

**APPENDIX 21** (John A. Hartford Foundation Inc, 2001)

# **VIDEO** **CASE OF MRS. CUERVO**

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

**VIDEO SCRIPT: “CASE OF MRS. CUERVO”**

*By the GITT Case Studies Work Group*

**Roles:**

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

**Narrator:** Four members of the health care team are assembled for their weekly 8 a.m. meeting. The purpose of this meeting is to develop a plan of action for the clients discussed. Present are Diane Collins, the social worker; Susan Knight, the nurse practitioner; Leo Smithfield, the pharmacist; and Myra Lopez, the internist.

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

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

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

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

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

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

**Physician:** Mrs. Cuervo’s been taking digoxin for 10 years after an episode of Afib and CHF. She also has a history of hypertension. She seems to have been diagnosed as having hypothyroidism some time in the

past, because she's taking thyroxine. Her other meds include a laxative, an over-the-counter sleeping pill, an NSAIDS for osteoarthritis. Susan, you also saw Mrs. Cuervo. What were the results of the mental status exams?

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

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

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

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

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

***Nurse Practitioner turns to Physician.***

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

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

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

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

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

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

***The pharmacist quietly says:***

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

***Physician returns to room while the pharmacist is commenting.***

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

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

***At this point, the meeting starts to break up.***

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

**End**

**QUESTIONS FOR STUDENT TO THINK ABOUT:**

**A. Team Dynamics Questions**

1. On a scale of 1-10 (1 is HIGHLY EFFECTIVE, 10 is HIGHLY INEFFECTIVE), choose a number that best represents your perception of the team's functioning.
2. Please list specific effective and ineffective behaviors you observed in the team meeting. Be as concrete as possible. For example, a correct answer would be, "the social worker disrupted the meeting when she arrived last" rather than "the social worker disrupted the meeting". You may want to consider skills in the following area: running meetings, leadership, communication, conflict management, recognition of other team members, etc.
3. List three different ways you would have responded to these ineffective behaviors.

**B. Team Effectiveness Questions**

1. How valuable was the team meeting in establishing or improving the care plan for the patient? On a scale of 1-10 (1 is NOT AT ALL VALUABLE, 10 is VERY VALUABLE), choose a number which best represents your judgement.
2. Please give three different reasons why you circled the number you did in Question 4.

## **FACULTY INFORMATION NOTES**

### **1. Team Dynamics/Effective Behaviors**

- A. The following examples represent **effective behaviors** (the discipline and their behavior).
1. SW assumed organizer role (agenda, moves meeting along).
    - SW controlled interruptions.
    - SW seemed to have the leadership in the meeting.
    - SW attempted to keep the meeting moving in a timely manner.
  2. Meeting began on time (SW).
    - SW got meeting off to a good start.
    - Tried to start on time.
    - Agenda timelines.
    - SW called meeting to order and organized discussion.
  3. SW/MD refocused meeting after Pharm disruption.
    - MD stopped her presentation when Pharm and NP were not listening.
    - MD curbed Pharm's distracting behavior.
  4. SW/NP knew family/identified family concerns.
    - Gave social/spiritual dimensions and recognized family roles.
    - NP raised concerns of depression, religion, and gave good suggestions.
    - SW reported patient preference.
  5. SW/MD were prepared to discuss the specifics of case when called upon.
    - SW presented case adequately and appeared informed about the clinical issues in the case.
    - NP prepared with psychosocial assessment of cognition and affect.
  6. MD asked NP to present.
    - All were willing to share observation and contribute.
    - MD asked for input from NP.
    - MD asked for another opinion.
  7. MD supported SW by thanking her for starting on time.

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- MD acknowledged GNP starting meeting.
  - MD acknowledged SW role as convener.
8. NP kept meeting focused (contributed with question and follow-up).
- NP followed through on care plan by suggesting priest visit patient.
  - MD at least remained for most of the meeting.
  - NP appeared sensitive to the socio-cultural and medical issues.
  - MD was more direct when the meeting continued.
  - NP picked up on SW's report of patient's need to burn candles in husband's memory and suggested involving a priest.
  - NP: although not prepared when called on, had good data and thoughtful recommendations.
9. Members prepared to discuss specifics of case.
- SW presented effective system approach to functional status.
  - Three disciplines were honored.
  - MD presented.
- B. The following examples represent **wrong answers** (e.g., effective behaviors):
1. Pharm attempted to participate/share.
  2. MD showed expertise on Thyroxin

## 2. Team Dynamics/Ineffective Behaviors

- A. The following examples represent **ineffective behaviors** (the discipline and their behavior).
1. Pharm arrived late, was disruptive.
    - Pharm disrupted meeting by being late.
    - Pharm disrupted meeting late/coffee.
    - Pharm arrived late, didn't listen, noisy.
  2. Pharm withdrew, was inattentive/unable to contribute appropriately.
    - Pharm off-handed comment regarding "start low and go slow" appeared trite and irrelevant.
    - Pharm sarcastic -- did not give direct input.
    - Pharm did not pay attention during SW's presentation.
  3. Pharm/NP side discussion.
    - Pharm disrupted with extraneous conversation, made noise with food.
    - NP and Pharm began speaking across the table.

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- NP and Pharm more interested in coffee than issues at hand.
4. Pharm ignored/not asked for opinion.
    - The role of Pharm was ignored.
    - MD seemed uninterested when presenting case and wasn't interested in listening to Pharm's input.
    - MD did not pay attention to the Pharm's recommendations.
  5. NP not respectful of SW role.
    - NP did not ask SW regarding her opinion in psych consult.
    - NP did not elicit SW's impressions before recommending psych consult.
    - Conflict between NP and SW when asked for psych consult.
  6. NP poor conflict management/defensive.
  7. NP not prepared to begin when asked.
    - NP not organized in advance.
    - NP did not have paperwork ready -- focused on coffee.
    - NP was inattentive at times and caused the group to waste time.
  8. MD interrupted Pharm's discussion.
    - The MD cut off everyone when she sat back down.
    - MD did not let the Pharm talk.
    - MD disrupted the meeting when she interrupted the Pharm upon returning to the table
  9. MD answered page/beepers on.
    - MD left meeting to take page.
    - MD allowed self to be disturbed at meeting.
    - Beepers should have been put on hold for interruptions.
  10. MD poor closure to meeting.
    - The MD did not give this case the attention it needed by not allowing enough time to complete.
    - The MD closed the meeting before the Pharm was able to adequately contribute.
    - MD left quickly.
  11. MD played expert/acted as authority.
    - MD was dismissive of Pharm's contributions.

