Topic 3: Team Communication and Conflict Resolution[1]

Overview

Communication is the foundation for all team functioning. It requires that all team members cooperate to establish ongoing communication with each other, with the patient, and family for the sole purpose of developing an integrated care plan that addresses each aspect of the needed care. According to Woods and Coutts,[2] the provision of effective coordinated care requires the team to have an effective mechanism for the exchange of information.

Objectives

- Recognize barriers that affect communication exchange among providers, patients, their families, and communities.
- Recognize some effective communication tools and techniques that will contribute to good team function.
- Identify how diverse styles of communication contribute to team function.
- Recognize sources and types of conflict in teamwork.
- Identify strategies for managing conflict in an interdisciplinary team.

Effective Team Communication

To provide effective, coordinated care, a team must have an efficient mechanism for exchange of information. At the simplest level, this requires the time, space, and regular opportunity for members to meet and discuss patient cases. An ideal system for interdisciplinary team communication includes:[3]

- A well-designed record system.
- A regularly scheduled forum for members to discuss patient management issues.
- A regularly scheduled forum to discuss and evaluate team function and development, and to address related interpersonal issues.
- A mechanism for communicating with the external system (e.g., hospital administration) within which the team operates.

Effective communication relies on listening, explaining perceptions, acknowledging, and discussing the differences and similarities in views, recommending appropriate treatment, and negotiating agreement. In our increasingly diverse workplaces, language and cultural barriers

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[1] Topic 5 is from Woods, A.M., & Coutts, L. (2001). In D. Long, & N. Wilson (Eds.), Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging (www.hcoa.org; 713-798-5804).

[2] Woods, A.M., & Coutts, L. (1999). Communication. In C. Fasser. Interdisciplinary team training curriculum resource document. New York: The Geriatric Interdisciplinary Team Training Resource Center of New York University.

[3] Grant, R.W., & Finocchio, L.J. (1995). California primary care consortium subcommittee on interdisciplinary collaborative teams in primary care. A model curriculum & resource guide. San Francisco: Pew Health Professions. Cited in D. Long, & N. Wilson (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)

can exist among members of a team. These barriers can make it difficult for one member to understand the finer points in the meanings, intentions, and reactions of other team members. Our cultural heritage, our sex, our class, and our stage of life – all of these influence our use of language and our perception of others. Some degree of cultural competency must be in place for team members to effectively communicate with each other as well as with patients and family members. (See Topic 5)

Decision-making and conflict resolution are also components of the communication process that must be acknowledged by teams. Establishing a planned process for decision-making is essential, and the process must also take resolution of conflicts into account, because conflict is inevitable.[4] The group process must integrate openness and confrontation, support and trust, cooperation and conflict, sound procedures for solving problems and getting things done, and good communication.[5]

Some barriers to effective communication and teamwork at the team level include:

- Lack of a clearly stated, shared and measurable purpose.
- Lack of training in interdisciplinary collaboration.
- Role and leadership ambiguity.
- Team too large or too small.
- Team not composed of appropriate professionals.
- Lack of appropriate mechanisms for timely exchange of information.

Even among team members of similar cultural backgrounds, members need to recognize and value the different competencies and approaches of different disciplines. People do not need to think the same to be unified. The key to team success is to value the differences on the team and use such diversity to achieve the team's common purpose.

Clark (1995), suggests that values are a major source of conflicting and competing communication patterns among health professionals, who are educated and trained in very different modes and methods of practice, in regard to their relationships to each other and to the patient and family.[6] The following tips will be helpful for valuing diversity on your team:

- Reasonable people can—and do—differ with each other. No two people are the same. Diversity among team members enhances creativity.
- Learn as much as you can from others. Learning the various backgrounds, cultures, and professional values of others can enrich your own skills and abilities.
- Evaluate a new idea based on its merits. Avoid evaluating ideas based on who submitted them or how closely they mirror your own personal preferences.

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[4] Saltz, C.C. (1992). The interdisciplinary team in geriatric rehabilitation. Geriatric Social Work, 133-143. Cited in D. Long, & N. Wilson (Eds.), Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging (www.hcoa.org; 713-798-5804).

[5] Woodcock, M., & Francis, D. (1994). Teambuilding strategy. VT: Gower Publishing. Cited in D. Long, & N. Wilson (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).

[6] Clark, P.G. (1995). Quality of life, values and teamwork in geriatric care: do we communicate what we mean? The Gerontologist, 35:402-411. Cited In D. Long & N. Wilson. (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).

- Avoid comments and remarks that draw negative attention to a person's unique characteristics. Humor is a key factor in a healthy team environment but should never be used at the expense of another's identity or self-esteem.
- Don't ignore the differences among team members. The differences should be honored and utilized to advance the goals of the team (Fisher, Rayner, & Belgard, 1995). [7]

Barriers to communication range from the lack of a shared language born of differences in core values and terminology used by different disciplines, to systems and organizational barriers. In a busy health care organization, one of the major hurdles is finding the time for a team meeting and developing methods for effective team communication. In an organization where care is being provided in multiple locations and settings, informal communication often occurs in hallways, elevators and by telephone, voice mail and e-mail. If members of an interdisciplinary team do not possess at least a basic understanding of each other's knowledge and values, then it is likely that misunderstandings will result. For example, most physicians equate quality of life with mental status or freedom from mental impairment, while many nurses relate quality of life to physical strength, seeing, hearing, and having someone who cares (Clark, 1995).

Because of differences in philosophies of practice and professional training and because communication skills are rarely taught or modeled in professional education programs, team members approach problems in highly individualized ways. It is possible, therefore, that team members from different disciplines will look at the same thing and not see the same thing (Clark, Spence, & Sheehan, 1986).[8] For example, a patient who is being seen by a team may have a problem with depression. A pharmacist might see a patient with no drug therapy; a social worker might see a socially isolated patient; and a physician might see a patient with possible dementia.

Team Conflict

Conflict is a natural and unavoidable part of human affairs, especially in such groups as interdisciplinary health care teams that seek to grow and develop. The various health professionals on a team have underlying differences in their modes and methods of practice that affect their relationships with each other, as well as with their patients. Clark cites the work of Qualls and Czirr[9] to illustrate these differences. They suggest that professionals may differ in their logic of geriatric clinical assessment, that is, how to define the problem.

This difference may be characterized by two different styles of practice. One of these is "ruling out" problems by systematically eliminating possibilities until only one problem and a corresponding solution remain. The other approach of "ruling in" problems relies on expanding the range of professional view to encompass an increasingly long list of potential factors. For example, physicians are trained in diagnostic techniques that narrow the range of options, relying heavily on such objective data as laboratory tests in the process. Social workers, on the other hand, are taught to go beyond the narrow presenting problems to view it within larger, encompassing psychosocial issues, such as income, family relationships, and environment. In addition to the diverse professional perspectives, team members also have different

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[7] Fisher, K., Rayner, S., & Belgard, W. (1995). Tips for teams: A ready reference for solving common team problems. New York: McGraw-Hill.

