

Chapter 5: **Assessing the Effectiveness of GITT** **Training for Students / Trainees**

A. Purpose

This chapter will provide an overview of GITT evaluation measures and how they can be used to:

- Benchmark attitudes and knowledge before and after GITT training.
- Evaluate a student / trainee's geriatric knowledge and team dynamics' knowledge following GITT training.
- Evaluate a student / trainee's understanding of teams and geriatrics throughout the course of the training.
- Evaluate and improve the GITT training.

B. Objectives

After reviewing this chapter, you will be able to:

1. Determine what to evaluate.
2. Differentiate the different types of GITT evaluation materials.
3. Determine if the GITT evaluation measures or another evaluation method should be used.
4. Use the GITT evaluation measures to examine student / trainee learning.
5. Decide which GITT evaluation measures are right for you.

C. GITT Materials

- Entry Attitudes Questionnaire
- Exit Attitudes Questionnaire
- Pre-Post Knowledge Questionnaire
- Ongoing Grading Exercise: Journaling
- Simulated Patient Teaching Module
- Geriatric Knowledge Final Evaluation: Case Study of Mrs. M
- Team Dynamics Final Evaluation: Videotape of Mrs. Busby
- Sample Course Evaluation

Introduction

As with all academic programs, the GITT program includes a variety of measures that can be used to measure students' academic development and, ultimately, their understanding of

1) attitudes toward geriatric interdisciplinary teams, 2) geriatric knowledge, and 3) team dynamics. This chapter discusses a variety of tools developed in the eight initial implementation sites, as well as tools used by all sites for national comparisons of student understanding of the three knowledge and attitude areas. It should also be noted that the majority of the instruments highlighted in this chapter were designed specifically to evaluate the national GITT program. Though separate instruments measuring team skills and geriatric knowledge exist, few instruments fuse the two.

What to Evaluate

The GITT evaluation measures have been designed to assess the students'/trainees' understanding of the fundamental topic areas presented in the GITT Core Curriculum. The evaluation measures will help faculty answer the following questions:

- What did students learn about interdisciplinary teams in terms of team leadership, roles on teams, conflict management, and communication skills?
- What did students learn about the care of older adults, as evidenced by their ability to develop a plan of care and their understanding of the role of other disciplines in providing care?
- How satisfied were the students with GITT training?
- How interested are GITT graduates in working in geriatrics or in team settings?
- How frequently have trainees used the team skills during the practicum training?

Ways to Evaluate

There are several different approaches you can take to evaluate a GITT trainee's knowledge of the important GITT concepts, as well as ways to evaluate the program itself. These approaches include: 1) pre- and post-testing / benchmarking, 2) grading assignments throughout the GITT experience, 3) final tests, and 4) student feedback

Pre- and Post-Testing / Benchmarking

Testing before training and then testing during or following the training was an important technique used to evaluate the national GITT program. While most coursework grading systems only examine a final score, it may be useful for the overall program to examine student learning — not against a blank slate but instead against their initial knowledge level. Such personal benchmarking can provide the program with an idea of how well each school's overall curriculum — to that point in the program — has integrated geriatrics and teaming into the curriculum and what changes may be attributable specifically to GITT-specific coursework and didactic practicum. Early baseline testing, especially in the first classes, can provide immediate suggestions about which portions of the planned curriculum should be highlighted and which portions may need less emphasis.

Nationally, the NYU GITT Resource Center has been using the GITT Common Core to measure trainee attitudes and knowledge before GITT training and then immediately following the training at the eight initial GITT program sites. In those eight program sites, a pooled data set from all participating institutions allowed each GITT site to compare its responses with those from other settings serving similar populations. Such "benchmarking" information provided a larger context for a site to judge its trainees' knowledge and attitudes as compared to trainees in other institutions. If sites wish to use these Common Core Measures and benchmark their results against the national pooled sample, they may do so by working with the NYU Resource Center on survey methods and analysis. We have included in this chapter a general overview of the Common Core Measures and

the activities that could take place if sites decided to use them for benchmarking purposes. When sites are ready to conduct the GITT Common Core measures, they should contact the Resource Center at (212) 998-5565 for further assistance.

In addition to the GITT Common Core, some of the original GITT sites developed their own pre- and post-benchmarking tests. University of Colorado Health Sciences Center GITT Program developed the example we provide in this chapter. This evaluation instrument, "Geriatric Interdisciplinary Team Training: Pre-Test and Post-Test Evaluation Questions," assesses a trainee's baseline knowledge on a wide range of topic areas: teams, conflict, Medicaid, ethical principles, health care systems, and health care costs. A pre-test can also serve faculty by identifying weak knowledge areas before training begins. In this way, faculty can tailor the curriculum to better facilitate student learning in those weak knowledge areas. A post-test at the end of the course can help the faculty to determine if the course adaptations lead to improvements in student/trainee knowledge.

Grading Exercises Assigned Throughout The GITT Experience

You may choose not to benchmark – preferring to grade trainees' comprehension of a topic area after that topic area is presented. There is an assortment of exercises in the GITT Core Curriculum 2001 that will help you assess the progress of your students / trainees. The following example is a specific technique to evaluate student/trainee progress throughout the course.

Journaling¹

The use of a journal by GITT trainees is designed to tie the didactic classroom to the team experience in the clinical setting. The trainees are asked to keep an ongoing journal of their team experiences — impressions, issues, techniques, and outcomes — for their own use to help them organize their thoughts and to provide a beginning guide for educational meetings with their faculty/preceptors. Trainees are encouraged to respond to specific questions that relate back to the topic areas. At the end of each seminar or lecture, the faculty should assign a journal topic to the trainees. Journal questions can be adapted easily to the curriculum and allow the faculty to track the progress of the trainees. Questions for the trainees might include: What is your initial impression of teams? How are tasks and responsibilities differentiated on your team? Do team members always fulfill the same role at each meeting? How is consensus reached? How is conflict resolved?

Final Tests

For a final exam, we recommend using 1) a written case study developed specifically for GITT, 2) a videotape developed specifically for GITT, and 3) a standardized patient case, following which a student participates on a team to develop a care plan. You may want to use all three or a combination of them.

Clinical Case Studies²

As part of the GITT Common Core, written case studies testing geriatric knowledge, and videotapes testing team dynamics, were developed. The GITT Case Study Work Groups developed both the case studies and the videotapes. Through a series of meetings, the Case Study Work Group and the Videotape Work Group refined the case studies and developed the test questions. To determine the best answers to the case studies, the case and questions were distributed to geriatric team

¹ Journal Guidelines from Mount Sinai GITT.

² Written Case Studies Coding and Scoring Manual, (1998). NYU / GITT Resource Center.

“clinical experts” across the eight GITT sites, who then read the cases and answered the test questions. The clinical experts’ answers were compiled into code clusters for each question. Each code cluster was then reviewed based upon both the number of experts responding within a code cluster and the distribution of disciplines across the code clusters. The case studies evaluate the trainee’s ability to respond appropriately to: 1) the one dominant issue with regard to the case, 2) the patient-specific problems that should be addressed first, 3) the factors that complicate the plan of care, 4) the positive factors that can enhance the plan of care, and 5) who should be involved in the development of the plan of care and what contributions they should make.

Videotapes³

The videotapes test trainees’: 1) recognition of effective and ineffective team behaviors, 2) knowledge of ways to respond to ineffective team behaviors, and 3) ability to distinguish team dynamics and meeting process from team outcome. The videos used in the GITT Common Core portray ineffective team meetings. Explicit behaviors were written into the videotape scripts based on categories of team behaviors developed by Theresa Drinka, Ph.D. Obvious ineffective behaviors were written into the scripts so trainees could recognize the behaviors quickly. Each of the video scripts used in the GITT Common Core include the following situations:

- Competent professionals who know the patient and family.
- Identification of important issues that should be addressed by the team
- Insights that reflect each discipline’s unique contribution
- A team leader who starts meetings with an organized structure that later falls apart
- No prioritization of patient/family needs
- No consensus on, or development of, an interdisciplinary care plan
- Interruptions from beepers, side conversations, etc.
- Conflict that is poorly managed (sarcasm, defensiveness, withdrawal, inappropriate comments)
- Unresolved conflict among team members
- No meeting output — no summary of assigned tasks or agreed-upon outcomes

Student Feedback

A course evaluation can help the student articulate what s/he learned, as well as provide important feedback to help course instructors identify what worked and what did not work. In this manual, we provide an example of a course evaluation used by the University of Colorado Health Sciences Center GITT program. This course evaluation includes questions pertaining to both the didactic and the practicum components of GITT. This evaluation asks the students to: 1) rate the usefulness/relevance of the topic areas and exercises presented in the GITT Core Curriculum, 2) rate the value of and comment on the practicum experience, 3) rate the preceptor or faculty on knowledge/expertise and teaching abilities, and 4) rate the workload in comparison to other classes. Administering and reviewing course evaluations can be especially useful in modifying and improving your GITT program.

More Information on GITT Common Core⁴

³ Videotape Scoring and Coding Manual. (1999). NYU/GITT Resource Center.

⁴ Fulmer, T., & Hyer, K. (1998). Evaluating the effects of geriatric interdisciplinary team training. In Seigler, E. et al (Eds.). Geriatric interdisciplinary team training. New York :Springer Publishing Company.

The GITT Common Core used to evaluate the original eight GITT programs was comprised of pre- and post-questionnaires. The pre-test included:

- A trainee pre-questionnaire, comprising 46 items, with sections addressing opinions about teams, self-assessment regarding team behavior, attitudes about teams, and career goals regarding geriatric training
- Clinical case studies with five test questions relating to appropriate geriatric care and team involvement, and
- A 3-to-4 minute videotape of a team in progress with five questions that address team dynamics.

The post-test includes 53 items, with the same pretest questions along with seven evaluation items of the GITT experience, a post-case study, and a post-videotape. The common core measures were pencil and paper. Trainees received two different case studies/videotapes at time one and at time two. The five case studies and the four videotapes were determined to be equally difficult.

For more information on the GITT Common Core, please visit our website: www.gitt.org.

GITT Materials

- Entry Attitudes Questionnaire
- Exit Attitudes Questionnaire
- Pre-Post Knowledge Questionnaire
- Ongoing Grading Exercise: Journaling
- Simulated Patient Teaching Module
- Geriatric Knowledge Final Evaluation: Case Study of Mrs. M
- Team Dynamics Final Evaluation: Videotape of Mrs. Busby
- Sample Course Evaluation

The John A. Hartford Foundation
 Geriatric Interdisciplinary Team Training Program (GITT)

A. TRAINEE ENTRY QUESTIONNAIRE

Instructions:

Your answers are confidential and will be reported only in grouped data.

Use a dark blue or black pen (not pencil) to complete questionnaire.

Print in capital letters as shown

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

Unless otherwise instructed, choose only one response to each question/statement.

Fill in bubbles completely as shown.

Do not fold or staple the pages.

Make no stray marks on the questionnaire.

