

Section 3.5 Design

Establishing the Care Team: Roles and Communications

This tool provides an overview of the new roles of health care professionals in a community-based care coordination (CCC) program, and describes why communication among the health care team is vitally important for patient safety and satisfaction, as well as for satisfactory working relationships among team members. It includes links to numerous resources to help facilitate a culture that supports team communication and collaboration.

Time required to review tool and resources: 3 hours

Time required to implement strategies: 10 hours over 6 months

Suggested other tools: Approaches to Patient Communications; Workflow and Process Analysis/ Redesign/ Optimization for CCC tool suite

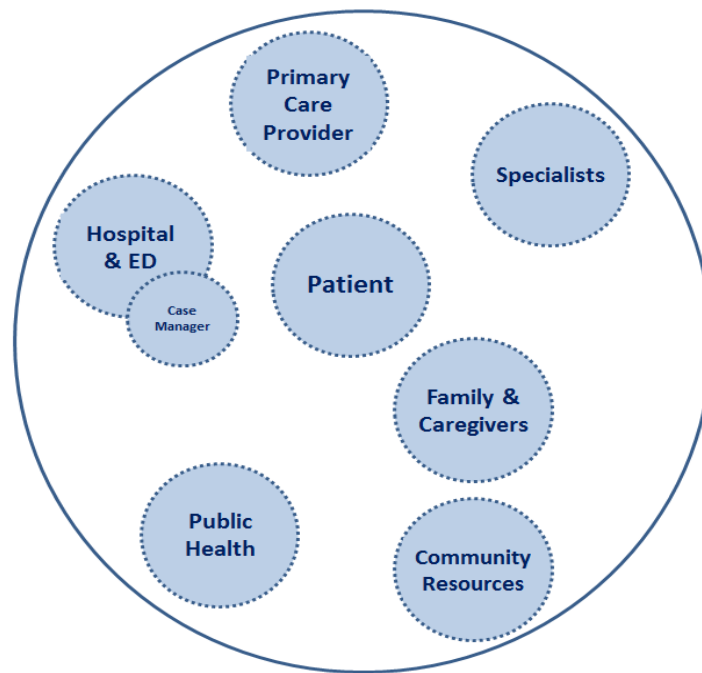
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Current State of the Health Care Team

The “health care team” has traditionally been a loose connection of an ever-growing number of health care professionals and entities, working quite autonomously within a hierarchical structure of handoffs. Physicians directed care and all others were subservient to them. Public health and community service organizations were very distant, and often were not considered part of patient’s health care support system. Patients were not always at the center of the health care team, and in fact often were not considered a part of the team at all. To use an analogy from business and industry, they were essentially “customers” or “products” even though these terms were never used. There certainly was no care coordinator to “connect the dots,” to guide or help navigate the patient and patient’s family/caregivers through the health care system. Figure 1 illustrates this state of affairs.

Figure 1. Current State of Health care Team



Traditional Health Care Team Roles and Relationship to Patients

The following table describes the health care professionals' roles in this traditional environment.

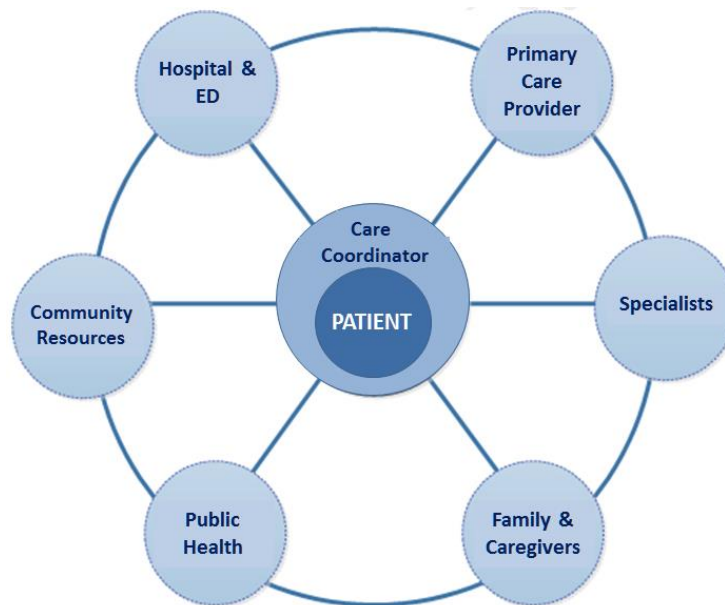
Primary Care	Emergency Department and Inpatient Care	Home
Primary care provider	Doctors	Patient (and family)
Nurse	Nurses	Home health nurse
Receptionist	(Many) other professionals	Community services
	Case manager	Public health
Patient	Patient's family	Primary care provider
	Patient	Specialty physicians

