Module # 2: Interdisciplinary Teamwork

Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum

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Module # 2: Interdisciplinary Teamwork

I. Overview

An interdisciplinary healthcare team brings together a group of individuals with diverse training and education to work on an identified task. These healthcare teams can include doctors, dentists, nurse practitioners and registered nurses, occupational therapists, pharmacists, physician assistants, physical therapists, social workers, nutritionists, and clergy. Team members collaborate to address patient problems that are too complex for one discipline, or even many sequential disciplines, to solve. At the most basic level, effective teamwork depends on the ability of members to determine the overall mission, establish shared and explicit goals, and work collaboratively to define and treat patient problems. Ideally, teams can also learn to accept and make use of disciplinary differences, differential amounts and types of power, and overlapping roles to clarify and evaluate the team's development and effectiveness. [1]

II. Learning Objectives

1. Define an interdisciplinary team.
2. Describe the need for interdisciplinary teamwork.
3. Delineate three goals of an interdisciplinary team.
4. Describe two benefits and two problems unique to a team environment.
5. Identify three types of interdisciplinary teams.
6. Identify the various roles of interdisciplinary team members.

III. Defining a Team

The word "team" derives from Old English and is defined as "a group of animals harnessed together to draw some vehicle". Today, there are many definitions and descriptions of teams, and the team 'concept' is broadly utilized in the corporate world, government agencies, and military organizations. For the purposes of this curriculum, however, we will focus on teams in the healthcare system.

A. **Multidisciplinary vs. Interdisciplinary Teams:** The terms **multidisciplinary** and **interdisciplinary** are often confused when referring to team structure and process in the healthcare setting. Members of a multidisciplinary team typically work together in caring for the patient, but only one team member, such as physician or nurse manager, makes the treatment decisions. On the interdisciplinary team, the decisions are made by the group.

B. **What is an Interdisciplinary Team?** Here are three definitions of the interdisciplinary team that can help frame a discussion on teamwork:

1. "A team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable." [2]

2. "The interdisciplinary team is a group of persons who are trained in the use of different tools and concepts among whom there is an organized division of labor around a common problem with each member using his own tools, with continuous intercommunication and re-examination of postulates in terms of the limitations provided by the work of the other members and often with group responsibility for the final product." [3]

3. "Teamwork can be broadly defined as a mechanism that formalizes joint action towards mutually defined goals." [4]

C. **Trans-disciplinary Teams:** Recently there has been a growing emphasis on "trans-disciplinary" (or "cross-disciplinary") teamwork. In these teams, which are rooted in the research and business worlds, members of different disciplines are not only proficient in their own specialties but also, through cross-training and working on the team, become knowledgeable in other specialties as well, making team members' skills overlap. Trans-disciplinary training and teamwork not only allow the provider to see a more complete picture of each patient, but also allow a single provider to assess and, in some cases, treat patients in an area other than his or her own.[5]

IV. The Rationale for Teamwork

A. **The Advantages of Teamwork:** There are many strong reasons for teamwork. Chief among these is the fact that teams are client-centered and helpful in addressing complex health and psychosocial issues such as in geriatric patients and those with life limiting illnesses. However, teamwork does require work and commitment from both the team members and the organization. For example, teams may be personnel and resource intensive, thus requiring commitment from institutional leaders. Furthermore, teamwork calls for tolerance and respect among members. Some health professionals shy away from teams because they have been members of teams which were dysfunctional for a number of reasons, including a lack of leadership, interest, structure, and process.

B. **Better Care for Patients:** Patients who are older or facing life limiting illnesses are best served by interdisciplinary teamwork as described below.

1. Within Geriatric Care: Older people are more likely to suffer from complex illnesses, and are thus best served by a team approach. The complexity of formulating a treatment plan entails addressing multiple illnesses, disabilities, medications, and procedures. Because geriatric patient care has often been uncoordinated, treatments may overlap or conflict causing great confusion. Therefore an interdisciplinary team can offer a comprehensive and integrated means of providing effective care.

2. Within End-of-life and Palliative Care: Traditionally, care at the end of life was administered solely by a physician. However, patients requiring palliative care generally suffer from an advanced disease in which problems and symptoms are complex and urgent. There are many aspects to palliative care such as pain management, advanced directives, and the alleviation of psychosocial and spiritual distress. Therefore, interdisciplinary care planning and coordination is essential.

V. Goals of the Team

A. **Guidelines:** Team goals will oftentimes vary. However, the following general guidelines will facilitate effective teamwork and maximize patient outcomes.

1. Interdisciplinary team members agree on the mission.

2. The mission of the geriatrics team is viewed as realistic and achievable. If not, team members agree to narrow the mission to a workable size.

3. There is a clear team vision, and the group can progress steadily towards the established goals.

4. The purpose of the meetings, discussions, individual efforts and other

activities is understood to relate to the larger project.[6]

VI. Benefits Unique to a Team Environment

A. **Recent studies** suggest that both patient and healthcare professionals involved in interdisciplinary teams experience many benefits.

