

Original Publication

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Team Retreats for Interprofessional Trainees and Clinic Staff: Accelerating the Development of High-Functioning Teams

Shalini Patel, MD, Bridget C. O'Brien, PhD*, Maya Dulay, MD, Gillian Earnest, MS, Rebecca L. Shunk, MD

*Corresponding author: bridget.obrien@ucsf.edu

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Abstract

Introduction: Teams are critical to managing the health care needs of patients with part-time trainee providers. High-functioning teams require trusting relationships among trainees and staff and opportunities to learn and practice skills together. Irregular trainee schedules, time-limited training programs, and lack of protected time for team development during clinic can hinder development of high-functioning teams. **Methods:** To provide time for team development, we created an annual half-day team retreat for interprofessional trainees and staff at three San Francisco Veterans Affairs primary care clinics. We used principles of high-functioning teams and relationship-centered communication to develop retreat content, then trained interprofessional faculty members to facilitate and role-model this content. Retreat objectives and content focused on building relationships, establishing team goals, clarifying roles, and learning communication skills. Postretreat surveys and qualitative content analysis of comments and team goals evaluated retreat objectives and opportunities for improvement. **Results:** Between 2011 and 2017, 16 team retreats were attended by 232 interprofessional trainees and 77 unique staff (some attended multiple times). Thirty-seven faculty facilitated. Most participants strongly agreed that they knew their team members better personally and professionally after the retreat ($M = 4.7$ out of 5, $n = 368$); 78% of teams ($n = 65$) submitted SMART goals addressing high-functioning teams. Participants' comments consistently reflected the benefits of protected time for team building. **Discussion:** This team retreat supports team development among trainees and staff on primary care teams by promoting relationship building, role clarity, communication, and team processes. It can be valuable for all interprofessional participants.

Keywords

Interprofessional, Primary Care, Team-Based Care, Team Building

Appendices

- Team Retreat Curriculum and Facilitator Guide.docx
- Team Retreat Handout - PEARLS.docx
- Team Retreat Handout - Effective Communication Resources.docx
- Team Retreat Evaluation Form.docx
- Team Retreat Standard Work Template.docx
- Team Development Measure.docx

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

Upon completion of this team-building retreat, participants will be able to:

- Identify the attributes of high-functioning teams and concrete actions team members can take to work toward these attributes.
- Describe at least one personal and one professional fact about each team member that they did not know before the retreat.
- Identify frameworks to improve communication with team members, particularly during difficult situations.

Introduction

High-functioning teams whose members display effective teamwork skills are increasingly recognized as an essential component in delivery of quality patient care. Effective interprofessional teamwork can improve patient outcomes and safety as well as decrease medical errors.¹⁻⁴ Additionally, teamwork can increase patient and provider satisfaction.⁵⁻⁸ Organizational team training has been shown to improve team performance^{9,10} and positively impact clinical processes and patient outcomes.¹¹ However, there is significant variability in training methods, design, duration, and intensity during local implementation.¹² A

recent review revealed the difficulty of identifying the most effective method for team-based interprofessional education involving different groups of trainees.¹³ Still, practice-based training that allows for guided practice in the workplace is widely recommended.¹⁴

Many health care settings have patient care–delivery teams that comprise interprofessional trainees, faculty, and staff. These teams present challenges for team development due to irregular or part-time trainee schedules, which lead to potentially less continuity with the rest of the team.¹⁵ Many existing interprofessional team-oriented interventions and curricula available in *MedEdPORTAL* and elsewhere address important skills but do not address team building and team development under these challenging circumstances.¹⁶⁻²⁰ To maximize uptake and use of communication and teamwork skills, it is critical that trainees and their team members have time to establish relationships, learn teamwork skills, and practice using them together outside the busy pace of a typical day in clinic.

To address the need for this team development, we created an annual half-day retreat attended by all second-year internal medicine residents, nurse practitioner students, associated health trainees, and their assigned primary care staff team members. Retreat content covered the following teamwork skills: building cohesion, improving communication, improving role clarity, and establishing shared goals. Our team retreat curriculum and facilitator guide make a unique contribution to the interprofessional education collection in *MedEdPORTAL* by focusing specifically on the early stages of team development for clinical teams comprising both trainees and staff who will work together longitudinally.

