

Steps for the Adult Team

There are five major steps in formulating and preparing the adult team:

1. Identifying a physician to direct the medical unit.
2. Identifying the other disciplines to participate on the adult team.
3. Recruiting and financially supporting the team members.
4. Developing a cohesive team.
5. Educating and training the team.
6. Preparing other caregivers.

Identifying a Physician

To initiate an adult unit, typically, direction for adult care needs must come from the pediatric unit. The identification of a physician in the adult setting implies finding an individual who has a personal interest in the population and sees developing this unit as consistent with his/her own career development. Once such an individual is identified, he/she must take leadership within his/her own institution and begin discussions with the section chief and departmental chairman. Enlisting the support of the department head and section chief is critical for the success of the program. Discussions may center around the need for the medical care, the financial viability of the program, and the academic potential such as training and research.

Identifying Other Disciplines

In planning an adult program for young adults with chronic illnesses, team care is essential. The disciplines involved in the team will depend upon the nature of the disease and accompanying disabilities. In developing the adult, it is helpful to first examine the components of the pediatric team from which patients will be transitioned. Usually the disciplines involved in the pediatric team will be similar to those needed for the adult unit. There clearly will be some variability. For example, on some pediatric teams special education will be a significant component, while for teams dealing with young adults, vocational rehabilitation may be a more appropriate and related service.

Using cystic fibrosis as an example, the following disciplines were essential for establishing the team:

1. Nursing to coordinate patient care, team activities, and communication with the pediatric team. (A master's level clinical nurse specialist is recommended, due to the multiple demands of the role on this sort of team.)

2. Social Work to support the patient and family around financial issues, life planning and coping with the patient's disease.
3. Nutrition to plan an adequate dietary program for each patient and provide patient education around nutritional issues.
4. Physical therapy to provide chest physiotherapy and physical training programs for patients.

Recruiting and Financing the Team

Before recruiting any team members, it is essential to enlist the support of the hospital administration. Hospital administrators will be interested in all aspects of financing of the program such as the payer mix, DRG reimbursement, average length of stay, resource allocation for the specific disease, whether or not a supplementary state program exists, and the number of personnel requested. Information on potential special support from public agencies, private foundations, drug companies, and individual donors will be important to ascertain. (See *Cystic Fibrosis Program Financial Projection Summary and Payer Mix for Total Number of Patients Registered*, and *Identifying Patient Demographics for Planning the New Health Care Program*, pages 23, 24, 25.)

CYSTIC FIBROSIS PROGRAM FINANCIAL PROJECTION SUMMARY

	<u>ACTUAL</u> <u>FY86</u>	<u>PROJECTED</u> <u>FY 87</u>
TOTAL NUMBER OF ADMISSIONS	-----	-----
GROSS CHARGES (Billed Services)	-----	-----
NET REVENUE (Collections after write-offs, etc.)	-----	-----
COSTS (Determine through hospital administration)	-----	-----
GAIN/LOSS	-----	-----
NOTES	-----	

Payer Mix for Total Number of Patients Registered

<u>Primary Payer</u>	<u>Number of Patients</u>	<u>% of Total # of Patients</u>
Blue Cross	-----	-----
Medical Assistance	-----	-----
Medicare	-----	-----
Commercial	-----	-----
CF-State	-----	-----
Self-Pay	-----	-----
TOTAL	-----	-----

Charges and Costs

Total Charges In-patient (from _____to_____) _____

Total Costs In-patient (from _____to_____) _____

Net Revenue _____

Total Charge Out-patient (from _____to_____) _____

Total Costs Out-patient (from _____to_____) _____

Net Revenue _____

**Identifying Patient Demographics for Planning
the New Adult Health Care Program**

This data should be obtained from the pediatric unit for planning the new adult program. This format can also be used to continue to maintain information about the progress of the new adult unit once it is established.