1. The interdisciplinary team will have broadened access to resources – funds, research design development, data collection, computerized data management, statistical consultation and data analysis, grant writing, support staff, sustained communication, and costs of presentations and publication.

2. The accountability that each team member has to one another will increase timely completion of designated tasks and maintain quality standards.

3. Shared responsibility for completion of tasks and preparation of materials for dissemination will enhance the geriatrics team's level of productivity.[7]

4. Team meetings offer opportunities for informal contacts and feedback among the disciplines concerning patient care that is unrelated to the specific cases scheduled for discussion.

5. The meetings also allow ease of access to each other and reduce time needed for healthcare professionals to connect with each other about patient care.

6. It is highly probable that interdisciplinary geriatrics team care for the elderly will prove to be more cost-effective than traditional medical approaches.[8]

VII. Problems Unique to a Team Environment

A. **Culture and philosophy of each discipline:** Every discipline has its own culture and philosophy toward geriatric patient care which can create misunderstandings and lack of sympathy by members of one discipline towards the members of another discipline. The culture also results in a specific language or jargon, which may lead to miscommunication. Until the members of the disciplines become familiar with these different nuances of meaning, difficulties may arise in both clinical and educational settings.

B. **Varying Qualifications:** Required qualifications for healthcare disciplines vary and can range from doctoral or fellow status to bachelor's degree or para-professional training. The differential status that is assigned by society because of educational attainment can influence how power and leadership are distributed on a team rather than actual knowledge, expertise or familiarity with the specific

patient case.

C. **Scheduling and Time Constraints:** Healthcare professionals may divide their time between various locations. The logistics of bringing the disciplines together for team meetings or even of engaging in telephone contacts can be daunting, especially when the various disciplines tend to follow different scheduling patterns.[9]

VIII. Types of Teams [10]

A. **By composition:** The University of Pennsylvania GITT planning year group identified five types of geriatric interdisciplinary teams based on their professional composition.

1. The Nurse-Dominated Team: This team consists of nurse practitioners, geropsychiatric clinical nurse specialist, registered nurses, physical and occupational therapists, speech and language pathologist, social worker, geriatrician, and psychiatrist. It is strongly patient-centered and focused on time-limited intensive rehabilitation of elders.

2. The Nurse-Physician Team: This team is composed of geriatricians, two nurse practitioners, and one social worker. It delivers community-based care in the patient's home and relies heavily on shared roles and informal mechanisms of communication and clinical management.

3. The Physician-Dominated Team: This team, which provides interdisciplinary assessment and primary care for older adults, consists of nine physicians, one registered nurse, two nurse practitioners, and one social worker. Patients are assigned to a physician and interact with other team members as appropriate.

4. The Social Work-Dominated Team: This team practices in an assisted living facility offering other levels of acute and skilled nursing home care. The team consists of an administrator, assistant administrator, social worker, physicians, nurse manager, and an activity coordinator. The team involves physicians as medical problems arise, but for the most part, social workers manage day-to-day care for these elders experiencing functional losses.

5. The Consensus Model Team: This type of team divides the facility into separate units, each of which is led by a nurse practitioner, in consultation with the medical director. It provides roles for a wide range of team members, including registered nurses, social workers, dietary staff, and recreational aides.

B. **By setting:** There are also types of teams based on the location of care and

the awareness that elders are often transferred from setting to setting.[11]

1. Hospital-Based Inpatient Team: Due to specific changes in medical status, patients are frequently admitted directly from the home, doctor's office, or the Emergency Department to a unit within the hospital. This hospital based inpatient team then provides acute care for the elderly within the hospital setting. Physicians and nurses perform an initial assessment, monitor the patient's health status by making rounds, and collaborate to formulate an effective treatment plan.

2. Ambulatory Care Team: The outpatient geriatrics interdisciplinary team is increasingly used for initial assessment and ongoing care coordination. Typically, the interdisciplinary team consists of a physician, nurse and social worker with the "extended team" comprised of representatives from rehabilitation therapy, psychiatry/psychology, nutrition, and pharmacy. A comprehensive initial assessment includes evaluation by each of the three core team members --physician, nurse practitioner and social worker-- with inclusion of other specialties on an as-needed basis. Some teams may assess patients on a quarterly basis with the team meeting more frequently for clients in acute care. Outpatient teams meet in a variety of ways, including face-to-face meetings, hallway conversations, and telephone consultations and increasingly through virtual means such as e-mail.

3. Emergency Department Team: This team, most likely not geriatrics specific, may consist of registered nurses, physicians, and/or surgeons that provide acute care during a medical emergency. Because of the nature of the department, the patient's time with this team is limited. Therefore, it is imperative that the emergency department team ensures that care is properly transferred to a member of the patient's usual interdisciplinary team.

