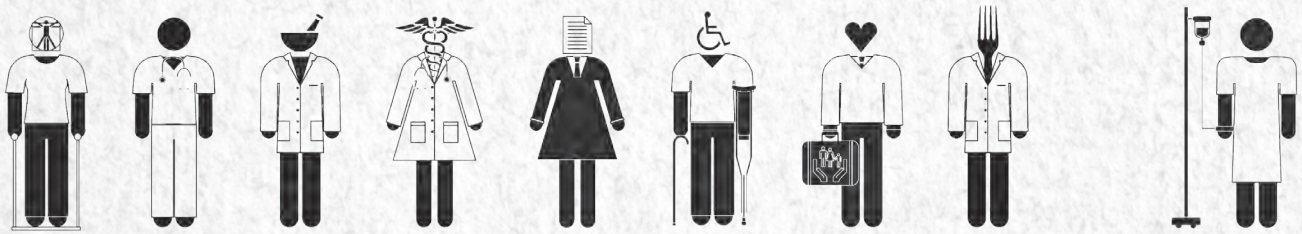
Advancing Collaborative Care Teams



A Guide for Teams and Facilitators

Winnipeg Regional Health Authority

Office régional de la santé de Winnipeg

Caring for Health
À l'écoute de notre san

Canadian Foundation for **Healthcare Improvement** EXTRA

Fondation canadienne pour **l'amélioration des services de santé** FORCES

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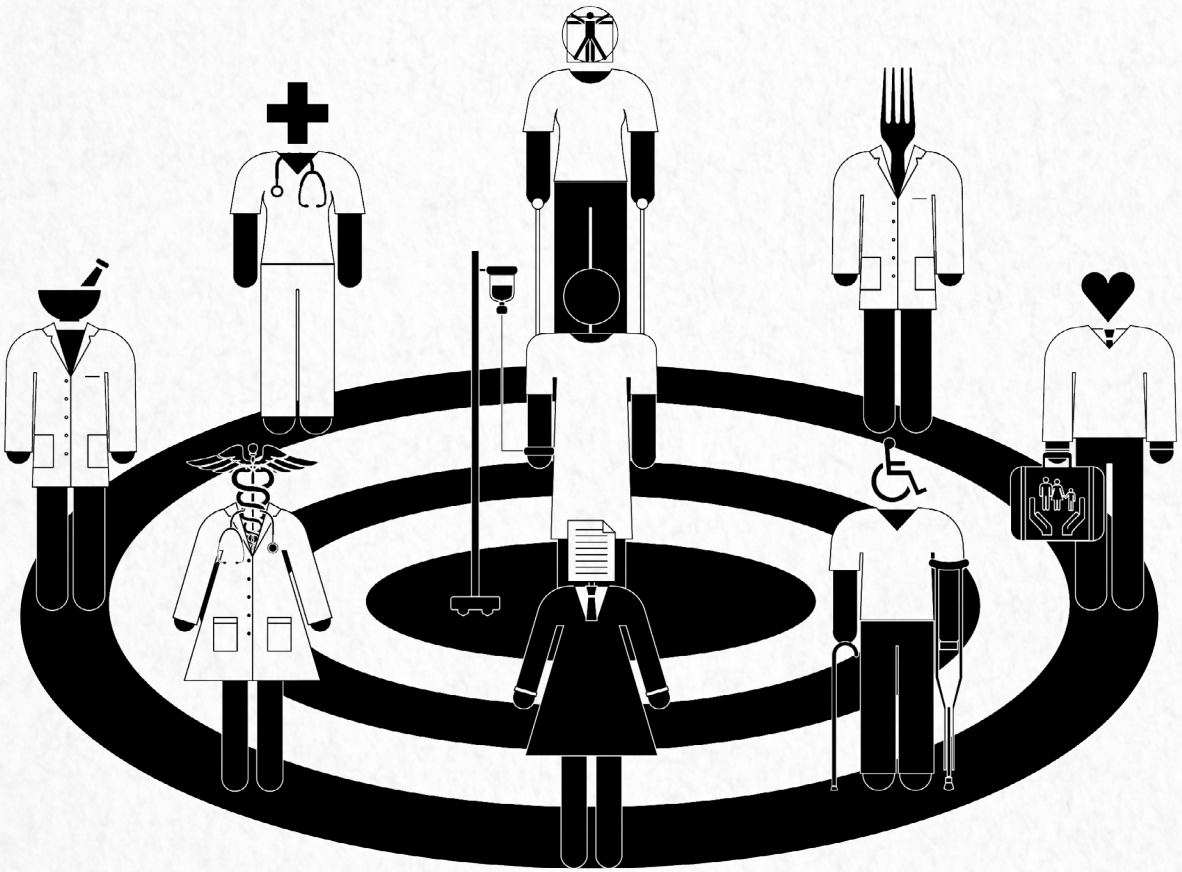


Why is Collaborative Care Important?

Collaborative care has been defined as when:
"Multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers and communities to deliver the highest quality of care across settings"[1].

High quality evidence links interprofessional collaborative care to improved patient outcomes, enhanced patient safety, increased patient/health provider satisfaction with care, and increased health system efficiency [1-3].