ID

Project ID

Today's Date

FIRST LETTER of last name plus

YEAR

LAST 4 DIGITS of Social Security No.

Clinical Setting ID

MONTH DAY

This is the 1st 2nd 3rd 4th 5th 6th or more time I have completed this questionnaire

Please indicate your trainee status: Student Trainee (includes medical residents)
 Staff Trainee (GITT is NOT part of a degree requirement)
 Other specify

We would like to know about your attitudes toward interdisciplinary health care teams and the team approach to care. By interdisciplinary health care team, we mean three or more health professionals (e.g., nurse, physician, social worker) who work together and meet regularly to plan and coordinate treatment for a specific patient population.⁵

"IN MY OPINION":

	Strongly Disagree	Moderately Disagree	Somewhat Disagree	Somewhat Agree	Moderately Agree	Strongly Agree	
1. Working in teams unnecessarily complicates things most of the time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A1
2. The team approach improves the quality of care to patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A2
3. Team meetings foster communication among team members from different disciplines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A3
4. Physicians have the right to alter patient care plans developed by the team	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A4
5. Patients receiving team care are more likely than other patients to be treated as whole persons	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A5
6. A team's primary purpose is to assist physicians in achieving treatment goals for patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A6
7. Working on a team keeps most	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

⁵ Heinemann, Schmitt and Farrell (1994). Attitudes Towards Interdisciplinary Teams, all rights reserved

Please rate your ability to carry out each of the following tasks at this point in your training using a five-point scale.⁶

	Poor	Fair	Good	Very Good	Excellent	
22. Function effectively in an interdisciplinary team	0	0	0	0	0	TSS1
23. Treat geriatric team members as colleagues	0	0	0	0	0	TSS2
24. Identify contributions to patient care that different disciplines can offer	0	0	0	0	0	TSS3
25. Apply your knowledge of geriatric principles for the care of older persons in a team care setting	0	0	0	0	0	TSS4
26. Ensure that patient/family preferences/goals are considered when developing the team's care plan	0	0	0	0	0	TSS5

Please rate your ability to carry out each of the following tasks at this point in your training using a five-point scale.⁷

	Poor	Fair	Good	Very Good	Excellent	
27. Handle disagreements effectively	0	0	0	0	0	TSS6
28. Strengthen cooperation among disciplines	0	0	0	0	0	TSS7
29. Carry out responsibilities specific to your discipline's role on a team	0	0	0	0	0	TSS8
30. Address clinical issues succinctly in interdisciplinary meetings	0	0	0	0	0	TSS9
31. Participate actively at team meetings	0	0	0	0	0	TSS10
32. Develop an interdisciplinary care plan	0	0	0	0	0	TSS11
33. Adjust your care to support the team goals	0	0	0	0	0	TSS12
34. Develop intervention strategies that help patients attain goals	0	0	0	0	0	TSS13
35. Raise appropriate issues at team meetings	0	0	0	0	0	TSS14
36. Recognize when the team is not functioning well	0	0	0	0	0	TSS15
37. Intervene effectively to improve team functioning	0	0	0	0	0	TSS16
38. Help draw out team members who are not participating actively in meetings	0	0	0	0	0	TSS17

⁶ Hepburn, Tsukuda, and Fasser (1996), Team Skills Scale, all rights reserved

⁷ Hepburn, Tsukuda, and Fasser (1996), Team Skills Scale, all rights reserved

Please rate your attitude, at this point in your training, using a five-point scale.

	Poor	Fair	Good	Very Good	Excellent	
39. Toward other disciplines working in the team setting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS18
40. Towards providing care to the elderly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS19
41. About practicing in a team care environment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS20

	Not at all				Extensively	
42. To what extent do you anticipate an emphasis in geriatrics in your career?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	B1

	Negatively		Neutral		Positively	
43. When choosing (looking) for your next position, how will the opportunity to participate in an interdisciplinary team influence your decision?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	B2

	Not Important				Very Important	
44. To what extent do you believe that your ability to work in an interdisciplinary team will contribute to your professional success?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	B3

	Highly Unlikely				Highly Likely	
45. What is the likelihood that you will seek additional training in team care after completing this program?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	B4

	Highly Unlikely				Highly Likely	
46. What is the likelihood that you will seek additional training in geriatrics after completing this program?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	B5

The John A. Hartford Foundation
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B. TRAINEE EXIT QUESTIONNAIRE

Instructions:

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Use a dark blue or black pen (not pencil) to complete questionnaire.

Print in capital letters as shown

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

Unless otherwise instructed, choose only one response to each question/statement.

Fill in bubbles completely as shown.

Do not fold or staple the pages.

Make no stray marks on the questionnaire.

ID

Project ID

Today's Date

FIRST LETTER of last name plus

MONTH

DAY

YEAR

LAST 4 DIGITS of Social Security No.

Clinical Setting ID

This is the 1st 2nd 3rd 4th 5th 6th or more time I have completed this questionnaire

Please indicate your trainee status:

Student Trainee (includes medical residents)

Staff Trainee (GITT is NOT part of a degree

requirement)

Other specify

We would like to know about your attitudes toward interdisciplinary health care teams and the team approach to care. By interdisciplinary health care team, we mean three or more health professionals (e.g., nurse, physician, social worker) who work together and meet regularly to plan and coordinate treatment for a specific patient population.⁸

"IN MY OPINION":

	Strongly Disagree	Moderately Disagree	Somewhat Disagree	Somewhat Agree	Moderately Agree	Strongly Agree	
1. Working in teams unnecessarily complicates things most of the time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A1
2. The team approach improves the quality of care to patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A2
3. Team meetings foster communication among team members from different disciplines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A3
4. Physicians have the right to alter patient care plans developed by the team	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A4
5. Patients receiving team care are more likely than other patients to be treated as whole persons	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	A5

⁸ Heinemann, Schmitt and Farrell (1994). Attitudes Towards Interdisciplinary Teams, all rights reserved

"IN MY OPINION":

Strongly Disagree Moderately Disagree Somewhat Disagree Somewhat Agree Moderately Agree Strongly Agree

to the team helps team members better understand the work of other health professionals

A21

Please rate your ability to carry out each of the following tasks at this point in your training using a five-point scale.⁹

	Poor	Fair	Good	Very Good	Excellent	
22. Function effectively in an interdisciplinary team	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS1
23. Treat geriatric team members as colleagues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS2
24. Identify contributions to patient care that different disciplines can offer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS3
25. Apply your knowledge of geriatric principles for the care of older persons in a team care setting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS4
26. Ensure that patient/family preferences/goals are considered when developing the team's care plan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS5

Please rate your ability to carry out each of the following tasks at this point in your training using a five-point scale.¹⁰

	Poor	Fair	Good	Very Good	Excellent	
27. Handle disagreements effectively	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS6
28. Strengthen cooperation among disciplines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS7
29. Carry out responsibilities specific to your discipline's role on a team	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS8
30. Address clinical issues succinctly in interdisciplinary meetings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS9
31. Participate actively at team meetings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS10
32. Develop an interdisciplinary care plan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS11
33. Adjust your care to support the team goals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS12
34. Develop intervention strategies that help patients attain goals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS13
35. Raise appropriate issues at team meetings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS14
36. Recognize when the team is not functioning well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS15
37. Intervene effectively to improve team functioning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS16

⁹ Hepburn, Tsukuda, and Fasser (1996), Team Skills Scale, all rights reserved

¹⁰ Hepburn, Tsukuda, and Fasser (1996), Team Skills Scale, all rights reserved

	Poor	Fair	Good	Very Good	Excellent	
38. Help draw out team members who are not participating actively in meetings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS17

Please rate your attitude, at this point in your training, using a five-point scale.

	Poor	Fair	Good	Very Good	Excellent	
39. Toward other disciplines working in the team setting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS18
40. Towards providing care to the elderly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS19
41. About practicing in a team care environment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	TSS20

	Not at all				Extensively	
42. To what extent do you anticipate an emphasis in geriatrics in your career?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	B1

	Negatively		Neutral		Positively	
43. When choosing (looking) for your next position, how will the opportunity to participate in an interdisciplinary team influence your decision?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	B2

	Not Important				Very Important	
44. To what extent do you believe that your ability to work in an interdisciplinary team will contribute to your professional success?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	B3

	Highly Unlikely				Highly Likely	
45. What is the likelihood that you will seek additional training in team care after completing this program?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	B4

	Highly Unlikely				Highly Likely	
46. What is the likelihood that you will seek additional training in geriatrics after completing this program?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	B5

Please indicate your level of agreement or disagreement with the following statements:

	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree	
47. My personal objectives for this training have been achieved	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SS1
48. I would recommend this training to other students.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SS2
49. The time devoted to this experience was well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

spent and worthwhile						SS3
50. This experience added to my knowledge of geriatrics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SS4
51. As a result of this experience, I feel more confident with geriatric patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SS5
52. This experience added to my knowledge of teams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SS6
53. As a result of this experience, I feel more confident working as part of an interdisciplinary team.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SS7

C. Pre-Test and Post-Test Knowledge Questionnaire

Name: _____

Date: _____

Discipline: _____

School: _____

This test consists of several different types of questions that are designed to assess your knowledge of issues in the care of the older adult. Please read the directions at the beginning of each section and answer accordingly.

Choose the single best answer:

1. Which of the statements below describes the key elements of an *interdisciplinary* team, as distinguished from a *multidisciplinary* team?
 - All of the choices below
 - A, B, and E
 - B, C, and D
 - None of them
 - A, C, and D
 - A. The team is comprised of a variety of professionals who primarily provide discipline-specific care in a parallel fashion.
 - B. Providers contribute care that is coordinated and negotiated with the members of the team, and with the patient and his or her family.
 - C. Leadership is variable depending upon the needs of the patient at any one point in time.
 - D. The values and desires of the patient and the patient's family are the primary foci of the interdisciplinary care plan.
 - E. Since the elderly have so many complex health care needs, the physician is the most important team member and should serve as leader.

2. Constructive *conflict resolution* should include which of the following:
 - A, C, and D
 - A and B

- B and C
- A and D
- All of the choices below

- A. First, openly acknowledge the issue.
- B. Appoint an outside mediator to resolve the issue.
- C. Recognize the underlying emotions.
- D. Put aside your personal and professional differences for the benefit of the patient and his or her family.

3. Which of the following statements about *Medicaid* are true?

- A, B, and D
 - B and D
 - A and D
 - B and C
 - B
- A. The federal government primarily administers Medicaid and the benefits are uniform across all states.
 - B. Medicaid is the single largest payer of long-term care.
 - C. Medicaid provides a comprehensive benefit package that includes dentures and eyeglasses.
 - D. Medicaid requires funds from each state that match the federal contribution.

4. *Competency* includes a thorough evaluation of a person's cognitive capacity and judgment. Which factors below should be used to determine competency?

- A, B, and C
 - All of the choices below
 - A, B, D, and E
 - A, B, C, and E
- A. Accuracy of the historical information provided by the patient.
 - B. Congruency of the information provided by the patient and the information provided by the patient's family.

