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The interdisciplinary nature of social work practice in geriatric health care settings

Mellor, Mary Joanna, D.S.W.

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U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

THE INTERDISCIPLINARY NATURE OF SOCIAL WORK PRACTICE IN GERIATRIC HEALTH CARE SETTINGS

by

M. JOANNA MELLOR

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Date

Mildred D Mailick
Chair of Examining Committee

1/25/94
Date

Executive Officer

Mildred Mailick, DSW

Rose Dobrof, DSW

Renee Solomon, DSW

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

THE INTERDISCIPLINARY NATURE OF SOCIAL WORK PRACTICE IN GERIATRIC HEALTH CARE SETTINGS

Adviser: Professor Mildred Mailick

This study was designed to describe the nature of interdisciplinary social work in geriatric health care settings, and to identify the knowledge and skills needed by social workers to function in this capacity. A survey was administered to 60 social workers employed in acute care, community care, and residential care settings; site observations were made of social workers as members of interdisciplinary teams in six health care facilities; and interviews were undertaken with the observed social workers. Similarities and differences in the nature of social work practice within each setting were identified.

Findings indicate that social work practice in a geriatric health care setting involves a substantial amount of interdisciplinary activities. Several discreet knowledge areas are required by the social worker in order to function as a member of an interdisciplinary team. Foremost among these are knowledge of medical terminology, psycho-social dynamics, and the older person and family relationships Specific cognitive, technical, and interpersonal skills are also required.

Educational preparation for interdisciplinary activities is frequently insufficient and unrelated to classroom education at the Master's level. This report concludes with specific suggestions to remedy this.

THE INTERDISCIPLINARY NATURE OF SOCIAL WORK PRACTICE IN THE GERIATRIC HEALTH CARE SETTING

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THE INTERDISCIPLINARY NATURE OF GERIATRIC SOCIAL WORK IN THE HEALTH CARE SETTING

Introduction

The huge increase in older persons in the United States is resulting in a growing number of persons in need of health and social services. Hence there is an increased demand for social workers to work with the geriatric population in providing such services. Furthermore, it is the responsibility of the social work profession to prepare geriatric social workers to meet this demand. Schools of social work, offering a Master's Degree in Social Work, (MSW), must provide education concerning the older population.

Within the health arena, care of the older patient/client is viewed as interdisciplinary in nature. Thus the purpose of this study is to identify the specific interdisciplinary skills and knowledge base required of geriatric social workers in the fulfillment of their work activities, in order to define what

elements of interdisciplinary understanding and expertise need to be incorporated into curricula at the Master's level.

The Case for Geriatric Social Work

Gerontology and geriatrics, as fields of knowledge, owe their enormous growth in stature to the demographic reality. At the beginning of this century there were only 3.1 million persons over the age of 65 years in the US, comprising just over 4% of the total population. Improved living conditions, changes in living styles, advances in medical and health knowledge and technology, have all combined to increase life expectancy. As a result, 31 million Americans are now over 65 years of age (13% of the population), and this number is expected to double by the year 2030, (US Senate Special Committee on Aging, 1991.) when it will be 21% of the whole. Hence the term, the 'graying of America.'

These statistics do not tell the entire picture. Within the over 65 population, the fastest growing segment is the old-old ie; those over the age of 85. This cohort is growing at five times the rate of the rest of the population. While the 'old' of today are healthier, wealthier and wiser than any previous over 65 year old group, the longer a person lives, the greater the likelihood of experiencing chronic illness and increasing frailty, requiring health and social services. Thus the enormous growth in the old-old population is exerting a growing pressure

on the country's service resources. It is because of these demographics and the concomitant demand for trained health and social service providers that gerontological and geriatric curricula and training are experiencing a surge in popularity. Before focusing on the relevancy of the content of this training within schools of social work, it is appropriate to review the history of geriatric/ gerontological education across disciplines and to assess its viability.

Gerontology and Geriatrics Education

Gerontological and geriatric education has been spurred by government funding. Prior to 1965 there were some gerontology courses offered by a few institutions but these were mostly offered as electives and no degree or certificate bearing programs existed. With the passing of the Older Americans Act in 1965, the Administration on Aging (AoA) provided funds to support gerontology career preparation programs in institutions of higher learning. (Peterson, David et al., 1987.) Funding for career training from the National Institute of Mental Health (NIMH) and from the National Institute on Aging (NIA) further added to the interest in academic gerontology offerings. The awarding of grants motivated colleges, community colleges and universities to offer a variety of programs of instruction.

The initial surge in programs led to uneasiness concerning the quality and content of the programs. In 1974, Clark

Tibbetts, of the Administration on Aging, brought together representatives of various programs to discuss these issues and this, in turn, led to the formation of the Association for Gerontology in Higher Education (AGHE). Similar groups formed at the State level. In New York, it was this interest in the teaching of gerontology activated by federal grants, that resulted in the birth of the State Society on Aging of New York. (Beattie, 1992.)

