TBC Basics

Historical and Current TBC Model

Today's Presenters

Susan J. Vos BSN, RN, CCM

Licensed RN in the State of Michigan with expertise in practice transformation, care management, quality improvement, and understanding of models of care and payment models in respect to the healthcare industry.

Lynn Klima DNP, APRN, CNE, ANP-BC

Dr. Klima is an adult nurse practitioner and academic nursing professor with over 40 years of experience spanning clinical practice, executive leadership, and nursing education. Her work focuses on leadership development, patient-centered care, and integrating evidence-based practices to improve outcomes across diverse care settings.

Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

Virtual Etiquette

- Meeting participation:
  - When we are taking breaks be sure not to leave the meeting but rather mute your audio and video
  - We want this to be a networking and interactive experience. Test turning on your video and communicating with audio vs using chat.

- Environment:
  - Be aware of your backgrounds to not be distracting.
  - Do what you need to do in order to care for yourself. Move around, have beverages/snacks available if this will help you.

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Introductions

Tell us your …

- Name
- Role and experience in the role
- Topic from team-based care most interested in

AGENDA

1	TBC Basics – Historical and Current TBC Model (1.5 hours)
2	Care Management & Care Coordination (1.5 hours)
3	Care Management & Care Coordination (1.5 hours)
4	Aims / Measurement / Quintuple Aim (1.5 hours)

Presenter	Topic	Time
Sue and Lynn	Welcome and Introduction to History and Background of TBC	5 minutes
Sue	• Overview of CCM, PCMH, TBC	10 Minutes
Sue	• Activity: Team Roles and Responsibilities	10 Minutes
Sue	• Engagement the Patient as Part of the Team	10 minutes
Sue	• Activity: Elevator Speech	5 minutes
	Break	***5 Minutes***
	Tools to Promote TBC	
Lynn	• Huddles, Meetings, Effective Communication	10 minutes
Lynn	• Communication Tools: SBAR	10 minutes
Lynn	• Activity: SBAR	5 minutes
Lynn	• Other Communication Tools to ensure clarity	10 minutes
Lynn	Establishing our "Why" to create a pathway to the what	5 minutes
Sue	Next Steps	5 Minutes

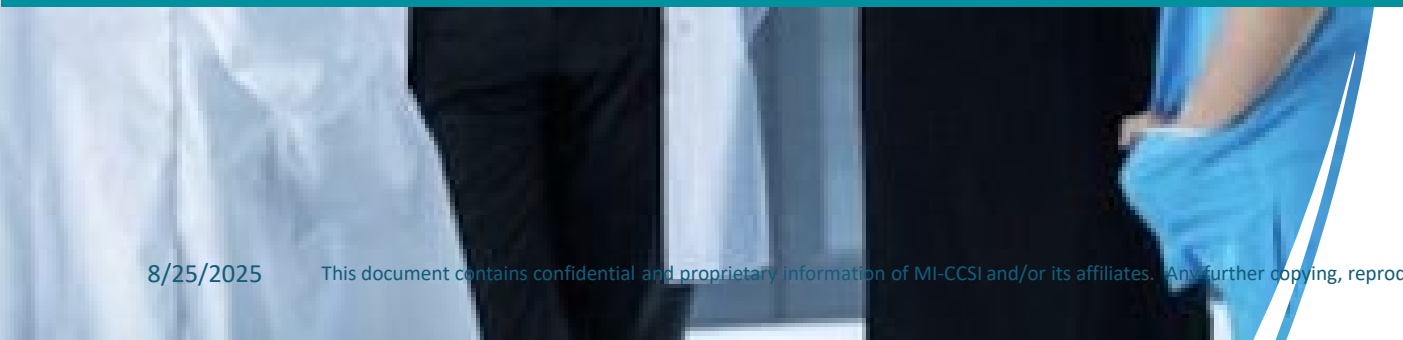
OBJECTIVES

At the conclusion of the presentation, the participant will be able to:

- Define the team-based model of care.
- Discuss how the team-based care model contributes to improved patient outcomes.
- Examine communication opportunities to integrate concepts of team-based care into your own clinical practice.

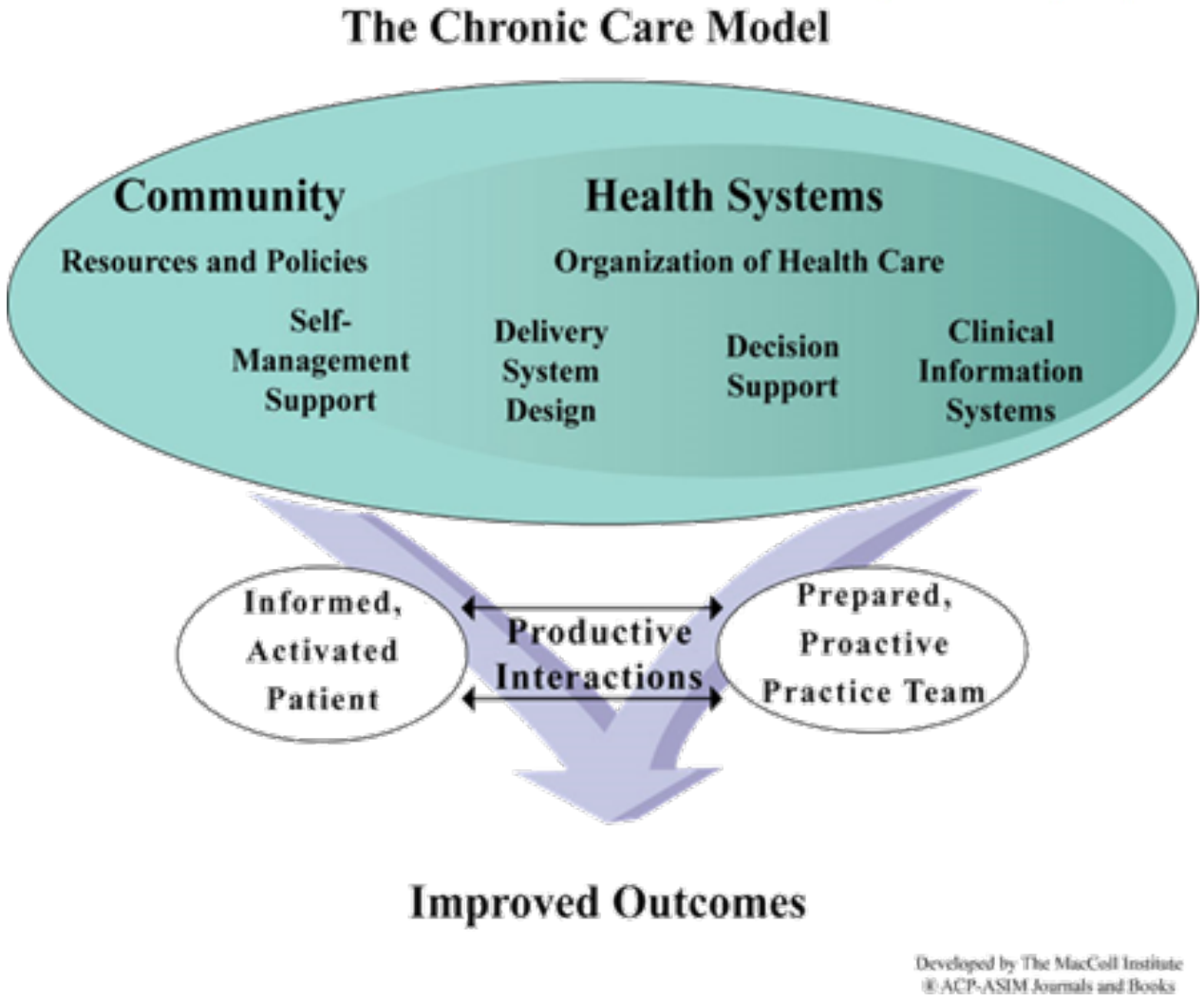
TBC Basics – Historical and Current TBC Model

