

Alliant Quality Quickinar: Utilizing Huddles for Care Optimization

Dr. Lesley Manson

Hello, the time is at 12:30 PM Eastern - the official start time for today. The topic today is Utilizing Huddles for Care Optimization in Integrated Care. Without further ado, I would like to turn things over to your host, Stacy Hull, behavioral health lead with Alliant Quality. Stacy, the floor is yours.

Thank you, good afternoon everyone. I would like to thank you for participating in Alliant Quality's learning and action network event today as your continued commitment to integrate behavioral health into your practices. Before we get started, I'd like to remind you that in addition to the monthly Quickinar, Alliant is available to provide free technical assistance to you and your staff. We can assist with trainings on process flow, motivational interviewing, and behavioral health resource coordination just to name a few. I invite you to take advantage of these services and to reach out to us. I would like to turn your attention to the alcohol screening codes. These are Medicare reimbursable billing codes. We encourage you to use them in your practice. Now, it is with great pleasure that I introduce Dr. Lesley Manson. Dr. Manson has spent over a decade providing direct services. She has spearheaded multi-disciplinary teams for primary care process improvement and population-specific quality improvement. She has led numerous national presentations on integration with both clinical and management focuses. Dr. Manson is a co-author of "Integrating Behavioral Health into the Medical Home." She currently serves as a clinical assistant professor and assistant chair of Integrated Initiatives at Arizona State University Doctor of Behavioral Health program. And now, I would like to turn it over to Dr. Lesley Manson.

Thank you, Stacy. Welcome everybody to a brief training on huddles. Today, I will review how huddles are an essential, core component to integrated team-based care. Team-based delivery and services rely on communication and coordination to optimize care. We will be reviewing and identifying tools which are industry-standard to facilitate huddles into integrated care. We will review strategies for effective huddle implementation and management. You will recognize the core components of successful huddles so that you can move forward and further care coordination and early identification using the screening tools. And you will identify ways to implement brief screening into the huddles for identification of comorbid management. Let's give this a start. The first piece I would like to open up is with a polling question. How often do you think huddles shared occur? Daily? Weekly? Monthly? Never? Or as problems arise?

Wonderful, thank you. As most of you noted, huddles should be occurring on a daily basis. A few of you noted weekly. This is really going to be up to your organization; however, the standard practice is daily. Let's talk a little bit more about huddles. When teams effectively utilize daily huddles, they will improve team-based services, early identification, care coordination and communication, chronic disease management, preventative care adherence, team member satisfaction, follow up on urgent whole health needs, and it prepares the staff for daily clinic planning. Effective huddles contribute to improved care coordination, team culture, and patient and family experience of care. We are saying huddles are essential and key component to the patient centered medical home model and also to the triple and quadruple aims of healthcare, which are to improve patient satisfaction, team satisfaction, reduce healthcare costs and errors, and improve the entire health of populations.

Let's start to talk a little bit about the basics of a huddle. I will review the definition, talk about evidence for brief screening, workflows and finally conclude at monitoring. Let's start here. As we work in integrated care and improve communication through the use of huddles, we are able to improve the satisfaction of our team, increase productivity and accuracy in our communication, and experience fewer medical errors. This has all been supported by medical research. As a result, there is reduced absenteeism and distraction on the team. Further, we have improved returns for our healthcare system.

Our patients, community, we are able to improve the overall satisfaction of our patients with early identification and recognition of needs. Improve communication of patient concerns with all team members, increase engagement by the patient due to recognition and obvious inclusion of team-based care. There are fewer missed appointments by patients when they recognize the team works well together - they feel that care for themselves. They are able to ensure that the preparation for the appointment is accurate and essential, and that their needs are being met. This culminates to improved healthcare outcomes and well-run healthcare system.

Huddles may operate in different ways depending on the facility, team members, and site. Let's look a little bit about some of the intricacies about defining a huddle. In general, huddles are typically short, 5-10 minutes in length. Daily meetings in which the team reviews patient lists for the day, for care coordination, continuity and efficiency. Often, team huddles are scheduled at the beginning of the day prior to appointments and at the beginning of the afternoon prior to appointments. If you operate in a facility where you schedule your first patient appointment at 8:30, the huddle should start at about 8:15. Often time, people will have an AM clinic huddle and a PM. Starting the PM clinic at 1:30 with patient appointments, the huddle would begin at 1:15. Who do you include in your huddles? It is up to your team. Most individuals that are included in the huddles are your providers, medical providers of different types, specialists, medical assistants, they can be an essential aspect of the huddle. There could also be nurses or other team members, nutrition, behavioral health, etc. Depending on what your site has and how they are included in general patient care and as members of the healthcare team.