By 1976, one third of all institutions of higher education offered some form of gerontology program (Johnson, Harold R. et al., 1980) but there was still little agreement over the necessary content. The Gerontological Society of America (GSA) and AGHE joined forces to undertake a study, the purpose of which was to develop a blueprint for academic programs in gerontology. Known as the Foundation Project, the study set out to determine whether there is a core of knowledge essential for all persons in the field of aging, regardless of either their specific discipline or the host setting for the gerontology/geriatric educational programs.

The study concluded that there is a basic core of gerontological content and even some consensus, between the professions, over the necessary content to be taught. The study was conducted against a backdrop of sometimes heated debate over whether gerontology was to be identified as a distinct profession in its own right or to be considered as a specialty within existing professional schools and departments. This debate,

which continues, is not the focus of discussion here but it is important to note that while gerontology degree programs do exist at both the undergraduate and graduate levels, it is generally agreed that gerontology is not a discipline in itself but gathers its strength from a variety of professions and disciplines and is best taught under the auspices of a host profession, whether this be medicine, nursing, or social work. The study advised that alternative forms of education be developed within the disciplines, suitable for use as inservice training and continuing professional education, as well as for inclusion in degree bearing academic programs.

Though the AGHE's Foundation Project recommendations were made in 1976 and the number of gerontology programs have grown since then, the increases were considered insufficient. By 1984, Ruth Weg was calling for a re-evaluation and recommitment to long range educational goals in gerontology. (Weg, 1984.) The number of gerontology programs has grown since the seventies but the rapidly increasing number of older persons and the accompanying increase in demand for services, means that the need for trained personnel is outstripping the supply.

There is some uncertainty about the actual extent of gerontology programs. A 1984 report by the National Institute of Aging on Education and Training in Geriatrics and Gerontology reviewed national data and determined that actual growth in gerontology programs was limited. The report was unable to state the exact number of institutions offering certificate and degree

programs in aging (perhaps because of the variability in how gerontological content is offered) but estimated that the number was between 100 to 125 with an additional 100 institutions offering some course work in gerontology. This estimate of 200-250 institutions offering course work in gerontology appears low in comparison to regional studies, institutional membership of AGHE etc. which would suggest higher numbers. In a 1985 AGHE listing of gerontological instructional programs - the Directory of Educational Programs in Gerontology (Lobenstine, 1985.) - over 250 institutions were identified as offering programs.

The later 1987 AGHE survey found that gerontology programs have for the most part become institutionalized and indicated that they are recognized on a par with other programs within the academic institutions. This survey concluded that "the growth of gerontology education has resulted in the creation of over 400 programs of instruction which culminate in the award of a gerontology credential." (Peterson, David et al., 1987. p.21.) The certificate in gerontology is the most common of these credentials. Overall, a total of 1,155 academic campuses were identified as engaged in some gerontology instruction.

Gerontological/Geriatric Education for Social Workers

It is clear that social workers will be increasingly needed to work with the older population. The question remains as to how frequently these gerontology and geriatric educational

programs are found within schools of social work.

Franklin Williams, as Director of NIA in 1984 stated; (Social Work AGEnda, 3,(1)):-

> I do not know the number of social workers needed, but I am confident that more social work services are needed now and in the future because of the increasing numbers of frail older persons --- to assist them and their families in considering and deciding about options for long term care; to work along with older clients as their conditions and needs change; to be advocates for them when family members do not exist to serve the role; to help staff the increasing number of day care programs, homecare programs, geriatric evaluation services, and other services that we will need. We need more such services by competent geriatric social workers now as well as in the future.

A Health and Human Services report to Congress in the mid-eighties (USDDHHS, 1987) stressed the need for increased numbers of professionals in all disciplines with expertise in geriatrics. Reviewing social work needs, the study committee projected that the number of full time social workers needed to serve the older population by the year 2,000 as 40-50,000, rising to 60-70,00 twenty years later. However a 1988 study of the National Association of Social Workers membership indicated that only 5,000 members consider work with the elderly as their principal field of practice. There is an urgent need for increased numbers of geriatric social work practitioners, and educators to train these practitioners to meet the service needs of the old.

Schools of social work were not especially in the forefront of the trend when gerontology courses first began to make an appearance. At the community college level, gerontology courses were most often offered within the social work and human service programs and, at the graduate schools, were likely to be found

within education and social work departments. However, among the universities and four year colleges, in which most of the gerontological curricula was located, gerontology courses were situated within gerontology programs, promoting gerontology as a discipline in its own right, within the psychology departments, or within the health fields - nursing, health education etc. (Johnson, David & Kim, 1984.)

