Topic 1: Teams and Teamwork[1]

Overview

According to the American Congress on Rehabilitation Medicine,[2] a team is capable of achieving results with patients that individuals who constitute the team cannot achieve in isolation. Simply forming a team comprised of several disciplines does not, however, guarantee that the team will function well or that the outcome of the process will be the desired one. Effective teaming as an interdisciplinary group requires the use of rules, attention to issues of leadership, and respect for one another's expertise.

Objectives

- Understand the need for and importance of collaboration and interdisciplinary teams;
- Understand the different types of teams;
- Understand and recognize the phases of team development;
- Understand the need for team rules and what they mean; and
- Recognize components of successful teamwork.

Collaboration and the Importance of Geriatric Interdisciplinary Teams[3]

Collaboration implies a process of shared planning, decision making, accountability, and responsibility in the care of the patient. In collaborative practice, providers work together well. They demonstrate effective communication, trust, mutual respect, and understanding of others' skills. While skills and services may overlap, most skills and services are complimentary and reinforce each other.

With advanced technology and the growth of community-based care, providers frequently provide home treatments or treatments in the nursing home that were previously delivered exclusively in the hospital setting. Monitoring older adults in these community settings requires well-honed communication skills, because providers need to understand and correctly implement complex plans of care. It is crucial to recognize when to alert other providers of change in status. It is also important to learn what information other team members require to make decisions about treatment.

With the advent of managed care, there is an emphasis on efficiency and appropriate use of resources. Skills in coordinating care and being responsive to elderly patients will increase in

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[1] Topic 1 is compiled from: Long, D.M. & Wilson, N.L., (Eds.) (2001), Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging. Mariano, C., Gould, E., Mezey, M., Fulmer, T. (Eds.). (1999) Best nursing practices in care for older adults. New York: John A. Hartford Foundation, Inc.

[2] American Congress on Rehabilitation Medicine. Cited by: Long, D.M. & Wilson, N.L. (Eds.) . (2001). Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging.

[3] Hyer, K., & Mariano, C. Interdisciplinary collaboration for elder care. In C. Mariano, E. Gould, M. Mezey, T. Fulmer (Eds.). (1999) . Best nursing practices in care for older adults (pp. 20.1-20.30). New York: John A. Hartford Foundation, Inc.

importance. Physicians, nurses, social workers, and other providers must recognize when referrals to other providers are necessary and know what outcome to expect. Knowledge of the skills of other health providers is increasingly important for all patients but is critical in the care of frail elders.

There are many reasons why collaborative care and interdisciplinary teams are particularly important for older adults. Older adults face an interplay of chronic and acute medical and psychosocial problems that may be too complex for one provider to handle alone. In addition, assembling a group of providers may enhance the care plan and provide knowledge from multiple disciplines. Providers can increase coordination by working together and the client will have important issues addressed in a comprehensive and integrated care plan.

It is particularly important for health care providers to have a working knowledge of the elderly population because of their growing numbers and because of the chronicity of many of their health related problems.

Types of Teams

Traditional care has tended to be physician-centered. The physician has been the initial contact and often works independently to address patients' needs. Tests or services are ordered as needed and there is limited input from others. Teams, in contrast, focus on common goals. The internal decision-making processes used to achieve that common goal can distinguish successful or problematic teams.

Teams can be unidisciplinary, interactive unidisciplinary, multidisciplinary, or interdisciplinary. [4:5]

Unidisciplinary:

A group of different people from the same discipline who work together. An example of a unidisciplinary team is a clinical teaching team involving an attending physician, a medical resident, and a medical student.

Interactive Unidisciplinary:

A group of people from one discipline representing different specialty areas.

Multidisciplinary:

A group of people from different disciplines who develop treatment plans independently. Generally, each discipline conducts an independent assessment of patient. One person, usually the physician, orders the services and coordinates the care. The group may meet but, in general, each discipline implements its independent plan as an additional layer of services. Patients' and families' goals may not always be considered together as a unit of care, and specific discipline goals are not always shared with other professional caregivers. Often one discipline is the case manager, thus, having more control and input than the other disciplines in the care-planning process. This lack of collaborative

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[4] Hyer, K., & Mariano, C. Interdisciplinary collaboration for elder care. In C. Mariano, E. Gould, M. Mezey, T. Fulmer (Eds.). (1999). Best nursing practices in care for older adults (pp. 20.1-20.30). New York: John A. Hartford Foundation, Inc.

[5] Long, D.M. & Wilson, N.L. (Eds.) . (2001). Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging.

care planning and goal setting can create an inconsistent patient and family approach that lacks cohesion.

Interdisciplinary:

A group of people from different disciplines who assess and plan care in a collaborative manner. A common goal is established and each discipline works to achieve that goal. Care is interdependent, complimentary, and coordinated. Joint decision making is the norm. Members feel empowered and assume leadership on the appropriate issue depending upon the patient's needs and their expertise.

Phases of Team Formation

Groups do not become well-functioning interdisciplinary teams by deciding to become a team. All teams develop through a series of phases that can last several months or longer. Sometimes a developed team will even return to a previous phase for a period of time and then work out of it. Tuckman[6] first labeled these phases and many experts who work with groups use these labels:

Forming: creation stage for the group.
Storming: tasks and roles are worked out through conflict.
Norming: norms and patterns are worked out.
Confronting: conflictual stage (some professionals use this label or the storming label but not both).
Performing: team working together for the care of the patient.

Drinka has described six phases of team development. Each stage and interventions needed to resolve problems are shown below.[7]

Forming:

Group is created.
Superficial sharing of name and background information.
Members size up and test each other categorizing with outside roles and status.
Members are guarded, more impersonal than personal, a few are active, others are passive.
Uncertainty over purpose.
Conflict is neither discussed nor addressed.

Norming:

Difficulty in understanding goals and purpose of the team.
Attempt to establish common goals.
Mistrust of each other exhibited by caution and conformity.
Role overlaps become evident.
Conflicts are present but are openly covered up or glossed over.
A few members attempt to establish bonds with others having similar views.
Team establishes ground rules and begins to clarify common roles.

[6] Tuckman, B.W. (1965). Developmental sequence in small groups. Psychological Bulletin, 63(6),384-399. Cited by: D.M. Long & N.L. Wilson (Eds.). (2001). Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging.

[7] Drinka, T. (1997). Types of groups and teams. Waupaca, WI: Interdisciplinary Teamwork System.

Team may want leader(s) to assume responsibility.
Numerous strategies for increasing equality of leadership (e.g., rotating leadership).
Increase in defensive communication and disruptive behavior.
Frustration among team members.
Some members project blame and responsibility toward the perceived leaders.
Competition among team members.
Some members come late or do not come to meetings.

Confronting:

Conflicts can no longer be avoided and some members verbally attack other members.
Increased conflicts over leadership, equality, and commitment
Anxiety over expression of affect.
Some conflicts are addressed in a direct manner.
Some members withdraw from the team.
Search for leader who will resolve conflicts.
Functional leaders emerge.
Realization that power is not equal.
Realization that everyone has power for leadership and decision making.
Constructive confrontation when conflict occurs
Goals and roles are re-clarified.
Coalitions form but change according to needs of the team.

Performing:

Differences of members are appreciated.
Members encourage and help each other.
Reality testing increases and grows stronger.
Self-initiated active participation is the norm.
Relationships are strengthened and members must trust each other.
Attendance at meetings is regular.
Conflicts seen as normal and are used as impetus for program improvement.
Emphasis on productivity and problem solving.
Increased responsibility for leadership in teaching, wherever skills warrant it.

Leaving:

Individual leaves.
Anger toward members of the team in general.
Denial of impending termination from team by disbelief and regret.
Expression of wish to remain with the team.
Regression to an earlier phase.
Member may express happiness over leaving the team.
Team Terminates.
Withdrawal by some members, depression, sadness.
Expressions of team's superiority.
Feelings are expressed as testimonials.
Need to affirm that team membership has been a valuable experience.

Aspects Affecting Team Development

Several variables can affect the development of interdisciplinary health care teams. These variables fall under four specific areas:

1) Personal/professional (what the individual brings to a team);

2) Intra-team (the structure and processes of the team);

3) Organizational (institutional contributions and commitment to the team); and

4) Team maintenance (team reflexivity – CQI).

Personal/Professional

Commitment to team concept;

- Willingness to engage in the work of the team and to improve it;
- Commitment to learn the values and knowledge bases of other professions;
- Mix of leadership styles;
- Openness to new knowledge and willingness to risk;
- Collective knowledge to do the job;
- Mesh of patient needs and professional expertise;
- Interdisciplinary protocols for patient care developed and used by the team.

Intra-Team

- Desk/office placement and structure for formal/informal interaction;
- Physical arrangement and technology maximize communication;
- Range of formal and informal team leaders ;
- All members view themselves and are recognized by others as leaders;
- Employ leadership according to the need;
- Common goals;
- Team goals are negotiated and reviewed periodically by the team;
- Negotiated roles;
- Members understand their team roles;
- Ongoing mechanisms for managing conflict;
- Conflict viewed as healthy;
- Willingness to address conflicts as they rise;
- All team members perceived as having power for decision-making.

Organizational

- Organization's philosophy consistent with the team's philosophy on patient care;
- Ongoing resource support from local organization;
- External organization(s) recognize and are willing to work on common problems.

Team Maintenance

- Team regularly evaluates and improves itself (products, protocols, and processes);
- Team empowers new members'
- Members teach team leadership skills to newer members;
- Team members welcome a questioning environment;
- Feedback is open and direct.

Teams and Team Member Rules

Team rules, both for team governance and for member behavior, are needed in the early stages of team development. Not having these rules is a primary cause of team problems later on and can slow or stop team development completely.[8] Rules for team governance should include some or all of the following:

- Share a clear understanding by all members (and the larger organization within which it operates) about the overall purpose of the team and the goals for each meeting.
- Determine the composition of the team, including which disciplines are needed as members and the number of members (enough to get the job done; not so many that the work cannot get done). Allow the problem to define the composition of the team, not vice versa.[9]
- Determine how often the team needs to meet and specify attendance requirements (Is there a core team of doctor, nurse, and social worker? Are other disciplines asked to participate on cases that require their expertise?).
- Identify time, place, and duration of team meetings.
- Determine a system by which cases are to be presented and by whom. Identify how care plans and action will be carried out and documented (Is one member chosen to write down the care plan or does this responsibility rotate?).
- Identify opportunities or requirements for team-building meetings and/or team training.
- Create mechanism for enforcing both governance and behavior rules (if rules are made and not enforced, the team can quickly become ineffective and be a negative experience for everyone involved).

People are usually more willing to expend time and energy if there is a clear understanding of what is going to occur and why it is needed. The time spent with participants clarifying rules and getting a commitment for involvement will prevent team problems and support the development of an effective and efficient team.

While the above were team governance rules, behavior rules are also needed for each team. They can include some or all of the following:

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[8] Harrington-Machkin, D.H. (1994). Let's meet: team meetings. In The team building toolkit: tips, tactics, and rules for effective workplace teams pp.31-52). New York: American Management Association. Cited by D.M. Long & N.L. Wilson (Eds.). Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging.