- The **primary care provider's** role has been to provide diagnosis and treatment recommendations, typically with rather limited nursing service support, and with the receptionist positioned as the gatekeeper. The patient has been relatively "distant" from the provider in this scenario, typically not participating in shared decision making. Similarly, the provider, nurse, and receptionist have had very distinct roles and have had little, if any, collaboration in health care decision making – either among themselves or with the patient.
- In the **emergency department** and **inpatient care** environments, there are many doctors whose roles have been to diagnose and direct treatment. There are many nurses, other nursing staff, and other health care professionals who (directly and indirectly) administer to the patient. There is often case manager (who may go by several designations, such as utilization manager, DRG coordinator, and others) who serves as the primary gatekeeper, determining the level of care the patient's insurance benefits permit, and coordinating in this regard with the patient's family. In this scenario, the patient is even more distant from the locus of health care decision making.
- Once **at home**, the patient is essentially in charge of his or her health destiny – often with little understanding or clarity surrounding what and how to perform in this new role. In the past, there was no one to provide guidance or to help coordinate basic community services needed to support important health needs. If there was home health care provision, it was often at a medical assistant, not registered nurse, level and there were very specific rules and limitations surrounding what services could be provided. Public health nurses or social workers may have provided some assistance in helping patients get community resources and directing them to financial resources. Primary and specialty care providers were distant to the patient. There was minimal or no follow up from them, and often patients did not sense they could reach out to them for basic health care needs within their homes.

Health Care Professionals' Roles in Community-based Care Coordination: Communications and Collaboration

To create an environment in which the patient is the focal point and health care professionals coordinate with the patient and collaborate with one another, such as illustrated in Figure 2, health care professionals roles may need to be seen in a different light and new communication skills may need to be learned.

Figure 2. Community-Based Care Coordination Communications and Collaboration Model



Care Coordinator and Case Manager Roles

A new role within this emerging model is that of the *community-based care coordinator* (CC). The care coordinator works in collaboration and continuous partnership with chronically ill, “high-risk” patients and their families/caregivers, primary care providers, specialists, hospitals and ED providers and staff, public health agencies, and community health care resources in a *team approach* to:

- Promote timely access to appropriate care
- Increase utilization of preventive care
- Reduce ED utilization and hospital readmissions
- Increase comprehension through culturally and linguistically appropriate education
- Create and promote adherence to a care plan, developed in coordination with the patient and the patient/family
- Increase continuity of care by managing relationships with tertiary care providers, transitions-in-care, and referrals

- Increase patients' ability for self-management and shared decision-making
- Provide medication reconciliation
- Connect patients to relevant community resources

The care coordinator's goal is to enhance patient and family health and well-being, increase patient satisfaction, and reduce health care costs. The care coordinator role may seem to overlap that of the case manager. Although these terms are sometimes used synonymously, for purposes of community-based care coordination, they are distinguished. An important step in care team communication is to ensure ongoing collaboration between the case manager and care coordinator if these functions are performed by different persons, as is often the case.

The following table describes the distinct roles of the case manager and care coordinator.