The evidence also tells us that providing objective performance based feedback to teams can improve quality of care and enhance overall team functioning [4-6].

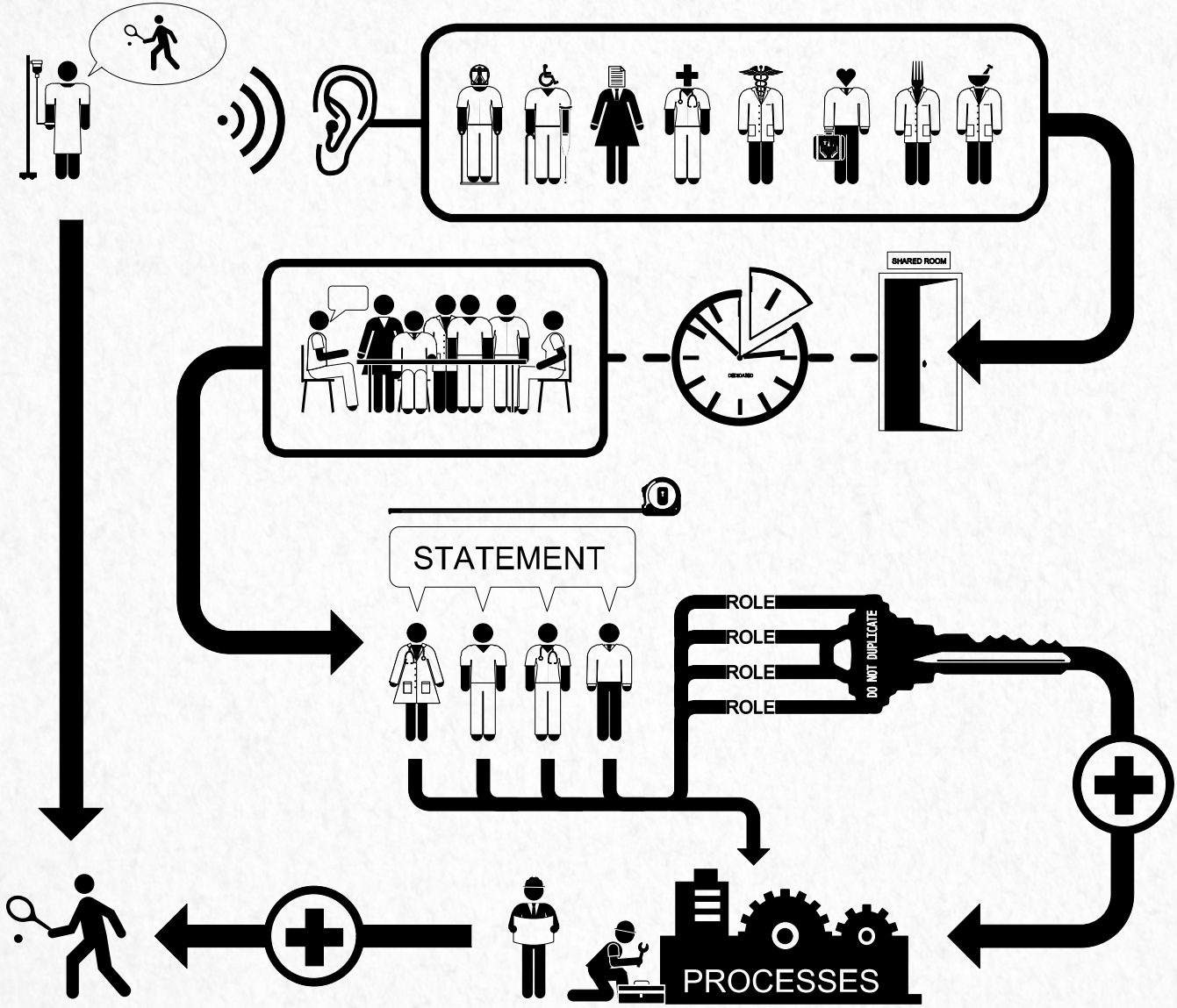
Purpose of this Guide

This guide is designed for use by interprofessional teams or facilitators working with interprofessional teams. This guide provides a standardized, evidence informed approach to assist interprofessional teams to further advance, measure and evaluate team effectiveness and performance.

Teams participating in the program will assess their current interprofessional team functioning and identify actions and strategies to further advance their collaborative practice. This guide will provide teams with a road map to further enhance effective collaborative care.

To assist teams in this work, the following standardized templates and power point presentations may be found at http://www.wrha.mb.ca/professionals/collaborativecare/ACCTProgram-Extra.php:

- CIHC Competency Framework Fact Sheets
- Team Self-Assessment Reporting Template– 8 Indicators of High Performing Collaborative Care Teams
- Next Steps Action Plan Template
- Balanced Score Card Recording Template
- PowerPoint - Advancing Collaborative Care Teams Program Overview
- Sample Gantt Chart of Timeline
- PowerPoint - Team Competencies/CIHC National Competency Framework (http://www.wrha.mb.ca/professionals/collaborativecare/files/S1-Team-CompEd.pdf)


SHARED ROOM
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ROLE
ROLE
ROLE
ROLE
DO NOT DUPLICATE
PROCESSES

Indicators of High Performing Collaborative Care Teams

Based on the results of a systematic scoping literature review, a region wide survey, stakeholder consultation, focus groups and pilot team feedback, eight indicators of effective, high performing teams were identified. These indicators, listed below, provide the framework upon which to assess and evaluate your team.