- C. The patient's acceptance of and compliance with the treatment plan.
 - D. The findings from a mental status evaluation performed at this point in time.
 - E. The patient's demonstrated ability to understand information and make informed choices.
5. Which of the following are *cost-control mechanisms* in a capitated health care plan?
- A, B, and C
 - B, D, and E
 - C and D
 - All of the choices below
 - None of the choices below
- A. Required pre-certification for most hospitalizations.
 - B. A restricted formulary.
 - C. Hospital and clinic quality assurance committees.
 - D. Designated primary care physicians.
 - E. A closed panel of consultants.
6. You are the primary care provider for an 85-year-old diabetic who develops renal failure. She has been frail for some time and has been receiving home health care services from your home health care program. She is enrolled in a capitated health care plan and has a living will. She has no family. You believe dialysis would maintain her current quality of life. The best course of action includes:
- All of the following
 - A, B, and C
 - A, B, C, and D
 - D and E
 - None of the following
- A. Review her values history in the chart to ascertain her stated wishes.
 - B. Reassess her physical status and her mental abilities for competency.
 - C. If she is competent, discuss the changes in her condition and elicit her desires.
 - D. Consult the bioethics committee.
 - E. Make your recommendations to the patient and then report to the team.

True / False

Denote whether the statements below are true or false.

7. True False Physicians and dentists are the only health professionals who have the legal authority to prescribe medications.
8. True False Teams must establish norms that are the basis for group process and for defining team roles.
9. True False Conflict within teams denotes pathological interpersonal communications among team members.
10. True False The practice of health professionals is defined within the discipline-specific Professional Practice Acts for each state.
11. True False All cultures incorporates their beliefs about health and disease into their health care systems.
12. True False One of the best ways to establish trust and rapport with an elderly client is to elicit his or her beliefs and values about end-of-life decisions.

13. There are a number of ethical principals that guide the provision of care to the older adult. Denote whether the *definitions* below are true or false.

- a. True False **Beneficence**
This principle applies to decisions that are made for the benefit of the entire population.
- b. True False **Autonomy**
This principle applies to the individual's right of self-determination.
- c. True False **Nonmaleficence**
This principle requires that we do no harm.
- d. True False **Veracity**
This principle of truth telling based upon the individual's duty to keep his or her promise or word.

14. Which of the following have been major contributors to *reducing health care costs* in geriatric capitated health care plans? Circle all statements that apply.

- Reduced total hospital stays.
- Greater mortality rates.
- Restricted formularies.
- Shorter hospital length of stays.

D. Ongoing Grading Exercise

Sample: Journal Guidelines

The use of a journal by the GITT trainee is designed to tie the didactic classroom to the team experience in the clinical setting. The trainees are requested to keep an ongoing journal of their team experience — impressions, issues, techniques, and outcomes — for their own use to help them organize their thoughts and to provide a beginning guide for educational meetings with their preceptors. In addition to keeping an ongoing journal, trainees will be encouraged to respond specifically to a series of questions. The questions have been selected to complement the curriculum content covered in the GITT Core Curriculum 2001.

Facilitator's Notes

- *At the end of each seminar, assign a journal topic to your students.*
- *Depending on the speed of the course, assign between one and three topics per seminar.*
- *Have the students keep their entries organized and in one place so that the individual student can use them as a reflection tool throughout the course.*

In addition, preceptors / faculty are advised to read the following article on the journaling technique.

Clark, P.G. (1994). Learning on interdisciplinary gerontological teams: instructional concepts and methods. *Educational Gerontology*, 20: 349.

Sample: Journal Questions

1. What is your initial impression of the team(s)? How did it feel to be a “new” member?
2. Describe your team. What kind of team is it?
3. Who does what on the team? Is it what you would expect?
4. How are tasks and responsibilities differentiated? Who decides?
5. In what ways do team members communicate?
6. Do team members always fulfill the same role at each meeting? Do team members move beyond the barriers of their own discipline?
7. How is the patient/family member included in the team decision making? What happens to the team?
8. When the team needs to interact with others outside the team, how is this handled?
9. How is consensus reached?
10. What happens when a “new” discipline / representative joins the team?
11. How important is the setting in which the team meets? Does it influence the team function?
12. How is conflict expressed on the team? What happens?
13. How does the team maintain itself?
14. What are the advantages / disadvantages to individual team members who are part of an interdisciplinary team?

Sample: Simulated Patient Teaching Module⁴

Preface

The simulated patient teaching modules have proven very effective for the GITT students at the University of South Florida, Suncoast Gerontology Center. The teaching modules have enabled the students to practice the basic principles of teamwork and the principles of comprehensive geriatric assessment.

The students reported a positive learning experience. They found the most beneficial aspects to be the live interviews and the team process needed to develop a comprehensive care plan. It encouraged them to employ their newly learned team skills. They formulated two holistic care plans, one early in the course and the other at midpoint. Their first experience was reported as difficult, because of their lack of assessment skills and their inexperience with teamwork. The second experience was reported as a much smoother and more rewarding process. They strongly recommended to continue this exercise and gave us some valuable input for changes that would make the experience even more valuable.

The instructors were able to appreciate a learning curve from the first to the second exercise. The interview process during the first module was slow, unorganized, and incomplete. The students had difficulty assigning tasks to appropriate disciplines. The interview process during the second module was organized. Reports from one interviewer to the other were communicated appropriately and decisions in other areas to assess were decided quickly. The care plan showed an increased understanding of priorities and tasks distribution.

Our objective to “identify and encourage the student to develop the skills necessary to employ a comprehensive geriatric assessment in order to formulate a holistic care plan,” was reached.

The development of these simulated patient teaching modules required the participation of a multidisciplinary team. I want to recognize and offer my appreciation to all the team members.

Overall Goal

1. Train participants in comprehensive geriatric assessment.
2. Train participants in interdisciplinary team process.
3. Train participants in interdisciplinary care planning.

Advanced Preparation

1. Obtain the paid services of actors for the roles of patient and caregiver. May be available through the College of Medicine or the Department of Communication.
2. The number of actors needed depends on the number of simulated teams.
3. Mail simulated patient script to actors 4 to 5 days in advance.
4. Give prior teaching to trainees on interdisciplinary team process.

Time Schedule

1. Schedule a period of 55 minutes for the interview process.
2. Schedule a period of 45 minutes for the interdisciplinary care planning.

Implementation Steps

1. Assign participants to interdisciplinary teams.
2. Assign faculty to observe the overall process of one team (see Faculty Observation Criteria).
3. Give the physician/ARNP participants the physical examination information regarding the simulated patient (see GITT Simulated Patient - physician/ARNP Information) that they will use after the team members determine the sequence of the assessment.
4. Give all participants the general information regarding the simulated patient (see GITT Simulated Patient - Participant Information).
5. Give participants the information on the class assignment (see GITT Simulated Patient - Discussion Matrix).
6. Instruct interdisciplinary team to determine team roles and who should do which part of the assessment and when.
7. The team then assesses the patient/caregiver.
8. Team members meet to discuss findings and to develop an interdisciplinary care plan.

Modifications

1. Ideally, actors play the role of the patient and of the caregiver. If a second actor is unavailable to portray the caregiver, the caregiver's script can be given to the participants instead and the caregiver interview omitted.
2. Optimally, the participants should include medicine, nursing, and social work at a minimum. If one of the disciplines is absent, a faculty member should sit in as a resource person and provide that discipline's perspective.

Attachments

1. Patient's script.
2. Caregiver's script.
3. Physician/ARNP information.
4. Trainee information.
5. Discussion matrix for participant.
6. Faculty observation criteria.
7. Sample interdisciplinary care plan.
8. Faculty information

Patient Script

IDENTIFYING INFORMATION:

I am a 74-year-old Caucasian widow. I have completed high school. I have lived in the area for 6 years. I live in my own home.

CHIEF COMPLAINT OR CONCERN:

I have back pain that is preventing me from getting out of bed. This morning I called 911 to take me to the emergency room and I called my friend to tell her to meet me there.

PRESENT ILLNESS:

In the past 3 days, I have had a fever, cough, and general aches and pains. Yesterday about 1 hour after going to bed, I got up to go to the bathroom. I was feeling unsteady and I toppled backward in the hall. I did not feel lightheaded or dizzy. There were no grab bars to steady myself, so I fell on my buttocks. After the fall I felt a sharp back pain but it did not last long and I was able to get up, walk to the bathroom and go back to bed. But this morning I could not get out of bed because of the back pain. I want to know why I am so unsteady and what I can do about it. I want to be able to walk and participate in activities and not end up in a nursing home.

MEDICAL HISTORY:

I suffer from the following medical conditions:

- Two small strokes, one a year ago and the other 6 months ago followed by problems with swallowing; right arm and leg weakness for a day or so.
- My blood pressure was high 10 years ago and the medication I take keeps it normal.
- I have been taking a baby aspirin once a day since my first small stroke and Propanolol 80 mg two times a day for the last 3 years.

Over-the-counter medications taken (do not mention that you are taking over-the-counter medications unless you are asked specifically):

- Centrum Silver 1 tab every day for the past 5 years.
- Vitamin E 400 units every day for the past year.
- Pepcid (you don't know the dosage) 1 to 2 tablets for stomach ache for the past year.
- Senokot 2 tabs at bedtime when I need it for constipation for the past 15 years.

PAST PSYCHIATRIC HISTORY:

I had a bout of depression following my (husband's / wife's) death. I was not eating, not sleeping, and crying all the time. My doctor gave me a medication for depression for 3 months. I don't remember the name of the medication. He also told me to participate in grief meetings given by hospice and that was very helpful. I did not see a counselor.

SOCIAL RESOURCES:

I have two children, Arlene and Ed. They live out of state and have children and grandchildren of their own. They come to visit a few times a year. My husband (or wife) died 2 years ago and I live on my own. I have several good friends who live in the area. I enjoy playing cards with my

friends and looking at a few favorite TV shows. I read a lot. I visit with my friends at least three times a week. My (husband / wife) left me very little money and this worries me.

REVIEW OF SYSTEMS:

I am unsteady since my two prior small strokes. I am not as active as I was because I am afraid of falling. I have no allergies to food or medication. I never smoked or abused alcohol. I have no problem with urine leakage. I have no family history of Parkinson's disease or Alzheimer's disease. I have arthritis in my fingers.