Methods

We developed team retreats in 2011 as part of a broader longitudinal interprofessional outpatient education curriculum at the San Francisco VA Center of Excellence in Primary Care Education.²¹

Setting and Participants

Participants in our team retreats belonged to patient-aligned care teams that worked together several days per week for at least 1 year in a primary care clinic. Members of these teams included trainees (internal medicine residents, nurse practitioner students and residents, psychology fellows, pharmacy residents, social work interns) and staff members (registered nurses, licensed vocational nurses, medical support assistants).

Retreat Content and Structure

The content and pedagogical approaches for the retreat were initially developed in 2011, using team-training materials (TEAMSTEPS) provided by the Department of Defense and the Agency for Healthcare Research and Quality,^{20,22,23} communication frameworks and tools available through the Academy of Communication in Healthcare,²⁴ and characteristics of effective teams (cohesiveness, communication, role clarity, and goals and means clarity).²⁵⁻²⁷

The retreat was 4.5 hours long including the lunch hour. Two to six clinical teams, each containing five to eight team members, were scheduled during the same half-day. We developed a detailed curriculum and facilitator guide for the large-group lunch and subsequent small-group breakout sessions (Appendix A).

The large-group session for all participants included an introduction to the educational objectives of the retreat, a social lunch, and an interactive team-building exercise, the marshmallow challenge (Appendix A).²⁸ Participants were seated with their clinical teams for the entire hour. The teams then transitioned to individual small-group meetings facilitated by two interprofessional faculty for the remainder of the retreat.

The activities in the small-group sessions were designed to support relationship building, cultivate trust among team members, and provide opportunities to learn and practice skills that improve team communication and team functioning. The sessions began with a review of the goals for the retreat and the agenda for the rest of the afternoon. Then, the teams participated in a brief round of introductions and an icebreaker, followed by a facilitated discussion of ground rules. This helped establish the retreat as a

safe space. The remainder of the retreat consisted of activities focusing on (1) getting to know one another and beginning a conversation about differences and backgrounds, (2) practicing communication skills, (3) reviewing characteristics of a high-functioning team and thinking about current team function, (4) discussing roles and challenging team experiences, and (5) developing SMART (specific, measurable, achievable, relevant, time-bound) goals for teams to work on. The small-group activities included the following:

- Activity 1: a speed-meeting exercise to engage team members in learning about one another professionally and personally.
- Activity 2: a discussion of personal sources of pride and challenge. This discussion included opportunities to practice relationship-centered communication through use of PEARLS (partnership, empathy, appreciation, respect, legitimation, support).²⁹ (See handout in Appendix B.)
- Activity 3: a discussion of attributes of high-functioning teams. Facilitators elicited team members' beliefs about the critical components of high-functioning teams, then linked them to a team development framework that included communication, cohesion, role clarity, and shared goals.^{25,26} At the end of this discussion, team members identified personal goals to work on in relation to high-functioning teams.
- Activity 4: Based on participants' goals, facilitators and participants selected from a variety of activities designed to support team members in discussion of roles, responsibilities, and challenging team experiences. Activities included reviewing and practicing effective team communication skills.^{20,29-31} (See handouts in Appendices B & C.)
- Activity 5: Teams were asked to identify one to three SMART goals that the team would continue to work on after the retreat.

The retreat concluded with a checkout and time for participants to evaluate the retreat (Appendix D).

Logistics/Preparation

The retreat organizer(s) (usually one or two faculty members) began preparation for each half-day retreat 4 months in advance (see Appendix E for the Team Retreat Standard Work Template). Selecting retreat dates with adequate lead time allowed trainee and facilitator schedules to be blocked. Planning far in advance was also necessary to arrange clinic coverage with nursing and clerical supervisors so staff members could attend. The retreat was delivered on 2-3 different days to reduce the impact on staffing in the clinic. Lastly, administrative support was needed to arrange for private space for each team during the entire half-day retreat and to coordinate learning materials and food. Retreats were held at the medical facility site to avoid additional costs, but spaces were selected to be geographically separate from the team's usual workplace to prevent disruption.

Retreat Faculty

Facilitators were recruited from an interprofessional group of educators including physicians, nurse practitioners, psychologists, pharmacists, and senior interprofessional trainees who worked in outpatient settings. Two facilitators were assigned to each team. The retreat organizer made sure facilitators had little interaction with members of their assigned team in order to minimize conflicts of interest and promote psychological safety and open discussion during the team retreat. For example, a faculty member would not facilitate a group if he or she supervised any of the staff members or trainees in that group. Each year, experienced faculty were paired with newer faculty members to provide mentorship.