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

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

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

13. No processing of care plan/SW took over.

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

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

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

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

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

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

1. Recognize conflict/use conflict management skills.

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

2. Review/revise protocol for presenting patients.

- Overview of meeting so everyone knows what it to be covered.
- Formalize a structure within which each team player is given time for input without being interrupted or shut down.

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- Have each of the practices get an amount of time to speak about the patient.
3. Facilitate meeting by refocusing discussion, collaborative language, appropriate interruptions.
    - Stopped side bar conversations by redirecting to group discussions.
    - Welcome Pharm, give him time to settle, and solicit him to shift from food and his problem to case.
  4. Team self-reflexivity: improve team dynamics through team reflection/time to review team issues/time to evaluate meeting.
    - Ask if as a team we could evaluate the process used, goals, and how we could be more effective.
    - Request several minutes to reflect on “team processing.”
    - Processing of team dynamics.
  5. Establish meeting structure and ground rules for behavior.
    - After meeting, discuss timelines and participation with Pharm.
    - Stress importance of starting on time and being prepared to discuss each patient.
    - Appoint a team leader.
    - Establish and stick to an agenda.
    - Ask all members to set their beepers on vibrating mode.
  6. Encourage collaboration/recognize roles of team members.
    - Encourage the SW to be less authoritative and give others a chance to express their opinions.
    - Intervene on SW's offer to develop treatment plan and get input from the Pharm.
    - Give equal recognition and opportunity to speak to each member and then allow other members to comment on what was said.
  7. Establish/review/summarize care plan and team decisions.
    - There needed to be a real plan for dealing with the thyroid medication dosage.
    - I would have tried to come up with a concrete treatment plan before concluding the meeting.
    - I would not have allowed the meeting to end if there were still issues and if a treatment plan had not been solidified
  8. Clearly define team members responsibilities.
    - Assign responsibilities/action items/review time at end of meeting for meeting patient's needs.

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- Remind the SW that a psych consult does not infringe on her responsibilities.
  - Explain to the SW that she is not qualified to assess a psych consult and that it is in the patient's best interest to get a psych consult.
9. Counsel team members privately.
- Speak to SW after meeting in private about why she got defensive at suggestion.
  - Talk to the person arriving late after the meeting to tell him how his late entrance affected things.
  - Take the Pharm aside and tell him that he should try to be more punctual next time.
- D. The following examples represent **wrong answers** to **ways to respond to ineffective behaviors**:
1. MD/NP/SW/Pharm "should."

### 3. TEAM EFFECTIVENESS.

- A. The following examples represent reasons why the team meeting was valuable in establishing and/or improving the care plan for the patient.
1. Patient problems identified and discussed.
    - SW discussed details of functional and social assessment.
    - The team members received more psychosocial information that might help the team to sort out problems.
    - Planning proceeded based on team's discussion.
  2. Agreed to specific care and task assignments.
    - Decision was made to change therapy care for patient with mechanism for assessing this change in future.
    - The team did not reach consensus on a few things.
    - They ended up having some plan for the thyroid.
  3. Team members engaged/group input.
  4. Team effectively solved problems.
- B. The following examples represent **wrong answers** to reasons why the team meeting was valuable in establishing and/or improving the care plan for the patient:
1. Care plan developed.
  2. Members assumed specific responsibilities.

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- C. The following examples represent reasons why the team meeting was **not valuable** in establishing and/or improving the care plan for the patient.
1. No care plan established.
    - The team did not make progress in identifying a consensus problem list on which to build a plan.
  2. Patient's problems identified but not resolved.
    - What happens to patient's meds- who is handling her meds?
    - The team's concerns were not adequately addressed; depression, family problems/lack of support, safety issues, etc.
    - The team did not hear/gather all of the pertinent information to plan for this patient.
  3. Conflict/ lack of respect for other team members.
    - MD cut off input from other disciplines.
    - Nothing was done to show values of various team members.
    - No input from Pharm.
    - The team had side conversations, distractions, and interruptions in the short time they were meeting.
    - Full contribution of team members not recognized or encouraged.
  4. No team process/lack of collaboration and communication.
    - Decisions were individual not team.
    - Problem solving did not follow problem identification.
    - Some problems were identified but no clear goals or approaches were identified.
  5. Implementation of plan not likely to be interdisciplinary.
    - Only one person is going to develop care plan. The group should develop care plan together.
    - Very little team interaction led to a new care plan (SW ended up developing the plan independently).
  6. No team leader/ineffective team leader.
    - Meeting was very disorganized -- needed team leadership.
  7. Confusion of responsibilities/roles.
    - Unclear responsibilities of members.
    - Did not define duties to follow-up on.

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8. Team did not provide a complete picture of all patient problems (environmental, social, etc.).
    - Important points involving patient were neither presented clearly nor addressed specifically.
    - Don't think the patient's issues were addressed.
    - The issue of the patient's depression seemed to be addressed inadequately.
- C. The following examples represent **wrong answers** to reasons why the team meeting was not valuable in establishing and/or improving the care plan for the patient.
1. Lack of respect for patient's family.
  2. Rushed to conclusions/needed more time for meeting.
  3. SW not best person for psych consult.
  4. Not enough time for meeting.

# VIDEO

## CASE OF MR. ROSARIO

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

### VIDEO SCRIPT: "CASE OF MR. ROSARIO"

*By the GITT Case Studies Work Group*

**Roles:**

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

**Narrator:** Four members of the health care team are assembled for their weekly 8 a.m. meeting. The purpose of this meeting is to develop a plan of action for the clients discussed. Present in the meeting are Andrea Brown, the social worker; Mary Thomas, the nurse practitioner; Simon Wilson, the pharmacist; and Jennifer Rodgers, the internist.

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

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

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

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

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

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

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

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

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

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

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

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

**Pharmacist:** Any medications besides tolbutamide?

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

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

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

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

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

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

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

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

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

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

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

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

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

End

**QUESTIONS FOR STUDENTS TO THINK ABOUT:**

D. A. Team Dynamics Questions

1. On a scale of 1-10 (1 is HIGHLY EFFECTIVE, 10 is HIGHLY INEFFECTIVE), choose a number that best represents your perception of the team's functioning.
4. Please list specific effective and ineffective behaviors you observed in the team meeting. Be as concrete as possible. For example, a correct answer would be, "the social worker disrupted the meeting when she arrived last" rather than "the social worker disrupted the meeting." You may want to consider skills in the following area: running meetings, leadership, communication, conflict management, recognition of other team members, etc.
5. List three different ways you would have responded to these ineffective behaviors.

**C. Team Effectiveness Questions**

1. How valuable was the team meeting in establishing or improving the care plan for the patient? On a scale of 1-10 (1 is NOT AT ALL VALUABLE, 10 is VERY VALUABLE), choose a number which best represents your judgement.
2. Please give three different reasons why you circled the number you did in Question 4.

