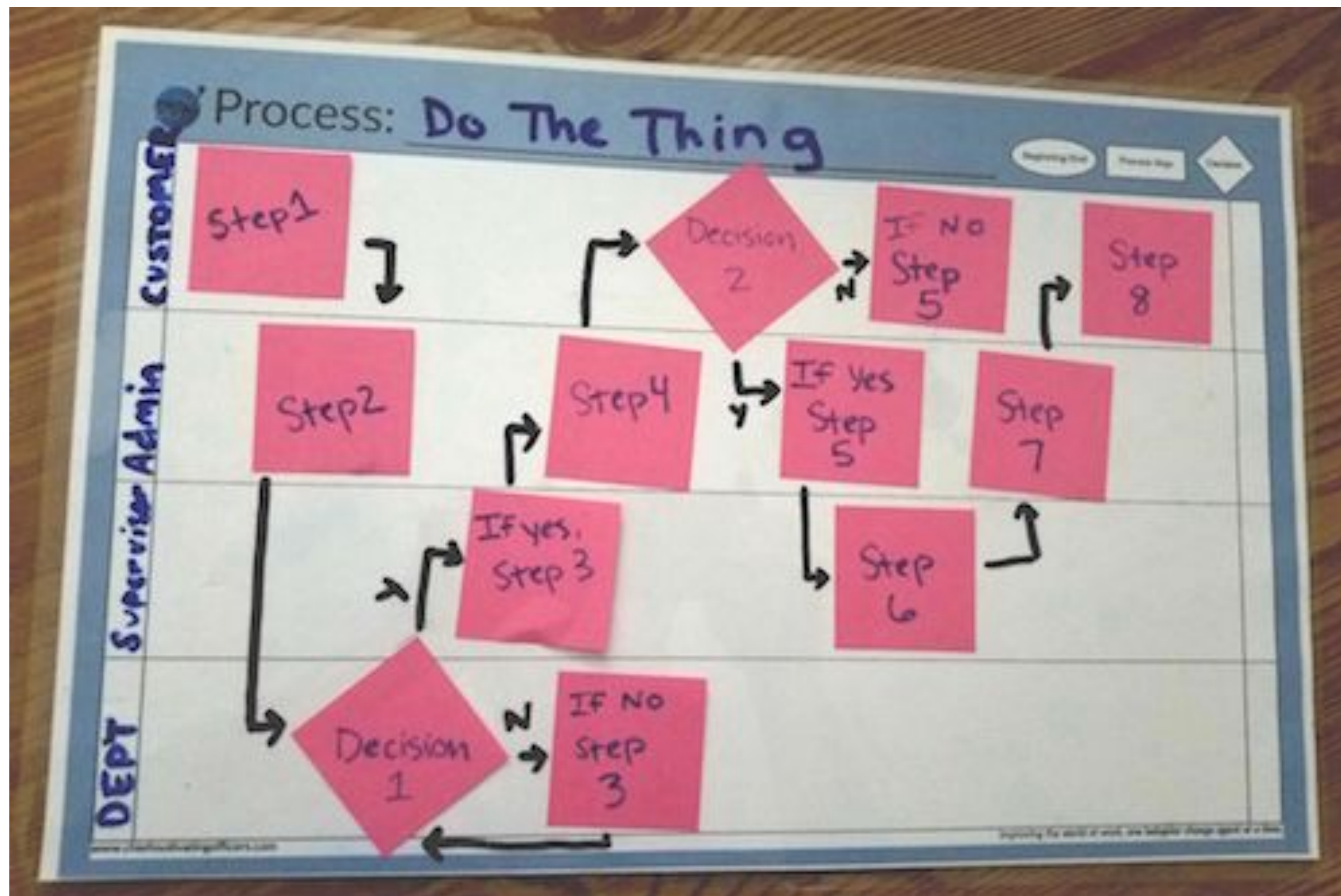

