

The John A. Hartford Foundation

Grant # 2000-0381

GRANTEE'S INTERIM PROGRESS REPORT

Grantee: Sacred Heart Medical Center Foundation

Project Title: A Senior Health Center Interdisciplinary Team Approach: Health and Organizational Outcomes

Starting Date: January 1, 2001 Reporting Period: July 1, 2001 through December 31, 2001

OBJECTIVES:

To test if the interdisciplinary team model of a specialized senior primary care center improves outcomes for older adults in an integrated healthcare system. Objectives for the second six months of the project were:

- Conduct project team meetings and communicate progress
- Update four-year project work plan, timeline, and revise project budget
- Present the modified study participant communication packet to Sacred Heart Medical Center Institutional Review Board for approval
- Review and finalize research methodology
- Continue to identify potential study participants and complete recruitment process
- Finalize development of survey instruments
- Complete study participant baseline data collection
- Identify potential caregiver study participants, complete recruitment process, and begin data collection
- Begin baseline data analysis
- Complete sub-contractor agreement with the Oregon Medical Professional Review Organization (Medicare cost data) and refine cost categories
- Continue development of the interdisciplinary team through training and education

ACTIVITIES AND RESULTS TO DATE:

Project Team – The project team (Appendix 1) meets on the third Thursday of every month for four hours. Team meetings were held on July 26, August 16, September 20, October 18, November 13, and December 20, 2001. The meeting agendas are developed based on the project work plan and timeline. The meeting minutes, project work plan, and timeline are forwarded to Christopher A. Langston, PhD, Program Officer, John A. Hartford Foundation, Inc.

Project Work Plan, Timeline and Budget – The project work plan and timeline (summarized in Appendix 2) is reviewed by the team at each meeting to identify tasks and activities to accomplish in the upcoming month. A budget revision was submitted on July 11, 2001, and approved by James F. O'Sullivan, Grants Manager for the John A.

Hartford Foundation, Inc., on July 30, 2001. The first six-month interim expenditure report was submitted on August 31, 2001.

Sacred Heart Medical Center Institutional Review Board – Revised letters to study participants have been submitted to the Sacred Heart Medical Center Institutional Review Board (IRB) chair on an “as needed” basis for approval. Annual IRB reviews of the research study are required. The IRB must also approve any proposed changes in the study design or study participant communication materials. Approval of survey instruments and data collection methodology has also been obtained from the Human Subjects Committee at the University of Oregon to comply with requirements for our data collection vendor, Oregon Survey Research Laboratory (OSRL).

Research Methodology – The proposed research methodology of a quasi-experimental, intention to treat design will be used as confirmed by Bill Mahoney, PhD, and Sarah Donelson, MA, of the PeaceHealth Methods, Outcomes, Measurement and Statistics Department. The research methodology and study group design are reviewed at each team meeting and reconfirmed as the study progresses. There are a total of three study groups. These groups represent three different models of care: Geriatric Interdisciplinary Team Model (Senior Health & Wellness Center), Physician-Care Manager Model (PeaceHealth Medical Group), and traditional Physician Practice (Health Associates of Peace Harbor and South Lane Medical Group). Study participants from the Senior Health & Wellness Center are defined to be the intervention study group and patients from PeaceHealth Medical Group, Health Associates of Peace Harbor, and South Lane Medical group are the comparison study group. Within each of these practice types, it was originally anticipated that the patients would be sorted into equal numbers of “Low Risk” and “High Risk.” Alternatively, since all patients were recruited from the prospect list, the impact of “risk” on outcomes will be analyzed as a separate variable.

A convenience sample of non-paid caregivers from all three groups (30 to 50 participants) is currently being recruited to measure satisfaction of care and caregiver burden. Collection of data from the caregiver group will follow the same intervals as the intervention-comparison study group.