History and Background of Team Based Care



The Chronic Care Model

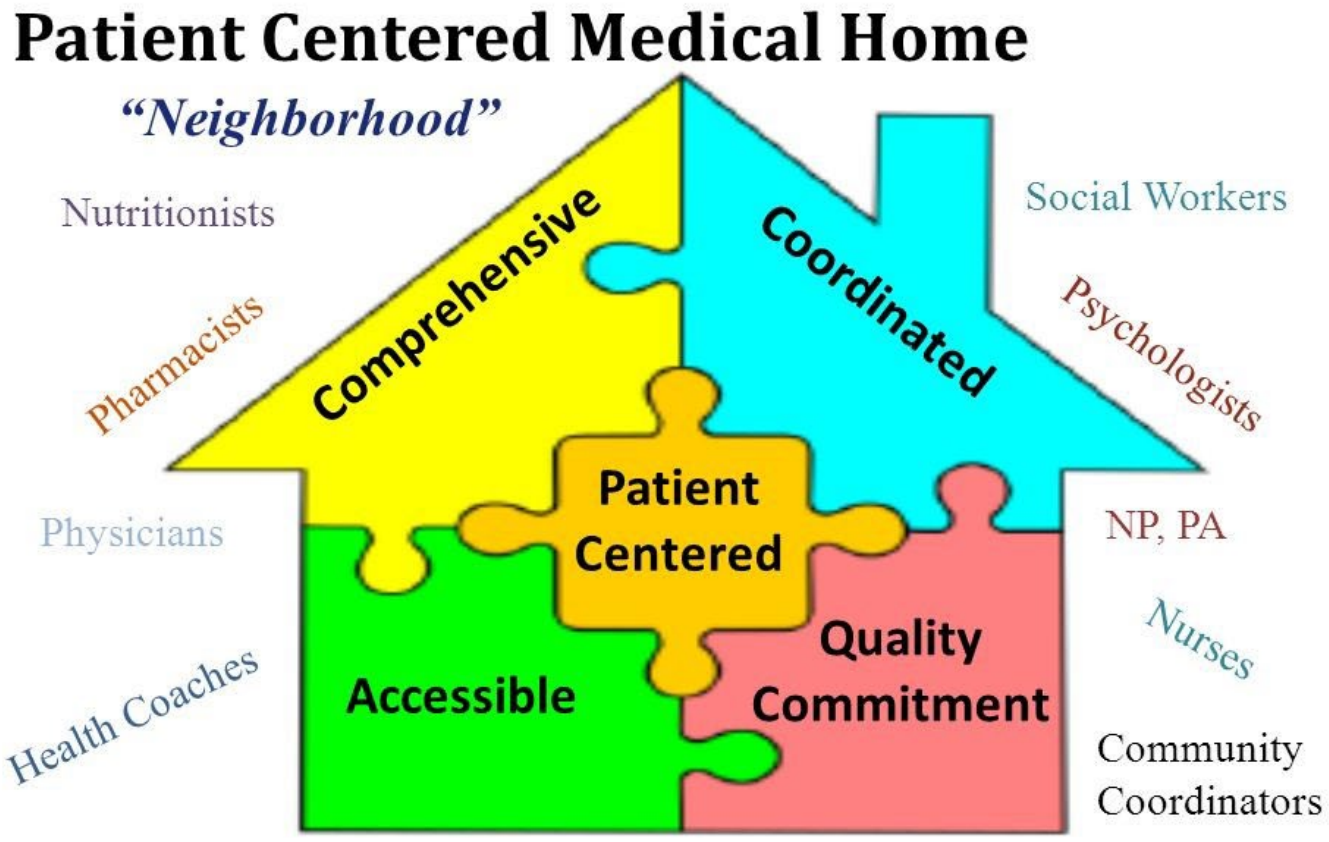
- An organized and planned approach to improving patient and population level health.
- Focus is on productive interactions to improve healthcare outcomes.



https://www.act-center.org/application/files/1616/3511/6445/Model_Chronic_Care.pdf

Patient Centered Medical Home
(PMCH)

PCMH is a care delivery model in which patient treatment is coordinated through primary care teams to ensure patients receive the necessary care when and where they need it, in a manner they can understand.



https://www.aafp.org/pubs/afp/issues/2007/0915/p774.html

PCMH and Chronic Care Model Alignment

- Comprehensive Evidence-Based Framework for improving care delivery and patient-centered chronic condition management across the spectrum of healthcare.
- Recognizes Primary Health Care as the necessary foundation from which the Community and Health System link to the patient
- Formal Quality Improvement process
- Self Management Support becomes universally accepted practice to engage patients across the spectrum of care continuum

https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod16.html


What is Team-Based Care?
Share
https://youtu.be/Kn3pXHcgG0A
WELL-AHEAD
Implementing Team-Based Care
What is Team-Based Care?
MORE VIDEOS
0:03 / 2:18
YouTube

ACTIVITY

Locate the form titled, “Roles and Responsibilities” on Page 4 of your workbook.

Beneath each role write down what you know and understand about that role and what the individuals in the role do on a day-to-day basis.

Now, as a team share your findings.

Discussion: Review Roles and Responsibilities

Task	Role				
	Provider	Office clerical	Clinic MA	Care Team Member	Patient
Participate in huddle					
Identify patients for care management					
Call patients after inpatient discharge within 48 hours					
Complete proactive outreach using patient registry lists					
Check-in process					
Complete screenings					
Complete patient assessment for plan of care					
Assist in the development of the patient plan of care					
Assess and reassess patient goals for success					
Assist with navigation of services					
Review/assist with medication management					
Provide self-management support					
Document/communicate the plan of care					
Schedule follow-up visits					
Coordinate case closures					

The role of **practice leadership is to support the tasks of the provider, office clerical, clinic MA, and care team members. They are not directly involved in the day-to-day tasks of developing the patient's plan of care.*

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Who is on the team? Examples of team roles

Provider	RN - CM	SW CM – Behavioral Health Specialist	Clinical Pharmacist	Community Health Worker	Office clerical	MA	Biller/Coder
• Annual Physical • Orders preventive care • Diagnosis, discussion of treatment options and management of acute and chronic conditions • Coordination of care and care team • Referrals to specialists • On call	• Provide care management for high-risk patients • Chronic illness monitoring response to treatment and titrating treatment according to delegated order sets	• Provide behavioral health services in the practice or by referral • Protocol or (service may be in the practice or at another site) • Urgent BH patient need	• Medication review for patients • Review prescribing practices • Assist patients with problems such as non-adherence, side effects, cost of medications, understanding medications, medication management challenges • Titrate medication for selected groups of patient under standing orders • Manages chronic conditions according to Collaborative Practice Agreements	• Provides self-management support • Coordinates care by helping patients navigate the healthcare system and access community services	• Assist with outreach to help patient establish overdue appointments • Assist patients with obtaining referral appointment, having preauthorization orders, and obtaining follow-up reports	• Collaborate with providers in managing a panel • Outreach on preventive services • Provides services to chronically ill patients such as self-management coaching or follow-up phone calls • Scrub chart, provides pre-visit screenings • Reviews medication list	• Transforms the diagnosis and treatment provided into an appropriate numeric or alphanumeric code. • Liaison between healthcare team and billing activities • Proper procedure (CPT/HCPCS) and diagnosis (ICD-10) coding is critical for obtaining appropriate payment and ensuring proper compliance with the law
	Quality Improvement Activities: Team conducts QI activities to monitor quality measures and improve metrics with involvement of patient and families Team monitors program targets and make changes to improve						

TBC Concepts

Engaging The Patient as a Part of the Team

"When a patient feels like they have a say or are making choices regarding their care, they are more likely to adhere to the programs.

Patient-centered care and allowing the patient to be involved in conversations about their health are key factors in the quality of service we provide and improve patient outcomes.

The healthcare team needs to include the patient in the decision-making process because the patient is the most important member of the team!"

https://ipe.umn.edu/news-media/collaboration-insights/engaging-patients-team-members#:~:text=Engaging%20patients%20in%20the%20decision,to%20better%20facilitate%20patient%20engagement.

TBC Concepts

Patient Provider Partnership Document

Goal:

Build provider care team and patient awareness of, and active engagement with, the PCMH model, clearly define provider and patient responsibilities, and strengthen the provider-patient relationship.

Team Leadership

Key Components of the Partnership Document

Practice unit has developed PCMH-related patient communication tools, has trained staff, and is prepared to implement patient-provider partnership with each current patient, which may consist of a signed agreement or other documented patient communication process to establish patient-provider partnership

Team Leadership

Key Components of the Partnership Document

PCP Guidelines:

- Patient communication process must include a conversation between the patient and a member of the clinical practice unit team. In extenuating circumstances, well-trained Medical Assistants who are highly engaged with patient care may be considered a member of the clinical practice unit team.
- Documentation does not need to be on paper. It may consist of note in medical record, sticker placed on front of the chart, indicator in patient registry, patient log, or similar system that can be used to identify the percent of patients with whom the partnership has been discussed.
- Documents and patient education tools are developed that explain PCMH concepts and outline patient and provider roles and responsibilities.
- Practice unit team members and all appropriate staff are educated/trained on patient-provider partnership concepts and patient communication processes.
- Process has been established for patients to receive PCMH information, and for practitioner to have conversation with patients about PCMH patient-provider partnership.
- Mechanism and process has been developed to document establishment of patient-provider partnership in medical record or patient registry.

TBC Concepts

Strategies to Engage Patients

Patient engagement…an increasing shift from more paternalistic models of care in which clinicians tell patients what they should do (and often ineffectively), to one in which clinicians' partner with patients.

- The collaborative partnership is intended to:
  - Help make better medical decisions
  - Educate patients about how to stay healthy and manage conditions
  - Develop systems and supports to activate patients
  - Sustain patient interest in their ongoing care

https://pmc.ncbi.nlm.nih.gov/articles/PMC6996004/

TBC Concepts

Fostering Patient and Family Caregiver Involvement

Embrace patients and family caregivers as separate, valuable, and contributing partners:

- Listen and elicit feedback from both patients and family caregivers.
- Assess patients' preference regarding involvement.
- Ask patients about their concerns.
- Speak to them in lay (plain language) terms.
- Allow time for patients and family caregivers to ask questions.
- Treat patients and family caregivers as distinct, with different information, preferences, and concerns.
- Help them access relevant information on a patient portal.