	Case Manager	Community-Based Care Coordinator
Objective	Ensures patients are prepared for next care setting	Ensures patients get needed care services to keep health stable and reduce risk of further expensive care services
Focus	Individual patients	Population of patients
Locus	Within one health care delivery organization	Coordinates health-related needs for patients at home
Care planning	Coordinates transitioning the care plan from one setting to a next setting	Helps patients follow their care plans
Timeline	Upon admission to a care setting through discharge from a care setting	Across all care settings for the duration of time that the patient's quality and cost of care is at risk
Collaboration and communication needs	Case manager works during the health care encounter with the patient/family and next level of care. Case manager should advise care coordinator of potential care coordination needs in the home setting.	Care coordinator works with patient prior to and after any given health care encounter. Care coordinator should be advised that patient is in a health care delivery setting and work with case manager to begin planning for return to home setting.

Other Health Care Professional Role Enhancements

The communication and collaboration fostered in a community-based care coordination environment necessitates a review of all health care professionals' roles. Very often it has been found that individuals in given health care roles are not working to the level of their qualifications or credentials. With a bit more guidance, reinforced training and feedback, many health care professionals could be more helpful to patients and improve workflow and productivity within a health care setting.

For example:

- **Reception staff** have often taken on the role of gatekeeper, primarily to preserve the physicians' schedules. They could easily take on additional tasks, such as checking on whether patients need routine lab work before a visit, reminding them of certain preventive service needs such as immunizations, asking them to bring their medications

or other health diary to the visit, and instructing them on logging onto the office portal to enter history of the present illness. These steps enable the patient and the office to be better prepared for the visit, allowing more time for communications with the patient. Some offices believe such communications violate HIPAA rules – but the receptionist is as much a part of the health care provider setting as any other staff member and should be so trained and treated. With recent changes in CLIA regulations to further support patient engagement¹, patients now have access to lab results as soon as they are available, ensuring more informed communications.

- **Nursing staff**, especially in provider offices, often include persons with a range of credentials. But all have specific skill sets that should be fully utilized. For example, unless clinically indicated, the blood pressure taken by the certified medical assistant during patient rooming should not have to be taken again by a registered nurse or physician. As another example and depending on state licensure laws, many credentialed nursing staff can manage prescription refills. Some physicians have been hesitant to have nursing staff engage very much with the patient, again citing confidentiality concerns. But the more patients understand that all staff within the office, including receptionists, nurses and others, are part of their care team the more coordinated their care can be, with the side benefit of office practice improvement.
- **Physicians** have long been recognized as not being the best communicators. A large body of current research, however, addresses the importance of effective, empathic physician-patient communication. Current research confirms that improved physician-patient communication improves patient compliance with their treatment regimen leading to better outcomes, and also highlights the need for continuing efforts to improve physician empathy, communication style, and tone of voice. Dr. Egner, writing in the *Journal of General Internal Medicine*, describes a number of ways to address physicians' "impaired communication skills."²
- **Pharmacists** play a key role in medication management. North Carolina pharmacists have spearheaded the creation of networking pharmacist programs, with the goal to minimize patient attrition (going without a needed medication) and to minimize to the extent possible prescriber and pharmacy disruption.³ Despite the much more widespread availability of drug information and patient-specific medication lists, the pharmacist's role in understanding the pharmacokinetics and pharmacodynamics of the ever-increasingly powerful drugs is invaluable to physicians.

Importance of Creating a Patient-Centric Community-Based Health Care Team

Creating more of a team environment, supported by enhancing the role of each individual and ensuring communications among individual team members, profoundly impacts patient safety, quality of outcomes, patient satisfaction, and health care professionals' job satisfaction.

Work done by the Department of Defense and the Agency for Health care Quality and Research (AHRQ) has found that ineffective team communication is the root cause for nearly two-thirds of all medical errors.⁴ An Institute of Medicine Report on Health Professions and Training has identified that doctors and other health professionals lack adequate training in communication skills, such as open-ended inquiry, reflective listening and empathy, as a way to respond to the unique needs, values, and preferences of individual patients.⁵