[8] Clark, P., Spence, D., & Sheehan, J. (1986). A service/learning model for interdisciplinary teamwork in health and aging. Gerontology and Geriatrics Education, 6: 3-16.

[9] Qualls, S.H., & Czirr, R. (1988). Geriatric health teams: classifying models of professional & team functioning. The Gerontologist, 28:372-376.

personalities that influence interactions among team members. Other factors that may lead to conflict in team care include scarce resources and organizational or professional change that threatens individuals or the overall program.

There are various frameworks for classifying the types of conflicts experienced by geriatric interdisciplinary team (GITT) members. These include:

Intrapersonal:

A team member may have conflicting feelings about a personal course of action with a patient or colleague. For example, a practitioner may feel conflicted about supporting a patient's choice to forego treatment for a problem.

Interpersonal:

Differences of opinion on patient care are to be expected: however, recurring differences between team members may reflect something about their roles that requires clarification or results in inappropriate interaction that requires a third-party mediator.

Intragroup:

In teams, there may be several parties to a conflict or subgroups within a team in conflict with each other.

Intergroup:

Most teams practice in a broader organizational context that may result in external pressures that produce conflicts between programs or teams. In geriatric care, this may involve the geriatric team united in opinion against the surgery team plan.

Each of these types of conflict influences the others, and team leaders will have to determine whether and how to intervene when conflict occurs. Participation on an interdisciplinary team requires individual professionals to relinquish familiar hierarchies and freedoms.

Self-Assessment of Conflict

Each individual has a personal way of handling conflict. Hall[10] states:

> "So it is that some of us have learned that winning is the goal, some of us believe in turning the other cheek, and others of us attend to how we play the game. The point is that when our underlying values are magnified by the importance of the issues in conflict, they rapidly emerge to shape and guide those actions we see as appropriate in conflict situations."

An important aspect of managing conflict in teamwork is self-awareness regarding each member's way of handling differences between themselves and others. Our cultural training influences what we consider appropriate in human relations. Many Asian cultures, such as Thai, Vietnamese, and Filipino cultures, seek to maintain harmony in relationships and, therefore, avoid conflict at all costs This approach to conflict differs widely from the dominant American culture, with its preference for direct confrontation. Likewise, health care professionals are trained to avoid highlighting mistakes and differing views.

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[10] Hall, J. Conflict management survey. *(*1969). Cited in D. Long, & N. Wilson (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.

Instruments are available to help delineate personal style in relating to conflict situations, including the Strength Deployment Inventory (Porter, 1996)[11], and the Thomas-Kilmann Conflict Inventory (Thomas & Kilmann, 1974)[12], and the Keirsey Temperament Sorter (Keirsey, 1998)[13]. It is also important to ask oneself, "What experiences in my life affect my response to conflict? How do I overcome my 'natural' conflict handling style if it is inappropriate in some situations?" Perhaps a team member grew up in a conflictual family and tries to avoid battles at all costs. Perhaps one thrives on argument. These styles need to be identified and recognized in how they shape the team's work.

[11] Porter, E. (1996). Relationship awareness theory: Manual of administration and interpretation. Carlsbad, CA: Personal Strength Publishing, Inc.

[12] Thomas, K., & Kilmann, R. (1974). Thomss-Kilmann conflict mode instrument. Tuxedo, NY:Xiocom.

[13] Keirsey, D.; Bates, M. Keirsey Temperament Sorter. Frank, S. H. (1992). Appendix: Inventory of psychosocial measurement instruments useful in primary care. In M. Stewart, F. Tudiver, M. J., Bass, E. V. Dunn, and P. G. Norton, (Eds.), Tools for primary care research (pp. 229-270). Thousand Oaks, CA: Sage.

Strategies for Preventing, Reducing, and Managing Conflict

Strategies for preventing, reducing, and managing conflict within an interdisciplinary team practice include the use of one or all of the following (Julia & Thompson, 1994)[14]:

- Built-in process to review decisions, including review and definition of goals, the direction of the team, and priorities.
- Role clarification through the discussion of such topics and knowledge base, professional stereotypes, specializations, autonomy, competencies, responsibilities, and codes of ethics.
- Examination of overlapping roles and renegotiation of role assignments.
- Recognition of professional hierarchies and discussion of their impact on team functioning (status and delegation of authority issues are a part of this activity).
- Opportunities for improving interprofessional skills of team members teaching processes for handling conflict.

Through the exchange of views that accompanies conflict, geriatric teams produce creative care plans while building trust and understanding between members. Effective teams seek to manage conflict to avoid the stagnation or apathy characteristic of repressed conflict as well as the threat of chaos from unmanaged conflict. (Kormanski, 1982)[15]. Table 3.1, "Using Conflict to Promote Interdisciplinary Problem Solving," identifies various methods and strategies for managing conflict along with the key variable of power. In interdisciplinary teams, there are different sources of internal power (e.g., knowledge or tenure), so some members have more power than others do. Mature teams and team members are able to select the most appropriate conflict-handling style for the situation. Successful resolution of conflict requires the ability to communicate effectively, as well as to confront issues, not people, focusing on the search for win-win solutions.

[14] Julia, M.C., & Thompson, A. (1994). Essential elements of interprofessional teamwork task and maintenance functions. In R.M. Casto, M.C. Julia, L.J. Platt, & et al. (Eds), Interprofessional care and collaborative practice. Pacific Grove, CA:Brooks/Cole Publishing Co.

[15] Kormanski, C. (1982). Leadership strategies for managing conflict. Journal of Specialists in Group Work, 5, 112-118.

Table 3.1 Using Conflict to Promote Interdisciplinary Problem Solving[16]

Methods/Strategies	Power	Conclusion	Use/Don't Use
Coerce-Force / One defensive; one offensive; emphasize differences; judge and accuse	Imbalance (real or perceived); attempt to retain imbalance	One yields or standoff	Emergency; unpopular issue, fixed resources, need decision/Need support or long-term relationship
Withdraw-Avoid / One defensive; one offensive; emphasize differences	Imbalance (real or perceived); attempt to retain imbalance or create new imbalance	One yields or standoff	Trivial issue; little power; nonrecurring problem; part of larger problem/Serious issue; critical goals; recurring problem
Negotiate-Compromise / Bargain; hoard information	Relatively equal; attempt to increase relative power	Different factions agree to accept decision; all win and lose	Mutually exclusive goals of moderate importance; balanced power; focused on roles/Early in problem; need more information
Accommodate-Oblige / Share *all* information, clarify *all* disagreements; equalize input	Relatively equal; attempt to further equalize power	Overt agreement; covert disagreement	When wrong; need social credits; goals not critical; to promote member responsibility/Issue important to team and relationships
Collaborate-Integrate / Openly present problems; use all power strategies; balance conflict and cooperation	Universal and unequal; members free to get more power; team controls power for decision making	Comprehensive solution and re-evaluation	Critical needs and goals; ill-defined problem; need commitment/No time; no trust

[16] SOURCE: Reprinted, with permission, from Drinka & Clark (2000) Health care teamwork: Interdisciplinary practice and teaching. Westport CT:Auburn House .