4. Home Care Team: This type of geriatrics team may include a social worker, a nurse practitioner, and/or a physician who make regular visits to the patient's residence to assist the patient's with his or her medical problems and to monitor the patient's ability to live at home. Because home care or hospice services enable the patient to remain in a familiar, comfortable environment with some degree of autonomy, this model of care is becoming increasing popular.

5. Nursing Home Team: Because the medical problems of elders are often chronic, complex and sometimes accompanied by limited cognitive capacity, older adults are not always able to continue living at home. When this occurs, the nursing home provides a setting for an interdisciplinary geriatrics team to monitor and treat the chronic illnesses of frail patients on an ongoing basis.

6. Palliative Care Team: The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care is both a philosophy of care and an organized system for delivering care. Comprehensive palliative care services often require the expertise of various healthcare professionals in order to adequately assess and treat the complex needs of seriously ill patients and their families. Members of a palliative care team may include professionals from nursing, medicine, social work, chaplaincy, nutrition, rehabilitation, pharmacy as well as other disciplines. Trained volunteers are sometimes part of palliative care teams as well. Team leadership, collaboration, coordination and communication are key elements for effective integration of these disciplines and services. [12,13,14,15]

7. Community-Based Assessment Teams: Elderly persons in rural areas are less willing to seek mental healthcare, despite the fact that they have a greater need for the services which may be available to them. Reasons for this behavior include factors associated with rural life, including poorer health status, greater poverty, and lack of specialized providers. One strategy which has been shown to increase the utilization of services in rural areas is a mobile multidisciplinary team of a psychiatrist or psychologist, nurse, and social worker that conduct in-home mental health assessments.[16]

IX. Geriatric Care Teams

A. **Geriatric teams** can be confined to one setting, such as a hospital unit, or span various settings, such as a geriatric consultation team. One of the major challenges in effective teamwork is ensuring successful transitions as the patient moves from setting to setting along the care continuum.

B. **Typical Settings for Geriatrics Teams:** Geriatric teams can be found in a multitude of settings, including just about any facility or agency that provides services for the elderly. Long-term care facilities, inpatient and outpatient mental healthcare agencies, home care agencies and facilities or agencies providing palliative care are all typical settings for Geriatric teams.

C. **Team Members: Professional Roles, Education and Skills:** See attached chart, "Houston Geriatric Interdisciplinary Team Training Manual: Team Members Overview" (See Learning Resource D)

X. Development of a Team

A. **It's a Process:** Becoming a team is a process in which missions and tasks are defined and the members define their roles and relationships.

B. **Phases of team development:**

- Forming- creation stage of the group
- Norming- norms and patterns are worked out
- Storming- tasks and roles are worked out through conflict
- Performing- team working together for improved patient care

For expanded explanation of the above, refer to the handout from the University of Colorado Health Sciences Center's Geriatrics Interdisciplinary Team Training Workbook: "Forming, Storming, Norming, and Performing"[17] (See Learning Resource D)

C. **Repeating the Process:** Each time the team composition changes, the process of team development is repeated. Particular attention must be given to the orientation of new team members.

XI. Different Roles Within a Team

A. **Team Functions:** Aside from the professional role as described in Section IX above, various team members also fulfill certain informal (but critically important) team functions and responsibilities. The assumption of these responsibilities for the group 'process' ensures that team decision-making, as well as care plan implementation, proceeds smoothly and efficiently. See Table 1: "Functions of Different Roles Within a Team".

Table 1: Functions of Different Roles Within a Team:
Developed by Howard Garner (1999)

ROLE	RESPONSIBILITIES
Facilitator	Leads the team through the agenda and the consensus making process.
Recorder	Writes down the team's decisions. Checks to make sure that what everyone hears is what the team member means.
Timekeeper	Watches the clock. Informs the team when half of the allotted time has expired, when only five minutes remain, and when time is up.
Encourager of Individuals	Encourages other members to express their ideas. Asks individuals what they think.
Initiator	Expresses his or her ideas. Gets the discussion going. Allows others to speak and then initiates again.
Summarizer	After two or three people have spoken, tries to summarize what has been said thus far. Should be done more than once.
Elaborator	Elaborates on a point someone else makes. Clarifies the point and adds to it.
Compromiser	Looks for the common ground between team members who disagree with one another. States the compromise position that

	he or she sees to the team.
Supporter	Shows acceptance and support for ideas and opinions that may differ from the majority.
Consensus Taker	Listens for the emergence of positions that the whole team can accept. States the position and sees if everyone on the team agrees.
Gatekeeper	Watches for members who are trying to speak but are cut off by others. Calls on the member to speak. Asks others to wait.
Encourager of Team	When the team is having difficulty making decisions, expresses his or her belief that a compromise can be found. Gives energy to the team.

SOURCE: "Assessing Your Skills in Team Leadership", Howard Garner, 1999. Virginia Commonwealth University, Richmond, Virginia.