## FACULTY INFORMATION NOTES

### 1. TEAM DYNAMICS/EFFECTIVE BEHAVIORS

- C. The following examples represent **effective behaviors** (the discipline and their behavior):
1. SW assumed organizer role (agenda, moves meeting along).
    - SW attempted to keep meeting focused and on schedule, clear agenda.
    - SW leadership role in initiating the meeting and ensured all team members had a list of patients to be discussed so that they were prepared for discussion.
    - SW was an effective manager of process; started meeting on time.
    - SW team leader, good control of meeting.
  2. SW facilitated/diffused conflict well between NP/MD (clarification of team rules on pts, stated ground rules).
    - SW clarified ground rules when a conflict arose regarding them.
    - SW—conflict management in restatement of ground rules for discussing patients and directing discussion.
    - SW clarified purpose of the team meeting to show support for the NP, who was defensive after MD accused her of wasting time with stable patient.
  3. MD good use of facilitation skills (refocused group/prompted pharmacist for information and help).
    - MD intervened in discussion to refocus group onto issues of medication -- a positive and appropriate way to keep group focused.
    - MD stopped Pharm's denigrating remarks to NP by asking him for his suggestion on alternative meds.
    - Some successful efforts of collaboration and appropriate accommodation (SW and MD).
  4. Meeting began on time (SW).
    - SW started meeting well, started meeting on time.
    - Team assembled and meeting started on time.
    - SW was an effective manager of process -- started meeting on time.
  5. NP prepared with patient presentation.

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- NP was well prepared.
  - NP gave good, concise summary of clinical issues.
  - NP stated why she is presenting.
6. SW set up nutrition consult.
- SW agreed to set up nutrition consult when no one else would.
  - SW accepted to do referral, even though busy.
  - Leader asked for a nutrition consultation.
7. Group attentive.
- Pharm attentive.
  - Team members seemed to be attentive and listened at least part of the time
  - All listened, attentive. and took notes on case under discussion.
8. MD did not answer page.
- At one point in team conference, MD did not answer her beeper, thereby avoiding an interruption.
  - MD shut off beeper and didn't let it interrupt meeting.
  - MD did not answer her page immediately.
9. NP empathy for patient.
- NP communicated care and empathy for patient.
10. SW facilitated meeting (prompted NP/Pharm about meds and dietary consult).
- SW creatively facilitated the meeting (i.e., kept members on the appropriate topic and acted as mediator during disagreements/conflicts).
  - SW — appropriate accommodation.
  - SW tried to involve Pharm and others in contributing ideas regarding patient's problems.
- D. The following examples represent **wrong answers** (e.g., effective behaviors):
1. Team members need/should.
  2. Team socially appropriate.
  3. Pharm contributed knowledge appropriately.
  4. MD sought clarification as to why case was being presented.
  5. SW used collaborative style.
  6. Group collaborative/ sharing.
  7. NP responded appropriately to conflict with MD & SW.

### 3. TEAM DYNAMICS/INEFFECTIVE BEHAVIORS

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- A. The following examples represent **ineffective behaviors** (the discipline and their behavior):
1. NP poor conflict management skills.
    - NP wanted to handle all of patient's problems and got defensive when other team members tried to contribute help.
    - NP reacted defensively to internist's question about why patient was being presented.
    - NP took physician's outburst personally rather than responding to the content.
  2. Pharmacist sarcastic/puts down NP.
    - Pharm reprimanded NP regarding the use of a specific medication.
    - Pharm was aggressive regarding Dalmane.
    - Pharm offered his ideas in judgmental and arrogant way, used sarcasm, personalized his comments to NP, acted as expert in disrespectful way.
  3. MD showed poor conflict management skills (aggressive/evaluator).
    - Clearly, MD somewhat confrontational in seeking clarification.
    - MD impatiently questioned need to discuss case -- created hostile situation.
    - MD reaction: are you wasting my time — leads to interruption — problem should have been more explicit
  4. NP presentation not appropriate for team care/planning/meeting.
    - NP presented patients as if all issues had been dealt with already; she gave the impression that the patient was stable when, in fact, this was not the case.
    - NP described patient's refusal to change dietary habits but did not seem to work with him from a participative approach (i.e., patient as part of the team).
    - NP presentation was not focused on team issues — patient problems needing their input not specified.
  5. SW defensive/poor conflict management skills.
    - SW defensive.
    - SW inappropriate accommodation.
    - SW, MD, Pharm seemed to gang up against the NP, as indicated by their facial expressions.
  6. SW/NP conflict/argue over responsibility for nutrition consult.

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- RN/SW both too busy to schedule nutrition consult — then SW agrees.
  - Defensiveness on the part of the SW when asked to help with referral for nutrition consultation.
  - SW's negative response to scheduling nutrition visit (too busy).
7. MD/Pharmacist side discussion.
- MD, NP, Pharm were unable to express their opinions without condescension and rudeness.
  - Eye contact between MD and Pharm disrespectful and disturbing.
  - Pharm and MD communicated their disapproval of things nonverbally and created an alliance of judges.
8. MD/Pharmacist showed lack of respect for team members (nonverbal eye rolling, condescending).
- MD, NP, Pharm were unable to express their opinions without condescension and rudeness.
  - Eye contact between MD and Pharm disrespectful and disturbing.
  - Pharm and MD communicated their disapproval of things nonverbally and created an alliance of judges.
9. Pharmacist is expert/lectured team on meds.
- Pharm began to pontificate about sleepers.
  - Pharm gave too much information, got into lecturing mode.
  - Pharm set himself up as expert on meds and put the NP on the defensive.
10. SW shows poor facilitation skills (changed topics/cut off Pharm).
- SW cut off discussion of sleeping medications by Pharm without finding a positive way to refocus him.
  - Before topic of sleep problem was resolved, SW jumped to nutrition, changing the subject before resolution had been reached.
  - SW avoided conflict by introducing other ideas.
11. Members did not recognize others' roles/lack of respect.
- Talked down to one another — factors emerged (SW/NP & MD/Pharm).
  - Each team member at some point ignored the roles of other team members.
  - Some members are first name, others "Dr. Rogers."
12. Beeper disruptive.

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- Beepers were disruptive.

13. No plan established.

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

14. Team members not paying attention.

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

15. No ground rules/organization.

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

16. Leadership not decided by group.

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

17. Poor distribution of workload/responsibility not taken.

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

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

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

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

1. Recognize conflict/use conflict management strategies.
  - The conflict needs to be addressed openly and constructively.
  - This might be done in the last 10-15 minutes of meeting during feedback discussions.
  - Encourage team members to disagree in ways that don't create defensive responses.
  - Stop the meeting and ask the combatants "what's going on?"
2. Review/revise protocol for presenting patients.
  - Suggest that, in giving the summary of status, that person presenting raise issues of concern as a starting point for discussion.