TBC Concepts

Patient and Family Caregiver Efficiency

Patients and Family Caregivers Can Function Effectively in Their Teams by:

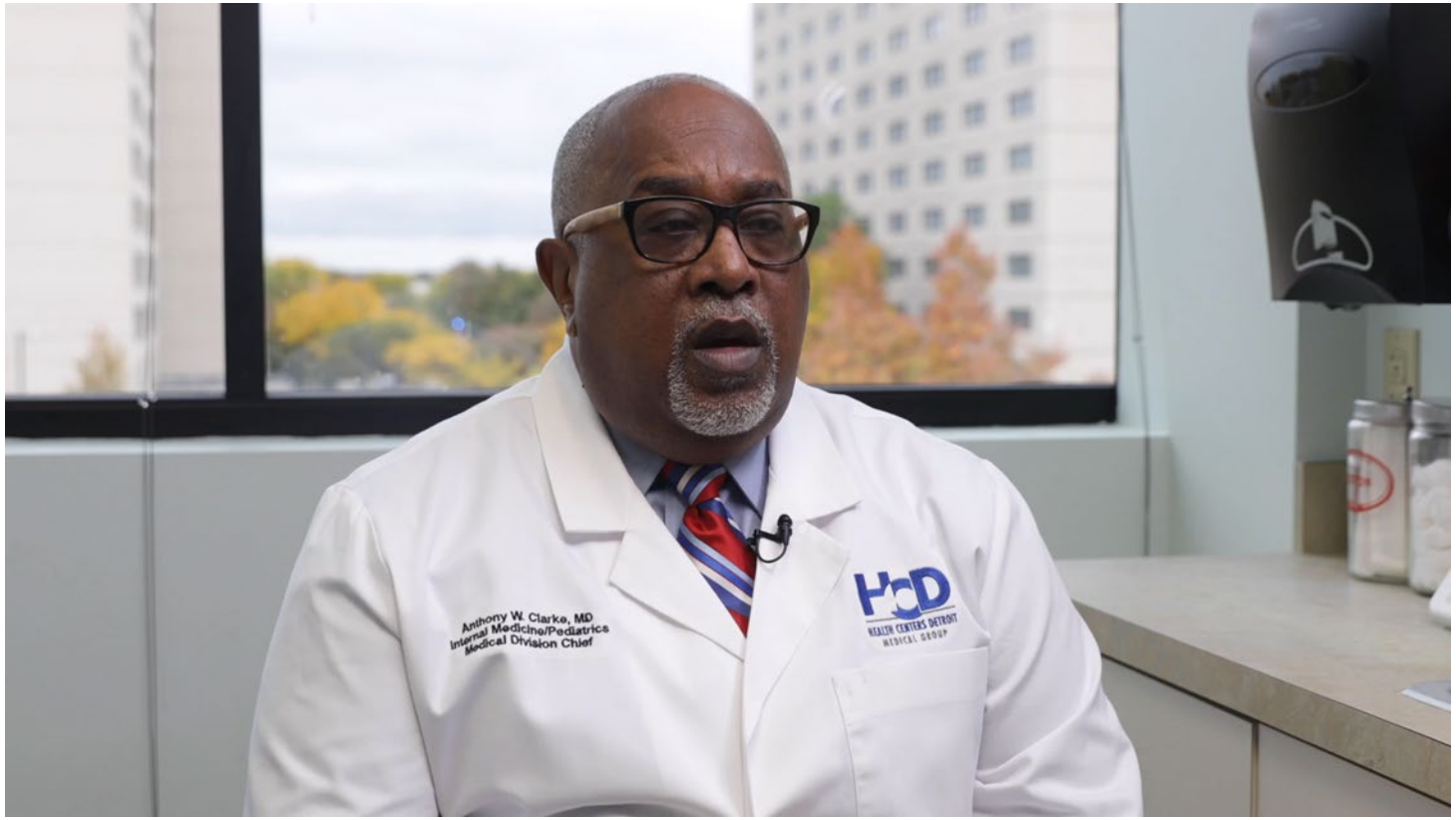
- Providing accurate patient information.
- Collaborating to create a care plan that they will follow (e.g., taking medications, scheduling and attending appointments).
- Asking questions and voicing any concerns regarding their care.
- Monitoring and reporting changes in the patient's condition.
- Coordinating and communicating with other family members.
- Encouraging and showing appreciation to other team members.

https://www.ihi.org/library/tools/ask-me-3-good-questions-your-good-health#downloads

How do Care Teams work together?

Dr. Anthony Clarke, MD

Health Centers Detroit Medical Group



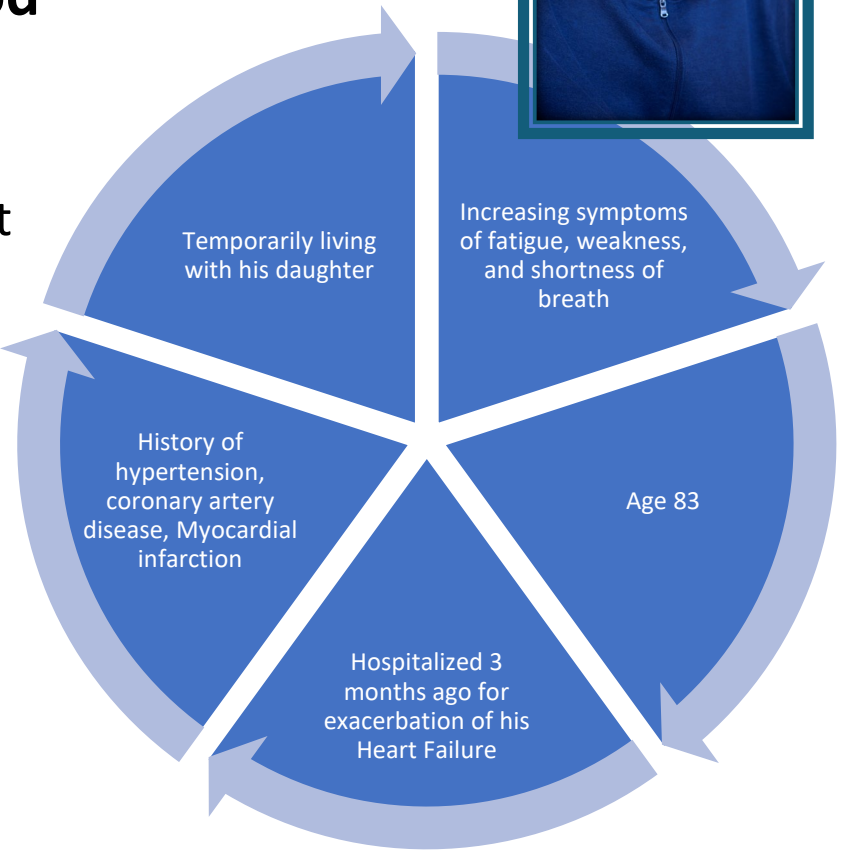
ACTIVITY

Think about a patient, neighbor, family member with a challenging healthcare experience…

- **Individually**
  - How could a team-based approach change that experience.
- **Group sharing**
  - 1 -2 volunteers sharing

Case Study: Mr. B Calls the Clinic

- **Unsure about his medications**
  - Specifically, in the hospital they held his hydrochlorothiazide and on discharge did not give any directions on what to do about that
- **States feeling "low"**
- **Not following the low-sodium diet – can't stand the food without seasoning**
- **Worried about his living arrangements**
  - Wants to go back home, but his daughter is concerned about that
  - He has fallen once, no injuries other than bruises on his forehead
  - He is unable to complete his own activities of daily living without some assistance
  - Tires easily and needs help dressing
  - He can do his hygiene
- **He's having trouble sleeping**
- **He completed the SDOH screening**
  - Needs assistance with transportation to medical appointments
  - Has housing needs (based on wanting to return home)



What is your elevator speech?

Defining Team-based Care at Southlake

ACTIVITY

Page 24 of workbook

TBC Basics – Historical and Current TBC Model

Tools to Promote Team Based Care

Tools to Promote Team Based Care

- Patient/Provider Partnership Document
- Meetings, Huddles, Care Conferences
- Policies and Procedures
- Standing Orders

So, now that we've reviewed the models of team-based care, we'd like to spend some time on the use of tools and communication approaches to support teamwork!