Recruitment of Study Participants – Initial patient screening criteria included: 1) 66+ years of age at baseline and 2) Medicare Fee for Service as the payor. Only patients meeting these criteria and receiving some level of physician care within the previous 12 months, May 2000 to May 2001, were selected in the prospect list. PeaceHealth Medical Group and the Senior Health & Wellness Center converted to a new computerized medical record and billing system on May 1, 2000. This conversion limited the selection of study participants to those patients who had received services since May 1, 2000. The original prospect list included 3,470 PeaceHealth Medical Group patients, 1,470 Health Associates of Peace Harbor patients, 1,322 South Lane Medical Group patients and 458 Senior Health & Wellness Center patients. A decision was made to include additional patient prospects for the Senior Health and Wellness Center by adding a cost-based Medicare insurance plan to increase the prospect list to 736 patients. From the PeaceHealth Medical Group, Health Associates of Peace Harbor, and South Lane

Medical Group prospect list, we randomly selected and mailed packets to 2,000 PeaceHealth Medical Group patients, 1,000 Health Associates of Peace Harbor patients, and 1,000 South Lane Medical Group patients. All 736 Senior Health & Wellness Center patients were mailed a packet. A total of 4,736 patient recruitment packets were mailed out the week of June 18, 2001. Reminder postcards were sent three weeks following the original recruitment packets. All Senior Health & Wellness Center potential study participants who had not responded were called and personally asked to participate.

The initial response rate did not yield a sufficient sample for each of the three groups. Additional patient recruitment packets were mailed to the remaining prospects for PeaceHealth Medical Group, Health Associates of Peace Harbor, and South Lane Medical Group. In August and September 2001, every eligible new patient at the Senior Health & Wellness Center was talked with prior to their scheduled appointment and asked to participate in the study. In October 2001, a group visit approach to recruit patients at the Senior Health and Wellness Center was implemented. An additional 191 recruitment packets were given to Senior Health & Wellness Center patients bringing the total patients contacted to 927. Both the individual meeting and group visit approach were very successful and resulted in the recruitment of approximately 150 study participants. Patient Informed Consents were sent to all patients who agreed to participate in the study. Only those patients who returned a signed Patient Informed Consent were interviewed for the study.

The final recruitment figures are:

Group	# Packets Sent	# Informed Consents Sent	# Informed Consents Received	# Sent to OSRL	# Interviews Completed
SHWC	927	519	478	478	445
PHMG	3318	1035	792	792	757
SL/HA	2619	656	546	546	518
TOTALS	6864	2210	1816	1816	1720

Survey Instruments – All survey instruments have been selected or developed and finalized with the exception of a tool to evaluate the dynamics of the Interdisciplinary Team. The survey instruments are:

1. Health Assessment and Risk Tool (HART) collected through the recruitment process
2. Short Portable Mental Status Questionnaire (SPMSQ)
3. PeaceHealth Physical Function Inventory
4. PeaceHealth Depression Scale (Revised Geriatric Depression Scale)
5. Simple Quality of Life 24 Scale (Revised SF36)
6. Patient Satisfaction Inventory
7. Perceived Health Competence Scale
8. Caregiver Burden Inventory
9. Caregiver Satisfaction Inventory
10. Team Development Questionnaire (In development)

Baseline Data Collection – The project team selected Oregon Survey Research Laboratory (OSRL) at the University of Oregon as the data collection sub-contractor for the project. The project team reviewed the participant survey script. The script and data collection process was tested on eight non-study participants. Sarah Donelson, MA, and Ron Stock, MD, met with all the OSRL telephone surveyors to review the instruments and prepare them for potential special needs of the older adult participants. All complaints/problems were reviewed first by the Project Coordinator and Principal Investigator, then reviewed monthly by the leadership team. Near the end of the data collection, Ron Stock, MD, Sarah Donelson, MA, and Lorelei Cesario interviewed the OSRL telephone surveyors and discussed problems and issues from their perspective.

The collection of baseline data began on September 19, 2001. There were 123 interviews completed in September 2001, 1433 interviews completed in October 2001, 143 interviews completed in November 2001 and 9 completed in December 2001. An additional 20 interviews are expected to be completed in December 2001. The drop-out rate, after receiving a signed patient informed consent, was 6 percent. Reasons for not completing the survey were 1) the participant's clinical status changed and was no longer able to complete a telephone survey (in several instances a proxy responder was found), 2) the participant died or moved from the area, and 3) the participant was unable to adequately complete the survey due to hearing problems. In most instances, the participant was able to complete the survey through a "relayer" or by arranging a face-to-face survey interview with an OSRL staff person. A total of 7 face-to-face interviews were completed. Proxies were used to complete the survey in 34 cases. All efforts, however, were made to have the participant complete the survey on their own.