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- Request/explain purpose in bringing case to meeting.
  - Set up discussion of each patient with ground rules in mind, such as, “what are the pressing issues and concerns for this patient?”
3. Facilitate meeting by refocusing discussion, collaborative language, appropriate interruptions.
- I would have let the pharmacist know that not everyone is an expert in pharmacology and that his opinions and input are needed. However, rudeness is never necessary.
  - Refocus team on goal of treatment plan development when they get sidetracked on sleep medication issue.
  - Intervene during the “too busy” comment by SW to point out that everyone is very busy, and ask team who could arrange the consult most easily.
4. Team self-reflectivity: Improve team dynamics through team reflection /time to review team issues/time to evaluate meeting.
- Restrain ground rules for meetings.
  - Suggest that the team get more training in team process and communication, including interpersonal issues (such as conflict) on teams and how to deal with them.
  - Recommend team building -- deal with respect for each others values, skills, feelings, and conflict.
5. Establish meeting structure and ground rules for behavior.
- Review ground rules for behavior.
  - Pagers on vibrate — decreasing interruptions.
  - Appoint a team leader.
  - Establish and stick to an agenda.
  - Ask team members to refrain from abrupt interruptions of others on the team.
6. Encourage collaboration/recognize roles of team members.
- Ask each team member to identify one goal for the patient and continue this discussion until no team member has a goal to contribute. Follow this with a discussion of which disciplines should be involved in working on the specific goals.
  - Draw all members into collaborative process.
  - Request to seek full consensus on what are the specific issues in this case that need action.
7. Establish/review/summarize care plan and team decisions.
- Provide some time at the end to summarize and assign tasks for follow-up.

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- Process leader should push more toward team's agreement on problems/priorities team is going to address and who will do this.
8. Define team members responsibilities clearly.
    - Establish clear guidelines for distribution of workload.
  9. Counsel team members privately.
    - I would ask to speak privately to the NP and the Pharm to express my experience of their participation at the meeting and encourage each of them to speak with other members to process unspoken issues.
- D. The following examples represent **wrong answers** to **ways to respond to ineffective behaviors**:
1. Did task myself.
  2. Be a good example.
  3. Patient should be able to be the focus of team meeting.
  4. MD/NP/SW/Pharm "should"

### 3. TEAM EFFECTIVENESS

- A. The following examples represent reasons why the team meeting was **valuable** in establishing and/or improving the care plan for the patient:
1. Patient problems identified and discussed.
    - Dialogue eventually led to identification of potential problems needing to be addressed -- Dalmane use, nutritional issues.
    - Team identified a broad range of issues: nutrition, safety, meds.
    - The team did identify some issues (such as medications, social support, and nutrition) that were relevant to improving the patient's level of functioning.
  2. Agreed to specific care and task assignments.
    - A plan was developed to promote dietary cooperation, by the referral to a nutritionist and the delegation of responsibility, to follow-through with the recommendation.
    - Outcomes -- MD to follow-up on sleep problem, NP on referral.
    - Patient to see nutritionist (consult to be arranged by SW).
    - Patient also to see SW about failing vision.
  3. Team members engaged/group input.
    - There was good input from all members of the team; they displayed good information seeking and sharing.

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- Team members were all actively engaged in this meeting.
- Team participated in this case -- info.

### 4. Team solving problems effectively.

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

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

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

### C. The following examples represent reasons why the team meeting was not valuable in establishing and/or improving the care plan for the patient

#### 1. No real plan of care developed.

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

#### 2. Patient's problems identified but not resolved.

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

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

- Little respect among team members.

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- Unresolved conflict among team members interferes with team process and treatment planning.
  - There was no positive appreciation expressed for any team member's contribution by anyone.
4. No team process/lack of collaboration and communication.
- SW attempted to run meeting but could do no more than stick to the schedule.
  - Insufficient attention paid by team members to each other, so no real pooling of concerns and problem solving.
  - Team members disagreed about the ground rules of their meetings
5. Confusion of responsibilities/ roles.
- People arguing over who would do what.
  - Were unclear on assigned role as to who should be doing these interventions.
6. Team does not provide a complete picture of all patient problems (environmental, social, etc.).
- Important medical/social issues not dealt with.
  - Did not identify all possible helps -- nursing home, rehabilitation, etc....

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

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

**VIDEO**  
**CASE OF MRS. BUSBY**

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

**VIDEO SCRIPT “CASE OF MRS. BUSBY”**

*By the GITT Case Studies Work Group*

**Roles:**

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

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

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

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

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

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

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

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

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

**Nurse Practitioner:** Oh, I don't remember getting the message but sure, I can start us off. Here she is. Mrs. Busby is an 88-year-old white woman living alone in a one-bedroom apartment over in the Fairhaven complex. She's been our patient for the last 6 months. She's got hypertension, congestive heart failure, osteoporosis, glaucoma, and hearing loss. I'm worried that she'll have difficulty maintaining her independence because her vision and hearing are really getting bad. She's able to perform all her ADLs now but she has to have help from neighbors with shopping. Her Mini Mental score is 27/30. I've decided to treat her with ramipril

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for her heart and fosamax for the osteoporosis. She takes an aspirin every other day. I've also ordered hearing and vision evaluations.

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

**Physician:** Hearing loss in the elderly can be caused by many different things. One needs to think about whether this is a buildup of wax, if this person has some sort of temporary hearing loss, or whether it's drug reaction. With acute hearing loss, one could also consider giant cell arteritis (GCA). The diagnosis is established with a temporal artery biopsy specimen, in which the characteristic necrotizing granulomatous vasculitis can be seen. The serious complication of blindness can be averted if the patient is treated quickly with daily oral prednisone ranging from 40 - 60 mg. The activity of GCA can be followed by monitoring the sedimentation rate. Any ischemic complications occurring before the treatment is begun, however, are not likely to be reversed.

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

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

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

Social Worker returns and cuts off NP.