Of the more than 250 undergraduate and 80 graduate schools of social work in the country in 1980, only 20 reported that they offered courses in aging when they were reviewed by the US Department of Labor that year. (Johnson, Harold et al., 1980.) This soon changed, however, for by the mid-eighties, all of the, by then, 89 graduate social work schools included some geriatric/gerontology courses in their programs, (Levine, 1985) and 50% of the MSW programs offered concentrations in the field of aging. (Nelson & Schneider, 1984.) This rapid increase in the extent of gerontological social work offerings appears to have been short lived. A 1988 survey of all BSW and MSW programs found that while 67% of the graduate and 20% of the undergraduate programs offered at least one course in aging, only 34% of the graduate and 9% of the undergraduate programs have concentrations in aging. The authors of the study conclude that "whatever progress was made between 1981 and 1984 appears to have been totally lost." Furthermore, in 1984, 66% of the graduate social work schools reported plans to develop aging curriculums but by 1988, only 15% held such intentions. (Lubben et al., 1992,

p.168.) This differential can hardly be accounted for by earlier intentions that were realized during the four years between the two surveys.

This decline in gerontological social work curricula is only now being recognized. Attention in the past decade has been focused, not on the need for gerontological offerings but, in the mistaken belief that this need was fully acknowledged and acted upon, on the content of the gerontological curricula.

The most comprehensive guidelines for curricula development are offered by the Council on Social Work Education (CSWE) in a series of publications. These publications were made possible by a 1983 grant from the Administration on Aging to CSWE to "infuse gerontological content into social work educational curricula." The series of booklets details course outlines, bibliographies, and course projects at both the undergraduate and graduate social work levels. The educational resources are offered to "stimulate social work programs to develop, adapt, and offer specialized courses in the field of aging" for purposes of preparing "students for careers in the field of aging." (Schneider et al., 1984.)

Of concern is that even if gerontology/geriatric courses were to be offered in increasing numbers within the schools, there will be a paucity of faculty able to teach these courses. "Faculty development is an urgent matter in view of the shortage of geriatric social work education." (Kim et al., 1987. p.76.) With the pressing need to train both faculty and students for

geriatric/gerontological social work, it becomes necessary to focus on the nature of geriatric social work education and ensure that the specific content is congruent with the knowledge and skills required by the reality of the work setting.

CHAPTER II

THE INTERDISCIPLINARY NATURE OF GERIATRIC HEALTH CARE AND THE REFLECTION OF THIS IN THE SOCIAL WORK CURRICULA

The growing number of older Americans is impacting upon every facet of society but for health and social service personnel, the greatest impact is the growing number of frail older persons requiring long term care. In this arena, the delivery of long term care is viewed necessarily as a team approach. "An understanding of the concerns of the elderly person, including the relationships of physical, psychological, social and economic determinants in the disease process is essential for total health care." (Kappelman et al., 1981. p.468.)

Interdisciplinary Care Needs of the Frail Elderly

It is universally recognized that the needs of the frail elderly are complex and require the skills and knowledge of numerous disciplines. The older patient/client faces chronic and long term health problems more often than the younger person who

tends to suffer acute episodes requiring health care. In addition the older person is likely to be suffering other losses apart from a decline in overall health and these, plus the reduced income, resources and stamina of the older person, all combine to create a psycho-social-physical state that demands the collaborative knowledge and skills of several disciplines. It is acknowledged that no one individual can possess all the needed skills and knowledge to provide the necessary holistic care.

Commenting from the viewpoint of a medical practitioner, Portnoi observed, over a decade ago, that while recreational, social, and legal services have not been regarded as important for health maintenance, these services are necessary to provide the elderly with healthy feelings of independence and self-esteem. (Portnoi, 1979.) Health care practitioners understand that the elderly who are the patients and clients of the acute care hospitals, the long term care facilities and the community home care agencies, present with a number of symptoms and a multitude of interrelated problems that require more than the therapeutic services of a physician or a nurse. Podiatrists, speech language pathologists and occupational therapists, as well as physical therapists, social workers and nutritionists, are just some of the disciplines that are needed to provide quality integrated care for the elderly.

With this belief that no one discipline has the ability to understand or to attend to all the needs of any one older person, the concept of integrated, interdisciplinary assessment and care, with the interdisciplinary team as its tool, is widely acknowledged as the ideal framework for the provision of care and services. In defining geriatric assessment, the National Institutes of Health, in a 1987 Consensus Development Conference statement, made the following pronouncement.

