Interprofessional Care: Why Teamwork Matters

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39.1 Why Interprofessional Care?

There is mounting and clear evidence that points to the positive outcomes of interprofessional care. Healthcare systems in both the private and public sectors – notably the Veterans Health Administration (VHA) – are mandated to provide team-based care. Interprofessional practice is the preferred method of care delivery in a range of settings, including hospitals, clinics, emergency departments, homes, long-term care facilities, and telehealth. Future clinicians will be in an advantageous position if they understand the principles and approaches of effective teamwork. When delivering geriatric care, interdisciplinary teams are particularly vital [16]. Team-based care refers to "…the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers- to the extent preferred by each patient- to accomplish shared goals within and across settings to achieve coordinated, high-quality care" [20]. Interdisciplinary teamwork is a multilayered process whereby different staff members work collaboratively and share their knowledge, skills, and expertise in order to affect patient care [22]. Interprofessional care encompasses collaboration and coordination to provide wide-ranging levels of care to patients.

Clinicians caring for older persons have been at the forefront of interprofessional care. The first reported interdisciplinary healthcare teams trace back to World War II, where the poor and underserved sought access to healthcare at community health centers [2]. Members of healthcare teams are expected to work collaboratively to better understand the shared objectives of caring for elderly patients and to deliver the highest quality of care [3]. Many older adults have complex healthcare needs which must be addressed by clinicians from several disciplines [14]. For some, this means managing multiple chronic conditions. Common geriatric syndromes such as falls, depression, delirium, dementia, frailty, and urinary incontinence often lead to comorbidities and poor health outcomes among older adults [10]. An interprofessional team approach has been found to improve patient outcomes and patient safety [3]. Geriatrics education and training on interprofessional collaboration can take many forms in geriatrics, from lectures, case discussions, workshops, rotations in geriatric evaluation clinics, and home visits [14, 16, 19].

The importance and benefits of interprofessional teamwork in healthcare have been more clearly demonstrated in the last 15 years [18, 22, 25]. High-profile national initiatives such as the US Department of Health and Human Services (HHS) Agency for Healthcare Research and Quality (AHRQ) funded TeamSTEPPS have been effectively engaging healthcare organizations, leaders, staff, funding agencies, and insurers in advancing the interprofessional practice movement [1]. Other initiatives, such as the Minnesota-based National Center for Interprofessional Practice and Education organization, align interprofessional education and collaborative practice by providing resources, evidence, and leadership through public-private partnerships [23].

In this chapter, we cover the major components and processes of interprofessional team-based care and discuss their impact on patient outcomes. We use the case of Jim Rich, an 84-year-old Korean War Veteran, to illustrate the importance, potential pitfalls, and nuances of effective and compassionate teamwork. In this case, we follow Mr. Rich from his admission to a nursing home to the last days of his life.

Introducing Mr. Rich

Jim Rich is an 84-year-old Veteran who was recently admitted to the nursing home following an above-the-knee amputation of his right leg. After drinking one night, he fell while walking to the bathroom in the dark and fractured his right ankle. He did not seek help for several days, as he did not recognize the severity of the injury. He was admitted to the hospital with a gangrenous right foot, which led to an above-the-knee amputation because of poor circulation. At the time of hospital admission, he was noted to be disheveled and poorly nourished. A psychiatric consult was obtained, and it noted that he appeared to be severely depressed. During the hospital stay, Mr. Rich was started on antidepressants. He was discharged to the nursing home on antidepressant medications and has a scheduled follow-up visit with the psychiatrist. He understands that placement in a nursing home is necessary for rehabilitation and that he will eventually get a prosthesis so that he will be able to walk again. Medicare benefits will probably cover the first 20 days of his stay as well as a portion of the next 80 days as long as he requires skilled services to progress with his rehabilitation.