IN-PATIENTS

Total Patients Registered (over 18) _____

Total Patients Admitted (from _____ to _____) _____

Total Number of Admissions (from _____ to _____) _____

Average Length of Stay _____

Median Length of Stay _____

Average Number of Patients In-House _____

Services Utilized _____

OUT-PATIENTS

Number of Visits (from _____ to _____) _____

Number of Patients (from _____ to _____) _____

Number of New Patients (from _____ to _____) _____

Services Utilized _____

Having gained the support of the hospital administration, the next step will be to contact each department that will be involved in the program such as nursing, social work, dietary, etc. Initial contacts should include discussions about the importance of the program, the structure of the program, and the potential role for the discipline. A strategy for discussing the role of the department in the program will be to articulate the support of the administration for the program and commitment to hiring personnel for adequately staffing the program so that the new program will not create an extra burden for the department. In planning for staffing, both in-patient and out-patient responsibilities must be considered. (See **Contact Checklist for Initiating a New Adult Health Care Program**, below.)

Contact Checklist for Initiating a New Adult Health Care Program

The following is a convenient checklist to assure contact with individuals important in the process of establishing a new program.

- _____ Section Chief

- _____ Department Chairman

- _____ Hospital Administrator

- _____ Individual Disciplinary Departments
 - _____ Nursing
 - _____ Social Work
 - _____ Dietary
 - _____ Physical Therapy
 - _____ Respiratory Care
 - _____ Psychology
 - _____ Other

- _____ Medical and Surgical Departments (to provide consultations)
 - _____ ENT
 - _____ Gynecology
 - _____ Urology
 - _____ Gastroenterology
 - _____ Diabetology
 - _____ Rheumatology
 - _____ Other

The department heads will share a leadership role in the recruitment of staff with the Medical Director of the program. In some disciplines this will be a difficult process because of the lack of trained personnel. A number of "pediatric diseases" in question are not known to health professional caring for adults; thus, it is difficult to find trained professionals. For example, in the cystic fibrosis program, it was possible to identify a nurse who had good experience in coordination of patient care and program administration but not with cystic fibrosis patients. Job descriptions for each position should be developed. Using the pediatric team's job descriptions may be a good starting place.

There was some initial discussion in planning our program about having the pediatric Clinical Nurse Specialist transfer to the adult care setting to be the Adult Team coordinator. There were several obvious advantages to this course, since she would then be familiar with the disease and the issues that the patients and families faced. In addition, she could play a major role in training the adult team members, as well as the inpatient nursing staff at the adult hospital. We quickly rejected the idea, because it undercut one of the important reasons for transition--a change to an adult oriented manner of providing care. The point of transition was to have caregivers with attitudes that were different than their counterparts in the pediatric setting. Having a pediatric caregiver coordinate the adult team, would have been counter-productive. Thus, we chose to take the time and effort to train an adult oriented nurse about the disease issues. The same principal applied across disciplines.

Developing a Cohesive Team

Once team members have been recruited, forming the adult team is a major task. Establishing the roles and responsibilities of each team member, gaining an understanding of each other's roles, assuring good communication within the team, and providing leadership for the team are the key objectives.

For establishing roles and responsibilities clear job descriptions must be developed to include both in-patient and out-patient responsibilities. As the program develops emphasis in roles may change and staff should be prepared for these changes. **Adult Care Team Job Descriptions** (page 28) is a summary of several job descriptions from the cystic fibrosis program that illustrates the service, administrative, and linkage functions of each of the professionals.

Adult Care Team Job Descriptions

Physician

Disciplinary Duties: Provide medical services to Cystic Fibrosis adult patients on a inpatient and outpatient basis; teach medical students, housestaff, fellows and colleagues about Cystic Fibrosis care.

Team Linkage Functions: Serve as medical director and coordinator of the overall adult program; fiscal administrator of program; liaison with the Medical Director at the Pediatric Center; representative and advocate of the program within the hospital and departmental administrative systems.