PHYSICAL EXAM:

- Temperature: 100.2°
- Pulse: 94
- Respiration: 24
- Weight: 140 lbs., with no significant gain or loss.
- Blood pressure: 130/82 lying
- You are alert and oriented (you know where you are and where you live).
- You are wearing a gown and a robe. You are clean and well-groomed.
- You cannot sit or stand because of pain.
- You eat two meals a day, mostly frozen food that you microwave.
- You prepare your own meal maybe once or twice a week. You go out to eat with friends twice a week.
- Your vision is good with bifocal glasses.
- Your mouth is dry.
- You have been coughing up some thick yellow stuff.
- Your second lumbar vertebra (your lower back) is tender to touch.
- When the nurse or doctor bends your arms, your movement is not smooth, but in little jerks.
- When you smile or laugh all your muscles are tight so you do not have much facial expression

TESTS DONE:

- Your blood test shows that your white blood cell count is high, indicating infection.
- An x-ray of your lower back shows a compression of the second bone in your lower spine, which corresponds to the area of your back pain. Your bones are also not as dense as they should be.
- A chest x-ray shows that you have pneumonia in your left lower lung.
- A test done on what you cough up will show what kind of pneumonia you have and will help the nurse or doctor determine which antibiotic to give you. The test will also show that you do not have tuberculosis.

DIAGNOSIS (what the nurse or doctor decides you have):

- 80% compression deformity of the second lumbar vertebra.
- Osteopenia (decreased bone density).
- Left lower lobe pulmonary infiltrate.

- Rule out (determine if you have) Parkinson's disease (because of the slow and decreased movements of your facial muscles and the atypical/abnormal movements of your arms).
- Rule out subdural hematoma (a blood clot in the outer brain that could have been caused by your fall).
- Rule out orthostatic hypotension (a larger than normal decrease in blood pressure when you stand up).
- Rule out TB (tuberculosis).
- Rule out TIA (transient ischemic attack or mini-stroke).
- At risk for PE (pulmonary embolism) and DVT (deep venous thrombosis), because of your age and the fact that you will have to stay in bed for a while.
- Chronic constipation.

MENTAL STATUS EXAMINATION:

A Mini-Mental State Examination (MMSE) shows mild cognitive impairment (see the attached copy of the test). During this exam, you make the following errors:

- You do not give the right date (but you give the right month and year).
- You also make a mistake in spelling "world" backward: you spell it as "D L O R W".
- You also cannot remember one of the three objects they ask you to remember.
- You pick up the paper they present to you with both hands

They also ask you to write the numbers on the face of a clock and to draw the small and long hands at a specific time. You can write the numbers at the right places but you make one error and then correct it. You can draw the small and long hands as requested.

FUNCTIONAL ASSESSMENT:

After 3 days of antibiotics and bedrest, the staff will notice that you require moderate assistance to arise from a chair. You also will show a strong retropulsion when you are attempting to walk (this means an involuntary backward walking). Your blood pressure will be 120/60 when you are lying down and 100/40 when you are standing up.

A Romberg's test is positive to the rear. (They will ask you to stand with your feet together, your arms stretched and palms turned up, and eyes open. Then they will ask you to close both eyes for 20 to 30 seconds.). You will not be able to maintain an upright position and will start falling backward.

A physical therapist will be consulted and will confirm the same things but no other muscular or sensory (feelings and reactions) deficits.

Adapted from Ulfarsson, J., & Robinson, B. E. (1997). Falls and falling. In R. J. Ham, & P. D. Sloane (Eds.), Primary care geriatrics: A case-based approach (2nd ed.). (pp. 360-364). St. Louis: Mosby.

Caregiver Script

SOCIAL RESOURCES:

My friend has two children, Arlene and Ed. They live out of state and come to visit a few times a year. They also call monthly to see how my friend is doing. My friend has been widowed for 2 years and she lives alone in a three-bedroom house. A neighbor's teenage son mows the lawn. My friend is quite active playing cards with our group, looking at TV shows, and reading. Our group of friends visits together three-to-four times a week. We sometimes go out to eat.

My friend is often worried about finances. The children are very supportive and often state that they want to be called about any medical or financial problems.

PHYSICAL HEALTH:

My friend had two episodes of TIAs (transient ischemic attacks) in the past 1½ years, the last one 6 months ago followed by difficulty swallowing and weakness of the right arm and leg for 2-to-3 days. She sometimes talks about having high blood pressure but says it is well-controlled with a prescribed medication. My friend has complained of stomach aches for the past year, mostly following a larger than usual meal.

MENTAL STATUS EXAMINATION:

My friend occasionally forgets which date it is but usually knows the month and the year. We all forget the date sometimes. My friend does not always remember receiving a phone call from the children or grandchildren. My friend does not smile as much as before, although there is still a good sense of humor present.

FUNCTIONAL ASSESSMENT:

My friend has difficulty getting up from lounge chairs and requires our help at times. We have noticed that occasionally my friend starts walking backward. Sometimes my friend's walk is somewhat slower than usual and the balance appears decreased. Our group of friends and myself are concerned about the recent fall and the fact that there is no one living with her.

Physician/ARNP Information

REVIEW OF SYSTEMS:

The patient reports being unsteady after she had two small strokes. The level of physical activity has been markedly reduced because of the fear of falling. There is no allergy to food or medication. The patient never smoked or abused alcohol. The patient denies problems with urine leakage or incontinence. There is no family history of Parkinson's disease or Alzheimer's disease. The musculoskeletal review is positive for arthritis in fingers.

PHYSICAL EXAM:

- Temperature: 100.2°
- Pulse: 94
- Respiration: 24
- Weight: 140 lbs., with no significant gain or loss.
- B/P: 130/82 lying down and 120/60 sitting up
- The patient is alert and oriented.
- The patient is wearing a nightgown and a robe, is clean and well-groomed.
- The patient cannot sit or stand because of pain.
- The patient eats two meals a day, mostly frozen food except for one-to-two meals prepared at home and two meals ordered at the restaurant with a group of friends.
- There is no decrease in visual acuity with bifocal glasses.
- Mouth is dry.
- Expectoration is yellow, obviously purulent sputum.
- There is tenderness overlying the second lumbar vertebra.
- Moderate diffuse cogwheel rigidity
- Diminished facial expression

TESTS RESULTS:

Lab results: white cell count is 13, 400.

X-ray of lumbar vertebrae shows an 80% compression deformity of the second lumbar vertebra, which corresponds to the area of her back pain. There is also presence of osteopenia.

Chest x-ray shows a left lower lobe pulmonary infiltrate.

Sputum gram stain shows many WBCs with mixed gram-positive and gram-negative organisms. The specimen was sent for culture and grew Haemophilus influenza. Sputum was negative for TB.

DIAGNOSES:

After review of systems and physical exam, you have given the following diagnoses:

- 80% compression deformity of the second lumbar vertebra
- Osteopenia

- Left lower lobe pulmonary infiltrate
- Rule out Parkinson's disease
- Rule out subdural hematoma
- Rule out orthostatic hypotension (when patient can stand up)
- Rule out TB (tuberculosis)
- Rule out TIA (transient ischemic attack or mini-stroke)
- At risk for PE (pulmonary embolism) and DVT (deep venous thrombosis)
- Chronic constipation

Trainee Information

IDENTIFYING INFORMATION:

The patient is a 74-year-old Caucasian widow. The patient has completed high school and has lived in the area for 6 years. The patient has been widowed for 2 years and lives alone in a three-bedroom home. The patient called 911 this morning because she could not get up out of bed after a fall sustained during the previous evening. The patient also called a friend who is now waiting in the emergency room. The patient was in the emergency room and is now being admitted to the hospital.

CHIEF COMPLAINT OR CONCERN:

The patient has a back pain that makes it impossible to get out of bed.

PRESENT ILLNESS:

In the past 3 days, the patient has had fever, cough, and general malaise. Yesterday about 1 hour after going to bed, the patient got up to go to the bathroom, felt unsteady, and toppled backward in the hall. There was no lightheadedness or dizziness. There was no grab bar and the patient fell on her buttocks. The patient felt a sharp back pain that did not last long, but she was able to get up, walk to the bathroom, and go back to bed. This morning, the patient could not get out of bed because of back pain. The admitting diagnosis is compression fracture of the second lumbar vertebra.

MEDICAL HISTORY:

The patient's medical history includes:

- Two small strokes, 1 year ago and one ½ year ago with dysphagia (swallowing difficulty) and right hemiparesis (weakness in right leg and right arm) for a day or so.
- Hypertension for 10 years.

The patient is currently taking the following medications:

- Baby aspirin 81 mg q. day since the first mini-stroke.
- Propranolol 80 mg bid for the last 3 years for hypertension.

PAST PSYCHIATRIC HISTORY:

The patient has a previous history of depression following the death of the spouse and was treated with medication for 3 months but does not know the name of the medication. She attended grief sessions at hospice but did not receive individual counseling. The grief sessions were very helpful to her.

Discussion Matrix for Participants

You have 55 minutes to complete the interviews.

Your group should function as a team playing the formal team roles (leader, facilitator, timekeeper, recorder) only if you believe they are necessary to conduct your team decision-making process for the assessment of this patient. Your goal in this class is to have one team member interview the patient at a time. Once one team member interviews the patient, you must send a different team member to interview the patient.

You may wish to use the attached discussion matrix as a guide, identifying the major medical, emotional, social, environmental, and economic issues in the case.

You have 45 minutes to develop an interdisciplinary care plan that addresses the following questions:

1. What is the main problem and goal for your patient?
2. Identify the major issues in this case and prioritize them from your perspective. Justify your priorities.
3. What are the strengths of the patient/family?
4. What, if any concerns (weaknesses) do you have about the care plan?
5. Who should work on what issue in what time frame?
6. How would you monitor the care plan?

Adapted from Minnesota Geriatric Interdisciplinary Team Training Program at the University of Minnesota. (1998). Steps in assessing patient needs. In M. Meako, & T. Fulmer (Prepared by) GITT Curriculum Compendium (Draft) (p. 387). New York: New York University, School of Education, Division of Nursing.

Faculty Observation Criteria

A. Observe the implementation of the seven-step meeting process.

1. Clarify the objectives.
Ensure that all trainees understand and are in agreement with the meeting objective.
2. Review the roles.
Review who will be timekeeper, recorder, leader, and facilitator. Decide how feedback on time will be given.
3. Review the agenda.
4. Work through the agenda items and seek closure on each issue raised.
5. Review the meeting's record, summarize agreements, and be certain each task has a person taking responsibility and specific timeline for completion of task.
6. Plan the next steps and the next meeting agenda.
Decide who will do what before the next meeting. Decide what the objective and agenda items will be for the next meeting.
7. Evaluate the meeting.
What did the team do well that it should continue doing? What could the team do differently to improve the meeting, group, and continual improvement processes?

Adapted from Executive Learning. (1997). Using teams for improvement. In Executive learning handbook for improvement: a reference guide for tools and concepts.(Healthcare 2nd ed., p. 66). Brentwood, TN.: Executive Learning.

B. Evaluate trainees' skills using preceptor evaluation form - Team Skills Scales.

1. See HGITT Team Observation Tool.
2. See the John A. Hartford Foundation GITT Preceptor Evaluation of Trainee's Team Skills.