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Meeting Examples

Huddle	Team Meeting
Short, patient centered	Has an agenda, operational
Frequent, even daily	Less frequent, but scheduled regularly or ad hoc
Goal is to discuss arising situations that need multi-disciplinary support and are complex enough for a conversation: • High risk patients, complex Plans of Care • ED or IP visits • Requests for different referrals • Concerns for a patient	Goal is to improve the overall program performance: • Review operational opportunities, such as scheduling or standing agreements/orders • Review process for referrals • Review outcomes measures / performance
Participants include the individuals directly involved with the huddle topics	Participants expanded to include all involved with the process on the agenda: front and back office, billing, PCP, Care Team, MA, Office Manager

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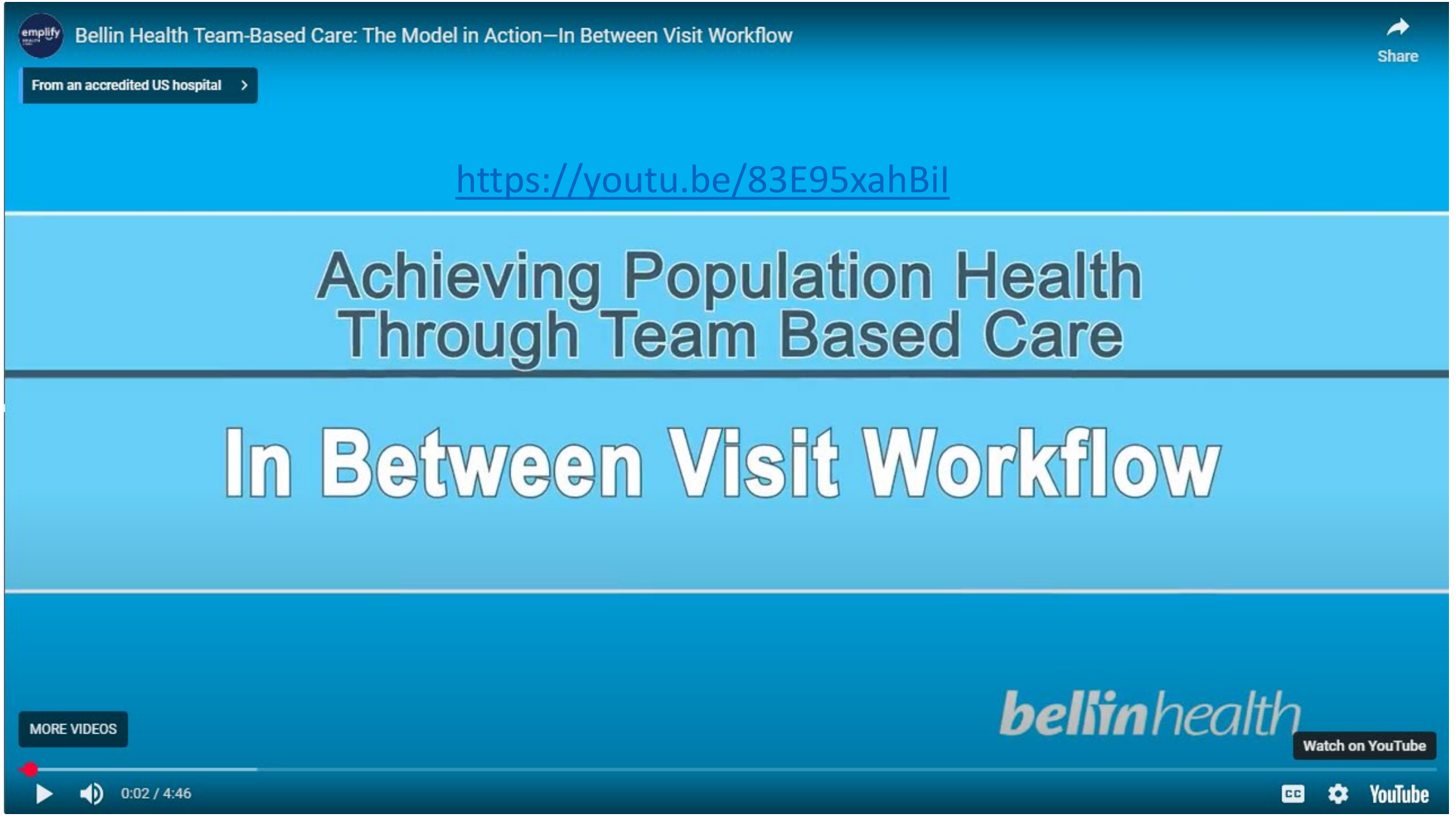

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Tools to Promote Team Based Care

Policies & Procedures

The value of policies and procedures:

- **Consistency in Care** – Ensures all team members follow the same evidence-based standards.
- **Improved Patient Safety** – Reduces errors by providing clear, step-by-step guidance.
- **Clear Roles & Responsibilities** – Minimizes confusion and overlap in tasks.
- **Regulatory & Compliance Support** – Meets legal, accreditation, and payer requirements.
- **Efficient Team Communication** – Provides a shared reference point for decision-making.
- **Training & Onboarding Tool** – Speeds up integration of new staff into workflows.

Tools to Promote Team Based Care

Policies & Procedures

In primary care, policies and procedures are formal, documented instructions and guidelines that define how specific tasks, processes, and situations should be handled. They aim to standardize care, ensure consistency, improve quality, and mitigate risk.

Policies are high-level statements that guide decision-making and establish overall direction. Procedures are detailed, step-by-step instructions for completing specific tasks or handling specific situations. Both are crucial for a well-functioning clinical setting.

EXAMPLES

Comprehensive Assessment

Scheduling practices

Medication Reconciliation

Documentation

Tools to Promote Team Based Care

Standing Orders & Agreements

Standing Orders/Agreements facilitate team-based care by giving blanket agreement for proactive outreach by the care team.

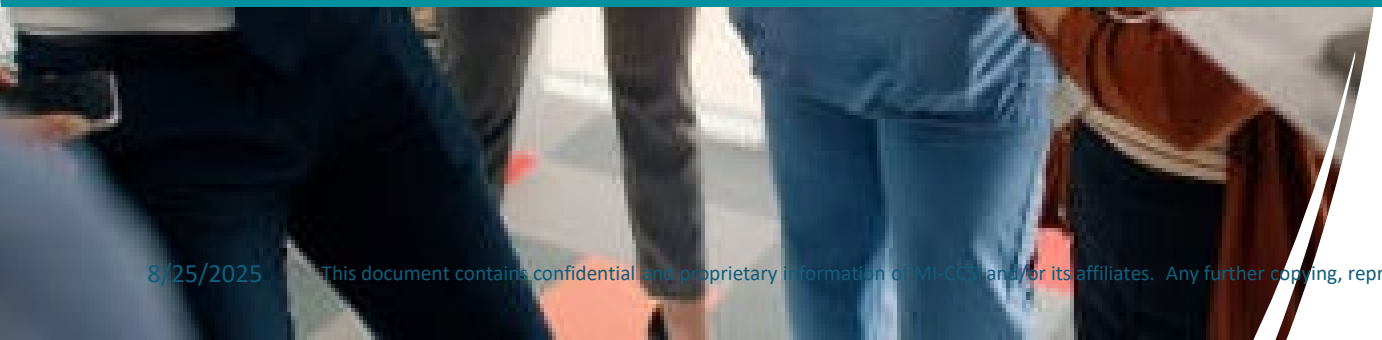
Standing orders examples:

- Transitions of Care phone calls
- Calling patients for gaps in care / other preventive care
- Immunizations procedures
- Enrollment into chronic care management

https://cepc.ucsf.edu/standing-order. https://www.jabfm.org/content/25/5/594

TBC Basics – Tools to Promote TBC

Team Communication



Let's Talk Team Communication

Communication is……..
…a taken-for-granted human activity that is recognized as important only when it has failed."

Complex Setting

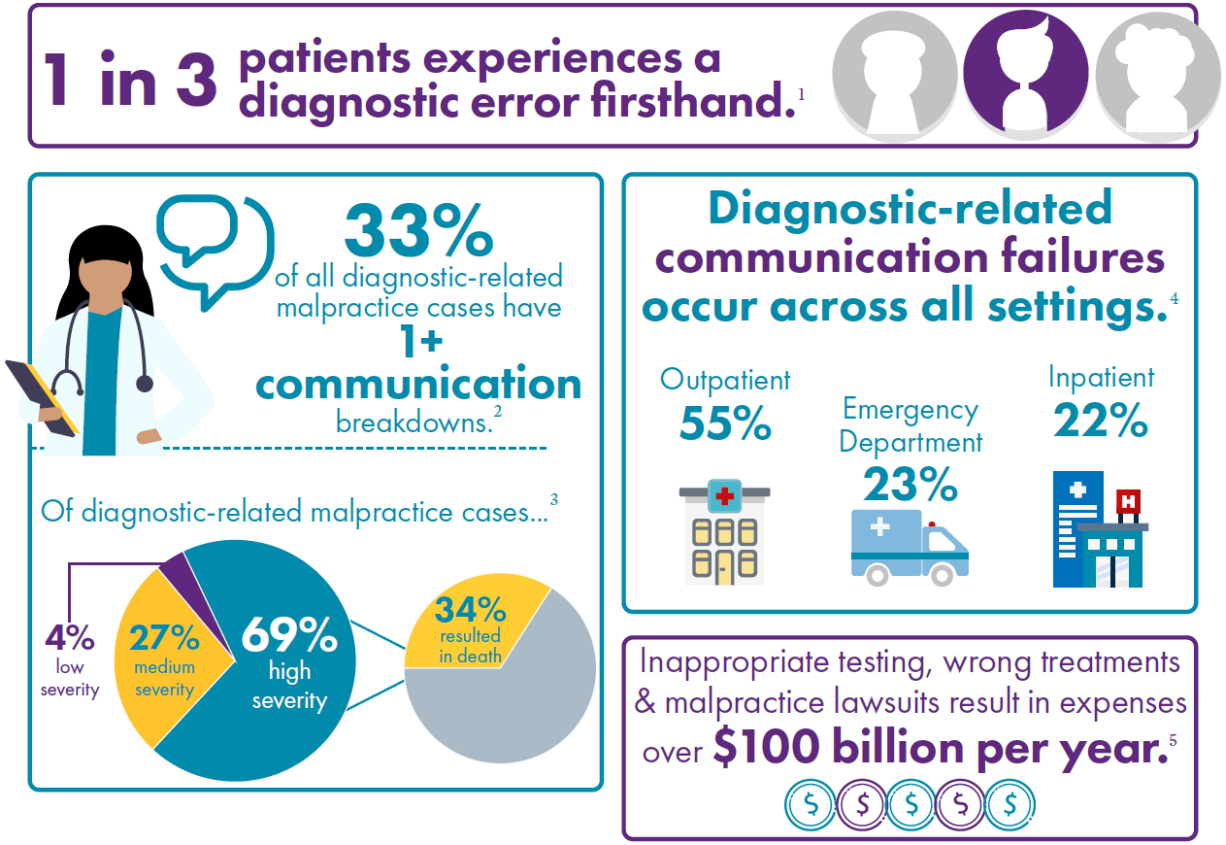
Complex Patients

Importance of Communication

Joint Commission data identify communication failures as a common cause of sentinel events.