Facilitators needed to have some experience working on teams, facilitating small groups, and applying the skills taught in the retreat, but they did not have to be content experts. Just-in-time training helped familiarize facilitators with content and provided time to practice skills. Prior to the retreats, one of the retreat organizers invited facilitators to meet as a group or in their facilitation pairs to review the facilitator guide. This was an opportunity to prepare for the retreat by going over content and general facilitation skills. This time also allowed faculty to strategize how to approach challenging scenarios (e.g., unengaged

trainees, staff struggling with burnout, understaffed teams). At the end of the retreat, facilitators met for 30 minutes to debrief. This provided an opportunity to share and reflect on best practices and to identify opportunities for improvement for individual facilitators and for overall retreat curriculum, facilitation, and structure. Facilitators also discussed what resources or support could be provided to address clinical teams' challenges.

Evaluation Plan

Our evaluation of the retreat included team member participation and satisfaction, achievement of the educational objectives, and identification of opportunities to improve the retreat.

To evaluate participation, we kept track of all team members who attended the team retreat. To evaluate participant satisfaction with the retreat, we asked trainees and staff to complete a locally designed retreat evaluation form (Appendix D) at the end of the retreat half-day. Participants evaluated the following aspects of the retreat on a 5-point Likert scale (from *strongly disagree* to *strongly agree*): clarity of objectives, organization, content presented at appropriate level, and overall quality. Participants also evaluated retreat facilitators on the following dimensions: teaching and modeling interpersonal skills, promoting inclusiveness for all participants, and overall effectiveness as a facilitator and cofacilitator. Additionally, the evaluation form included an open-ended question asking participants to describe the most valuable aspects of the retreat.

To evaluate achievement of educational objectives, we included survey questions on the evaluation form that aligned with the educational objectives. Participants rated these items on a 5-point Likert scale (from *strongly disagree* to *strongly agree*). We also asked participants to identify one thing they planned to work on as a result of the retreat, and we collected the SMART goals identified by teams during the retreat. SMART goals were submitted to the retreat organizer and administrative coordinator by team facilitators or a designated team member, then entered into an Excel file for tracking and qualitative content analysis.

To identify opportunities for improvement, we included one open-ended question on the evaluation form soliciting participants' suggestions for how to improve the retreat.

Finally, to gauge how teams continued to develop after the retreat, we included an optional supplemental evaluation component. We administered the Team Development Measure (TDM; Appendix F),²⁷ a 31-item questionnaire about perceptions of cohesiveness, communication, role clarity, and goals/means clarity on a team, 1 month prior to the retreat and approximately 6 months after the retreat. We compared each team's preretreat TDM score to its 6-month postretreat TDM score. Although we recognized that multiple factors could contribute to team development over this 6-month time frame, we expected the retreat to start teams on a positive developmental trajectory and thus that we would find most teams scoring higher on the TDM at 6 months postretreat compared to preretreat.

Data Analysis

We analyzed survey items using descriptive statistics, including mean, standard deviation, and range. A staff member compiled all responses to open-ended questions from 2011 to 2017. One faculty member and one staff member used qualitative content analysis to review all responses in order to identify content-based categories relevant to retreat goals and objectives (e.g., relationship building/cohesion, communication, role clarification, goals), then coded all comments as one or more of these categories.³² Team goals were analyzed by two faculty members and one staff member using conventional qualitative content analysis that focused on goal alignment with retreat objectives.³²

Results

Participation and Participant Satisfaction

Sixteen team retreats were attended by 65 teams comprising 115 internal medicine residents, 46 nurse practitioner trainees, 71 associated health trainees (psychology fellows, pharmacy residents, social work

interns), and approximately 77 unique staff members from 2011 to 2017. Some staff members attended the retreat in multiple years, so the total number of evaluations exceeded the number of unique participants.

Retreat evaluations indicated that participants felt many aspects of the retreat went well. Participants rated the organization, level of material, objectives, and overall quality of the retreat highly (overall $M = 4.4$ - 4.6 out of 5, $n = 445$; see Table 1). Facilitators received very high ratings for demonstrating and modeling the skills emphasized during the retreat, promoting inclusiveness of all members, and overall facilitation (4.7-4.8 out of 5; see Table 1). Several open-ended comments highlighted the “excellent” and “skilled” facilitators as a valued part of the retreat.