For example, studies of clinician-patient visits reveal that patients are often not provided the opportunity or time to tell their story during the history-taking component of a visit with their physician. As a result, patients perceive that what they are saying is not important and leads to patients being reticent to offer additional information.⁶ Not surprisingly, research bears out that nearly three-quarters of all malpractice claims arise out of a physician-patient communication problem.⁷ A study funded by the Commonwealth Fund found that a quarter of patients report they did not follow their clinician's advice because they disagreed with the recommended treatment, were concerned about cost, found the instructions too difficult to follow, felt it was against their personal beliefs, or reported they did not understand what they were supposed to do.⁸ Very importantly, job satisfaction and nurse turnover⁹ improve when communication about tasks and responsibilities is done well and a culture of mutual support is cultivated.¹⁰

Team Communications in Community-Based Care Coordination

There is a wealth of research data that supports the benefits of effective communication and health outcomes for patients and health care teams. It has been observed that the connection a patient feels with his or her clinician can ultimately improve his or her health, mediated through participation in care, adherence to treatment, and patient self-management. Within the context of community-based care coordination – where the health care team is much broader than doctor-nurse-patient – attention to team building, recognizing each team member's role, and enhancing communication skills is even more vital. Community-based care coordination is characterized by a broad spectrum of team members whose roles and responsibilities with respect to a patient shift over time and by location of patient.

Collaboration in health care has been defined as “health care professionals assuming complementary roles and cooperatively working together, sharing responsibility for problem-solving, and making decisions to formulate and implement plans for patient care.”¹¹ There is growing evidence of the need for ongoing collaboration, defined even more broadly now to include, “individualized evidence-based treatment plans, care coordination, health status monitoring, coaching in self-management, and promotion of community-based services.”¹²

Resources Available for Establishing a Culture to Support Communication and Collaboration

The following links provide tools, videos, PowerPoint presentations, and other materials to take practical steps in establishing a culture to support team communication and collaboration. See also *Approaches to Patient Communications* in this toolkit.

Care Team Communication Strategies

- ☐ **Huddles** – Short, daily sessions for the care team to rapidly prepare for managing the day's patients. Huddles should be conducted in stand-up mode, for not more than five minutes, generally at the start of a day. Topics include anything from adjustments to workflow, crisis management, patient access issues, and special care challenges for certain patients. Some clinics will document these huddles, often annotating patient-specific issues in their EHR or on an agenda that may be a printout from a registry or schedule for the day. Others use a white board to note agenda items throughout the day for the next day's discussion. A photograph of this can be taken for documentary

- ❑ evidence of performing the huddle. If the office is seeking NCQA recognition as a patient-centered medical home, documentation should be kept as evidence of conducting such huddles. Additional information and examples are available at: <http://www.aafp.org/fpm/2007/0600/p27.html>.
- ❑ **Team meetings** – Formal meetings to make organizational decisions. These are more formal meetings than huddles and usually address changes in policies or procedures, plans for conducting special events, or new information on health care practices. Training might be included in this category of communication. Documentation should include an agenda, minutes, and/or keeping a copy of the training materials and attendees. Additional information is available at: https://www.aamc.org/members/gfa/faculty_vitae/148582/team_meetings.html
- ❑ **Virtual rounds** – Educational programs on important clinical topics delivered via the web. These should be attended by all members of the applicable care team. For example, if a new procedure, protocol, drug, or other clinical information being delivered addresses an orthopedic issues, the orthopedists and associated nurses, physical therapists, pharmacist, and others as applicable should attend. Some of these offer continuing education for physicians and/or nurses, and usually require some form of post-test or quiz to be completed and potentially submitted to the web host. Additional information and examples are available at: http://mghcme.org/page/virtual_grand_rounds_series
- ❑ **Conducting a family conference** – Health care professionals, including the care coordinator and potentially community service representatives, meet with a patient and/or patient's family, often to discuss options for treatment, to help the patient and family prepare for a significant change in lifestyle, or to face a life-changing event. It is important to prepare carefully to ensure a successful conference. Important tools that are complementary to such conferences are shared decision making and patient self-management (see Patient Empowerment below). For additional information on how health care professionals can prepare for a family conference, see: http://depts.washington.edu/oncotalk/learn/modules/Modules_06.pdf. For information on preparing patients and family for a team conference, see: <http://www.whca.org/directory/all-about-care-conferences/>