Before I move on to the rules of huddles, let's check in one more time with polling question. The question is: Who should be a part of the huddle team? Front desk, nurses, medical assistants, physicians, all team members identified.

It appears that most people came to the same conclusion: All identified members. Everyone who is part of the medical team should be invited to the huddle. There might be some barriers. We will discuss this later.

Let's discuss the rules of huddles. They are standard. Again, they are brief, lasting no more than 10 minutes. They are scheduled at a specific time and place. That is essential. One of the largest barriers to successful team huddles is getting everyone together. Sometimes in medical facilities, it could be very kin to herding cats. It is hard to get everyone to arrive at the same time and to be ready and prepared for a huddle. It is important for each team member to be present and if not, they need to include and have already reviewed all of the patients for that day and provided that written feedback on each patient even if it means n/a - nothing at this time – related to the patients and their views. Rules to huddles include: no interruptions and active involvement in the huddle. Often times, team members with go around in a circle and ensure each team member speaks in regard to each patient.

Due to everyone sitting in close proximity using evidence-based communication techniques, such as SBAR, can be really essential. SBAR, in case you are unfamiliar, is a communication technique that is evidence-based and has actually been proven to reduce medical errors and improve efficiencies in healthcare. It is also supported by several regulatory boards and organizations. SBAR stands for situation, background, assessment, and recommendations. Using a communication technique like that, especially in huddles, can reduce the concerns of individuals who might be storytellers, etc. Next, how we assign roles and responding in specific ways is very important; such as noting brief screening, special care needs, medic-patient adherence concerns, behavioral support needs, recommendations, referrals, community support. The huddles need to be succinct, efficient, and brief.

The roles that individuals may be assigned to the huddle could be timekeeper, facilitator – the facilitator ensures to keep the huddle moving and team members away from storytelling. They keep everyone on track and efficient. At times, we can all get off track and discuss items which may be irrelevant. The timekeeper will help the group to start and stop on time, really showing visuals or letting people know to keep moving. It is important to develop a facilitation where everyone participates. If in a huddle, you have individuals that sit back and are not really active, that can destroy your huddle ongoing. It is important that everyone knows that this is a circle routine and everyone's view is important and essential.

To be successful in huddles, we do need to do work ahead of time. Pre-work, such as using a huddle template or at checklist for efficiency is important. In addition, it takes time to make it fluid. The more we practice, the better we are. A little bit later today, we will go over a few different types of huddle monitoring and checklists, and providing you with examples. It's important that you consider designing your own or using some of those tools to better design something that will be customized for your facility.

When we think about huddles, it is important to think about the types of information that needs to be shared. And thus, it is important to customize for your healthcare site for success. Huddle templates can be built into online access shared systems, EHRs, it could be through the use of Google Docs, which can be HIPAA compliant and shared with team members. It could be on a clipboard for the day if needed and checkmarks or comments are made. We need to allow for tracking and history taking. Having the use of forms is essential. Typically, members of teams of huddles will do things such as review schedule changes for the day, rapid review of patient needs, so that all patients who are going to be seen or those in critical need or need to be slipped into the daily schedule, health maintenance, standing orders and assessments such as depression screenings, referrals are needed, adherence concerns, chronic disease management and self-management skill building with a focus on all of the emergent needs. These are the typical areas that are highlighted in huddle checklists and forms.

One of the essential features of a huddle, is to identify the patient needs. An example to implement tools of early identification are brief screenings such as depression screenings. Teams may wish to use the huddle to discuss specific tools needed for specific patients. In some clinics, all patients may be screened on a regular basis. But additional screenings might need to be needed related to specific topics such as depression screenings, screenings for substance abuse – such as SBIRT, brief intervention, referral treatments, symptom or disease monitoring, diabetes distress, insomnia or health related such as healthy days or due questionnaires.

Screening is a standardized and best practice recommendation for medical and behavior health professionals. Screening is the completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms. Such as, looking at this depression screening, these depression screening codes could be implemented into the daily happenings of a healthcare center. When you can identify them in the huddle, then you can link these screening codes with your daily review. Such as, if an individual is coming in for an annual screening, you can utilize G0444 coding. Perhaps this appointment today is for preventative physical examination, the G0402 code, and you're going to be implementing depression screenings there. Or an annual wellness visit. It is essential to review these codes, the standards and recommendations to the Medicare preventative visit screening codes and the inclusions of twelve-month cycles on some of these codes. We note this code in specific because one in six individuals experience depression to a clinical significant level, especially in individuals over the age of 55, in fact, over all the specifics note, that individuals will

actually present to primary care and medical individuals prior to psychiatric, behavioral or psychological individuals in the community when they have suicidal thoughts or depression. They actually present 50 to 75% of the time to a primary care provider in the 30 days prior to suicide, and 40% of individuals who complete suicide, actually present to a primary care provider the week that they complete. Screening is essential for these populations.