XII. Team Leadership

A. **Shared Leadership Roles:** Although one or more individuals may have a formal designation as group leader or facilitator, teamwork is most effective when all members are willing to share the responsibilities of leadership. Such responsibilities can include:

1. Scheduling, arranging and conducting meetings.
2. Preparing an agenda and ensuring that it is followed during the meeting.
3. Helping to clarify and identify team goals.
4. Identifying common topics and summarizing the ideas discussed to maintain direction of discussion.
5. Encouraging everyone to participate throughout the discussion.
6. Ensuring that all team functions are assigned to various team members.
7. Emphasizing the importance of being open to new and different ideas without becoming immobilized by conflict.
8. Making the group aware of its own resources and how best to use them.
9. Helping the group evaluate its progress and development.

XIII. Team Meeting Process

A. **Guide to meeting process:** The following 7-step meeting process provides a guideline for facilitating an effective interdisciplinary team meeting with optimal outcomes for the patient:

1. Clarify objectives

2. Review roles

3. Review agenda

4. Work through agenda

5. Plan next steps

6. Evaluate meetings

XIV. Team Communication [6, 18]

A. **Importance of effective communication:** Particularly in an interdisciplinary setting where team members do not always possess a basic understanding of each other's knowledge, skills and professional and personal values, it is possible that *misunderstandings will result*.

B. **Encouraging and Reinforcing Responses**

1. Be *succinct* and avoid long anecdotes or examples.

2. Make an effort to use positive *body language* such as head nodding, eye contact, and leaning toward the speaker.

3. In order to show interest, *repeat one or two key words from the person's last sentence*. This encourages the speaker to continue talking and enhances his or her sense of being heard.

4. To ensure that the message is understood, *paraphrase and reflect* by repeating a person's statement in his or her own words.

5. *Avoid using technical jargon if possible*; if a condition is best described in technical terms, however, members should make sure that everyone on the team understands those terms.

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Learning Resource A

Material from the John A Hartford Geriatric Interdisciplinary Team Training Program (GITT)

1. GITT Implementation Manual. Hyer, K., Flaherty, E., Fairchild, S., Bottrell,M., & Fulmer, T. This comprehensive manual provides summary information about the National Geriatric Interdisciplinary Team Training Initiative funded by the John A. Hartford Foundation, Inc. Drawing on lessons learned and materials provided by the eight sites, content includes information critical for the development, implementation and evaluation of a successful GITT Training Program. Chapters address such topics as institutional planning, structuring didactic and clinical practicum training, and assessing the effectiveness of GITT training. http://www.gitt.org/products/products.htm

2. GITT Curriculum. Hyer, K., Flaherty, E., Fairchild, S., Bottrell, M., & Fulmer, T. A cross-site curriculum includes six chapters with teaching resources on: teams and teamwork, care planning, ethics and teams, communication and conflict resolution, multiculturalism, and team member roles and responsibilities. More information about this can be found on their web site:
http://www.gitt.org/products/products.htm

3. Geriatric Interdisciplinary Team Training: A Curriculum from the Huffington Center on Aging at Baylor College of Medicine: Long, D. & Wilson, N. (Eds.) (2000). This curriculum includes materials in hard copy text format, and floppy disks that contain nine chapters of core geriatric interdisciplinary team topics, along with training resources, a PowerPoint slide floppy disk, a CD-ROM that includes embedded hot links, and video and audio sections covering the nine core geriatric interdisciplinary teams interacting around four different cases. To order or for more information, contact the Huffington Center on Aging through their website:
http://www.hcoa.org or by phone: 713-798-5504

4. Geriatric Interdisciplinary Team Managed Care Training of Trainers Program: Kaiser Permanente and the University of California-Los Angeles (1997). This training curriculum was developed to prepare facilitators for team training and includes five content areas: principles of team care, team stages, structure and leadership, information sharing and communication, problem solving, and conflict management and evaluation. A training manual includes student handouts, trainers' notes and brief team lessons. To order a copy, contact Pamela Jackson-McCall, California Geriatric Education Center, UCLA School of Medicine, 10945 Le Conte Avenue, Suite 2339, Los Angeles, CA 90095-1687.

5. Mount Sinai Geriatric Interdisciplinary Team Training Resource Manual. This 74-page manual provides information on Geriatric Interdisciplinary teamwork for preceptors, faculty, and trainees. It is a compilation of material developed by GITT sites around the country and includes an overview of roles and responsibilities of team members, case studies, exercises, teambuilding games, readings, and web resources. Contact Kristy Kime at 212-241-6353.

