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INTEGRATING TEAM-BASED CARE TO IMPROVE CLINICAL OUTCOMES

A GUIDE FOR HEALTH CENTERS

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

ABOUT THE NATIONAL NURSE-LED CARE CONSORTIUM

The National Nurse-Led Care Consortium (NNCC) is a national leader supporting and advocating on behalf of nurse leaders. NNCC is a nonprofit member-supported organization, and provide a wide range of services to educate and support both nurses and other primary health care professionals. NNCC advances the quality of health care through policy, consultation, and programs to reduce health disparities and meet people's primary care and wellness needs. NNCC is an affiliate of Public Health Management Corporation (PHMC).

INTRODUCTION

As health centers seek to improve patient health outcomes, boost their bottom line, and keep up with shifts towards value-based care, the team-based care model serves as a comprehensive strategy to not only survive but thrive in this new healthcare landscape. The team-based care model has been repeatedly shown to improve healthcare delivery and achieve the quadruple aim: improved patient satisfaction, improved patient health outcomes, improved provider satisfaction, and reduced health care costs. The purpose of this publication is to outline elements of a successful interdisciplinary care team model and to provide strategies for implementing team-based care in a federally qualified health center setting. For more information on value-based care, see our companion publication **Preparing for Value-Based Care: A Guide for Health Centers**.

WHY TEAM-BASED CARE?

Core characteristics of the team-based model of care include universal communication styles, optimized roles and responsibilities of care team members, streamlined workflows for redesigned roles, and the incorporation of the patient and family into the interdisciplinary care team. Such characteristics have been shown to enhance patient-provider communication, improve patient health outcomes, boost staff satisfaction and engagement, and reduce burnout and turnover among team members - placing the participating practice on a trajectory to succeed in a value-based payment environment.

Additional benefits of the team-based model of care are seen among patient populations. The incorporation of the patient and family into this model has been shown to increase overall satisfaction, level of engagement, autonomy in self-care, and positive disease-specific outcomes (See Table 1 on the next page).

Patient Outcomes (% change) n=8	**Satisfaction** 50% n=4	**Engagement** 13% n=1	**Adherence/ Self-Care** 25% n=2	**Positive Diabetes Specific Clinical Outcomes** 25% n=2
Care Team Outcomes (% change) n=7	**Satisfaction** 43% n=3	**Productivity/Efficiency** 57% n=4	**Accuracy/Fewer Errors** 29% n=2	**Fewer Turnovers** 29% n=2

Table 1. *Outcomes associated with effective, multidisciplinary team medical care identified through a literature review of care team interventions (N=15). Patient outcomes include increases in satisfaction,[1-4] engagement,[5] adherence/self-care,[6,7] and positive diabetes-specific clinical outcomes[1,8] (HbA1c and blood pressure improvement). Team outcomes include increases in satisfaction,[9-11] productivity/efficiency,[3,4,12,13] accuracy,[13,14] and fewer turnovers.[13,15]*

ELEMENTS OF SUCCESSFUL CARE TEAMS

The interprofessional team-based model of care refers to care delivered by intentionally created work groups in health care who are recognized by others (and themselves) as having a collective identity and shared responsibility for a patient or group of patients. There are four core competencies that guide the formation of any interprofessional collaborative practice. Known as the Interprofessional Education Collaborative (IPEC) competencies, they guide and inform the creation and maintenance of modern care teams.[16] These competencies are:

- Values/Ethics for Interprofessional Practice
- Roles/Responsibilities
- Interprofessional Communication
- Teams and Teamwork

The IPEC competencies feature describe care that is: community and population oriented, relationship focused, process oriented, linked to measurable activities, and outcome driven. This guide seeks to link the above IPEC competencies to specific tools and strategies of effective teamwork.