Common Approaches Conflict Resolution[17]

Take the following actions to manage team conflict (Ajemian, 1993[18]; Grant, Finnochio, and the California Primary Care Consortium Subcommittee on Interdisciplinary Collaborative Teams in Primary Care, 1995[19]; University of Colorado Health Science Center, 1995[20]):

- Welcome the existence of the conflict, bring it into the open, and use it as potential for change.
- Separate the person from the problem in an effort to diffuse the emotional component of the conflict by showing respect, listening carefully, and giving all parties an opportunity to express views.
- Clarify the nature of the problem as seen by both parties. Is this the real problem?
- Deal with one problem at a time, beginning with the easier issues.
- Listen with understanding (interest) rather than evaluation. Use the communication skills of listening, reflecting, and clarifying.
- Attack data, facts, assumptions, and conclusions but not individuals (e.g., "I disagree with your assumptions").
- Brainstorm about possible solutions.
- Use objective criteria when possible.
- Invent new solutions where both parties gain.
- Implement the plan.
- Evaluate and review the problem-solving process after implementing the plan.
- Identify areas of agreement. Focus on common interests not positions.

Characteristics of Constructive Feedback[21]

Constructive feedback is:

1. *Positive and negative feedback.* Feedback requires the giver to pay compliments as well as to note improvements.

2. *Given with attention to context and caring.* Review the actions and decisions that led to the moment. The giver must pay attention to what he or she is doing while giving feedback. This promotes a two-way exchange with some depth of communication. Allow ample time for discussion and be sure there is privacy.

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[17] Long, D., & Wilson, N. (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).

[18] Ajemian, I. (1993). The interdisciplinary team. In D. Doyle, G.Hanks, Q. MacDonald (Eds.), Oxford Textbook of Palliative Medicine, 17-19. New York: Oxford University Press.

[19] Grant, R.W., & Finocchio, L.J. (1995). California primary care consortium subcommittee on interdisciplinary collaborative teams in primary care. A model curriculum & resource guide. San Francisco: Pew Health Professions.

[20] University of Colorado Health Sciences Center. (1995). Interdisciplinary rural teams training project resource manual. Boulder CO: The Colorado Area health Education Center

[21] Adapted from Scholtes, P., Joiner, B.L., Streibel (1996) *"The Team Handbook." Constructive Feedback p 6-23--6-32. (Madison, WI: Oriel Incorporated.)*

3. *Invited by the recipient.* Feedback is most effective when the recipient has invited the comments. This provides a platform for openness and some guidelines; it is also gives the recipient an opportunity to identify and explore particular areas of concern.

4. *Expressed directly.* Be descriptive and as objective as possible. Give specific examples and use “I” statements, talking about yourself first, rather than “you” statements. “I” messages create an adult/peer relationship and people are more likely to remain open to message.

5. *Expressed fully.* Effective feedback requires more than a bald statement of facts. Feeling reactions also need to be expressed so that the recipient can judge the full impact of his or her behavior.

6. *Uncluttered by evaluative judgements.* Feedback is most helpful when it is not exaggerated or consists of judgments, or evaluations, such as assuming the other person’s motivation or intentions. Avoid exaggerations such as “always” and “never” and judgmental words such as “should,” “good,” “bad” and “worst.” If judgments must be included, the giver should first state clearly that these are matters of subjective evaluation, then describe the situation as he or she sees it and, finally, let the recipient make the evaluation.

7. *Well timed.* The most useful feedback is given when the recipient is receptive to it and is sufficiently close to the particular event being discussed for it to be fresh in his or her mind. Storing comments over time can lead to a building of recriminations that reduces the effectiveness of the feedback when it is finally given.

8. *Easily acted on.* The most useful feedback deals with the behavior that can be changed by the recipient. Feedback concerning matters outside the recipient’s control is not often useful. Often it is helpful to suggest alternative ways of behaving and allow the recipient to think about new ways of tackling old problems.

9. *Checked and clarified.* If possible, the recipient of the feedback should check with other people to determine whether the giver’s perceptions are shared by others. Different viewpoints can be collected and assimilated, points of difference and similarity clarified, and a more objective picture developed.

Conflict Management Techniques[22]

Working with Differences

1. *Questions to consider:*

- What creates differences?
- What are the underlying factors that cause differences?
- How are differences played out?

1. *Types of differ*
2. *ences: what people fight over:*

- Information/facts

[22] Whitelaw, N., & Moore, S. (1997). Great lakes GITT team learning guide. Detroit, MI: Great Lakes GITT.

- Goals
- Methods
- Values

3. *Underlying factors that cause differences:*

- *Different personal histories* -- experiences that influence mindset.
- *Varied access* -- to same information.
- *Perceptual differences* -- perceptions become one's reality.
- *Role factors* -- expectations and resources differ.

4. *Stages of evolutions of differences:*

- *Anticipation* -- know something will happen that will result in a dispute.
- *Aware* -- but unexpressed verbal differences to others.
- *Discussion* -- differences begin to emerge openly during discussions.
- *Open dispute* -- differences are sharpened.
- *Open conflict* -- positions are locked in, often a win-lose mentality. Attempts are made to undermine the other side.

5. *Transforming conflict into a problem solving situation:*

- Encourage differences to surface and be expressed.
- Listen with understanding rather that evaluation.
- Clarify the nature of the conflict.
- Recognize and accept feelings of the involved individuals.
- Explore who and how the decision will be made.
- Discuss ground rules for resolving differences up front.
- Attend to the relationship as well as the business.
- Create humane vehicles for communicating with others.
- Focus on content and processes issued at the same time.
- Explore ways to facilitate problem solving

6. *Key summary points:*

- People: separate people from the problem.
- Interests: focus on interests not position.
- Options: generate possibilities.
- Criteria: results based on mutually agreed standards.

7. *Some Competencies that influence encounters with difference.*

- Active listening.
- Suspending judgment.
- Attack problems not people.
- Identify, explore, and use resistance.
- Ability to disengage.
- Ability to bracket.
- Ability to manage emotions.
- Ability to depersonalize.
- Ability to alter behavior, context, judgments, interfaces, and communication.

- Grace in ourselves, faith in others.

8. Mediating differences -- varied roles of a facilitator.

Working through differences involves creating mutuality and respect for opposing positions and people. Engaging intense differences requires being adaptive, strong, and emphatic, while not loosing track of issues and feelings. Creating common ground involves expressing relational energy in varied ways: catharting, catalyst, confronting, prescribing, and supporting.