So screening is the completion of clinical or diagnostic tool to identify people at risk for having or increasing symptoms of a specific disease or condition. Regarding depression screening, we want to use very specific depression screening tests. Remember, these tests, they may not always completely provide information that is critical for diagnosing; however, they indicate severity of depression symptoms within a given period of time, the past several days, weeks, including the day they present. When we use these tools, we want to ensure that the tools we use are normalized and validated for the patient population that we are using. For example, we might want to use PHQ2 or 9. These tools are both normalized and validated to be used in primary care as well as hospital systems and emergency departments. They could be used with a range of patients from adolescents to older adults, male and female. They are actually delivered in multiple languages and have been validated in multiple cultures. In addition, there are other more sensitive screening tools for children, adolescents, women who are in postpartum care or specific older adult populations, if you need them.

Let's talk a little bit about the workflow for adding a screening tool into practice, which may include having front desk, medical assistants, nurse, behavioral health, or other providers work and identify it within the huddle. Here is a typical review of a service structure. Typically, individuals will present, they will move to the front desk, go to the medical assistant, perhaps see a nurse or behavioral health provider if needed, and then they are finally touched by the physician. We could also look at this in other orders – the front desk, medical assistant, then perhaps a medical provider of some kind, then then a handoff to a nurse or behavior health provider, if needed. This is a typical service structure in primary care. When we look at it through the lens of diagnosis and depression screening, we can see that the front desk might be able to implement a screening tool if needed. They could provide essential elements to hand out the screening tools. If you had a huddle and you identified that the tool needed to be utilized, you could give it out at any of these times. In addition, these may be team members that you might invite to the huddle. You could assign a specific task related to each of them. This gives a brief review of how you can utilize each of these team members for effectiveness and efficiency when it comes not only to huddles but also specific tools like depression screenings.

Teams can use huddle competency checklists and need to monitor their huddles for effectiveness and efficiency. Let's look at a few essential elements you can utilize. Here is a brief screening tool where you can see at the top, it has a screen shot of the team huddle competency checklist with scoring key. Now that has been provided to all of you to access today, it is a checklist for huddles that has been studied and can be customized so you can download this and change it based off of the customized need of your facility. Typically should be done on a monthly basis at the first time of huddle and then perhaps every six months to a year after that. Once individuals have a great routine going. You can also look at the bottom screenshot. Here is an image on the bottom of the slide which is of shared Google doc which is HIPAA compliant. This would be a Google Doc that all team members can go and input information into the team huddle checksheet before the huddle happens. This might be an assignment for the MA for the front desk at the end of the day, so that the huddle preparation is ready for the next day or in the beginning of the morning. This allows your huddles to be brief and efficient and allows your team members to prep for the huddle and focus on what is essential, especially if you are part of multiple huddles and have to move around, medical assistants, nurses, behavioral health providers, they might

all be shared among different physician or medical provider teams. This is an easy way to look at it. Just to give a brief example of how to review and utilize this, in a huddle, it would sound something like:

“Hey everybody, thanks for huddling today, we have Mark Smith coming in today and it looks like we have already identified he needs a PHQ9 for his depression screening. He has had no ED visits so I’m going to move past that. Let’s not do an alcohol or drug screen today, we are already going to do the depression, there’s no chronic health conditions for him, he is not on opioid medications, he has not gotten of flu shot, let’s get that ready and prepped, no other standing orders. Behavioral health, let’s do that consult because I’ve had concerns with that, and let’s have him come in after we have the PHQ9 screening. Brenda Mark, let’s do an AUDIT today, last ED visit was in the last 30 days, we need to get forms and I want to see what their after visit summaries look like, we would like to do an AOD screening, and perhaps a PHQ2 screening on her, she’s got diabetes type 2 so it’s essential we do that. Flu shot let’s get that prepped, and let’s get that standing order of a hemoglobin A1C today.”

Next. It is about 10 seconds per patient. There are times you can discuss it further, but only if it is needed. It is important that the communication you provide is critical and essential. We can all talk more because we know more about them, perhaps we know intricacies of their lives, however is that pertinent in this time period for the huddle? That is critical. An evaluation, having the timekeeper and having the individual continue to make the communication efficient is essential in huddles. Using forms like this will help individuals to stay on track.