> This process, comprehensive geriatric assessment, is defined as a multidisciplinary evaluation in which the multiple problems of older persons are uncovered, described and explained, if possible, and in which the resources and strengths of the person are catalogued, need for services assessed, and a co-ordinated care plan developed .... comprehensive geriatric assessment involves clinicians from the many health care professions who are necessarily involved in good geriatric care. (NIH, 1987. p.1)

The Interdisciplinary Team

There are differences of opinion over the optimum makeup of the interdisciplinary team and views vary depending upon the professional perspective of the speaker. (Clark et al., 1986; Pesznecker, 1982.) Traditionally the physician and the nurse are recognized as the foundation of the team and generally the third discipline of social work is included in this core team. (Kappelman et al., 1981; McPherson et al., 1984.) There may be differences over the inclusion of other disciplines, and, in some settings, other disciplines may be rarely included, not because their expertise is not needed but because the members of the core

team and the health care administrators view their ongoing inclusion as unnecessary or not justified when measured against the amount of time required. There is general agreement, however, that at any given point for a specific patient/client, additional members may be needed as adjuncts to the core team. (Faulkner, 1985.) For example, the home care patient who has a severe hearing loss requires the assistance of an audiologist to make assessments and develop care plans that will be integrated into the overall care and delivery of services. Unless and until the hearing loss is assessed and possibly corrected, the assessment of mental functioning that the psychologist is to make, cannot be performed accurately.

Therefore the size and composition of the interdisciplinary team will vary depending on each specific set of circumstances. The concept is of an inner circle of a core team (however constituted) with outer, concentric rings formed of the non-core disciplines. Representatives of these non-core disciplines may be brought into the team as needed, dependent upon their perceived importance to the specific case under review.

It is to be expected that this universally held view of geriatric health care be reflected in the education of the professionals entering the geriatric health care arena.

Interdisciplinary Team Work as Taught Within the Curricula

Gerontology/geriatrics is generally accepted as a distinct content area within existing disciplines, rather than a cross

cutting discipline in its own right, but the necessity for interdisciplinary understanding and teamwork is recognized. The need to include this facet in geriatric/gerontological education is perhaps even more important just because geriatrics/ gerontology is taught within the frameworks of specific disciplines and not as a distinct discipline. Geriatrics/ gerontology as taught within the discipline of nursing will be influenced by the philosophy, concepts, and terminology of nursing and thus vary from the geriatrics/gerontology taught within schools of social work. This is considered appropriate but when these nurses and social workers work together as members of an interdisciplinary team, they will require both an understanding of each other's disciplines and also skills in interdisciplinary collaboration, in order to work effectively together.

This being so, the current task is to ensure that interdisciplinary learning, collaboration and teamwork is incorporated into the educational programs so that gerontologists and geriatricians within any discipline are equipped to provide quality care to the elderly in need of health and social services.

This is not a new insight. The need for interdisciplinary expertise has been recognized and stressed repeatedly over the past fifteen years. The Annual Meeting of AGHE in 1977 included several presentations dealing with the state of the art in gerontology. Thomas Hickey, in reviewing the offerings, noted

that many of them characterize what he termed the "third stage" of development of gerontological education. By the "third stage" he means the co-ordination and collaboration of the various professions. (Seltzer, Mildred et al., 1978.)

Beginning in the early seventies and building through the eighties, there were a number of presentations at professional conferences and articles in professional journals related to the topic of interdisciplinary teamwork and methods of teaching this model of professional care. The articles tended to be either prescriptive, i.e., calling for an educational focus on this aspect, or descriptive i.e., reporting on programs and beginning curricula in the area.

State of the Art

Prescriptive

Not surprisingly most of the prescriptive writings appeared prior to the descriptive ones. As early as 1973, Sheps was calling for interprofessional learning. Sheps argued that educational preparation for future interdisciplinary teamwork "must begin before students from related professions are joined together" and he charged that academic institutions must include such content in their curricula and take responsibility for equipping gerontologists and geriatricians for their future work experiences. (Sheps, 1973.) This advice was echoed by Beattie who stated that the interdisciplinary dimensions of gerontology are critical for the design of educational programs and should be

included in every aspect of administration, curriculum development, and faculty approaches to aging. (Beattie, 1974.)

"Integrated and collaborative functioning is all important in achieving the goals of patient care" (Rao, 1977. p.89.), and this integration is prescribed at all levels of education and learning, if society is to be responsive to the needs of its elderly population. This message has been repeated through the eighties, though emphasis has shifted to acknowledge the difficulties and barriers to interdisciplinary teamwork. The difficulties inherent in this mode of work serve, themselves, as justification for focusing on interdisciplinary work in geriatric/gerontological educational programs.

> Most health care professionals are taught in isolation from each other. Therefore, it is hardly surprising that many of them know relatively little about the knowledge and skills of other disciplines and even less about collaborative teamwork. There is a clear need for greater and earlier contact between students in the health care professions, preferably involving common courses and early collaborative experiences around clinical tasks that synthesize knowledge, judgement, psychomotor skills, and decision making ability. (Baldwin et al., 1984. p.429.)

Descriptive

The descriptive literature of the early eighties deals with both model educational programs and curriculum design.

Model Programs Many of the programs reported in articles and papers have been funded by federal grants and the literature speaks of a national trend towards encouraging interdisciplinary health care teams and using them as loci of geriatric education.

(Beard et al., 1983; Euster, 1984; Papsidero et al., 1980.)