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

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

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

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

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

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

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- Social Worker:** Medicare doesn't cover hearing aids. Mrs. Busby doesn't have other insurance and she's really worried about money. I got her into the state-subsidized prescription program last month and I promised her I'd start her Medicaid application as soon as I got the medical information I need. Phil, are there any recommendations you'd make about her drugs in terms of cost and compliance? Generics are required in the state-subsidized program, aren't they?
- Pharmacist:** They sure are. Rosemarie's recommended an ace inhibitor and fosamax. Both are expensive. Fosamax also needs to be taken with a large glass of water prior to eating. Patients generally take it in the morning; many don't tolerate it well. I'm not even sure if that's on the approval list of drugs yet. Some of the ace inhibitors have less expensive generic equivalents. We might want to think about one of them.
- Physician:** I agree. I'll order the generic.
- Nurse Practitioner:** Wait a minute, Gloria. (Let's not be too hasty). *I'm* the one who ordered the prescriptions. Phil, would going with the generic pose any problems in managing her CHF and hypertension? What do I look for in monitoring Mrs. Busby's response to changing the ace inhibitor?
- Pharmacist:** Sure there are differences. I'll figure out the side effects and give you a call. Then you and Gloria can fight over who orders the new ace inhibitor and if you want to continue with the fosamax.
- Social Worker:** Okay, guys, let's move along here. Rosemarie, if you get me the medical information I need to process the Medicaid application, I'll file it right away.
- Nurse Practitioner:** Sure. I do everything else around here. I'll put it in my pile and get back to you.
- Social Worker:** Okay. Let's keep plowing through these cases. We have 18 minutes for the next five patients and Mr. Heineman's waiting for me in the ER.
- End.**

**QUESTIONS FOR STUDENTS TO THINK ABOUT:**

**A. Team Dynamics Questions**

1. On a scale of 1-10 (1 is HIGHLY EFFECTIVE, 10 is HIGHLY INEFFECTIVE), choose a number that best represents your perception of the team's functioning.
6. Please list specific effective and ineffective behaviors you observed in the team meeting. Be as concrete as possible. For example, a correct answer would be, "the social worker disrupted the meeting when she arrived last" rather than "the social worker disrupted the meeting." You may want to consider skills in the following area: running meetings, leadership, communication, conflict management, recognition of other team members, etc.
7. List three different ways you would have responded to these ineffective behaviors.

**D. Team Effectiveness Questions**

1. How valuable was the team meeting in establishing or improving the care plan for the patient? On a scale of 1-10 (1 is NOT AT ALL VALUABLE, 10 is VERY VALUABLE), choose a number which best represents your judgement.
2. Please give three different reasons why you circled the number you did in Question 4.

## **FACULTY INFORMATION NOTES**

### **1. TEAM DYNAMICS/EFFECTIVE BEHAVIORS**

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

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

## 2. TEAM DYNAMICS/INEFFECTIVE BEHAVIORS

- A. The following examples represent **ineffective behaviors** (the discipline and their behavior).
1. SW not effective team leader.
    - SW was in too much of a rush and closed discussions prematurely.

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- MD side conversations with NP/Pharm over coffee even though SW had initiated meeting.
  - Too many patients for the time allotted -- too pressured.
  - SW brought up unrelated issues -- encounter forms.
2. SW interrupted/disrupted meeting.
- SW interrupted meeting to get page and when she returned, talked about another case.
  - SW: beeper interruption, left meeting, interrupted inappropriately.
  - SW: left, returned, interrupted group discussion, and then hurried the team through the case before care decisions were finalized.
3. SW started meeting late.
- Team off to a late start.
  - SW started the meeting late.
  - The meeting began late due to involvement in coffee and donuts ritual; yet all team members emphasized how stressed for time they were.
4. NP unprepared to present first case.
- NP was not aware that she was scheduled to present the case.
  - NP unprepared for case discussion and annoyed with SW re: lack of communication.
  - Team members were not clear on patients scheduled to be discussed at this meeting, which put NP on the spot.
5. NP defensive/sarcastic (she feels that she does all the work).
- NP was sarcastic about assuming more responsibility "I do everything anyway," instead of requesting the sharing of responsibility.
  - NP made passive/aggressive remark about "doing all the work."
  - NP defensive in her presentation about patient's hearing loss.
6. NP/SW poor conflict management (over hearing aid order, presentation of case).
- Not well organized — poor comments between SW and NP.
  - SW and NP argue over who will take responsibility for ordering hearing aid.
  - NP personalized problem — SW/MD.
7. NP/MD conflict over professional skills (med orders).
- MD ignored NP's role and says she'll order generics.
  - MD dominated discussion without involving NP.

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- Power struggle -- lack of role clarity (NP and MD).
8. MD “expert” (inappropriate/ pushes unwarranted diagnosis).
- MD digressed by giving into technical discussion about GCA.
  - MD offered off-the-wall diagnosis for a patient she had not personally examined or assessed.
  - MD spoke in medical jargon, which did nothing to contribute to the treatment planning.
9. Pharmt sarcastic/ condescending.
- Pharm condescending to NP over ACEI conflict.
  - Pharm ineffective in attempt to diffuse conflict with joke (“I’ll leave you two to fight it out”).
  - Pharm taunted MD and NP about ordering ACE inhibitor (feeble attempt to diffuse anger).
10. Poor team communication (eating, interruptions, distractions).
- MD/PH/SW: several members seemed distracted, not committed to meeting (“very busy today -- need to hurry”).
  - People interrupted each other disrespectfully (MD at beginning of meeting, SW interrupted NP).
  - All were eating at meeting.
  - MD discounted that SW had already attempted to start the meeting.
11. Unresolved conflict and poor role definition.
- NP did not address conflict -- issue left hanging.
  - Tensions were not dealt with (roles and responsibilities).
  - Avoidance (SW left the room and MD made sarcastic comment).
12. No emphasis on care plan/patient follow-up.
- No conclusions or care plan was developed. Each did their own thing without using the others’ info.
13. Beepers disruptive.
- Beeper interrupted discussion.
14. Members did not recognize others’ roles/unequal roles/lack of respect.
- Arguing between all -- everyone not paying attention and walking out.
- B. The following examples represent examples of **wrong answers** (e.g., ineffective behaviors).

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1. Pharm not knowledgeable about meds.
  2. NP not supported.
  3. Team lacked agenda.
  4. MD did not elicit NP's opinion.
- C. The following examples represent ways to respond to these **ineffective behaviors**.
1. Recognize conflict/use conflict management strategies.
    - Address source of conflict. Get team members to define, clarify, understand, and support one another's professional roles.
    - I would intervene in argument between NP and SW over responsibility for follow-up, and I would ask which follow-up would make the most sense and be of most value to the patient.
    - Stop the meeting and asked the combatants "what's going on?"
  2. Review/revise protocol for presenting patients.
    - Decide at end of meeting which patient will be discussed at next meeting and who will present.
    - A list of patients to be discussed via some kind of meeting agenda would improve efficiency and preparedness.
    - Arrive at agreement at end of meeting regarding who will present case at next meeting. Determine who will lead next meeting. The leader of the scheduled meeting should confirm with case presenter that s/he is scheduled to present at next meeting.
  3. Facilitate meeting by refocusing discussion, collaborative language, appropriate interruptions.
    - Would have intervened during the MD's lengthy, unrelated lecture.
    - Would have suggested moving to the next patient when NP clearly not prepared to present Mrs. Busby.
    - Redirect attention of group to the NP after interruption by SW. Maybe even ask her to stop and start again in her report.
  4. Team self-reflexivity: improve team dynamics through team reflection/ time to review team issues/ time to evaluate meeting.
    - Provide feedback to team members as a group regarding team's negative behavior.
    - Set aside time each week for team to consider only concerns about team communication and process (how are we doing as a team?).
    - Request a separate meeting to discuss team maintenance issues.
  5. Establish meeting structure and ground rules for behavior.

