MI-CCSI
Partnering to Better Care

SOUTHLAKE TEAM BASED CARE SESSION 1 WORKBOOK

TEAM BASED CARE BASICS – HISTORICAL AND CURRENT MODELS

MI-CCSI
Center for Clinical Systems Improvement

Revision Date: 08.26.25

CONTENTS

AGENDA

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 PE 2024	5 Minutes

TEAM ROLES AND TASKS

Task	Role							
	Family Physician	Nurse Practitioner (NP)	RN Care Manager	Care Manager (Social Worker)	Community and Clinic Integration Lead	Registered Pharmacist	Registered Practical Nurse (RPN)	Other
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								

Share the Care: Assessment of Team Roles and Task Distribution

This is an example of a planning tool, to assess who is currently doing what tasks in your practice and then who should be doing each task, based on how we learned that LEAP sites define clear roles and responsibilities. There is no "right answer"; task distribution will vary from practice to practice, based on contextual and internal factors. The tool is in the discussion about roles that this worksheet can stimulate. Your practice may be able to redistribute the tasks in a way that better fits your workforce and patients.

Instructions:

1. Modify the worksheet so that the columns reflect all care team roles and the rows contain the most important tasks in your practice. (Note: we use the term "lay person" to mean someone without medical background, so this may include lay caregivers such as Community Health Workers or administrative staff members such as Front Desk staff).

2. Gather a group of staff members who are engaged in redesigning care roles, representing all the roles on the care team.

3. Assess your practice at the current time, for each task. The tasks are organized by categories, such as "communications with patients, outside of the patient office visit." Check boxes to indicate "**Who does it now?**"

4. Next, use the worksheet to think about "**Who Should Do It?**" Discuss which roles are capable of doing each task and how well the work is distributed across roles. Use a different color to check boxes where you think that tasks can be redistributed for improvements to everyone's workload.

Task	MA	RN	Lay person	PharmD	BH specialist	No one	Other
Communication with patients, outside of patient office visit							
Answer phones, triage calls							
Help manage/triage provider electronic inbox							
Serve as primary point of contact for patients							
Conduct patient outreach for outstanding labs, etc.							
Follow-up by phone or email after visits to make sure that patient understood instructions							
Follow-up with patients after hospital discharge							
Follow-up with patients after Emergency Department visit							
Respond to patient calls requiring clinical assessment and decision-making							
Community-based efforts to connect new patients to the practice							
Notify patients about normal lab results							
Notify patients about abnormal lab results							
Preparation for patient visits and proactive population management							
Pre-visit planning/chart scrubbing							
Conduct patient outreach for outstanding labs, etc.							
Independent visit to prepare patients for a provider visit							
Participate in care team huddles to review the plan for the day							
Participate in regular meetings to review outcomes for patients who have not yet reached chronic disease-related clinical goals							
Participate in regular meetings to review outcomes for patients who have not yet reached chronic mental health-related clinical goals							
Patient visit tasks							
Perform injections							
Reconcile medications							
Scribe for providers							
EKGs							
Spirometry							

Task	MA	RN	Lay person	PharmD	BH specialist	No one	Other
Assist with basic procedures							
Conduct well visits (with provider oversight)							
Conduct preventive care visits (with provider oversight)							
Patient education, coaching, and care management							
Perform "teach-back" with patient at end of visit							
Orient new patients to the practice							
Develop care plans with patient							
Help address barriers to patient goals							
Health coaching and motivational interviewing							
Patient health education							
Conduct group visits							
Conduct home visits							
Complex care management							
Medication titration, by protocol							
Run patient support groups							
Meet with patients about concerns or resistance with taking medications							
Conduct thorough medication reviews with patients							
Provide self-management support to patients							
Screen patients for depression and other chronic mental health disorders							
Screen patients for substance use disorders							
Administrative and Quality Improvement							
Participate in quality improvement and practice improvement activities							
Lead quality and practice improvement activities							
Coordinate/track outgoing referrals							
Close the loop on referrals (consult notes from the specialist have been received and added to our EHR)							
Administrative tasks around medication refills, labs, imaging							
Pre-authorizations							

Task	MA	RN	Lay person	PharmD	BH specialist	No one	Other
Check patients in							
Check patients out							
Generate exception reports or registries in order to conduct population management/outreach							
Generate team-level QI reports							
Supervise and support MAs							
Lead the care team							
Other services							
Run specialized care services, such as programs for obstetric patients or Coumadin patients							
Connect patients to resources in the community							
Help patients navigate the health care system							
Consult providers and clinical staff on medication use and dosing							
Provide brief or short-term counseling for patients coping with an episodic behavioral health concern							
Consult with providers on evidence-based treatment for depression, anxiety, or bi-polar disorders							
Other tasks:							
Other tasks:							
Other tasks:							
Other tasks:							
Other tasks:							

Every time you talk with a health care provider

ASK THESE 3 QUESTIONS

1 What is my main problem?

2 What do I need to do?

3 Why is it important for me to do this?

When to ask questions

You can ask questions when:

- You see a doctor, nurse, pharmacist, or other health care provider.
- You prepare for a medical test or procedure.
- You get your medication.

What if I ask and still don't understand?

- Let your health care provider know if you still don't understand what you need.
- You might say, "This is new to me. Will you please explain that to me one more time?"
- Don't feel rushed or embarrassed if you don't understand something. Ask your health care provider again.

Who needs to ask 3?

Everyone wants help with health information. You are not alone if you find information about your health or care confusing at times. Asking questions helps you understand how to stay well or to get better.

Ask Me 3®
Good Questions for Your Good Health

Institute for Healthcare Improvement

To learn more, visit ihi.org/AskMe3

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Write your health care provider's answers to the 3 questions here:

1. What is my main problem?

2. What do I need to do?

3. Why is it important for me to do this?

Asking these questions can help you:

- ☑ Take care of your health
- ☑ Prepare for medical tests
- ☑ Take your medications the right way

You don't need to feel rushed or embarrassed if you don't understand something. You can ask your health care provider again.