39.2 The Evidence

Interprofessional collaboration has a number of benefits, including improved quality of care, health outcomes, enhanced systems and processes, and patient safety [17, 28, 29]. Interprofessional care decreases the likelihood of service duplication, reduces the risk for medication errors, and eases patient transitions between sites of care. It also permits healthcare practitioners to practice specific clinical skills at the "top of their licenses," which assists in evenly distributing workload among team members. In healthcare settings, this is particularly important because there may be clinician shortages and overburdened administrative infrastructures, particularly on busy services such as inpatient units, emergency rooms, and outpatient clinics. In the field of geriatrics, collaborative teamwork is especially needed because of the presentation of patients with multiple comorbidities and psychosocial and economic challenges. When team members share ideas, expertise, knowledge, and skills pertinent to their disciplines, the older patient

benefits from a collaboration which takes into account the "whole person" with respect to medical, psychosocial, family, and economic needs. It is important to note here that optimal geriatrics teamwork includes family and caregiver input as well.

39.3 History of Interprofessional Practice and Team-based Care

Over the last 20 years, the need for interprofessional care has been demonstrated and reinforced in various forms. VHA has been a leader in developing interprofessional programs and services in the fields of geriatrics, hospice, and palliative care [4]. Additionally, VHA has had a long-standing commitment to workforce development as demonstrated through both interprofessional education and practice [9]. VHA has explored several approaches to integrating interprofessional education into clinical settings, which include offering robust clinical placement settings to associated health trainees, hosting interprofessional palliative care fellowship programs, expanding training and education programs into rural and highly rural areas, and leading an initiative to develop strategies for integrating education into the VHA's model for patient-centered care [9]. The VHA model of interprofessional care, known as the Patient Aligned Care Team (PACT), was initiated in 2010 and is the VHA's form of the patient-centered medical home model being used in the private sector [26]. The PACT model provides Veteran-driven, personalized care in the form of teamlets in an effort to improve care coordination for Veterans.

Although much of the evidence has shown that effective teamwork is fundamental to successful healthcare delivery, there has been less research done that addresses how individual healthcare professionals may contribute to successful teamwork [15]. Education and training needs of team members should be explored, and team-based competencies should be clearly established to help identify what makes effective team members [15]. To best foster interdisciplinary evidence-based practice, there needs to be a paradigm shift among team members across disciplines to move from an individual professional mentality to a synergistic, collaborative approach to care [24].

An Institute of Medicine (IOM) report in 2003 pointed to the pressing need for an overhaul in health professions education because education had not successfully kept up with developing changes in the healthcare system, patient demographics, and practice environments [11]. Subsequent IOM activities addressed five competencies in health professions education, including (1) patient-centered care, (2) interdisciplinary teams, (3) evidence-based practice, (4) quality improvement, and (5) informatics [12]. It was recommended that clinicians "cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable" [12].

In 2008, the Institute of Medicine released *Retooling for an Aging America: Building the Health Care Workforce*, which highlighted a looming healthcare crisis relating to the care of older adults in the United States [13]. The report underscored the lack of geriatrics-trained healthcare specialists needed to care for the expanding aging population and issued a call for action to educate and train healthcare providers and informal caregivers to increase their geriatric competence [13]. The healthcare workforce receives minimal to no geriatrics training, and it is vital that direct practice workers as well as other healthcare professionals, paraprofessionals, and unpaid caregivers have a fundamental knowledge of geriatrics. Recruitment and retention of geriatrics-trained specialists play a pivotal role in this shortage, as does lack of interest and available training and education programs [13]. With regard to medicine, less than 3% of medical students choose to take geriatrics electives in medical school [21]. As students move from medical school through residency programs, there are limited opportunities to complete geriatric fellowships in the United States. The American Geriatrics Society recognizes this shortage as well as the growing need for caring for older patients with multiple chronic conditions and functional limitations in the rapidly aging society.

Several team initiatives have been developed in recent years such as the John A. Hartford Foundation funded Geriatric Interdisciplinary Team Training (GITT) Program, initiated in 1995, geared to improving care for older adults by enriching interdisciplinary training of healthcare trainees in social work, nursing, and medicine [7]. In 2010, the VHA Office of Rural Health Geriatric Scholars Program adapted GITT for rural VHA providers; this program, referred to as Rural Interdisciplinary Team Training (RITT), is now in its eighth year and has trained over 1500 rural clinicians and staff at 106 clinics.

