



DEAR DR. JEFF

Jeffrey Nichols, MD, CMD

Steps Toward Building a Better Team

Dear Dr. Jeff:

Everything I read about long-term care seems to suggest that the interdisciplinary team is the solution to all problems. But at our facility we don't really have a team. Different specialties complete their sections of the Minimum Data Set in their offices on the computer, nursing makes up a care plan that everyone else is supposed to sign, while the physicians and nurse practitioners on the units proceed to order what they think is best without regard to the care plan. How do we turn this into a team with everyone playing together?

Dr. Jeff responds:

Last month in this column (“There’s No ‘I’ in ‘Team’: Working Together in Long-Term Care.” *Caring for the Ages*; 17[10]:6) I answered this question with a discussion of the many barriers to effective team functioning. In addition to historical interprofessional rivalries and hierarchical structures, the barriers include fears of diluted professional integrity and clinical responsibility, the emphasis on rapid decision making, and differences in professional language and jargon, in professional training and requirements, in schedules and professional routines, and in rewards and reimbursement mechanisms. Issues of educational preparation and status frequently prevent nursing assistants from contributing to the team process. Differences in gender, age, social class, and ethnicity may also contribute to team dysfunction. The medical director has a responsibility to both address and overcome as many of these barriers as possible, particularly as they represent obstacles to quality care of our residents.

Although some facilities have failed to involve their medical directors in the development and functioning of the interdisciplinary process, it is clear from the Federal Code and Interpretive Guidelines to Surveyors that this does relate directly to the responsibilities of the medical director. Section 42 CFR §483.75(i) regarding the medical director, as expressed in survey data tag F-tag 501 — after the requirement that facilities have a designated licensed physician serving in this role — essentially defines two key expectations for this position. These are that the medical director provides input and guidance regarding the development and implementation of resident care policies, and that the medical director provides facility-wide coordination of medical care services. Explicitly included in the first of these responsibilities are policies regarding:

“The integrated delivery of care and services, such as medical, nursing,

pharmacy, social, rehabilitative and dietary services which includes clinical assessments, analysis of assessment findings, care planning including preventive care, care plan monitoring and modification, infection control (including isolation or special care) transfers to other settings, and discharge planning.” (*Centers for Medicare & Medicaid Services Manual System. Pub. 100-07 State Operations. Provider Certification. Transmittal 15. Nov. 28, 2005*).

That is to say, the medical director leads the interdisciplinary care process. The Interpretive Guidelines additionally and separately included within the responsibility for resident care policies those related to communication between attending physicians and facility staff. The responsibility for coordination of care also includes the establishment of a framework for physician participation in the facility; the resolution of concerns among physicians, health care practitioners, and facility staff; and the education of physicians regarding the specific expectations of their performance in the facility.

First, Alert the Team

When a medical director recognizes that the interdisciplinary care team is dysfunctional, or even nonfunctional, the first step is to make sure the leadership team is aware of the problem and ready to address it. The change process also must be interdisciplinary, although not necessarily unanimous.

Fortunately, for the facility that wishes to change there are a number of resources for assistance and guidance. One excellent place to start is the website for the federal Agency for Healthcare Research and Quality (www.ahrq.gov). The agency has developed a program called TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety). These include a wide variety of team-building and team-organizing programs and educational materials. Different health care locations can make use of individualized portions. While most do not relate directly to the long-term care environment, many are applicable or modifiable to meet the needs of a skilled nursing facility.

Assess the Facility

Thoughtful assessment of facility’s strengths and weaknesses is an excellent starting point. A self-assessment tool to determine the facility’s readiness to begin the process is particularly useful. The TeamSTEPPS program offers free 2-day training workshops for master trainers at eight sites nationwide. Facilities must send at least three staff members for training

who can return to implement a train-the-trainer model for the facility as a whole. Participation is a demonstration of the facility’s good faith commitment to change and develops both trainers and “champions” for the process. TeamSTEPPS has been proposed as a national standard for the development of health care teams, and has even been used by CMS to enhance the functioning of survey teams.

Even without the support of key members of the leadership team, or an investment of some funds and substantial time, many strategies are readily available that can still move the facility in the right direction. Some of these make use of the QAPI (Quality Assurance and Performance Improvement) process. Individual facilities may choose to focus on specific clinical problems, typically problems identified from poor performance on CMS quality indicators. Organizing a quality improvement project around one of the Society’s Clinical Practice Guidelines ensures an interdisciplinary approach to that problem.

As different disciplines are encouraged to work together around a specific clinical problem such as urinary incontinence or falls, each may learn the benefits of a collaborative approach to problem solving. As different clinical problems are addressed through this process, besides the individual contribution to improved patient care, there may be carryover into care planning and clinical management processes in general. The medical director can use these successes as a demonstration of the advantages of a team approach.

Employ the Best

The medical director plays an important role in the recruitment and credentialing of physicians and allied health practitioners. The ability to function within an interdisciplinary care process is a core competency for any clinician practicing in the LTC setting, and a powerful predictor of the quality of clinical care the practitioner will provide. The medical director is responsible for clarifying expectations regarding care practice within the facility.

Physicians who fail to meet standards should not be encouraged to practice in a skilled nursing facility. Those already caring for residents in our facilities need to have their deficiencies addressed. Many facilities already have one or two practitioners whom staff are loath to call because of their rude telephone behavior. When staff hesitate to inform a physician of a potential problem or change in condition, everyone suffers, but most importantly the residents. In those instances in which behaviors are genuinely inappropriate or

abusive, it is the job of the medical director to confront the perpetrator quickly.

Communicate Effectively

Effective communication is a critical component of interdisciplinary care. This is particularly true in long-term care, where mountains of documentation often obscure genuine information exchange on charts, and organizational constraints limit the time or possibility for face-to-face communication. The SBAR (Situation, Background, Assessment, Recommendation) is a key tool to organize and enhance clinical communication.

The SBAR is a template to organize information for prompt and effective communication. It has been endorsed by The Joint Commission and is a component of both the INTERACT model (Interventions to Reduce Acute Care Transfers) and TeamSTEPPS. Downloadable templates are available, and staff can easily learn to use them. The structured format encourages staff to analyze a problem rather than simply reporting it, and the recommendation portion helps the recipient of the communication to evaluate possible responses and to understand staff needs. Of course, the SBAR is simply a process and does not ensure that necessary information has been collected or communicated. But when SBAR is combined with the Society’s “Know-it-All Before You Call” data collection system, the potential for interdisciplinary discussion that produces useful outcomes increases dramatically.

We have an opportunity in the facility to model the care practices we are urging for others. Although actual participation in interdisciplinary care conferences may not be possible within a demanding schedule, having familiarity with the care plan, holding routine discussions with the nursing leadership, reaching out for direct conversations, and encouraging the involvement of other disciplines such as social work, rehabilitation, and nutrition should be second nature. As you make rounds, interact with the nursing assistants on the unit. Respect them as the excellent information source they can be, and share with them your observations and proposed changes to the care plan.

Staff members who experience this from you may come to expect it from others. The bumper sticker’s injunction “Be the change you wish to see in the world,” often attributed to Gandhi, is still good advice for medical directors. 

Dr. Nichols is president of the New York Medical Directors Association and a member of the *Caring for the Ages* Editorial Advisory Board.