Recruitment of Caregiver Participants – Potential caregiver study participants were identified using questions answered in the HART screen. The potential caregiver study participants were contacted by telephone to request their participation and a *Caregiver Informed Consent* document was sent for their signature. All those non-paid caregivers who have signed a Caregiver Informed Consent will be contacted by phone to complete a survey of their caregiver involvement, satisfaction with care and the Caregiver Burden Inventory. Caregiver telephone interviewing began December 26, 2001.

Begin Baseline Data Analysis - Complete baseline data on all study participants will be sent to PeaceHealth's Division of Measurement, Outcomes, Methods and Statistics (MOMS) during the week of December 24. Analysis of baseline data will commence upon receipt of the data file.

Oregon Medical Professional Review Organization (OMPRO) Data – Study participant utilization and cost data will be obtained from OMPRO. Baseline data will be collected for the 12-month period beginning October 1, 2000, and ending September 30, 2001. Subsequent data for study participants will be collected for the 6-month period beginning October 1, 2001, and ending March 31, 2002, the 18-month period beginning October 1, 2001, and ending March 31, 2003, and the 30-month period beginning October 1, 2001, and ending March 31, 2004. There is a six-month waiting period to obtain data from OMPRO to assure all utilization and cost data has been submitted to

Medicare and OMPRO. A contract for OMPRO services to be delivered to PeaceHealth has been completed. Cost data will be analyzed for all participants who signed a patient informed consent. Those who signed the patient informed consent but were unable to complete or refused to complete the survey interview will be evaluated separately from participants who completed the survey interview.

Interdisciplinary Team Training Plan

The PeaceHealth Senior Health & Wellness Center (SHWC) GITT in Practice training has begun to evolve over the past six months. The overall approach to interdisciplinary team development can be divided into the following key areas.

Address workflow to design a system that reduces waste, eliminates rework, and provides for effective, efficient use of valuable staff resources. The objective is to free up staff time to introduce and incorporate “team” approaches to care. A one-day rapid process improvement (RPI) exercise facilitated by PeaceHealth’s Center for Healthcare Improvement (CHI) occurred on June 27 & June 28, 2001. The focus of the RPI was to implement a clinic-wide process to manage all the paperwork (faxes, labs, x-rays, consult reports, nursing home orders, telephone messages, insurance forms) which we refer to as “Very Important Papers (VIP)”. The RPI team was composed of representative providers, nurses, receptionists, medical records and a CHI facilitator. The process that was implemented was actually designed and tested successfully in other PeaceHealth clinic offices. This VIP workflow process has been highly successful and has been met with high satisfaction among team members. Process measures have been built in and continuous monitoring of the volume of VIP backlog has helped us maintain our “gains”. Utilizing “nursing care teams” to support the clinic office workflow has continued to be an effective approach to interdisciplinary care teams. Attached in Appendix 3 is a description of the roles for each of the nursing functions. Nurses rotate through the listed nursing roles in order to support the cross-training objective of team development. Nursing staff satisfaction has been high regarding this approach to staff resource utilization. A second “rapid process improvement” (RPI) is planned for the spring of 2002. Focus of that RPI is yet to be determined.

Improve communication among team members through understanding personal communication styles and learn specific communication skills to enhance the clinician-patient relationship. A workshop on team development with a focus on understanding team member’s personal communication style, particularly under stressful conditions, was conducted on June 23, 2001, facilitated by the George Parsons’ Consulting Group. Staff was also asked to develop “promises” that were negotiated between groups of staff members (e.g. providers, GNPs, nurses, reception, ancillary providers, management). A follow-up second session with George Parsons occurred on November 1 for the purpose of reviewing what had been achieved by knowing team members’ communication styles, and to introduce new members and their communication styles to the team. Additionally, all SHWC team members participated in a workshop on November 17, 2001, entitled “Clinician – Patient Communication to Enhance Health Outcomes” led by a Bayer Institute for Health

Care Communication facilitator. Techniques learned at the workshop will be reinforced by routinely reviewing and discussing them at weekly team meetings.