[9] Pew Health Professions Commission and California Primary Care Association. (1995). Interdisciplinary collaborative teams in primary care: a model curriculum and resource guide. San Francisco, CA: Pew Health Professions Commission. D.M. Long & N.L. Wilson (Eds.) . Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging.

- Ensure clear understanding by all team members of what an interdisciplinary team is.
- Promote understanding and respect for others' expertise.
- Recognize the idioms of the professions involved. Learn how to articulate your information clearly to others (for example, client and patient mean the same thing in different professional groups. Health care goals will come from different perspectives from different disciplines).
- Share information and expertise openly.
- Identify and follow a decision process when roles overlap. Resist setting rigid boundaries on roles. Instead, promote effective ways of sharing responsibilities and tasks.[9]
- Define acceptable behavior (for example, willingness to work with other professionals to develop a care plan, active participation, respect for others' roles).

Principles of Successful Teamwork

The essential elements of teamwork are: coordination of services, shared responsibility, and communication. Effective teams must work across settings and have well-organized mechanism to share information. Assessment of elderly clients is usually shared with one or more providers who administer geriatric assessment tests. Because the focus of the team is on the older person, providers must share information clearly and effectively. By focusing on the client, the team shares a common goal. Collaboration involves skills and hard work.

In addition to team ground rules and individual rules of behavior, effective meetings have structure.

Structure

Structure refers to the organization of the meeting. Ideally, the structure encourages efficient and effective meetings. Elements essential to the structure of an effective meeting are [4:5]

1. Agenda (what do we expect to accomplish?)

2. Estimated timeline for completing agenda (reasonable time frames).

3. Establishment of roles at meeting. Members can and should rotate the following roles but every meeting should include:

    - Leader (calls meeting to order, has agenda, sets expectations).
    - Timekeeper (keeps group on task).
    - Recorder (keeps track of agreements about the care plan and modifications, and is responsible for recording changes to care plan).

4. Summary of agreements (recorder reports agreements).

5. Evaluation/reflection on team process (both team process and outcome of the meeting are discussed).

The Seven-Step Meeting Process

The Seven-Step Meeting Process is a defined meeting process that standardizes the method of conducting a meeting and assists in the effective execution of critical meeting tasks. Not only do

these seven steps help in structuring a meeting, they also help teams review and assess their efficiency and productivity.[10]

Step 1. Clarify Objectives

Ensure that all understand and are in agreement with the meeting objectives.

Step 2. Review Roles

Review who will be timekeeper, recorder, leader, and facilitator. Decide at what intervals feedback on time will be given.

Step 3. Review Agenda

Review details of agenda items listed under step 4. Ensure that all team members understand and are in agreement with the agenda items.

Step 4. Work Through Agenda Items

Step 5. Review Meeting Record

Review the flipchart record on the walls but do not read all charts. Look for changes and additions. Decide which charts should be kept and which should be discarded.

Step 6. Plan Next Steps and Next Meeting Agenda

Decide who will do what before the next meeting. Decide what the objectives and agenda items will be for the next meeting.

Step 7. Evaluate 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?

Characteristics of Effective Teams

Teams are more likely to be effective when:

- Purpose, goals, and objectives are known and agreed upon.
- Roles and responsibilities are clear.
- Communication is open, sharing, and honest. There is disagreement without tyranny and constructive criticism without personal attack.
- Team members listen to each other.
- Team members are competent, professional, personally effective, and make appropriate contributions.
- Teams cooperate and coordinate activities. Decisions are reached by consensus.
- When decisions are made, assignments are made clearly, accepted, and carried out.
- Leadership shifts depending on the circumstances.
- Team members support each other and act as different resources for the group.
- Team members trust each other, minimize struggles for power, and focus on how best to get the job done.

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[10] Resource Center Medicine Special Interest Group of the John A. Hartford Foundation Geriatric Interdisciplinary Team Training Program. (1999). GITT. New York: New York University.

- The team evaluates its own operations.

Exercises

1. Pre-Test on Interdisciplinary Team Concepts.

This true/false and multiple choice test was created to introduce and develop your student's awareness and understanding of the interdisciplinary team.

2. What is your interdisciplinary IQ.

This true/false test on interdisciplinary teams is similar to the pre-test on interdisciplinary team concepts. It too asks the student to think about team concepts.

Facilitator's Notes

1. *These tests are best administered before the students begin to familiarize themselves with the major concepts of the geriatric interdisciplinary team.*
2. *Many of the questions will help you lead the group into discussions of the overarching themes of interdisciplinary care and how they differ from conventional medical practice and elder care.*
3. *The two tests can be separated and administered at the beginning and then at the end of the Topic 1 curriculum to assess acquired knowledge.*

3. Case Study: Initial Meeting for the Geriatric Interdisciplinary Team[5]

This is an introductory exercise for an individual or an already formed team. As an exercise, it tests the understanding of the developmental stages of team development and begins to have students think about leadership roles on teams.

Facilitator's Notes

1. *This case study is best suited to be administered after the Stages of Team Development section in Topic 2.*
2. *It is written as an individual assignment but can also serve as a valuable group activity and discussion.*
3. *Have students individually search for differences between the initial meeting and the team meeting after several months and then return as a group to have a discussion of their findings.*
4. *Administer the summary questions.*

4. Team Fitness Test[11]

[11] Bendaly, L. (1996). Games teams play: dynamic activities for tapping work team potential. New York: The McGraw-Hill Companies.

This exercise serves as a tool to determine the fitness of a team. Students are asked to rate their teams on a scale of 1-4 based on the applicability of a series of statements to the practices of their own teams. These ratings can then be applied to a scoring sheet that provides a numeric value indicating how fit the team is.

5. *Team Observation Tool*[5]

This exercise provides students with a series of questions regarding specific behaviors within their teams. The questionnaire requires thought about professional roles, leadership, and communication skills of each team.

Facilitator's Notes

1. *It is necessary for the students to be in functioning teams for the exercise to be effective.*
2. *The team fitness test and the team observation tool can be administered numerous times throughout training to determine if the team is performing better or worse than their last assessment.*
3. *The team fitness test serves best as a survey.*
4. *The team observation tool is more personal and asks for specifics about individual team's practices.*

6. *GITT Video Scripts*[12]

These four video scripts include the text of the videotaped test geriatric interdisciplinary team meetings developed by the GITT Case Studies Work Group. Actual videotapes of the meetings are available from the Resource Center at New York University. Each script includes multiple clinicians and a variety of clinical issues. Questions for students to consider are provided after each videotape. Faculty notes are also provided to help faculty lead discussions.

Facilitator's Notes

1. *Play video.*
2. *Have students discuss questions for students in small groups.*
3. *Conduct large group discussion with students based on faculty notes.*

[12] GITT Case Studies Work Group. GITT Videotapes. (1998). New York: The Geriatric Interdisciplinary Team Training Resource Center.

References

Bendaly, L. (1996). Games teams play: dynamic activities for tapping work team potential. New York: The McGraw-Hill Companies.

Drinka, T. (1997). Types of groups and teams. In Interdisciplinary teamwork systems. Waupaca, WI.

Harrington-Machkin, D.H. (1994). Let's meet: team meetings. In The team building toolkit: tips, tactics, and rules for effective workplace teams (pp. 31-52). New York: American Management Association.

Hyer, K., & Mariano, C. Interdisciplinary collaboration for elder care. (1999). In C. Mariano, E. Gould, M. Mezey, & T. Fulmer (Eds.) Best nursing practices in care for older adults (pp. 10.1-20.30). New York: John A. Hartford Foundation, Inc.

Long, D.M., & Wilson, N.L. (Eds.). (2001). Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging. (www.hcoa.org, 713-798-5804).

Mariano, C., Gould, E., Mezey, M., & Fulmer. T. (Eds.). (1999). Best nursing practices in care for older adults. New York: John A. Hartford Foundation, Inc.

Pew Health Professions Commission and California Primary Care Association. (1995). Interdisciplinary collaborative teams in primary care: a model curriculum and resource guide. San Francisco, CA: Pew Health Professions Commission.

GITT Resource Center Medicine Special Interest Group of the John A. Hartford Foundation Geriatric Interdisciplinary Team Training Program. (1999). GITT. New York: New York University.

Tuckman, B.W. (1965). Developmental sequence in small groups. Psychological Bulletin, 63(6),384-399.

GITT Exercises: Topic 1

Pre-Test on Interdisciplinary Team Concepts

(Long, D.M., & Wilson, N.L. (Eds.). (2001). Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging.)

The purpose of the following true/false and multiple choice questions is to orient the reader to this curriculum. This preview is an exercise meant to introduce one to overall core team issues. In addition to this exercise, summary questions at the end of each topic are meant to help readers assess their grasp of key content for that particular topic area.

____ 1. An interdisciplinary team approach to health care is viewed as unimportant by the changing health care industry.

____ 2. An interdisciplinary team differs from other groups or teams in that members represent different disciplines, are interdependent, and one care plan is developed for the client or patient by the entire team.

____ 3. Health care professionals on a newly developed health care team have clear understandings about each other's roles.

____ 4. The patient and family members are not a necessary part of the interdisciplinary health care team.

____ 5. An interdisciplinary team develops in phases over time.

____ 6. In order to fulfill leadership functions on an interdisciplinary team, a member must have a formal designation of authority.

____ 7. It is always most appropriate for a physician to perform the major leadership functions on an interdisciplinary health care team.

____ 8. Within a team of health care professionals, members from different disciplines speak different "languages."

____ 9. Which technique(s) can help overcome communication barriers within a health care team?
- a. confrontation
- b. insight into another culture's belief system
- c. trust development among different disciplines
- d. the ability to explain one's beliefs about a care plan

____10. As team members have more experience working together, members can anticipate an increase in conflict between or among team members.

____11. No approach to managing conflict works in the face of strong emotions.

____12. A patient who believes in folk medicine needs to be educated about why it won't

work.

____13. Health care professionals need to be knowledgeable about cultural issues within their client population.

____14. In an interdisciplinary team, treatment goals are determined by:
- a. the physician
- b. full-time members only
- c. patient and family only
- d. the entire team

____15. The efficiency of a health care interdisciplinary team is determined by:
- a. time involved in patient care
- b. cost of care and productive meetings
- c. team goals met and the time and cost of patient care

____16. The Balanced Budget Act of 1997 modified the Medicare managed care program by
- a. phasing out Medicare
- b. cutting the salaries of health care providers
- c. creating the Medicare + choice program

____17. Team care is not an efficient way to provide health services in a Medicare managed care setting.

____18. Using a continuum of care by providing alternate care settings does not reduce costs of care and therefore is not supported by managed health care programs.

Answers to Pretest Questions

1. False (p. 00)
2. True (p. 00)
3. False (p. 00)
4. False (p. 00)
5. True (p. 00)
6. False (p. 00)
7. False (p. 00)
8. True (p. 00)
9. a, b, c, and d (p. 00)
10. True (p. 00)
11. False (p. 00)
12. False (p. 00)
13. True (p. 00)
14. d (p. 00)
15. c (p. 00)
16. c (p. 00)
17. False (p. 00)
18. False (p. 00)

Pre-Test on Interdisciplinary Team Concepts

(Long, D.M. & Wilson, N.L. (Eds). (2001). Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging.)