IPEC®	Teamwork Tools & Strategies
Teams and Teamwork	• **Recognizing high-performing teams**
Roles/Responsibilities	• **Role Maps** • **Role Redesign**
Interprofessional Communication	• **Recognizing effective communication** • **SBAR Communication**

TEAMS AND TEAMWORK

Who is on your team? The first step in the creation of any high-functioning care team is to define its members. Is your team limited to the core Provider-MA dyad? Do you include front desk staff as members of the team? Is there a place for the patient and family on your team? Re-defining clinical care teams is the first step in team transformation and optimization. Successful care teams are interprofessional - made up of individuals from diverse professional backgrounds working together to deliver the highest quality of care.

There is a growing body of research about what constitutes a high-performing team. Salus et. al describes "The 6 C's of Effective Teamwork" as outlined below.[17]

- **Communication**: Care team members must demonstrate clear, concise, and comprehensive communication in their unique roles, while understanding how to most efficiently engage the rest of the team. Effective communication increases satisfaction, care quality, and patient outcomes while decreasing gaps in care and medical errors.[18]
- **Coordination**: Care team coordination is essential in the process of transforming individual and collective resources into outcomes.[17] Coordination involves preemptive management of each member's roles and responsibilities to allow for seamless integration in accomplishing interdependent tasks.
- **Conflict**: A care team's conflict resolution capacity is a significant predictor of both positive and negative team-based outcomes.[17]
- **Cognition**: Cognition within a care team is the result of consistent exchanges that contribute to a shared understanding among team members. Cognition acts as a precursor for coordination as it enables team members to anticipate the needs of the rest of the team.[17] This skill increases team efficacy in navigating dynamic healthcare and patient circumstances.
- **Cooperation**: Cooperation among care teams refers to multiple factors that influence motivation to perform optimal teamwork. Perceptions of team cohesion, trust, collective efficacy, psychological safety, and empowerment influence individual attitudes surrounding the team culture as well as team outcomes.[17]
- **Coaching**: Within a care team, coaching involves maintaining the responsibility of each member to lead and follow when necessary for the good of the team. Effective coaching practice encourages action and facilitates problem-solving processes among team members.[17] A shared understanding throughout the care team positively contributes to the selective leadership necessary for effective coaching.

ROLES/RESPONSIBILITIES

What roles do different members of your care team have? High-functioning care teams often require a practice to re-think the roles and responsibilities of its team members. Do current roles and responsibilities fit the needs of the practice? Do they fit the needs of the patient population? Do they fit the needs of the team members themselves? Role redesign, role clarity, and role optimization may be needed. Forming a care team with a diverse group of contributors requires thoughtful and strategic planning to ensure that patients' needs are met and that each team member is able to act to their full scope of practice. Each member of the team must understand their role and the role of others. Roles should be based in competencies, scope of practice, education and accreditation, and licensure.

When re-thinking the makeup of a care team, a patient-centered practice will take into consideration the role of the patient and family. What role and value do the patient and family provide? Strong patient outcomes are associated with patients that are not just "engaged" but also "activated" in their care.[19]

In defining roles for specific tasks, it can be helpful to form a RACI Matrix. The acronym RACI refers to the differing roles a team member might have in various care-related tasks: Responsible, Accountable, Consulted, and Informed.

The Responsible party in a RACI matrix is the person who will be carrying out the work. There can only be one R in each row. The Accountable column, on the other hand, need not be used for every task. In some circumstances there may be up to one person who is ultimately accountable for the result of any decision made. There may be multiple people who are Consulted for a task. These team members give input prior to decision-making, either out of professional expertise or because they will be affected by the outcome of the decision. There may also be multiple people listed to be Informed, who will receive information after the decision has been made or work is completed.

In one health center, the care team designed a RACI matrix to help manage their diabetes population. Table 2 is a matrix used to identify the level of knowledge and input each person on the team has in caring for this population.