How do we recognize success in huddles? You can utilize the monitoring form and you could see how your huddles are growing and advancing. We can also recognize huddles by taking more stats and looking at our data. We can look at outcomes to identify those individuals prior to huddle and after; have we been able to identify more conditions earlier? Have we been able to be more successful in monitoring or managing our population health? Have we looked at our health maintenance and seen a noticeable improvement from when we started the huddles, and ensuring that we had our immunizations and flu shots on track? Are we noticing reduced medical errors happening? Can we recognize that there is improved teamwork, engagement, or satisfaction? Are we monitoring that? Is there improved chronic care management because we are bringing in our chronic care management templates or population management templates into the huddle? Perhaps you have very specific screening tools for specific populations and perhaps you might utilize specific labs that you are going to use for every population and timing. You bring that into the huddle, and once you are able to do that, you're able to see how efficient the moving and the use of those population screening tools are done within the huddle. You can see that there is improved satisfaction of the team and improved healthcare outcomes overall. It also helps to see the preparation for visits and clinic preparation. Some studies show that huddles reduce patient “doorknobbing”. If you are unfamiliar with doorknobbing, it is when a patient will at the end of a visit say by the way, I have this. And it is typically 10 more things or something that is a high need to be recognized and reviewed within the medical appointment. Like I have chest pain for example. When teams huddle, they are more efficient in communicating to the patient with the plan for the day is and then including the patient in that so when they come off of the huddle, they meet the patient, the medical assistant or the medical provider, whoever is setting the stage for the agenda for the appointment with the patient, is more able and more efficiently able to communicate this is what we are doing today, I want to ask what your needs are, here are the top concerns for us, let’s prepare us for this visit and move forward.

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Let's take a time and a moment to do another polling question. Thinking about everything that you have heard today, these rules and definitions of huddles, who you need to have involved, and also the use of these healthcare huddle tools, how likely are you to implement and utilize huddles now? Most likely? Not at all? Sometimes? Never?

Wonderful. It appears that there are many people who say most likely. There is one that says somewhat, and if you who are not answering. I am really glad to hear that most likely, individuals are planning to implement huddles into their daily life. I want you all to remember that with huddles, it is essential. They take time, experience and practice. Utilizing communication strategies such as SBAR, following formats and rules, ensuring to document your huddles so that you can understand them, especially if you are a facility that might be going for a patient-centered medical home model, you actually need to video tape or document your huddle – that's part of standard application. Implementing this and meeting these minimal basics of the standardization of huddles, is going to improve your healthcare practice efficiency and flow. To ensure that you are able to do this, I would love to hear some questions, perhaps even note of some barriers people are thinking about, and let's get working on the intricacies related to managing and implementing huddles.

Thank you. It appears that we have one question. That is how do you know when a huddle is not working well?

That is a great question. Part of how I like to recognize when a huddle is not working well, is first if I am utilizing a huddle monitoring tool, I will notice that the score is going less. If I am not utilizing that or if I am observing the huddle, I will recognize that team members are disengaged from the huddle. They are arriving late when they are noted to be part of the huddle, they are disengaged on the phone or looking through the computer's EHR system preparing for another patient, but they are disengaged from the team and that's noticeable. That is a critical component to the success. It is not just of the huddle itself but as the working of the team. That is one of the number one characteristics that I will see then after that, I will notice that communication and efficiency. I will see storytelling or communication that last longer for 10 minutes for one patient alone. These types of indicators are essential to monitor for. When huddles are lasting 15-30 minutes, it becomes inefficient. If there are times where individuals in teams feel like they need to go over patients at a deeper level, you might want to consider a team meeting or identify that this is a person you would like to talk further about in another way so that you could do that and make time and plans. Those are the essential times and places where you will see the huddle moving away from effective organized and efficient team-based care to disorganized conversations about our huddle experience.

Thank you, Dr. Manson. At this time, we are near the end of our time and I will turn this over to Stacy Hull.

Thank you, Dr. Manson for such a valuable presentation. I would also like to thank everyone on the call for joining us. Our next Quickinar will be an encore presentation on July 27 at 7 PM. You will hear Dr. Lori Raney discuss providing and financing new evidence-based behavioral health approaches in primary care. On August 17, we will host another live session at 12:30 PM. Dr. Tiffany Cooke will discuss understanding and applying the SBIRT model in primary care. Please join us and remember if you have any questions or need technical assistance, please reach out. Enjoy the rest of your day.