AHRQ-funded research identifies communication and inadequate information transfer as the top two causes of medical errors.

Diagnostic errors are common, harmful, and often the result of communication breakdowns.



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Source for infographics: https://www.ahrq.gov/sites/default/files/wysiwyg/teamstepps/diagnosis-improvement/dxsafety-infographic.pdf

Team Communication
TeamSTEPPS 3.0

- TeamSTEPPS is an evidence-based framework to optimize team performance across the healthcare delivery system.
- It requires clearly defined and appropriate team structure and the use of four teachable-learnable skills: Communication, Team Leadership, Situation Monitoring, and Mutual Support.
- The TeamSTEPPS framework reflects the connections between these four skills and how they contribute to the knowledge, attitudes, and sustained high performance needed to achieve highly reliable, safe, and effective care for every patient.

Knowledge: Shared Mental Model
Attitudes: Mutual Trust, Team Orientation
Performance: Adaptability, Accuracy, Productivity, Efficiency, Safety, High Reliability
Sustainability: Enduring Culture of Safety

https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/index.html

Team Communication

Key Skills

Communication

A verbal and nonverbal process by which information can be clearly and accurately exchanged among team members.

Team Leadership

Ability to lead teams to maximize the effectiveness of team members by ensuring that team actions are understood, changes in information are shared, and team members have the necessary resources.

Situation Monitoring

Process of actively scanning and assessing situational elements to gain information or understanding, or to maintain awareness to support team functioning.

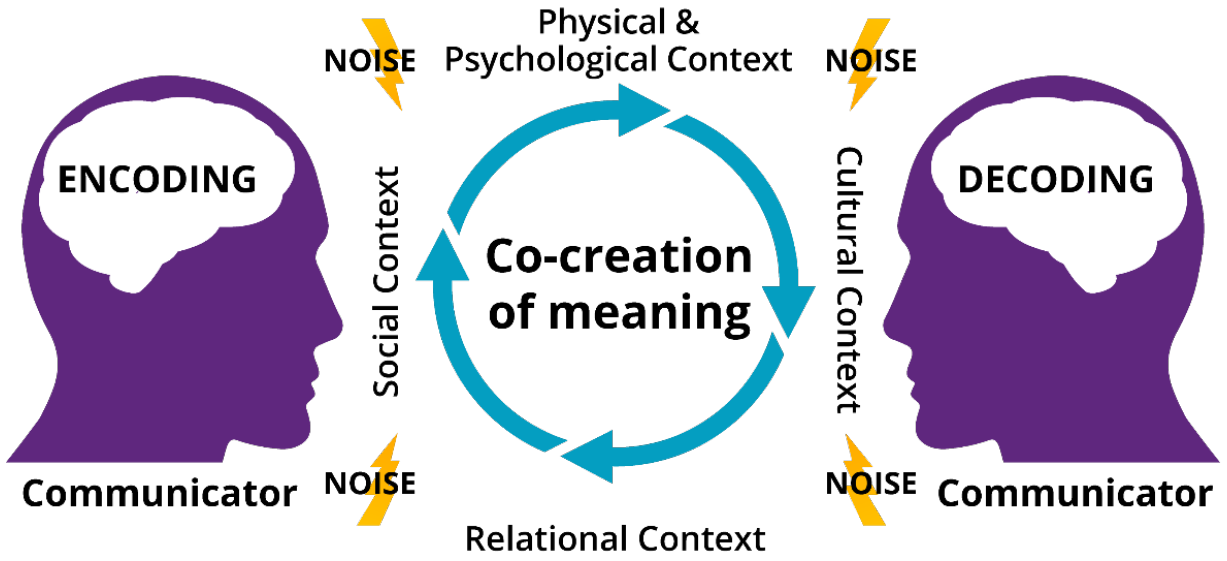
Mutual Support

Ability to anticipate and support team members' needs through accurate knowledge about their responsibilities and workload.

Team Communication

Communication Is …

- Both sending and receiving messages.
- The co-creation of meaning that may differ from the intended meaning.
- Affected by noise, context, and communicator assumptions.
- The mode by which most TeamSTEPPS strategies and tools are executed.



https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/index.html

Team Communication
Effective Communication Skills

- Are vital for patient safety.
- Enable team members to effectively relay information, build trust, and provide reassurance and emotional support.
- Are the mechanism by which most TeamSTEPPS strategies and tools are executed.

https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/index.html

Team Communication

Standards of Effective Communication

Complete

Communicate all relevant information

Clear

Convey information in plain language

Brief

Communicate information in a concise manner

Timely

Offer and request information in an appropriate timeframe

Respectful

Use communication to foster psychological safety and affirm other team members, not just to give instructions or share information

Team Communication

Barriers to Good Communication

Personal

- Diverse thinking styles
- Memory limitations
- Stress/anxiety
- Fatigue, physical factors
- Multi-tasking
- Flawed assumptions
- New role/new team

Environmental

- Multiple modes of communication
- Many modes communication
- Rapid change
- Variations in team culture
- Time pressure
- Distractions
- Interruptions

Team Communication
Relationship & Engagement

It's about Relationship and Engagement with Team members

- Seek out opportunities for interactions
- Shadow and reverse shadow team members
- Be curious
- Recognize common goals and values
- Recognize there may be differences in communication style
- Seek to understand-address proactively
- Assume the best

Performance Assessment Results

Discussion on Categories of Best/Opportunities

Team Communication
Promoting & Modeling Teamwork

Effective leaders (team members) cultivate desired team behaviors and skills through:

- Open sharing of information.
- Role modeling and effective cuing of team members to use prescribed teamwork behaviors and skills.
- Constructive and timely feedback.
- Facilitation of briefs, huddles, debriefs, and conflict resolution.
- Mitigation of conflict within the team.

TBC Basics – Historical and Current TBC Model

Tools to Promote Team Communication

Team Communication

Communication Tools

- Clear patient encounter documentation in the EHR
- Messaging (TEAMS, instant messenger embedded in EHR)
- Ad hoc conversations (which are unplanned, for an immediate need)
- Information Exchange Tools

Different communication tools serve different purposes – all are meant to keep the team informed of patient progress, plan of care changes, and operational changes that support better patient outcomes.

Feedback Loop for Communication

1. Sender
2. Receiver
3. Message
4. **Feedback**
    a. Teach-back
    b. Show-back

Example:

- Patient was prescribed a hypertensive medication.
- Patient filled the medication
- At the next visit, BP was still elevated.
- Provider would have prescribed more medication, but the care team member asked how the patient was taking the meds.
- Patient revealed that no meds were taken because of side effects.
- Care team member communicated this to provider before script was changed.

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Information Exchange Tools

- Situation – Background – Assessment – Recommendation or Request (SBAR)
- Call-Out
- Check-Back
- Teach-Back
- Handoffs (including I-PASS)

SBAR

SITUATION

What is going on with the patient?

"Dr. Lu, this is Alex, a nurse from your 5th Street office. I am calling about your patient, Mr. Webb. He reports being in substantial discomfort and that there is not much urine in his catheter bag."

BACKGROUND

What is the clinical background or context?

"Mr. Webb is an 83-year-old patient that has a catheter in place during his recovery from bladder cancer treatment."

ASSESSMENT

What do I think the problem is?

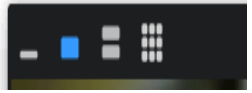
"He also reports a temperature of 100.4 and that the urine in his bag is cloudy and slightly red. I am concerned he may have an infection and that his catheter may be clogged."

RECOMMENDATION OR REQUEST

What would I do to correct it?

"I would like him to come into the office this morning for you to see him. When he arrives, would you like us to get labs, including blood cultures, to check for infection?"

- Do not forget to introduce yourself—you should not assume that everyone knows who you are.
- SBAR is adaptable. Think of it as a menu: the parts you choose to use and the order in which they are used depend on your team's unique needs. Determine which parts of SBAR are relevant to your team's needs and use those when communicating critical information among your team members.
- SBAR can be modified for use by the patient or family caregivers to communicate with the care team. For example, your facility could provide patients with a summary of SBAR to enable them to share information about their own situation, background, assessment, and recommendations or to ask the care team about their care.
- Consider saying the actual words to keep yourself on track: "The situation is..., The background is..., My assessment is..., I recommend..."