	Medical Director	RN	MA	Clinic Director	Student Intern
Coordinate monthly diabetes education seminars	I	A		C	R
Test all diabetes patients for A1C levels on an annual basis	I	C	R	A	
Refer diabetic patients to behavioral health	A			R	
Identify patients in need of screening in the EHR	I	R	I		
Provide educational resources after visit		R	I	C	
Ensure that pharmacy has adequate supply of prescriptions	R			A	
Call patients to remind them about upcoming appointments or discuss follow-up		C	R		

Table 2. *RACI matrix for diabetes management. RACI stands for Responsible, Accountable, Consulted, and Informed.*

INTERPROFESSIONAL COMMUNICATION

Interprofessional communication is considered a core component of any high-functioning care team. The method and means by which care team members communicate with one another is reported to be a major factor in effective care teams.[20] Care team members that feel heard by their colleagues are more likely to report stronger work satisfaction, and have reduced likelihood of leaving their job.[21]

Conversely, poor communication in healthcare is the 5th leading cause of death, leads to increased employee absenteeism and turnover, accounts for 80% of serious medical errors, and is responsible for 35-40% of malpractice claims in the U.S.[22,23] At the core of building a successful team is developing strong, efficient, and universal communication patterns among team members. Care team members must demonstrate clear, concise, and comprehensive communication in their unique roles, while understanding how best to engage the rest of the team. Effective communication increases satisfaction, care quality, and patient outcomes while decreasing gaps in care and medical errors. [18] Four components to consider when creating a team communication strategy are frequency, timing, accuracy, and focus. Team members should know how often they need to check in with each other, and when. Scheduled communication should remain specific, accurate, and focused on essential topics of discussion.

CHECKLIST

- [ ] **Frequency**: How often will our team check in?
- [ ] **Timing**: At what point during the day will our team check in, and for how long?
- [ ] **Accuracy**: How do we bring an informed perspective to our check in?
- [ ] **Focus**: How will we limit our discussion to the most pertinent issues?

A helpful tool for developing efficient and thorough communication patterns among your team members is the acronym SBAR: Situation, Background, Assessment, Recommendation.[24]

S = Situation: A brief and focused description of the problem or need, no more than 1-3 sentences. The presentation of the situation usually includes:

- Name and location of the patient.
- Description of the problem:
    - What's the problem?
    - When did it start?
    - How severe is it?

B = Background: Includes the patient history or essential information related to the problem or need. The background may include:

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

A = Assessment: Your focused assessment of what is happening. Your assessment will be based on the situation and background, your role, scope of practice, and may include:

- Significant change in an ongoing problem.
- Preliminary diagnosis or concern regarding acute problem.
- Issue with medication taking, adherence, and/or interaction.
- Inadequate community supports.

R = Recommendation: Your recommendation of what should be done to address the problem or need. **Your recommendation should be consistent with your role and scope of practice and may address:**

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

Any assessments or recommendations should be consistent with the role and scope of the care team member delivering the SBAR script. An SBAR communication is a useful communication strategy that can be utilized in a variety of settings and situations, such as: morning huddles, warm handoffs, and management situations in which objectivity is crucial.

GETTING STARTED

There are a variety of resources available to support health centers in the creation of high-functioning, interdisciplinary care teams. One such resource is the "Formation & Optimization of Interdisciplinary Care Teams for Practice Transformation" workshop. This workshop was developed by the Arizona State University Center for Advancing Interprofessional Practice, Education and Research in collaboration with the National Nurse Led Care Consortium in Philadelphia, PA. This workshop, designed using a train-the-trainer approach, arms learners with tangible skills and resources to:

1. Build interdisciplinary care teams and optimize their use for patient-centered care
2. Clarify team roles and responsibilities to optimize efficiency, outcomes, and accountability
3. Enhance continuity of patient care so that patients, caregivers, and providers recognize each other as partners in care.

This interactive workshop was designed with primary care practices in mind and is modeled after core tenants of patient-centered care, nurse-led care, and the IPEC competencies of team-based care. Reach out to NNCC for information about how to bring this workshop to your health center, or for additional resources.

CONCLUSION

As the health care system and patient needs become more complex, creating systems of team-based care can help to reach the quadruple aim: improved patient satisfaction, improved patient health outcomes, improved provider satisfaction, and reduced health care costs. Building a care team in your health center requires deliberate and intensive focus to ensure that team members remain informed, communication is strong, care is well-coordinated and patient centered, and that community resources are identified and utilized.

Endnotes

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