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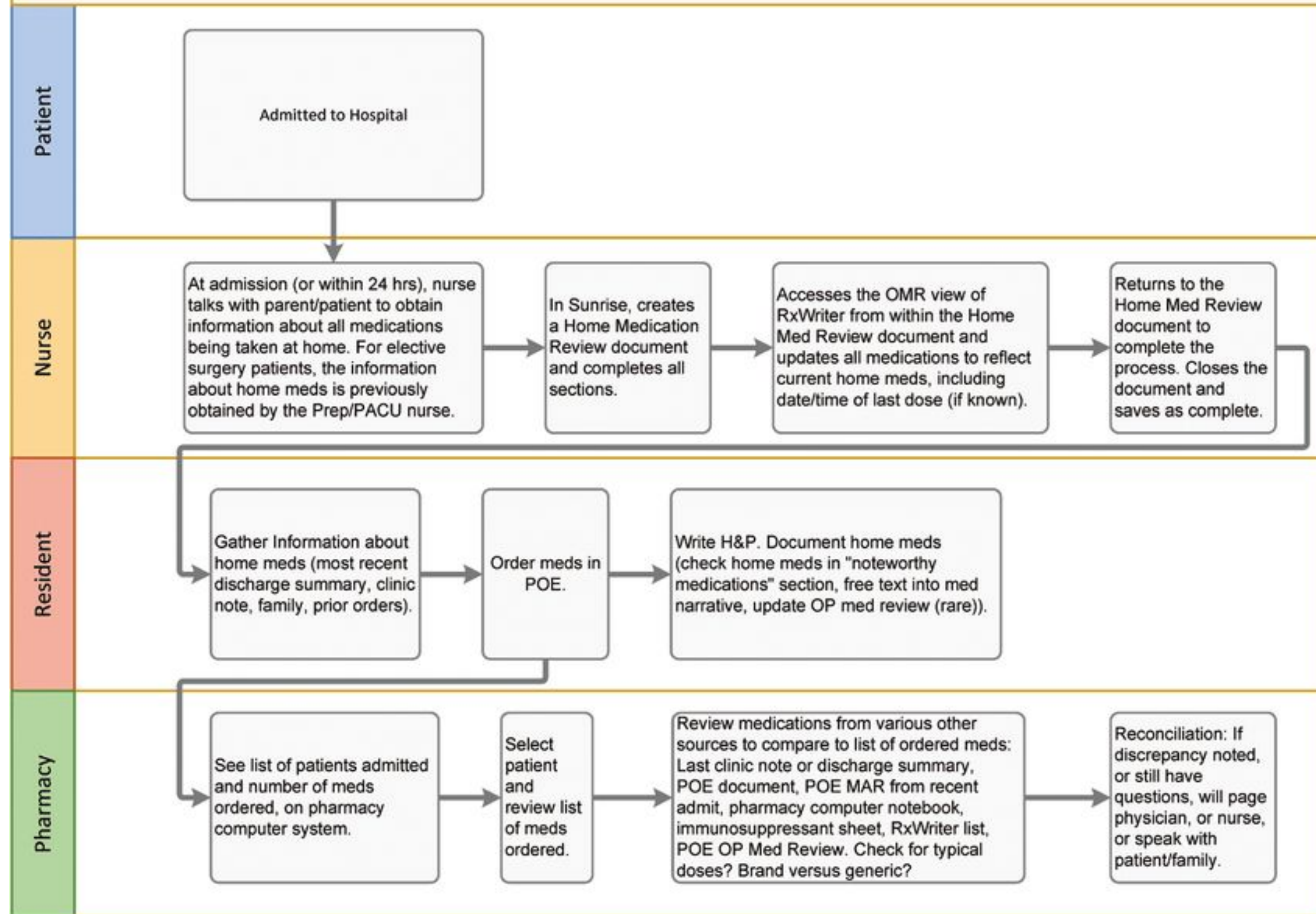