Please complete the following true/false and multiple choice questions. This pre-test was created to introduce and develop your self-awareness of team issues.

<u>False</u> 1. An interdisciplinary team approach to health care is viewed as unimportant by the changing health care industry.

<u>True</u> 2. An interdisciplinary team offers from other groups or teams in that members represent different disciplines, are interdependent, and one care plan is developed for the client or patient by the entire team.

<u>False</u> 3. Health care professionals on a newly developed health care team have clear understandings about each other's roles.

<u>False</u> 4. The patient and family members are not a necessary part of the interdisciplinary health care team.

<u>True</u> 5. An interdisciplinary team develops in phases over time.

<u>False</u> 6. In order to fulfill leadership functions on an interdisciplinary team, a member must have a formal designation of authority.

<u>False</u> 7. It is always most appropriate for a physician to perform the major leadership functions on an interdisciplinary health care team.

<u>True</u> 8. Within a team of health care professionals, members from different disciplines speak different languages.

<u>b,c,d</u> 9. Which technique(s) can help overcome communication barriers with a health care team?

a. Confrontation
b. Insight into another culture's belief system
c. Trust development among different disciplines
d. The ability to explain one's beliefs about a care plan

<u>True</u> 10. As team members have more experience working together, members can anticipate an increase in conflict between or among team members.

<u>False</u> 11. It is best to avoid addressing strong emotions. No approach to managing conflict works in the face of strong emotions.

<u>False</u> 12. A patient who believes in folk medicine needs to be educated about why it won't work.

True 13. A health care professional needs to be knowledgeable about the cultural issues with his/her client populations.

__d__14. In an interdisciplinary team, treatment goals are determined by:

a. The physician
b. Full members only
c. Patient and family only
d. The entire team

a, b, c 15. The efficiency of a health care interdisciplinary team is determined by:

Time involved in patient care
Cost of care and productive meetings
Team goals met and the time and cost of patient care

What is your Interdisciplinary Teamwork IQ?

Answer the following questions, True or False.

1. Individuals who seek health care should be seen by an interdisciplinary team. __
2. Health professionals who are highly grounded in their own disciplinary views are best able to gain an understanding and appreciation for the knowledge and skills of other professions. __
3. Teams with members from multiple disciplines can make decisions more efficiently than teams that contain members of only one discipline. __
4. Individuals who are team members perceive that they have more control over their professional roles than those who are not members of teams. __
5. Health care professionals who are team members of successful teams possess higher levels of morale and job satisfaction that those who are not members of teams. __
6. In contrast to multidisciplinary teams, interdisciplinary teams are characterized by members of different disciplines who are involved in the same task, working along side of each other, functioning independently. __
7. In well-functioning interdisciplinary teams, leadership is vested in the discipline with the most training and status. __
8. A goal of interdisciplinary teams is to encourage team members to think similarly about a problem. __
9. Interdisciplinary teams processes usually require that participants take into account the contributions of their team members when making decisions. __
10. In most well-functioning interdisciplinary teams, roles are clear, tasks are delegated, and the structure is usually hierarchical. __

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Case Study: Initial Meeting for the Geriatric Interdisciplinary Team

(Developed by Mehrnaz S. Gill, M.S., Huffington Center on Aging, Baylor College of Medicine)

Today is the first day of the geriatric interdisciplinary team case meeting. The team members include:

- John, the physician (MD)
- Helen, the advanced nurse practitioner (NP)
- Joe and Julie, second year residents (R)
- Debra, the pharmacist (Ph)
- Mary, the social worker (SW)
- Jeff, the clinic coordinator (CC).

This meeting is the first of mandatory weekly team meetings.

John (MD) is hoping to begin the meeting promptly at 7:30 a.m. because he has to round at 9:00 a.m. and the team has a long list of patients to discuss. However, some of the team members are late. The meeting finally begins at 7:45 a.m. John (MD) begins the meeting by thanking everyone for coming and reminding them that the meetings will begin promptly at 7:30 from now on. Debra (Ph) quietly tells Jeff (CC) that it is very difficult for her to get to the meeting on time because she has a 45-minute commute. Jeff comments that he does not know why he has to be at the meeting at all and that it will probably be a waste of time. John (MD) tries to ignore the side conversation between Debra and Jeff and asks Helen (NP) to present her first case, Mrs. James. Helen passes out a patient information sheet on the first patient.

Mrs. James, a fairly new patient at the clinic, is an 87-year-old woman with hypertension, coronary disease, and poor vision. The initial screening questionnaire and home interview made by Mary (SW), identified her as widowed for 3 years and living alone in a clean one-story home. She is taking seven medications and gives conflicting reports regarding how she is taking them. Mary (SW) notes that Mrs. James seems somewhat forgetful, confused and depressed. John (MD) asks the members of the team for their input. Joe (R), is somewhat hesitant about expressing his opinion. Based on the patient's initial physical and psychosocial assessment, he suggests that she may be suffering from some type of dementia. Debra (Ph) suggests taking a closer look at her medication and that "drug interaction may be having an adverse effect on her cognition." Mary (SW) believes that loneliness and lack of social interaction may be the cause of her depression and confusion. John (MD) suggests further evaluation of Mrs. James for discussion at next week's meeting and asks Joe (R) to present the next case. Helen would like to discuss the case further, but decides not to say anything.

Team Meeting After Several Months

(Developed by Mehrnaz S. Gill, M.S., Huffington Center on Aging, Baylor College of Medicine)

The case meeting of the geriatric interdisciplinary team begins promptly at 7:30 a.m. Various team members present the patient cases, while Jeff (CC) writes the problem lists on the blackboard. The last case, Mr. Jones, is presented by Julie (R). Mr. Jones is a 75-year-old African American man with arthritis, coronary artery disease, and diabetes who has been insulin dependent for the past 3 years. He also has poor vision and hearing difficulties. He is on five medications and is non-compliant with requirements to use his glucometer to check his blood sugar. He lives in his own house with his unemployed daughter and two grandchildren.

Pointing to the blackboard, Helen (NP) expresses her concern about Mr. Jones's noncompliance with his glucometer. Debra (Ph) asks, "Does he know how to use it?" Helen responds that has shown him how to use it and has left written instructions; however, communication is hard since he has difficulty with his hearing and vision. John (MD) suggests that Helen (NP) show Mr. Jones's daughter how to use the glucometer so that she can assist him. Helen responds, "I have, but she does not seem very cooperative. I'm not sure if she really cares about her father's health." Mary (SW) is quite surprised by Helen's (NP) comments and says that Mr. Jones's daughter is very devoted to him but is still grieving over the death of her husband. Helen asks Mary to speak with Mr. Jones's daughter about this matter. Joe (R) asks about whether Mr. Jones is taking his medication properly. Debra (Ph) says that she has been working with Helen (NP) on monitoring his medications and has provided him with a large-print weekly pill box.

John (MD) expresses his concern about Mr. Jones's driving and comments that Mr. Jones "has been late or missed several of his appointments." Jeff (CC) comments that he has had to reschedule Mr. Jones several times and that it has become a problem. Joe (R) asks, "Does this have anything to do with his failing eyesight?" John (MD) responds, "I recommend further evaluation to determine whether he has cataracts, glaucoma, or if this is related to his diabetes."

It is almost 9:00 a.m., and John (MD), Joe (R), and Julie (R) have to leave to round. Helen (NP) asks them to stay a few more minutes in order to address the last issue on Mr. Jones's problems list. She is very concerned about Mr. Jones's increasing hearing difficulties and asks Mary (SW) to look into hearing aids for Mr. Jones. The cost is a factor, so she asks Mary about different options to cover the cost of the hearing aid. Mary (SW) agrees to look into it. John (MD) asks Mary (SW) to wait since he would like to refer Mr. Jones to a specialist for his hearing problems. This will be discussed further at the next meeting.

Summary Questions[13]

Answer the following questions about the initial meeting:

1. What phase is the team in? Why do you think so?

2. Who is the current leader of the group? Why do you think so?

[13] Long, D.M., & Wilson, N.L. (Eds.). (2001). Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging.

Team Fitness Test

Rate each of the following statements as it applies to your team using the following rating scale:

Statement	Rating
This statement definitely applies to our team.	4
This statement applies to our team most of the time.	3
This statement is occasionally true for our team.	2
This statement does not describe our team at all.	1

Enter the score you believe appropriate for each statement beside the statement number on the Scoring Sheet.

____ 1. Each team member has an equal voice.

____ 2. Members make team meetings a priority.

____ 3. Team members know they can depend on one another.

____ 4. Our mandate, goals, and objectives are clear and agreed upon.

____ 5. Team members fulfill their commitments.

____ 6. Team members see participation as a responsibility.

____ 7. Our meetings produce excellent outcomes.

____ 8. There is a feeling of openness and trust in our team.

____ 9. We have strong, agreed upon beliefs about how to achieve success.

____ 10. Each team member demonstrates a sense of shared responsibility for the success of the team.

____ 11. Input from team members is used whenever possible.

____ 12. We all participate fully in team meetings.

____ 13. Team members do not allow personal priorities/agendas to hinder team effectiveness.

____ 14. Our roles are clearly defined and accepted as defined by all team members.

____ 15. Team members keep each other well informed.

____ 16. We involve the right people in decisions.

____ 17. In team meetings we stay on track and on time.

____ 18. Team members feel free to give their honest opinions.

____ 19. If we were asked to list team priorities, our lists would be very similar.

____ 20. Team members take initiative to put forth ideas and concerns.

____ 21. Team members are kept well informed.

____ 22. We are skilled in reaching consensus.

____ 23. Team members respect each other.

____ 24. When making decisions, we agree on priorities.

____ 25. Each team member pulls his or her own weight.

Team Fitness Interpretation Sheet

Column	Your Score	Your Ranking	Team Score	Team Ranking	Range of Score	Team Range	Team Fitness Element
I							Shared Leadership
II							Group Work Skills
III							Climate
IV							Cohesiveness
IV							Team Members' Contribution

Your lowest score will be ranked number 1, second lowest score number 2, etc.

Team Fitness Scoring Sheet

I		II		III		IV		V	
Statement	Score	Statement	Score	Statement	Score	Statement	Score	Statement	Score
1		2		3		4		5	
6		7		8		9		10	
11		12		13		14		15	
16		17		18		19		20	
21		22		23		24		25	
Total		**Total**		**Total**		**Total**		**Total**	

Team Observation Tool[14]

Team______________________________ **Date**_______________________

Team Goals

1. Does this team have an apparent goal? __Yes __No What is it?__________________

____ _______

Professional Roles

2. Circle the disciplines attending the meeting. MD MSW NP RN Pharm OT PT
3. Do team members appear knowledgeable about their roles? ___Y ___N
4. Do team members appear knowledgeable about the roles of other disciplines? __Y __N
5. Are there disciplines participating on the team with whose roles you are not familiar__Y__N

   If so, which ones?____

Leadership

6. Who is (are) the team leader(s)?____
7. Does the leadership change during the meeting? ___Y ___N
8. What behaviors do the leaders use (summarizing, initiating…)_____________________

____

Communication and Conflict

9. Is there any open sharing of information? ___Y ___N
10. Note any barriers to communication you observe (side conversations…)________________

____

11. Is there an opportunity for differences of options to be discussed? ___Y___N
12. What are the examples of conflict? How were they handled?