1. The team has identified a standardized way to measure team performance. Team performance indicators are monitored regularly and guide team decision making.

2. Care is organized based on the goals of patients (as opposed to the needs of health care providers).

3. Team members have dedicated time for team development activities.

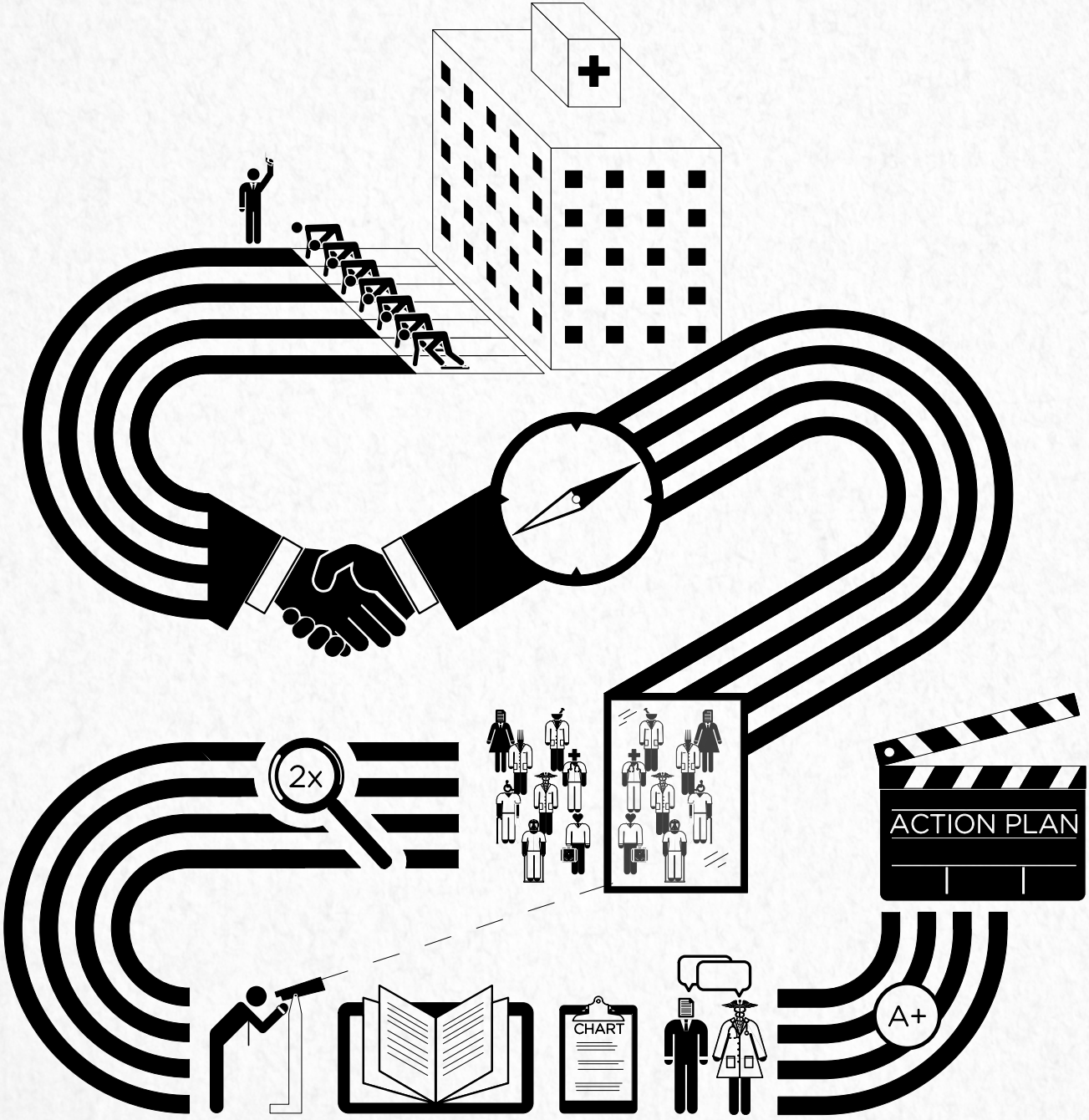
4. There is shared space in the environment for teams to work/socialize together.

5. The team has a defined team role statement and team goals.

6. Processes are in place for interprofessional care planning (discharge rounds, care conferences, care rounds).

7. Team composition and roles are defined by the needs of patients, scope of service, and the goal of optimizing scope of practice of health providers.

8. Standard operating procedures/clear role statements for all team members exist and minimize unnecessary duplication of service.