USF - GITT Simulated Patient Teaching Module - Interdisciplinary Care Plan

Date	Problems/Needs	Goals	Interventions	Discipline	Eval date
<p>Main Problem: Main Goal: Friend: fall prevention Patient: relieve pain, return to ambulatory state as soon as possible, learn origin of unsteadiness and prevent it Team: rehabilitation, fall prevention, and return to safe home environment</p>					
01/06/00	Low back pain secondary to compression deformity.	<ol style="list-style-type: none"> 1. Maintain pain to a tolerable level for the patient. 2. Prevent constipation secondary to meds. 3. Return to ambulation as soon as possible 	<ol style="list-style-type: none"> 1. Monitor pain q. 6 hrs based on scale of 0-10. Roxicodone 5 mg q. 6 hours. Monitor side effects q. 6 hrs. 2. Monitor bowel movements. Prophylactic stool softener (Senokot 2 tabs at bedtime). 3. Consultation to PT for ROM and ambulation. 	RN/LPN DR/ARNP RN/LPN/ CAN - DR DR/ARNP PT	01/06 01/06 01/06
01/06/00	Acute illness: pneumonia	<ol style="list-style-type: none"> 1. R/O TB 2. R/O aspiration pneumonia. 3. Maintain patent airway. 4. Maintain Pulse Ox at > 90% 5. Prevention measures 	<ol style="list-style-type: none"> 1. Cephalosporin IV x 3 days than po x 4-7 days Follow-up chest x-ray 2. Sputum for C&S and AFB smear 3. History of skin testing 4. Follow-up CBC with/diff, chem. panel 5. Mucomist 10%, 2cc with Albuterol nebulizer sol. 1 vial via nebulizer q. 8 hrs x 2 days 6. Deep breathing, coughing, and turning q. 4 hrs 7. Pulse Ox q. 8 hrs and prn 8. Monitor VS q. 4 hrs x 48 hrs than q. 8 hrs 9. Initiate influenza vaccination and pneumococcus vaccination 	DR/ARNP RN/LPN X-Ray tech DR/ARNP Lab tech RN/LPN DR/ARNP RT/ RN/LPN RN/CAN RT/LPN CAN DR/ARNP	01/06 01/06 01/07 01/08 01/08 01/06 01/06 pre-D/C
01/06/00	At risk for complications of immobility	<ol style="list-style-type: none"> 1. Prevent pulmonary embolism and DVT 2. Maintain functional ability 	<ol style="list-style-type: none"> 1. Support stocking 2. ROM q. 4 hours 3. Sequential compression device q. day 4. Aspirin 81 mg q. day 5. Evaluate for dyspnea, tachycardia, pleural rub, 	RN/CAN PT/CAN DR/ARNP PT DR/ARNP RN/LPN	01/07 01/06 01/07 01/07 01/06

Date	Problems/Needs	Goals	Interventions	Discipline	Eval date
			pleuritic pain q. 4 hours while on bedrest 6. Deep breathing, coughing, and turning q. 2 hours x 24 hours than q. 4 hrs	RT LPN/CNA	01/06
01/06/00	Cognitive impairment	1. R/O TIA 2. R/O subdural hematoma 3. R/O dementia vs. delirium (reversible causes) 4. Safety issues 5. R/O depression	1. CT scan of the brain. 2. MMSE. 3. Assess for impaired judgment, IADLs and ADLs 4. Assess for ability to take medications and simplify medication routine. 5. Complete dementia workup: TSH, Folate, B12, Chem. panel, RPR, Mg, Ca, UA w/C&S, CBC w/diff. 6. Geriatric depression scale	DR/ARNP RN/LPN SW RN/LPN CNA/OT RN/LPN DR/ARNP DR/ARNP RN/LPN SW	01/07 01/08 01/08 01/10 01/08 01/08
01/06/00	At risk for fall	1. Obtain history of fall 2. Safe and increased mobility 3. Safe environment 4. Rule out orthostatic hypotension 5. Prevent post-fall syndrome 6. 24 hr Holter monitor, rule out SSS (sick sinus syndrome)	1. Fall risk assessment scale 2. Gait assessment (Tinetti balance and gait evaluation) and train in assistive device if needed 3. Screen for functional ability (mobility assessment test) 4. ROM especially cervical ROM and response to head movement, joint deformity and stability 5. Muscle strength and tone (lower extremities) 6. Exercise prescription when patient stabilized 7. Blood pressure when lying, sitting and standing 8. Medication review (change Propanolol to another antihypertensive, not beta-blocker) 9. Perform cerebellar tests 10. Evaluate visual acuity 11. Peripheral sensation, test for P.A.D., and stretch reflexes 12. Feet and footwear 13. The Cage questionnaire (alcohol use) 14. Home evaluation 15. Evaluate cognition (already planned)	RN/LPN RN/LPN PT PT OT/CNA PT PT CNA DR/ARNP DR/ARNP DR/ARNP DR/ARNP PT Podiatry SW	01/08 01/08 01/08 01/06 01/08 pend. 01/08 01/10 01/10 01/10 01/10 01/11 01/11

Date	Problems/Needs	Goals	Interventions	Discipline	Eval date
				OT/SW	by NH
01/06/00	Parkinsonism signs	<ol style="list-style-type: none"> 1. Rule out Parkinson's disease 	<ol style="list-style-type: none"> 1. Obtain family history of Parkinson's disease 2. Complete neuromuscular evaluation 3. Start treatment if indicated 4. Prevent secondary constipation (high fluid intake, high-residue diet) – Senokot prn. 	RN/LPN Psy/Neuro Psy/Neuro DR/ARNP RN/Dietic.	01/10 01/10 01/11 01/11
01/06/00	Osteopenia	<ol style="list-style-type: none"> 1. Rule out endocrine abnormalities 2. Rule out nutritional deficiencies 3. Pain management 4. Prevention of fractures 5. Minimize bone loss 	<ol style="list-style-type: none"> 1. Thyroid profile, Ca serum level 2. Serum albumin and pre-albumin 3. Calcitonin-salmon (Calcimar or Myacalcin) for analgesia 100 IU daily 4. Elemental calcium 1000 mg with vitamin D 400 IU daily 5. Weight-bearing exercises 6. Calcitriol therapy 	DR/ARNP DR/ARNP DR/ARNP DR/ARNP PT DR/ARNP	01/08 01/08 01/07 01/08 Pend Pend
01/06/00	Poor economic resources	<ol style="list-style-type: none"> 1. Obtain economic support necessary for rehabilitation and post-rehabilitation 2. Involve children in planning of economic resources 	<ol style="list-style-type: none"> 1. Assess financial needs and children's financial support 2. If necessary, explore sources of financial aid, particularly as it related to alternative medications not covered by traditional programs (drug-free programs) 3. Explore possibility of assistance with home care including house cleaning, laundry 	SW/Case Manager SW/Case Manager SW/Case Manager	01/08 01/08 01/08
01/06/00	Discharge planning	<ol style="list-style-type: none"> 1. Continued rehabilitation 2. Safe transition to home environment 3. Maximum independence 4. Case management oversight 	<ol style="list-style-type: none"> 1. Discuss with patient, friend, family the temporary placement in a safe environment (nursing home) for a continued rehabilitation program with follow-up home health care. 2. Complete home evaluation and environmental modifications to eliminate fall risks. 3. Plan for community-based services: Meals-on-Wheels, emergency service. 4. Medication reminder system. 5. Assess access to transportation for Dr. visits, 	SW/Case Manager (CM) DR/ARNP SW/HH SW/PT HH SW/CM RN/HH	01/09 Pend. Pend. Pend. Pend.

Date	Problems/Needs	Goals	Interventions	Discipline	Eval date
			groceries, etc. 6. Contact representative from social network if patient agrees to obtain support in implementation of care plan.	SW/CM	01/09
01/06/00	Status of advanced Directives	1. Evaluate advanced directives including DNR 2. Find out the designated health care surrogate 3. Determine who will be designated as health care decision maker in case of emergency	1. Discuss with patient on admission – if no advanced directives written, explain the need to have a hospital standard form signed by patient 2. Discuss with children, close friend, and patient who will be designated as health care surrogate and who will make decisions in case of emergency (need for a person living in close proximity to the patient)	Admission SW SW DR/ARNP	01/06 01/10
01/06/00	Emotional issues	1. Facilitate adjustment to discharge planning 2. Guide through adaptation to disease process	1. Contact minister if patient agrees 2. Administer the “Worry Scale” and Geriatric Depression Scale 3. Discuss coping strategies 4. Patient education on fall prevention and disease process 5. Suggest lifeline to reduce patient and family anxiety regarding the potential for fall 6. Refer to Parkinson’s disease self-help group	SW/CM Parish nurse SW DR/ARNP RN/LPN SW/ARNP DR/ARNPP T/RN DR/ARNPS W/CM DR/ARNPS W/CM	01/07 01/09 01/09 01/06 Pend. 01/10

Louissette A. Boucher, ARNP, Regina Velasco, M.D, Geri-Psych. Fellow, & Sandra Mutolo, LCSW, Paatricia L. Geasa. University of South Florida, Suncoast Gerontology Center, 01/06/2000.

Faculty Information

1. Teaching points

The team should recognize that patient, family, and close friend are an integral part of the team.

This case gives an opportunity to discuss the following:

Falls

- Complex background of a simple incident.
- Processes and falling (dynamic balance, sensory and central processes, MS function).
- Factors increasing the falling risk.
- Disorders commonly associated with gait disturbance.
- Examination of the unsteady or falling older adult.
- Interventions to prevent falls.
- Assessment scales (ex: fall risk, Tinetti, ADLs).
- Exercise program for older adults.
- Factor to assess for home safety.
- Definition of post-fall syndrome.
- Premonitory fall is a common presentation of illness in older adults and the fall may dominate the picture.
- Patients with dementia are prone to undertake activities exceeding their abilities.
- Functional changes must be considered as subtle indication of potential thyroid disorder.
- Discuss use of Holter monitor to diagnose possible sick sinus syndrome.

Delirium versus dementia

- Discuss differential diagnosis between delirium and dementia.

Pneumonia

- Expected signs and symptoms are frequently absent in older adults; Tachypnea (>28) is often the earliest clue.
- Normal breath sounds and voice sounds in older adults whose baseline is diminished may actually signify increased transmission and consolidation.

Tuberculosis

- Older adults remain the major reservoir.
- TB has a higher incidence in nursing homes.

Parkinson's disease

- Two or more symptoms should be documented on PE for at least 6 months or more consecutive exams to give the diagnosis.

Subdural hematoma

- The symptoms may not be evident for days or weeks due to the cerebral atrophy of normal aging.

Functional ability

- Older adults often view their health status from a “functional viewpoint.”
- Acute illness often results in functional losses that may become permanent if a rehab approach is not used.

2. What is the main problem and goal for your patient?

The **main problem** in this simulated case is prevention of recurrent falls.

The **main goal**:

- for the friend is to mobilize support in order to decrease fall risks.
- for the patient is to control pain and return to safe ambulation.
- for the team is to plan a rehabilitation program, prevent further falls, and return the patient to a safe environment.

