# Care Coordination Series, Season 1, Episode 4: INTERACT, Stop and Watch, SBAR

[00:00:00] Welcome to our care coordination quick in our series and our featured guest speaker for today is Dr. Albert Lamb, who is the Cal TCM immediate past president and his presentation is going to focus on key communication tools that are part of the interact program. I am going to turn it over to Dr. Lamb for today's presentation.

So, Dr. Lamb, the floor is yours. Thank you so much, Lindsay. And I'm really excited to join this group here on this side of the pandemic. The last time I was involved in a HSAG presentation like this was oh, oh, gosh, well, over 5 years ago. So, it's really exciting to get back with this educational push and to be all with all of you.

So, what is the SBAR? Is that a powerful tool? Is it a critical piece of documentation? Does it result in improved [00:01:00] assessment or is it useless paperwork? Is it slowed care? Is it frustrating work? These are things that I've heard from frontline nurses and leaders with my team at CalTCM and with other teams in over 60 nursing facilities in California to develop a way of improving care in facilities.

We wanted to encourage and build up individual and team competency rather than penalizing and really punishing and tearing down this program that we created is called CalTCM SNF 2. 0, and it has been purchased by leaders of nursing homes, big and small, to help prepare their staff for the—what we used to say was—the coming wave. I think, post-pandemic, that wave is here and we have really been challenged with those sicker patients and how to take care of them well. An interesting thing happened as we poured education and encouragement into these leaders, [00:02:00] nurses, CNAs, housekeepers, therapists, dietitians, and more. What we found was that nursing home communication improved and many nurses, which is super exciting, they rediscovered their love for nursing and the patients were the ones who reaped the benefits. With patient satisfaction moving from 70 percent of patients reporting overall, very good, or excellent care, to 90 percent and above. So, the SBAR was a critical part of the success we helped facilities to achieve. And that's what I wanted to share about today.

Even though a lot of us are in nursing homes, we are just one part of a system to deliver care the best care possible for our patients. One of the things that all of us have seen over many years is that it's really a team effort that will allow you to do this over time and maintain that high [00:03:00] level of care.

The talk that we're having today really is based on many, many years of doing a training and mentorship with nursing facilities. So, in around 2010, 2011, Cal TCM rolled out its premium training, what they called premium training for nursing facilities. It was live training with an action planning session. It was … it involved one-on-one telephonic coaching sessions for folks like you over the course of six months. And we really wanted to provide extra tools in a telephonic session to be able to help people, leaders in nursing facilities to lead their facilities better. In a sample of 13 nursing homes in the training program they had a 10.4 percent readmission reduction after six months of this training. So, pretty good results.

And then SNF 2. 0 was created by me and several colleagues of mine [00:04:00] up here in the Bay Area. We really felt that a one-on-one mentorship-based program with incentive programming would really help not only train and motivate people but also help make it a fun program to improve care, to deliver great care and to

improve the care that we deliver for patients. It included education, leadership training, and a focus on patient satisfaction, as I shared before. What we found in the initial pilot was a 33 to 66 percent readmission reduction, which is huge. And any of these readmissions from 10.4% to 66%, you know, we would take any of those improvements as a proxy, as a placeholder, for the quality of care that we provide.

What we did was we combined those two programs into what we refer to as CalTCM SNF 2. 0. It involves maximizing the results with what we learned.

I just want to share [00:05:00] briefly five principles you can … these are very high yield if you can implement it. Train-the-mentor principles that we use are there's a lot to it. Principle one is see every moment as a teaching moment. Principle two is promote accountability in a no-shame, no-blame environment. Principle three is never allow someone to do a first SBAR provider call alone. Principle four is to learn to walk others through the process and principle five is to really show appreciation. And I put that there because we oftentimes, we do appreciate what people have done, even when they don't do things exactly correctly, but we know that it put forth the effort. And sometimes we just in this, in the heat of the moment, or in the rush of all the things that we have to do, we need to remember to show that appreciation.

And this is from one of the people who really designed the SBAR for healthcare. The, he said, you know, when they call me in the middle of the night, they tend to ramble. It's not very [00:06:00] clear what their assessment is. I don't know what they want most of the time, and most of the calls, quite frankly, are of no use. And that's the feedback that the creators of the SBAR were getting from physicians and other people who were taking care of patients. If it sounds familiar, it happens every single day and night in every single healthcare setting in America. When we have communication that is like that's described where people, things are not very clear and you really don't have a good idea about what's going on, that can lead to patient harm. And this swish-cheese concept: that sometimes one mistake, oftentimes one mistake isn't, isn't going to be enough to cause patient harm. But if you have multiple mistakes, one of those mistakes will not get caught and will actually go all the way to the point where the patient is harmed. [00:07:00] And that's what we really want to do is we want to be able to catch that before there's patient harm to recognize that there are mistakes happening all the time, but we have multiple levels and teams that are taking care of things to help prevent those things from getting all the way to that point.