The Administration on Aging has been responsible for a number of grants to academic institutions to develop interdisciplinary, gerontological training programs. The Institute of Aging, University of Washington, developed teams of graduate students at community based clinical sites (Pesznecker et al., 1982.) while the University of Rhode Island addressed the need for professional, interdisciplinary training at the undergraduate level, (Spence et al., 1985.) and for the development of advanced undergraduate and graduate interdisciplinary student teams. (Clark et al., 1987.)

This development of interdisciplinary student teams assigned to clinical sites has emerged as a common program design. The understanding and learning of the interdisciplinary team approach is viewed as best secured through actual field experience. Thus the University of Maryland, School of Medicine, reports on its model of assigning students to interdisciplinary teams for eight weeks at a time with heavy emphasis on interprofessional learning objectives. (Kappelman et al., 1981.) The students are expected to acquire, through the team experience, an understanding of the team approach and the skills of functioning as a team member, and to absorb the philosophy that underpins the organization of a geriatric facility as an interdisciplinary entity. A similar interdisciplinary field experience for students was developed at Ohio State University by the Interdisciplinary Health Care for the Aged Project (IDHCAP).

(McPherson et al., 1983.)

Curricula Design The model programs described through the 1980s were established within academic institutions and included curriculum development. The team experiences were linked to formal teaching with specific geriatric/gerontological topics taught across disciplines to the team members through case conferences (Kappelman et al., 1981.) and classroom teaching. Curricula content focussed on the theoretical base of effective functioning of the interdisciplinary team. (McPherson et al., 1983.)

Other curricula models were designed without the inclusion of actual clinical and field experience. The Scripps Foundation Gerontology Center at Miami University (Atchley & Seltzer, M., 1977.), developed curricula including course materials, syllabi and bibliographies for use by other academic institutions.

Interdisciplinary Geriatric/Gerontological Education Within Social Work Curricula.

The work of the Scripps Foundation was a precursor to the work of the Council on Social Work Education which has issued a number of publications detailing geriatric social work curricula at both the graduate and undergraduate social work levels. These curricula include an emphasis on education re the interdisciplinary approach. The practice skills and knowledge areas promoted are those that emerged from a 1980 study and which included "interdisciplinary collaboration" as one of the

identified content areas.

> The future practice of social work with the elderly will necessarily entail cooperating with a variety of other disciplines such as medicine, nursing, physical therapy, law, gerontology etc. Every effort should be made to guarantee students a field practicuum within an interdisciplinary setting or with an agency that can offer a consistent experience of collaboration with members from other disciplines.
> (Schneider et. al., A Curriculum Concentration in Gerontology for Graduate Social Work Education, p.20.)

Though social work as a profession frequently views itself as a linking profession, it has been comparatively slow to promote the interdisciplinary aspect of gerontological education. The CSWE curricula design is timely but most of the existing literature has been produced from other than a social work framework. Most of the pressure and interest in educating for future teamwork has come from the medical profession. This is ironic as physicians are often stereotyped as being non-team players on the interdisciplinary team. One exception to the lack of interest on the part of social work schools occurred as early as 1973, when a task force from the Hunter College School of Social Work and the Mount Sinai Medical School developed a proposal, submitted to NIMH for funding, with the objective of training social workers for work in community health. The program was based on an "interprofessional design" and part of the curricula content emphasized "interprofessional collaboration" and the "integrative approach" to practice.

The social work profession is beginning to catch up with its medical colleagues in promoting teaching content on inter-disciplinary collaboration as a necessary ingredient of

professional education. Interviews with 25 hospital social workers in 1975, regarding the collaborative process with physicians, identified a need for educational preparation for interdisciplinary work. (Feiman et al., 1975.) A 1976 study concluded that social work students require both a theoretical understanding of interdisciplinary collaborative work and practice experiences in the team process. McBroom, 1976.) In 1983, a study of gerontology master degree recipients added to the growing pressure for academic preparation to strengthen the fieldwork experiences. The study found that while the majority of these students felt that their course and fieldwork had proven valuable in their subsequent employment, the program would have been more beneficial if it had contained courses in program management and administrative skills and interpersonal communication skills, both between worker and client and also between worker and representatives of other professions. (Peterson, David, 1985.)

Faulkner, in a 1985 study of the preparation of social workers for interdisciplinary team practice, found that while the social workers in her study were well prepared for their social work role, their preparation for interdisciplinary teamwork was "serendipitous" and described as incomplete and unplanned. The needed knowledge and skills were acquired for the most part during post MSW professional practice. (Faulkner, 1985.) The CSWE includes interdisciplinary content areas in its curricula and this is, perhaps, the first step towards a more stringent

adoption by the schools of social work. Unfortunately for those whose interest lies in the interdisciplinary nature of geriatric social work, this aspect of the geriatric curriculum is rarely considered of prime importance and is rated as subsiduary to other content areas.