When you Ask 3, you are prepared. You know what to do for your health.

Your providers *want* to answer 3

Are you nervous to ask your provider questions? Don't be. You may be surprised to learn that your medical team wants you to let them know that you need help or more information.

Like all of us, health care providers have busy schedules. Yet they want you to know:

- All you can about your health or condition.
- Why their instructions are important for your health.
- Steps to take to keep you healthy and any conditions under control.

Bring your medications with you the next time you visit a health care provider. Or, write the names of the medications you take on the lines below.

Like many people, you may see more than one health care provider. It is important that they all know about all of the medications you are taking so that you can stay healthy.

Ask Me 3® is an educational program provided by the Institute for Healthcare Improvement / National Patient Safety Foundation to encourage open communication between patients and health care providers.

Institute *for* Healthcare Improvement

Ask Me 3®
Good Questions for Your Good Health

My Health Checklist

A guide to help you prepare for your medical appointment

Name _____

Date _____

Age-Friendly Health Systems

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

This work was made possible by The John A. Hartford Foundation.

This guide is designed to help you get ready for your medical appointment.

It's meant especially for older adults.

First, it will help you think about different aspects of your health and living well. Then it will help you identify the most important questions or concerns you want to talk about with your provider. A provider is a doctor, nurse practitioner, primary care practitioner (PCP), etc.

Being prepared for your appointment can help you get the care that's right for you. You are part of the team. You can have a say in your care.

This guide focuses on four areas that can help you think about your health.

What **Matters** to you in your life

Medication you may take

Your **Mind** and sense of well-being

Your **Mobility**

The 4Ms

For each of the 4Ms, we'll ask you about your situation now, what's going well, and what could be better. Then you can write down any questions you have or things you want to share with your provider.

Tips for completing this guide

- **You can complete this guide in any order you like.** This is about what works for you.
- **Take it in small pieces.** It's always okay to skip a question. It's fine to take a break and come back later.
- **You can talk about your answers with someone you trust.**
- **These pages are for you — to help you gather your thoughts.** Later, you can decide what to share with your provider.
- **You can print this guide in a larger font.** Go to ihi.org/myhealthchecklist for instructions and more resources.

If you are helping someone else complete this guide:

- Talk about why this will help. You might say, "I want to make sure we talk about what's most important to you, so we (or you) can have a more useful conversation with your provider."
- Focus on what matters to the person you support. Remember this is a conversation about their care needs and goals.

If you are completing this guide on a computer:

First, save the guide to your desktop.

Then open your saved guide and type in your answers.

(Otherwise, what you type will not be saved.)

What Matters

Think about what is most important to you and what you enjoy most. This can help you think about what's most important for your health.

- **Your situation now** • What are the most important things in your life right now? Have there been any health or life changes since your last appointment?

SOME IDEAS Being regularly in touch with the people I care about • Adjusting to retirement • Experiencing grief or regret • Feeling anxious or worried

- **What's going well?** What activities do you like to do?

SOME IDEAS Play music • Watch sports • My job • Visit my grandchildren • Involved in my community

- **What could be better?** Is anything getting in the way of what you like to do?

SOME IDEAS Trouble sleeping • Taking care of a sick relative • Low energy • Harder to get around • Bladder control issues • Hard to get healthy food • Trouble hearing conversations

- **What do you want your provider to know about you?**

SOME IDEAS Who I'm responsible for • Any goals for the year • Who I live with • Who or what in my life makes me feel better • Who or what makes me feel worse

Medication

If needed, medication can be an important part of your health. It's important to make sure it's working well.

Some medication affects us differently as we age. It may interact with other medication or with food, sometimes negatively. We might want to start or stop taking it, or try a different dose.

Your situation now • What medications do you take regularly (if any)? What medications do you take only when needed?

Include vitamins and supplements, prescriptions, over-the-counter medications, and herbal remedies.

SOME IDEAS Calcium • Heart medicine • Inhaler (when my allergies act up) • Diabetes medicine • Daily aspirin

What's going well? Are your medications helping you reach your goals?

SOME IDEAS More active • Better appetite • Sleeping better

NOTE

Always talk with your provider before starting or stopping a medication or changing how much you take.

- **What could be better?** Are your medications causing any problems?

SOME IDEAS Tired all the time • Medicine costs too much • Not sure if medicine is working • Feeling dizzy or nauseated • Bad reaction to medicine • Hard to keep track of what to take and when

- **What questions or concerns do you have for your provider?**

SOME IDEAS I can't afford to pay for my medicines • Do I still need all of these medicines? • Should we check my cholesterol/ blood pressure? • Who can I call if I have questions? • Are my vaccines up to date?

Mind

This is about your mood and your sense of well-being.
It's also about your mental ability, including your memory.

Use the scales below to think about your situation now.
There are no right or wrong answers.

Your situation now

How happy do you feel on most days?

Mostly unhappy — Mostly happy

How much do you worry about changes in your memory?

Very worried — Not worried

If applicable, how much do people near you worry about changes in your memory?

Very worried — Not worried

Do you want to add anything about your answers?
Have you noticed any changes in your mood or memory?

SOME IDEAS Feeling happier • Worrying more or feeling anxious • Forgetting words • Forgetting where I'm going — getting lost

What's going well?

SOME IDEAS Doing well at work • Excited to see my grandchild • When I feel upset, I have someone I can call • Started volunteering

What could be better?

SOME IDEAS Feeling down most days • Trouble focusing • Want to spend more time with people • Overwhelmed with tasks • Feeling lonely • Relationships and intimacy

What questions or concerns do you have for your provider?

SOME IDEAS Sometimes I forget things — does that mean I have a health problem? • I'm feeling anxious that I won't have the help I need

Mobility

Mobility is about how you move and get around. This includes everything from exercising to getting around the house to going places.

Your situation now • How do you move around at home? How do you get from place to place?