Nurse Coordinator

Disciplinary Duties: Provide direct care (teaching, counseling, assessments and medical treatments); take patient calls and act as a resource for patients about needed medical services (e.g. home care, equipment); provide education and consultation to in-patient nursing staff about Cystic Fibrosis care and related issues; develop patient education programs.

Team Linkage Functions: develop policies and procedures in relation to Cystic Fibrosis Program; coordinate care provided by multi-disciplinary team to inpatients and outpatients; facilitate communication among team members about team function and patient care; facilitate communication between Cystic Fibrosis team and inpatient nursing staff.

Social Worker

Disciplinary Functions: Do complete psychosocial assessment of all patients considered for Transition program and identify problem areas needing intervention; provide counseling and other interventions to aid in adjustment to transition and enhance growth and independence; develop support groups .

Team Linkage Functions: Communicate and discuss plan with team both verbally and in the written record; assist the team in determining patient's appropriateness for transition and possible issues of concern; work with other team members in development of a total care plan for patient and family.

Dietician

Disciplinary Functions: Visit inpatients within 24-48 hours of admission to do initial nutritional assessment and make recommendation for nutritional needs, set up appropriate meal pattern; arrange for supplemental feedings when necessary; and make recommendations for nutrition support regimens (TPN, etc.) and make recommendations re: use of pancreatic enzymes An outpatient clinic will provide consultation to patients, and develop or acquire information for patients related to nutrition.

Team Linkage Functions: Provide consultation to team members on nutritional issues; communicate diet plan in writing and verbally to team; conduct research with team; attend patient conferences to aid in total care plan development.

Physical Therapist

Disciplinary Functions: Deal with equipment needs inpatient; provide chest Physical Therapy (pulmonary hygiene and toilet); develop rehabilitation plan including assessing motion, strength, posture and ambulation and prescribing appropriate exercises to increase aerobic endurance and lead to a safe resumption of pre-admission life.

Team Linkage Functions: Develop overall care plan with team; provide consultation to team members about Physical Therapy and equipment issues; report verbally and chart Physical Therapy activities.

Understanding each person's role is essential for the smooth functioning of a team. Sharing job descriptions is a first step in this process. Devoting team meeting time to sharing perceptions of each others roles is a way of establishing a good communication process and of developing rapport among team members. As the team progresses in its work together, a simple exercise the teams can use to assure ongoing communication about roles and responsibilities is the **Role Message Exercise**. (see **Role Messages Exercise and Role Messages Format**, pages 30 and 31.)

Role Messages Exercise

A simple process for examining and intervening in role definition problems has been developed for use with health teams. The process has four basic steps:

- Step 1 Share mutual role expectations by writing "role messages".
- Step 2 Identify role ambiguities and conflicts generated in the role messages.
- Step 3 Discuss alternatives and negotiating the best, most realistic, solution.
- Step 4 Implement a "role agreement" that specifies role expectations and commitments.

A role message is a written note to a fellow group member (one should be written by each team member to every other team member). Using the form on the next page each team member can then draw-up a tally for him/herself in each category (more of, less of, same as) making a sheet with a column for each category. This helps each member to identify problem areas. The input and response form the basis of negotiating sessions with the entire team to develop agreements about role functions. Obviously, institutional rules and regulations may have to be considered here as well. For more details on this process read: Module Four and Five in *Improving the Coordination of Care: A Program for Health Team Development* by I. Rubin, M. Plovnick and R. Fry. This approach is adapted from: Rubin, Irwin, M., Plovnick, Mark S., & Fry, Ronald E. *Improving coordination of care: A Program for health team development*. Cambridge, MA: Ballinger Publishing Co., 1975.

Role Messages Format

TO:

FROM:

(fill in whatever is appropriate to any group task)

In order to help me

I need you to do:

1. More of:

2. Same as

3. Less of:

This approach is adapted from: Rubin, Irwin, M., Plovnick, Mark S., & Fry, Ronald E. Improving coordination of care: A Program for health team development. Cambridge, MA: Ballinger Publishing Co., 1975.