TeamSTEPPS is an evidence-based teamwork model aimed at improving communication and teamwork skills for healthcare professionals, which was launched in 2003. Developed by the U.S. Department of Defense's Patient Safety Program in collaboration with the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality [1], it provides ready-to-use materials and training curriculum for healthcare professionals. Prior to the development of TeamSTEPPS, there was no consensus model of teamwork in healthcare.

Let's revisit the case of Mr. Jim Rich, who was admitted to the hospital after his fall. The geriatrics inpatient team was consulted on the case and found the following upon admission.

Mr. Rich

Past Medical History:

1. Hypertension
2. Forty pack-year history of smoking
3. History of myocardial infarction 8 years ago (after which he quit smoking)
4. Alcoholism for which he has been treated 2–3 times

Allergies: No known allergies

Medications: Sertraline 50 mg qd; amlodipine 5 mg qd; Tylenol #3 1 tab q 6 hr prn pain

Social History: Jim Rich is a retired insurance salesman from a small town who was living alone in an apartment. He has had a long history of alcoholism and has gone through treatment "two or three times" with his wife's support while she was living. Since her death 1 year ago, he has become more and more isolated, drinking heavily alone in his apartment. He has about $5000 in a savings account which he hopes will cover his funeral expenses. He lives on his Social Security check, which is about $1300/month. Mr. Rich has had to borrow money from his daughter at times to make ends meet. His son John and daughter Julie are both married and have responsibilities of their own. At one point in his life, Mr. Rich was active in his community, serving as president of the local Rotary Club, and involved with little league. Now, he mainly watches TV and reads the newspaper.

Review of Symptoms: Stump pain; poor circulation in left leg; constipation; depression; hard of hearing; alcohol abuse

Activities of Daily Living (ADLs): Able to feed, dress, and bathe himself; assistance to toilet × 1; assistance to wheelchair × 1

Instrumental Activities of Daily Living (IADLs): Although able, he exhibits signs of lack of interest in many activities.

Advanced Directives: He has no living will or healthcare proxy.

Environment: Currently lives in nursing home for rehabilitation. Previously lived alone in an apartment.

Physical Exam: Weight: 200 lbs. Height: 6′2″ BP: 146/90 P: 80

On exam, Mr. Rich is alert, oriented, and pleasant, although responses are limited to a few words. His only complaint is occasional pain in the amputated leg at night and constipation. His vision is excellent with corrective lenses; he can easily read newsprint. His hearing is moderately impaired on gross exam. Chest is clear. Cardiovascular exam reveals a regular heart rate, no murmur or gallop. Abdominal exam reveals bowel sounds throughout, although he has a large amount of hard stool in his rectum. Examination of his left lower extremity reveals normal proximal pulses, but diminished distal pulses. There is an absence of toe hair on the left foot and a mild rubor when the foot is dangling. The right stump is wrapped with a compression bandage and shows a well-approximated healing incision and some mild edema. The skin over the lower portion of the sacrum is noted to be red and non-blanching.

MMSE: 27/30; Mr. Rich had to be prodded for answers, but usually responded correctly.

39.4 Types of Teams

The gold standard for teamwork has evolved greatly over the years [27]. Depending on the clinical setting, there may be major differences in what healthcare teams look like. The three most common types of healthcare teams are *multidisciplinary teams, interdisciplinary teams, and transdisciplinary teams*. Each type of team serves a specific purpose and function [8, 17]. In this chapter, we will distinguish between multidisciplinary and interdisciplinary healthcare teams and describe their purpose in a healthcare setting.

39.4.1 Multidisciplinary Team

In *multidisciplinary teams*, team members work alongside each other to provide patient care. Team members function within their own discipline, so they are only responsible for completing specific tasks relating to their respective discipline. For example, a physician may be the sole team member to diagnose and treat an illness. That physician may then ask the pharmacist on the team to counsel the patient on medication use and safety. The pharmacist may subsequently refer the patient to the social worker on the team to help coordinate resources in the community. As illustrated, each team member has a designated role in caring for the patient. While each team member is contributing to the overall care of the patient, the roles are clearly distinct among team members. While effective multidisciplinary teamwork is not impossible to achieve, there are some challenges that may arise when utilizing a multidisciplinary approach.