Nationally there are a number of geriatric and gerontological educational consortia, funded by a variety of federal funding streams, which receive grants on the basis of their interdisciplinary focus. These tend to be located within the Veterans Administration Medical Centers and graduate schools within universities. These programs have already led to the development of geriatric curriculum resources (Missouri GEC - Self Study series, 1988; Northwest GEC - Model Curricula Series, 1987; Pacific GEC - Assistive Geriatric Education System, 1991-2) and it can be anticipated that a continuing stream of published papers and articles will define and promote interdisciplinary and interprofessional educational programs for a variety of professions, social work among them. The discussion, concerning the inclusion of interdisciplinary skills and knowledge in the education of geriatric social workers has only just begun.

CHAPTER III

STUDY RATIONALE:THE INTERDISCIPLINARY FOCUS

Social workers are seen as valued members of the interdisciplinary team and thus education concerning interdisciplinary teamwork, especially for those social workers in health care settings with a client population of frail elderly persons, is essential. If social work curricula in geriatrics/gerontology are to change to reflect this need, it is necessary, not only to accept the concept of interdisciplinary teamwork but also to determine the extent to which the geriatric social worker is really involved in interdisciplinary practice and the exact nature of this interdisciplinary practice. It is one thing to prescribe interdisciplinary work activities but may be another thing entirely to experience interdisciplinary teamwork on the job.

Interdisciplinary work is not merely working alongside a worker from another discipline to one's own, nor do a group of persons from different disciplines, gathered together in one place, necessarily constitute an interdisciplinary team meeting. There is a distinction between a multidisciplinary and an interdisciplinary team. It is important, therefore, to examine the work of the

geriatric social worker in the practice setting to determine whether interdisciplinary work is a reality, and to do this, it is first necessary to agree on what is meant by the term "interdisciplinary teamwork."

The Theory of the Interdisciplinary Team

The theoretical basis of the interdisciplinary team and interdisciplinary geriatric health care lies in an acknowledgement that representatives of various identified disciplines together assess, treat, and order the health and social service care needs of the individual older person. This appears rational, is widely accepted throughout the health care system and even mandated under some health care regulations. Beckhard defines the interprofessional team as "a group with a specific task or tasks, the accomplishment of which requires the interdependent and collaborative efforts of its members." (Beckhard, 1972.)

Even earlier, in 1958, Luszki proposed a definition which enfolds all the recognized ingredients. An interdisciplinary team is a -

> group of persons who are trained in the use of different tools and concepts, among whom there is an organized division of labor around a common problem with each member using his own tools, with continuous intercommunication and re-examination of postulates in terms of the limitations provided by the work of the other members and often with group responsibility for the final product."
> (Luszki, 1958, as cited in Given & Simmons, 1977. p.166.)

In order for an interdisciplinary team to exist and function, several assumptions are made. Baldwin offers a list of these

assumptions. (Baldwin and Tsukuda, 1984. p.421.) They are:-

1. The problem is complex enough to require more than one set of skills and knowledge

2. The amount of relevant knowledge/skills is so great that one person cannot possess them all

3. Assembling a team of professionals with more than one set of knowledge and skills will enhance the solution

4. In the solution of the problem, the possessors of the relevant skills/knowledge are considered to be equal

5. All of the involved professionals are working for a common goal for which they are willing to sacrifice some professional security (Baldwin and Tsukuda, 1984)

The overall justification for an interdisciplinary team is seen as the efficient use of resources on behalf of the patient. Several advantages of this approach also accrue to the health care professional. These include increased access to a variety of health professions and services; the availability of a wider range of knowledge and skills and the opportunity to learn these; coordination and integration of services; increased communication and support among the service providers; and the opportunity to practice at the highest level of skill and training. (Kane, Rosalie, 1975.)

The question still remains as to whether the interdisciplinary team can be and is a reality or exists only as an elegant concept. Groups of professionals representing different disciplines do frequently meet in health care settings to determine

patient needs. A setting in which different disciplines come together is not, however, synonymous with the existence of an interdisciplinary team or with interdisciplinary teamwork.

There is general agreement in the literature concerning the defining attributes of interdisciplinary work. Interdisciplinary work is based on the acceptance of a common goal, the attainment of which requires the skills of different disciplines. Emphasis is on collaboration and interdependence of each participating discipline. "The cornerstone of teamwork is a sharing of planning and action with a joint responsibility for outcome." (Baldwin and Tsukuda, 1984.) The interdisciplinary team itself then becomes a mechanism by which the joint action towards mutually accepted goals is formalized.

Little formal study has been undertaken of the interdisciplinary team in the work setting. Most of the literature is prescriptive or busies itself with the necessary education for being a member of an interdisciplinary team. Informally, team members often report that the interdisciplinary "team" is a forum for decisions made by the physician to be relayed to other members of the care providing group, or a perfunctory gathering in which no shared assessment and problem solving actually occurs.

