

**University of North Carolina at Chapel Hill**  
**Health Affairs Interdisciplinary Case Conference (HAICC)**  
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**Background on Teamwork, Arena Assessment and the**  
**International Classification of Functioning, Disability and Health (ICF)**  
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The value of teamwork in healthcare is most apparent when learners face in the real world someone like Mr. Lee, a 62-year-old with a history of bipolar disorder, impaired cognition, hearing loss, emphysema and congestive heart failure. His wife of 40 years died 4 weeks prior, prompting him to relocate from his home to live with his son and 10 year old grandson. In the past month the family noted declines in: oral hygiene and grooming, taking medication, gait, and ability to stay engaged in activities during the day. The family wishes to keep him at home, but asks for advice on low cost residential settings that accept persons with Mr. Lee's limitations. The problems to be solved in this case are in the realms of many different disciplines who ideally *work together* to manage the situation and make plans to prevent future decline. Mr. Lee is one example of the many patients who need a team.

### **TEAMWORK AS AN ESSENTIAL PART OF EDUCATION**

*Coach Dean Smith to Michael Jordan in his freshman year at UNC:  
Michael, if you can't pass, you can't play.<sup>1</sup>*

An essential feature of quality health care is effective teamwork. No perceptive clinician or patient could disagree. Teamwork is not a peripheral, but a *core* competency for health professionals.<sup>2,3</sup> Yet, how is teamwork brought into the education of future clinicians? Education in health care is segregated by discipline, where discussions can deteriorate to "if we only get [insert the other discipline name here] to do their work our way." Guest speakers from other disciplines give a snapshot into other ways to see the patient, or relief that there is someone else to handle [insert your least favorite patient problem]. There is more to teamwork than dividing work.<sup>4</sup>

When do students learn how to be *part of* interdisciplinary health care services? Faculty and students alike can be overwhelmed with the volume of content in their own discipline that must be force fit into a few years of coursework. The information burden leaves little room to interact with an interdisciplinary team while on campus. Thus, some myths can grow about disciplines and teamwork. For example, there is a belief that teamwork drives up costs, when good teamwork can contribute to lower cost health care.

The Health Affairs Interdisciplinary Case Conference (HAICC) occurs because the Health Affairs and Social Work schools see the need for students to have interdisciplinary teamwork experiences on campus. Funded by the Carolina Provost office, originally through a small grant and now a budget item to the School of Medicine, this program has occurred since 2001. Between 500 and 650 students have participated each year, including students from: audiology, dentistry, medicine, nursing, occupational therapy, pharmacy, physical therapy,

public health, rehabilitation counseling and psychology, speech/language pathology, and social work. The provost office funding only begins to cover administrative efforts to plan, coordinate and evaluate this large endeavor. Thus the program is heavily supported by *volunteer* faculty and staff hours to coordinate and facilitate sessions, reflecting a shared belief that teamwork matters to quality health care.

Not only does teamwork matter to patients and their families, teamwork can be a major source of satisfaction for professionals. And of course when teamwork does not happen, it can be a major source of professional dissatisfaction for team leaders and members. Ultimately, the HAICC sessions are designed for participants to have a guided interdisciplinary experience *to learn more about the roles of other team members, to share responsibility for assessment and care planning, and to understand why interdisciplinary teamwork improves care.*

### **HAICC SESSION FORMAT**

*It is amazing how much you can accomplish when it doesn't matter who gets the credit.*

*Unknown<sup>1</sup>*

In the HAICC sessions each student participates with a group of 8-10 students from other disciplines to discuss a case about a 'standardized patient', develop an interdisciplinary plan and reflect on teamwork. Having received training, a schedule and supporting materials, a facilitator from one of the disciplines guides the process within each group. The process consists of identifying questions from background materials, planning and executing an encounter with the patient, reflection and development of an action plan, sharing that plan in collaboration with the patient, and then evaluating the team process.

Two aspects of the HAICC sessions are often new to students and facilitators. First is the use of an *Arena Assessment*, to allow for a first hand contact of the student team members with other disciplines' ways of thinking and domains of concern. Second is application of an interdisciplinary model and terminology, the International Classification of Function, Disability and Health (*ICF*), to frame the problems presented by the case. The following sections will describe these two aspects of the HAICC sessions.