Review GITT approaches to team development and learn from participants' previous experiences of what works and what doesn't. On October 8, 2001, the project leadership team participated in a telephone conference call with Steve Rothschild, MD and Stan Lapidos, MS to discuss the Rush Medical Center experience with the GITT initiative. Attached in Appendix 4 is a summary of our "takeaways" from that discussion. Materials and reports from the GITT Initiative have been reviewed.

Adopt the "Eight Principles of Successful Teamwork" generated through the GITT initiative. Strategies to support the development of each of these principles will be initiated within the SHWC interdisciplinary team, and reviewed on a regular basis. Attached in Appendix 5 are the "Eight Principles of Successful Teamwork." Under each principle is listed a draft of the team commitments to support the development of that principle. It's anticipated that the commitments and the strategies to address those commitments will evolve over the next 12 months as part of the team process. Bill Mahoney, PhD, Measurement Specialist, is currently developing a team member self-report survey instrument intended to measure "team" characteristics and functions. This tool is currently in the process of item validity testing and is in its first draft.

Develop "subteams" within the SHWC to address the critical pieces of the team care process. In order to address clinical care processes within the context of the interdisciplinary team, several smaller work teams of SHWC staff have been meeting on a continuous basis. The following is a list of those work teams:

- Diabetes Wellness and Assessment Program (DWAP) – this is a region-wide initiative to improve diabetic care. Our pharmacist and dietician are working with our providers to enhance this program using their specialized expertise in a team setting.
- Care plan work group – this group has met to develop the SHWC care planning process which includes the weekly care conference.
- Senior frail registry (Senior GEM) – the purpose of this work team is to define a registry of frail, high risk patients and the standard documentation of geriatric syndrome clinical care protocols using this registry.
- Patient service quality standards – this team is comprised primarily of office and reception staff and is focusing on "service" standards/expectations.
- Provider clinical quality standards – all providers have been involved in establishing and agreeing to clinical standards of care.

- “Pre-visit orientation” group visit subteam – the purpose of this team is to plan a process for introducing new patients to the SHWC and the interdisciplinary team approach. This has already had a positive impact on clinic workflow and patient/family satisfaction.

PROBLEMS AND PROSPECTS:

Recruitment of Study Participants – The initial patient prospect list for the Senior Health & Wellness Center (intervention study group) had 736 patients who met the criteria for the study. Multiple study participant packets, reminder postcards, and 2 series of direct telephone contacts were made to recruit 500 participants for the study intervention group during July and August 2001. As of August 1, only 300 Senior Health & Wellness Center patients had been recruited. In August and September 2001, every eligible new patient at the Senior Health & Wellness Center was talked with prior to their scheduled appointment and asked to participate in the study. In October 2001 a group visit approach to recruit patients at the Senior Health and Wellness Center was implemented. Both the individual meeting and group visit approaches were very successful and resulting in the recruitment of approximately 150 study participants.

Data Collection Plan – Data collection occurred over a longer time period than had been planned. However, as noted previously, 1556, or 91%, of the participant’s data was collected during the planned period. Because some data was collected at a later date, all attempts will be made to collect the six-month data as close to the six-month interval as possible. A data collection time variable will be a component of the data analysis plan.

Quality Assurance – As recruitment for study participants and collection of data ensued, continuous monitoring of participant questions, issues, and problems were recorded and reviewed by the Project Coordinator, Principle Investigator, and leadership team. A document summarizing these findings will be prepared at the end of the baseline and data collection period and presented at the SHMC IRB annual review in March 2002. All patient concerns noted by OSRL, or received in our study office, were reviewed and followed-up by a personal phone call by the Project Coordinator.