Table 1. End-of-Retreat Evaluations

Question	n^a	M^b	SD
The objectives for the retreat were clear.	445	4.4	0.7
The retreat was well organized.	445	4.6	0.6
The level of the material covered during the retreat was appropriate for me.	445	4.5	0.7
I know my team members better on a <i>personal</i> level as a result of the retreat.	369	4.7	0.5
I know my team members better on a <i>professional</i> level as a result of the retreat.	369	4.7	0.6
I am likely to make changes in my interactions with my team as a result of this retreat.	307	4.6	0.6
Our facilitators demonstrated strong interpersonal skills (listening, interest in the opinion of others, etc.).	445	4.8	0.5
Our facilitators modeled and demonstrated the skills being taught (PEARLS).	445	4.7	0.5
Our facilitators effectively promoted inclusiveness for all group members.	445	4.8	0.5
Facilitator was effective. (Note: two facilitators per retreat 2012-2017.)	814	4.8	0.5
Overall, these facilitators cofacilitated effectively.	369	4.8	0.4
The overall quality of the retreat was high.	445	4.6	0.6

Abbreviation: PEARLS, partnership, empathy, appreciation, respect, legitimation, support.

^aSample sizes vary because some questions were added in later years. Sample size exceeds number of unique participants because several staff members attended retreats in multiple years and completed multiple evaluations.

^bScale: 1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, 5 = *strongly agree*.

Participants’ comments on the most valuable aspects of the retreat emphasized the opportunity to spend time getting to know one another socially and professionally. They learned more about one another’s roles, perspectives, and challenges. Participants appreciated having time to work together to identify goals, discuss problems, and strategize improvements. The following comments reflect participants’ deep appreciation for and value placed on the retreat:

- “Having been given this time & opportunity meant like ‘we matter’, that being a ‘great’ team is important because we are doing something about it” (registered nurse, 2015).
- “Learning more about our team, their background, motivation. Also, clarifying their understanding of their roles” (internal medicine resident, 2017).

Achievement of Educational Objectives

Multiple sources of data indicated that the educational objectives of the retreat were generally met.

Educational Objective 1. Identify the attributes of high-functioning teams and concrete actions members of the team can take to work toward one of these attributes (Table 1 & Table 2): Forty-five of 58 teams (78%) fulfilled the request to submit SMART goals at the end of the retreat (a request initiated in the 2012 retreats). Our coding of these goals found that many addressed aspects of high-functioning teams: 89% of goals addressed communication, 51% goals/means clarity, 44% cohesiveness, and 42% role clarity. Many SMART goals addressed more than one of these characteristics. One example of a team’s SMART goals follows:

Team X Goals (2016)

1. We will develop a process to alert each other re: departures or extended vacation/sick leave for team members. Champion: [name]. Timeframe: 1-2 months.

2. We will clarify with RN on the team (who was unfortunately on vacation during the retreat) whether we accurately listed her roles during the retreat; we will see if there are things that we are asking her to do that could/should be done by another team member or staff member. We will discuss this in huddle w/ the whole team. Champion: [name]. Timeframe: 1-2 months.

Table 2. Team Retreat Educational Objectives Mapped to Data Sources and Outcomes

Educational Objective	Data Sources Used to Evaluate Objective	Outcome
1. Identify the attributes of high-functioning teams and concrete actions members of the team can take to work toward one of these attributes.	SMART goal submitted by each team and content related to high-functioning teams.	2012-2017: 78% of teams submitted at least one SMART goal, many of which reflected characteristics of high-functioning teams.
2. Describe at least one personal and one professional fact about team members that you did not know before the retreat.	End-of-retreat survey items: "I know my team members better on a <i>professional</i> level as a result of the retreat." "I know my team members better on a <i>personal</i> level as a result of the retreat."	Most team members agreed or strongly agreed that they knew their team members better on a professional and personal level as a result of the retreat ($M = 4.7$ out of 5 for both).
	Open-ended comments about valued aspects of the retreat.	The most frequently mentioned valued aspects of the retreat related to learning about one another personally and professionally (42% of comments, 160 out of 382).
3. Identify frameworks to improve communication with team members, particularly during difficult situations.	SMART goal submitted by each team and content related to communication.	89% of SMART goals submitted by teams addressed communication (40 out of 45).
	Responses to the open-ended question "What is the one thing you plan to work on as a result of the retreat?"	43% of responses described communication skills that could help with difficult situations (173 out of 399).

Abbreviation: SMART, specific, measurable, achievable, relevant, time-bound.