SBAR ResourceAHRQ: https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/sbar.html

SBAR Ineffective Communication

https://youtu.be/CtdNQ-sfKg8

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SBAR Effective Communication

https://youtu.be/fsazEArBy2g

Case Study: Mr. B Calls the Clinic

- **Unsure about his medications**
  - Specifically, in the hospital they held his hydrochlorothiazide and on discharge did not give any directions on what to do about that
- **States feeling "low"**
- **Not following the low-sodium diet – can't stand the food without seasoning**
- **Worried about his living arrangements**
  - Wants to go back home, but his daughter is concerned about that
  - He has fallen once, no injuries other than bruises on his forehead
  - He is unable to complete his own activities of daily living without some assistance
  - Tires easily and needs help dressing
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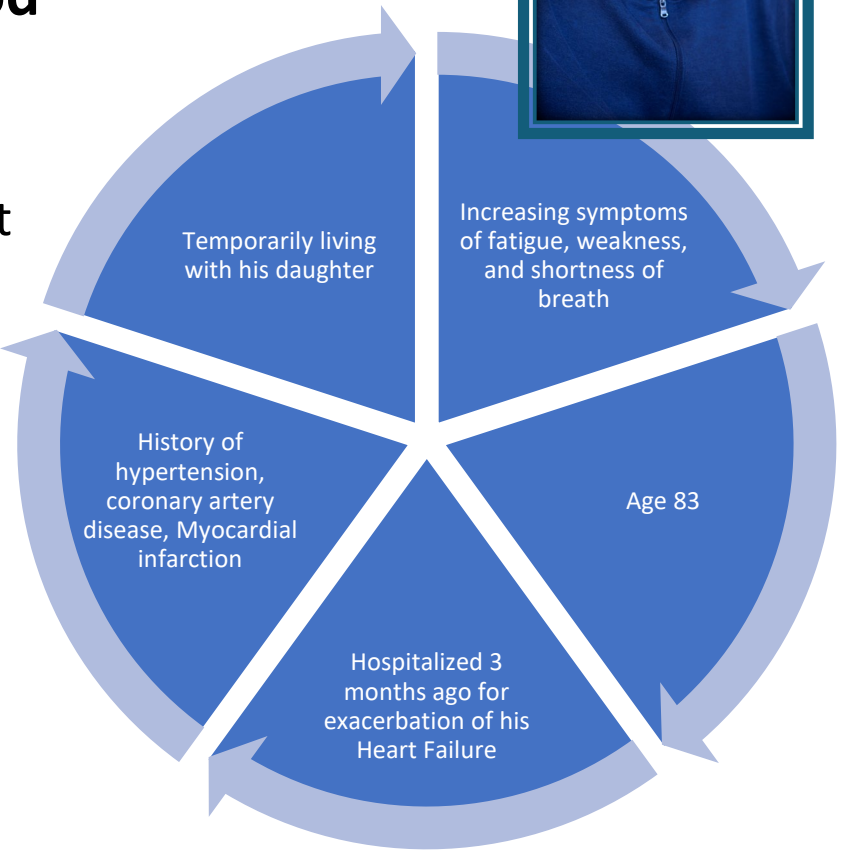
- **He's having trouble sleeping**
- **He completed the SDOH screening**
  - Needs assistance with transportation to medical appointments
  - Has housing needs (based on wanting to return home)



Let's Try…

Situation	Background	Assessment	Recommendation

Let's Try…

Situation	Background	Assessment	Recommendation
Increasing symptoms of fatigue, weakness, shortness of breath	• Age 83 • Hospitalized 3 months ago for exacerbation of his Heart Failure • History of hypertension, coronary artery disease, Myocardial infarction • Temporarily living with his daughter – wants to go home	Unsure about his medications Specifically, in the hospital they held his hydrochlorothiazide and on discharge did not give any directions on what to do about that Difficulty Sleeping He is unable to complete his own activities of daily living without some assistance Feeling LOW	**Appointment today with daughter.** • Physical assessment • Review meds and determine medication plan for heart failure. • Homecare referral for home assessment for supportive resources and DME needs **Comprehensive Assessment** • Depression screen • SDOH assessment

Team Communication

Call-Out

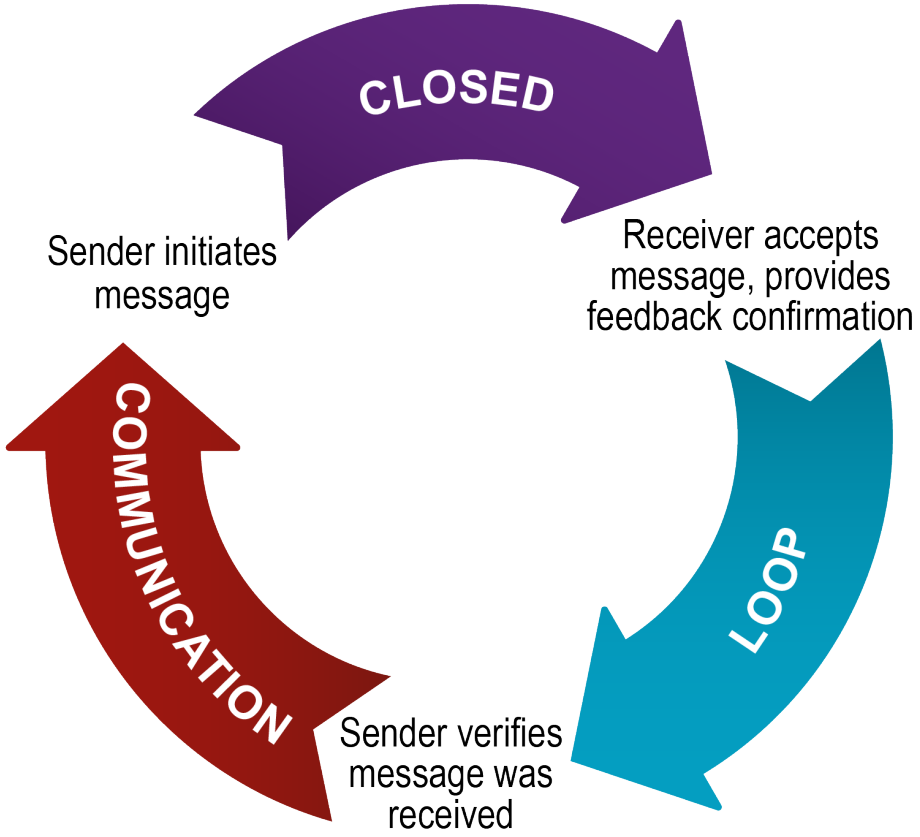
A strategy used to communicate important or critical information:

- It informs all team members simultaneously during emerging situations.
- It helps team members anticipate next steps.

Team Communications
Check-Back

Sometimes also called a Repeat-Back.

TeamSTEPPS also includes a Teach-Back tool, which can be used with patients and family caregivers.



Check-Back

A closed-loop communication strategy used to ensure that information conveyed by the sender is correctly understood by the receiver.

Example:

Dr. Moss:
"Mary, please share the information pamphlet on cholesterol management with Mr. Garcia and arrange for him to come for a followup visit in a month."

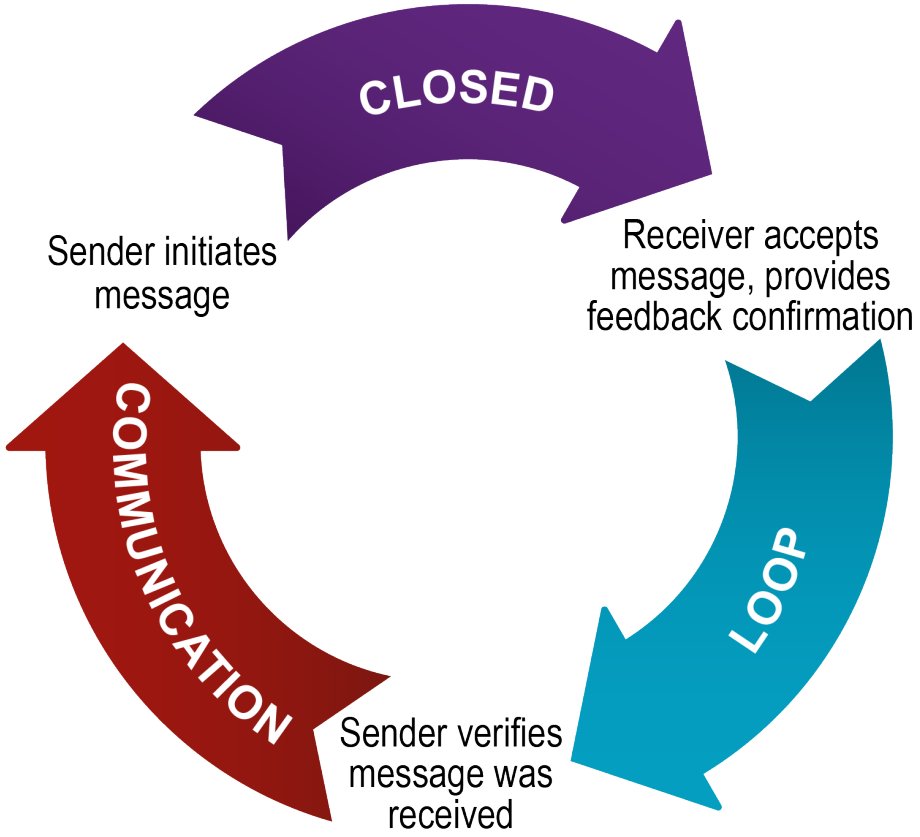
Mary:
"Confirmed. I'll share the information pamphlet on cholesterol management and arrange a followup visit for Mr. Garcia in a month."