Conflict	Strategies used to handle

Meeting Skills

13. How is the meeting organized? (agenda…)_____________________________________

____

Outcome

14. What was accomplished or produced during the meeting?_________________________

____

15. Are decisions and next steps clear? ___Y___N
16. Was the meeting efficient? ___Y___N Elaborate_______________________________

____

[14] Long, D.M., & Wilson, N.L. (Eds.). (2001). Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging.

VIDEO: Case of Mrs. Cuervo

1. **Script**
2. **Questions for Students to Think About**
3. **Notes for Faculty**

Video Script: "Case of Mrs. Cuervo"

By the GITT Case Studies Work Group

Roles:

Physician: Myra Lopez
Nurse Practitioner: Susan Knight
Pharmacist: Leo Smithfield
Social Worker: Diane Collins

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 are Diane Collins, the social worker; Susan Knight, the nurse practitioner; Leo Smithfield, the pharmacist; and Myra Lopez, the internist.

Social Worker: Good morning. Well everyone's here except Leo and we really have to get started because it's already 8:10. I have to be out of here by 9:00. We're beginning today with Mrs. Cuervo, a 78-year-old woman who's just come to the clinic for an evaluation. Dr. Lopez, would you present the case?

Physician: Thanks for getting us started. I met with Mrs. Cuervo and her daughter-in-law last week. The daughter-in-law states that Mrs. Cuervo's memory seems to be getting worse over the last few months. She further reports that her mother-in-law has difficulty remembering to take all of her medications. Sometimes she finds Mrs. Cuervo's noontime pills on the kitchen counter when she comes home in the afternoon. Mrs. Cuervo insists that this is the only happened once but she does admit it's been difficult to adjust. She moved a few months ago. She says she just doesn't feel like she's established a comfortable routine yet.

Leo Smithfield rushes in the room, apologizes for being late.

Pharmacist: Sorry folks, the coffee line was so long. I'm just not used to lines this long. It only took a minute to get coffee when I was over at Westhaven. You know, I can't function this early without caffeine. Here, I bought an extra because I figured one of you loves hazelnut. Any takers?

NP smiles, grabs the coffee and Pharmacist settles and chats with NP.

Social Worker: OK everybody, let's settle down. Dr. Lopez can you continue?

Physician: Mrs. Cuervo's been taking dioxin for 10 years after an episode of a fib and CHF. She also has a history of hypertension. She seems to have been diagnosed as having hypothyroidism some time in the past, because she's taking thyroxin. Her other meds include a laxative, an

over-the-counter sleeping pill, an NSAIDS for osteoarthritis. Susan, you also saw Mrs. Cuervo. What were the results of the mental status exams?

Pharmacist and NP stop their side conversation at sound of "Susan."
NP shuffles her papers and starts.

Nurse Practitioner: Oh, just a sec. Yes, here's Mrs. Cuervo's record…On examination, Mrs. Cuervo's MMSE score was 22. She knew the data but couldn't remember objects and she didn't do simple math calculations. Her Geriatric Depression score was 9, which is just below the borderline. Her physical exam including a neurological was unremarkable except for some mild edema in her feet. However, I think this lady could use a psych consult.

Social Worker: Why don't you think I'm able to handle the mental status issues in this case? I'm a mental health counselor. I've also interviewed Mrs. Cuervo and understand the family system issues.

Nurse Practitioner: Sorry, Diane. I'm just saying that this lady's psychiatric condition needs to be assessed further.

Social Worker: Well, I think I've got a good handle on this case. I'm also concerned about Mrs. Cuervo's possible depression. Mrs. Cuervo was very tearful during the interview. She also complained about not having as much energy as she used to. I found out that the son has started to drink heavily again and the daughter-is-law is worried about becoming the primary caregiver for both him and Mrs. Cuervo. Mrs. Cuervo was windowed about 10 years ago and has three children. She currently lives in a small apartment with her son and daughter-in-law. Before moving here from North Dakota, Mrs. Cuervo lived alone in a small apartment. She says she'd prefer to be on her own again, but she doesn't know if she can manage it financially because apartments here are more expensive. Her son and daughter-in-law encouraged her to move in with them after she slipped on ice last winter and sustained a Colles fracture. She can do most ADLs. She has some trouble with bathing because the tub in the son's apartment is small. She's a devout Catholic and wants to burn small candles in her husband's memory but her son and daughter-in-law don't want her to. They're afraid of a fire because they think she's so forgetful. Mrs. Cuervo gets very upset at not being able to light the candles and frequently demands to be taken to a priest to seek solace. So far, she hasn't gone.

Nurse Practitioner turns to Physician.

Physician's beeper sounds and she reads the beeper number and starts to leave.

Nurse Practitioner: I'm concerned about her fatigue. Myra, what about her thyroid management?

Physician: Sorry, I have to take this. I'll be back in a minute…

A lull in the conversation ensues. Pharmacist is obviously busy doing other work.

Nurse Practitioner: Diane, Mrs. Cuervo might benefit from a visit with a priest?

Social Worker: Yes, I've thought of that and I've already contacted her local parish and requested that a priest visit her at the apartment. They promised someone will get over there in the next couple of weeks.

The pharmacist quietly says:

Pharmacist: About the thyroxin…. you know, thyroxin needs to be carefully monitored….

Physician returns to room while the pharmacist is commenting.

Physician: Sorry for the interruption. Where was I? Oh, yes. Susan's question about the thyroxin management. We need to run some tests to see what's wrong. It's probably just hypothyroidism and she needs to have her thyroxin adjusted. There was an interesting article in JAMA which recently talked about the under diagnosis of the hypothyroidism and the failure to do the appropriate tests. I'll have to dig it out and get everybody a copy.

Social Worker: Dr. Lopez, why don't I organize a treatment plan for Mrs. Cuervo?

At this point, the meeting starts to break up.

Pharmacist: You're ending already? Well, I'd like to make my contribution. "Remember, start low, go slow."

End

Questions for Student to Think About:

A. Team Dynamics Questions

1. On a scale of 1-10 (1 is HIGHLY EFFECTIVE, 10 is HIGHLY INEFFECTIVE), choose a number that best represents your perception of the team's functioning.

2. Please list specific effective and ineffective 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 last" rather than "the social worker disrupted the meeting". You may want to consider skills in the following area: running meetings, leadership, communication, conflict management, recognition of other team members, etc.

3. List three different ways you would have responded to these ineffective behaviors.

B. Team Effectiveness Questions

1. How valuable was the team meeting in establishing or improving the care plan for the patient? On a scale of 1-10 (1 is NOT AT ALL VALUABLE, 10 is VERY VALUABLE), choose a number which best represents your judgement.

2. Please give three different reasons why you circled the number you did in Question 4.

Faculty Information Notes

1. TEAM DYNAMICS/EFFECTIVE BEHAVIORS

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

1 SW assumed organizer role (agenda, moves meeting along).

- SW controlled interruptions.
- SW seemed to have the leadership in the meeting.
- SW attempted to keep the meeting moving in a timely manner.

2 Meeting began on time (SW).

- SW got meeting off to a good start.
- Tried to start on time.
- Agenda timelines.
- SW called meeting to order and organized discussion.

3 SW/MD refocused meeting after Pharm disruption.

- MD stopped her presentation when Pharm and NP were not listening.
- MD curbed Pharm's distracting behavior.

4 SW/NP knew family/identified family concerns.

- Gave social/spiritual dimensions and recognized family roles.
- NP raised concerns of depression, religion, and gave good suggestions.
- SW reported patient preference.

5 SW/MD were prepared to discuss the specifics of case when called upon.

- SW presented case adequately and appeared informed about the clinical issues in the case.
- NP prepared with psychosocial assessment of cognition and affect.

6 MD asked NP to present.

- All were willing to share observation and contribute.
- MD asked for input from NP.
- MD asked for another opinion.

7 MD supported SW by thanking her for starting on time.

- MD acknowledged GNP starting meeting.
- MD acknowledged SW role as convener.

8 NP kept meeting focused (contributed with question and follow-up).

- NP followed through on care plan by suggesting priest visit patient.
- MD at least remained for most of the meeting.
- NP appeared sensitive to the socio-cultural and medical issues.
- MD was more direct when the meeting continued.
- NP picked up on SW's report of patient's need to burn candles in husband's memory and suggested involving a priest.
- NP: although not prepared when called on, had good data and thoughtful recommendations.

9 Members prepared to discuss specifics of case.

- SW presented effective system approach to functional status.
- Three disciplines were honored.
- MD presented.

B. The following examples represent **wrong answers** (e.g., effective behaviors):

1 Pharm attempted to participate/share.

2 MD showed expertise on Thyroxin

2. TEAM DYNAMICS/INEFFECTIVE BEHAVIORS

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

1 Pharm arrived late, was disruptive.

- Pharm disrupted meeting by being late.
- Pharm disrupted meeting late/coffee.
- Pharm arrived late, didn't listen, noisy.

2 Pharm withdrew, was inattentive/unable to contribute appropriately.

- Pharm off-handed comment regarding "start low and go slow" appeared trite and irrelevant.
- Pharm sarcastic -- did not give direct input.
- Pharm did not pay attention during SW's presentation.

3 Pharm/NP side discussion.

- Pharm disrupted with extraneous conversation, made noise with food.
- NP and Pharm began speaking across the table.
- NP and Pharm more interested in coffee than issues at hand.

4 Pharm ignored/not asked for opinion.

- The role of Pharm was ignored.
- MD seemed uninterested when presenting case and wasn't interested in listening to Pharm's input.

- MD did not pay attention to the Pharm's recommendations.

5 NP not respectful of SW role.

- NP did not ask SW regarding her opinion in psych consult.
- NP did not elicit SW's impressions before recommending psych consult.
- Conflict between NP and SW when asked for psych consult.

6 NP poor conflict management/defensive.

7 NP not prepared to begin when asked.

- NP not organized in advance.
- NP did not have paperwork ready -- focused on coffee.
- NP was inattentive at times and caused the group to waste time.

8 MD interrupted Pharm's discussion.

- The MD cut off everyone when she sat back down.
- MD did not let the Pharm talk.
- MD disrupted the meeting when she interrupted the Pharm upon returning to the table

9 MD answered page/beepers on.

- MD left meeting to take page.
- MD allowed self to be disturbed at meeting.
- Beepers should have been put on hold for interruptions.

10 MD poor closure to meeting.

- The MD did not give this case the attention it needed by not allowing enough time to complete.
- The MD closed the meeting before the Pharm was able to adequately contribute.
- MD left quickly.

11 MD played expert/acted as authority.

- MD was dismissive of Pharm's contributions.
- MD was disruptive, self-centered, and not appreciative or respectful of team members, especially Pharm.
- MD got team off the subject by discussing a journal article.

12 SW poor conflict management/defensive re: psych consult/angry.

- SW abrupt with Pharm who was late.
- SW created conflict over mental health assessment.
- SW defensive about her ability to perform psych consult.