2x
ACTION PLAN
CHART
A+

Steps to Advancing Collaborative Care

1. Determine Team and Organizational Readiness
2. Initial Meeting with Team Leadership (1 hour)
3. Team Orientation Session (1.5 hours)
4. Team Self-Assessment – 8 Indicators of High Performing Collaborative Care Teams (2 hours)
5. More Detailed Team Self-Assessment (Variable)
6. Team Observation/Documentation Review (~6-8 hours)
7. Balanced Score Card and Debriefing Session (1.5 hours)
8. Develop Action Plan
9. Follow-Up Sessions


ARE YOU READY TO .. ?!?

Determine Team and Organizational Readiness

Before your team decides to begin this work, consider these key questions:

- Is your organization/program willing to commit the necessary time and resources for your team to do this work?
- Is there support at all levels of management to do this work – senior management, first line manager, physician leaders, nurse leaders, allied health leaders, etc?
- Do you have access to a facilitator to assist with this work or is there a member of your team/site champion willing to take the lead on this work?
- Does your team recognize the importance of interprofessional collaborative care in improving patient outcomes?
- Is your team willing to set aside time to set team goals and discuss team functioning, etc?
- Has your team started to implement innovative ways to promote effective team work and person centered care?
- Is your team open to critically assessing itself and to identify ways to further enhance interprofessional collaborative care? Is there a willingness to challenge the status quo?
- Has your team determined how participation in this work will be communicated to all members of the team, across the organization/program?

If your answers to the above questions are "yes", your team is likely ready to take the next step.

While timing should be carefully considered in light of competing priorities, framing this work around a key safety or quality improvement initiative or around changes in team composition/role is suggested.


HI

Initial Meeting with Team Leadership

Time Required: One hour

Who to invite: The meeting should include the first line manager, related allied health managers, physician leader(s) and any other informal/formal leaders linked to the team (e.g. clinical resource nurse, educator, etc).

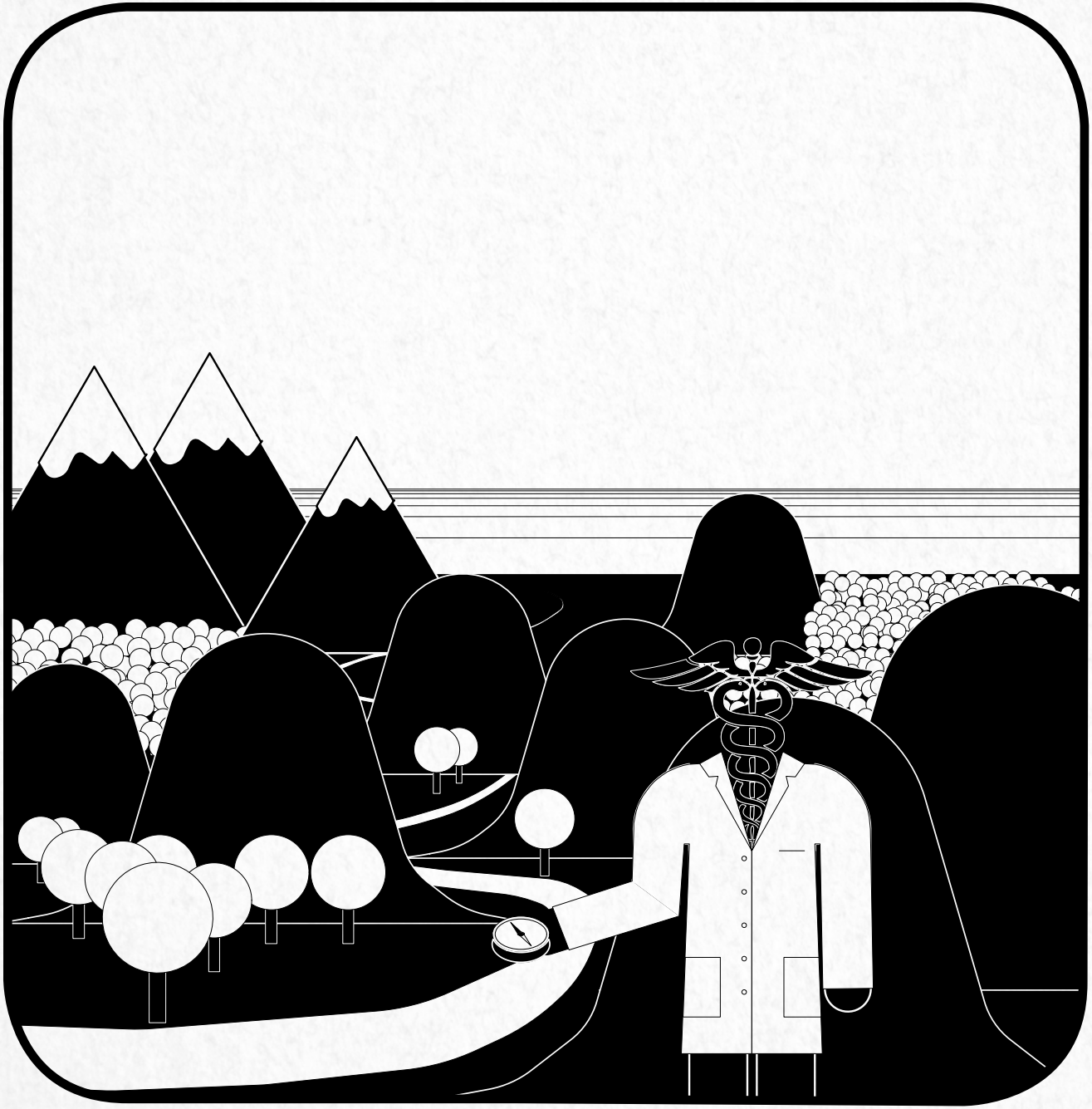
Meeting Objectives:

1. To confirm team and organizational support to proceed

2. To outline the steps in the program and time commitments for each step

3. To clearly identify and define the "team":
    a. How many individuals comprise the team?
    b. What professions comprise the team? Remember to consider support and administrative staff as well.
    c. Will all members of the team be participating in the various elements of this work or selected members?
    d. Who will be the key team contact person for all communication?