Educational Objective 2. Describe at least one personal and one professional fact about team members that you did not know before the retreat (Table 1 & Table 2): Most participants strongly agreed that they knew their team members better on both a personal and professional level after attending the retreat ($M = 4.7$ out of 5, $n = 369$). This suggests team members were establishing relationships and cohesion. Responses to open-ended questions about the most valuable aspects of the retreat further confirmed this as participants expressed appreciation for the dedicated time away from clinical responsibilities to get to know one another and work on skills to improve their teamwork. Examples of such comments included the following:

- "Getting to know one another personally & professionally, hearing the barriers to a cohesive team from each person in order to better understand how to address the communication breakdowns" (psychology fellow, 2016).
- "It was really interesting to learn about different personalities and hear thoughts from the different groups (ex. extroverts vs. introverts). It really helped to understand how people perceive different situations" (pharmacy resident, 2011).
- "Creating an atmosphere to talk to each team member and sharing difficult situations. Knowing their perspective was very helpful" (registered nurse, 2015).
- "The small group sessions with my team were so helpful. We brainstormed about feedback in new and creative ways which had never been suggested before. It was also a great opportunity to get to know my team, something that doesn't always happen in the clinic setting" (nurse practitioner student, 2011).

Educational Objective 3. Identify frameworks to improve communication with team members, particularly during difficult situations (Table 1 & Table 2): As reported above, 89% of SMART goals submitted by teams addressed communication. Additionally, 43% (173 out of 399) of responses to the open-ended question

“What is the one thing you plan to work on as a result of the retreat?” described communication skills that could help with difficult situations. Examples included the following:

- “Active listening, therapeutic pause” (nurse practitioner student, 2016).
- “Empathizing and/or helping with the challenges faced by my teammates” (internal medicine resident, 2012).
- “Eye Contact” (administrative support assistant, 2016).
- “Use PEARLS technique to communicate with team, staff, and patients” (licensed vocational nurse, 2015).

Opportunities for Improvement

Roughly half the participants offered suggestions for improvement. Retreat organizers made adjustments where possible based on participants’ comments and retreat facilitators’ feedback. For concerns such as providing more or less time for specific aspects of the retreat, more time was allotted for activities such as goal setting and problem solving and less time for large-group activities. Additionally, based on participants’ feedback requesting more frequent retreats, we initiated follow-up retreats for more advanced learners. Though the retreat ratings have been consistently high since first implementation, a slight upward trend in later years suggests the improvements have been well received.

Follow-up Assessment of Team Development

All 65 teams participating in the retreat from 2011 to 2017 completed the TDM preretreat and 6 months postretreat. Response rates within each team ranged from 67% to 100%. The mean response rate within teams preretreat was 87% and 6 months postretreat was 79%. The mean TDM score preretreat was 65.7 ($SD = 7.3$; range, 48-82), and the mean TDM score postretreat was 69.2 ($SD = 7.1$; range, 55-88). The majority of teams showed positive team development from preretreat to 6 months postretreat ($n = 46$; 71%). While these developments cannot be directly attributed to the team retreat, the findings indicate that team members perceived improvements in team functioning over time. The team retreats may have been a contributing factor.

Discussion

We designed, implemented, and evaluated a half-day team retreat to provide dedicated time and space for team development among staff and trainees from multiple professions working together longitudinally on primary care teams. The content and pedagogical approaches used in the retreat were derived from evidence-based resources and curricula on teamwork and communication skills, as well as guidance from experts in these areas.

Our evaluation findings show that a team retreat can be a meaningful curricular activity for team development among interprofessional trainees and staff on primary care teams. Participants rated the overall quality of the retreat very highly. Although we cannot claim that positive retreat experiences enhance team effectiveness, some literature suggests that such experiences can have a positive impact on trainee engagement and teamwork strategies.¹¹ We found that providing protected time for team members to improve their work together was one of the most valued aspects of the retreat.

We made several strategic decisions about the design of our retreats and would encourage others to carefully consider many of these aspects to optimize the value of their own retreats. The first was retreat timing. We chose to hold retreats in the fall, after all trainees had started their academic year and most of them had at least 1 month on the team. While it was important to deliver the team retreat curriculum early in the year, we felt a more informed, constructive team discussion could occur when the trainees already had some experience on the team.

The second strategic decision was choosing to have all team members participate, not just trainees, and getting buy-in from clinic leadership and faculty. While this decision was logistically challenging and

potentially burdensome for the clinic in the short term, we believe it was essential for success. To garner support from leadership and faculty members, we outlined the anticipated benefits of our team retreat curriculum for our institutions and for the success of the interprofessional education programs valued by our institutions.³³ This was done by highlighting the benefits of communication, role clarity, and improvements in morale that our team retreat could provide all institutional staff and faculty. Additionally, the retreats have served as a tool for new staff members, including faculty, in the clinic to orient to roles, communication tools, and other staff members personally. Our medical center leadership now supports these team retreats for teams in other clinic settings, including those that do not involve trainees. In addition to leadership buy-in, we have observed that participant engagement is critical. We addressed this by educating participants on the objectives of the retreat prior to the actual retreat date. Lastly, we observed that having as many members of the actual working team participate as possible was more beneficial than trying to include a balanced mix of participants based on backgrounds and training levels.