13 No processing of care plan/SW took over.

- No goals/treatment plan or delegation of duties was achieved during the meeting.
- Meeting ended precipitously without processing out.
- SW developed plan of care without input from others.

14 Members did not recognize others roles/unequal roles/lack of respect.

- All clear inequality of status re: names.
- SW only seemed interested in MD's input.
- NP inadequately communicated request for psych referral and priest.
- Pharm unable to get MD to discuss meds.
- Entire group was egocentric.
-

B. The following examples represent **wrong answers** (e.g., ineffective behaviors).

1. SW not respectful of patient.
2. Patient and family ignored.

C. The following examples represent **ways to respond** to **ineffective behaviors**.

1 Recognize conflict/use conflict management skills.

- Acknowledge defensive behavior.
- Team should address underlying tensions.
- Address SW defensiveness more directly.
- Diplomatic approaches to acknowledging and resolving conflict between the SW and the NP.

2 Review/revise protocol for presenting patients.

- Overview of meeting so everyone knows what it to be covered.
- Formalize a structure within which each team player is given time for input without being interrupted or shut down.
- Have each of the practices get an amount of time to speak about the patient.

3 Facilitate meeting by refocusing discussion, collaborative language, appropriate interruptions.

- Stopped side bar conversations by redirecting to group discussions.
- Welcome Pharm, give him time to settle, and solicit him to shift from food and his problem to case.

4 Team self-reflexivity: improve team dynamics through team reflection/time to review team issues/time to evaluate meeting.

- Ask if as a team we could evaluate the process used, goals, and how we could be more effective.
- Request several minutes to reflect on “team processing.”
- Processing of team dynamics.

5 Establish meeting structure and ground rules for behavior.

- After meeting, discuss timelines and participation with Pharm.
- Stress importance of starting on time and being prepared to discuss each patient.
- Appoint a team leader.
- Establish and stick to an agenda.
- Ask all members to set their beepers on vibrating mode.

6 Encourage collaboration/recognize roles of team members.

- Encourage the SW to be less authoritative and give others a chance to express their opinions.
- Intervene on SW's offer to develop treatment plan and get input from the Pharm.
- Give equal recognition and opportunity to speak to each member and then allow other members to comment on what was said.

7 Establish/review/summarize care plan and team decisions.

- There needed to be a real plan for dealing with the thyroid medication dosage.
- I would have tried to come up with a concrete treatment plan before concluding the meeting.
- I would not have allowed the meeting to end if there were still issues and if a treatment plan had not been solidified

8 Clearly define team members responsibilities.

- Assign responsibilities/action items/review time at end of meeting for meeting patient's needs.
- Remind the SW that a psych consult does not infringe on her responsibilities.
- Explain to the SW that she is not qualified to assess a psych consult and that it is in the patient's best interest to get a psych consult.

9 Counsel team members privately.

- Speak to SW after meeting in private about why she got defensive at suggestion.
- Talk to the person arriving late after the meeting to tell him how his late entrance affected things.
- Take the Pharm aside and tell him that he should try to be more punctual next time.

D. The following examples represent **wrong answers** to **ways to respond** to **ineffective behaviors**:

1 MD/NP/SW/Pharm "should."

3. 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.

- SW discussed details of functional and social assessment.

- The team members received more psychosocial information that might help the team to sort out problems.
- Planning proceeded based on team's discussion.

2. Agreed to specific care and task assignments.

   - Decision was made to change therapy care for patient with mechanism for assessing this change in future.
   - The team did not reach consensus on a few things.
   - They ended up having some plan for the thyroid.

3. Team members engaged/group input.

4. Team effectively solved problems.

B. The following examples represent **wrong answers** to reasons why the team meeting was valuable in establishing and/or improving the care plan for the patient:

1. Care plan developed.
2. Members assumed specific responsibilities.

C. 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.

   - The team did not make progress in identifying a consensus problem list on which to build a plan.

2. Patient's problems identified but not resolved.

   - What happens to patient's meds- who is handling her meds?
   - The team's concerns were not adequately addressed; depression, family problems/lack of support, safety issues, etc.
   - The team did not hear/gather all of the pertinent information to plan for this patient.

3. Conflict/ lack of respect for other team members.

   - MD cut off input from other disciplines.
   - Nothing was done to show values of various team members.
   - No input from Pharm.
   - The team had side conversations, distractions, and interruptions in the short time they were meeting.
   - Full contribution of team members not recognized or encouraged.

4. No team process/lack of collaboration and communication.

   - Decisions were individual not team.
   - Problem solving did not follow problem identification.
   - Some problems were identified but no clear goals or approaches were identified.

5. Implementation of plan not likely to be interdisciplinary.

   - Only one person is going to develop care plan. The group should develop care plan together.
   - Very little team interaction led to a new care plan (SW ended up developing the plan independently).

6. No team leader/ineffective team leader.

   - Meeting was very disorganized -- needed team leadership.

7. Confusion of responsibilities/roles.

   - Unclear responsibilities of members.
   - Did not define duties to follow-up on.

8. Team did not provide a complete picture of all patient problems (environmental, social, etc.).

   - Important points involving patient were neither presented clearly nor addressed specifically.
   - Don't think the patient's issues were addressed.
   - The issue of the patient's depression seemed to be addressed inadequately.

D. The following examples represent **wrong answers** to reasons why the team meeting was invaluable in establishing and/or improving the care plan for the patient.

   1. Lack of respect for patient's family.
   2. Rushed to conclusions/needed more time for meeting.
   3. SW not best person for psych consult.
   4. Not enough time for meeting.

VIDEO: Case of Mr. Rosario

1. **Script**
2. **Questions for Students to Think About**
3. **Notes for Faculty**

Video Script: "Case of Mr. Rosario"

By the GITT Case Studies Work Group

Roles:

Physician: Jennifer Rodgers
Nurse Practitioner: Mary Thomas
Pharmacist: Simon Wilson
Social Worker: Andrea Brown

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. resent in the meeting are Andrea Brown, the social worker; Mary Thomas, the nurse practitioner; Simon Wilson, the pharmacist; and Jennifer Rodgers, the internist.

Social Worker: It's 8. Let's get started. Everybody has the list of patients we're reviewing today? The first patient is Henry Rosario. Mary, you're the nurse practitioner on this case and you've asked to present your patient. Why don't you start?

Jennifer and Simon are laughing and having a side conversation when Andrea begins.

Mary shuffles through her papers and takes another moment to get oriented.

Nurse Practitioner: Ah ... just a moment, Hmmm, Oh here's the file. Mr. Rosario is an 81-year-old white man with adult onset diabetes who lives alone in a two-story walk up. He's unable to control his blood sugar with diet alone so he takes tolbutamide 250 mg twice a day. He has been taking his medicine as prescribed for the past 6 months and seems to be in good control. His diet is "iffy;" he has a sweet tooth and he loves junk foods despite my repeated instructions about the need to change his eating habits. His eyesight's been declining over the past year, and it'll probably continue to decline, but so far he can read his medication label and is able to do things like get his key in the door. Basically, he sees well enough to be safe at this time. He'll be coming in for routine blood work and I've got the podiatrist scheduled to look at his feet and cut his nails. I'm sure he'll be fine.

Physician: If he's stable why are we discussing him? We have such limited time, and I have a lot of work to do. We need some rules for these meetings if we're going to get anything out of them.

Nurse Practitioner: Dr. Rodgers, I've listened to your presentations no matter what you choose to focus on. The information I'm presenting is very important and is exactly what we agreed should be the content of these team meetings. I am telling you he is stable now, but is likely to be at risk for accidents and hyperglycemia in the future. Since everyone here may see Mr.

Rosario sometime in the next few months, I think this presentation is highly relevant.

Social Worker: We're supposed to present cases that seem complicated or require the input of others. Those are our ground rules. Was there something specific about the case that you wanted us to review? Do you think I should speak with him about his declining vision and other supports he might need?

Nurse Practitioner: Sure. I'll tell him about you when he's in today.

Social Worker: How about the medications Mr. Rosario is taking, is there some medication that Simon should review?

Simon is doodling on a pad and appears slightly startled when his name is said.

In the meantime, Jennifer's beeper goes off. Jennifer quickly silences the beeper, she reads the number, and jots something down on the pad.

Pharmacist: Any medications besides tolbutamide?

Nurse Practitioner: He's also on Tylenol 650 mg for some mild arthritis. He takes Dalmane 30 mg for sleep and sometimes repeats it once.

Pharmacist: Dalmane? Dalmane's a really bad drug for geriatric patients. He shouldn't be on Dalmane.

Nurse Practitioner: Really. He's been on Dalmane for 30 years.

Physician: Can you recommend a different drug or a different dose? Sleep problems in the elderly are really common. What should we know?

Pharmacist: Sorry, I thought nurse practitioners would know about sleep medications.

Simon begins a careful discussion about the newest sleep research. He assumes the role of know-it-all.

Pharmacist: Well, it is true that people over 60 consume 40% of the sleep medications but Dalmane creates problems because of its very long half-life. It's at least 2 days – which potentiates problems that all hypnotic drugs have such as hallucinations, agitation, and changes in memory and gait. Actually, it turns out that benadryl in low doses, say 25 mg, can be effective and relatively free from harmful side effects. Sometimes the anticholinergic effects of benadryl can be a problem but that can be monitored...

Social Worker: Thanks, Simon. We'll all think more carefully about sleep medications now.

Physician: What's the history of the sleep problem? Maybe he doesn't even need it any more, and could be tapered off over time? Do you think it's a serious problem like sleep apnea that wakes him?

Nurse Practitioner: No. It doesn't sound like sleep apnea to me.

Social Worker: Seems like you'll work on the sleep problem. I'm concerned about his nutrition. I think we need to get a nutrition consult. I wonder if he can carry groceries up those two flights of stairs.

Nurse Practitioner: I've tried to get him to change his diet but he's just not compliant. Maybe a nutrition consult will help. Sure, why don't you set it up?

Social Worker: I've got a full day already. But if you don't think you can manage it, I guess I can. Anything else? Let's move on to the next patient.

End

Questions for Students to Think About:

A. Team Dynamics Questions

1. On a scale of 1-10 (1 is HIGHLY EFFECTIVE, 10 is HIGHLY INEFFECTIVE), choose a number that best represents your perception of the team's functioning.

2. Please list specific effective and ineffective 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 last" rather than "the social worker disrupted the meeting." You may want to consider skills in the following area: running meetings, leadership, communication, conflict management, recognition of other team members, etc.

3. List three different ways you would have responded to these ineffective behaviors.

B. Team Effectiveness Questions

1. How valuable was the team meeting in establishing or improving the care plan for the patient? On a scale of 1-10 (1 is NOT AT ALL VALUABLE, 10 is VERY VALUABLE), choose a number which best represents your judgement.

2. Please give three different reasons why you circled the number you did in Question 4.

Faculty Information Notes

1. TEAM DYNAMICS/EFFECTIVE BEHAVIORS

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

1 SW assumed organizer role (agenda, moves meeting along).

- SW attempted to keep meeting focused and on schedule, clear agenda.
- SW leadership role in initiating the meeting and ensured all team members had a list of patients to be discussed so that they were prepared for discussion.
- SW was an effective manager of process; started meeting on time.
- SW team leader, good control of meeting.