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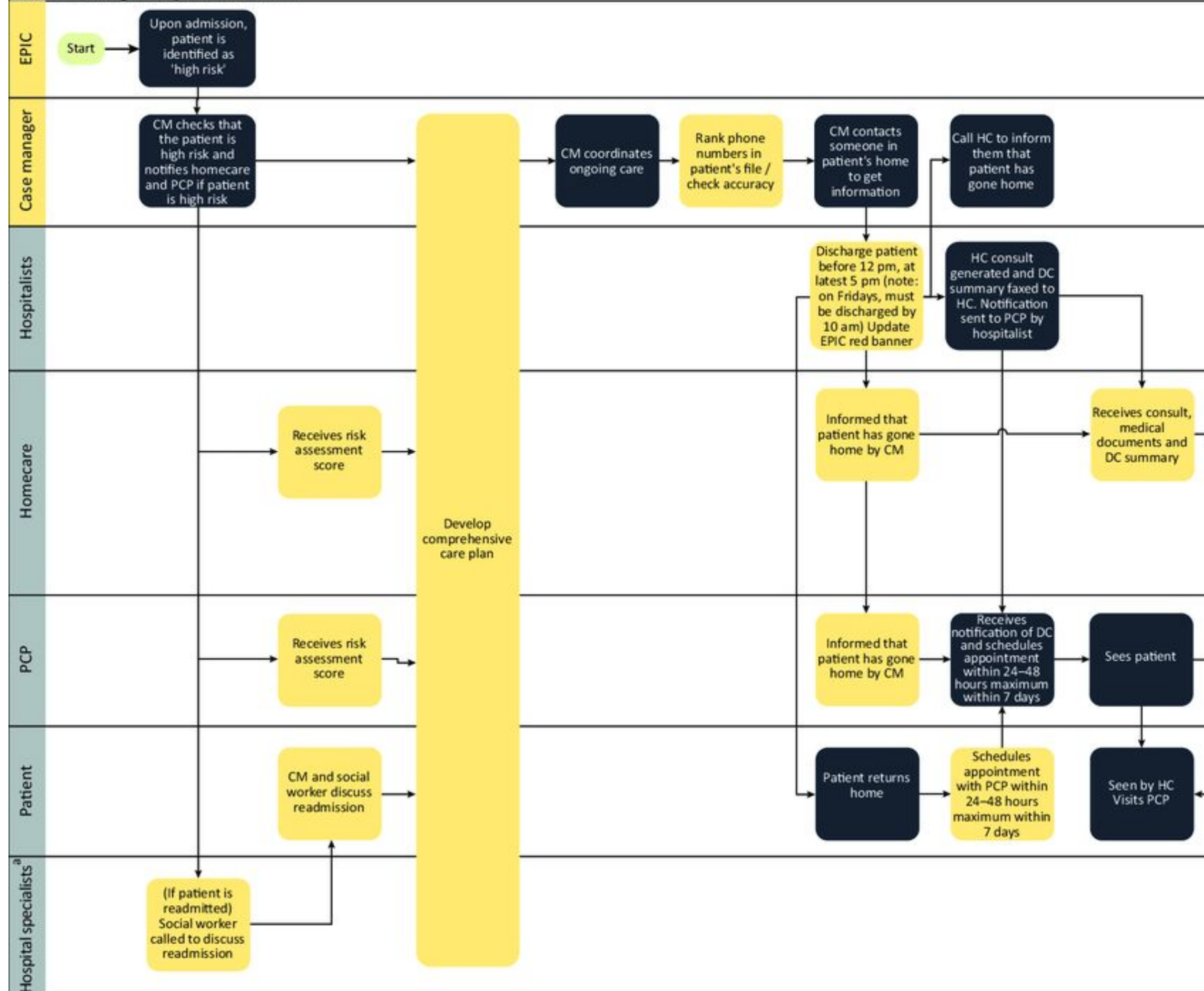

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RACI Matrix Activity

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RACI Matrix Example

Responsible - Does the task, one per row
Accountable - "Buck stops here", not necessary
Consulted - Prior to task, someone affected
Informed - After the fact, useful to know

Institute new colorectal cancer screening	Medical Director	RN	MA	Clinic Director	Student Intern
Research new iFOBT colorectal cancer screening tool	R	I		A	
Arrange for training for iFOBT work flows	R			C	
Create new screening protocols	R	C			
Identify patients in need of screening in the EHR	I	R	I		
Educate patients and provide iFOBT cards		R	I		
Run weekly reports to see how many returned cards				I	R
Call patients to remind them to return cards or discuss follow-up		C	R		

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Case Study

ABC Health Center is considering implementing a shared medical appointment model for patients with A1C>9 and co-occuring depression. Patients will attend group visits with a behavioral health provider.