3. Identify the major issues in this case and prioritize them from your perspective. Justify your priorities.

See care plan for issues and prioritization.

4. What are the strengths of the patient/family?

- Patient’s desire to return to ambulatory state as soon as possible.
- Patient’s engagement with friends and family.
- Potential to mobilize support from friends and family.
- Potential to involve children in financial support.
- Patient’s mild comorbidity.
- Patient’s negative history of smoking and alcohol use.

5. What, if any, concerns (weaknesses) do you have about the care plan?

- Unknown environmental hazards.
- Patient’s level of cognitive impairment.
- Economic resources.
- Chances of returning to live in her own home.

6. Who should work on what issue in what time frame?

See Interdisciplinary Care Plan.

7. How would you monitor the care plan?

See Interdisciplinary Care Plan.

8. Teaching tools

A. *Ulfarsson, J., & Robinson B. E. (1997). Falls and falling. In R. J. Ham, & P. D. Sloane (Eds.), Primary care geriatrics: A case-based approach (2nd ed.).(pp. 311-320). St. Louis: Mosby.*

- Disorders commonly associated with gait disturbances p. 315
- Examination of the unsteady or falling patient p. 315
- Interventions to prevent falls p. 316
- Exercise prescription for the older person p. 317

B. *Functional Assessment Tools* handout:
Ebersole, P., & Hess, P. (1994). Toward healthy aging: Human needs and nursing response(4th ed.). St. Louis: Mosby.

- The worry scale p. 577.

E. Geriatric Knowledge Final Evaluation: Case Study of Mrs. M.

Mrs. M.

Written by: Bob Kane, Neil Henderson, and Kathy Hyer for CSWG
Revision 5/29/97
The John A. Hartford Foundation, Inc.
Geriatric Interdisciplinary Team Training Program (GITT)

INSTRUCTIONS FOR CASE STUDY:

You are part of a new training program on Geriatric Interdisciplinary Team Training funded by The John A. Hartford Foundation of New York City. You are about to read a short patient vignette describing the medical and psycho-social issues surrounding a fairly typical geriatric patient. The vignette is deliberately brief but contains enough information for you to answer the questions on the attached page. Please take no more than 20 minutes to read the case and answer the questions.

Mrs. M is a 76-year-old widow with a history of chronic obstructive pulmonary disease (COPD) and hypertension. She comes to the clinic today complaining about wheezing and difficulty walking. A month ago, she was discharged from the hospital two weeks after falling and fracturing her hip. A hip prosthesis was inserted and she was sent home with physical therapy at (PT) home for weight bearing and to teach the use of a four-pronged cane. Her current medications include a calcium channel blocker (for hypertension), a Ventolin inhaler (for COPD), Ativan (a sleeping pill), and Dyazide (a diuretic).

She lives alone in a first floor apartment. She can perform all of her basic ADLs although she has a little difficulty getting on and off the toilet and taking a full bath. Due to her problems with walking and shortness of breath, she cannot clean her apartment and can only prepare light meals. Mrs. M rarely leaves her home and has reduced her phone visits with friends and family due to hearing loss. Mrs. M has a close relationship with all of her three children. Her one local daughter currently does all of Mrs. M=s shopping and transportation and also helps with meal preparation. She is also receiving six hours a week of personal care from a home health aide.

Mrs. M receives Social Security and a small widow ' s annuity and the PT and home health aide are Medicare-reimbursed services. Her daughter has accompanied her to the clinic visit and expresses concern that Mrs. M is too unsteady to stay at home alone.

GITT Implementation Manual 2001

She feels that Mrs. M should enter some type of assisted living for her safety and for more companionship than she has living alone. Mrs. M is vehement in her desire to stay in her apartment.

TRAINEE TEST OF GERIATRIC INTERDISCIPLINARY CARE

Trainee ID	<input type="text"/>	Trainee DOB	<input type="text"/>	<input type="text"/>	<input type="text"/>
	First Letter of Last Name and Last 4 digits of Social Security Number		Month	Day	Year
Today's Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	Project ID	<input type="text"/>
	Month	Day	Year		
Case Study ID	<input type="text"/>	Clinical Setting ID	<input type="text"/>		

DIRECTIONS: Take no more than 20 minutes to read and to answer the following questions about the case you just read. Be specific with your answers. We penalize guessing. Be careful with abbreviations. PLEASE PRINT

A. IDENTIFYING THE DOMINANT ISSUE

1. What is the **ONE** dominant issue with regard to this case?

CS1

2. What are the **THREE** patient-specific problems that should be addressed first?

- | | |
|----|-------|
| a. | CS2a. |
| b. | CS2b |
| c. | CS2c |

B. DEVELOPING A PLAN OF CARE

3. List the **THREE** most important factors that complicate the plan of care.

- | | |
|----|------|
| a. | CS3a |
| b. | CS3b |
| c. | CS3c |

4. List the **THREE** most important positive factors in this case that you would build on for the plan of care.

- | | |
|----|------|
| a. | CS4a |
| b. | CS4b |
| c. | CS4c |

TRAINEE TEST OF GERIATRIC INTERDISCIPLINARY CARE

Trainee ID

5. Thinking about the three patient-specific problems you listed in question 2, who is most appropriate to be involved in developing the plan of care? What are the primary contribution(s) that each person would make? If a nurse is involved in the plan of care, please be specific about the type of nurse

Who is most appropriate to be involved in developing the plan of care?	What are the primary contribution(s) that each person would make?
cs5a1	cs5b1
cs5a2	cs5b2
cs5a3	cs5b3
cs5a4	cs5b4
cs5a5	cs5b5

Who is most appropriate to be involved in developing the plan of care?	What are the primary contribution(s) that each person would make?
<p style="text-align: right;">cs5a6</p>	<p style="text-align: right;">cs5b6</p>
<p style="text-align: right;">cs5a7</p>	<p style="text-align: right;">cs5b7</p>
<p style="text-align: right;">cs5a8</p>	<p style="text-align: right;">cs5a9</p>
<p style="text-align: right;">cs5a9</p>	<p style="text-align: right;">cs5b9</p>
<p style="text-align: right;">cs5a10</p>	<p style="text-align: right;">cs5b10</p>

CASE STUDY 1: QUESTION 1

What is the one dominant issue?

CODE CATEGORY	SCORE
Ability to maintain independent living / living alone	3
Different expectations between patient and daughter	2
Safety concerns	2
Patient's functional self-care decline	2
Decreased mobility	1
Patient competency	0
Isolation	0
Medical illness	0
Risk for falls	2
Wrong	0

CASE STUDY 1: QUESTION 2

What are the three patient specific problems that should be addressed first?

CODE CATEGORY	SCORE
Safety concerns / risk for falls	3
COPD not well controlled	3
Immobility	3
Hypo / hypertension	2
Instability of medical problems	2
Patient compliance with medications	2
Social isolation	2
Medication review and adjustment	2
Medication side effects	2
Potential for depression	1
Limited finances	1
Sleep disturbances	1
Hearing loss	2
Need for assist with ADL	3
Patients inability to live alone	1

CASE STUDY 1: QUESTION 3

List the three most important factors that complicate care.

CODE CATEGORY	SCORE
Conflict with daughter / different expectations	3
Patient's desire for independence / to stay in her own home	3
COPD not well managed	3
Medication side effects	2
Medication compliance	2
Patient lives alone	1
PT / HHA benefits about to expire	1
Need for additional support systems	0
Nutrition risk	0
Possible depression	0
Cognitive status	-1
Recent hip FX with rehab issues	2
Mobility	1
Difficulties with ADLs	2
Limited resources	2
Social isolation	2
Dependent on DTR for ADL needs	0
Hearing loss	2

CASE STUDY 1: QUESTION 4

List the three most important positive factors in this case that you would build on for the plan of care

CODE CATEGORY	SCORE
Family support	3
Patient's desire for independence	3
Living in apartment complex	1
Patient's independence	3
Desire to stay in apartment	2
Home care in place	2
Potential for improvement in health	1
Patient had ADL function	2
Community resources possible	2
Medicare reimbursement	2
Patient lives on first floor	2
Patient willing to accept assistance	2
Some financial resources	1
Cognition intact	0
Potential to improve social isolation	0

CASE STUDY 1: QUESTION 5a

Who is most appropriate to be involved in developing the plan of care?

CODE CATEGORY	SCORE
F. Physician / Primary Care Provider	1
NP /PA	1
Social Worker / Social Services	1
Patient	1
Family (Spouse / Child / Daughter-in-law)	1
Visiting Nurse	1
PT / OT / Kinesiotherapist	1
Pharmacist (RPh)	0
Mental Health Professional	0
Nutritionist / Dietitian	0
Neurologist	0
Pastor / Chaplain	0
Nurses Aide	0
Speech Therapist	0
Clinic Staff	0
Clinic Nurse	0
Recreation Therapy / Activity Therapy	0
Attorney	0
Team Leader	0
Geriatric Specialist	0
Medical Ethicist	0
Other Person (Housekeeper, Homemaker, Volunteer...)	0
Non-Person (Home Care, Meals on Wheels, Community Resources, Transportation...)	0
Case Manager	0
Audiologist / ENT	0
Respiratory Therapist	0
Orthopedist	0

CASE STUDY 1: QUESTION 5b

MD Tasks

CODE CATEGORY	SCORE
Evaluate and change medications as needed	1
Order home health care	1
Assess and evaluate COPD	1
Medical assessment and work up	1
Evaluate falls risk	1
Evaluate hypo / hypertension	1
Assess hip fracture	1
Evaluate and treat blood pressure	1
Evaluate sensory deficits	1
Assess mental health (cognitive status and depression)	1
Evaluate competency of patient and daughter	1
Evaluate insomnia	1
Evaluate adequacy of assistive devices	1
Osteoporosis screen	1
Jargon	0

CASE STUDY 1: QUESTION 5b

NP / PA Tasks

CODE CATEGORY	SCORE
Evaluate ataxia / falls risk	1
Hearing evaluation	1
Evaluate and review medications	1
Assess ADL / potential for improved function	1
Physical exam	1
Evaluate need for assistive devices	1
AD discussion	1
Home visits for follow-up care	1
Evaluate depression	1

CASE STUDY 1: QUESTION 5b

SW Tasks

CODE CATEGORY	SCORE
Work with family	1
Coordinate community and home care services	1
Assess caregiver burden	1
Assess finances / entitlements	1
Explore and coordinate alternative living arrangements	1
Order medical equipment	1
Review advance directives	1
Home assessment	1
Obtain history	1
Assist with increased socialization	1

CASE STUDY 1: QUESTION 5b

PATIENT Tasks

CODE CATEGORY	SCORE
Ensure patient participates in decision making	1
Determine patient's goals	1
Maintain compliance with medical regime	1

CASE STUDY 1: QUESTION 5b

FAMILY Tasks

CODE CATEGORY	SCORE
Establish legal guardianship	1
Support patient	1
Express their needs	1
Monitor care	1
Assist with ADL	1

CASE STUDY 1: QUESTION 5b

VISITING NURSE Tasks

CODE CATEGORY	SCORE
Home Evaluation	1
Coordinate care plan / case management	1
Evaluate falls risk	1
Review medications and compliance	1
Review health maintenance	1
Evaluate sensory deficit	1
Educate patient / family	1
Monitor blood pressure	1
Assess mental status (cognition and depression)	1
Assess COPD	1
Assess sleep	1
Assess for complications of hip fracture	1

CASE STUDY 1: QUESTION 5b

PT / OT Tasks

CODE CATEGORY	SCORE
Assess the hip fracture	1
Assess ADL	1
Assess falls risk / gait / mobility	1
Home evaluation	1
Evaluate and adapt home with devices	1
Strengthening exercises	1
Teach ADL skills	1

F. Team Dynamics Final Evaluation: Videotape of Mrs. Busby

Mrs. Busby: Script

Video Script 3 “Case of Mrs. Busby” **By the GITT Case Studies Work Group**

Roles:

Physician:	Gloria Schmitt
Nurse Practitioner:	Rosemarie Toner
Pharmacist:	Phil Drinka
Social Worker:	Ruth Ann Thomas

Narrator: Four members of the health care team are assembled for their weekly 8 a.m. meeting. The purpose of this meeting is to develop a plan of action for the clients discussed. Present in the meeting are Ruth Ann Thomas, the social worker, Rosemarie Toner, the nurse practitioner, Phil Drinka, the pharmacist and Gloria Schmitt, the internist.