First, team members might layer chart notes, orders, and medications, which may cause confusion and unnecessary work among team members. There may also be an increased risk of uncoordinated care delivered by multiple professions, due to the lack of communication within team members. As a result, patients may suffer due to the lack of proper coordination. Additionally, some of the difficulties that occur in multidisciplinary teams stem from differing attitudes about what constitutes as the best health outcome [6]. Team members from different disciplines may have varying opinions on what an ideal health outcome looks like and often turn to their own profession for guidance, resulting in different allegiances [6].

39.4.2 Interdisciplinary Team

Interdisciplinary teams differ from multidisciplinary teams in several important ways. In an interdisciplinary team, team members have shared responsibility in decision making. Each individual member of the team is contributing to reach a common goal, following the same protocols. Individual disciplines contribute to integrated assessment and care plans for the patient. Communication and collaboration

within the team often results in a positive role overlap. With an interdisciplinary team approach, team members must consider the contributions of other team members when making their own contributions. Also, in interdisciplinary teams, clinicians are generally free to work at the "top of their licenses," which refers to working at the maximum extent of training and not spending unnecessary time completing tasks that someone else on the team can perform. This is a critical component of interdisciplinary teams, because it enables healthcare professionals to maximize their time, efforts, and contributions on the team. This is especially important for busy physicians, whose time is often limited due to high patient caseload.

While the interdisciplinary approach to care has increasingly become accepted as the preferred model of care delivery in healthcare settings, interdisciplinary teams may also experience unique challenges. Some examples of possible challenges faced by interdisciplinary team members may include opposing goals and objectives between team members; communication issues both within the team and within the broader senior management of a given organization; mixing of professional roles and responsibilities; issues with morale and motivation; and differing opinions on patient interventions and outcomes [22]. At their highest levels of functioning, interdisciplinary teams may also be referred to as "transdisciplinary." This occurs when team members often cross traditional professional and disciplinary boundaries to work together in providing patient care and share disciplinary roles.

Mr. Rich

One day after Mr. Rich was admitted to the hospital, the geriatrics inpatient team rounded and saw Mr. Rich. At the weekly team meeting the next day, the team sat down to discuss his case and develop a care plan. The team members at the meeting included the physician, registered nurse, social worker, physical therapist, pharmacist, and dietician.

Based on what you know about Mr. Rich at this point in time, think about the following questions:

1. What are the important issues affecting Mr. Rich's health? What are the social issues affecting his lifestyle?
2. What is the team's primary goal for this patient? Which team members should be assigned to dealing with Mr. Rich's various needs?
3. How can the team address Mr. Rich's financial situation?
4. Consider community and family resources. How might they be utilized to improve Mr. Rich's condition?
5. What are the advantages of the team approach for Mr. Rich?

39.5 Team Members

The size of healthcare teams, as well as the team composition varies significantly depending on the healthcare setting and purpose of the team. ◘ Table 39.1 provides a snapshot of disciplines who may work on teams with brief descriptions of required education and training, scope of practice, and typical team roles. There are variances among US states in scopes of practice in some cases; for the purpose of this table, we have used New York State as an illustration.

39.6 Healthcare Settings

Interprofessional care often includes coordination of care services, management of chronic health conditions, or referrals to other providers. There are several types of healthcare settings involved in team practice. Here are the most common settings where interprofessional care is delivered to older adults:

- Hospital/institutional care (inpatient setting)
- Outpatient clinic
- Office
- Managed care organizations
- Hospitals (proving general care, acute care, or specialty care)
- Long-term care facilities (e.g., nursing homes, assisted living facilities)
- Outpatient clinics
- Ambulatory or surgical care centers
- Doctor's offices (generalist or specialty practice)

Now let's revisit Mr. Rich, who was discharged from the hospital to his home 1 month ago. His son, David Rich, is very concerned about his father and has called the hospital geriatrician at least twice a week since he left the hospital. The geriatrician recommends that he try to get an appointment at the nearby VHA medical center where there is a well-known geriatrics clinic. His son calls and is able to get an appointment the next week because of a cancellation. The clinic geriatrician notes that Mr. Rich's weight has dropped from 200 to 188 pounds since he left the hospital 5 weeks ago and that his blood pressure has risen from 146/90 to 180/100. The physician is also worried because Mr. Rich is unkempt, wearing his slippers to the appointment, and smells of alcohol. Also, his stump has not yet healed and he has some yellow discharge from the incision site. In addition, he has a new stage 2 pressure ulcer on his sacrum.