In general, our preliminary analysis of patient concerns shows that most of the concerns (about 10) had to do with how the interview information was going to be used and the level of confidentiality of the data. This was of particular concern to some patients when we asked their mothers’ maiden name as part of the SPSMQ survey questions. Other concerns included hesitancy or refusal to answer questions related to mental health and difficulty with being able to hear some of the questions over the phone.

Appendix 2

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High Level Timeline/Workplan

<u>Targeted Completion Date</u>	<u>Description of Task/Activity</u>	<u>Percent Complete</u>
02/22/2001	Data collection vendor RFP Proposal bid done	100%
03/01/2001	Finalize instrument selection OASIS newsletter recruitment due	100% 100%
03/02/2001	Present project to IRB for approval	100%
03/15/2001	HART screen mailing process/timeline complete	100%
04/11/2001	Senior Class newsletter recruitment	100%
05/01/2001	HART screen modifications complete Order HART screen forms	100% 100%
05/10/2001	Identify patient prospect list Selection of data collection vendor Team training plan/curriculum complete Recruitment plan complete MD practice recruitment	100% 100% 100% 100% 100%
05/15/2001	OASIS newsletter mailed out	100%
05/23/2001	PACE site visit	100%
05/24/2001	Meeting with data collection vendor Meet with OMPRO – report design complete	100% 100%
05/30/2001	PACE site visit	100%
06/15/2001	Begin patient recruitment/HART screen mailing	100%
06/23/2001	Team training with George Parsons	100%
06/27&28/2001	RPI #1 at SHWC	100%
06/30/2001	Access database in place with access for Bill	100%
07/01/2001	01/01/01 to 06/30/01 progress report to Hartford Budget Revision Request for Hartford	100%
07/15/2001	Survey Instruments to OSRL	100%
07/27, 30/2001	Complete return phone calls	100%
07/30, 31/2001	Informed consents to SHWC patients	100%

07/30, 31/2001, 08/01/2001	Mail out 2000 additional packets	100%
07/30/2001 – 08/08/2001	All received forms scanned	100%
08/10/2001	Cut off date for patient recruitment	100%
08/13/2001 – 08/17/2001	Finalize scanning database	100%
08/17/2001	Data to Sarah for random selection of study participants	100%
08/23, 24/2001	Informed consents to all participants	100%
09/01/2001	Expense report to Hartford Telephone Survey Pretesting Begins	100% 100%
09/07/2001	Patient recruitment complete (informed consents logged into database)	100%
09/12/2001	Data files to OSRL- Phase I	100%
09/17/2001	Begin baseline data collection	100%
10/01/2001	All intervention strategies initiated	70%
10/05/2001	Data files to OSRL – Phase II	100%
11/09/2001	Data files to OSRL – Phase III	100%
11/15/2001	OMPRO contract complete	100%
11/16/2001	Caregiver database to OSRL	80%
11/17/2001	Bayer Institute Training	100%
12/2001	Caregiver recruitment/IC complete	80%
12/01/2001	CPT/Chargemaster data to OMPRO	80%
12/07/2001	Send out “thank you”/magnets to SCIT participants	12/31/01
12/17/2001	Annual report to Virginia	100%
12/20/2001	Caregiver list to OSRL	100%
12/20/2001	Baseline data collection complete	100%
12/21/2001	Send annual report to Hartford	12/27/01
12/22/2001	SCIT baseline data back from OSRL	100%
12/26/2001	Caregiver data collection begins	
01/01/2002	07/01/01 to 12/31/01 progress report to Hartford	100%
01/15/2002	Clean up “tracking” db (signed IC’s) Add SS#, gender, Medicare ID#, DOB	50%

01/31/2002	Baseline data to OMPRO*
02/08/2002	Baseline data analysis complete
03/01/2002	01/01/01 to 12/31/01 expense report to Hartford
03/2002	IRB will mail annual status report form
04/01/2002	Begin 6 month data collection
05/01/2002	Begin 6 month caregiver data collection
07/01/2002	01/01/02 to 06/30/02 progress report to Hartford
09/01/2002	01/01/02 to 06/30/02 expense report to Hartford
01/01/2003	07/01/02 to 12/31/02 progress report to Hartford
01/31/2003	Period 1 data to OMPRO*
03/01/2003	01/01/02 to 12/31/02 expense report to Hartford
04/01/2003	Begin 18 month data collection
07/01/2003	01/01/03 to 06/30/03 progress report to Hartford
01/01/2004	07/01/03 to 12/31/03 progress report to Hartford
01/30/2004	Period 3 data to OMPRO*
04/01/2004	Begin 30 month data collection
07/01/2004	01/01/04 to 06/30/04 progress report to Hartford
03/01/2005	01/01/01 to 12/31/04 FINAL report to Hartford

