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## **Coaching the Huddle**

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In April 2010, as part of ongoing work on teamwork and interprofessional care at the Veterans Administration, as well as in response to the Affordable Care Act's focus on "medical homes" (a health care delivery model based on teams), a new team-based model of primary care was launched throughout the VA system. All primary care clinics in the VA nationwide are expected to launch Patient Aligned Care Teams (PACTs) that include primary care providers (physicians and nurse practitioners), registered nurses (RNs), licensed vocational nurses (LVNs), and clerks.

One critical part of this model is implementing what are known as "huddles." In the primary care clinic the huddle is a preclinic meeting where team members come together to review the schedule for the day, consider the needs of patients, troubleshoot problems, plan for upcoming visits, and discuss between-visit patient communications, which we refer to as telephone visits.

As a primary care provider and a leader in our clinic where we train new physicians, I was expected to help implement the huddle process. The problem was that although I had done significant reading on the topic of medical homes and knew about the existence of huddles, I knew very little about how to actually participate in a huddle. Implementing this team-based approach turned out to be much more involved than reading the literature or going to a seminar.

I remember the first day of huddling. I arrived at the clinic ready for my

usual eight o'clock patient only to hear our team nurse say that my schedule had been changed, and we were going to huddle instead. We gathered in the assigned clinic room, looked at one another, and I asked, "Does anyone know exactly what we actually do in a huddle?" So began what turned out to be a rewarding adventure in team-based care.

Our learning curve as a team quickly accelerated when, several months later, our academic faculty team received a Center of Excellence (COE) award in Primary Care Education. The Office of Academic Affiliations in the VA provided \$5 million to develop innovative ways to teach interprofessional trainees the key concepts of team-based patient-centered care. With the award we rapidly ramped up our education in the team-based model, moving beyond the concepts and into the tangible items such as developing a common language. Our practical training included an interprofessional group retreat to train in TeamSTEPPS. In all we sent over twenty people, including key RN and LVN staff, a chief resident, and psychologists, as well as a nurse practitioner (NP) and a physician (MD) who were faculty members. Ultimately, the VA delivered to all PACT teams a hands-on nuts-and-bolts training for two and a half days that accelerated our skills even further.

Nonetheless, in the early stages of our PACT, the huddles were not always happening, and when they did occur some providers and staff did not find them useful. This was primarily because people did not know the purpose of the huddle or their roles in it. When our first cohort of trainees arrived, we quickly realized that we needed to improve the functioning of the huddles—the key place where interprofessional trainees and staff communicate and collaborate.

We initially implemented a master huddle schedule and a huddle checklist. The checklist provided structure to the huddle, reminding all team members about the clinically meaningful components of the huddle. Key items are to review the patients of the day and their agendas; recent hospital charges; and complex patients who would

benefit from seeing other members of the team such as those from behavioral health psychology, pharmacy, or social work. Although the huddle checklist did provide needed structure, it did not assure that the huddles actually happened or that all parts of the huddle occurred. We devised a plan to have the clinic preceptors of the day become huddle coaches. Our huddle coach program has made all the difference in helping our teams become high functioning.

Each interprofessional faculty member (NP and MD) was assigned a huddle. Huddle coach brainstorming sessions led by local experts in patient and team communication initially helped determine best practices for huddle coaches, as this was new to all of us. In the early stages of new huddles, the huddle coach simply made sure everyone attended the huddle. This commonly meant tracking down missing team members (trainee and staff) and reinforcing the importance of the huddles. Early on, coaches prioritized the need for a check-in so team members got to know one another personally and professionally, which fostered team cohesion. As team members gained more experience with the huddles and learned about each other, they began to find value in them, especially in how huddles assist in care coordination.

Once everyone was committed to attending the huddles, the coach moved on from confirming attendance to more advanced huddle coaching. Coaches began interjecting clinical content (how the trainee can treat hypothyroidism for example) and also clinic systems content (such as where patients can get their blood drawn). Arguably, the most important role the huddle coach plays is that of process observer. The huddle coach comments on team process, reminding the team, for example, that the RN does not schedule patients for the team; the clerk does. It also includes making sure all team members' voices are heard, including that of the clerk, NP student, or pharmacist. Team communication skills such as closed-loop communication and check-back are reinforced and noted when absent. Huddle coaches find that even seasoned teams occasionally require reinforcing for early-stage issues such as a check-in or timeliness. For the huddle coaches this simply reinforces their value to the team. Even though we've been doing this now for four years, huddle coach brainstorming sessions

continue and help support our huddle coaches through peer-to-peer teaching and feedback.

Our huddle coaching program was initially designed to support the huddles for our Center of Excellence trainees. As a result of our coaching-trainee huddles, the staff in those huddles have taken what they have learned and have coached other huddles. The RN, LVN, and clerk staff are now the experts and act as informal coaches and active teachers of the new trainees when they arrive each year.

It is hard to describe the impact that team-based care has had on the clinic. Our huddle coaching program is a key part of developing these high-functioning teams. Skilled coaches praise collaborative care, point out communication lapses, and model nonhierarchical practice. Our high-functioning teams are best illustrated in the story of Maria, a clerk in our clinic. Although she has worked in our primary care clinic for many years, I am embarrassed to say I did not know her name prior to implementation of PACT. She has grown into her role as the clinic has become a true medical home. As her role in the huddle has been defined she has been given an important voice that makes a difference in the team.

I remember the day I realized we had truly changed the culture of our clinic. We were having our morning huddle when I asked Maria to cancel the appointment of a patient who had schizophrenia. Maria, who previously would not have spoken to me or challenged anything I had to say, asked me if I really thought it was a good idea to cancel him. She went on to elaborate. She told me she had to make three different phone calls to arrange for his visit and that scheduling the appointment I was about to cancel had required extensive cajoling. She added, "Do you remember he has trust issues? I am not sure he will ever come back if we cancel this appointment."

It was at that moment I realized the change we had made and that we had reached a critical point. Everyone had learned to work together, and we would never go back to our silos again. We all know now that working together we provide better care to our veterans.

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