Perhaps emphasis on the interdisciplinary team, suggesting a gathering of persons from different disciplines, clouds the issue as to what constitutes interdisciplinary teamwork. Interdisciplinary teamwork may be any aspect of the health care work that is undertaken with other members of other disciplines on

behalf of a common goal. In this sense, one to one contacts between two disciplines may be viewed as part of this interdisciplinary work. The interdisciplinary team, however, is a tool for organizing and directing this work and interdisciplinary work is carried on both within and outside the parameters of a group meeting.

Involvement in an interdisciplinary team demands not merely that each member contributes his/her own specific body of knowledge but that each member is able to function as a team member. Interdisciplinary behavior is "a form of behavior that must be specifically learned and involves persons who make mutual adaptations to each others differences around such variables as profession, method, use of knowledge, skill and professional goal." (Falck, 1977. p.36.)

The Interdisciplinary Health Care Team

The interdisciplinary health care team concerned with care of the elderly is convened for the purpose of clinical assessment, intervention and management of patient care. (Faulkner, 1985.) Given this framework, there are specific content areas which inform the deliberations of the team and about which the team needs to be knowledgeable. These content areas are the aging process and an understanding of the distinction between normal aging and age-related disease, and an understanding of the various clinical procedures and treatment options available. Family dynamics (eg; family development, assessment, and counseling), psycho-social

issues and the provider-patient relationship are all needed knowledge areas. The development of treatment plans demand knowledge of community resources, entitlements, and the rules and regulations governing care. And, the team will further require an understanding of the ethics and values in health care and an appreciation of organizational theory and the administrative setting in which the team functions. "Acquisition of knowledge and skills in these areas hopefully will enhance not only the working relationships on and between a team and its external systems, but will also promote a more humanly satisfying environment in which to work." (Baldwin and Tsukuda, 1984. p.430.) Knowledge in these areas will also help assure that optimum care is planned and provided for the geriatric patient/client.

Interdisciplinary work in geriatric health care further requires a variety of skills and shared knowledge areas. In order for a team to develop, it is deemed essential that each of the team members possess knowledge and skills in management, group process, interpersonal communication abilities and commitment to interprofessional interaction. (Eichhorn, 1978.) Beyond these 'major content' areas, (Baldwin & Tsukuda, 1984.) a number of knowledge and skill areas have been noted as needed by a health care professional functioning as an interdisciplinary team member. Several observers have identified these (McPherson et al., 1985; Clark et al., 1987; Sheps, 1973; Baldwin and Tsukuda, 1984; Compton & Galaway, 1989.) and for purposes of clarification, these may be grouped under three categories, i.e., cognitive, technical and

interpersonal skills.

Cognitive Skills.

Each person involved in interdisciplinary work in geriatrics possesses a unique body of knowledge based on his/her professional discipline. It is this knowledge which makes each individual team member essential to the overall functioning of the interdisciplinary team. Beyond this, all team members require a common knowledge akin to the knowledge required by the team as a whole, as indicated above.

These knowledge areas are not specific to the domain of the interdisciplinary team, for every geriatric health care worker is expected to be knowledgeable in these areas. However, a shared knowledge base, encompassing these content areas, is essential for the operation of the team. There may be differences in priorities, opinions and philosophies among the team members concerning each of these areas but the important aspect is that the members are familiar with the knowledge areas and possess this shared framework upon which to build their care management of the individual geriatric patient/client. The cognitive skill areas are defined as follows.

1. Primary care of the elderly - an understanding of the bio-psycho-social aspects of the aging process, familiarity with age-related diseases, and knowledge of health care interventions and treatments that are available
2. Family dynamics - a knowledge of family relationships and an

appreciation of reciprocity between members, and of the stresses and rewards of family caregiving

3. Provider-patient relationships - an understanding of the power/control situation inherent in the care provider/patient relationship and its impact on outcome

4. Ethics and human values - acknowledgement of the ethical component in health care decision making, and the potential for competing rights and values.

5. Organizational and systems theory - knowledge of the policy issues and trends that impact on the delivery of health care, and understanding of the management and interrelation of provider systems (Baldwin and Tsukuda, 1984.)

Technical Skills.

Working interdependently, members of the interdisciplinary group require technical, collaborative team skills. The 1987 Consensus Development Conference emphasizes, in its statement, the three skills of:-

1. Problem identification - ability to integrate information and pinpoint the problem areas

2. Decision making - ability to formulate care decisions based on synthesized information

3. Problem solving - ability to search out information, and to reformulate the knowledge, enabling the team to identify solutions

If the purpose of the interdisciplinary team is to engage in

these activities on behalf of the older patient, then its members require the technical skills to carry out these tasks. In order to reach some agreement, further skills are needed.