4. To start to identify key team processes that should be observed as part of the team assessment and evaluation (e.g. home visits, patient admission/intake, team meetings, care conferences, etc.).



Team Orientation Session

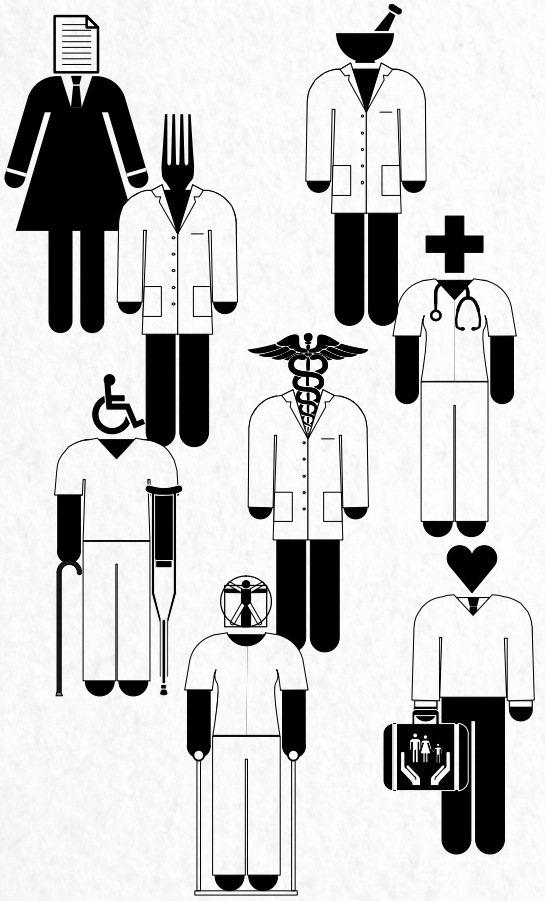
Time Required:	1.5 hours
Who to invite:	All members of the team. Depending on the size of the team, this session may need to be offered on several occasions.
Room Set-Up:	Classroom style or round tables
Equipment Required:	LCD projector, laptop, & screen if possible. Alternatively, if equipment is not available, can provide handouts to team and walk through presentations in this way.

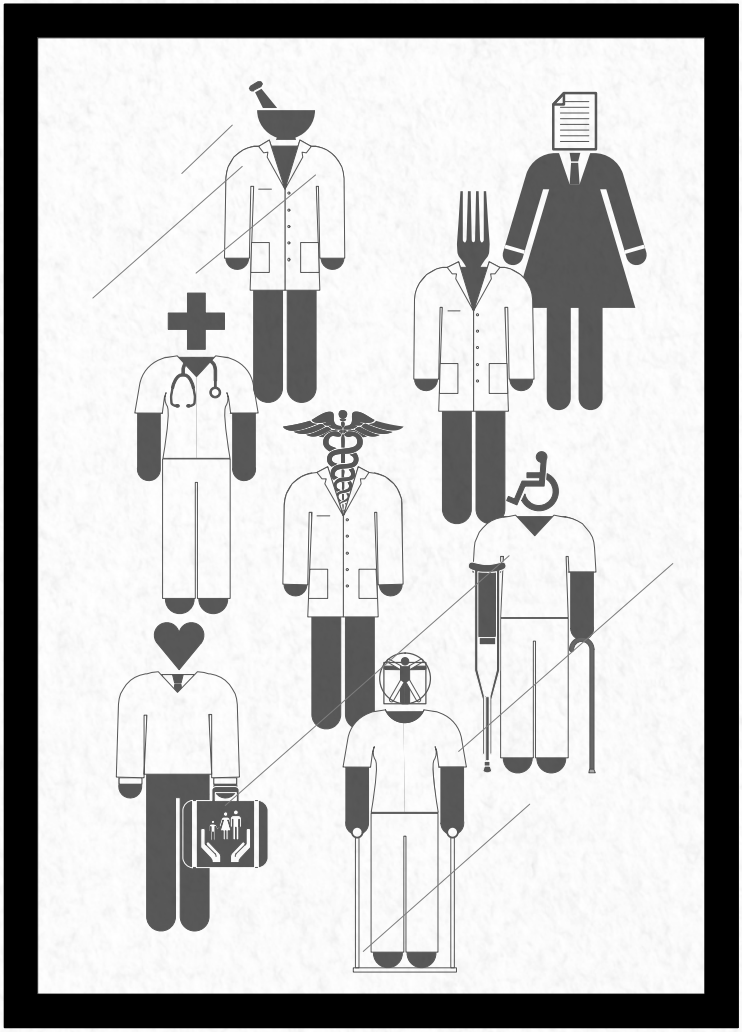
Session Objectives:

1. To define collaborative care and discuss the core competencies/indicators of high performing collaborative care teams.
2. To understand the importance of interprofessional collaborative care on patient outcomes and team effectiveness.
3. To describe the "Advancing Collaborative Care Teams" program and the anticipated benefits of participating in this program.