6. Geriatric Interdisciplinary Team Training Workbook. Miller, C. L., (1999). This workbook consolidates key interdisciplinary health science team principles into five objectives to be practiced and learned in this GITT course. The five learning objectives are: goals and process, roles and responsibilities, structure and process to outcome, client/family's interests, and verbal and non-verbal behaviors. To order a copy or for more information, contact Ernestine Kotthoff-Burrell at 303-315-8234 or by email at ernestine.kotthoff-burrell@UCHSC.edu

Learning Resource B

Multimedia Learning Resources

1. Geriatric Medicine Self-Instruction Modules. Now in its third edition, this Windows-based CD-ROM contains 17 self-paced multimedia modules on topics important in geriatric care, including HGITT's interdisciplinary teams. Hot links embedded in text and graphics, plus animation, video, and audio allow the users to progress through the clinical topics at their own pace and "toward" specific material that they wish to access. Modules include learning objectives, self-tests, up-to-date educational content, case studies, patient information materials, and references. This CD was developed by Thomas A. Teasdale, Dr. P.H., through the John A. Hartford Foundation Geriatrics Residency Training Initiative. Dr. Teasdale is an assistant professor in the Department of Medicine at Baylor College of Medicine in Houston and affiliated with Baylor's Huffington Center on Aging.

These modules were developed in response to medical residents' requests for more geriatric content in this program. The modules use an interdisciplinary approach for in-depth study and discussion of the topics by the teams of practitioners and students.
Selected titles of modules included in this CD-ROM are: Geriatric Assessment, Falls and Mobility, Hormone Replacement Therapy, Confusion, Involuntary Weight Loss, and Elder Abuse.

The format used for the modules includes:

- A case study
- An interdisciplinary discussion guide
- Learning assessment questions
- Articles on the topic from the literature of the primary disciplines

Currently, production is underway for the fourth edition. More information can be found at http://www.hcoa.org/hcoa

2. GITT Videos/Scripts. These video scripts include the text of five 5-minute videotaped geriatric interdisciplinary team meetings developed by the GITT Case Studies Work Group. The scripts are found on the web at http://www.gitt.org. Actual videotapes of the meeting are available from the GITT Resource Center at New York University. Each script includes multiple clinicians and a variety of clinical issues and examples of positive and negative team behaviors in the domains of: meeting behavior/style, conflict management, teaching/learning, leadership style, defining the patient/family problems, and recognition of roles of professionals, patient and family. Questions for students to consider are provided after each videotape.

General Teaching Guidelines:

- Identify key issues and questions for trainees to focus on during video viewing
- Show video
- Have students discuss their responses to questions for students in small groups
- Conduct large group discussion with students

3. The Colorado Geriatric Interdisciplinary Team Training (GITT) Project Videotape and Guide. This video presents a case from patient interview through the team meeting used to develop a care plan. The accompanying video guide provides the objectives, learning points, and discussion questions. To order a copy or for more information, contact Ernestine Kotthoff-Burrell at 303-315-8234, or by email at ernestine.kotthoff-burrell@UCHSC.edu

4. GITT Pocket Cards. These downloadable "interdisciplinary team training pocket cards" were developed by GITT Special Interest Groups and designed to help clinicians work in teams. Topics include: 8 Principles of Successful Teamwork, a 7-Step Meeting Process, how to be an effective team member, team dynamics checklist, and guidelines for using different conflict handling styles. These cards are available through the New York University GITT Resource Center at http://www.gitt.org/products.html

5. GITT Nurse Practitioner Clinical Preceptor Guide. This 3-fold clinical preceptor guide was developed by the GITT Nursing Special Interest Group. It describes the role of the preceptor, micro skills for clinical teaching, setting up expectations for student performance, and expected progression of a nurse practitioner student from beginning through advanced. These guides are available through the New York University GITT Resource Center at http://www.gitt.org/products.html

Learning Resource C

Geriatric Training Tools

1. Hospice/Palliative Care Training for Physicians: UNIPACS 1-5: A series of self-study curricula developed by The Academy of Hospice and Palliative Medicine. *UNIPAC Five, Caring for the Terminally Ill: Communication and the Physician's Role on the Interdisciplinary Team* has been successfully used in HGITT workshops. For more information, contact Kendall/Hunt at http://www.kendallhunt.com or by calling: 1-800-338-8290

2. Geriatric Syndrome Learning Modules. The Great Lakes GITT Team developed four curriculum modules on the geriatric syndromes (end of life treatment goals, urinary incontinence, delirium, and falls) using an interdisciplinary approach for in-depth study. They are available online at http://www.129.22.12.42/framea.html or by contacting the Great Lakes GITT.

3. Geriatrics at Your Fingertips. A small (4"x 6") portable booklet designed so that practicing clinicians spend a minimum amount of time searching for specific information. It provides assessment instruments, recommended diagnostics tests, and management strategies. Published by the American Geriatrics Society through Kendall/Hunt, more information is found at http://www.americangeriatrics.org or by calling 1-800-247-4779. It can also by ordered ($9.95) by calling Kendall/Hunt at 1-800-338-8290.