*For each study period, send the following data to OMPRO:

Study Population for Intervention and Comparison Group

- Patient name
- Medicare health identifier number (Medicare number)
- Social security number
- DOB

Primary Care Practitioners for Intervention and Comparison Groups

- Name
- Medicare Unique Practitioner Identification Number (UPIN)
- Medicare Clinic UPIN

Interventional Procedures

- All CPT codes for outpatient or ambulatory procedures

PT/OT treatment

- All CPT codes for PT/OT treatment

Appendix 3 Roles & Responsibilities

Resource 1	Resource 2	Roomer
<p><u>Phone Triage:</u></p> <ul style="list-style-type: none"> • Receive and review all phone messages from patients or outside callers. • Call patients back; determine if appt. is required. • Schedule Appt. • Proactive calls to patients. • Triage Walk-ins. * • Prioritize calls and Walk-ins & delegate to Resource 2 when appropriate. <ul style="list-style-type: none"> • Lab Results • Triage Rx refills • Walk in patient <p>*Reception will call Resource 1. If not available may then call Resource 2. (Resource 2 must communicate to resource 1)</p>	<p><u>Paper work & call backs:</u></p> <ul style="list-style-type: none"> • Retrieve, sort & prioritize paper <ul style="list-style-type: none"> • Provider Mail • Faxes • Rx Refill requests • DME • Lab Letters • Receive appropriate phone messages from Resource 1 and calls patient. • Helps roomers when needed. (pro-active) • VIP (numbers slush & files in folders) • Can assist with procedures 	<p><u>Room Patients:</u></p> <ul style="list-style-type: none"> • Room patients • Intake documentation • Assist with procedures • Reschedule appt. • Patient education • Turn rooms over • Keep the provide on schedule <p>* During down time can help with:</p> <ul style="list-style-type: none"> • Rx Refill • Phone messages • Lab letters • Restock rooms • VIP

Standard Phone Message Documentation:

- Name of the Patient
- DOB
- MRN
- Provider
- Name of the caller (if not the patient)
- Phone number
- Call regarding: (Basic information)
 - Refills (have pt spell the name of the medication)
 - Note if the patient is returning our call
 - Use complete sentences

- ◆ A consensus agreement: Reception will take notes for all calls except “Urgent” calls. These will be flagged as urgent and communicated directly to Resource 1.

Appendix 4

GITT Initiative phone discussion with Rush Medical Center

The following is a list of “takeaways” from a telephone discussion held on October 8, 2001, with Steve Rothschild MD and Stan Lavidos MS from Rush Medical College, Chicago. Participants from the PeaceHealth SCIT (Senior Clinic Interdisciplinary Team) Project leadership team included Ron Stock MD, Sarah Donelson MA, Mary Backus RN, and Dan Reece MSW. The focus of the discussion was to learn about the Rush Medical Center experience with the Hartford funded geriatric interdisciplinary team training (GITT) initiative. The following is a summary of the key learning points:

- 1) The "8 Principles of Successful Team Work and Team Competencies" is a good guide to use for planning strategies to develop/implement teams, and to use as an evaluative tool to maintain and measure gains. Specifically, use the "Principles Guide" as a check-in at the end of each team meeting or care conference. Use this tool as a feedback mechanism to providers/staff to educate them about team roles/responsibilities.
- 2) A team is not a group who meets once a week to talk about patients. A team must be a group of people working together all of the time - there may be hallway conversations, e-mail, telephone calls, notes in charts. The team is constantly working together in a wide variety of configurations and settings.
- 3) Although the Rush GITT project's focus was on trainees, eg students and residents, it was very important to bring faculty and departmental leadership on board with the principles of team development. This has relevance for us as well in that we need to bring our key leadership, physician champions, on board with "team" development principles before we start rolling this out to our clinic nurses, receptionists, social workers, pharmacists, etc.
- 4) Leadership needs to "model" team behaviors inside and outside of care conferences/team meetings. We need to reinforce team behaviors at all levels of pt care, in other words, "walk the walk" and "talk the talk".
- 5) Leadership needs to be proactive with setting the "norms"/ground rules for team behaviors.
- 6) Establish a "team" handbook to facilitate institutional memory and help train future team members.