Collaborative Care Webpage Resources:
http://www.wrha.mb.ca/professionals/collaborativecare/ACCTProgram-Extra.php

- CIHC Fact Sheets
- PowerPoint - Team Competencies/CIHC National Competency Framework (http://www.wrha.mb.ca/professionals/collaborativecare/files/S1-T eam-CompEd.pdf)
- PowerPoint-AdvancingCollaborativeCareTeamsProgramOverview
- Café Style overview of the CIHC National Competencies Framework http://www.wrha.mb.ca/professionals/collaborativecare/files/S1-Team-CompEd.pdf





Team Self-Assessment – Eight Indicators of High Performing Collaborative Care Teams

Time Required: 2 hours

Who to invite: Entire team if possible. Maximum number of participants should be 20. If working with a large team, could run additional sessions.

Room Set-Up: Write each of the eight indicators (see page 3) on separate pieces of flip chart paper. Draw a line down the centre of each piece of paper. Write "What we do well" on the left hand side of the paper. Write "What we could do better" on the right hand side.

Sample:

The team has identified a standardized way to measure team performance. Team performance indicators are monitored regularly and guide team decision making.

What we do well	What we could do better

Equipment Required: Flipchart sheets, Sticky notes, Markers/pens

Session Objectives:

1. To have the team conduct a self-assessment using the eight indicators of high performing collaborative care teams
2. To identify possible areas for improvement

How to Facilitate Sessions:

- Provide instructions on exercise
- Depending on size of group, divide team into small teams of 2-3
- Each small team will start at a separate indicator
- Each team will spend approximately 5 minutes per indicator writing down their thoughts and then will move onto the next indicator. Each small team should have the opportunity to reflect on each of the eight indicators. Takes 45-60 minutes to complete a full cycle.
- Ideas/thoughts can be written on sticky notes and affixed to the flip chart paper or can be written directly on the paper
- Upon completion, the facilitator will then go through each indicator and highlight what was identified by the team. Additional suggestions/ideas raised by the team during this group discussion should be added to the flip chart by the facilitator. Takes 45-60 minutes.

Prompts/Guided Examples:

If the team needs some examples illustrating the eight indicators, try the following:

1. The team has identified a standardized way to measure team performance. Team performance indicators are monitored regularly and guide team decision making.
   - How do you know your team is doing a good job?
   - What indicators do you measure e.g. patient satisfaction, trending of patient outcome measures, wait times, access, workload etc?
   - How and with whom is this information shared?
   - Is the information used to change practice and team processes?

2. Care is organized based on the goals of patients (as opposed to the needs of health care providers).
   - How are patient goals and objectives identified?
   - How are they evaluated?
   - Are they developed with the patient (rather than for the patient)?

3. Team members have dedicated time for team development activities.
   - Do you have regular team meetings that are not focused solely on patient care issues?
   - Have you ever engaged in a team development/team-building activity?
   - Does the team ever take time to reflect on team communication and team processes?

4. There is shared space in the environment for teams to work/socialize together.
   - Is there a shared lunch room?
   - Is there space for formal and informal team discussion and dialogue?
   - How are spaces referred to – "nursing station", "doctors lounge" vs. more collaborative, inclusive language?

5. The team has a defined team role statement and team goals.
   - How were the role statement and goals developed?
   - When were they developed?
   - How often are they reviewed?
   - Are team goals used to set priorities?
   - Are team goals measurable and regularly measured?

6. Processes are in place for interprofessional care planning (discharge rounds, care conferences, care rounds).
   - What processes are in place?
   - How are they working?
   - Are the right players at the table?
   - How are patient goals embedded into interprofessional care planning processes?

7. Team composition and roles are defined by the needs of patients, scope of service, and the goal of optimizing scope of practice of health providers.
   - Can team members clearly articulate the role of other members of the team?
   - What are the needs of patients? How were these assessed?
   - Do you have the right members of the team in light of patient needs? If vacancies arise, would there be any consideration given to changing team composition?
   - Do team members feel that they are working to their full scope of practice?

8. Standard operating procedures/clear role statements for all team members exist and minimize unnecessary duplication of service.
   - Does the team use an interprofessional team assessment form?
   - Are the same questions asked of patients by multiple health providers?
   - Do clinical practice guidelines, protocols exist that aim to standardize care in an evidence informed manner?