Communication Strategies for Health Care Professionals

- ❑ **TeamSTEPPS Quick Facts** – Tools for complete, clear, brief, and timely communications among health care professionals (using tools such as SBARQ, CUS, Two Challenge Rule, Call Outs, and Check Backs). When a care coordinator, nurse, pharmacist, specialist, or other health care professional needs to have a discussion with the primary care provider or another health care professional concerning a specific patient care event, it is important to be as concise, specific, and focused as possible. Tips for effective communications using these tools are available at: [http://www.med.unc.edu/ihqi/files/teamstepps/implementation-package/TeamSTEPPS%20QuickFacts%20\(4\).pdf](http://www.med.unc.edu/ihqi/files/teamstepps/implementation-package/TeamSTEPPS%20QuickFacts%20(4).pdf)
- ❑ **Guidelines for nurse communications with physicians using SBAR** – a framework for (primarily) nurses to brief physicians on their patients. The framework suggests a method for ensuring that the situation is fully described, background information is provided, assessment that the nurse has made is delivered, and recommendations are offered. Some

add a “Q” (SBARQ) to follow up with questions. Additional information is available at : <http://lifewithjess.files.wordpress.com/2014/01/sbar-guidelines-kaizer-permanente.pdf>

Overcoming Behavioral Barriers between Patients and Staff and Among Staff

This has been an important focal point of recent industry discussions. Such behavioral barriers include:

- ❑ **Overcoming disruptive behavior** (which may be defined as any conduct that interferes with the effective operation of the organization, or suggests a threat to organizational personnel or to patient care). It is important to note that behavior that is unusual, unorthodox, or different is not alone sufficient to classify it as disruptive. Additional information on spotting and overcoming disruptive behavior is available at: http://www.med.umich.edu/umhshr/doc/Disruptive_Behavior_Toolkit.pptx
- ❑ **Overcoming gender barriers**, where certain roles are often heavily populated by certain genders. Issues with both genders are addressed in: <http://leannecarey713.wordpress.com/2012/06/12/gender-communication-barriers-there-is-no-crying-in-baseball/>
- ❑ **Advancing diversity in health care**, both with respect to health care professionals who often come from many different parts of the world, and to patients who live in the “melting pot” of the US. Good ideas are offered at: http://explorehealthcareers.org/en/issues/news/Article/244/Why_Diversity_Matters_in_the_Health_Professions
- ❑ **Overcoming generational barriers** are increasingly evident in health care as more people continue to work well beyond the traditional retirement age. The American Hospital Association recently addressed the issue of four generations of health care professionals now actively involved in delivering care at: http://www.hhnmag.com/display/HHN-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Magazine/2013/Jan/0113HHN_coverstory

Patient Empowerment

Patient empowerment has many aspects to it. The key focus is to encourage such empowerment as a means to bring the patient to the forefront of their health care, and their decision making and responsibility for treatment and wellness. The following are several strategies:

- ❑ **Shared decision making** refers to communications with patients to enable them to make informed choices about what is best for their personal situation. (See *Shared Decision Making* in this Toolkit.) A video of the Stillwater Medical Group discussing the benefits of shared decision making is available at: <http://www.informedmedicaldecisions.org/what-is-shared-decision-making/>
- ❑ **Patient self-management** is even broader than shared decision making. It is the process to help patients move from the care delivery system where health care professionals provide many of the care management tasks to being independent in taking medications, keeping provider appointments, making appropriate lifestyle changes, and ultimately being responsible for their own health and wellness. (See *Patient Self-Management* in this Toolkit.) Specific steps are also described at: <http://www.aafp.org/practice->

[management/pcmh/patient-care/educate-self-management.html](http://www.pcmh.org/management/pcmh/patient-care/educate-self-management.html) A set of tools for patient self-management is also available at:

<http://www.ihl.org/resources/pages/tools/selfmanagementtoolkitforclinicians.aspx>