R = Responsible: The person or function that performs the work. *There must be one "R" in every row, no more and no less.*
A = Accountable: The person or function *ultimately accountable* for the work or decision being made. Use this letter when appropriate, but not to excess – only when an important decision or task is at hand. *There can be from zero to one "A" in each row, but no more than one.*
C = Consulted: Anyone who must be consulted prior to a decision being made or a task completed. A "C" is typically a subject matter expert or a functional leader whose team will be affected by the decision/action. *There can be from zero to multiple "C's" in each row as appropriate.*
I = Informed: Anyone who must be informed after a decision is made or work is completed.
There can be as many "I's" as are appropriate in each row.

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RACI Matrix Grid

Task	Front Desk	Clinical Manager	Group Visit Providers	RN	MA	IT
Identify patients		A	I	I	R	C
Patient has to be called and enrolled	R	A				
Collect and evaluate data			C			R

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Break Time

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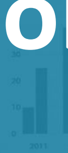
Care Coordination Map Activity



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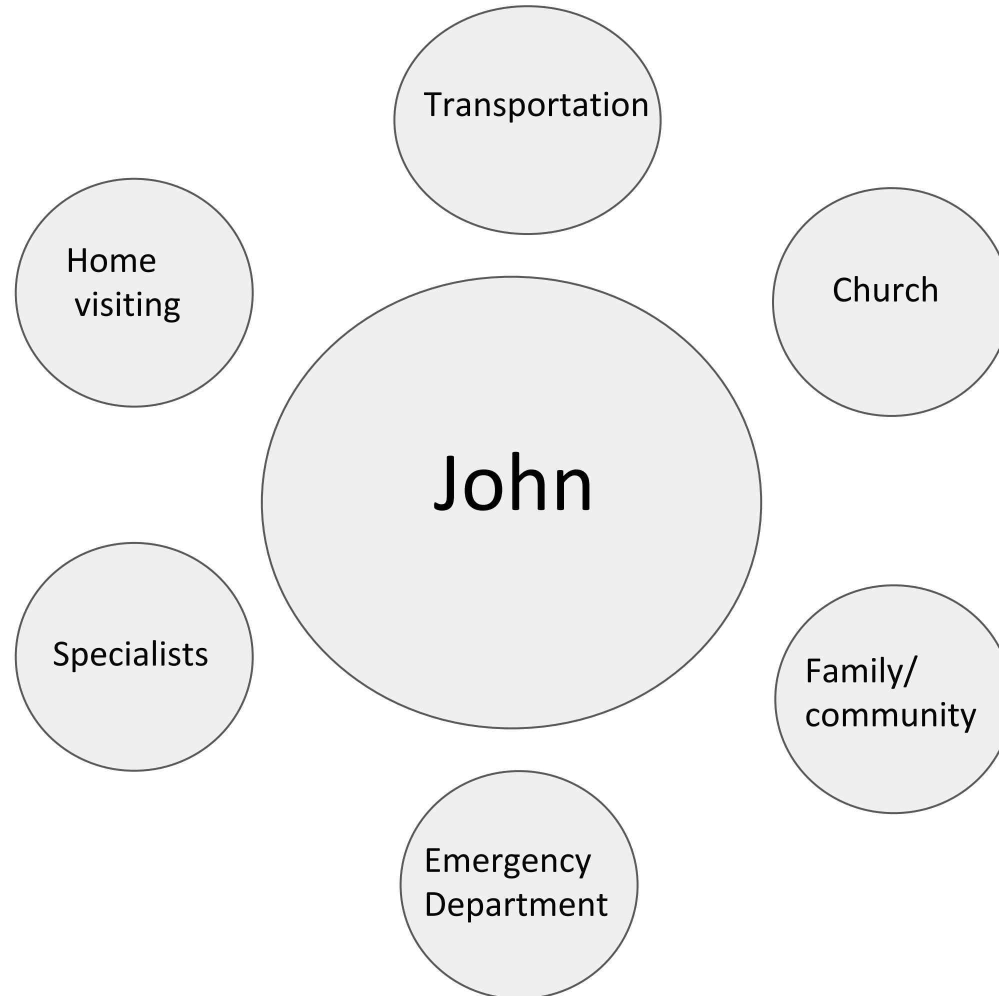
Case Study