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- Help team develop rules and procedures about eating and drinking before, during breaks, or after the meeting time; help them see how this activity makes them less efficient during the meeting; also, help them develop a procedure insuring that all the team members have the meeting agenda prior to the team meeting.
  - Appoint a team leader.
  - Establish and stick to agenda.
  - Suggest they start their meeting on time and discuss what are appropriate agenda items.
  - Beepers should be on vibrator mode.
6. Encourage collaboration/ recognize roles of team members.
- Suggest that the NP and MD have some boundary issues to sort out outside the meeting.
  - Discuss role conflicts and roles in general.
  - Support efforts to use other disciplines as a resource.
7. Establish/reviews/summarize care plan and team decisions.
- Would have tried to seek clarification of plan of care priorities and who is doing what before session ended.
  - Use summarization skills to integrate the information with a focus on patient needs.
  - I would ask for a summary and agreement over which team members take responsibility for which aspects of case management.
8. Define team members' responsibilities clearly.
- Identify goals to be accomplished with each patient. Assign specific team members stewarding of goals.
9. Counsel team members privately.
- The NP and the MD have issues. I would advise them to meet to discuss and resolve those issues.

### 3. TEAM EFFECTIVENESS

- A. The following examples represent reasons why the team meeting was valuable in establishing and/or improving the care plan for the patient.
1. Patient problems identified and discussed.
- Medication management was carefully considered.
  - Looked at lower costs of medications.
  - Team focused on hearing problem and set appropriate goals.

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- SW revealed information re: application for Medicaid that no one seemed aware of.
  - Some benefit accrued to patient in the development of a financially feasible medication plan.
2. Agreed to specific care and task assignments.
    - Who will take action was addressed.
    - Several new tasks were assigned based on interchange of ideas.
  3. Team members engaged/ group input.
    - Pharm and MD offered expert opinion, although MD became too technical. This information was relevant and appeared useful to the NP.
    - Team members did ask appropriate questions.
    - Important information for patient's care was exchanged.
- B. The following examples represent **wrong answers** (e.g., valuable meeting).
1. Care plan developed.
  2. Team effectively solving problems.
- C. The following examples represent reasons why the team meeting was **not valuable** in establishing and/or improving the care plan for the patient.
1. No care plan established.
    - No clear goals defined for the patient.
    - Several ideas generated about patient but plan seems disjointed -- who is doing what needs to be determined.
    - Reports were not integrated into measurable treatment plan.
  2. Several patient problems (vision, ADLs) not addressed at all.
    - No problem solutions for concerns of individual client, besides medications.
  3. No team process/lack of collaboration and communication.
    - No real communication or collaboration in problem solving.
    - Nothing really happened that was interdisciplinary other than perhaps some discussion (meds).
    - Concerns were not fully aired and few decisions were made.
    - Discipline focused, not patient focused.
  4. Confusion of responsibilities/roles.

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- It was not clear which team member(s) was/were taking responsibility for implementing the care plan.
  - Roles were ill defined.
  - No one assumed responsibility for follow-up.
5. No team leader/ ineffective team leader.
- No leadership or organization.
6. Conflict/lack of respect for other team members.
- Conflicts over territory between NP and MD and defensiveness of NP further undermined effective meeting process.
  - Conflict among team members and constant time constraints prevented the development of a truly integrated care plan.
  - Too much fighting -- nonproductive behavior.
7. Team did not provide a complete picture of patient problems (environmental, social, etc....).
- Many questions were left unanswered and this same discussion will all have to take place again.
  - Not all issues were discussed fully.
  - Review of the patient was incomplete.

# VIDEO

## **CASE OF MRS. LIN TSAI**

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

VIDEO SCRIPT “CASE OF MRS. LIN TSAI”

**By the GITT Case Studies Work Group**

**Roles:**

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

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

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

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

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

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

**Pharmacist:** Vacation? Where are you going Nancy?

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

**Pharmacist:** Sounds great.

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

**Nurse Practitioner:** Kathy, can you please start.

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

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

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

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

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

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

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

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

***Physician returns to the table after answering the beeper.***

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

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

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

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- Pharmacist:** What about the medications she's on?
- Nurse Practitioner:** Apart from the Haldol and some Chinese herb, I don't show anything.
- Pharmacist:** What about aspirin? I'm sure that was ordered after the CVA.
- Nurse Practitioner:** It's not in the record.
- Physician:** Well, if it's not there, let's start her on it.
- Nurse Practitioner:** OK.
- Social Worker:** During my interview the daughter mentioned that the Chinese herbal medicine was helping her. I wrote it down ... here it is ... Huperzine A. Ever hear of it?
- Physician:** Oh no. Not another patient who's self-medicating with herb stuff.
- Social Worker:** Don't you think we need to be a bit more sensitive to their cultural preferences? Maybe there's something to it.
- Pharmacist:** Well, actually Huperzine A is one of the new herbs being studied by the NIH in alternative medicine trials. It's a potent inhibitor of acetylcholinesterase referred to as HupA. For centuries it's been used in China to treat fever and inflammation. But a purified compound's been a prescription drug for treating dementia in China for the past few years.
- Nurse Practitioner:** How am I supposed to monitor the effects of an herb I've never heard of?
- Social Worker:** I'm sure the daughter can explain how much she's taking. Maybe you can work out with Bob what the dosage should be. Sounds pretty interesting.
- Nurse Practitioner:** I don't think so. I bet the side effects aren't even known.
- Physician:** I agree it's crazy but you're gonna be monitoring her anyway. You'll notice if there are abnormal clinical signs indicating toxicity.
- Pharmacist:** Actually, the results of the clinical trial in China suggest that the drug has low toxicity. Part of the benefit of A ChE-HupA complex is its longer half-life. It seems to have fewer cholinergic effects like nausea, vomiting and sweating. It may prove to be better than the FDA drugs recently approved for Alzheimer's but the results really aren't clear yet.
- Physician:** Aren't we ahead of ourselves? We need the results of the workups I've ordered and somebody should schedule her for a neuro consult. Hey, I've got to get out of here. It's after 9:00 and I have patients waiting.