### **ARENA ASSESSMENT**

The format for the sessions is an *Arena Assessment* model. This model has been described in pediatrics and geriatrics to counter problems of fragmented care for people who have complex issues.<sup>4,5</sup> The arena assessment promotes a shared evaluation process, and requires a high degree of interdisciplinary collaboration. In this model the patient (and sometimes family or caregivers) are brought into the same room with an interdisciplinary group of professionals who have in advance identified key concerns to be addressed in the encounter. The patient is made comfortable by the interest of the group, body language and positioning of the group in a circle. A team member, identified in advance, begins the interaction by explaining what will occur in the assessment, followed by engaging the patient in sharing something about themselves and their concerns. The focus extends beyond medical problems to getting to know the patient as a person, and understanding their physical and social environment and lifestyle, in relation to their physical and mental health. The team members participating broaden the range of assessment

beyond what one discipline could deliver, and moves all disciplines to a higher level of seeing the patient as a whole.

The Arena Assessment is a patient-centered process. As with all good practice, the clinician draws out concerns of the patient and family in their own words. Those concerns shape the thinking and dialogue along with the questions that the team explores. The patient does not experience the interaction as an interrogation. Rather, the assessment has a conversational nature, with a flow of issues that emerge, drawing in team members who take the lead depending on the topics at hand.

The benefits of simultaneous assessment of the patient are most clear when single questions bring about evaluative information for many disciplines. The simple question “How do you spend your days?” can shift the conversation depending on whether the answer is: “I am so weak that I can’t get myself out of bed”, “I think about how lonely I am”, “I stay so busy I just can’t stop doing things”, “I don’t have anything to do”. “My jaw hurts so bad I can’t get out of bed”, “I just take medicine all day”. Everyone pays attention to the dialog to gain a full picture of the patient, and to know when to enter the conversation. New topics are introduced with appropriate transitions, for example “May I ask who helps you get to medical appointments?” In this group context, basic conversational rules, such as one person speaking at a time and turn taking, can make or break the session for the patient and the team members. Closure is also critical and collective: Asking if anyone has further questions, thanking the patient, and identifying when the next contact will occur.

It comes as a surprise to many that all disciplines can participate in a simultaneous interaction with one patient. This is possible in part because patients for the HAICC sessions have problems within the domain of all disciplines present. Although one team member starts and ends the encounter, all team members talk with the patient at some point during the session and have input to the planning process. At times ‘role release’ is needed, when for example, the social worker is asked about medications, or the pharmacist social issues. The team works together to balance whether people are talking too much or too little, using ‘rules’ of social communication where all participants are equals. Roles of informal leaders, clarifiers, timekeepers, etc, may emerge naturally. The team as a whole adjusts to the unfolding session, each contributing to the pace and topics, sharing responsibility for how the session goes.

## **INTERNATIONAL CLASSIFICATION OF FUNCTION, DISABILITY AND HEALTH (ICF)<sup>7</sup>**

One of the challenges of bringing varied disciplines together around one case is that each profession has a particular domain of knowledge and a way of framing or listing problems. It is therefore difficult sometimes to frame problems outside of that way of thinking. The World Health Organization, over the course of many years and with the input of many disciplines and cultures, has developed an interdisciplinary framework. This framework blends medical model and social model concerns into a classification system for a more comprehensive understanding of function, disability and health. This system is designed to build interdisciplinary communication by using shared language and also a model that encompasses concerns of many disciplines. Thus the model has been selected because it is not from one discipline, but instead allows a framework for students to combine assessment findings and treatment plans, and see relationships between health problems, environment, functional issues and social concerns.

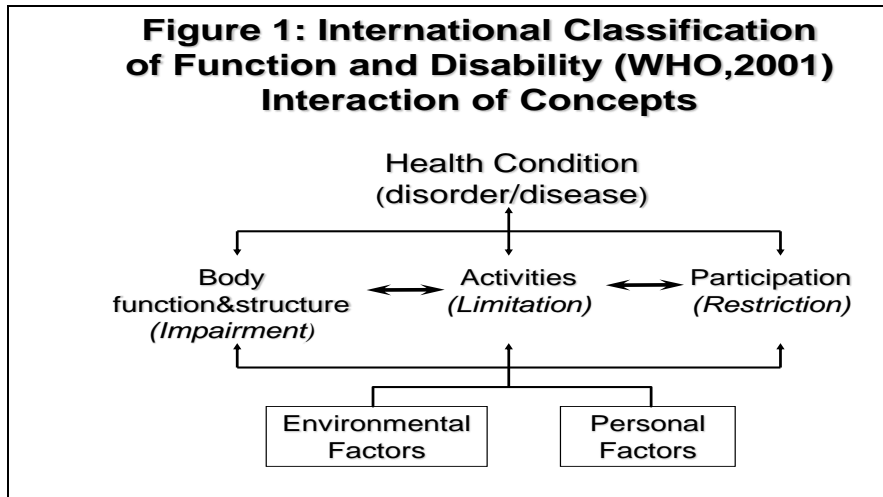


Figure 1 shows the relationship of social and medical concepts in the ICF. For readers who are unfamiliar with this model, three key points for the purpose of this project are as follows:

1. *Health conditions are but one contributor to function.* Personal factors and the environment also play a large role in how a person functions in life. Disability often is the result of the interplay of the person in the environment, such as the relationship of depression and social isolation, or the impact of environments that promote inactivity causing physical debilitation. Personal beliefs influence health through lifestyle and behaviors.
2. The model is *about ablement and disablement.* Factors in the person and environment can enable or disable someone. The model helps explain the process of ablement, and what might be done to promote health and functionality. The model, by including “person factors”, supports the oft quoted statement by William Osler, MD : “ *It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.*”<sup>8</sup>
3. Function can be thought of at *three levels* which are described below. It is important to know that function means different things to different professionals, but not to become mired in discussion about which level of function a problem falls within during the HAICC sessions.
  - i. *Body functions and body structures:* These are the smallest units of physical and psychological function. Medical professionals tend to focus on these capacities, which include such things as muscle strength, hearing, pulmonary function, vision, and memory. Problems at this level are called *impairments*. Medicines, surgery and exercise to improve physiology and psychological functions at this level to improve capacity to participate with life.
  - ii. *Activity:* This level of function consists of the *ability* to do particular things, ranging from simple actions, like picking up a glass to balancing a checkbook or driving a car. Some disciplines focus on activities of daily living, and have myriad strategies to enable people to overcome *activity limitations* using compensation, assistive devices, or environmental modifications.

iii. *Participation*: The ultimate goal of ablement is participation in life circumstances. Participation means not just capability, but actually having a life that is filled with purposeful occupations and relationships that promote health and wellbeing. Participation can take many forms, but it always means that the person feels part of the world and connected to people and places.

By referring to this model in the HAICC sessions, students can see that concerns of other disciplines contribute to the overall function, health and wellbeing of the person. In the process, students have an opportunity to learn how different professions address environmental problems, health problems, functional issues and so on. The model is new for most students and many facilitators. Its use in the context of one case-based session is to ensure the team assessment is comprehensive and includes all domains of concern. It is important to note that the ICF is not the focus of the session, but a conduit to ensure comprehensiveness. It is better not to get bogged down in 'levels of function', for example, or what fits in what box, but just to use the ICF as a general guide.

*We must all hang together,  
or assuredly, we shall all hang separately.  
Benjamin Franklin<sup>1</sup>*

## **PREPARING FOR THE SESSION**

Although the need for teamwork in healthcare is undeniable, there are mental blocks to learning to be *part of* a team. Those blocks are problematic for the learner and can diminish the experience for team members. Examples of those blocks are thinking that:

- I don't need to learn teamwork because I am the team leader.
- If it's not a real patient and real team, then I won't learn anything.
- Teamwork is what other people need to learn, I already get it.
- Where I plan to practice there won't be a team.
- I do teamwork activities only so others can learn about my discipline.
- Working with other people is inefficient, it slows down my work.
- I am not a team leader, so I will just follow along.

The HAICC sessions are most helpful when students approach the session with clear understanding of the goals, and the corresponding frame of mind to participate.

Come prepared to:

1. learn more about the roles of other team members and tell them a little about yours.
2. share responsibility for assessment and care planning.
3. seek to understand why interdisciplinary teamwork improves care.

## References

1. <http://www.heartquotes.net/teamwork-quotes.html>; Retrieved 3/10/08
2. Berwick (2002). IOM report "User's manual for the IOM's 'Quality Chasm' Report. *Health Affairs: Project HOPE–The People-to-People Health Foundation, Inc.*, 21, 3, p80-90. (also available <http://content.healthaffairs.org/cgi/reprint/21/3/80.pdf> retrieved 3-6-08)
3. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* (2001). Washington: National Academy Press, 2001.
4. Drinka, T., Clark P. *Health care teamwork: Interdisciplinary practice and teaching*. 2000. Westport CT: Auburn House.
5. Foley G. (1990). Portrait of the arena evaluation: assessment in the transdisciplinary approach. In E. Gibbs & E. Teti (eds.) *Interdisciplinary assessment of infants: A guide for early intervention*. 271-286. Baltimore: Paul Brooks.
6. Coppola S, Rosemond C, Greger-Holt N, Soltys F, Hanson L, Snider M, Busby-Whitehead J. (2002). Arena assessment: Evolution of teamwork for frail older adults. *Topics in Geriatric Rehab*. 17(3), 13-28.
7. World Health Organization (2001). *International Classification of Functioning, Disability and Health*. Geneva: WHO.
8. [http://www.brainyquote.com/quotes/authors/w/william\\_osler.html](http://www.brainyquote.com/quotes/authors/w/william_osler.html) (retrieved 3/10/08)