SOME IDEAS

At home... I go for walks • On my feet a lot • I use a cane at times • I do physical therapy • I use a wheelchair

Getting around... I take the bus • My friend and I drive to errands together • I walk • There's no transportation for me

What's going well?

SOME IDEAS

My home is comfortable to move around in • I regularly do exercise videos • My foot pain is better • I walk my dog

What could be better? Does anything limit you?

SOME IDEAS Trouble breathing when I walk • Feel unsteady when I shower • I've tripped and had a couple of falls • I don't want to drive at night • It's hard to carry my laundry to the machine • Hard to reach higher shelves lately • My back pain means I don't want to exercise

What questions or concerns do you have for your provider?

SOME IDEAS I've had shoulder pain for a long time — what should we do about it? • Need a way to get groceries • What changes could make it safer to move around in my home? • What activities are safe for me? • What if I can't live in my house anymore?

Next Steps

- **Look back over all of your answers.**
  Write up to 3 of your most important questions or concerns for your provider.

  1. _____

  2. _____

  3. _____

  SOME IDEAS How can I reduce my knee pain? • Can I take a test to check my memory? • How can I get stronger?

- **You may want to talk your answers over with someone else** — a family member, a friend, or another person. If you want, you can ask them to come with you to your appointment.

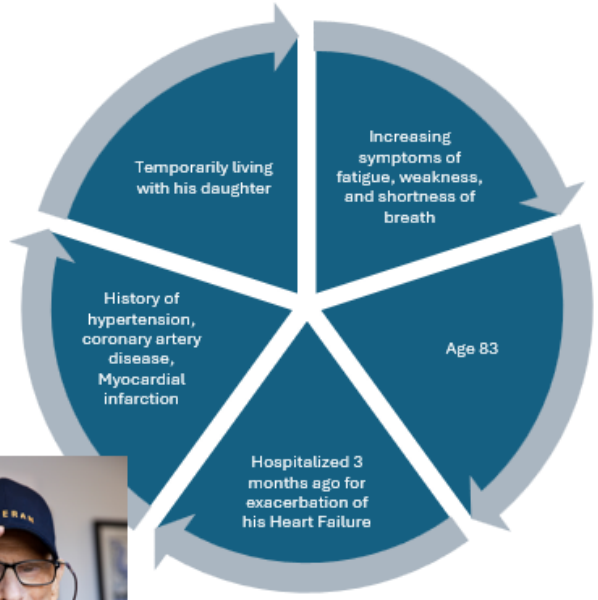
  Their name: _____

- **Your answers may change over time.** You can come back to this guide any time to update your answers and write down more questions for your provider.

Bring your questions (and this guide) to your next appointment. Talking about the things that matter to you helps them understand you better. Then together you can choose the kind of care that's right for you.

To start the conversation, you might say: "I have a couple of things that are really important to me. Can we talk about them?" It's okay to ask questions more than once if the answer isn't clear.

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)

ELEVATOR SPEECH

Acknowledge/Agenda: Hello (Patient Name)	**Example**
	Hello Mrs. Smith-what do you prefer I call you? (smile, eye contact, welcoming). You have just seen Dr Jones because you've been to the Emergency room for your heart. What is your understanding of his concerns and why he referred you to me?
Permission/expected time	
	Would it be ok if I took 10 minutes now to tell you more about that?
Describe role	
	My name is Jane, and I am a nurse. They call me a nurse care manager and I work right here in your doctor's office.
Relationship to provider and team	
	I work with Dr Jones and his care team. Some of the care team works directly with you and others work behind the scenes for you. My job is to work with you between visits with Dr Jones. That way we can address your concerns sooner and get ahead of problems.
What the patient gains from your role	
	You might be wondering why you would want to do this. I hope to get to know you so that together we can discover ways that will help you feel better and manage the heart failure in ways that work for you in your everyday life.

The patient's role working with you	**Example**
	You have a part in this too. We will work as partners. You are the expert on your life so your input will be important. And I might have ideas to consider too. So, you will need to be honest with me. Also agree to participate with phone calls or visits and try things out to see what works for you.
What the patient can expect	
	The first visit is longer so I can get to know you better and we can begin our work together. After that, contacts could be by phone, virtually or in person. They will be more frequent at first, like once a week and then stretch out longer as things stabilize. Altogether this often takes about 6-12 months.
Questions/Closure	
	What questions do you have? You don't have to decide now. You can think about it, and I can call you in a few days. Thank you for taking the time to meet with me today. Is there anything else I can do you now? (provide contact information)

STANDING ORDER [EXAMPLE]

Examples of Standing Orders for Registered Nurses for Prescription Refills.*

Diabetes			
Appointment in Past 6 Mo	Glycated Hemoglobin ≤7.5%	Normal Creatinine and Potassium for Past 6 Mo	How to Refill
Yes	Yes	Yes	3-mo supply (1 refill)
	Yes or No	No†	1-mo supply (no refill), order lab tests, schedule appointment
	No	Yes	1-mo supply (no refill), schedule appointment
No	Yes	Yes	3-mo supply (no refill), schedule appointment
	No	Yes or No†	1-mo supply (no refill), schedule appointment
Hypertension			
Appointment in Past 6 Mo	Systolic Blood Pressure ≤130/80 mm Hg	Normal Creatinine and Potassium for Past 6 Mo	How to Refill
Yes	Yes	Yes	3-mo supply (1 refill)
	Yes or No	No†	1-mo supply (no refill), order lab tests, schedule appointment
	No	Yes	1-mo supply (no refill), schedule appointment
No	Yes	Yes	3-mo supply (no refill), schedule appointment
	No	Yes or No†	1-mo supply (no refill), schedule appointment
Hyperlipidemia			
Appointment in Past 6 Mo	LDL Cholesterol ≤100 mg/dl for Patients with Diabetes, Cardiovascular Disease, or Both; ≤130 mg/dl for Other Patients		How to Refill
Yes	Yes		3-mo supply (2 refills)
Yes or No	No†		1-mo supply (no refill), schedule appointment
No	Yes		3-mo supply (no refill), schedule appointment

* LDL denotes low-density lipoprotein.
† The standing order would delineate seriously abnormal levels that would trigger urgent clinician review.