4. Core Curriculum in Ethnogeriatrics, 2nd Ed. This curriculum was developed by the members of the Collaborative on Ethnogeriatric Education. It includes five modules covering culturally appropriate geriatric care: Overview, Patterns of Health Risks, Knowledge, Assessment, and Healthcare interventions. The modules can be downloaded in Adobe Acrobat format from the website: http://www.stanford.edu/group/ethnoger

Learning Resource D

Team Building Resources

1. Houston Geriatric Interdisciplinary Team Training Manual: Team Members Overview*

Discipline	Practice Roles/ Skills	Education/ Training	Licensure/Credentials
Nurse	Licensed vocational nurse (LVN)- basic nursing skills that are dictated by the facility; and under the supervision of a registered nurse (RN)- associate degree, BS or higher. RN has increased scope of practice, including planning for optimal functioning, coordination of care, teaching, and direct and indirect patient care.	LVN- 1 year of training; RN with associate degree- 2 years of training, usually in a community colleges; BS, RN- 4 years in college: MS/MA, RN- 2 years of graduate specialty study; PhD/DNSc/EdD. RN- 3 to 4 years of doctoral studies.	LVN – exam required for licensing, CE requirements in some states. RN- can be RN; BS, RN; APN; MS, GNP or other specialty RNs; PhD RN: all must pass the national licensure exam and in some states are required to have a prescribed number of CEUs per year. In New York, CEUs are not required.
Nurse Practitioner	Health assessment, health promotion, histories and physicals in outpatient and acute/home/long-term care settings; order, conduct, and interpret	Master's degree with a defined specialty area such as gerontology (GPN) or a post-master's certificate program.	In addition to RN licensure, NPs pass a National Certification Exam in the appropriate specialty area (e.g. gerontology or family practice). In New York,

	lab and diagnostic tests; prescribe medications, teaching and counseling.		NP is licensed as an RN and certified by the State Education Department as an NP.
Physician	Diagnose and treat diseases and injuries, provide preventative care, do routine checkups, prescribe drugs, and perform some surgery.	Physicians complete medical school (4 years) plus 3 to 7 years of graduate medical education.	State licensure required for doctor of medicine degree; exam required and possible exams required for specialty areas. CE requirements.
Geriatrician	Physician with special training in the diagnoses, treatment, and prevention of disorders in older people; recognizes aging as a normal process and not a disease.	Completion of medical school, residency training in family medicine and internal medicine, and 1-year fellowship program in geriatric medicine.	Completion of fellowship training program and/or passing examination for Certificate of Added Qualifications in Geriatric Medicine. (CAQ). Re-certifications by examination required every 6 years.
Physician Assistant	Practice medicine with the supervision of licensed physicians; exercise autonomy in medical decision-making and provide a broad range of diagnostic and therapeutic services; practice is centered on patient care.	Specially designed 2-year PA program located at medical colleges and universities. Most have bachelor's degree and over 4 years of healthcare experience before entering a PA program.	State licensure or registration plus certification by NCCPA. Re-certification every 6 years by examination. Requires 100 hours of CME every 2 years.
Social Worker	Assessment of individual and family psychosocial functioning and provision of care to help enhance or restore capacities; this can include locating services or providing counseling.	There is a 4-year college degree (BSW); 2 years of graduate work (MSW), and doctoral degree (PhD); 15 hours of continuing education is required every year.	The MSW (for master's level); BSW (BS level); SWA is a social work associate with a combination of education and experience. ACP- signifies licensure for independent clinical practice. In New York, after obtaining the MSW, a social worker may take the state licensing examination and, if

			successful, is recognized as a licensed social worker (LMSW or LCSW).
Psychologist	Assessment, treatment, and management of mental disorders; psychotherapy with individuals, groups, and families.	Graduate training consists of 5 years beyond undergraduate training; most coursework includes gerontology and clinical experience.	PhD or EdD or PsyD are degrees awarded. State licensure; the American Psychological Association has ethics codes as do most states.
Psychiatrist	Medical doctors who treat patients' mental, emotional, and behavioral symptoms.	Medical school and residency specializing in psychiatry. Residency includes both general residency training and 2 to 3 years in area of specialization (e.g. geriatrics, pediatrics).	State exam to practice medicine; board of Psychiatry and Neurology offers exam for diplomat in psychiatry.
Pharmacist	Devise and revise a patient's medication therapy to achieve the optimal regime that suits the individual's medical and therapeutic needs; information resource for the patient and medical team.	Pharmacists can receive a baccalaureate (B.S.) – 5-year program; or doctorate degree (PharmD). Annual CEUs required range from 10-15 hours.	National exam (NABPLEX); given every quarter; board certifications in specialties available (pharmacotherapy, nuclear pharmacy, nutrition, psychiatric and oncology in near future).
Speech-Language Pathologist[19]	Assessment and treatment of full range of speech, language, and swallowing disorders; functions within ambulatory or inpatient clinical settings; provides individual or group therapy to maximize individual's functional communication and swallowing ability.	Masters Degree and completion of 9 month Clinical Fellowship Year (CFY) post-M.A./M.S. required to practice nationwide. Annual CEU's required.	CCC-SLP (Certificate of Clinical Competence in Speech Language Pathology) awarded by American Speech Language Hearing Association following completion of National Examination (NESPA) and CFY. State licensure required in 45 states.
Audiologist[19]	Identification, assessment, and management of auditory and balance disorders;	Masters Degree and completion of 9 month Clinical Fellowship Year	CCC-A (Certificate of Clinical Competence in Audiology) awarded by American Speech