John is 75 years old and lives with his wife. His daughter, son-in-law and their two children live close by in the same neighborhood. John has diabetes, congestive heart failure, hypertension and most recently, depression. His wife, Connie, has been more forgetful in the last six months along with having difficulty managing a number of chronic illnesses of her own. In the last year, John has visited the emergency department of his local hospital three times and has been hospitalized twice. He has Medicare Part A and Part B but has not paid for medication coverage. He is supposed to see his primary care team and a number of specialists for his diabetes and other chronic health problems. He has missed his regular appointments to have his eyes and feet checked. Most recently, John has been reluctant to see a behavioral health provider saying, "Of course, I'm said – I'm worried about my Corrine. I don't drive anymore and I don't want my Angie (his daughter) to have to take me everywhere. I'll be fine." He seems comfortable talking with the nurse and social worker on the primary care team during his visit.

John has been prescribed 8 medications. After his last hospital stay, a home care nurse saw him for a few weeks and set up a medication box for him. Members of his and Connie's church have tried to set up a neighborhood support system for them but have backed off since John and Connie insist on serving them meals when they visit.



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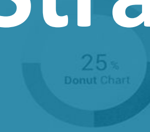
Risk Stratification



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Level 1 PRIMARY PREVENTION	Level 2 PRIMARY PREVENTION	Level 3 SECONDARY PREVENTION	Level 4 SECONDARY PREVENTION	Level 5 TERTIARY PREVENTION	Level 6 CATASTROPHIC CARE
GOAL: To prevent onset of disease (Low Resource Use)	GOAL: To prevent onset of disease (Low Resource Use)	GOAL: To treat a disease, reduce rising risk, and avoid serious complications (Moderate Resource Use)	GOAL: To treat a disease, reduce rising risk, and avoid serious complications (Moderate Resource Use)	GOAL: Treat the late or final stages of a disease and minimize disability (High Resource Use)	GOAL: May range from restoring health to only providing comfort care (Extremely High Resource Use)
CARE PLAN SUGGESTIONS • Preventive screenings and immunizations • Patient education • Health risk assessment (annual) • Appropriate monitoring for warning signs	**CARE PLAN SUGGESTIONS** • Preventive screenings and immunizations • Patient education and engagement • Health risk assessment (annual) • Appropriate monitoring for warning signs • Interventions for unhealthy lifestyle/habits • Links to community resources to enhance patient education, self-management skills, or special facilities	**CARE PLAN SUGGESTIONS** • Preventive screenings and immunizations • Patient education and engagement • Health risk assessment (semi-annual) • Appropriate monitoring for warning signs • Interventions for unhealthy lifestyle/habits • Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** • Group visits • Home self-monitoring • Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings	**CARE PLAN SUGGESTIONS** • Preventive screenings and immunizations • Patient education and engagement • Health risk assessment (semi-annual) • Appropriate monitoring for warning signs • Interventions for unhealthy lifestyle/habits • Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** • Group visits • Home self-monitoring • Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings • Health coach • Referrals, as appropriate	**CARE PLAN SUGGESTIONS** • Preventive screenings and immunizations • Patient education and engagement • Health risk assessment (quarterly) • Appropriate monitoring for warning signs • Interventions for unhealthy lifestyle/habits • Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** • Group visits • Home self-monitoring • Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings • Health coach/personalized care plan/management and resources • Referrals, as appropriate • Home health	**CARE PLAN SUGGESTIONS** • Hospitalization • Rehabilitation • Long-term care • Hospice/palliative care **TEAM/PLANNED CARE** • Support groups • Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings • Health coach/care management • Referrals, as appropriate • Home health • Personalized intensive care plan/ management and resources

Source: AAFP Algorithm for Risk Stratification. American Academy of Family Physicians. 2014. Available at: http://www.aafp.org/practice-management/transformation/pcmh/high-impact.html

John Swim Lane

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Activity

Care Coordination Swim Lane Activity

Instructions:
Create a care coordination swim lane diagram for John's first primary care visit following a hospitalization for congestive heart failure. Refer to the patient case study (below). Experiment with developing workflows across current primary care team members in your practice that:

1. Support each team member working to his/her highest level of expertise, skill, and licensure. Add/delete team members for your practice as needed.
2. Engage patient and family.
3. Incorporate preferred practices in transitional care (below) for patients with complex care needs.