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

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

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

**End.**

**QUESTIONS FOR STUDENTS TO THINK ABOUT:**

**A. Team Dynamics Questions**

1. On a scale of 1-10 (1 is HIGHLY EFFECTIVE, 10 is HIGHLY INEFFECTIVE), choose a number which best represents your perception of the team's functioning.
8. Please list specific effective and ineffective behaviors you observed in the team meeting. Be as concrete as possible. For example, a correct answer would be, "the social worker disrupted the meeting when she arrived last" rather than "the social worker disrupted the meeting." You may want to consider skills in the following area: running meetings, leadership, communication, conflict management, recognition of other team members, etc.
9. List three different ways you would have responded to these ineffective behaviors.

**E. Team Effectiveness Questions**

1. How valuable was the team meeting in establishing or improving the care plan for the patient? On a scale of 1-10 (1 is NOT AT ALL VALUABLE, 10 is VERY VALUABLE), choose a number that best represents your judgement.
2. Please give three different reasons why you circled the number you did in Question 4.

## **FACULTY INFORMATION NOTES**

### **1. TEAM DYNAMICS/EFFECTIVE BEHAVIORS**

- G. The following examples represent **effective behaviors** (the discipline and their behavior).
1. SW respected patient's culture/ helped team develop sensitivity.
    - SW was effective in presenting the cultural dimensions of the case (at least partly) and in convincing other members of the team about their importance.
    - SW defended patient's right to use alternative strategies.
    - SW able to differ from MD's assessment that confusion might be an indication of depression vs. multi-infarct dementia and able to remind MD to be culturally sensitive to this family's use of herbal medication.
  2. NP refocused meeting/effective leader.
    - NP brought discussion back to patient after others digressed and discussed the SW's pending vacation.
    - NP as facilitator; handled Pharm's request to leave early well.
    - Gave brief answer that SW would be on vacation next week and that they would end on time.
    - Leader kept agenda, kept group on task well, began and ended meeting on time.
  3. NP clarified sudden patient behavior change.
    - NP attentive and clarified some information that wasn't clear.
  4. MD handed off discussion to SW.
    - Physician took page, but handed off discussion to SW so discussion continued without interruption in her absence.
    - MD and SW shared case presentation.
    - MD requested members continue her report when she was distracted.
  5. Pharm educated other team members.
    - Pharm tried to interest others in medical effects of herbs.
    - Pharm comments regarding alternative herbal medication use were very informative.
    - Pharm interjected expert opinion; prepared with good information related to patient.

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6. Team members recognized roles/discussed issues.
  - SW able to call upon Pharm as ally in educating staff. Used other team members effectively to make her point.
  - All listened to each other, especially Pharm's presentation; also, accepted recommendation for aspirin.
  - NP recognized importance of SW role -- appropriate questioning of side effects.
7. Members prepared to discuss specifics of case.
  - MD and NP were well prepared.
  - SW prepared agenda, timeline,, asked appropriate questions.
  - MD reported on diagnostic opinion and tests that have been ordered.
8. Team cohesiveness/friendly/attentive.
  - All team members sensitive to maintenance needs of group by discussing SW's vacation plans.
  - At the beginning, team members were attentive and listening.
  - Flow of ideas/relaxed atmosphere.
9. Team members demonstrated collaboration.
  - All members contributed effectively and collaboratively.
  - MD appropriate interjections, nonthreatening questioning, accommodated request to continue to use of the herb.
  - All disciplines had some input.
10. MD knowledgeable.
  - MD provided concrete suggestions regarding patient's evaluation.
11. SW provided clear, succinct summary.
  - SW suggested depression as something team should look into.
  - SW presented detailed history.

#### 4. TEAM DYNAMICS/INEFFECTIVE BEHAVIORS

- A. The following examples represent **ineffective behaviors** (the discipline and their behavior).
  1. MD/NP not culturally sensitive/ignore role of patient/family.
    - MD, NP, Pharm not really interested in cultural aspects of care.
    - MD was not culturally sensitive.

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- NP mentioned Chinese herb but ignored it.
2. MD dominated/played expert role.
    - MD convinced of her diagnosis, did not want to hear other possibilities from team members.
    - MD knew everything that was important.
    - MD re-entered and acted like an expert -- focused things medically.
  3. MD/NP reject herb treatment.
    - MD rejected Chinese cultural herb treatment as “nonsense,” “ridiculous herbs.”
    - NP/MD considered folk medicine unimportant.
    - MD diminished significance of herbal therapy even after Pharm’s discussion.
  4. MD disruptive when taking page.
    - MD answered beeper and disrupted meeting while taking call.
    - Beeper disrupted meeting. MD talked loudly and disrupted meeting.
    - MD came back from her page and jumped back into conversation with her diagnosis without finding out what pertinent information she may have missed from SW’s presentation.
  5. MD dismissed SW’s suggestion of depression.
    - MD too dismissive of SW re: discussion of depression as a possible etiology and a little too domineering.
    - SW’s concerns re: depression were dismissed unnecessarily by MD.
    - MD put SW’s suggestion aside, too.
  6. Side discussion about SW’s vacation.
    - SW: initial discussion of vacation when pressed for time.
    - NP, MD, and SW digressed from patient-oriented to social agenda by discussing SW’s vacation.
    - Derailed on vacation plans.
  7. Members did not recognize others’ roles/unequal roles/lack of respect.
    - MD and NP uninterested in information provided by Pharm.
    - MD and NP ruled — accommodated others but did not collaborate.
    - No one supported SW’s effort to raise role of depression in the patient’s diagnostic and treatment processes.

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8. No consensus on care plan.
    - At the meeting's end, the NP simply announced that she will "figure out the plan" for what to do with the patient -- there is no group consensus that integrates the different perspectives.
    - Group needed to take time to pull out a consensus for a plan.
    - NP was fairly passive and also took on job of writing up care plan.
  9. Team members resisted prolonging meeting.
    - Pharm tried to avoid rest of meeting at beginning.
    - Pharm wanted to wait until next week, mumbled when overruled.
    - Pharm tried to cut off case discussion at outset.
  10. MD ended meeting abruptly.
    - MD ended meeting abruptly without complete discussion of plan.
  11. Pharmacist interrupted/side tracked discussion.
    - Pharmat beginning of meeting sidetracked the discussion somewhat by proposing to discuss clients at a later date.
- B. The following examples represent **wrong answers** (e.g., ineffective behaviors).
1. NP defensive/sarcastic.
  2. NP not an effective leader.
  3. SW reflected leader.
  4. SW reflected insightfully.
  5. Pharm confronts inappropriately about Haldol.
  6. Pharm plays expert role.
  7. Inappropriate negotiation of conflict.
  8. Meeting time not well managed.
  9. Second patient never addressed.
  10. Team lacks agenda.
- C. The following examples represent **ways to respond** to ineffective behaviors:
1. Recognize conflict/use conflict management strategies.
    - Spoken up in support of SW to look into depression.
    - Objectively assert that depression is common after CVA and maybe MD could consider that diagnosis along with the others she has mentioned.
    - Mediate negative attitudes toward alternative therapies until more is known about them.
  2. Train team members re: family/patient culture/alternative.