Role	**When to Use**
Catharsis .	Provides opportunity to ventilate feelings and common emotions Clarify, restate, paraphrase, and reflect. Develops openness and fruitful trust levels. Lowers tensions and anxiety.
Catalyst	Creatively sharing new information (e.g., stories, examples). Helping others to see things in new ways. Exploring alternatives. Organizing data into information.
Confrontation	Directly challenging the status quo. Gently but persistently questioning the underlying rationale. Keeping the focus on the conflict. Maintain the tension. Compare critical positions and assessments (yours/theirs).
Prescription	Occurs after assessing/diagnosing the situation. Recommends course of actions or previously discussed options. Ask check out questions: “Does that make sense to you? Why?”

Techniques that Encourage Communication[23]

Closed Questions

- Closed questions focus on specific problems and elicit limited responses, often just a yes or no. Example: “Have you reviewed the patient’s medications?”
- Closed questions rarely elicit a lot of additional information but they are appropriate when specific information is needed quickly.

[23] Adapted from Storey, P., & Knight, C.F. (1998). Unipac five: care for the terminally ill. Gainesville, FL: American academy of hospice & palliative care. Cited in D. Long, & N. Wilson (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).

Open Questions

- Open questions give people permission to say more about what they are thinking and feeling. Examples: “What else can you tell me about…?” “Can you tell me more about…? “What are some examples of the things you want to talk about today?”

Minimal Leads and Accurate Verbal Following

- Minimal leads indicate interest and encourage people to continue talking. Examples: “Uh-huh.” “Umm.” “Hmm.” “Ah.”
- Minimal nonverbal leads include head nodding, eye contact, and leaning toward the speaker.
- Accurate verbal following indicates understanding.

Repetition

- Repetition involves repeating one or two key words from the person’s last sentence, which indicates the team member is listening, encourages people to keep talking, and enhances their sense of being heard.
- Repetition does not mean that one agrees with another; it only means the person is listening.
- Repetition is an important skill, but it should be mixed with other techniques to avoid sounding like a parrot.

Paraphrasing and Reflecting

- When people paraphrase and reflect, they repeat a person’s statement in their own words to ensure that the message is understood.

Clarifying Responses

- Clarifying responses help people understand the facts and the other person’s feelings and attitudes. Examples: “Is it possible that you feel…?” “Can you give me an example of what you are talking about?”
- Clarifying responses also help people think about what they have just said, examine their choices, and look at their life patterns.

Confrontation and Honest Labeling

- Confrontation and honest labeling are techniques for gently exploring uncomfortable subjects such as distortions of reality or differences between words and actions. This is not an angry demand that people confront any subject. Examples: “I hear anger in your voice…” or “You sound sad even though you say everything is fine.”

Integrating and Summarizing

- Integrating and summarizing help ensure that the main concerns are understood. They help team members clarify their thoughts and feelings and encourage them to further explore confusing and conflicting issues.

Exercises

1. Process Improvement Model- Force Field Analysis[22]

The Force Field Analysis is a tool used in teams to identify resistance to change. "Driving Forces" move a situation toward change. "Obstacles" block this movement. This exercise asks students to think together about all the facets of a desired change creatively. The Force Field Analysis serves as a starting point for action by encouraging students to agree about the relative priority of factors on each side of the provided balance sheet. Ideally, the team should try to find ways to weaken the obstacles while strengthening the drivers.

Facilitator's Notes

1. *Identify an issue or problem each team is having.*
2. *Explain to each team that it should establish a desired change or solution to the problem.*
3. *On the left side of the activity chart, list the "Driving Forces." These are reasons why the change should occur.*
4. *On the right side of the activity chart, list the "Obstacles." These are the forces preventing change from occurring.*
5. *Ask the teams to assess which "Driving Forces" can be strengthened, and determine which of the "Obstacles" could be removed or minimized.*
6. *Develop a plan of action.*

2. GITT Journal Entry Schedule[22]

This long-term exercise allows the students to reflect on their team training experience by creating and keeping a journal. The exercise provides each student with a series of questions that will help them flush out ideas about their individual teams and team practice as a whole.

Facilitator's Notes

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

3. Mt. Sinai Standardized Patients[24]

A standardized patient is a training tool in which an actor is trained to present signs and symptoms of a specific disease or syndrome. Standardized patients are common training

[24] Cassel, C., Howe, J., & et al. (2000). Mount Sinai geriatric interdisciplinary team training program. New York: Department of Geriatrics and Adult Development, The Mount Sinai Medical Center.

tools for medical students' skills in assessment and diagnosis. The Mt. Sinai GITT developed these standardized patient outlines to teach team skills in addition to assessment and diagnosis.

Facilitator's Notes

1. *Conduct individual team orientation.*
2. *After students have completed the interview with the standardized patient, reconvene students as a team.*
3. *Have students process the problems for the case and develop a plan of care.*
4. *Observe team interactions in the observation theatre.*
5. *Use trainee feedback form for standardized patient exercise to evaluate each team member's contribution to the quality and content of the team interaction and identify behaviors that keep or hinder team interaction.*
6. *Conduct a briefing/feedback session after the team meeting to help students reflect on their team process.*

4. *Rush GITT Case Studies*[25]

These two case studies provide facilitators an alternate way to examine conflict and communication. In one case (Mr. Alex Green), conflict is seen within the family and the goal of the team is to examine how the health system's goals may be at odds with the goals of the family. The second case involves restructuring the process of care and turf battles between disciplines and between components of the health care system.

[25] Rush Geriatric Interdisciplinary Team Training Program, Case Studies. Chicago, IL: Program in Ethics and Ethics Consultation; 2000

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GITT Exercises: Topic 3

Force Field Analysis for Benefits Barriers Exercise

This exercise takes about 20minutes with discussion and is useful to assist an interdisciplinary team to explore the benefits of teamwork in interdisciplinary care and to think about ways to reduce the barriers to team work in interdisciplinary care.

Force-Field Analysis

This tool is used to identify resistance to change. It was developed by Kurt Lewin as a way to identify forces: “driving forces” that move a situation toward change and “obstacles” that block this movement. This tool forces people to think together about all the facets of a desired change and it encourages creative thinking. It encourages people to agree about the relative priority of factors on each side of the “balance sheet” and provides a starting point for action. Ideally, the team should try to find ways to weaken the obstacles while strengthening the drivers.

Procedure

1. Identify the issue or problem.
2. Suggest the change or solution desired
3. On the left side of the flip chart, list the “Driving Forces.” These are the reasons why change should occur.
4. On the right side, list the “Obstacles.” These are the forces preventing the change from occurring.
5. Determine which driving forces can be strengthened and determine which obstacles can be removed or minimized.
6. Develop a plan for action to strengthen and minimize the obstacles.

Process Improvement Model

FORCE-FIELD ANALYSIS

DRIVING FORCES	OBSTACLES
→	←
→	←
→	←
→	←
→	←

GITT Journal Entry Schedule

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

Mount Sinai Standardized Patient Exercise

Sarah Datford- Background Information for Standardized Patient

Age: 73

Marital Status: Widowed for 8 years

Social History: My husband Frank, has been dead for a long time; he just died in his sleep one night. Frank taught French at New York University up until the time he died. He was 74 when he died. He got pneumonia and just never got better. Frank's heart wasn't really very strong either. But Frank did not like doctors and wouldn't talk to anyone about it. Frank and I couldn't have children, so now my only family is my nephew, Mark, who lives in San Bernardino, California, with his wife and children. I wish I heard from them more often.