7) Spread leadership responsibilities around to different team members ("rolling roles").

8) Physicians need to learn to be comfortable with giving up the "sole leader/authority" role and will likely require training/feedback processes to promote the team role.

9) Focus on the boundaries where roles overlap since this is where most conflicts occur. For example, in our clinic we now have a process where the pharmacist and dietitian contact diabetic pts proactively and bring them in to do dietary counseling and adjustments of the meds by the pharmacist within parameters set by the MD's. Having pharmacists adjust meds challenges the usual role of the MD and is a boundary "ripe" for role conflict.

10) Review the published literature on team development, especially articles published by Theresa Drinka.

11) Sarah and I had a discussion about incorporating some measurement of "team" outcomes. Sarah was going to consider developing some outcome measurement tool that reflected the 8 principles that could be used with team participants. We need some way to measure whether the training methods are producing the desired outcome. Obviously, we would expect that clinical, functional, and satisfaction outcomes will be improved if we think this is a better model of care.

12) Develop a training manual/curriculum on "Clinic Interdisciplinary Care Team Development". As we proceed with our IT training at the Senior Health & Wellness Center we will be developing a manual that can be used in clinic sites in other regions of PeaceHealth. No doubt this will be an iterative process, but critical if we are to spread this model of care to other sites. We have already found that a 1 day workshop for our staff on understanding each others personal communication styles has had a significant impact on the "team". We have another workshop planned for the staff in November on provider-pt communication training done by the Bayer Institute. Roles/responsibility discussions with the staff have also been effective. It is hard to learn from abstract principles, people need to "see it and do it".

Principles of Successful Teamwork and Team Competencies**The eight principles of successful interdisciplinary teamwork with proposed team commitments are:**

1. The team should have explicitly stated team goals.
 - ◆ Each Senior Health & Wellness Center (SHWC) team member will be able to state the team's purpose and goals.
 - ◆ All team members will have the opportunity to participate in the SHWC annual strategic planning process.
2. The patient and family are at the center of all team activities and are active team members
 - ◆ Patient/family health care goals will be explicitly discussed at all individual care plan conferences.
 - ◆ Patients/family members/caregivers may be invited to participate in care planning.
 - ◆ Care plans are discussed with all patients/families
3. Professional roles must be clearly defined and understood.
 - ◆ All team members will have a role definition and this will be shared with team members.
 - ◆ Team members will understand their role in individual care plans.
 - ◆ Focused discussions will be held among team members where roles overlap.
4. All team members should contribute to team function through constructive individual behaviors, including leadership.
 - ◆ Team members will understand their own and other team member's communication styles.
 - ◆ All team members will understand the indications for using specific team behaviors
 - ◆ All team members will participate as facilitators for team meetings.
5. There must be effective team communication across all work settings.
 - ◆ All team members will be trained in effective clinician-patient communication.
 - ◆ Team members will understand their personal communication style under stress.
6. The team must have tools or strategies for the effective management of conflict.
 - ◆ All team members will be trained in conflict management.
7. The team should have explicit rules about participation and decision making.
 - ◆ Decisions will be made by "consensus."
 - ◆ Team members will identify when a vote might be needed.
 - ◆ When decisions are being discussed, all team members will have the opportunity to provide their opinion.
 - ◆ Ground rules will be established.
 - ◆ Team members will be knowledgeable of other group process techniques to ensure balanced participation.
8. The team must be adaptable, responding to new challenges and conditions as they develop over time.
 - ◆ The team is committed to trying new approaches to established problems.