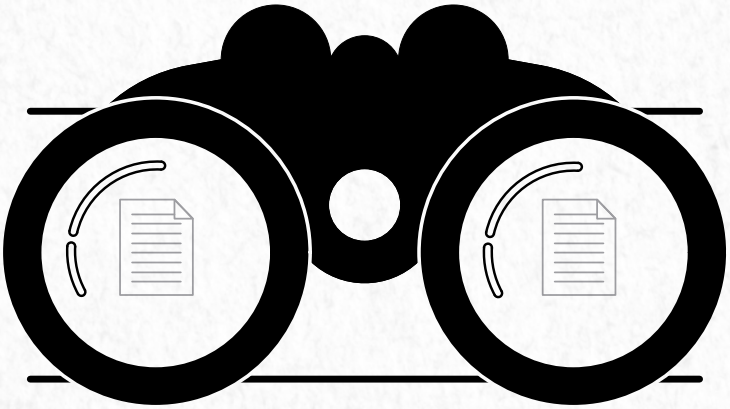
Summary of Findings:

The summary of findings of this session will guide further team self-assessments. A template for summarizing the findings can be found at http://www.wrha.mb.ca/professionals/collaborativecare/files/TeamSelfAssessment.pdf

More Detailed Team Self-Assessment:

Depending on the findings from the team self-assessment on the eight indicators of high performing collaborative care teams, the team may also wish to engage in more detailed team self-assessment activities. Additional tools are available on the Winnipeg Health Region webpage for collaborative care.

See http://www.wrha.mb.ca/professionals/collaborativecare/step-2.php.



Team Observation/Documentation Review

Two key elements of assessing a team relative to their current level of collaborative care and opportunities for improvement are team observation and documentation review.

Time Required: 6 to 8 hours depending on the team

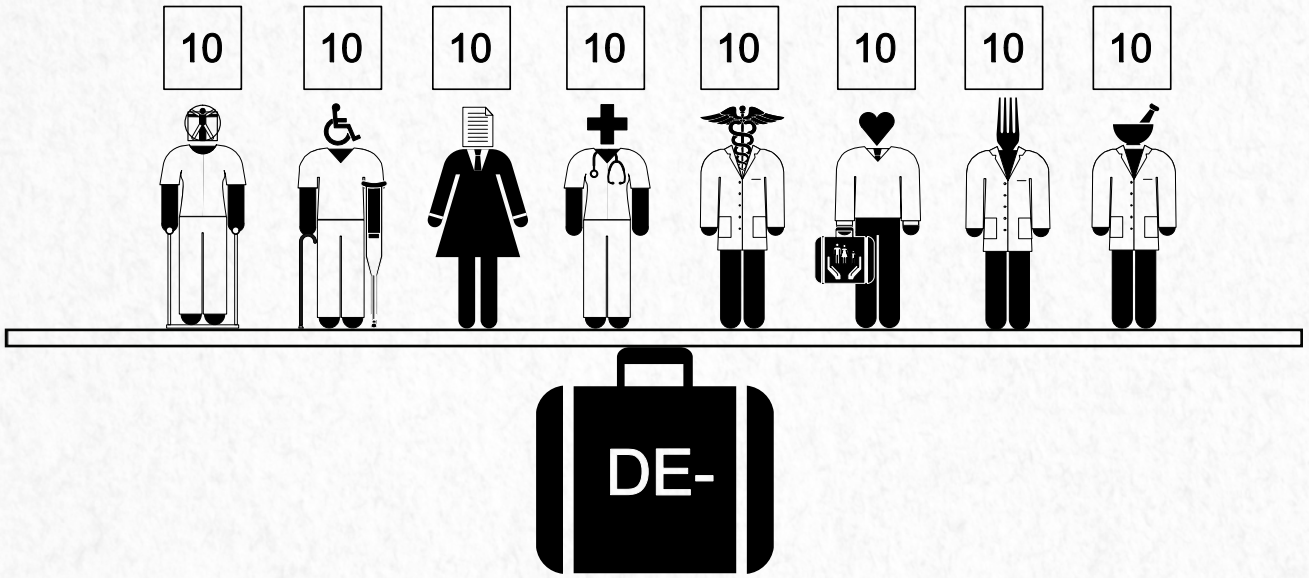
Tour: Arrange for a full tour of the unit/program space. Look at communication tools, shared spaces for team members to connect/work/socialize.

Team Observation Points: The team should be asked to identify those core activities that would best demonstrate team functioning. Some activities to consider observing include:

- Team meetings
- Care conferences
- Family conferences/meetings
- Patient intake/initial assessments
- Patient interventions/interactions

Documentation Review: Review team documentation including:

- Assessment forms
- Minutes of team meetings
- Team strategic plan, team goals, etc.
- Findings from patient and family satisfaction surveys
- Other summaries of team performance indicators
- Job descriptions
- Team orientation checklists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Balanced Score Card and Debriefing Session

The findings of the various team self-assessments, team observation and review of team documentation can be summarized in the Balanced Score Card (template available on the Collaborative Care webpage).
The Balanced Score Card provides a succinct summary of team strengths and identifies areas for possible improvement. The Balanced Score Card should be presented at a debriefing session.