I live by myself in a one-bedroom apartment by Washington Square. Frank and I moved into it right after he got the teaching job at NYU and liked the apartment so much we decided to stay.

I get money from Frank's pension and, of course, I have my Social Security. I do fine if I pinch my pennies. My good friend, Ruth, lives close by. She arranged for my Social Security checks to go right to my bank. She'll cash a check for me or sometimes we'll go to the bank together. I take a little out each week for groceries. Ruth has been paying my rent and utility bills for me because once I forgot to pay my bill and the phone company disconnected my phone! Ruth says it's easy -- she just pays hers and mine at the same time. She's a good friend.

Ruth is always dropping by. I guess to make sure that I am OK. That's nice, isn't it? Sometimes we have lunch together. I eat all my meals at home. I still cook and clean for myself- I do not have any problems with that yet. I do not eat anything fancy, just some cereal in the morning and some meat or chicken and potatoes for lunch. I usually just have soup and maybe half a sandwich for dinner (I like to have my big meals in the middle of the day). I like to watch TV while I have dinner. I've been eating the same foods for years; I have not lost any weight and I do not usually skip a meal or forget to eat.

I also read quite a bit. I used to love to go to all the museums and the library but, you know, I don't anymore. I am afraid I might forget where I was or how to get home.

I worked as a monitor at IS 44 until about a year ago. They asked me to retire. I think it was because they thought the work was too much for me.

History of Present Illness: Some time ago, I found myself on a bus and couldn't remember where I was going or why I was on the bus or even what bus it was. So I just got off somewhere and called Ruth. She makes me carry her phone number in my purse. She asked me to read the street signs at the corner where I was calling her from and told me to stay put. She got there in about 15 minutes and took me back home. I have not taken the bus anywhere since.

Grocery shopping and clothes shopping aren't so much fun anymore. I get so mixed up with money sometimes! The nice lady who works at the grocery will help me out, but it's hard. Sometimes, I forget what I went to the store for. I'll stand there and think, but it doesn't help. I just go back home without buying anything.

Family History: My dad died at 70 in a nursing home. The doctor said he'd become senile and that was about 3 years before he died. I mean, I guess I don't really know what senile means, but I think it means forgetfulness and maybe being childish. My mom died in a car accident a long time ago.

Habits: Rx Medications: None

Over the counter: Occasional Milk of Magnesia

Diet: Eats three simple meals a day

Exercise: She doesn't really go anywhere since she got lost

Caffeine: A cup of tea in the morning with her breakfast

Allergies: None

Notes for Standardized Patient: Sarah is in the early stages of Alzheimer's. Her long-term memory is OK but she has difficulty with short-term memory. She knows she is at the doctor's office, but won't remember the specific name of the hospital. Her attention will drift if you don't keep her engaged, or if there is a significant pause in the conversation.

Regarding the Mental Status Tests the students should do:

1. Spell "world." Sarah can spell the word forwards, but if asked, is unable to spell it backwards.
2. Remember three objects: The student will give Sarah three objects to remember saying the word and then having Sarah repeat it immediately afterward. The student should then talk about something else for a few minutes and then come back to the three items. Sarah will not remember them.
3. Perform a specific task: The student may ask Sarah to take a piece of paper, write her name on it, fold it in half and place it on the floor. Sarah can do the first step and then will forget the next steps and hand the paper back to the student.

Financial Situation: The following financial information is as factual as possible given Sarah's husband's work history. He would most likely have been tenured and have been making between $60,000 and $70,000 a year at the time of his retirement. Since Ruth has been taking care of Sarah's finances for some time, Sarah most likely won't remember what her monthly income is. Since the bus episode, Sarah doesn't feel safe going anywhere and, thus, has developed a simple lifestyle. Overtime, she began to believe it's based on necessity.

Monthly Income:

Combined Social Security and Pension: ………………………………………… $3,167.00

Monthly Expenses:

Rent (rent stabilized)…………………………………………………………… $450.00
Utilities and phone……………………………………………………………… $90.00
Food………………………………………………………………………………… $300.00

Total Expenses……………………………………………………………………$840.00

Sarah Datford—Presenting Situation

Sarah Datford, a 73-year-old woman, comes to The Mount Sinai Geriatrics Clinic complaining of memory problems.

Vital Signs:

Temperature:	98.4 oral
Pulse:	76
Blood Pressure:	142/84
Respiratory Rate:	16

Read the following instructions carefully:

1. You have a maximum of 20 minutes to perform a focused history on this patient.
2. After you have finished your interview, please go to the proctor for the questionnaire pertaining to this patient.
3. Take any notes you think necessary.
4. Leave this file at the door when finished with the patient.
5. Discuss the case with your team.

Samuel Hertz- Background Information for Standardized Patient

Age: 74

Marital Status: Bachelor

Social History: Sam grew up as an orphan in Brooklyn. He has been a bachelor all his life and has lived in an apartment alone on Coney Island for the last 35 years. Both his parents were from Hamburg, Germany. His mom was Jewish and his father Catholic; he never considered himself religious about anything except his music. He was brought over from Europe by an uncle at age 7 because both his parents had died very young (his father died in WW 1 and his mother died of leukemia.) He served in WW 2 in the Air Corp as a navigator and actually took part in air raids of his home town of Hamburg.

He had one long on-and-off relationship with Rita Carpoleto, with whom he had a daughter, Judy (41 years old). He was not a big part of her growing up. She got in touch with him several years ago when her mom died but they were never an active part of each other's lives.

Sam is an ex-jazz musician who plays the clarinet. He used to play gigs with Cab Callaway and many others in Manhattan and the East Coast. He burned many bridges because of his quick temper and defensiveness.

Mr. Hertz is well known in the community for hanging out on the beach and boardwalk in Brighten as well as a few local bars. He's somewhat of a local fixture. He dated almost every widowed or divorced woman in the area, but it never seemed to last. Sam sat in with trios and quartets a lot in the 50s and 60s and is quite nostalgic about his "good old days." He had is own jazz band called Cymba's for 15 years but the group broke up in '67, a sore spot he does not like to discuss.

Sam has always been able to "hold his liquor" and has been a happy but obnoxious drunk. Over the past 5-6 years, he's been more reclusive and drinks a lot alone at home, which he never used to do. It was more a social and musician thing to do.

The current urinary problems have increased his drinking of alcohol and thickened his depression about almost everything. He doesn't want Judy to see him like this so he has been refusing her awkward but nonetheless, persistent offers to help. He's so disgusted with himself at this point he had to see someone. His daughter mentioned Mount Sinai as having a very good geriatrics department.