Dr. Moss:
"Correct."

https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/index.html

Team Communications
Teach Back

- Evidence-Based Health Literacy Intervention
- Promotes patient engagement, adherence, and safety
- A way to confirm that you have explained information clearly
- Assess family/caregivers understanding



https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/index.html

Team Communication

Handoff

The transfer of information during transitions in care across the continuum:

- Includes an opportunity to ask questions, clarify, and confirm.
- Is relevant during shift changes, transfers between departments, and care team transitions.
- Is sometimes done virtually or with e-handoff functions within an electronic health record.

Handoffs include:

- Transfer of responsibility and accountability.
- Clarity of information.
- Verbal communication of information.
- Acknowledgment by receiver.
- Opportunity to review.

https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/index.html

Team Communication
Handoff Tool

MI-CCSI
Center for Clinical Systems Improvement

I-PASS:
A Common Handoff Tool

Illness Severity
- Stable, watcher, unstable

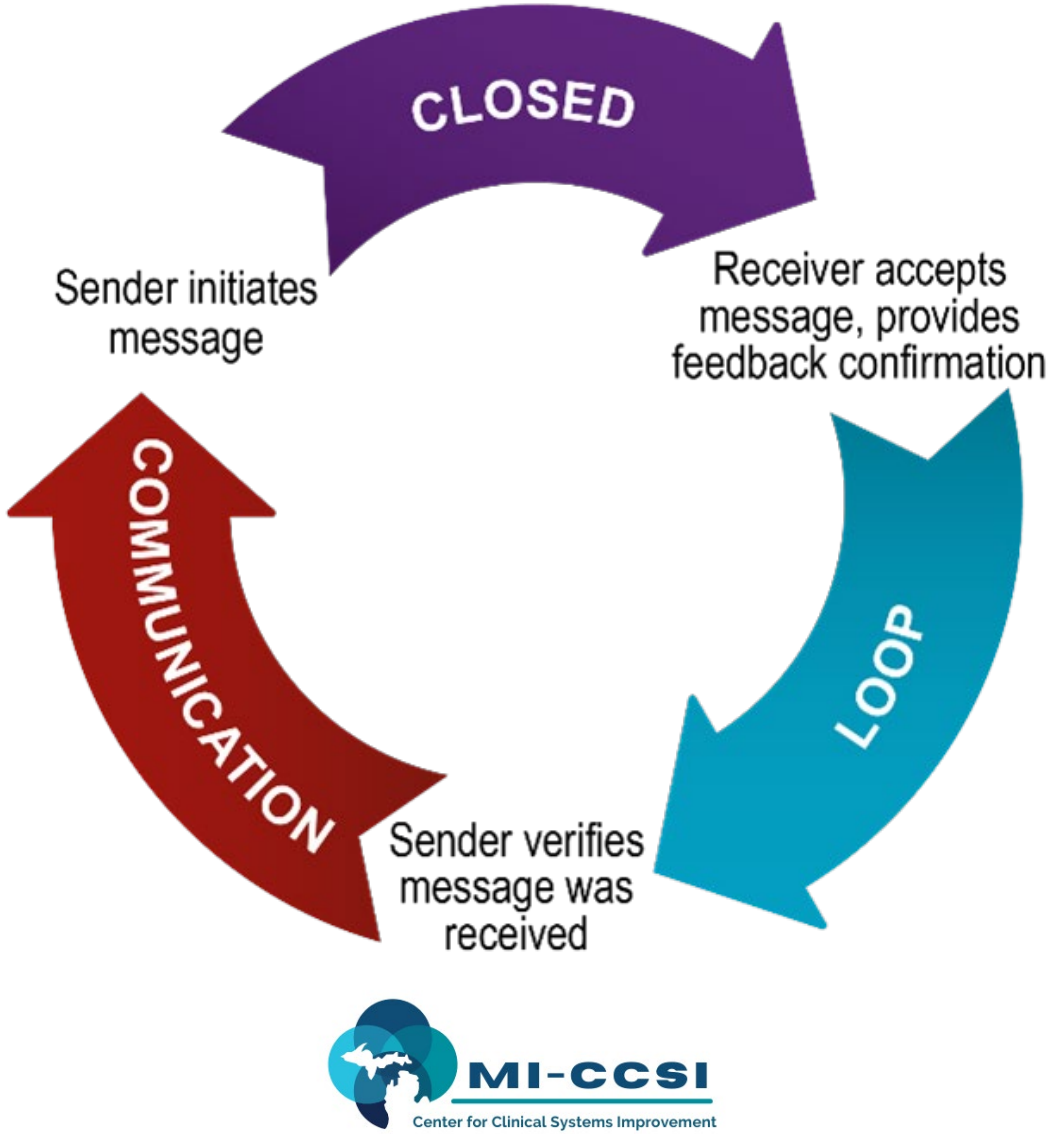
Patient Summary
- Summary statement
- Events leading up to admission or care transition
- Hospital course or treatment plan
- Ongoing assessment
- Contingency plan

Action List
- To-do list
- Timelines and ownership

Situation Awareness & Contingency Planning
- Know what's going on
- Plan for what might happen

Synthesis by Receiver
- Receiver summarizes what was heard
- Asks questions
- Restates key actions/to-do items

Closed Loop Communication



MI-CCSI
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Team Communication
Other Handoff Tools

- **ANTIC**ipate
  - **A**dministrative Data; **N**ew clinical information; **T**asks to be performed; **I**llness severity; **C**ontingency plans for changes
- **SHARQ**
  - **S**ituation; **H**istory; **A**ssessment; **R**ecommendations/Result; **Q**uestions

https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/index.html

Why: Connecting

https://youtu.be/1ytFB8TrkTo

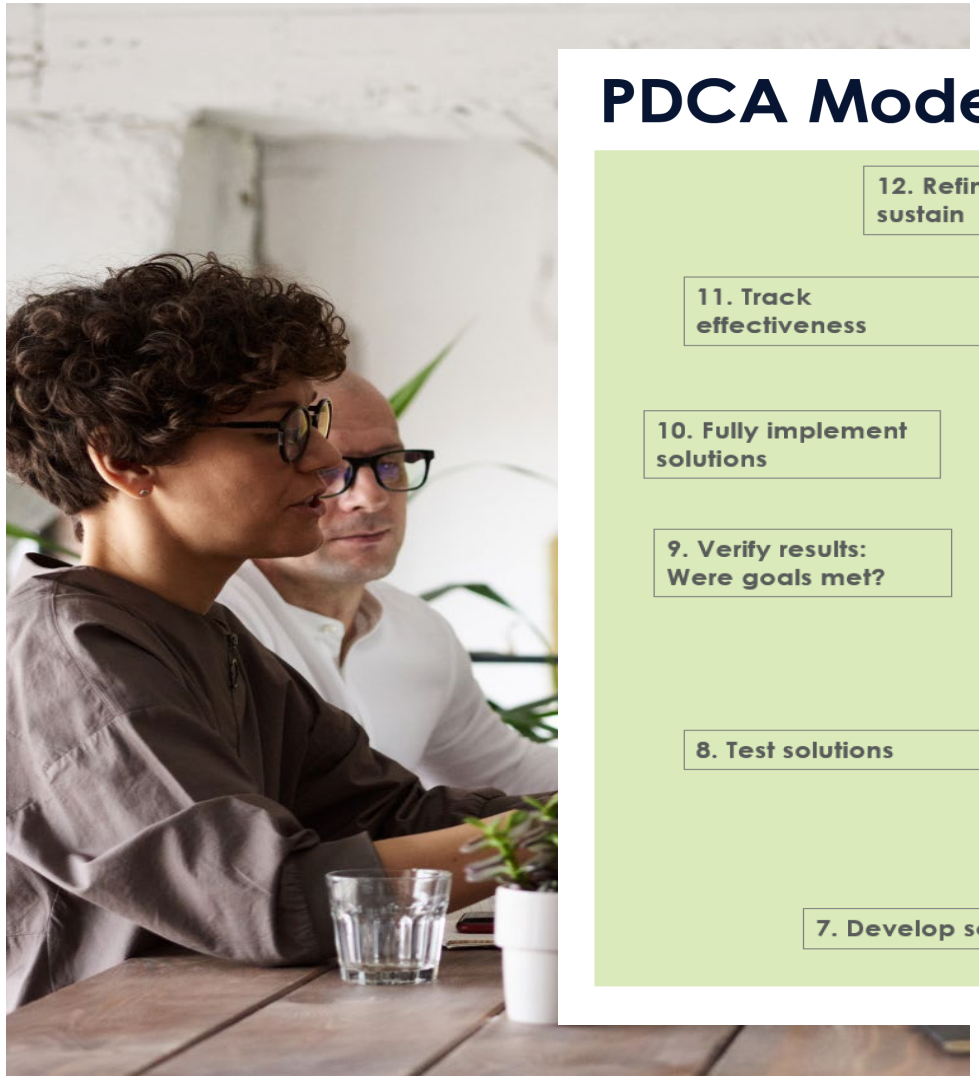
MI-CCSI
Center for Clinical Systems Improvement

