

JOINT TEAM STEPS

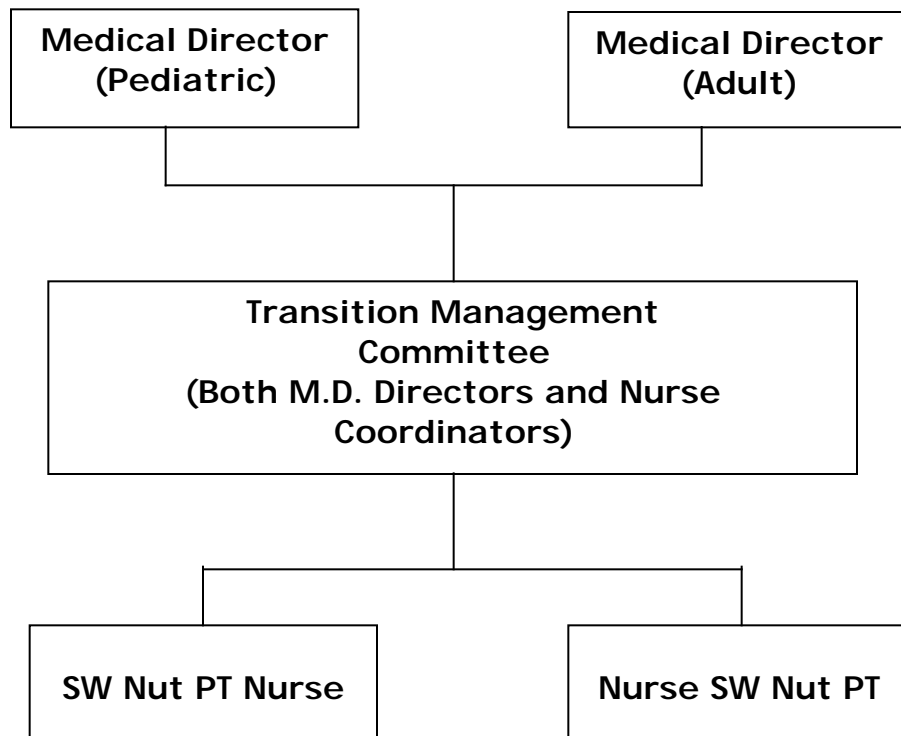
There are two main steps for the teams to address jointly:

1. Developing a structure for the transfer of care
2. Building inter-team relations.

Developing a Structure for the Transfer of Care

Organizational Structure

The overall organizational structure of the transition effort will vary depending upon a variety of parameters related to the specifics of the program (e.g., number of institutions involved, the organizational structure of each institution, etc.), but the structure of the actual transition effort should be similar regardless of these differences. The following organizational chart represents a recommended model for structuring the transition program.



For managing the transition program a Transition Management Committee should be established across the two institutions. The organizational chart reflects the minimum

membership of this committee-the two physician directors and the two nurse coordinators. This committee serves a policy making and trouble shooting function for the program.

Administrative and Patient Care Meetings

From the outset joint team meetings are at the heart of an effective transition program. Time spent in developing good communication between the teams early on is a key to smooth and efficient transfer of patients as the program becomes established.

Initially, the adult team can begin by observing the pediatric team to become familiar with the patients and the style of care. These meetings typically can occur weekly following the pediatric clinic. In addition at this time the adult team members may attend several pediatric clinic sessions as discussed in the previous section. It should be noted that sometimes the adult physician will see patients with the pediatric team before a formal adult team is established. Once the adult team is established, within a reasonable period of time, it will offer its own clinic for the patients who are being transferred. There will be a period of time where the pediatric team will attend the adult team clinics and team meetings. This, of course, will vary depending upon the logistics involved. For a program to be an effective "transition" and not merely "transfer" program there must be ongoing contact between the two teams.

Once the two teams have established a trust in each other these meetings will be less frequent. A monthly Transition Conference, that is a joint case conference on patients being transferred should continue to occur. At this conference both teams will discuss patients who are being prepared for transfer.

Because quality of care is such an important issue for both teams, a monthly **Consensus Management Conference** is a useful vehicle for establishing guidelines for care and discussing care management issues. Annually, as a part of this conference, major care management issues are discussed and treatment protocols formulated for distribution to both teams. An example from the cystic fibrosis transition program of a product that evolved out of this type of meeting is a protocol on management of hemoptysis, pneumothorax, and distal intestinal obstructive syndrome.

Written Transfer of Information

To maintain a programmatic consistency, certain features of the program should be preserved as a written record for communication between the teams and with patients.

- Patient Transmittal Form to transfer pertinent information about each patient to be transferred. (See Medical Summary Transfer Form, page 45).
- Coverage Schedule to inform patients and families about whom to call for problems and emergencies when in transition from one unit to the other.

- Patient's list of the appropriate numbers to call and a coverage schedule to be posted for both teams.
- Inter-office Memorandum to clarify issues and maintain as a reference for future considerations.