Physical History: Mr. Hertz has a history of TURP (trans urethral resection of the prostate) 6 years ago and a reversible stroke (TIA- transient ischemic attack) 3 years ago. He had the procedure done at the VA hospital in Brooklyn by doctor Jeremy Collier. He has had hypertension for 10 years for which he takes hydrochlorothiazide 50 mg every evening and Dalmane occasionally to help him sleep. He has been suffering from arthritis of the right hip for years and cannot walk very fast. He usually pops a few aspirin when it gets bad. That sometimes takes the edge off.

Mr. Hertz's urinary problems have existed for a long time (a couple of years or so) but over the past 3 months he has progressively found it harder to make it to the toilet in time. As soon as he finds the urge to urinate, he must find a toilet in minutes or he wets himself. This has made it

increasingly necessary to stay close to home instead of going out for long walks, which he enjoyed. This has also kept him from going to jazz clubs, which was one of his favorite evening pastimes. Mr. Hertz is embarrassed by his incontinence and bothered by the fact that his house now smells of urine. Mr. Hertz has been urinating very frequently for the last 3 months (approximately four times a night and at least six times during the day); it does not burn when he urinates and his urine does not have a foul smell. Mr. Hertz does not have to strain to urinate; he voids without hesitancy, and his urine flow is normal. He wets himself two-to-three times a week now, particularly at night or when he is far from a toilet; he does not wet himself when coughing, carrying heavy objects, or straining. The only medication he takes is hydrochlorothiazide for hypertension.

Habits:

Tobacco: 1- 1 ½ packs per day over 52 years

ETOH: Six pack of beer or several scotches every night

Illegal Drugs: None currently (past: over 12 years ago- pot, acid, coke)

Diet: Fast foods, packaged foods, meat and potatoes (and eats at the diner and deli a lot)

Exercise: Some swimming and walking (used to exercise very regularly up until 1 year ago)

Coffee: 5-6 cups a day

Allergies: Nuts

<u>Samuel Hertz- Presenting Situation</u>

Samuel Hertz, a 74-year-old man, comes to The Mount Sinai Geriatrics Clinic complaining of urinary frequency.

Vital Signs:

Temperature:	99.0 oral
Pulse:	75
Blood Pressure:	140/80
Respiratory Rate:	16

Read the following instructions carefully:

You have a maximum of 20 minutes to perform a focused history on this patient.
After you have finished your interview, please go to the proctor for the questionnaire pertaining to this patient.
Take any notes you think necessary.
Leave this file at the door when finished with the patient.
Discuss the case with your team.

Samuel Hertz- Physical Examination Results

Vital Signs: Temperature: 99.0
Pulse: 62
Blood Pressure: 160/100
Lying Down: 150/100
Respiratory Rate: 14

HEENT: Eyes: Anicteric, arcus senilis, B/L cataracts, fundi not well visualized
Mouth: Poor dentition, pharynx WNL
Ears: cerumen bilaterally, TMs not visualized
Minimal temporal wasting

Neck: Supple, no lymphadenopathy, no thyromegaly

Chest: Hyper-resonant, decreased breath sounds bilaterally

Cardio: No JVD, pulse regular with occasional extra beats, PMI enlarged, normal S1 and S2, positive S4, no murmurs

Abdomen: Soft, non-tender, slightly enlarged liver span, no masses

Extremities: Poor pulses in distal lower extremities. Thickened toenails. Hyperpigmentation at shins

Musculo: Crepitus at knees. Decreased ROM at right hip

Skin: Dry, no lesions

Genital: Normal testes, no penile discharge, shotty inguinal lymphadenopathy

Rectal: Normal tone, enlarged smooth prostate, non-tender

Neuro: Orientated to person, place date; motor 4+/5 bilaterally; poor finger to nose testing; gait moderately wide based; equivocal Romberg; sensation grossly intact

Marion Benjamin- Background for Standardized Patient

Age: 69

Marital Status: Widow for 3 years

Social History: I've been living alone since my husband Lawrence passed away 3years ago; he died of a heart attack. We were very lucky to have been married for 49 years. Unfortunately, we were never able to have any children; I guess that's just the way it was meant to be.

I attended Columbia University for 2 years but never completed my studies because Lawrence and I got married. I just assumed we would have a family soon; I guess one can never predict or be certain about the future. Subsequently, I started working as a secretary at the law office Sanford, Cahill and Morris in the Wall St. area. They were good to me and I got really great benefits. Unfortunately, once I retired, so did the benefits. Lawrence was a professor of German at Columbia. We both retired at about the same time so we could travel and do things together.

We had about 3 years after our retirements to do things together. We took a cruise through the Greek Islands, a trip to England and Ireland, and went to the Bahamas. At home Lawrence and I liked to attend concerts at Lincoln Center and we were active members of the Metropolitan Museum. I also enjoy theatre. I usually go with my friends, Lawrence isn't so crazy about musicals and such, he finds them silly.

When Lawrence died, I tried very hard to be independent. I renewed my subscriptions to Lincoln Center and the City Center Ballet with a few friends of mine. I've been attending church each Sunday, at a nearby church that Lawrence and I belonged to for many years.

Certainly, I am on Medicare, but recently I saw a commercial on TV about switching to Oxford HMO. The ad said the HMO would cover all my prescriptions completely, which I could really use. However, would it cover a home nurse or, God forbid, a nursing home?

Currently, I don't have a living will or proxy. When Lawrence died, our regular will was reviewed and the lawyer took care of the pension and things. The attorney explained the basics of a living will but I just couldn't handle it then.
(I asked, I never heard of a proxy.)

History of Present Illness: I'm here because I keep falling down and I'm afraid that I might break a bone or something. I sprained my wrist in a fall about 2 weeks ago, but the last time I fell was just 2 days ago. It seems like I've been falling a lot over the last month -- maybe seven times. It happens mostly at night when I'm getting out of bed to go to the bathroom. It's hard to see, of course, because my bedroom is dark, but I'm not tripping or slipping on anything. I don't have any rugs in my bedroom and there isn't any furniture in my way to trip over. I just begin to feel off balance -- and I just fall usually backwards. Then I have to crawl over to a chair to pull myself up.

It's terrible suddenly not wanting to go out because of my fear of falling. I'm just not secure and solid when I am on my feet. It's embarrassing. What if I can't get up? I'd be at the mercy of strangers or, even worse, muggers. My fear is that I'm just going to get worse and worse. This unsteady feeling started about 4 months ago. I remember because I fell and bruised my hip

quite badly. I think I fell off and on for the first couple of months -- it wasn't until recently that I began falling more frequently. To steady myself as I walked, I started using an old cane of my husband's (which is too tall for her and should have a rubber tip). My doctor suggested I go back to my neurologist when he learned that I had been feeling unsure on my feet for a while. The neurologist said the falling was a symptom of Parkinson's disease, and that I should go see a specialist in geriatrics because he knew nothing specific to do for the falling.

