TeamSTEPPS Community Call 12/17/15

Next Calls and Upcoming Events
Wednesday Jan. 20, 2016 at 1100 CST
Thursday Feb. 18, 2016 1400 CST

DIAL IN INFORMATION FOR CONFERENCE CALL...
Dial (888) 820-1398 enter the Attendee Code: 7283774#
*6 to mute or unmute your line

Reminder: Notes from past calls are available at http://www.unmc.edu/patient-safety/teamstepps/calls.html

Agenda

1. Roll Call – 6 hospitals participated in the call.

2. Tips for Teaching and Using TeamSTEPPS Tools: Leading Teams. Briefs, huddles, and debriefs are the key tools taught in TeamSTEPPS to provide designated and situational leaders with the ability to plan, adjust, and learn.
   1) We begin TeamSTEPPS training by teaching managers these three leadership tools so that leaders can quickly begin to role model use of the tools and accelerate integration of information from individual situation monitoring, which leads to task assistance, and team adaptability.
   2) Briefs, huddles, and debriefs are key tools in the successful implementation of the patient-centered medical home (PCMH) in ambulatory care
      i. PCMH is a model of team-based, integrated care to decrease cost, improve quality
      ii. Characteristics
         a. Comprehensive care provided by integrated team of providers
         b. Patient-centered philosophy
         c. Care is coordinated across the continuum of levels and settings and is consistent with patient values and preferences
         d. Commitment to quality improvement
      iii. PCMH implementation is a complex social intervention (CSI); CSIs are characterized by multiple components implemented at multiple levels. Thus planning, adapting and learning by using briefs, huddles, and debriefs are key to implementation of PCMH.

3) Tools available on our web site at http://www.unmc.edu/patient-safety/teamstepps/toolkit.html and in the Communication section of the AHRQ TeamSTEPPS binder.

3. Current use of Briefs, Huddles, Debriefs
   - Managers and supervisors use these tools to improve quality, employee satisfaction, and work flow.
   - Many hospitals continue to use hospital-wide morning briefs to create a shared mental model of the anticipated work load.
   - A larger hospital described how they use a bedside brief in the morning and a 4 PM staffing brief to manage issues that have come up during the day. They explained that prior to TeamSTEPPS training, briefs and huddles were seen as tasks to accomplish as opposed to essential tools to share information needed to manage changing workloads, achieve a Shared Mental Model, and achieve the goal.
   - In another hospital, debriefs are required with all responders after a code, and the debrief is required no later than the day after it occurred. In their current culture, not having a debrief is considered as a missed learning opportunity (see their Code Debrief Checklist on the Toolkit page of our TeamSTEPPS web site http://www.unmc.edu/patient-safety/teamstepps/toolkit.html)
To make the most of Debriefs:

- Document what you learn using a database, checklist or notebook.
- Recognize that conducting debriefs supports implementation of a Just Culture as it focuses on learning from processes and not blaming people.
- Designate a leader that facilitates but does not dominate the debrief. An example of how to effectively lead a debrief in the context of a post-fall huddle is available at http://www.unmc.edu/patient-safety/capturefalls/tool-inventory.html Click on Post Fall Huddle Tools

4. In the literature... Open access; a hard copy is freely available at the link below.


Background: Like other transformative healthcare initiatives, patient-centered medical home (PCMH) implementation requires substantial investments of time and resources. Even though PCMH and PCMH-like models are being implemented by multiple provider practices and health systems, little is known about what facilitates their implementation. The purpose of this study was to assess which PCMH-implementation resources are most widely used, by whom, and which resources primary care personnel find most helpful.

Methods: This study is an analysis of data from a cross-sectional survey of primary care personnel in the Veterans Health Administration in 2012, in which respondents were asked to rate whether they were aware of and accessed PCMH-implementation resources, and to rate their helpfulness. Logistic regression was used to produce odds ratios for the outcomes (1) resource use and (2) resource helpfulness. Respondents were nested within clinics, nested, in turn, within 135 parent hospitals.

Results: Teamlet huddles were the most widely accessed (80.4% accessed) and most helpful (90.4% rated helpful) resource; quality-improvement methods to conduct small tests of change were the least frequently accessed (42.4% accessed) resource though two-thirds (66.7%) of users reported as helpful. Supervisors were significantly more likely (ORs, 1.46 to 1.86) to use resources than non-supervisors but were less likely to rate the majority (8 out of 10) of resources as “somewhat/very helpful” than non-supervisors (ORs, 0.72 to 0.84). Longer-tenured employees tended to rate resources as more helpful.

Conclusions: These findings are the first in the PCMH literature that we are aware of that systematically assesses primary care staff’s access to and the helpfulness of PCMH implementation resources. Supervisors generally reported greater access to resources, relative to non-supervisors, but rated resources as less helpful, suggesting that information about them may not have been optimally disseminated. Knowing what resources primary care staff use and find helpful can inform administrators’ and policymakers’ investments in PCMH-implementation resources. The implications of our model extend beyond just PCMH implementation but also to considerations when providing implementation resources for other complex quality-improvement initiatives.