	audiological rehabilitation; selection, fitting, and dispensing of amplification systems; consumer education.	(CFY) post-M.A./M.S. required to practice nationwide. Annual CEU's required.	Language Hearing Association following completion of National Examination (NESPA) and CFY. State licensure required in 47 states.
Occupational Therapist	One who utilizes therapeutic goal-directed activities to evaluate, prevent, or correct physical, mental, or emotional dysfunction or to maximize function in the life of the individual.	BS or MS in OT with a minimum of 6 months of field work; for OT assistant, an associate degree or OT assistant certificate is required with a minimum of 2 months fieldwork.	State exam required for the credential of OTR. (Occupational Therapist Registered). Exam also required for COTA (Certified Occupational Therapy Assistant). These exams are given at least 2 times/year.
Physical Therapist	The evaluation, examination, and utilization of exercises, rehabilitative procedures, massage, manipulations, and physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound in the aid of diagnosis or treatment.	Four-year college degree in physical therapy is required to be eligible for the state exam; master's degree in physical therapy is available; 3 CEUs every 2 years are required.	PT is the credential that is used by licensed physical therapists and PTA is the credential for licensed physical therapist assistant. To use either of these titles, one must pass a state exam. CEUs are required for both; titles and licenses must be renewed biennially.
Chaplain	Provide visits and ministry to patients and family.	Master's degree in theology, plus a minimum of 1 year of clinical supervision, if fully certified. Can work in some settings without being fully certified.	Certification is through the Chaplaincy Board of Certification – credentials for this are BCC; however, credentials are not normally used. Most chaplains are ordained ministers, but not all. CEUs required are 50 hours per year.
Dietitian	Evaluate the nutritional status of patients; work with family members and medical team to determine appropriate nutrition goals for patient.	BS degree in food and nutrition and experience are required to be eligible for exam; CEs are required for both the LD (6 clock hours/year) and RD (75 clock hours year	RD is the credential for a registered dietitian. For RD, must pass the national exam of the American Dietetic Association; LD is the credential for a licensed dietitian; same exam is required but processing

		every 5 years); MS degree is available also.	of paperwork/fees is different.
Client/Patient	Consumer	Provide information necessary for assessment planning of care. Bring their needs and perspectives on illness, treatment and what they view as the major goals of care. Care goals must be endorsed by the client/patient in order to achieve successful adherence to a therapeutic plan.	Illness - Cognitive status – Important to remember that while global decision-making may be diminished, capacity in specific areas can be retained. While unable to manage financial matters, may retain ability to determine end-of-life decisions.
Family caregiver Spouse/Children	Consumer Advocate for client Provider of direct care	Provide a wealth of information regarding the client/patient - pre-illness functioning, hobbies, interests, and concerns. Offers direct input about ability and willingness to assist in care.	May not have detailed knowledge of disease process or the roles and function of the professionals on the team. May not live close to the client. Family history and/or dynamics may interfere with knowledge of client and ability to participate.
Caregiver outside family/ Neighbor/ Friend	Advocate for Client Provide direct care for client	Provide information regarding the client/patient - pre-illness functioning, hobbies, interests, and concerns. Offers direct input about ability and willingness to assist in care.	May not be identified.

*This chart has been adapted; Texas-specific information was deleted and New York-specific information was added; Speech-Language Pathology and Audiology disciplines were also added.

Reproduced from Geriatric Interdisciplinary Team Training: A Curriculum from the Huffington Center on Aging at Baylor College of Medicine, edited by Dianne M. Long and Nancy L. Wilson (New York: John A Hartford Foundation, Inc., 2001).

2. The University of Colorado Health Sciences Center's Geriatrics Interdisciplinary Team Training Workbook: "Forming, Storming, Norming, and Performing"

A. **Forming:** creation of the feeling of being a group through a transition from individual to group member status.

1. Goal of this stage is to reduce ambiguity and discover acceptable interpersonal behaviors and actions of the other group members.

2. Members get to know each other.
    a. Superficial sharing of name and background information.
    b. Sizing-up -and testing each other.
    c. Categorization of one another, with outside-of-team roles and status determining team roles.
    d. Relationships are guarded- more impersonal than personal.

3. Uncertainty regarding purpose
    a. Attempt is made to define task and methods.
    b. Lofty, abstract discussions of concepts and issues are common.
    c. Discussion of problems related to team function are common.
    d. There may be difficulty in identifying the problems, which are most relevant to the team's purpose.
    e. Complaints about the organization and the barriers to accomplishing tasks begin to surface.

4. Goal formation should be the primary task.
    a. A shared sense of mission is needed to establish the basic conditions required for cooperation, collaboration and interdependent function.
    b. Goals provide a rationale for the team's development.
    c. Goals provide incentive for team members to re-prioritize individual and discipline interests.