I had a Metropolitan Opera subscription. They're doing the complete "Ring Cycle" of Wagner's (pronounce Vahgner) this year. I cancelled my subscription because I'm afraid I won't be able to climb up and down those steep steps without falling. None of my close friends have this problem. I know they're wondering why I keep refusing invitations but I'm too embarrassed to tell them what's happening to me. It's gotten to the point where it's even stopping me from doing my usual activities like grocery shopping. This change has made me somewhat anxious and depressed. Occasionally I can't sleep at night and lately, I've begun to fall asleep in front of the TV. I hate being so self-conscious of everything I do but I don't trust myself anymore.

Sexual History: I loved my husband very much. He was patient with me. I never was with anyone else except him. You know what I mean. I was so disappointed that I couldn't have children. I blamed myself for a long time. Lawrence said to put it behind us and get on with life. He had a career he loved so I guess he could do it easier than I could. They never explained fully what was wrong, except that I had bad fibroids and some cysts in my ovaries. Eventually, I had a hysterectomy. Who knows whether it really was necessary or not, I just did what they told me. I was 35 when I had the operation.

Past Medical History: A neurologist diagnosed me with Parkinson's about a year ago. I went to the doctor because I couldn't control this tremor (resting tremor) in my right hand. I also started having problems walking as fast as I used to and climbing stairs. The neurologist prescribed Sinemet 25-100, to be taken three times a day. My primary care physician diagnosed me with mild hypertension, also about a year ago, and prescribed Lasix 40 mg (a diuretic), to be taken once a day. I usually take it at bedtime. The only time I was hospitalized was when I had a hysterectomy when I was 35 years old.

Family History: Mom died 2 years ago at the ripe old age of 92. She was an incredibly strong-willed woman who was quite healthy most of her life. She took care of Dad for nearly 20 years. He had really bad Parkinsonism and had a lot of trouble taking care of himself and getting around. She did everything for him. He died at 83. It was a stroke that killed him. He just didn't have the strength to recover. I have one younger brother, Gerald, and we're not very close. He lives in New Jersey. My niece Julie, comes to visit once in a while. She's going to grad school at NYU. She's a sweet girl; I used to take her to the theatre once in a while. I remember taking her to her first Broadway play, "Cats." She's very busy now and what would she want with an old lady like me anyway.

Habits:

Tobacco:	Has never smoked
ETOH:	May have a drink socially
Illegal Drugs:	None
Rx Medications:	Sinemet 25-100 TID, for Parkinson's; Lasix 40 mg QD, for blood pressure

Diet: She used to eat out a few times a week with friends. Now she stays in to eat meals, which she cooks herself (small, simple).

Coffee: A cup or two in the morning

Allergies: None

Specific physical capabilities/limitations

<u>Marion Benjamin—Presenting Situation</u>

Marion Benjamin, a 69-year-old woman, comes to The Mount Sinai Geriatrics Clinic complaining of memory problems.

Vital Signs:
- Temperature:
- Pulse:
- Blood Pressure:
- Respiratory Rate:

Read the following instructions carefully:

You have a maximum of 20 minutes to perform a focused history on this patient.
After you have finished your interview, please go to the proctor for the questionnaire pertaining to this patient.
Take any notes you think necessary.
Leave this file at the door when finished with the patient.
5. Discuss the case with your team.

Trainee Feedback Form for Standardized Patient Exercise

Evaluate each student team member's contribution to the quality and content of the team interaction and team processing of case content. Review the list of team behaviors to identify behaviors exhibited by students that help or hinder quality team interactions.

	Never	Rarely	Occasionally	Frequently	Almost Always	N/A
Advocated solutions benefiting all team members.	1	2	3	4	5	6
Worked for consensus.	1	2	3	4	5	6
Agreed to accept responsibility for an equitable share of the group workload.	1	2	3	4	5	6
Showed openness to receiving information and assistance from other team members.	1	2	3	4	5	6
Demonstrated good listening skills (e.g., not interrupting, positive body language).	1	2	3	4	5	6
Demonstrated good speaking skills (e.g., making interpretations based on data presented, not speaking for others).	1	2	3	4	5	6
Identified and encouraged others to identify the needs and wants of the client.	1	2	3	4	5	6
Indicated awareness of client's cultural background.	1	2	3	4	5	6
Generated and encouraged others to generate possible solutions in a non-critical, brainstorming manner.	1	2	3	4	5	6

Name of Trainee ________________________________

Name of Evaluator ______________________________
Date:

Team Behaviors

The following list of team behaviors was originally developed by Theresa Drinka, Ph.D. and modified by the GITT Case Study Work Group. Check as many behaviors that apply for the trainee.

Meeting Behavior / Style

- ☐ Coercive or forcing behavior
- ☐ Defensive Reactions
- ☐ Everyone too accommodating/disinterested
- ☐ Sarcastic
- ☐ Angry
- ☐ Collaborative
- ☐ Disagree appropriately
- ☐ Use collaborative style to help them think about current negative behavior

Leadership Style

- ☐ Organizer/mover/assignor of tasks
- ☐ Attempts to create alliances
- ☐ Appropriately interjects expert opinion
- ☐ Reflects insightfully on value laden or difficult issues
- ☐ Gives feedback on team process to improve team meetings
- ☐ Dominating/disruptive
- ☐ Diplomatic/attempts to break up conflict
- ☐ Expert (constantly tries to show everyone how much he knows)
- ☐ Judges/evaluator (every suggestion is wrong)
- ☐ Reviewer (says meeting is fine never really reviews)

Conflict Management

- ☐ Collaboration
- ☐ Appropriate accommodation
- ☐ Withdrawal/defensive meeting
- ☐ Inappropriate accommodation

Meeting Skills and Process Issues

- ☐ Preparedness of members/Attentiveness to meeting
- ☐ Organizational skills/structure: Agenda, Timeliness
- ☐ Side conversations/Distractions/Interruptions
- ☐ Ability to repress dominant members
- ☐ Contributions from all members/appropriate learn presentation

Teaching / Learning

- ☐ Demonstrates unwillingness to listen to presentations from others
- ☐ Pretends to know it all
- ☐ Act as though what is being taught is unimportant
- ☐ Guards knowledge as private
- ☐ Demonstrates willingness to listen and learn from others
- ☐ Willingness to teach or mentor other members
- ☐ Asks appropriate questions

Defining the Patient / Family Problem(s)

- ☐ Ability of member to define problem(s)/strengths of patient within an interdisciplinary focus rather than thinking of issues as discipline specific

Recognize Other Professional Roles

- ☐ Members recognize/ignore the role of others
- ☐ Members ask appropriate/inappropriate person to discuss

Recognize Patient /Family Issues/ Roles

- ☐ Appropriately/Inappropriately presents patient/family concerns
- ☐ Demonstrates respect/disrespect for patient/family
- ☐ Effective/Ineffective communication with family
- ☐ Recognize patient/family role in team's care planning

Rush GITT Case Study- Mr. Alex Green

You are a home care team consisting of a geriatric nurse practitioner, an occupational therapist, a social worker, and a primary care physician. Other disciplines (physical therapy, speech pathology, respiratory therapy, home health aide, home-maker service, pharmacist, nutrition, etc.) are available to participate on your team but must be invited to a team meeting on an as-needed basis. The philosophy of your home care agency is that patients and/or family members are also members of the health care team in that they must be part of goal setting and the implementation plan.