Source: Ghorob, A., & Bodenheimer, T. (2012). Sharing the care to improve access to primary care. New England Journal of Medicine, 366(21), 1955–1957. https://doi.org/10.1056/NEJMp1202775

TeamSTEPPS® 3.0

TeamSTEPPS Team Performance Observation Tool

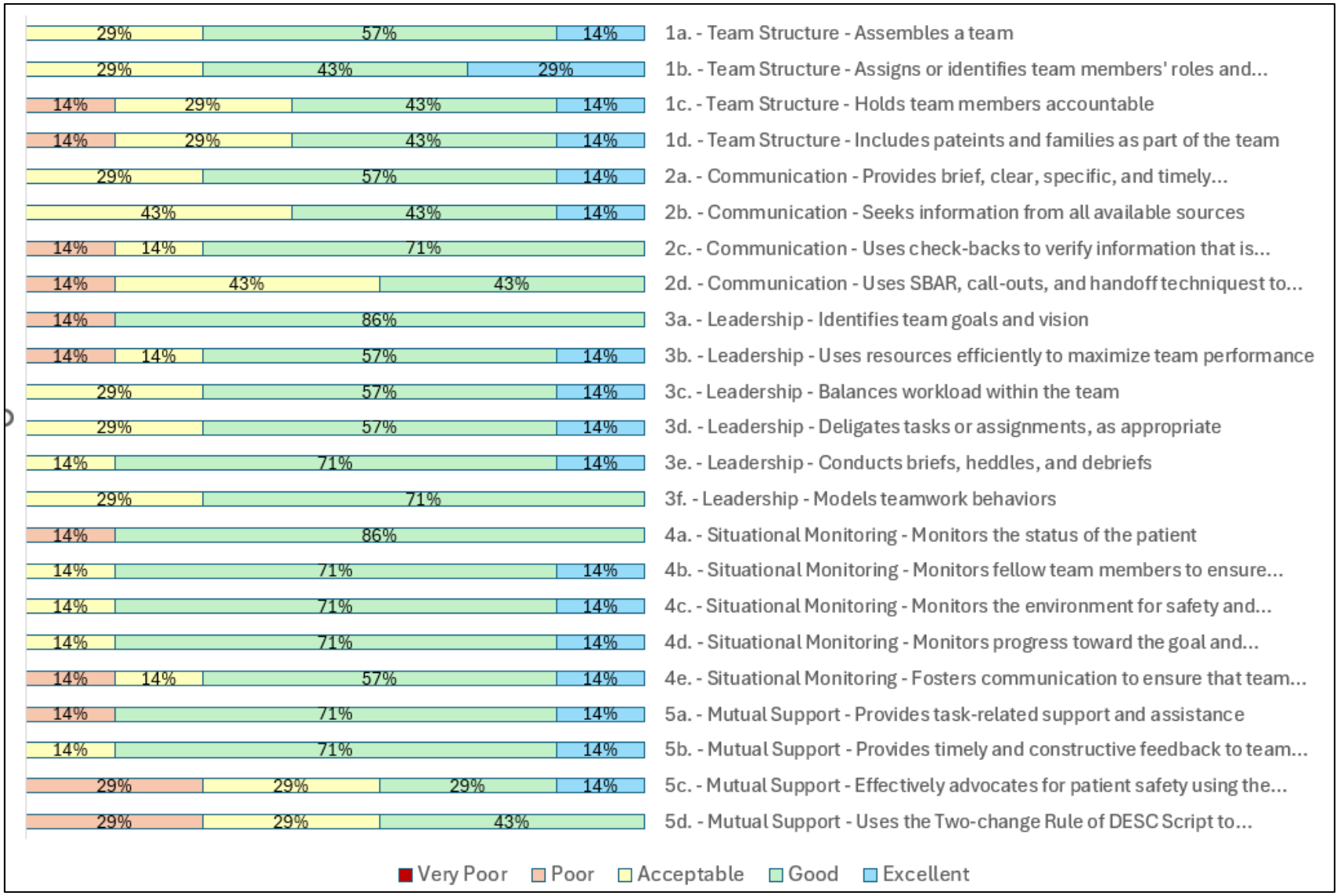
Date: _____
Unit/Department: _____
Team: _____
Shift: _____

Rating Scale *Please comment if 1 or 2.*

1 = Very Poor
2 = Poor
3 = Acceptable
4 = Good
5 = Excellent

1. Team Structure	**Rating**
a. Assembles a team	
b. Assigns or identifies team members' roles and responsibilities	
c. Holds team members accountable	
d. Includes patients and families as part of the team	
Comments: **Overall Rating – Team Structure**	
2. Communication	**Rating**
a. Provides brief, clear, specific, and timely information to team members	
b. Seeks information from all available sources	
c. Uses check-backs to verify information that is communicated	
d. Uses SBAR, call-outs, and handoff techniques to communicate effectively with team members	
Comments: **Overall Rating – Communication**	
3. Leadership	**Rating**
a. Identifies team goals and vision	
b. Uses resources efficiently to maximize team performance	
c. Balances workload within the team	
d. Delegates tasks or assignments, as appropriate	
e. Conducts briefs, huddles, and debriefs	
f. Models teamwork behaviors	
Comments: **Overall Rating – Leadership**	
4. Situation Monitoring	**Rating**
a. Monitors the status of the patient	
b. Monitors fellow team members to ensure safety and prevent errors	
c. Monitors the environment for safety and availability of resources (e.g., equipment)	
d. Monitors progress toward the goal and identifies changes that could alter the plan of care	
e. Fosters communication to ensure that team members have a shared mental model	
Comments: **Overall Rating – Situation Monitoring**	
5. Mutual Support	**Rating**
a. Provides task-related support and assistance	
b. Provides timely and constructive feedback to team members	
c. Effectively advocates for patient safety using the Assertive Statement, Two-Challenge Rule, or CUS	
d. Uses the Two-Challenge Rule or DESC Script to resolve conflict	
Comments: **Overall Rating – Mutual Support**	
TEAM PERFORMANCE RATING	

AHRQ Agency for Healthcare Research and Quality



SBAR TOOL

Agency for Healthcare Research and Quality

SBAR, which stands for Situation, Background, Assessment, and Recommendation (or Request), is a structured communication framework that can help teams share information about the condition of a patient or team member or about another issue your team needs to address.