To assure communication among team members takes time and commitment. Regular team meetings are essential to discuss patient issues as well as communication issues among members. The cystic fibrosis team conducts a team meeting after every out-patient clinic day, periodically during the stay of any in-patient, and others times as needed. All team members have access to written records and have a designated place in the chart for writing notes. When new teams are formed, it is sometimes useful to conduct a series of team building sessions. An outside facilitator skilled in team building can be helpful in conducting these sessions. A variety of techniques can be used to accomplish this. See **Team Building Program Activities** (below) for a few suggestions.

Team Building Program Activities

- Pick a regular team meeting time. At first you may use this time to get to know one another and plan how your team will function. Later this meeting will be used to plan patient care and develop programs.
- Develop a structure for case management. Who will see that all appropriate services are provided? Who will communicate needed information to all team members? Who will act as a liaison between the team and outside agencies or consultants? Typically, the nurse will act as the coordinator, but this may vary from setting to setting.
- Clarify roles of the various team members. (See *Role Messages Exercise*, page 30). There are many overlapping areas of expertise and responsibility on a team. For the team to function smoothly, each team must decide how decision making and work will be divided.
- Develop a system of team communication. Is there one person who will always be sure others hear of events, information about patients, etc.? Are there mailboxes for all team members in a central place? Do they all carry pagers?
- Consider having the team housed as close together as possible or have some space that team members can share when doing team activities. Patient records may be kept here as well. Frequent contact is an important component of the team developing an identity.
- Consider having members' name tags and business cards identify them as members of the team.
- Social events can solidify a sense of team identity.
- "Retreats"--taking time away from the workplace to concentrate on improving team functioning.

Team leadership has several aspects that should be addressed. Clearly the physician is the director of the medical program, but in terms of total patient care all team members are equal partners. Depending upon the presenting problem at a given point in time, leadership around the solution may vary. Every team needs a constant facilitator who takes responsibility for calling the meeting, conducting the meeting and seeing that all members actively participate. This facilitator may or may not be the medical director. Sometimes these responsibilities are shared among more than one team member. Frequently the nurse, because of her coordination responsibilities for patient care, will take this role. See **Leadership Assessment** (page 34) for suggestions.

Leadership Assessment

There are at least two types of leadership needed for any group to work effectively;

Task Leadership -- making sure that the goals of the group are met.

Process Leadership -- making sure that interpersonal interactions among team members run smoothly.

It is rare for one person to be equally effective in both areas of leadership. Usually these leadership roles may be shared among several team members. Occasionally a team is made up in such a way that there is no one who can exercise one of these needed forms of leadership. Other times, a team leader cannot see the importance of both types of leadership and team functioning suffers. As your team evolves it may be helpful to assess the leadership needs for the group at that time. Asking team members to fill out the following checklist (anonymously) may help the team coordinator assess the effectiveness of leadership on the team:

	YES	NO
Most members are committed to the mission of our team.		
Our team has formulated clear goals.		
The atmosphere on our team makes it easy for me to make a useful contribution.		
Our team encourages all members to participate.		
I feel our team is productive in meeting its goals.		
Our team meetings are run effectively.		
I am clear about my responsibilities to the team.		
I trust the other members of our group as we work toward our goals.		
Most members feel good about being part of this team effort.		
There is recognition for a job well done on this team.		

It is also helpful to get some idea about which team members have recognized leadership ability in one or both leadership areas. You will clarify your roles as caregivers and team members using the Role Messages Exercise (page 30) Now you can clarify leadership roles on the team using the following exercise.