Debriefing Session:

Time Required: 1.5 Hours

Who to invite:	Entire team. It is recommended to discuss with site leadership whether they wish to review a copy of the Balanced Score Card prior to presentation to the larger team.
Room Set-Up:	Classroom style or round tables
Equipment Needed:	Copies of Balanced Score Card and Action Plan template for all those attending the session

Session Objectives:

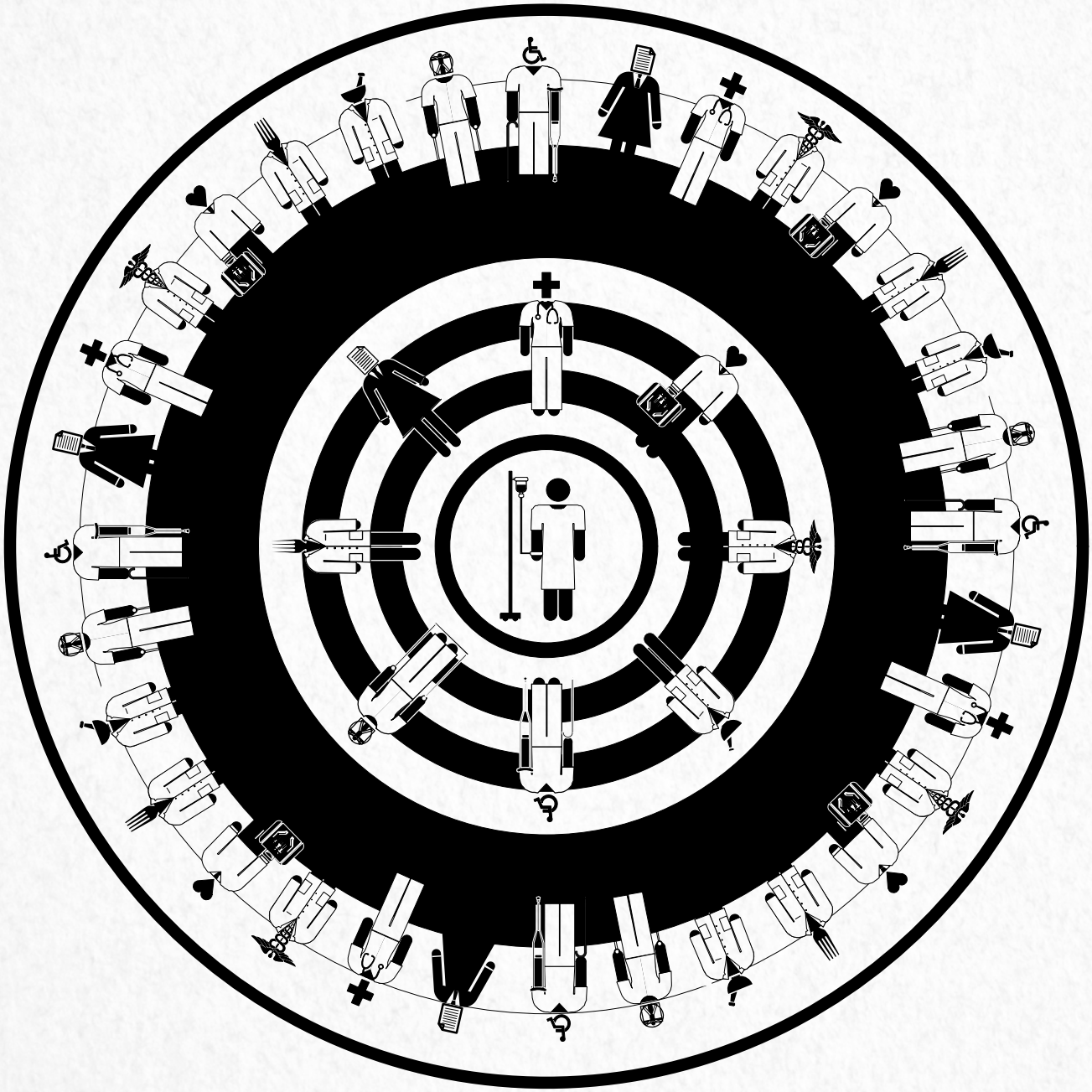
1. To recognize and celebrate areas where the team is doing well

2. To provide recommendations as to how the team could further enhance their collaborative care

3. To initiate the development of a Collaborative Care Action Plan and to identify next steps. This Action Plan needs to clearly outline concrete, attainable steps to address those areas of improvement identified in the Balanced Score Card. The Action Plan should also identify timelines and those responsible for each action listed.

Resources from Collaborative Care Webpage:
http://www.wrha.mb.ca/professionals/collaborativecare/ACCTProgram-Extra.php

- Balanced Score Card Recording Template
- Next Steps Action Plan Template



Follow-Up Sessions

It is strongly recommended to schedule regular “check-ins” with the team (e.g. 3 months, 6 months) to:

1. Review progress on the Collaborative Care Action Plan
2. Celebrate successes
3. Review and revise timelines, goals, priorities, etc. as required
4. Ensure continued focus on advancing collaborative care

Other Available Resources

The Winnipeg Health Region Webpage on Collaborative Care
- http://www.wrha.mb.ca/professionals/collaborativecare/index.php

University of Manitoba Interprofessional Education Initiative
- http://umanitoba.ca/programs/interprofessional/index.html

Canadian Interprofessional Health Collaborative Competency Framework
- http://www.cihc.ca/

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