The SBAR is an important part of this. So, the SBAR was developed by Michael Leonard, Doug Bonacum, and Suzanne Graham at Kaiser Permanente, Colorado in 2002. And I thought, well, where did this come from? And what I found was that this SBAR really came from the Navy and it was, it was a young ensign on a U.S. nuclear submarine—an ensign that's a pretty low rank—who found himself reporting to the captain of the ship following his night shift. And so, what you have is someone who is very young, [00:08:00] inexperienced, who is reporting to very experienced superior many levels above him in the hierarchy and levels of an experience or inexperience who have to communicate something very important to so on above them. And they develop this technique in the Navy to allow a system to allow people who don't have as much training to really communicate clearly, and succinctly, quickly to higher ups about potentially dangerous situations, so you avoid the problems from happening. So, this ensign later joined Kaiser and became a member of this … Dr. Leonard's team and that person was Doug Bonnecombe. When you look at his LinkedIn account, and I did reach out to him and asked him if I could include this, and he allowed me to, you can see that at the very bottom of his LinkedIn he was a. U.S. submarine force officer from 1983 to 1991, and later brought that [00:09:00] brought that technique into healthcare.

The original S-B-A-R or SBAR involved a situation and that includes things like, what am I calling about? What are the vital signs? B, which is background. What is the mental status? How is the skin? Is the person on oxygen?

What is my assessment after I've reported that? What do I think the problem is? And then after I tell you, the captain, or the physician, or the PA or NP, what I think the problem is, what is my recommendation? I suggest or request that you do what? Transfer the patient? Come see the patient? Talk to the patient? Are there any tests needed? Am I requesting that you do an x-ray? An EKG? If, there's a change in treatment, do I then ask a couple of follow-up questions? And that's what the original SBAR out of Kaiser Permanente in Colorado for hospitals. It [00:10:00] was used selectively for critical, stable patient situations. More critical than stable for interdepartmental transfers, post-acute transfers, and inter-shift handoff report, which nursing leadership has actually said is very helpful in that inter-shift handoff. And then, electronic health record is built with SBAR-handoff methodology, pooling relevant data from medical records. So, that's how the hospitals use spars.

There are, however, as many of you know, nursing differences between what happens in the hospital and what happens in nursing facilities. For example, in the hospital, the nurse-to-patient ratios may be 1-to-1 or 1-to-2 to 1 point… 1-to-8. So, 1 nurse to 8 patients. Whereas in the nursing facility, it can be 1-to-20 or even 1-to-40. Multidisciplinary teams, including social work, pharmacists, therapists, techs, and physicians, work together in the hospital, whereas in [00:11:00] nursing facilities, people tend to come at different times, and it's a patchwork of teams. It's fragmented.

In the hospital, there are frequent opportunities for education, and in nursing facilities, there are potentially less frequent or you have to go out of your way or out of the facility to really access a lot of this, these educational opportunities, although virtual access has made it a lot easier. In the hospital, you have top-pay opportunities and the pay in nursing facilities, even though has gone up, still is below that of a hospital and physicians are more present in the hospital. Whereas in the nursing facility, they're less present. And then finally, warm handoffs are standard in a hospital, whereas in nursing facilities, the best nursing facilities, it is standard, but in many facilities, that's not actually what happens.

Alright, so, we know that nursing facility SBARs are the key to improved [00:12:00] assessments and communication. The INTERACT program took the hospital SBAR and adapted it for nursing facilities, and that team was led by Dr. Alexander, Jerry Lamb, Lori Herndon, Ruth Tappan, Joe Taylor, and many others. We know that the SBAR in the in the SNF is longer. And we know that some people can see that as more cumbersome. We know that as people get more into the documentation, that sometimes you can get lost in the weeds. So, the question is why? Well, the reason why is for all those reasons that I listed before that the…a nursing home is really at a disadvantage because of the nursing ratio, the lack of present teams, the differences in availability of education. So, all of these things make it very important to make sure that despite the differences, that we can have people from different backgrounds, educational [00:13:00] experiences, be able to do a really good evaluation and assessment.

So, going back to the question, what is the SBAR? Is it a powerful tool? Is it a critical documentation? Is it improved assessment or is it useless paperwork? Does it slow down care and is it frustrating work? I see this as really a battle of two things. And I put the light bulb on the left side and the time the hourglass on the right side because I feel like the areas where feedback from nurses oftentimes are challenged by using that SBAR is because they feel like it's a time sink. And that's why the hourglass is there. But the ones that really start to embrace it, they embrace it not because they like to spend the time, extra time, but because they realize that it stimulates their thinking process, and allows them to express themselves better, and allows them to process and be able to digest the things that they're concerned about, and be able to share it in really rewarding [00:14:00] ways with other team members that might not be able to understand what they're seeing.

I just want to end with the Stop-and-Watch. Well, the SBAR is really about nurses. The Stop- and-Watch is about everybody and it's about everybody just being able to quickly be able to communicate when they have a concern. You access it in the paper format. You can access it for free. You just search “pathways INTERACT” and you can access this. You have someone just circle what they think is a concern and hand it to the nurse and the nurse will be able to go through the SBAR format to figure out what the right response is for the concern. It is a critical part of the interact process and I encourage you to implement this as well.

Great. Thank you so much. Dr lamb. That was excellent information.

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