Social Worker: It’s already 8:05. Let’s start our meeting you guys. I want to remind you that you have to fill out the entire patient encounter form when you see the patient. Whenever you leave stuff out, it makes my job a lot more difficult, so I’m asking you to please go back and fill in the missing data.

Physician: Can we move this meeting along? I’ve got a lot of patients scheduled today.

Physician’s beeper sounds but she writes down the number and doesn’t leave the meeting.

Pharmacist: Yeah, I've got a really crazy day, myself.

Social Worker: Rosemarie, you said you'd begin with Mrs. Busby. Right?

Nurse Practitioner: I didn't know I was scheduled to begin with Mrs. Busby. When did you decide that?

Social Worker: Last week. Remember Mrs. Busby was scheduled for last week's meeting but you had to leave half way through? I left a message on your voice mail. Didn't you get it?

Nurse Practitioner: Oh, I don't remember getting the message but sure, I can start us off. Here she is. Mrs. Busby is an 88-year-old white woman living alone in a one-bedroom apartment over in the Fairhaven complex. She's been our patient for the last six months. She's got hypertension, congestive heart failure, osteoporosis, glaucoma and hearing loss. I'm worried that she'll have difficulty maintaining her independence because her vision and hearing are really getting bad. She's able to perform all her ADLs now but she has to have help from neighbors with shopping. Her Mini Mental scores 27/30. I've decided to treat her with ramipril for her heart and fosomax for the osteoporosis. She takes an aspirin every other day. I've also ordered hearing and vision evaluations.

Social Worker's beeper goes off and she leaves to answer it.

Physician: Hearing loss in the elderly can be caused by many different things. One needs to think about whether this is a build-up of wax, if this person has some sort of temporary hearing loss, or whether its drug reaction. With acute hearing loss one could also consider giant cell arthritis. The diagnosis is established with a temporal artery biopsy specimen in which the characteristics necrotizing

granulomatous vasculitis can be seen. The serious complication of blindness can be averted if the patient is quickly treated with daily oral prednisone ranging from 40 - 60 mg. The activity of GCA can be followed by monitoring the sedimentation rate. Any ischemic complications occurring before the treatment is begun however are not likely to be reversed.

Nurse Practitioner: But, the patient never complained about pain when chewing food or about temporal pain.

Pharmacist: Why are you suggesting that her hearing loss may be a symptom of giant cell arthritis? That's extremely rare. And Rosemary's just said there's no temporal pain.

Physician: Yeah, you're right, GCA is highly unlikely. Rosemarie what were your findings when you did her workup for hearing loss?

Social Worker returns and cuts off NP.

Social Worker: Remember John Heinemann who was here last month? Well, he's back in the ER. I've gotta get down there soon. Have we got a plan for Mrs. Busby?

Nurse Practitioner: I was answering Gloria's question about Mrs. Busby's hearing. When I examined her there was wax in her ears, but I cleaned it out and her hearing was still poor. I've ordered a hearing evaluation. When we get the results, I'm sure I'll need Ruth Ann to order the hearing aid.

Social Worker: Maria's the Clerk, she orders hearing aids.

Nurse Practitioner: Can you follow up with her to be sure?

Social Worker: Maria's very efficient. By the way, how will the cost of the hearing aid be covered?

Nurse Practitioner: Covered? I thought the hearing aid would be covered by Medicare. She's 88.

Social Worker: Medicare doesn't cover hearing aids and Mrs. Busby doesn't have other insurance and she's really worried about money. I got her into the State subsidized prescription program last month and I promised her I'd start her Medicaid application as soon as I got the medical information I need. Phil are there any recommendations you'd make about her drugs in terms of cost and compliance? Generics are required in the state-subsidized program, aren't they?

Pharmacist: They sure are. Rosemarie's recommended an ace inhibitor and fosomax. Both are expensive. Fosomax also needs to be taken with a large glass of water prior to eating. Patients generally take it in the morning; many don't tolerate it well. I'm not even sure if that's on the approval list of drugs yet. Some of the ace inhibitors have less expensive generic equivalents. We might want to think about one of them.

Physician: I agree. I'll order the generic.

Nurse Practitioner: Wait a minute Gloria. (Let's not be too hasty). *I'm* the one who ordered the prescriptions. Phil, would going with the generic pose any problems in managing her CHF and hypertension? What do I look for in monitoring Mrs. Busby's response to changing the ace inhibitor?

Pharmacist: Sure there are differences. I'll figure out the side effects and give you a call. Then you and Gloria can fight over who orders the new ace inhibitor and if you want to continue with the Fosomax.

Social Worker: Okay guys, let's move along here. Rosemarie, if you get me the medical information I need to process the Medicaid application, I'll file it right away.

Nurse Practitioner: Sure. I do everything else around here. I'll put it in my pile and get back to you.

Social Worker: Okay. Let's keep plowing through these cases. We have 18 minutes for the next five patients and Mr. Heinemann's waiting for me in the ER.

End.

TRAINEE TEST OF TEAM DYNAMICS

Trainee ID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Trainee DOB	<input type="text"/> <input type="text"/> <input type="text"/>	
	First Letter of Last Name and Last 4 digits of Social Security Number	Month	Day	Year
Today's Date	<input type="text"/> <input type="text"/> <input type="text"/>	Project ID	<input type="text"/>	
	Month	Day	Year	
Video ID	<input type="text"/>	Clinical Setting ID	<input type="text"/>	

DIRECTIONS: You have just viewed a video of a geriatric team meeting. Please take 10 minutes to complete these questions. The first three items focus on team dynamics and the final two items focus on the effectiveness of the team meeting in meeting the patient's needs. In the first three questions please be certain to list specific behaviors you observed. The final questions require a judgment and request up to three reasons why you feel the meeting was very valuable or not valuable in establishing or improving the care plan for the patient. **PLEASE PRINT**

A. Team Dynamics Questions

1. On the scale below, please circle a number representing your perception of the team's functioning. **10 is HIGHLY EFFECTIVE** and **1 is HIGHLY INEFFECTIVE**.

Highly
Effective 10 9 8 7 6 5 4 3 2 1 Highly
Ineffective

2. Please list specific behaviors you observed in the team meeting. Be as concrete as possible. For example, a correct answer would be, "the social worker disrupted the meeting when she arrived late" rather than "the social worker disrupted the meeting". You may want to consider skills in the following areas: running meetings, leadership, communication, conflict management, recognition of other team members, etc.

TRAINEE TEST OF TEAM DYNAMICS

Trainee ID

--	--	--	--

Effective Behaviors : List the discipline and the behavior	Ineffective Behaviors: List the discipline and the behavior
v2a-z	v2aa-zz

3. List **THREE DIFFERENT** ways you would have responded to these ineffective behaviors.

- a.
v3a
- b.
v3b
- c.
v3c

B. TEAM EFFECTIVENESS QUESTIONS

4. How valuable was the team meeting in establishing or improving the care plan for the patient?
Please circle a number that represents your judgement. **10 is VERY VALUABLE and 1 is NOT AT ALL VALUABLE.**

v4

Very Valuable **10** **9** **8** **7** **6** **5** **4** **3** **2** **1** **Not at All Valuable**

5. Please give **THREE DIFFERENT** reasons why you circled the number you did in Question 4.

- a.
v5a
- b.
v5b
- c.
v5c

Faculty Information Notes

Video Tape #3: Mrs. Busby

RANK TEAM'S FUNCTIONING:

An answer of 3, 4, or 5 is the best answer (if scoring, this would receive 10 points).

An answer of 2 or 6 would receive 5 points.

An answer of 1, 7, 8, 9, or 10 is wrong and would receive no points.

EFFECTIVE BEHAVIORS

The following examples represent **effective behaviors** (the discipline and their behavior).

1. SW raised patient's finances/asked Pharm appropriate questions re: generic drugs.
 - SW drew out Pharm on cost/reimbursement issues.
 - Pharm and SW voiced agreement re: ordering generic drugs.
 - SW saw problems of patient (i.e., financial stress) as an interdisciplinary issue re: med management, payment for hearing aid -- attempted to resolve problem.
2. Pharm educated other team members.
 - Pharm offered helpful alternative medications and responded effectively to NP request for advice.
 - Pharm shared information and made commitment to get more info to group.
 - Pharm willing to share helpful information re: medication compliance.
3. NP/Pharm appropriately confronted MD re: GCA.
 - Pharm and NP voiced agreement re: hearing loss symptoms.
 - Pharm and NP posed appropriate questions to MD about why she is concerned about giant cell arteritis.
 - Pharm was able to raise with MD why she was discussing a real medical diagnosis for patient's hearing loss.
4. NP elicited expertise from Pharm re: generics.
 - Respectful dialogue between Pharm and NP.
 - NP asked Pharm appropriate question about ACE inhibitor.
 - NP willing to listen to Pharm's recommendations on generics.
5. NP presented cohesive information re: case.
 - NP was willing to present patient despite not knowing in advance that she was going to be requested to do so. She demonstrated flexibility and she was prepared.
 - Although caught by surprise, the NP was prepared and willing to give her report.