Personal Profile of the Kinds of Contributions I Make to My Team

Types of Contributions Related to Our Task	I see myself as good at	Others see me as good at
Initiating		
Giving Suggestions		
Giving Opinions		
Giving Information		
Seeking Suggestions		
Seeking Opinions		
Seeking Information		
Elaborating and Clarifying		
Summarizing		

Types of Contributions Related to Our Team's Process	I see myself as good at	Others see me as good at
Encouraging		
Harmonizing		
Compromising		
Relieving Tensions		
Supporting Other Member		

My Profile of Contributions
Other Team Members Make

Types of Contributions Related to Our Task	Individuals Who are Good at This On Our Team
Initiating	
Giving Suggestions	
Giving Opinions	
Giving Information	
Seeking Suggestions	
Seeking Opinions	
Seeking Information	
Elaborating and Clarifying	
Summarizing	

Each member should fill in this checklist anonymously. See directions on next page for tallying results.

Types of Contributions Related to Our Task	Individuals Who are Good at This On Our Team			
Initiating	<table border="1" style="width: 100%; height: 100%;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>			
Giving Suggestions	<table border="1" style="width: 100%; height: 100%;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>			
Giving Opinions	<table border="1" style="width: 100%; height: 100%;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>			
Giving Information	<table border="1" style="width: 100%; height: 100%;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>			
Seeking Suggestions	<table border="1" style="width: 100%; height: 100%;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>			
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After team members fill in this checklist anonymously, someone tallies the group profile and presents a consolidated picture of how members perceive each other. Each member can see whether he/she sees him/herself the way others on the team do. More importantly for the group, the team can see if leadership styles are lopsided (too much task and no atmosphere) or whether there is some critical component of needed changes themselves. Other times, outside consultation is needed to unravel the team's difficulties. The following are RED FLAGS that indicate a team may need help from an outside consultant:

Is the current leadership on the team overwhelming to most group members?

Is there an unwillingness to assume leadership on the team?

Is the group unable to confront the leader or resolve the issue of absence of leadership?

Is there widespread apathy on the team, rendering it ineffective?

Is there conflict within the team that continuously prevents the team from resolving issues or focusing on the task?

Are team members rapidly losing interest in the work of the group?

Is the team continuously unable to reach effective decisions?

Does the team spend a lot of time on problems/issues without taking any action steps?

Sample Tally of Leadership Contributions for Team

Type of Contribution

Tally Profile

Initiating

Tom (4), Barbara (2), Jim (8)

Giving Suggestions

Carolyn (6), Tom (2), Alice (1)

This approach to leadership assessment is from: Magrab, Phyllis, *Human factors in interagency teams*. In Magrab, P., Elder, J., Kazuk, E., Pelosi, J. and Wiegerink, R. *Developing a Community Team*, prepared for HEW interagency Task Force under Grant # 54-P-7147613-02 by American Association of University Affiliated Programs.

Educating and Training the Team

The adult team needs to develop a knowledge base around a disease about which it may not be familiar and evolve a philosophy of care that is consistent with the needs of the patients and the families. Adult health care professionals more typically are not team oriented and are not accustomed to responding to patients who have conditions emanating from childhood. This has important implications for designing training and education experiences. Issues related to sex, marriage, pregnancy, child rearing, jobs, morbidity, code status and prognosis are other important areas to consider in evolving a philosophy of care. These are issues adult health care specialists deal with more comfortably.

Using the cystic fibrosis program as an example, the following kinds of training an educational activities are important:

1. Dissemination of relevant literature.
2. Informal reporting to one another on issues important to each other's discipline -- such as the social worker talking about the financial problems related to the patient population, etc.
3. Inservices by team members on topical issues of importance to all the team members.
4. Lectures from the pediatric team on the disease process itself, aspects of care such as nutrition, etc.
5. Formal rounding with the pediatric team.
6. Attendance at pediatric team meetings.

Preparing Other Caregivers

In developing an adult program, there are health professionals outside the immediate team who will be important in the process. These include other physicians who provide back-up coverage for the patients, the head nurse and floor nurses on the inpatient unit, and house staff and fellows in the section.