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- Support creative ways of interacting with other cultures and incorporating their concerns.
  - Schedule speaker to address team on cultural sensitivity.
  - Distribute literature about new treatment regimes for review and future discussion.
3. Facilitate meeting by refocusing discussion, collaborative language, appropriate interruptions.
- Point out that the vacation discussion is wasting valuable time with only 10 minutes and two patients to discuss.
  - Restate problems: we need to address the following issues: 1) Mrs. Tsai's sudden mental status change, 2) stroke risk prevention, 3) etc.
  - Probe for specific issues/clarify problems: e.g., "what side effects of the herb should we be monitoring?"
4. Team self-reflexivity: improve team dynamics through team reflection, time to review team issues/time to evaluate meeting.
- Suggest that the team needs to establish a clear time to discuss team procedures and communication issues -- not a time when the team is considering actual clinical cases and issues.
  - Give feedback regarding team process in order to improve it.
  - Evaluate meeting -- identify opportunities for improvement.
5. Establish meeting structure and ground rules for team behavior.
- Set ground rules re: pagers and ask MD to answer pages outside of room.
  - Emphasize that while cohesion among team members is important, it must be balanced with an emphasis on completing the team's tasks. The team spent too much time discussing the SW's vacation plans.
  - Appoint a team leader.
  - Establish and stick to an agenda.
  - I would have halted the meeting while the MD was on the phone, and on her return suggested that the team consider ways to manage the intrusion of beepers so that it does not distract from the meeting.
6. Review/revise protocol for presenting patients.
- Emphasize that patients not discussed due to lack of time should be put on the agenda for next week.
  - Set and clarify agenda so Tsais were not viewed as an add on.
  - Encourage team to present new cases at beginning of meeting.
7. Establish/review/summarize care plan and team decisions.

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- Enable group to avoid abrupt ending of meeting, leaving plan to others to pull together.
  - Would have asked if SW and Pharm could spend a little more time to make progress for Tsais.
  - Attempt to create alliances based on patient/family focus and development of treatment plan addressing all areas of expertise.
8. Encourage collaboration/recognize roles of team members.
- Give positive feedback to Pharm where it is clear he knows about team needs to know about Chinese herb treatment. Ask him to summarize in a handout for team members to keep meeting process moving on.
  - Remind MD and Pharm of the need for their expertise today in dealing with these patients.
  - Work harder to seek consensus.
9. Confront MD about dismissal of SW's concern re: depression.
- SW should be encouraged to offer suggestions regarding next steps in terms of the evaluation and treatment of depression.
  - I would have pursued further discussion about exploring the role of depression in the patient's presentation.
  - SW should have been a little more assertive re: workup for depression. It is important since 20-30% of patients have pseudodementia.
10. Ensure adequate time for meeting.
- Prepare a more reasonable schedule.
  - Help the team with time management or suggest that the team needs to scale down its meeting agenda.
  - Issue of rescheduling -- to end early -- group could discuss use of time.
11. Clearly define team members' responsibilities.
- Ask MD to be more clear on delegation.
12. Counsel team members privately.
- Speak to MD after meeting re: how disruptive her behavior was answering her page.
- D. The following answers represent **wrong answers** to ways to respond to ineffective behaviors:
1. Identify team leader.
  2. MD/NP/SW/Pharm "should."

**3. TEAM EFFECTIVENESS**

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

1. Team learned to monitor/tolerate herbal medicines.
  - MD was negative about herb treatment, but did not block other team members' interests in exploring and monitoring its use.
  - MD did not acknowledge (indirectly) that family would continue to use herbs so asked NP to monitor toxicity level. Pharm was able to point out that it has low side effects (toxicity level).
  - Intervention and explanation re: folk medicine by Pharm helped to moderate team members' negation of its use. Perhaps will lead to increased patient understanding.
2. Team members engaged/ group input.
  - Evidence of effective role interdependence among the team members.
  - Team members worked pretty well in sync. When team member asked for help – i.e., MD asked SW to pick up from where she left off or MD asked someone to order neuro consult -- NP said she would without any resentment.
  - Interest, effective communication, and camaraderie were demonstrated.
3. Patient problems identified and discussed.
  - Data regarding patient were shared.
  - Patient will get some evaluation.
  - Responsibility for follow-up was assumed so one hopes that further case assessment is provided and treatment given.
4. Agreed to specific care and task assignments.

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

1. Care plan developed.

G. The following examples represent reasons why the team meeting was **not valuable** in establishing and/or improving the care plan for the patient:

1. No care plan established.
  - No real care plan established -- NP left to do it.

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- Although issues were raised well, a clear/definite care plan wasn't reached.
  - The NP took responsibility for developing the care plan outside the team meeting.
2. Confusion of responsibilities/roles.
- No one took responsibility for implementing plans.
  - There was no consensus among team members about what should be included in the plan of care.
  - NP took responsibility for doing the plan outside the team -- unclear how various perspectives (pt./family) and MD activities/ideas will be integrated, if at all.
3. Patient problems identified but not resolved.
- The issue of depression was addressed inadequately.
  - Team identified problems/concerns but did not explore depression adequately — MD overbearing, did not give SW a chance to explain why she thought there was depression.
  - Some of the problems identified were not addressed at all (family burden issues, for example).
4. No team process/lack of communication.
- Team members didn't listen to one another when they disagreed with what was being said.
  - Not clear at all that evaluation is what patient needs because not based on full discussion of all team members' views.
  - MD discounted everyone's suggestions but her own and insisted upon her plan.
5. Participants are not open minded.
- Two of the members did not seem to be responsive to cultural issues.
6. Conflict/lack of respect for other team members.
- Some members not respecting other member's opinions and views.
  - There didn't seem to be much respect for disciplines -- the patient isn't going to get really comprehensive care if not all ideas and professional opinions are regarded.
  - Team members did not always show respect for each others' opinions.
7. Team did not provide a complete picture of patient problems (environment, financial, etc.).

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

8. Not enough time/ more time needed.

C. The following examples represent **wrong answers** to reasons why the team meeting was **not** valuable in establishing and/or improving the care plan for the patient:

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