2 SW facilitated/diffused conflict well between NP/MD (clarification of team rules on patients, stated ground rules).

- SW clarified ground rules when a conflict arose regarding them.
- SW—conflict management in restatement of ground rules for discussing patients and directing discussion.
- SW clarified purpose of the team meeting to show support for the NP, who was defensive after MD accused her of wasting time with stable patient.

3 MD good use of facilitation skills (refocused group/prompted pharmacist for information and help).

- MD intervened in discussion to refocus group onto issues of medication -- a positive and appropriate way to keep group focused.
- MD stopped Pharm's denigrating remarks to NP by asking him for his suggestion on alternative meds.
- Some successful efforts of collaboration and appropriate accommodation (SW and MD).

4 Meeting began on time (SW).

- SW started meeting well, started meeting on time.
- Team assembled and meeting started on time.
- SW was an effective manager of process -- started meeting on time.

5 NP prepared with patient presentation.

- NP was well prepared.
- NP gave good, concise summary of clinical issues.
- NP stated why she is presenting.

6 SW set up nutrition consult.

- SW agreed to set up nutrition consult when no one else would.

- SW accepted to do referral, even though busy.
- Leader asked for a nutrition consultation.

7 Group attentive.

- Pharm attentive.
- Team members seemed to be attentive and listened at least part of the time
- All listened, attentive. and took notes on case under discussion.

8 MD did not answer page.

- At one point in team conference, MD did not answer her beeper, thereby avoiding an interruption.
- MD shut off beeper and didn't let it interrupt meeting.
- MD did not answer her page immediately.

9 NP empathy for patient.

- NP communicated care and empathy for patient.

10 SW facilitated meeting (prompted NP/Pharm about meds and dietary consult).

- SW creatively facilitated the meeting (i.e., kept members on the appropriate topic and acted as mediator during disagreements/conflicts).
- SW — appropriate accommodation.
- SW tried to involve Pharm and others in contributing ideas regarding patient's problems.

B. The following examples represent **wrong answers** (e.g., effective behaviors):

1 Team members need/should.
2 Team socially appropriate.
3 Pharm contributed knowledge appropriately.
4 MD sought clarification as to why case was being presented.
5 SW used collaborative style.
6 Group collaborative/ sharing.
7 NP responded appropriately to conflict with MD & SW.

2. TEAM DYNAMICS/INEFFECTIVE BEHAVIORS

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

1. NP poor conflict management skills.

- NP wanted to handle all of patient's problems and got defensive when other team members tried to contribute help.
- NP reacted defensively to internist's question about why patient was being presented.
- NP took physician's outburst personally rather than responding to the content.

2. Pharmacist sarcastic/puts down NP.

- Pharm reprimanded NP regarding the use of a specific medication.
- Pharm was aggressive regarding Dalmane.
- Pharm offered his ideas in judgmental and arrogant way, used sarcasm, personalized his comments to NP, acted as expert in disrespectful way.

3. MD showed poor conflict management skills (aggressive/evaluator).

- Clearly, MD somewhat confrontational in seeking clarification.
- MD impatiently questioned need to discuss case -- created hostile situation.
- MD reaction: are you wasting my time — leads to interruption — problem should have been more explicit

4. NP presentation not appropriate for team care/planning/meeting.

- NP presented patients as if all issues had been dealt with already; she gave the impression that the patient was stable when, in fact, this was not the case.
- NP described patient's refusal to change dietary habits but did not seem to work with him from a participative approach (i.e., patient as part of the team).
- NP presentation was not focused on team issues — patient problems needing their input not specified.

5. SW defensive/poor conflict management skills.

- SW defensive.
- SW inappropriate accommodation.
- SW, MD, Pharm seemed to gang up against the NP, as indicated by their facial expressions.

6. SW/NP conflict/argue over responsibility for nutrition consult.

- RN/SW both too busy to schedule nutrition consult — then SW agrees.
- Defensiveness on the part of the SW when asked to help with referral for nutrition consultation.
- SW's negative response to scheduling nutrition visit (too busy).

7. MD/Pharmacist side discussion.

- MD, NP, Pharm were unable to express their opinions without condescension and rudeness.
- Eye contact between MD and Pharm disrespectful and disturbing.
- Pharm and MD communicated their disapproval of things nonverbally and created an alliance of judges.

8 MD/Pharmacist showed lack of respect for team members (nonverbal eye rolling, condescending).

- MD, NP, Pharm were unable to express their opinions without condescension and rudeness.

- Eye contact between MD and Pharm disrespectful and disturbing.
- Pharm and MD communicated their disapproval of things nonverbally and created an alliance of judges.

9 Pharmacist is “expert”/lectured team on meds.

- Pharm began to pontificate about sleepers.
- Pharm gave too much information, got into lecturing mode.
- Pharm set himself up as expert on meds and put the NP on the defensive.

10 SW shows poor facilitation skills (changed topics/cut off Pharm).

- SW cut off discussion of sleeping medications by Pharm without finding a positive way to refocus him.
- Before topic of sleep problem was resolved, SW jumped to nutrition, changing the subject before resolution had been reached.
- SW avoided conflict by introducing other ideas.

11 Members did not recognize others’ roles/lack of respect.

- Talked down to one another — factors emerged (SW/NP & MD/Pharm).
- Each team member at some point ignored the roles of other team members.
- Some members are first name, others “Dr. Rogers.”

12 Beeper disruptive.

- Beepers were disruptive.

13 No plan established.

- No agreed-upon plan. No follow-up established.

14 Team members not paying attention.

- Little attention paid by other disciplines when someone was talking.

15 No ground rules/organization.

- Goals of team meeting seemed unclear to the team members.
- Should know goals of group discussion — everyone should be aware.

16 Leadership not decided by group.

- In general, no one was running the meeting.
- The leader of the meeting was not identified clearly.

17 Poor distribution of workload/responsibility not taken.

- Difficulty distributing workload.
- All: no one had the time in the end to actually do anything.

B. The following examples represent **wrong answers** (e.g., ineffective behaviors):

1. Difficulty distributing workload.
2. No one had the time in the end to actually do anything.

C. The following examples represent **ways to respond** to these **ineffective behaviors:**

1. Recognize conflict/use conflict management strategies.

- The conflict needs to be addressed openly and constructively.
- This might be done in the last 10-15 minutes of meeting during feedback discussions.
- Encourage team members to disagree in ways that don't create defensive responses.
- Stop the meeting and ask the combatants "what's going on?"

2. Review/revise protocol for presenting patients.

- Suggest that, in giving the summary of status, that person presenting raises issues of concern as a starting point for discussion.
- Request/explain purpose in bringing case to meeting.
- Set up discussion of each patient with ground rules in mind, such as, "what are the pressing issues and concerns for this patient?"

3. Facilitate meeting by refocusing discussion, collaborative language, appropriate interruptions.

- I would have let the pharmacist know that not everyone is an expert in pharmacology and that his opinions and input are needed. However, rudeness is never necessary.
- Refocus team on goal of treatment plan development when they get sidetracked on sleep medication issue.
- Intervene during the "too busy" comment by SW to point out that everyone is very busy, and ask team who could arrange the consult most easily.

4. Team self-reflectivity: Improve team dynamics through team reflection /time to review team issues/time to evaluate meeting.

- Restrain ground rules for meetings.
- Suggest that the team get more training in team process and communication, including interpersonal issues (such as conflict) on teams and how to deal with them.
- Recommend team building -- deal with respect for each other's values, skills, feelings, and conflict.

5. Establish meeting structure and ground rules for behavior.

- Review ground rules for behavior.
- Pagers on vibrate — decreasing interruptions.
- Appoint a team leader.
- Establish and stick to an agenda.

- Ask team members to refrain from abrupt interruptions of others on the team.

6. Encourage collaboration/recognize roles of team members.

- Ask each team member to identify one goal for the patient and continue this discussion until no team member has a goal to contribute. Follow this with a discussion of which disciplines should be involved in working on the specific goals.
- Draw all members into collaborative process.
- Request to seek full consensus on what are the specific issues in this case that need action.

7. Establish/review/summarize care plan and team decisions.

- Provide some time at the end to summarize and assign tasks for follow-up.
- Process leader should push more toward team's agreement on problems/priorities team is going to address and who will do this.

8. Define team members responsibilities clearly.

- Establish clear guidelines for distribution of workload.

9. Counsel team members privately.

- I would ask to speak privately to the NP and the Pharm to express my experience of their participation at the meeting and encourage each of them to speak with other members to process unspoken issues.

D. The following examples represent **wrong answers** to **ways to respond** to **ineffective behaviors**:

1. Did task myself.
2. Be a good example.
3. Patient should be able to be the focus of team meeting.
4. MD/NP/SW/Pharm "should"

3. 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.

- Dialogue eventually led to identification of potential problems needing to be addressed -- Dalmane use, nutritional issues.
- Team identified a broad range of issues: nutrition, safety, meds.
- The team did identify some issues (such as medications, social support, and nutrition) that were relevant to improving the patient's level of functioning.

2. Agreed to specific care and task assignments.

- A plan was developed to promote dietary cooperation, by the referral to a nutritionist and the delegation of responsibility, to follow-through with the recommendation.
- Outcomes -- MD to follow-up on sleep problem, NP on referral.
- Patient to see nutritionist (consult to be arranged by SW).
- Patient also to see SW about failing vision.

3. Team members engaged/group input.

- There was good input from all members of the team; they displayed good information seeking and sharing.
- Team members were all actively engaged in this meeting.
- Team participated in this case -- info.

4. Team solving problems effectively.

- Despite defensiveness and poor communication, the team was able to successfully move from problem identification to problem solving.
- Team is still in storming phase but they are working effectively through their team issues.
- Although the team disagreed inappropriately at times, they were able to get past that and attend to the patient's needs.

B. The following examples represent wrong answers (e.g., valuable meeting).

1. Care plan established.
2. Meeting productive.
3. Team learned from Pharm about sleep meds.

C. The following examples represent reasons why the team meeting was invaluable in establishing and/or improving the care plan for the patient

1. No real plan of care developed.

- No real plan of care developed, especially regarding sleep and medication.
- Team never arrived at a complete care plan. There may have been social or medical issues as to why he wasn't eating well or how diabetes was managed, also what was cause of sleep problem.
- No integration of discipline specific issues into overall treatment plan.

2. Patient's problems identified but not resolved.

- The sleep issue remains unresolved and mutually agreed upon.
- Many issues have been brought up but none resolved adequately because of ineffective communication.
- Addressing medications and sleep problem seen as very important by Pharm was postponed. Meeting created additional work rather than clarifying path forward.

3. Conflict/lack of respect for other team members.

- Little respect among team members.

- Unresolved conflict among team members interferes with team process and treatment planning.
- There was no positive appreciation expressed for any team member's contribution by anyone.

4. No team process/lack of collaboration and communication.

   - SW attempted to run meeting but could do no more than stick to the schedule.
   - Insufficient attention paid by team members to each other, so no real pooling of concerns and problem solving.
   - Team members disagreed about the ground rules of their meetings

5. Confusion of responsibilities/ roles.

   - People arguing over who would do what.
   - Were unclear on assigned role as to who should be doing these interventions.