39.7 Geriatrics Healthcare Teams

Geriatrics healthcare teams may vary a great deal in clinical focus. This is usually contingent upon where care is being delivered. Many healthcare settings throughout the United States still do not have existing geriatrics healthcare teams in

Table 39.1 Healthcare team members

Profession	Education	Residency	Scope of practice	Role on team
Physician (MD)	4-year undergraduate degree 4 years of medical school	3–8 years of residency training	Diagnosis, examination, treatment, advisement, or prescription for human disease, ailment, or injury Also performs surgery (if certified to do so)	Provides leadership to other team members in developing and supervising patient's healthcare plan
Physician (DO)	4-year undergraduate degree 4 years of osteopathic medical school	3–4+ years of residency training	Diagnosis, examination, treatment, advisement, or prescription for human disease, ailment, or injury Also performs surgery (if certified to do so)	Provides leadership to other team members in developing and supervising patient's healthcare plan
Physician assistant (PA)	4-year undergraduate degree 2-year physician assistant program	Currently not required	Works under the direction and supervision of a physician to perform various procedures (dependent upon type of practice)	Works with physician to manage patient's healthcare plan and provide guidance to other team members
Nurse practitioner (NP)	4-year bachelor's degree in nursing 1–3-year master's degree (length depends on specialty)	N/A	Works independently to see patients Diagnoses and treats acute illnesses Orders diagnostic testing Prescribes certain medications (varies by state) Performs certain medical exams; supervises and delegates to other nursing professionals (e.g., registered nurses, licensed practical nurses)	Delivers direct care to patients; coordinates interdisciplinary care plan with other team members; helps educate patients about their care plan
Registered nurse (RN)	2-year associate's degree in nursing or 4-year bachelor's degree in nursing* *Now becoming the requirement for most settings	N/A	Performs certain medical exams; supervises and delegates to other nursing professionals (e.g., licensed practical nurses)	Provides direct and indirect care to patients; communicates with physician on the team regarding healthcare plan
Psychiatrist	4-year undergraduate degree 4 years of medical school	4 years of residency training	Medical doctor specializing in mental health Assesses mental and physical aspects of psychological problems	Offers team members unique skills and recommendations for mental health related patient treatment plans
Psychologist	4–5-year bachelor's degree in psychology 2–3-year master's degree in psychology 4–7-year doctoral degree* *Doctor of Psychology (PsyD) or Doctor of Philosophy in Psychology (PhD) depends on career in practice (PsyD) or research (PhD)	2 years of supervised internship (depends on the state)	Assesses behavioral and mental conditions Diagnoses neuropsychological disorders Prevention and treatment of behavioral and mental disorders and dysfunctions	Assists team members with mental health counseling and preventive care as necessary
Pharmacist (PharmD)	3–4 years of undergraduate pre-professional (prerequisite) work 4 years of PharmD program	Residency is not required at this time, although highly encouraged for clinical pharmacists	Conducts health and wellness testing Initiates, monitors, and modifies patient's drug therapy Medication reconciliation	Provides pharmacological recommendations to physicians and other team members Assists team in reducing prescribing errors
Social worker	4-year undergraduate degree in Social Work* 2-year master's degree in social work *Needed for some entry-level social work positions	N/A	Conducts biopsychosocial intake assessments Diagnoses mental, emotional, behavioral, and addictive developmental disorders and disabilities Discharge planning Makes referrals for community resources as necessary Assists with questions regarding entitlement programs	Assists healthcare team in providing biopsychosocial support to patient Provides mental health counseling services as appropriate