Medical Summary Transfer Form

Name _____
Birthdate _____ Age at Diagnosis _____
Presentation (MI, Bronchitis, FTT, etc.) _____

SWEAT
TESTS _____

Other Tests _____

Family (structure, siblings, Cystic Fibrosis, problems) _____

Occupation/Education _____

Allergies _____

Previous Complications _____

Previous Surgery _____

Hospitalizations Previous Year _____

Last S-K Score _____ Last Brasfield Score _____

Last Sputum C/S _____

Copies of Laboratory Reports Attached (most recent):

CXR _____ PFT _____ CBC _____ Biochemical Profile _____ U/A _____ Other _____

Course over last year, special problems, "Things you out to know" _____

- Patient Records to be transferred from the pediatric unit to the adult team, which usually will require a patient release form. The teams will have to decide what aspects of the record will be necessary for transfer such as annual summaries, etc.
- Statistical Summaries to be prepared annually by both teams. These data will be important to share for program planning and evaluation purposes. The elements of the summaries will vary according to the nature of the disease served by the program. See Program Statistics Form (page 48) for an example.
- Brochures and Letterheads to reference each other's programs are helpful sources of communication to patients and families and demonstrate the relationship of the two programs. An example of this in the cystic fibrosis transition program is the letterhead used by the pediatric team that also includes the location of the adult team and the names of the adult team members. Additionally, the pediatric team brochure lists the adult team contact person and phone number.

Program Statistics Form

PERIOD JULY 1, 19____ - JUNE 30, 19_

TOTAL # PATIENTS _____
 # PATIENTS IN TRANSITION PROGRAM _____
 TOTAL # ADMISSIONS _____

MULTIPLE ADMISSIONS (Please list the number of patients with each number of multiple admissions, e.g., 2 patients with 3 admissions, etc.)	#PATIENTS	#ADMISSIONS
	-----	-----
	-----	-----
	-----	-----
	-----	-----

AVERAGE LENGTH OF STAY _____

MEAN LENGTH OF STAY _____

AVERAGE # PATIENTS IN HOUSE _____

AVERAGE # DAYS BETWEEN ADMISSIONS _____

PAYER MIX

	<u>ACTUAL</u>		<u>REGISTERED IN PROGRAM</u>	
	#	%	#	%
MA	-----	-----	-----	-----
MC	-----	-----	-----	-----
BC	-----	-----	-----	-----
CF	-----	-----	-----	-----
HMO	-----	-----	-----	-----
COMM	-----	-----	-----	-----

Building Inter--team Relations

Two types of activities are needed to build connections and a good working relationship between the pediatric and adult care teams. First, feelings and attitudes about each other must be addressed. Then practical problem solvings strategies need to be developed so that the two teams can develop a smooth way of functioning together.

Feelings and Attitudes

- Consider having the first meeting in a "neutral" place.
- Have both team leaders present the concept of the program.
- Plan for regular, periodic meetings during the first year or two to discuss issues of concern to team members. This should be a mandatory meeting for all team members and clinical activities should be planned accordingly. There should be no reason or excuse for a disgruntled team member not to come to these meetings to resolve problems.
- Let team members know that negative concerns can be brought up at the meetings. It will be helpful for team leaders to model this behavior. If a team member feels very uncomfortable about bringing up a particular issue, then the team leader may do it.
- It is important to share one's feelings of loss, worry and concern about the transfer of patients so that the other team can understand both perspectives.. This sharing process must, however, be done carefully, to avoid it becoming a destructive force. There are a few guidelines (see below) that can help although it may be useful to have an outside consultant to make sure this process is productive. Consultants may be available from mental health departments in your institution, from university faculty in social and industrial psychology, business administration, educational psychology, etc. If you decide to try this on your own, use the following guidelines:

Guidelines for Sharing Feelings and Attitudes

- Use "I" statements only -- I feel sad about not seeing my favorite family any more. I feel that this family needed more contact with your social worker during the last hospitalization. I feel like I've entrusted my children to you, and I don't even know you well enough to be sure you'll do a good job.
- Share good feelings as well as bad
- Share your feelings and then try to explain how the other team might feel about the same issue

Procedures for Inter-team Problem Solving

At each inter-team meeting, you can use this procedure to structure the problem-solving process. Assign one person to facilitate the meeting. It is helpful if this person has a blackboard or "flip charts" to record the process. In addition, assign one person to be the recorder so that all decisions are recorded and written copies distributed to all members of each team.

Step 1 Have each person write down the following:

A. Goals of the project (Goal statements should be very broad--see *Self-Assessment* on page 7 for examples).

B. Things that are going well toward meeting each goal

C. Problems that are preventing meeting each goal

Step 2 Go around the room asking each person to share two goals. This is done quickly, with no discussion or elaboration. Write these on the board. If there are any remaining goals, solicit them.

Step 3 Discuss any disagreements in project goals and develop a consensus.

Step 4 Take each goal and elicit things that are going well and problem areas for each goal.

Step 5 Take each problem area and spend a short time (5 minutes, tops) brainstorming about the sources and possible solutions to each problem.

Step 6 After brainstorming for each problem, assign a person or persons responsible for developing the solutions for each. Give a deadline for completion of the task and a way to report results back to the total group. Be sure that those responsible have the power to develop or implement their solutions or have the support of those that do.

Step 7 Send a written memo of all actions taken in the meeting to all team members.

An example of the results of this process are:

Goal -- Smooth transfer of patients' care to adult team

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Problem -- Patients are not sure which team to call with night and evening emergencies. When they call the adult team's hospital, there is no one designated to take call.

Persons Responsible -- Team physicians

Task -- Develop on-call schedule, see that operator has it, ask team nurse to develop and send brochure on this issue to all new patients.

Deadline -- Two weeks

CONCLUSION

Congratulations! You have at least read through this entire manual. We hope you have stopped along the way to use the self-assessment exercises, as needed, and are now headed in the right direction. You may want to refer back to this manual frequently during your efforts. Developing an adult care team and developing a process of transition are challenging tasks. They are also worthwhile tasks. The steps you take will vary in their difficulty and you will undoubtedly find some steps you need to take that we have not included. Each project will be different. We hope our manual has at least given you a basic outline for approaching this task.

Remember, transition is an issue that will tax your minds and your hearts as you tackle it. Pay attention to both, if you are to succeed.