6. Team does not provide a complete picture of all patient problems (environmental, social, etc.).

   - Important medical/social issues not dealt with.
   - Did not identify all possible helps -- nursing home, rehabilitation, etc.…

D. The following examples represent wrong answers (e.g., non-valuable meeting).

1. Patient not present at meeting/ no focus on patient.
2. Not enough time/ more time needed.
3. No team leader/ ineffective team leader.
4. Meeting not valued.

VIDEO: Case of Mrs. Busby

1. **Script**
2. **Questions for Students to Think About**
3. **Notes for Faculty**

Video Script "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 6 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

score is 27/30. I've decided to treat her with ramipril for her heart and fosamax 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 buildup of wax, if this person has some sort of temporary hearing loss, or whether it's drug reaction. With acute hearing loss, one could also consider giant cell arteritis (GCA). The diagnosis is established with a temporal artery biopsy specimen, in which the characteristic necrotizing granulamatous vasculitis can be seen. The serious complication of blindness can be averted if the patient is treated quickly with daily oral prednisone ranging from 40 - 60 mg. The activity of GCA can be followed by monitoring the sed 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 arteritis? That's extremely rare. And Rosemarie'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 work up 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 got to 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. 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 fosamax. Both are expensive. Fosamax 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 fosamax.

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. Heineman's waiting for me in the ER.

End.

Questions for Students to Think About:

A. Team Dynamics Questions

1. On a scale of 1-10 (1 is HIGHLY EFFECTIVE, 10 is HIGHLY INEFFECTIVE), choose a number that best represents your perception of the team's functioning.

2. Please list specific effective and ineffective 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 last" rather than "the social worker disrupted the meeting." You may want to consider skills in the following area: running meetings, leadership, communication, conflict management, recognition of other team members, etc.

3. List three different ways you would have responded to these ineffective behaviors.

B. Team Effectiveness Questions

1. How valuable was the team meeting in establishing or improving the care plan for the patient? On a scale of 1-10 (1 is NOT AT ALL VALUABLE, 10 is VERY VALUABLE), choose a number which best represents your judgement.

2. Please give three different reasons why you circled the number you did in Question 4.

Faculty Information Notes

1. TEAM DYNAMICS/EFFECTIVE BEHAVIORS

A. 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.

B. The following examples represent wrong answers (e.g., effective behaviors)

1. SW began meeting on time.
2. SW accepted responsibility for follow-up.
3. Pharm facilitated conflict between NP/MD over medication orders.
4. NP confronted SW and MD.
5. Team accepted MD expertise.
6. Team on time.
7. NP accepted responsibility.
8. MD shared knowledge

2. TEAM DYNAMICS/INEFFECTIVE BEHAVIORS

A. 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, which put NP on the spot.

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.

B. The following examples represent examples of **wrong answers** (e.g., ineffective behaviors).

1. Pharm not knowledgeable about meds.
2. NP not supported.
3. Team lacked agenda.
4. MD did not elicit NP's opinion.

C. The following examples represent ways to respond to these **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.

3. 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.
   - Team members did ask appropriate questions.
   - Important information for patient's care was exchanged.

B. The following examples represent **wrong answers** (e.g., valuable meeting).

1. Care plan developed.
2. Team effectively solving problems.

C. 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.…).

   - 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.

VIDEO: Case of Mrs. Lin Tsai

1. **Script**
2. **Questions for Students to Think About**
3. **Notes for Faculty**

Video Script "Case of Mrs. Lin Tsai"

By the GITT Case Studies Work Group

Roles:

Physician: Kathy Kane
Nurse Practitioner: Terry Whitelaw
Pharmacist: Bob Wilson
Social Worker: Nancy Fulmer

Narrator: A primary care team is in the middle of its weekly meeting to review new geriatric clients who may need the center's case management services. The purpose of the meeting is to develop a plan of action for the clients discussed. Present at the meeting are the Physician, Kathy Kane; Nurse Practitioner, Terry Whitelaw; Pharmacist, Bob Wilson; and Social Worker, Nancy Fulmer.

Nurse Practitioner: All right, our last clients are new –- Mr. George Tsai and his wife, Mrs. Lin Tsai. They were seen by Nancy and Kathy. Who wants to begin?

Social Worker and Physician are talking while Nurse Practitioner is talking.

Pharmacist: Terry, we only have 10 minutes before we're supposed to end. How can we review two new cases? Why don't we discuss them next week and end early for once?

Nurse Practitioner: Nancy's on vacation next week and she's important in this case. We'll be OK, this was the agenda we set. Kathy, do you want to present the case?

Pharmacist: Vacation? Where are you going Nancy?

Social Worker: We've rented a cottage at the lake for a week. Same place as last year. The kids had a fabulous time swimming and running around.

Pharmacist: Sounds great.

Physician: Wish I were on vacation next week. I'm not scheduled for another month.

Nurse Practitioner: Kathy, can you please start.

Physician: Sure. I saw Mrs. Lin Tsai, an 80-year-old woman who has a history of a left CVA. She was hospitalized at University 11 months ago. Her right-sided weakness markedly improved after a 2-week stay in their rehab unit. She returned home able to perform all her ADLs and seemed to be fine. Apparently, about 2 months ago she became very agitated and the Tsais went to the clinic on Sweetwater Street. The doctor prescribed Haldol 2 mg/hs to treat the agitation.

Pharmacist: She's not still using Haldol, I hope. Why does anyone prescribe that drug with geriatric patients?

Physician: No, she's not on it any longer. The family tried it for a few days but they realized that it made her even more agitated and they stopped it. That's when they decided she needed to see someone else. They are friendly with the Huis who come to our clinic. Mrs. Hui convinced Mr. Tsai's daughter that she should bring both of her parents in here for an evaluation.

Physician's beeper goes off and she goes to the phone in corner and dials the number.

Physician: I've got to take this. Nancy, why don't you continue to present the Tsais.

Social Worker: Sure. I interviewed the husband, Mr. George Tsai, who was accompanied by their married daughter, Susan Tan. Mr. and Mrs. Tsai have three children, two daughters and a son. They all live here in the city. Susan is the youngest daughter and she lives two blocks from the parents and seems attached to both parents. Both the husband and the daughter are concerned about Mrs. Tsai. Mr. Tsai complains that about 3 months ago, right around Thanksgiving, Mrs. Tsai began to be "forgetful." Her cooking that holiday was terrible and Mr. Tsai's daughters basically made the holiday dinner because nothing was ready, which surprised them.

Nurse Practitioner: So, then, this is a sudden change in behavior?

Social Worker: Right. The daughter also said that her mother frequently cries for no apparent reason and seems disinterested in everything. The daughter is constantly cleaning the house for her parents. Her father doesn't know how to cook or clean so it's beginning to be a real issue for the daughter. Mr. Tsai, who was present during the interview, seemed to be very uncomfortable with his daughter's assessment. He denied there were any problems and kept insisting that his was wife was fine only tired as a result of her heart.

Physician returns to the table after answering the beeper.

Physician: I suspect this lady has multi-infarct dementia and I've ordered a CAT scan and a dementia workup. I'm waiting for the results. We probably need a neuro consult, as well.

Social Worker: Couldn't she also be depressed? She's tearful, had a stroke, and we know strokes are often associated with depression.

Physician: This is a clear diagnosis of stroke. Why do you want to complicate it with depression?

Pharmacist: What about the medications she's on?

Nurse Practitioner: Apart from the Haldol and some Chinese herb, I don't show anything.

Pharmacist: What about aspirin? I'm sure that was ordered after the CVA.

Nurse Practitioner: It's not in the record.

Physician: Well, if it's not there, let's start her on it.

Nurse Practitioner: OK.

Social Worker: During my interview the daughter mentioned that the Chinese herbal medicine was helping her. I wrote it down ... here it is ... Huperzine A. Ever hear of it?

Physician: Oh no. Not another patient who's self-medicating with herb stuff.

Social Worker: Don't you think we need to be a bit more sensitive to their cultural preferences? Maybe there's something to it.

Pharmacist: Well, actually Huperzine A is one of the new herbs being studied by the NIH in alternative medicine trials. It's a potent inhibitor of acetylcholinesterase referred to as HupA. For centuries it's been used in China to treat fever and inflammation. But a purified compound's been a prescription drug for treating dementia in China for the past few years.

Nurse Practitioner: How am I supposed to monitor the effects of an herb I've never heard of?

Social Worker: I'm sure the daughter can explain how much she's taking. Maybe you can work out with Bob what the dosage should be. Sounds pretty interesting.

Nurse Practitioner: I don't think so. I bet the side effects aren't even known.

Physician: I agree it's crazy but you're gonna be monitoring her anyway. You'll notice if there are abnormal clinical signs indicating toxicity.

Pharmacist: Actually, the results of the clinical trial in China suggest that the drug has low toxicity. Part of the benefit of A ChE-HupA complex is its longer half-life. It seems to have fewer cholinergic effects like nausea, vomiting and sweating. It may prove to be better than the FDA drugs recently approved for Alzheimer's but the results really aren't clear yet.

Physician: Aren't we ahead of ourselves? We need the results of the workups I've ordered and somebody should schedule her for a neuro consult. Hey, I've got to get out of here. It's after 9:00 and I have patients waiting.

Nurse Practitioner: I'll figure out the plan for Mrs. Tsai. Thanks. Have a good time on your vacation Nancy.

Physician: Yeah. Nancy have a great time and enjoy those kids.

Everybody joins in wishing Nancy a good time as they leave the room.

End.

Questions for Students to Think About:

A. Team Dynamics Questions

1. On a scale of 1-10 (1 is HIGHLY EFFECTIVE, 10 is HIGHLY INEFFECTIVE), choose a number which best represents your perception of the team's functioning.

2. Please list specific effective and ineffective 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 last" rather than "the social worker disrupted the meeting." You may want to consider skills in the following area: running meetings, leadership, communication, conflict management, recognition of other team members, etc.

3. List three different ways you would have responded to these ineffective behaviors.

B. Team Effectiveness Questions

1. How valuable was the team meeting in establishing or improving the care plan for the patient? On a scale of 1-10 (1 is NOT AT ALL VALUABLE, 10 is VERY VALUABLE), choose a number that best represents your judgement.

2. Please give three different reasons why you circled the number you did in Question 4.

FACULTY INFORMATION NOTES

1. TEAM DYNAMICS/EFFECTIVE BEHAVIORS

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

1. SW respected patient's culture/ helped team develop sensitivity.

   - SW was effective in presenting the cultural dimensions of the case (at least partly) and in convincing other members of the team about their importance.
   - SW defended patient's right to use alternative strategies.
   - SW able to differ from MD's assessment that confusion might be an indication of depression vs. multi-infarct dementia and able to remind MD to be culturally sensitive to this family's use of herbal medication.

2. NP refocused meeting/effective leader.

   - NP brought discussion back to patient after others digressed and discussed the SW's pending vacation.
   - NP as facilitator; handled Pharm's request to leave early well.
   - Gave brief answer that SW would be on vacation next week and that they would end on time.
   - Leader kept agenda, kept group on task well, began and ended meeting on time.