Occupational therapist (OT)	2-year associate's degree or 4-year undergraduate degree 2-year master's degree in occupational therapy	N/A	Treats ill, injured, or disabled patients through therapeutic use of everyday activities Helps patients improve, develop, recover, and maintain necessary skills for working and daily living	Assists healthcare team in providing patients with appropriate occupational therapy as needed
Physical therapist (PT)	4-year bachelor's degree in health field 3-year Doctor of Physical Therapy (DPT) degree	Optional 1-year clinical residency for specialty areas of care	Helps patients reduce pain and improve/restore mobility Works with patients to help loss of mobility before it occurs	Assists healthcare team in providing patients with appropriate physical therapy as needed Develops fitness and/or wellness-oriented programs for patients
Dietician	4-year bachelor's degree or higher accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND)	Must complete dietetic internship of at least 800 hours of supervised practice	Assesses patient's nutrition needs and food patterns Plans and directs provision of food as appropriate Provides nutrition counseling	Assists healthcare team in assessing and developing nutrition plans for patients
Medical receptionist	High school diploma	–	Answers telephones and patient questions, schedules appointments, registers patients, and updates patient records Provides calm and efficient environment for patients, families, and caregivers	Assists healthcare team with necessary patient information Communicates patient health information to team members as needed Helps coordinate day-to-day schedules of healthcare team members
Family member	–	–	–	Assists healthcare team with developing appropriate, culturally competent, and acceptable treatment plan for patients

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place. Below are examples of the most common types of healthcare teams present when working with older adults:

- Geriatrics team
- Palliative care team
- Geriatrics palliative care/oncology team
- Pain management team
- Special focus teams (liver, cancer, addiction, etc.)

39.8 Key Elements of Team Effectiveness and Efficiency in Geriatrics Practice

Having clearly defined team goals is one of the most important elements that will drive a team's success. Additionally, having strong communication among team members and understanding professional differences will result in better patient care [5]. Other factors that may impact team effectiveness and efficiency include the following:

- Understanding the agency/organizational mission
- Identifying operational, measurable objectives for all team members
- Ensuring that administrative and clinical systems are in place to ensure successful teamwork
- Having clearly defined tasks and labor division among team members (e.g., assign responsibilities/tasks across the team)
- Team training and education opportunities
- Ongoing team training is necessary
- You can cross-train team members to substitute other roles
- Training for functions

Engaged and effective teams have strong relationships and clearly identified team functions. Figure 39.1 represents the key components of strong relationships as well as the ideal functions of the healthcare team as identified in the VHA PACT model. As team relationships and functions increase, so will the effectiveness of the team. There are two sides that must work simultaneously together in order to achieve engaged and effective teams. These include *Team Relationships* and *Team Functions*. Components of successful team relationships include civility, respect, psychological safety, and cohesiveness. Components of effective team functions include team purpose and methods, clarity of roles and responsibilities, effective communication, and team responsiveness and awareness.

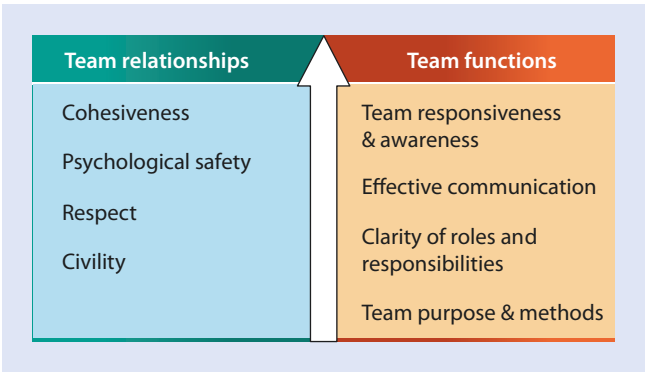

Fig. 39.1 Engaged and effective teams. (Adapted from the VHA PACT Training Manual train-the-trainer materials, as developed by the VHA National Center for Organization Development, October, 2010)

Mr. Rich

While Mr. Rich was at the VHA geriatrics clinic, he was also seen by the social worker because of Dr. Wallace's concerns about his appearance and his son David's distress about his condition. The next day, at team rounds, Mr. Rich was presented to the team. David is invited to join the discussion about his father and his treatment plan. Dr. Wallace wants Mr. Rich to be placed in a nursing home, but his son, David, is uncertain on what to do, and Mr. Rich's daughter, Julie, has deferred decision making to her brother. Mr. Rich wants to stay in his home.