In phrasing a conversation with another team member, consider the following:

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?"

SBAR is one of the most widely used TeamSTEPPS tools for many reasons:

- Structured communication tools such as SBAR can enhance communication between members of the healthcare team.
- SBAR provides a vehicle for individuals to speak up and express concern in a concise manner.
- SBAR is useful for framing any conversation, especially critical ones requiring a team's immediate attention and action, such as when a patient's condition is rapidly deteriorating. It may also be useful with providers who are not part of the core team, such as remote consultants or mental health providers.

Using SBAR effectively requires careful attention to each step:

- **Situation** states what is currently happening with the patient. It usually begins with the identity of the person communicating the SBAR, patient identifiers such as age and gender, and a brief statement of the current problem or situation.
- **Background** covers clinical background such as patient history related to the current situation, signs and symptoms of the presenting complaint, and any test results, such as lab or imaging reports.
- **Assessment** reports what the person communicating the SBAR thinks the problem is. It states what the nurse or other provider has assessed based on the background information, patient history, and observations. Assessment asks what else it can be, provides sense making, considers sources of other information to provide clarity, and relates actions to consequences. Assessment can also include objective data such as vital signs.
- **Repeat-Back Recommendations and Requests** states an initial recommendation, what is needed and when, and repeats back the stated response from the other provider or patient to ensure accuracy.

Additional notes on using SBAR include:

- 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..."

The table shows other practical examples of SBAR.

Step	Desired Message	Starter Phrases
Situation	Confirming understanding of the symptoms.	*"I am glad you came to the clinic. I want to confirm my understanding of your symptoms…[list symptoms]. Is there something I missed?"*
Background	Acknowledge the impact of the symptoms.	*"From what you have explained, your symptoms are impacting you…[describe how symptoms are impacting the patient]. Is there anything else I should know?"*
Assessment	State your initial thinking about the working diagnosis.	*"My initial thinking is that your symptoms are consistent with XXX [name the diagnosis]."*
	Share any uncertainty about the diagnosis.	*"I believe that something is going on, but I do not yet know what it is." "You have some symptoms that are not typical of this diagnosis, and we need to follow them up."*
	Invite patient's concerns.	*"What is most concerning for you about the initial diagnosis?"*
Recommendations and Request	What should the patient do next?	*"I would like you to have some additional tests." "I would like to have you seen by [consulting clinician] to help us get to the bottom of this."*
	How will doing this next step impact the diagnosis?	*"This test/consult will allow us to start to pinpoint the cause of your symptoms and help us achieve the diagnosis."*
	What should the patient expect from any treatment or test?	*"I would like you to have the test/start this treatment." "You should complete the test within 2 weeks and come back to see me so we can talk about the results and any next steps."*
	When should the patient follow up?	*"If you experience X or Y new symptoms, please come back in or call the office."*

To expand your understanding of and ability to use SBAR, choose from the options below:

Reflect on a patient story involving the use of SBAR. After watching the video, consider:

- Why is SBAR particularly helpful in situations where rapid and accurate decisions are essential?
- How do trust and positive working relationships between team members affect the use of SBAR?

Reflect on a video scenario involving the transfer of information using SBAR. After watching the video, consider:

- How did the SBAR technique improve communication between the nurse and physician?
  - The nurse identified herself and the reason she was calling.
  - The physician was quickly made aware of Mrs. Everett's deteriorating situation.
  - The nurse provided the background of the deep vein thrombosis (DVT) diagnosis and all current labs.
  - The recent assessment of the patient has led the nurse to call the physician with her concerns.
  - The recommendation was initiated by the nurse for additional labs, and a plan was discussed for future care.
- How would SBAR help you in similar encounters within your healthcare context?

Reflect on your own experience with SBAR.

- Have you used SBAR in your institution? If so, how was it used? What was the result of its use?
- What were the challenges to implementing SBAR and how were these challenges overcome?

https://www.ahrq.gov/teamstepps-program/curriculum/communication/tools/sbar.html
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ROLE PLAY

WORK IN YOUR GROUP

- Using the Mr. B. case study below, develop an SBAR communication
- Role play with your partner
- Share experiences as the person reporting off the information
- Share experiences as the person listening to the SBAR

MR. B

- Age 83
- Increasing symptoms of fatigue, weakness, shortness of breath
- Hospitalized 3 months ago for exacerbation of his Heart Failure
- History of hypertension, coronary artery disease, Myocardial infarction
- Temporarily living with his daughter
- 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's having trouble sleeping
- He is unable to complete his own activities of daily living without some assistance
    - Tires easily and needs help dressing
    - He can do his own personal hygiene
- He completed the SDOH screening
    - Needs assistance with transportation to medical appointments
    - Has housing needs (based on wanting to return home)

SITUATION:

BACKGROUND:

ASSESSMENT:

RECOMMENDATIONS:

Situation	Background	Assessment	Recommendation

Teach-Back

A Guide for Staff

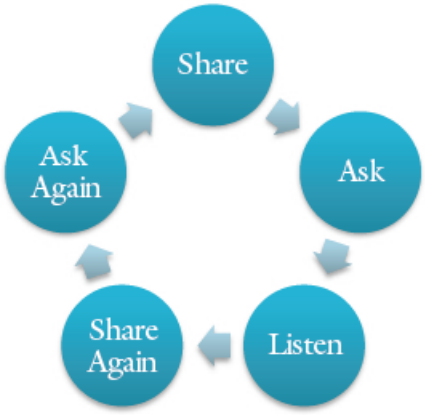
What is teach-back?