You have received a referral from the Medicare HMO that contracts with your agency for services for a Mr. Alex Green, a 68-year-old, man patient with the following diagnoses:

Congestive Heart Failure
COPD
Coronary Artery Disease
Hypertension
Diabetes

Mr. Green has a history of presenting to the emergency room short of breath with fluid retention. He is sometimes admitted and sometimes treated as an outpatient by his primary physician. Little has been done to break the cycle of treatment failure. The case manager in the utilization management department at his HMO wants to try another approach. Out patient treatment will be authorized together and bundled into one payment for the primary care physician, home care, and any other community-based care.

His current medications are as follows:

- Cardizem 240 mg q day
- Lasix 40 mg q day
- Theodur 200 mg. TID
- Maxide 1 tab q day
- K-dur 20 meq q day
- Glucotrol 5 mg BID
- Nitrodisc q 4-6 hr PRN for chest pain

Mr. Green is on a low sodium diet, 1500cc fluid restriction, but has not followed it in the past. Mr. Green lives with his daughter, her husband, and their three children, ages 17, 19, and 23. He also has a son and his family who live in the neighborhood within easy walking distance. The daughter-in-law likes Mr. Green but doesn't like her sister-in-law and, as a result, refuses to visit him. The family is described by emergency room staff as dysfunctional, unaware of the seriousness of Mr. Green's condition, and unwilling to be a part of his treatment plan. They believe that it is too much trouble to prepare special meals for Mr. Green and that the emergency room is an appropriate place to bring him for treatment after he has eaten high sodium and high carbohydrate meals. However, Mr. Green has received a letter from his HMO notifying him that it will deny payment for any further ER visits caused by inappropriate diet intake and that in those circumstances, he will have to pay for the ER visits himself.

There are also several smokers in the family and they refuse to limit their smoking or smoke outside. It's our house, he is a guest. If he shouldn't be around smoke then he should go outside.

The outpatient plan of care calls for the following services:

- 02 2L/ nasal cannula
- 02 saturation readings per oximeter q week
- SMA drawn in 1 week
- Daily weight, abdominal girth, & check for pedal edema (coordinate with primary care physician)
- Teach low sodium, fluid restriction diet
- Evaluate home situation and family's ability to participate in the plan of care
- Teach energy conservation techniques
- Pulmonary function testing and x-ray

Mr. Green's HMO will authorize a total of $1000 to cover the outpatient care (physician office, home care, community care) charges and is allowing the providers to distribute the money in a manner that best supports a plan to provide care to Mr. Green and reduces emergency room visits.

What should be the team's plan of care in this case?

Team Discussion Questions

1. What is the outpatient plan of care for Mr. Green?
2. Establish the goals, outcomes, and time line for evaluation.
3. What approach or strategy should the team use in working with Mr. Green's family to making his home environment and relationships with his family more conducive to maintaining his health and preventing serious deterioration in his medical condition?
4. Decide what disciplines will be directly and indirectly involved in the plan of care.
5. How shall the money be divided among the organizations?
6. What measures will be used to determine if the management of Mr. Green's care is effective?
7. Who will collect the data/measures? How will the data be evaluated?
8. How will communication occur with the HMO? What if the plan of treatment needs to be changed before the goals are met? What if the plan of treatment cannot be achieved with the amount of money allocated? Who will negotiate with the HMO? What will you try to negotiate? What if the HMO says no additional funds or services will be authorized for this case?
9. What, if any, ethical issues are associated with this case?
10. What team process issues did you experience during this exercise?
11. Were you able to apply team concepts in your approach to this case?

Rush GITT Case Study - System Changes

A Rush 2000 design team has completed an evaluation of the way geriatric services are organized and delivered in the Rush System for Health and proposed a number of recommendations for achieving greater efficiencies and economies in how these services will be provided in the future.

Chief among the design team's recommendations is a reconfiguration in the primary care management of geriatric patients. The design team expects that transition to this model of geriatric primary care will improve accessibility and quality, increase patient satisfaction, and save the Rush System approximately $3 million annually. The design team anticipates that this will make Rush more competitive as a Medicare risk program as well as more attractive to other Medicare HMOs interested in including Rush in their managed care networks.

The design team has proposed that primary care be managed and coordinated through collaborative teams led by primary care physicians and geriatric nurse practitioners. Although patients will see a physician for more complex medical problems and procedures, the geriatric nurse practitioner (GNP) will primarily be responsible for the following areas of patient care:

1. Check-ups for ongoing medical problems.
2. Treatment of patients for urgent care visits.
3. Medication refills, as needed.
4. Patient education for specific health problems and health promotion.
5. Coordination of care with other providers including social worker, nutritionist, and other disciplines
6. Ongoing monitoring and assessment of patients in long-term care facilities.
7. Coordination of communications and meetings with patient family members and other caregivers, as needed.

Concurrent with the recommendations made by the design team regarding the role of GNPs are other changes occurring in the Rush system. These include using a different home health care agency from the one that has served as the primary source of patient referrals at Rush. In addition, both inpatient and outpatient physical and occupational therapy services have been contracted to a managed care company specializing in providing rehabilitative services.

You are a member of an interdisciplinary committee that has been given the responsibility for organizing the implementation of this proposed system. Your committee’s responsibilities include putting together an implementation plan and timetable for the new system, developing communication and coordination procedures for participating disciplines to work together, and establishing guidelines for involving patients and their families in care and treatment decisions.

For this case study exercise, address the following questions:

1. Having learned of the design team's proposals, the Departments of Family Practice and Internal Medicine immediately raise strong objections to the new system. What do you think the objections would be? Describe what approaches and strategies you would use to gain physician's support and participation.

2. How do you think the roles of the providers listed below will change under the new geriatric system?

   - Social worker
   - Pharmacist
   - Occupational Therapist
   - Physical Therapist
   - Speech Therapist
   - Audiologist
   - Ethicist

3. How do you think patients and family members will be affected by this new system? What should the system do to accommodate their needs and concerns?

4. The recommendation to begin using another home health care agency and rehabilitation services organization in place of current Rush-affiliated providers causes considerable opposition from those professional groups affected, as well as the Rush physicians who have been referring patients to them for so many years. What objections do you think will be raised? Describe the method/strategy you would use to transition home care and rehabilitation services to these new providers.

5. Describe how you would promote the new system of primary care management to managed care organizations looking to contract with primary care provider and hospital organizations.

6. Describe how cost management and utilization will be handled under this new primary care model and who will be responsible for monitoring and managing it.