Team Communication
Tools and Strategy Summary

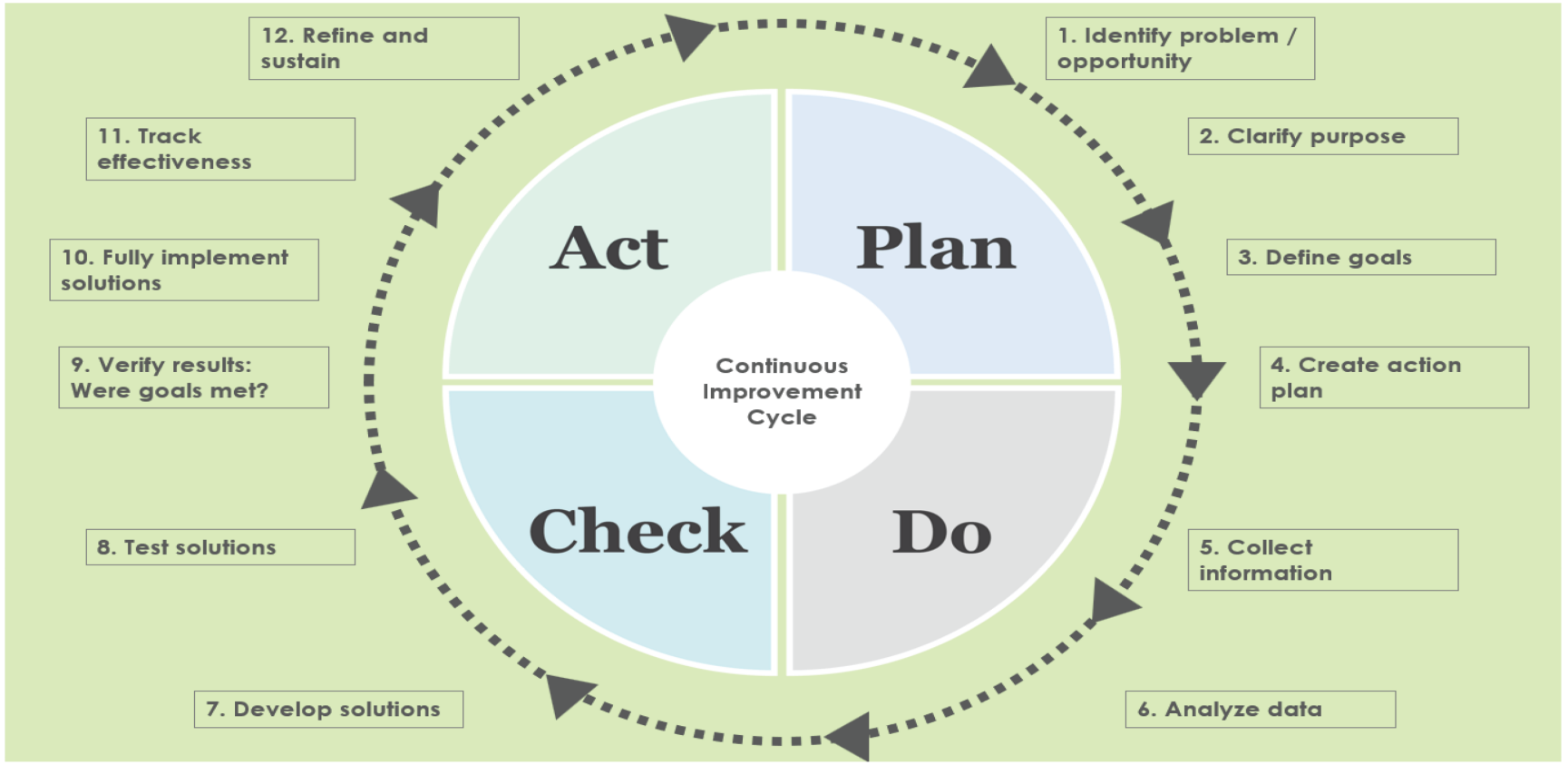
BARRIERS	TOOLS and STRATEGIES	OUTCOMES

• Inconsistency in Team Membership
• Lack of Time
• Lack of Information Sharing
• Hierarchy
• Defensiveness
• Conventional Thinking
• Complacency
• Varying Communication Styles
• Conflict
• Lack of Coordination and Follow-Up
• Distractions
• Fatigue and Burnout
• Workload
• Misinterpretation of Cues
• Lack of Role Clarity
	• Communication
	  • SBAR
	  • Call-Out
	  • Check-Back
	  • Handoff
	  • Teach-Back
	  • I-PASS
		• Shared Mental Model
		• Adaptability
		• Team Orientation
		• Mutual Trust
		• Reduced Burnout
		• Psychological Safety
		• Effective Team Performance
		• Safe, Highly Reliable, Patient-Centered Care

Next Steps – Post Training Activities



PDCA Model Chart Template



Team Actions

Review the Team Roles and Responsibilities Document.

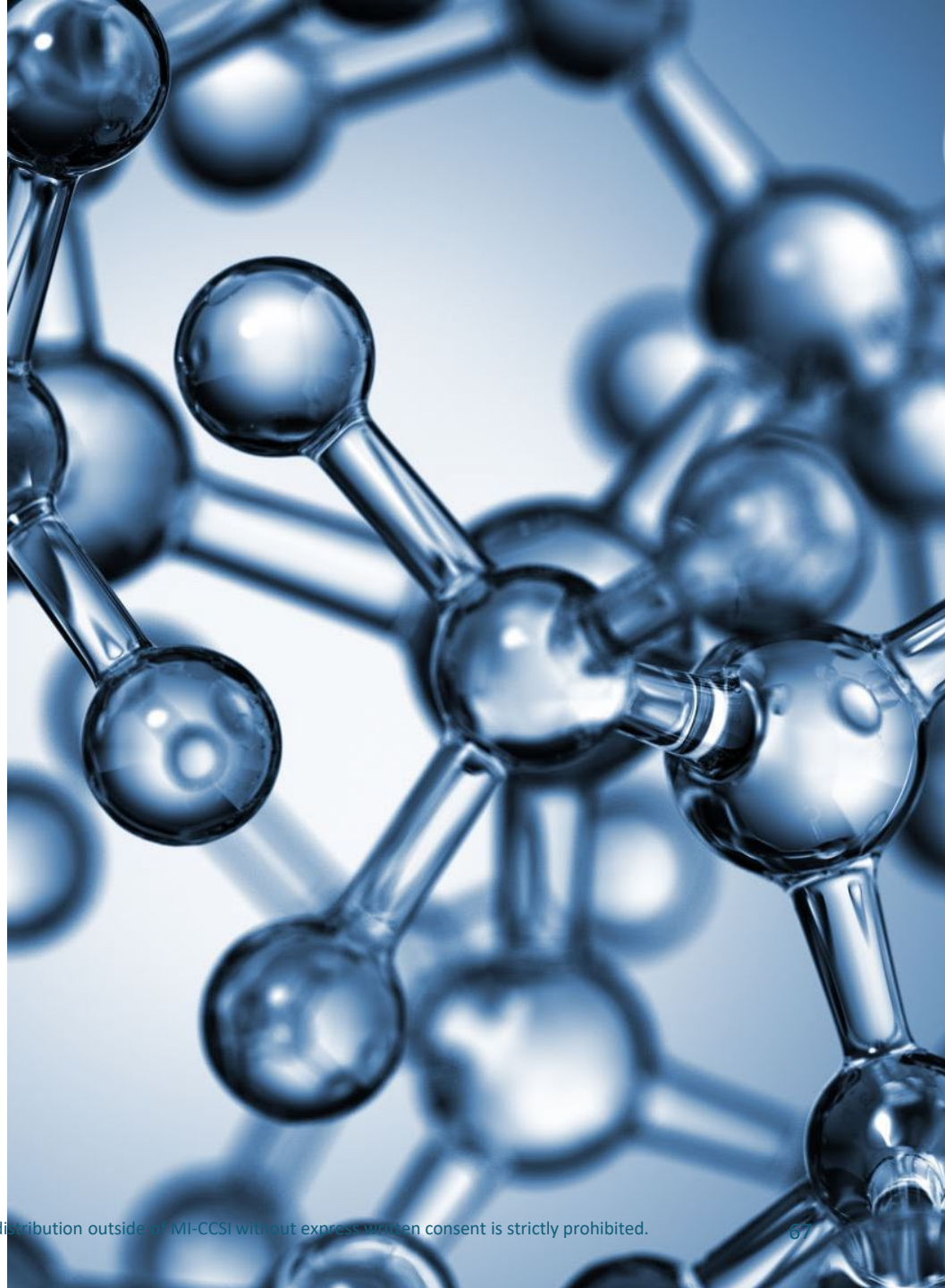
- Where are there opportunities for improvement (minimize rework, fill in gaps, clarify roles and hand-offs)?
- Identify the team member who will lead this quality improvement activity and monitor actions to implement changes.

As a team:

- Finalize the practices Team-based Care elevator speech.
- Create a draft of the patient/provider partnership agreement.
  - Establish a plan for implementation and use of these documents.

Review the communication tools. Select 1 tool to start with.

- Create a PDSA to identify what data you will collect to determine what is working and what requires modifications.
- Create an SBAR for one of the conditions the team would like to focus on (COPD, HF, Depression, Diabetes).
  - Discuss with the provider and clinical team members the key information needed from the situation and background for the condition in order to make decisions.



Questions?