Teach-back **IS** a way for you to make sure your patients understand what you tell them.

Teach-back **IS NOT** a test or a quiz for patients.

How do I use teach-back?

Just ask patients to explain what you have told them using their own words. For example, if you explain what they need to do to prepare for a procedure, ask them if they can ***teach back*** to you how they are going to prepare.



Why should I use teach-back?

As part of the care team, you have an important safety role in making sure your patients understand all the information they are given during their visit.

Did you know that patients forget up to 80% of what you tell them after a visit?[1] If they do remember, only half of what they remember is correct.[2]

When should I use teach-back?

Use teach-back whenever explaining important concepts to patients regarding their health care, including:

- Medicines.
- Home care instructions.
- Use of a new device.
- Next steps in their care.
- Anything else that is important for them to understand.

1. Kessels RP. Patients' memory for medical information. J R Soc Med 2003;96(5):219-22. PMCID:PMC539473.
2. Anderson JL, Dodman S, Kopelman M, et al. Patient information recall in a rheumatology clinic. Rheumatology 1979;18(1):18-22.

AHRQ Agency for Healthcare Research and Quality

Guide to Patient and Family Engagement in Primary Care

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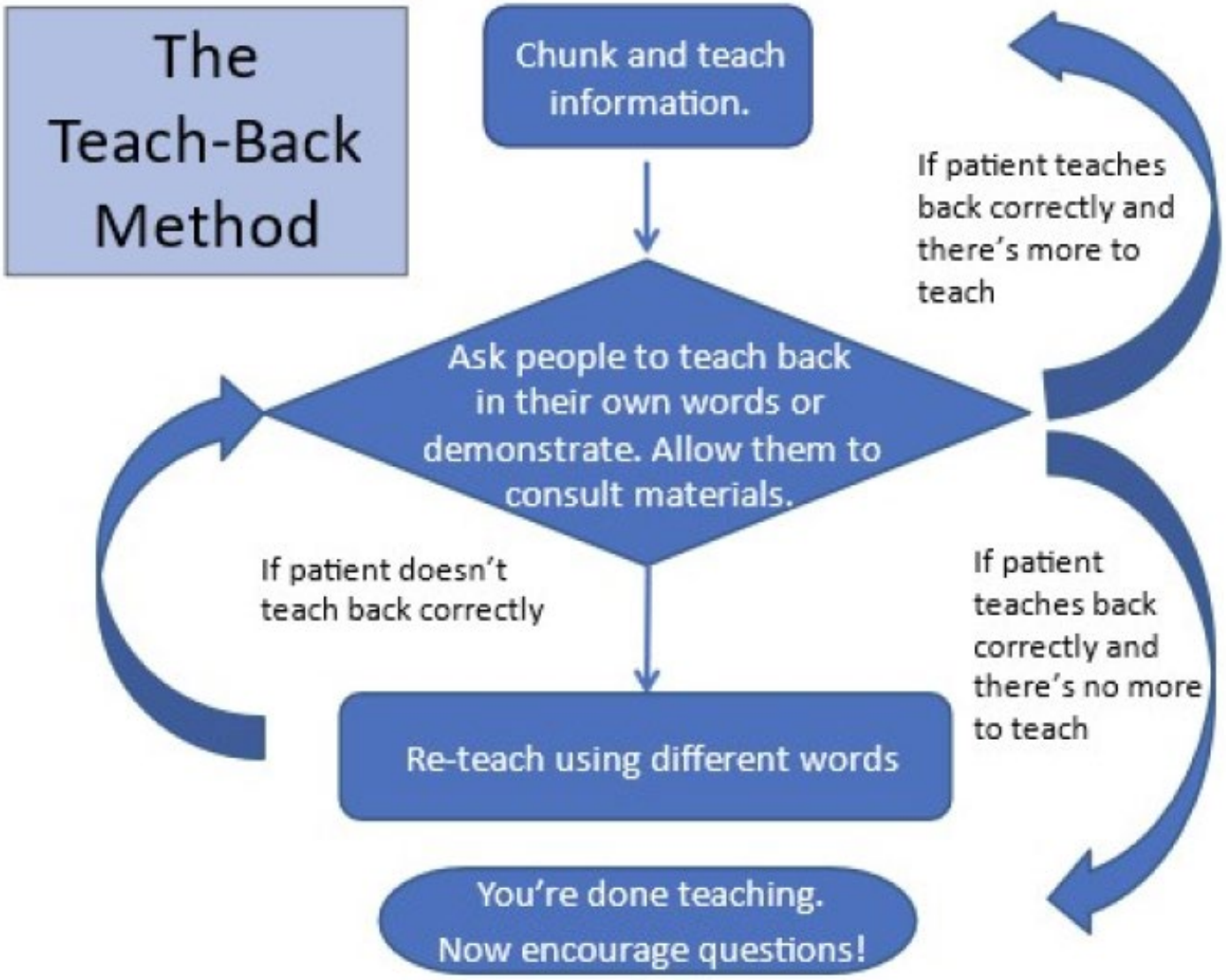

The Teach-Back Method
Chunk and teach information.
Ask people to teach back in their own words or demonstrate. Allow them to consult materials.
If patient teaches back correctly and there's more to teach
If patient doesn't teach back correctly
Re-teach using different words
If patient teaches back correctly and there's no more to teach
You're done teaching. Now encourage questions!

Teach-Back Quick Guide

- → Use teach-back for ALL patients.
- → Start with most important message.
- → Limit to 2-4 key points.
- → Use plain language.
- → Rephrase message until patient demonstrates clear understanding.