Think about the following issues and tasks facing the members of the geriatrics team as Mr. Rich continues to decline:

1. What are the important issues facing Mr. Rich and his family at this time?
2. How should the team consider issues of patient autonomy versus beneficence given that Mr. Rich has no living will or healthcare proxy?
3. How can community and personal resources and entitlements be used in developing a plan of care?
4. In developing the care plan, which tasks should be delegated to which team members?
5. What would have happened if Mr. Rich didn't have a team caring for him?

39.9 Team Challenges in Interprofessional Care

Some of the challenges for team members when providing interprofessional care include changing roles of healthcare professionals, varied settings of care, medical hierarchies, and team instability. The most common challenges for team members are related to *cohesion, communication, role clarity, transitions, and phases*.

- **Cohesion**
  - Team cohesion is based on civility, respect, and psychological safety.
  - Team agrees on acceptable behavior(s).
  - Team encourages open and balanced discussion.
- **Communication**
  - Open, honest discussion is important.
  - Team members need to be truthful.

- Team should identify efficient mechanisms for information exchange.
- All team members should have the opportunity to participate in discussions and provide feedback.

- **Role Clarity**
  - Team members should have formally designated roles.
  - Team should understand what roles can be shared among different members.
  - Team members agree how work is to be carried out.
- **Transitions**
  - Team should carve out ample time for effective communication.
  - Lack of understanding along continuum of care results in poor transitions.
  - Team should be able to negotiate between VA and non-VA healthcare systems as necessary.
- **Phases** [5]
  - All teams go through team phases – *forming, norming, confronting, performing, and leaving.*
  - *Forming* – getting to know team members
  - *Norming* – shared expectations among team members
  - *Confronting* – working conflict out with team members
  - *Performing* – team functioning smoothly
  - *Leaving* – team readjustments due to team member turnover

39.10 Physician as a Team Leader

With so many possible members of a healthcare team, team members may occasionally get confused or frustrated by a lack of a clear team leader. Regardless of team size or setting, there should be an established team leader who helps lead the team to make decisions and hold individual members accountable for their contributions (or lack thereof). A leader models team behaviors for other members and encourages junior members of the team to become integrated members of the team, alongside seasoned clinicians. Physicians often assume team leadership roles since they are ultimately responsible for the overall care being provided to the patient. It is important that physician leaders be sensitive to other disciplines and properly manage team conflict, keeping teams current, emerging, and effective. Physicians should model appropriate leadership by working collaboratively with other team members to work efficiently and overcome any challenges that may arise.

So, to conclude the case of Jim Rich, he was admitted to the nursing home, where he died 5 days later. While his death was unexpected, his son and daughter were relieved that he did not die alone in his apartment and that he was no longer suffering. David and Julie were pleased with the team-based care that Mr. Rich had received up until the end of his life and vowed to complete their own advance directives and express their healthcare wishes to their respective families. They made small donations in their father's name to the hospital, outpatient clinic, and nursing home facilities that cared for their father.

Benefits of Interprofessional Care

The benefits of interprofessional care in the case of Mr. Rich include the following:

- Timely, coordinated care
- Ease in transitions of care
- Productive and civil communications among team members
- Input from Mr. Rich's family members

39.11 Looking Ahead to the Future

With the aging of the Baby Boomers, the need for high-quality care is as great as ever. Providing interprofessional care is the cornerstone of successful healthcare delivery. While healthcare teams may vary in their structures and processes, all team members should remain active, participatory, and engaged members of the team. Teams must identify challenges early on and work together to be as effective and efficient as possible. This will help establish and maintain trust within team members. Additionally, team members need to work together to create a culture of open communication and continuous learning from team members. Shared goals and clearly defined values of team members make for strong, cohesive teams. The physician's role as a team leader plays an important part in successful interprofessional care. Managing team dynamics is everyone's responsibility and will help foster a healthy, collaborative environment for all team members to contribute to the care of older adults.

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