The third strategic decision was using our own interprofessional faculty members and advanced trainees as facilitators. This cut costs and enriched the commitment to effective teamwork and communication in our clinics and educational programs. In addition, it built and strengthened connections between faculty, staff, and trainees in our clinics. The retreats also provide an opportunity for faculty development. We provided advance preparation in the form of a guide for facilitators (Appendix A) and individual coaching as needed. This was essential, particularly because teams have different needs and facilitators have to be prepared to help each group decide which activities best match its needs. Facilitators may also need time to practice facilitation and communication skills that they will use during the retreat. Discussing these aspects with peers for an hour or more prior to the retreat is believed to be a powerful way to prepare. Over time, a core group of expert facilitators can help train others.

While our team retreats were created to support team development for primary care teams working with interprofessional trainees, we believe the retreat curriculum can be successful in many other team-based contexts. The three strategic decisions described above can be tailored to a variety of institutions and settings. Specifically, the timing, number of retreats, key participants, and facilitators can be selected and customized by the retreat organizer(s). Although these factors may vary depending on the team, the activities and objectives outlined in the retreat curriculum and facilitator guide (Appendix A) are widely applicable to a broad spectrum of health care teams. Additionally, the guide allows delivery of this curriculum within an institution without external support.

Although we firmly believe team retreats play an important part in team development and ongoing performance, we recognize the difficulty of directly measuring the impact of the retreat on these broad goals. Our 6-month postretreat TDM scores suggest a positive trend in team development following the retreat, but many factors such as team huddles, formal curricular sessions, case conferences, and panel management sessions likely contribute to team development and performance over time. Team retreats can serve as an important catalyst for team development, but the work initiated at the retreat must continue and be supported through additional structures and initiatives for sustained development.

Limitations

The required resources are a key limitation of this team retreat. Arranging time away from clinical work for a half-day can be challenging, and it takes planning in advance to have full attendance by those invited to the retreat while not burdening those who remain in the clinic. We found that scheduling several retreat sessions so as to have fewer clinical teams per retreat half-day helped address this problem. Due to the advance planning and time required, each clinical team had only one team retreat per year. It is unclear what the optimal duration and intensity are for interprofessional team training of health professional trainees.¹³ Our evaluations consistently called for more frequent retreats as an area for improvement. In 2017, we began piloting an advanced learner retreat the year after the initial team retreat. Our evaluation of the retreat is limited by our reliance on self-report data reflecting participants' perceptions of the retreat,

rather than higher level outcomes such as behavior change and impact on clinic functioning and patient care.

Future Directions

The dedicated team time that a retreat provides could be an opportunity in the future to discuss many other aspects of patient care, such as population health data, patient and staff diversity, and quality improvement.

Maintaining the momentum of a team retreat is also an important consideration. The SMART goals established during retreats were to be periodically addressed by the team during weekly huddles. We also emailed team members a reminder of their SMART goals approximately 3 months after the retreat. In the future, a follow-up system with more accountability may increase the likelihood of sustained changes in teamwork.

Shalini Patel, MD: Associate Professor, Department of Medicine, University of California, San Francisco, School of Medicine; Chief of Primary Care, San Francisco VA

Bridget C. O'Brien, PhD: Associate Professor, Department of Medicine, University of California, San Francisco, School of Medicine; Director of Scholarship and Evaluation, Center of Excellence in Primary Care Education, San Francisco VA

Maya Dulay, MD: Associate Professor, Department of Medicine, University of California, San Francisco, School of Medicine; Associate Director for Clinical Care and Education, San Francisco VA

Gillian Earnest, MS: Research Data Analyst, University of California, San Francisco, School of Medicine; Research Data Analyst, San Francisco VA

Rebecca L. Shunk, MD: Professor, Department of Medicine, University of California, San Francisco, School of Medicine; Associate Chief of Staff for Education, San Francisco VA; Co-Director, Center of Excellence for Primary Care Education, San Francisco VA

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Ethical Approval

The University of California, San Francisco, Institutional Review Board and the VA Office of Research & Development approved this study.

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