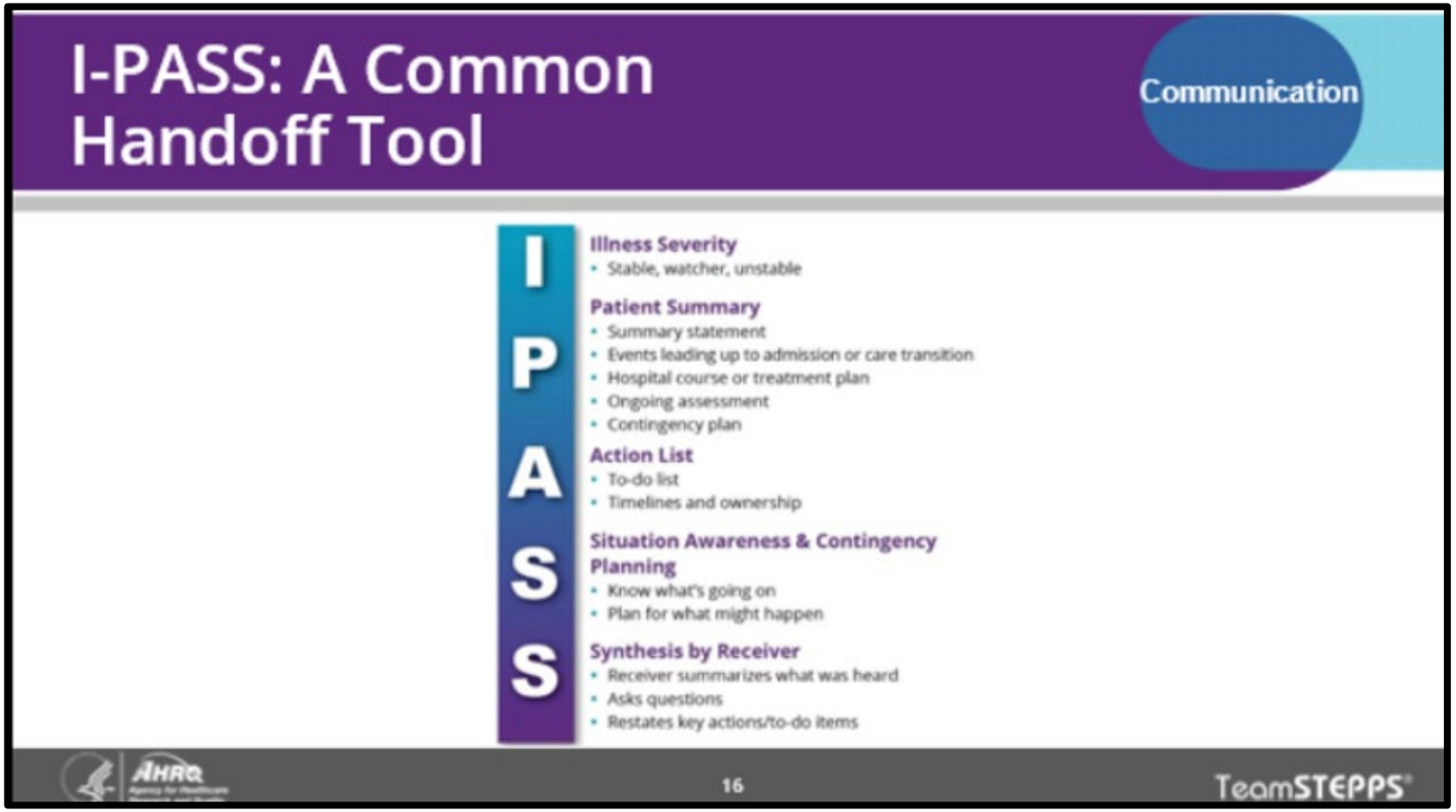
Examples of Teach-Back Starters

- → "Just to be safe, I want to make sure we are on the same page. Can you tell me…"
- → "I want to make sure that I explained things clearly. Can you explain to me…"
- → "Can you show me how you would use your inhaler at home?"

Use Plain Language

Use these words	Avoid these words	Use these words	Avoid these words
reduces swelling	anti-inflammatory	heart doctor	cardiologist
blood thinner	anticoagulant	skin doctor	dermatologist
take before meals	take on an empty stomach	doctor who treats diabetes	endocrinologist
take after meals	take on a full stomach	stomach doctor; doctor for digestion problems	gastroenterologist
high (low) blood sugar	hyper(hypo-)glycemic	doctor for women	gynecologist
high (low) blood pressure	hyper(hypo-)tension	doctor for the brain, spine, and nervous system	neurologist
fats	lipids	cancer doctor	oncologist
overweight	obese	eye doctor	ophthalmologist
weak bone disease	osteoporosis	lung doctor	pulmonologist
not cancer	benign	joint, bone, and immune system doctor	rheumatologist

I-PASS TOOL


I-PASS: A Common Handoff Tool
Communication
I
P
A
S
S
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
AHRQ
16
TeamSTEPPS

I	**ILLNESS SEVERITY** • Stable, watcher, unstable	
P	**PATIENT SUMMARY** • Summary statement • Events leading up to admission or care transition • Hospital course or treatment plan • Ongoing assessment • Contingency plan	
A	**ACTION LIST** • To Do List • Timelines and ownership	
S	**SITUATION AWARENESS AND CONTINGENCY PLANNING** • Know what's going on • Plan for what might happen	
S	**SYNTHESIS BY RECEIVER** • Receiver summarizes what was heard • Ask questions • Restates key actions / to do items	

Institute for Healthcare Improvement

QI Essentials Toolkit:

PDSA Worksheet

The Plan-Do-Study-Act (PDSA) cycle is a useful tool for documenting a test of change. Running a PDSA cycle is another way of saying testing a change — you develop a plan to test the change (Plan), carry out the test (Do), observe, analyze, and learn from the test (Study), and determine what modifications, if any, to make for the next cycle (Act).

Fill out one PDSA worksheet for each change you test. In most improvement projects, teams will test several different changes, and each change may go through several PDSA cycles as you continue to learn. Keep a file (either electronic or hard copy) of all PDSA cycles for all the changes your team tests.