Case Study:
John is 75 years old and lives with his wife. His daughter, son-in-law and their two children live close by in the same neighborhood. John has congestive heart failure, diabetes, hypertension and most recently, depression. His wife, Connie, has been more forgetful in the last six months along with having difficulty managing a number of chronic illnesses of her own. In the last year, John has visited the emergency department of his local hospital three times and has been hospitalized twice. He has Medicare Part A and Part B but has not paid for medication coverage. He is supposed to see his primary care team and a number of specialists for his diabetes and other chronic health problems. He has missed his regular appointments to have his eyes and feet checked. Most recently, John has been reluctant to see a behavioral health provider saying, "Of course, I'm said – I'm worried about my Corrine. I don't drive anymore and I don't want my Angie (his daughter) to have to take me everywhere. I'll be fine." He seems comfortable talking with the nurse and social worker on the primary care team during his visit.

John has been prescribed 8 medications. After his last hospital stay, a home care nurse saw him for a few weeks and set up a medication box for him. Members of his and Connie's church have tried to set up a neighborhood support system for them but have backed off since John and Connie insist on serving them meals when they visit.

Preferred Practices in Transitional Care (Post-Acute Primary Care Visit):

- Review hospital transfer record.
- Assess symptoms.
- Review self-care management (knows when to seek care, chronic illness management).
- Medication review and reconciliation.
- Assess gaps in home assistance/community supports and initiate referrals as indicated and acceptable to patient safety and family.
- Coordinate specialty and community service follow-up.

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Care Coordination Swim Lane Activity (cont.)

Patient (John)	Arrives and checks in at reception
Medical Assistant	
Registered Nurse	
Social Worker	
Care Coordinator/Case Manager	
Primary Care Provider	
Pharmacist	
Nutritionist	
Diabetes Educator	
Family/Supports	
Community Resources	
Other	

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Videos + Resources

- Pre-Visit Planning:
    - https://www.aafp.org/fpm/2015/1100/p34.pdf
    - https://edhub.ama-assn.org/steps-forward/module/2702514
    - Hold a pre-clinic team huddle.
    - Use a pre-appointment questionnaire.
    - Hand off patients to the physicians.
- In-between visit planning:
    - https://youtu.be/83E95xahBiI 4.45mins
    - Perform visit preparations.
    - Use a visit prep checklist to identify gaps in care.
    - Send patient appointment reminders.
    - Consider a pre-visit phone call or email.

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Videos + Resources (cont.)

- Office Visit: Example
    - https://youtu.be/pXatZM_Rie8 9mins
    - Reappoint the patient at the conclusion of the visit.
    - Use a visit planner checklist to arrange the next appointment(s).
    - Arrange for the laboratory tests to be completed before the next visit.
- MA scrubbing chart
    - https://youtu.be/QZIhDN2NaYM 5.59mins
- Tool for scrubbing charts:
    - https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Healthy_Huddles_Warm_Up_14-0602.pdf
- Care Team Meeting example
    - https://www.youtube.com/watch?v=zEYrxavdHnM 7.05mins

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EHR Discussion

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Break Time

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Specific

I will develop a Huddle pilot study at Main Street Health Center.

I will identify and train 3-4 care team members for this pilot program, inclusive of a Provider, MA, and RN.

In training this pilot group, we will introduce SBAR and Huddle techniques learned today and test competency through role play activities and learner assessment.

Measurable

Members of our pilot huddle program will achieve a score of 80% on the huddle assessment during training before “going live”.

Attainable

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.

Time-Bound

My pilot group will be identified and trained by April, 2018.

45 Day Commitments:

(e.g., SBAR, Huddles, Role Optimization, Shared Care Planning)

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Considerations

- Report cards for staff (either public or private)
  - https://www.aafp.org/fpm/2014/0500/p5.html#fpm20140500p5-t1
- Continuity despite turnover at health centers and partner organizations

Evaluation
and Wrap-up
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Final Questions

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