3. NP clarified sudden patient behavior change.

   - NP attentive and clarified some information that wasn't clear.

4. MD handed off discussion to SW.

   - Physician took page, but handed off discussion to SW so discussion continued without interruption in her absence.
   - MD and SW shared case presentation.
   - MD requested members continue her report when she was distracted.

5. Pharm educated other team members.

   - Pharm tried to interest others in medical effects of herbs.
   - Pharm comments regarding alternative herbal medication use were very informative.
   - Pharm interjected expert opinion; prepared with good information related to patient.

6. Team members recognized roles/discussed issues.

   - SW able to call upon Pharm as ally in educating staff. Used other team members effectively to make her point.
   - All listened to each other, especially Pharm's presentation; also, accepted recommendation for aspirin.
   - NP recognized importance of SW role -- appropriate questioning of side effects.

7. Members prepared to discuss specifics of case.

   - MD and NP were well prepared.
   - SW prepared agenda, timeline,, asked appropriate questions.
   - MD reported on diagnostic opinion and tests that have been ordered.

8. Team cohesiveness/friendly/attentive.

   - All team members sensitive to maintenance needs of group by discussing SW's vacation plans.
   - At the beginning, team members were attentive and listening.
   - Flow of ideas/relaxed atmosphere.

9. Team members demonstrated collaboration.

   - All members contributed effectively and collaboratively.
   - MD appropriate interjections, nonthreatening questioning, accommodated request to continue to use of the herb.
   - All disciplines had some input.

10. MD knowledgeable.

    - MD provided concrete suggestions regarding patient's evaluation.

11. SW provided clear, succinct summary.

    - SW suggested depression as something team should look into.
    - SW presented detailed history.

2. TEAM DYNAMICS/INEFFECTIVE BEHAVIORS

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

1. MD/NP not culturally sensitive/ignore role of patient/family.

   - MD, NP, Pharm not really interested in cultural aspects of care.
   - MD was not culturally sensitive.
   - NP mentioned Chinese herb but ignored it.

2. MD dominated/played expert role.

   - MD convinced of her diagnosis, did not want to hear other possibilities from team members.
   - MD knew everything that was important.
   - MD re-entered and acted like an expert -- focused things medically.

3. MD/NP reject herb treatment.

- MD rejected Chinese cultural herb treatment as “nonsense,” “ridiculous herbs.”
- NP/MD considered folk medicine unimportant.
- MD diminished significance of herbal therapy even after Pharm’s discussion.

4. MD disruptive when taking page.

- MD answered beeper and disrupted meeting while taking call.
- Beeper disrupted meeting. MD talked loudly and disrupted meeting.
- MD came back from her page and jumped back into conversation with her diagnosis without finding out what pertinent information she may have missed from SW’s presentation.

5. MD dismissed SW’s suggestion of depression.

- MD too dismissive of SW re: discussion of depression as a possible etiology and a little too domineering.
- SW’s concerns re: depression were dismissed unnecessarily by MD.
- MD put SW’s suggestion aside, too.

6. Side discussion about SW’s vacation.

- SW: initial discussion of vacation when pressed for time.
- NP, MD, and SW digressed from patient-oriented to social agenda by discussing SW’s vacation.
- Derailed on vacation plans.

7. Members did not recognize others’ roles/unequal roles/lack of respect.

- MD and NP uninterested in information provided by Pharm.
- MD and NP ruled — accommodated others but did not collaborate.
- No one supported SW’s effort to raise role of depression in the patient’s diagnostic and treatment processes.

8. No consensus on care plan.

- At the meeting’s end, the NP simply announced that she will “figure out the plan” for what to do with the patient -- there is no group consensus that integrates the different perspectives.
- Group needed to take time to pull out a consensus for a plan.
- NP was fairly passive and also took on job of writing up care plan.

9. Team members resisted prolonging meeting.

- Pharm tried to avoid rest of meeting at beginning.
- Pharm wanted to wait until next week, mumbled when overruled.
- Pharm tried to cut off case discussion at outset.

10. MD ended meeting abruptly.

- MD ended meeting abruptly without complete discussion of plan.

11. Pharmacist interrupted/side tracked discussion.

    - Pharm beginning of meeting sidetracked the discussion somewhat by proposing to discuss clients at a later date.

B. The following examples represent **wrong answers** (e.g., ineffective behaviors).

1. NP defensive/sarcastic.
2. NP not an effective leader.
3. SW reflected leader.
4. SW reflected insightfully.
5. Pharm confronts inappropriately about Haldol.
6. Pharm plays expert role.
7. Inappropriate negotiation of conflict.
8. Meeting time not well managed.
9. Second patient never addressed.
10. Team lacks agenda.

C. The following examples represent **ways to respond** to ineffective behaviors:

1. Recognize conflict/use conflict management strategies.

    - Spoken up in support of SW to look into depression.
    - Objectively assert that depression is common after CVA and maybe MD could consider that diagnosis along with the others she has mentioned.
    - Mediate negative attitudes toward alternative therapies until more is known about them.

2. Train team members re: family/patient culture/alternative.

    - Support creative ways of interacting with other cultures and incorporating their concerns.
    - Schedule speaker to address team on cultural sensitivity.
    - Distribute literature about new treatment regimes for review and future discussion.

3. Facilitate meeting by refocusing discussion, collaborative language, appropriate interruptions.

    - Point out that the vacation discussion is wasting valuable time with only 10 minutes and two patients to discuss.
    - Restate problems: we need to address the following issues: 1) Mrs. Tsai's sudden mental status change, 2) stroke risk prevention, 3) etc.
    - Probe for specific issues/clarify problems: e.g., "what side effects of the herb should we be monitoring?"

4. Team self-reflexivity: improve team dynamics through team reflection, time to review team issues/time to evaluate meeting.

- Suggest that the team needs to establish a clear time to discuss team procedures and communication issues -- not a time when the team is considering actual clinical cases and issues.
- Give feedback regarding team process in order to improve it.
- Evaluate meeting -- identify opportunities for improvement.

5. Establish meeting structure and ground rules for team behavior.

- Set ground rules re: pagers and ask MD to answer pages outside of room.
- Emphasize that while cohesion among team members is important, it must be balanced with an emphasis on completing the team's tasks. The team spent too much time discussing the SW's vacation plans.
- Appoint a team leader.
- Establish and stick to an agenda.
- I would have halted the meeting while the MD was on the phone, and on her return suggested that the team consider ways to manage the intrusion of beepers so that it does not distract from the meeting.

6. Review/revise protocol for presenting patients.

- Emphasize that patients not discussed due to lack of time should be put on the agenda for next week.
- Set and clarify agenda so Tsais were not viewed as an add on.
- Encourage team to present new cases at beginning of meeting.

7. Establish/review/summarize care plan and team decisions.

- Enable group to avoid abrupt ending of meeting, leaving plan to others to pull together.
- Would have asked if SW and Pharm could spend a little more time to make progress for Tsais.
- Attempt to create alliances based on patient/family focus and development of treatment plan addressing all areas of expertise.

8. Encourage collaboration/recognize roles of team members.

- Give positive feedback to Pharm where it is clear he knows about team needs to know about Chinese herb treatment. Ask him to summarize in a handout for team members to keep meeting process moving on.
- Remind MD and Pharm of the need for their expertise today in dealing with these patients.
- Work harder to seek consensus.

9. Confront MD about dismissal of SW's concern re: depression.

- SW should be encouraged to offer suggestions regarding next steps in terms of the evaluation and treatment of depression.
- I would have pursued further discussion about exploring the role of depression in the patient's presentation.
- SW should have been a little more assertive re: workup for depression. It is important since 20-30% of patients have pseudodementia.

10. Ensure adequate time for meeting.

    - Prepare a more reasonable schedule.
    - Help the team with time management or suggest that the team needs to scale down its meeting agenda.
    - Issue of rescheduling -- to end early -- group could discuss use of time.

11. Clearly define team members' responsibilities.

    - Ask MD to be more clear on delegation.

12. Counsel team members privately.

    - Speak to MD after meeting re: how disruptive her behavior was answering her page.

D. The following answers represent **wrong answers** to ways to respond to ineffective behaviors:

1. Identify team leader.
2. MD/NP/SW/Pharm "should."

3. 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. Team learned to monitor/tolerate herbal medicines.

    - MD was negative about herb treatment, but did not block other team members' interests in exploring and monitoring its use.
    - MD did not acknowledge (indirectly) that family would continue to use herbs so asked NP to monitor toxicity level. Pharm was able to point out that it has low side effects (toxicity level).
    - Intervention and explanation re: folk medicine by Pharm helped to moderate team members' negation of its use. Perhaps will lead to increased patient understanding.

2. Team members engaged/ group input.

    - Evidence of effective role interdependence among the team members.
    - Team members worked pretty well in sync. When team member asked for help – i.e., MD asked SW to pick up from where she left off or MD asked someone to order neuro consult -- NP said she would without any resentment.
    - Interest, effective communication, and camaraderie were demonstrated.

3. Patient problems identified and discussed.

    - Data regarding patient were shared.
    - Patient will get some evaluation.

- Responsibility for follow-up was assumed so one hopes that further case assessment is provided and treatment given.

4. Agreed to specific care and task assignments.

B. The following examples represent **wrong answers** to reasons why the team meeting was valuable in establishing and/or improving the care plan for the patient:

1. Care plan developed.

C. 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 real care plan established -- NP left to do it.
- Although issues were raised well, a clear/definite care plan wasn't reached.
- The NP took responsibility for developing the care plan outside the team meeting.

2. Confusion of responsibilities/roles.

- No one took responsibility for implementing plans.
- There was no consensus among team members about what should be included in the plan of care.
- NP took responsibility for doing the plan outside the team -- unclear how various perspectives (pt./family) and MD activities/ideas will be integrated, if at all.

3. Patient problems identified but not resolved.

- The issue of depression was addressed inadequately.
- Team identified problems/concerns but did not explore depression adequately — MD overbearing, did not give SW a chance to explain why she thought there was depression.
- Some of the problems identified were not addressed at all (family burden issues, for example).

4. No team process/lack of communication.

- Team members didn't listen to one another when they disagreed with what was being said.
- Not clear at all that evaluation is what patient needs because not based on full discussion of all team members' views.
- MD discounted everyone's suggestions but her own and insisted upon her plan.

5. Participants are not open minded.

- Two of the members did not seem to be responsive to cultural issues.

6. Conflict/lack of respect for other team members.

- Some members not respecting other member's opinions and views.

- There didn't seem to be much respect for disciplines -- the patient isn't going to get really comprehensive care if not all ideas and professional opinions are regarded.
- Team members did not always show respect for each others' opinions.

7. Team did not provide a complete picture of patient problems (environment, financial, etc.).

   - Emotional/psychological/physical aspects of patient not dealt with.
   - Not all clinical information available to team.

8. Not enough time/ more time needed.

D. The following examples represent wrong answers to reasons why the team meeting was invaluable in establishing and/or improving the care plan for the patient:

1. Lack of respect for family/culture.
2. No team leader/ineffective team leader.