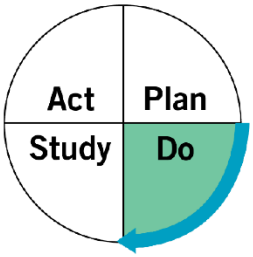
IHI's QI Essentials Toolkit includes the tools and templates you need to launch and manage a successful improvement project. Each of the nine tools in the toolkit includes a short description, instructions, an example, and a blank template. NOTE: Before filling out the template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

- Cause and Effect Diagram
- Driver Diagram
- Failure Modes and Effects Analysis (FMEA)
- Flowchart
- Histogram
- Pareto Chart
- **PDSA Worksheet**
- Project Planning Form
- Run Chart & Control Chart
- Scatter Diagram

Instructions

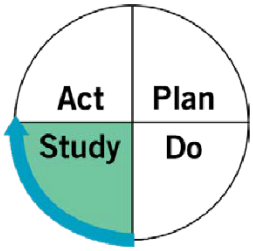
Plan: Plan the test, including a plan for collecting data.

- State the question you want to answer and make a prediction about what you think will happen.
- Develop a plan to test the change. (Who? What? When? Where?)
- Identify what data you will need to collect.



Do: Run the test on a small scale.

- Carry out the test.
- Document problems and unexpected observations.
- Collect and begin to analyze the data.



Study: Analyze the results and compare them to your predictions.

- Complete, as a team, if possible, your analysis of the data.
- Compare the data to your prediction.
- Summarize and reflect on what you learned.

Act: Based on what you learned from the test, make a plan for your next step.

- Adapt (make modifications and run another test), adopt (test the change on a larger scale), or abandon (don't do another test on this change idea).
- Prepare a plan for the next PDSA.

Example: PDSA Worksheet

Objective: Test using Teach-Back (a closed-loop communication model, in which the recipient of information repeats the information back to the speaker) with a small group of patients, in hopes of improving patients' understanding of their care plans.

1. Plan: Plan the test, including a plan for collecting data.

Questions and predictions:

- How much more time will it take to use Teach-Back with patients? It will take more time at first (5 to 10 minutes per patient), but we will start to learn better communication skills and get more efficient.
- Will it be worthwhile? The extra time will feel worthwhile (and possibly prevent future rework).
- What will we do if the act of "teaching back" reveals a patient didn't understand the care plan? If a patient is not able to explain his or her care plan, we will need to explain it again, perhaps in a different way.

Who, what, where, when:

On Monday, each resident will test using Teach-Back with the last patient of the day.

Plan for collecting data:

Each resident will write a brief paragraph about their experience using Teach-Back with the last patient.

2. Do: Run the test on a small scale.

Describe what happened. What data did you collect? What observations did you make?

Three residents attempted Teach-Back at the end of the day on Monday. Two residents did not find anything they needed to ask patients to Teach-Back. Jane found that her patient did not understand the medication schedule for her child. They were able to review it again and, at the end, Jane was confident the mother was going to be able to give the medication as indicated.

3. Study: Analyze the results and compare them to your predictions.

Summarize and reflect on what you learned:

- Prediction: It will take more time at first (5 to 10 minutes per patient), but we will start to learn better communication skills and get more efficient. *Result: Using Teach-Back took about 5 minutes per patient.*
- Prediction: The extra time will feel worthwhile (and possibly prevent future rework). *Result: Jane felt the time she invested in using Teach-Back significantly improved the care experience.*
- Prediction: If a patient is not able to explain his or her care plan, we will need to explain it again, perhaps in a different way. *Result: After a second review of the medication orders, the patient was able to Teach-Back the instructions successfully.*

In addition to the team confirming all three predictions, Jane realized the medication information sheets she had been handing out to parents weren't as clear as she thought. She realized these should be re-written — maybe with the input of some parents.

4. Act: Based on what you learned from the test, make a plan for your next step.

Determine what modifications you should make — adapt, adopt, or abandon:

Jane is planning to use Teach-Back any time she prescribes medication. Although it may take more time, she now understands the importance. The other residents are going to work on using Teach-Back specifically for medications for the next week.

They would like to pull together a team to work on some of the medication information sheets with parent input, but they are first going to gather more information through more interactions in the coming days.

Before filling out the template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

Template: PDSA Worksheet

Objective:

1. Plan: Plan the test, including a plan for collecting data.

Questions and predictions:

-
-

Who, what, where, when:

Plan for collecting data:

2. Do: Run the test on a small scale.

Describe what happened. What data did you collect? What observations did you make?

3. Study: Analyze the results and compare them to your predictions.

Summarize and reflect on what you learned:

4. Act: Based on what you learned from the test, make a plan for your next step.

Determine what modifications you should make — adapt, adopt, or abandon:

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.

SBAR – Case Presentation Tool	
S	**Situation:** **67 year old transfer to me when a former partner left the office. On schedule for chronic pain follow up renewal of medications.** **On norco 10/325 two pills 4 times a day.**
B	**Background:** **On disability for 10 years from manufacturing job. History of three back surgeries last one a fusion more than 10 years ago. Concerned can't get back to his hunting blind as trouble walking. Admits to 6 alcoholic drinks a day sometimes more if buddies come over. Trouble sleeping. Widespread pain in lower back down both legs.**
A	**Assessment:** Alcohol Overuse possible Alcohol use disorder Chronic opioid use Chronic pain with central sensitization
R	**Recommendation OR Question:** **Connect with him** **Shared my concerns for his safety** **Acknowledge the importance of getting to his deer blind** **Common goal: safely get to and enjoy his deer blind.**

ADDITIONAL RESOURCES

TeamSTEPPS

https://www.ahrq.gov/teamstepps-program/resources/pocket-guide/index.html

RISK STRATIFICATION

https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/medical-home/care-management/risk-stratification-rubric-algorithm.html

SBAR

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

TEACHBACK

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

PDSA

https://www.ihi.org/library/tools/plan-do-study-act-pdsa-worksheet