6. MD followed-up with NP re: hearing evaluation.
 - MD asked NP about results of hearing test.
 - RN, MD, Pharm explored alternative causes for hearing loss.
7. Team members recognized roles/discussed issues.
 - All team members were prepared and participated in discussion.
 - Provision of food at beginning of meeting suggested some level of informal sharing among team members.
 - The team continued their discussions when facilitator left the meeting abruptly.
8. MD ignored page.
 - MD did not respond to her beeper when it went off.
9. Group attentive.
 - Pharm seemed attentive.
10. SW assumed organizer role (agenda, moves meeting along).
 - SW brought session to closure to move people along (process, leadership).
 - SW organized, assigned tasks, tried to maintain focus.
 - At least SW appeared motivated to move the group on tasks but did not know how.
11. The following examples represent **wrong answers** (e.g., effective behaviors)
 - SW began meeting on time.
 - SW accepted responsibility for follow-up.
 - Pharm facilitated conflict between NP/MD over medication orders.
 - NP confronted SW and MD.
 - Team accepted MD expertise.
 - Team on time.
 - NP accepted responsibility.
 - MD shared knowledge

INEFFECTIVE BEHAVIORS

The following examples represent **ineffective behaviors** (the discipline and their behavior).

1. SW not effective team leader.
 - SW was in too much of a rush and closed discussions prematurely.
 - MD side conversations with NP/Pharm over coffee even though SW had initiated meeting.
 - Too many patients for the time allotted -- too pressured.

- SW brought up unrelated issues -- encounter forms.
2. SW interrupted/disrupted meeting.
 - SW interrupted meeting to get page and when she returned, talked about another case.
 - SW: beeper interruption, left meeting, interrupted inappropriately.
 - SW: left, returned, interrupted group discussion, and then hurried the team through the case before care decisions were finalized.
 3. SW started meeting late.
 - Team off to a late start.
 - SW started the meeting late.
 - The meeting began late due to involvement in coffee and donuts ritual; yet all team members emphasized how stressed for time they were.
 4. NP unprepared to present first case.
 - NP was not aware that she was scheduled to present the case.
 - NP unprepared for case discussion and annoyed with SW re: lack of communication.
 - Team members were not clear on patients scheduled to be discussed at this meeting
 5. NP defensive/sarcastic (she feels that she does all the work).
 - NP was sarcastic about assuring more responsibility "I do everything anyway," instead of requesting the sharing of responsibility.
 - NP made passive/aggressive remark about "doing all the work."
 - NP defensive in her presentation about patient's hearing loss.
 6. NP/SW poor conflict management (over hearing aid order, presentation of case).
 - Not well organized — poor comments between SW and NP.
 - SW and NP argue over who will take responsibility for ordering hearing aid.
 - NP personalized problem — SW/MD.
 7. NP/MD conflict over professional skills (med orders).
 - MD ignored NP's role and says she'll order generics.
 - MD dominated discussion without involving NP.
 - Power struggle -- lack of role clarity (NP and MD).
 8. MD "expert" (inappropriate/ pushes unwarranted diagnosis).
 - MD digressed by giving into technical discussion about GCA.
 - MD offered off-the-wall diagnosis for a patient she had not personally examined or assessed.
 - MD spoke in medical jargon, which did nothing to contribute to the treatment planning

9. Pharm sarcastic/ condescending.
 - Pharm condescending to NP over ACEI conflict.
 - Pharm ineffective in attempt to diffuse conflict with joke (“I’ll leave you two to fight it out”).
 - Pharm taunted MD and NP about ordering ACE inhibitor (feeble attempt to diffuse anger).
10. Poor team communication (eating, interruptions, distractions).
 - MD/PH/SW: several members seemed distracted, not committed to meeting (“very busy today -- need to hurry”).
 - People interrupted each other disrespectfully (MD at beginning of meeting, SW interrupted NP).
 - All were eating at meeting
 - MD discounted that SW had already attempted to start the meeting
11. Unresolved conflict and poor role definition.
 - NP did not address conflict -- issue left hanging.
 - Tensions were not dealt with (roles and responsibilities).
 - Avoidance (SW left the room and MD made sarcastic comment).
12. No emphasis on care plan/patient follow-up.
 - No conclusions or care plan was developed. Each did their own thing without using the others’ info.
13. Beepers disruptive.
 - Beeper interrupted discussion.
14. Members did not recognize others’ roles/unequal roles/lack of respect.
 - Arguing between all -- everyone not paying attention and walking out.
15. The following examples represent examples of **wrong answers** (e.g., ineffective behaviors).
 - Pharm not knowledgeable about meds.
 - NP not supported.
 - Team lacked agenda.
 - MD did not elicit NP’s opinion.

WAYS TO RESPOND TO INEFFECTIVE BEHAVIORS

1. Recognize conflict/use conflict management strategies
 - Address source of conflict. Get team members to define, clarify, understand, and support one another’s professional roles.

- I would intervene in argument between NP and SW over responsibility for follow-up, and I would ask which follow-up would make the most sense and be of most value to the patient.
 - Stop the meeting and asked the combatants “what’s going on?”
2. Review/revise protocol for presenting patients.
 - Decide at end of meeting which patient will be discussed at next meeting and who will present.
 - A list of patients to be discussed via some kind of meeting agenda would improve efficiency and preparedness.
 - Arrive at agreement at end of meeting regarding who will present case at next meeting. Determine who will lead next meeting. The leader of the scheduled meeting should confirm with case presenter that s/he is scheduled to present at next meeting.
 3. Facilitate meeting by refocusing discussion, collaborative language, appropriate interruptions.
 - Would have intervened during the MD’s lengthy, unrelated lecture.
 - Would have suggested moving to the next patient when NP clearly not prepared to present Mrs. Busby.
 - Redirect attention of group to the NP after interruption by SW. Maybe even ask her to stop and start again in her report.
 4. Team self-reflexivity: improve team dynamics through team reflection/ time to review team issues/ time to evaluate meeting.
 - Provide feedback to team members as a group regarding team’s negative behavior.
 - Set aside time each week for team to consider only concerns about team communication and process (how are we doing as a team?)
 - Request a separate meeting to discuss team maintenance issues.
 5. Establish meeting structure and ground rules for behavior.
 - Help team develop rules and procedures about eating and drinking before, during breaks, or after the meeting time; help them see how this activity makes them less efficient during the meeting; also, help them develop a procedure insuring that all the team members have the meeting agenda prior to the team meeting.
 - Appoint a team leader.
 - Establish and stick to agenda.
 - Suggest they start their meeting on time and discuss what are appropriate agenda items.
 - Beepers should be on vibrator mode.
 6. Encourage collaboration/ recognize roles of team members.
 - Suggest that the NP and MD have some boundary issues to sort out outside the meeting.
 - Discuss role conflicts and roles in general.

- Support efforts to use other disciplines as a resource.
7. Establish/reviews/summarize care plan and team decisions.
 - Would have tried to seek clarification of plan of care priorities and who is doing what before session ended.
 - Use summarization skills to integrate the information with a focus on patient needs.
 - I would ask for a summary and agreement over which team members take responsibility for which aspects of case management.
 8. Clearly define team members' responsibilities.
 - Identify goals to be accomplished with each patient. Assign specific team members stewarding of goals.
 9. Counsel team members privately.
 - The NP and the MD have issues. I would advise them to meet to discuss and resolve those issues.

RANK TEAM'S VALUE IN IMPROVING CARE PLAN:

An answer of 4 or 5 is the best answer (if scoring, this would receive 10 points).

An answer of 3 or 6 would receive 5 points.

An answer of 1, 2, 7, 8, 9, or 10 is wrong and would receive no points.

TEAM EFFECTIVENESS

- A. The following examples represent reasons why the team meeting was **valuable** in establishing and/or improving the care plan for the patient.
 1. Patient problems identified and discussed.
 - Medication management was carefully considered.
 - Looked at lower costs of medications.
 - Team focused on hearing problem and set appropriate goals.
 - SW revealed information re: application for Medicaid that no one seemed aware of.
 - Some benefit accrued to patient in the development of a financially feasible medication plan.
 2. Agreed to specific care and task assignments.
 - Who will take action was addressed.
 - Several new tasks were assigned based on interchange of ideas.
 3. Team members engaged/ group input.
 - Pharm and MD offered expert opinion, although MD became too technical. This information was relevant and appeared useful to the NP.

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- Team members did ask appropriate questions.
 - Important information for patient's care was exchanged.
4. The following examples represent **wrong answers** (e.g., valuable meeting).
- Care plan developed.
 - Team effectively solving problems.
- B. The following examples represent reasons why the team meeting was **invaluable** in establishing and/or improving the care plan for the patient.
1. No care plan established.
- No clear goals defined for the patient.
 - Several ideas generated about patient but plan seems disjointed -- who is doing what needs to be determined.
 - Reports were not integrated into measurable treatment plan.
2. Several patient problems (vision, ADLs) not addressed at all.
- No problem solutions for concerns of individual client, besides medications.
3. No team process/lack of collaboration and communication.
- No real communication or collaboration in problem solving.
 - Nothing really happened that was interdisciplinary other than perhaps some discussion (meds).
 - Concerns were not fully aired and few decisions were made.
 - Discipline focused, not patient focused.
4. Confusion of responsibilities/roles.
- It was not clear which team member(s) was/were taking responsibility for implementing the care plan.
 - Roles were ill defined.
 - No one assumed responsibility for follow-up.
5. No team leader/ ineffective team leader.
- No leadership or organization.
6. Conflict/lack of respect for other team members.
- Conflicts over territory between NP and MD and defensiveness of NP further undermined effective meeting process.
 - Conflict among team members and constant time constraints prevented the development of a truly integrated care plan.
 - Too much fighting -- nonproductive behavior.
7. Team did not provide a complete picture of patient problems (environmental, social, etc....).

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- Many questions were left unanswered and this same discussion will all have to take place again.
- Not all issues were discussed fully.
- Review of the patient was incomplete.

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3. Please circle the number under the comment that best describes your response to each presentation and the associated handouts. We are interested in knowing how useful the individual presentations and exercises were in enhancing your understanding of Geriatric Interdisciplinary Team Care.

Topic Areas	Not Useful At All	Somewhat Useful	Very Useful	Extremely Useful	Cannot Recall
Interdisciplinary Teams and Geriatric Knowledge					
Presentation	1	2	3	4	5
Exercises	1	2	3	4	5
Teams and Team Work					
Presentation	1	2	3	4	5
Exercises	1	2	3	4	5
Team Member Roles and Responsibilities					
Presentation	1	2	3	4	5
Exercises	1	2	3	4	5
Care-Planning Process					
Presentation	1	2	3	4	5
Exercises	1	2	3	4	5
Team Communication and Conflict Resolution					
Presentation	1	2	3	4	5
Exercises	1	2	3	4	5
Multiculturalism					
Presentation	1	2	3	4	5
Exercises	1	2	3	4	5
Ethics and Quality of Life					
Presentation	1	2	3	4	5
Exercises	1	2	3	4	5

4. Are there any other comments you would like to make about the classroom experience?

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1. His or her knowledge or expertise in the area?
2. His or her teaching abilities?
7. Please comment on the usefulness of the pre-test and the post-test.
8. Please comment on the usefulness of journaling.
9. Was the workload of this class similar to the workload of other classes you have taken that carry the same number of credit hours? Please explain.
10. Would you recommend this course to other students? Why or why not?