5. Conflict is usually neither discussed nor addressed at this stage of development.

B. **Storming:** Most difficult and conflictual stage. Task and roles begin to be perceived as different and more difficult than members originally anticipated.

1. Goal of this stage is to resolve the internal conflicts and focus on the task at hand.

2. Difficulty in understanding the goals and purpose of the team; attempt to establish common goals.
3. Role overlaps become evident.
4. Concerns about excessive workload.
5. Conflicts are present but are covered up or glossed over.
6. Arguing among members is common, even when they agree on basic issues.
    a. Questioning the wisdom of those who selected this project and appointed the members of the team.
    b. Defensiveness and competition lead to development of factions; sides are chosen.
    c. The implicit or explicit hierarchy, which had developed earlier, is often challenged, which commonly leads to disunity, tension, and jealousy.

C. **Norming:** The establishment of norms and patterns for regulation of the group process, reconciliation of competing loyalties and responsibilities, and acceptance of roles and team rules.

1. The goal of this stage is to develop cohesiveness and overcome any resistance in an effort of pulling together.
2. Establishing and maintaining ground rules and boundaries.
    a. Attempt to achieve harmony by setting norms -and avoiding conflict.
    b. Determine norms for acceptable group behavior and methods for dealing with group problems.
    c. More friendliness begins to be seen, with members confiding in each other, sharing personal problems, discussing the team's dynamics.
3. Preliminary agreement on shared goals is usually achieved.
    a. A sense of team cohesion develops, with a sense of purpose and common goals.
    b. Decision is made as to what information needs to be gathered.

D. **Performing:** When a strong sense of group identity and each member's role is developed, useful work can finally be consistently performed.

1. The goal of this stage is to resolve structural issues and generate energy to the task at hand.
2. Focus of group meetings is on problem solving.
    a. Relationships and expectations are finally clear.
    b. Common goals for patient outcomes are agreed upon across disciplines.
    c. A mechanism exists that enables all to contribute and share information essential for effective patient care.
    d. Protocols are established which ensure that care plans are implemented, services are coordinated, and the performance of the team is evaluated.

3. Conflicts begin to be seen as normal and are used as impetus for improvement.
    a. Differences are generally understood and appreciated.
    b. Each member recognizes, accepts, and respects the roles of the others.
    c. Mechanisms for conflict management are in place.

E. **Bringing new team members on board:** (Rubin, et.al, 1975)

1. Invest time in the joining-up process. Don't expect that a new member can be brought up-to-speed immediately. It is not a "one shot" effort but an effort over time. Don't expect too much from the newcomer right away.

2. Orientation is best accomplished through face-to-face interactions between the team members and the new member. Written materials alone are an inadequate orientation.

3. Orientation should include:
    a. Team goals
    b. Team members and their roles and responsibilities
    c. Team functioning: problem solving, decision making, conflict resolution
    d. Unique aspects of the team

4. If adequate time is not taken to incorporate a new team member, the following may occur:
    a. New members will experience considerable confusion and uncertainty about the way many of the things which you have learned to take for granted are supposed to be done on the team.
    b. Old members will experience disappointment in the new member who does not seem "to know anything" and may be hesitant to use the new member's resources.
    c. Morale, satisfaction, and productivity may be reduced.
    d. The new member might quit because he/she never quite felt like he/she belonged on the team.

F. **Adjourning:** When either a member leaves the team or the team disbands, the termination process is important.

1. Individual leaves
    a. Team and departing member may avoid the difficult and unpleasant work of termination.
    b. Depending on the circumstances, the team and the departing member may feel anger, disbelief, anxiety, relief, etc.
    c. The team may place subtle pressure on a member not to leave group.
    d. Team may regress to an earlier phase of team development.

2. Team terminates

a. Teams may decide to disband (i.e., conflicts within team) or they may be forced to disband for external reasons (i.e., need no longer exists, funding for group is no longer available).
b. When teams disband, members experience a sense of loss. To deal with feelings of loss and anxiety, team members tend to avoid these feelings in a number of ways: withdrawal, devaluing the importance of the team, anger toward the team leader or other team members, silence and inactivity, and/or leaving the team prematurely.
c. Feelings are expressed as testimonials (i.e., review of team's accomplishments or outstanding contributions of individuals to the team).
d. Team membership is affirmed as a valuable experience.

3. Termination issues that need to be addressed
   a. Review the team's departing members' experience and goals. Verbalize what has been accomplished.
   b. Formally acknowledge the change by allowing team members to say their good-byes and plan for the transition.
   c. Address feelings of loss, anger, or relief rather than avoiding them.
   d. Finish unfinished business with the departing member/the whole team.
   e. Give feedback to each other on what they have learned.
   f. Generalize what has been learned from the team experience so that it can be applied elsewhere.
   g. Notify patients of the team disbanding or change in team composition. Acknowledge loss for patient. Reassure patients that their continued care (by individual providers or the remaining team) is addressed.