- ❑ **Motivational interviewing** is technique to support patient self-management by being supportive and encouraging. Although the phrase “motivational interviewing” is proprietary, the technique of such an interviewing style is universal. (See *Supportive Communications* in this Toolkit.) An example of an interview is also available at: <http://www.youtube.com/watch?v=dm-rJJPCuTE>

Clarity on Roles, Authority and Responsibility

This is an important element of communications for all parties to the communication. In addition to the following specific traits identified below, see *Approaches to Patient Communications* in this Toolkit:

- ❑ **Leadership** is an important trait – but should be focused on taking leadership in any situation, not just heading up an organization. For example, if there are issues with any aspect of care coordination, the care coordinator must take the lead in finding resolution. The Joint Commission offers an excellent primer on leadership for all health care professionals: http://www.jointcommission.org/assets/1/18/wp_leadership_standards.pdf
- ❑ **Staff enablement** refers to encouraging all staff to be “masters of their own destiny” and to assume leadership roles with respect to their own work. The following is an excellent publication on such enablement: <http://www.clinicalmicrosystem.org/assets/materials/publications/JQIPart8.pdf>
- ❑ **Interdisciplinary teamwork** is at the crux of any form of health care, but is often more challenging when it must be accomplished in the community with the patient at home rather than in an organized provider arrangement. The following resource offers strategies for working together in teams in such an environment: <http://dcahec.gwumc.edu/education/session3/models.html>
- ❑ **High functioning teams** refer to the fact that teams who excel do so because they have a shared set of values. An excellent resource is available at: <http://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-Values.pdf>

References

¹ HHS strengthens patients’ right to access lab test reports (Fe. 3, 2014). Available at:

<http://www.hhs.gov/news/press/2014pres/02/20140203a.html>

² Egener, B. (Nov. 2008). Addressing Physicians’ Impaired Communication Skills J Gen Intern Med. 23(11): 1890–1895. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585668/>

³ New Approach to Improving Health Care Delivery Systems, Community Care of North Carolina, Module 9: Establishing a Network Physician Program. Available at:

<http://commonwealth.communitycarenc.org/toolkit/9/default.aspx>

- ⁴ King, H. et al. TeamSTEPPS™: Team strategies and tools to enhance performance and patient safety, Department of Defense and Agency for Healthcare Research and Quality. Available at: http://www.ahrq.gov/downloads/pub/advances2/vol3/advances-king_1.pdf
- ⁵ Greiner, AC and E. Knebel, eds. (2003). Committee on the Health Professions Education Summit, Health Professions Education: A Bridge to Quality, National Academies Press, Washington, DC. Available at: <http://www.iom.edu/Reports/2003/health-professions-education-a-bridge-to-quality.aspx>
- ⁶ World Health Organization (2003). Adherence to long-term therapies: Evidence for action. Switzerland: WHO Library Cataloguing. Available at: http://www.who.int/chp/knowledge/publications/adherence_introduction.pdf
- ⁷ Beckman, H.B. et al. (1994). The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. Archives of Internal Medicine, 154(12) 1365-1370. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/8002688>
- ⁸ Davis, K. et al. (2002). Room for Improvement: Patient Report on the Quality of their Health Care. New York: Commonwealth Fund. Available at: http://www.commonwealthfund.org/usr_doc/davis_improvement_534.pdf
- ⁹ Lein C. and C.E. Wills. (2007). Using patient-centered interviewing skills to manage complex patient encounters in primary care. American Academy of Nurse Practitioners, 19:215-220. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/17489953>
- ¹⁰ DiMeglio K. S. Lucas, and C. Padula. (2005). Group Cohesion and Nurse Satisfaction: An Examination of a Team-Building Approach. Journal of Nursing Administration. 35:3, 110-120. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/15761307>
- ¹¹ Fagin, CM. (1992). Collaboration between nurses and physicians: no longer a choice. Academic Medicine; 67(5):295-303. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/1575859>
- ¹² Martin, JS. (2010). Interprofessional collaboration among nurses and physicians: making a difference in patient outcome. Swiss Medical Weekly. Available at: <http://www.smw.ch/docs/pdfcontent/smw-12648.pdf>

For support using the toolkit

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