For the physicians who provide additional coverage for the patients, it is critical to instill a philosophy of care as well as a sufficient knowledge base so that they are compatible with the program. To accomplish this, a variety of informal experiences coupled with a few formal educational activities are necessary. These physicians should be encouraged to attend a few out-patient clinics and subsequent team meetings on a regular basis so they have a familiarity with the program and the patients. They should attend several in-patient rounds. A few well structured lectures on the nature of the disease, disease management and team care should be offered. Through their informal relationship with the medical director of the program they will have an opportunity to observe an effective role model.

The head nurse is a vital link in the continuity of care of these patients. Integrating these patients onto the in-patient unit will take preparation of the floor nursing staff. Using the cystic fibrosis program as an example, a good working relationship between

the team and the in-patient unit was accomplished by the nurse coordinator of the team and the head nurse of the in-patient unit meeting to discuss the needs of young adults with cystic fibrosis. Through these meetings key issues were identified: promoting independence of the patient, providing emotional care, scheduling meal times and aerosol-chest physiotherapy, and establishing changes in the I.V. policy to maintain the same line. These issues were then addressed through inservices and the development of the Cystic Fibrosis Patient Guidelines (page 41). This sheet is useful not only for the nurses but for the interns and the residents as well.

The interns, residents and fellows will all require preparation for providing care to these patients. The interns and residents should receive inservices and go on rounds with the medical director. The fellows, while they are on rotation, participate in all clinics, team meetings, conferences, and in-patient rounds. A few special lectures are designed to teach the fellows about the disease as well as the philosophy of care for these patients and their families.

Cystic Fibrosis Patient Guidelines

I. TESTING

Admission Labs

1. CBC with differential
2. Chemistry Admission Package
3. UIA
4. ABG or O2 SAT
5. Sputum C&S -- state patient has CF (needed for Cepacia)
6. Chest x-ray
7. Theophylline level if on a theophylline drug
8. Spirometry

During Treatment

1. CBC with differential
2. Tobra Levels -- peak and trough
3. Theophylline levels, prn
4. Pulmonary function tests after 2 weeks of treatment -- predischarge
5. UA, BUN and Creatinine, weekly
6. Bedside portable O2 if needed
7. Abdominal ultrasound prn
8. Vitamin E level

Before Discharge

1. CBC
2. Chemistry package
3. Chest x-ray if needed
4. Sputum on discharge
5. Complete pulmonary function tests or spirogram on discharge

II. PATIENT MANAGEMENT:

Continue patient's normal pancreatic enzyme (Pancrease or Cotazyme S) 1-3

tablets with meals; 1-2 with snacks. Pancreatic enzymes are to be kept at bedside.

Vitamin Therapy to be continued.

Hep Lock only to be changed with signs of early infiltration.

Aerosol therapy with_____and 2 cc N.S. tid or Qid basis followed by Chest Physical Therapy (Nursing will assign specific times).

Please avoid any unnecessary "sticks" Order a.m. labs to be drawn with levels.

No invasive-treatments or diagnostic studies after 8:00 p.m.

The aminoglycosides: Tobramycin, Gentomicin, Amikacin -- will be on a Q6 (10-410-4) schedule to ensure proper peak and trough levels and inactivation of amino glycoside with other antibiotics. All other penicillins should be on an alternate schedule.

After 12:00 am an IV solution will run KVO with piggyback antibiotic for ease of administration and patient consideration for sleep.

Calorie counts will be done on all patients for the first 3 days of hospitalization and prn thereafter.

Weights daily.

Double House Diet with extra salt. Nutritional supplements as recommended by the nutritionist.

Humidifier -- prn.

III. CF TEAM TO BE CONSULTED ON PATIENT'S ADMISSION

	<u>Name(s)</u>	<u>Phone/Beeper #</u>
Physician		
Nursing		
Social Services		
Nutrition		
Physical Therapy		