4. Role negotiation - ability to define the care management roles and avoid role blurring

5. Task differentiation - ability to define tasks of the specific disciplines and facilitate team agreement

A newly formed team may be ill equipped to attempt these tasks but these activities must be accomplished during the development and growth of an interdisciplinary gathering into a functioning team. (Baldwin and Tsukuda, 1984.) It is not merely during the infancy of a team that these skills are required. However smoothly the team is operating as an interdisciplinary entity, situations will arise over time which demand that individual roles be renegotiated or the differentiation of tasks be reiterated. "Even after a team is well-established, the need occasionally arises to go back and rework one or another issue." (Baldwin and Tsukuda, 1984.) Membership of the team may change over time, leading to shifts and a realignment of each member's tasks and roles, and turf battles can re-emerge with each fresh situation that confronts the team. If a team member is proficient in these technical skills, it is likely that he/she also possesses the following abilities.

6. Team maintenance - ability to maintain and strengthen the team As Clark et al. acknowledge "effectively functioning teams do not just 'happen,' " but require nurturing. (Clark et al, 1986.)

7. Communication - the ability to communicate clearly, to be understood by other team members from different discipline backgrounds, as well as the ability to comprehend the contributions of others. Communication is considered "particularly essential" (Clark et al., 1986). "Clarity and brevity have to be worked at in the collective." (Sheps, 1979).

To function as a team, each member requires skill in these areas to enable the work to be accomplished smoothly. These technical skills are closely allied to the interpersonal skills needed, for without ownership of a set of interpersonal skills, the interdisciplinary team members are unlikely to master the technical skills.

Interpersonal Skills.

The failure of an interdisciplinary team is often attributed to the lack of interpersonal skills by its members. This may not be always so, as organizational and system barriers may also be responsible for failure, but it is safe to state that if team members are without interpersonal skills, the smooth functioning of interdisciplinary work is doomed. "Teamwork requires an openness to differences of view and opinion, comfort with conflict, and a willingness to negotiate differences." (Compton & Galaway, 1989, p. 599)

Baldwin and Tsukuda (1984) identify the skills required of the interdisciplinary team member.

> Personal and professional qualities that generally are seen as desirable in 'good' collaborators and team members include the

> ability to listen, to trust, to be open, and to communicate clearly and effectively, as well as a willingness to give feedback, to live with uncertainty and ambiguity, to take personal and professional risks, and to share power and expertise. These may be named essential 'membership' (as opposed to leadership) skills. (Baldwin and Tsukuda, 1984. p.425)

Thus the list of needed interpersonal skills are:-

1. Ability to listen

2. Openness and trust of others

3. Clear and effective communication

This skill is more than the technical skill of being able to communicate clearly. It is the interpersonal ability to interact with others so as to engage them and facilitate communication in both directions between self and others.

4. Willingness to give feedback

5. Courage to take risks

This skill may be particularly necessary in the formative stages of an interdisciplinary team while trust and respect for each member and the disciplines is being established.

6. Willingness to share power

This includes a willingness to recognize and overcome professional and gender power differentials.

7. Commitment to the functional advantages of collaboration

This might better be described as a held philosophy than an interpersonal skill but its existence or otherwise is conveyed in interpersonal attributes of demeanor, body language, and enthusiasm for the task at hand. "Team members need to be committed to the interdisciplinary process, to risk taking, and to

interdependence." (Nevlund, 1990).

8. Flexibility

This interpersonal skill incorporates a number of attributes. Clark et al. (1987) suggest that flexibility encompasses "open-mindedness, the tolerance of different perspectives, the willingness to experience new modes of interaction, the acceptance of changes in authority and status, and even a taste for adventure and the desire for challenge."

Barriers to Interdisciplinary Team Work

The range of skills required suggests that successful interdisciplinary teamwork is not easy. Recent literature, as well as presentations at both regional and national conferences, reflect growing interest in factoring out the variables involved in teamwork. As the number of functioning interdisciplinary teams increases within health care, we can expect a corresponding increase in reports from the front lines, and analysis of both barriers and enabling influences to successful team functioning. (Mellor and Solomon, 1992)

Barriers and enabling influences to the interdisciplinary team in a health care setting may be apparent at a variety of conceptual levels. On a macro level, the nature of the organization in which the team is located and the organizational philosophy and administrative structure that exists, will either support or discourage the successful functioning of the team. At an intermediate level, the various professions and disciplines

represented by the team membership will all influence the working of the team. Each team member will be affected by his or hers professional framework, mores and principles and these pressures can work for or against teamwork. Finally, the interdisciplinary team members themselves can, in their interactions, establish barriers to effective teamwork or, conversely, develop a climate that is conducive to successful functioning. These barriers and enabling influences at the macro (organizational), intermediate (professional), and micro (individual) levels will be discussed below in greater detail.

Organizational Sanctions.

The interdisciplinary team does not exist in a vacuum and, vital to its functioning, is the sanction and support of the host organization. Whether sanction is granted is dependent to some degree on the structure and nature of the organization. The setting and its philosophical underpinnings will dictate the nature and the type of interdisciplinary team that evolves. The study reported on here included observations of interdisciplinary team meetings in three distinct settings - the institutional long term care setting (the nursing home), the acute care hospital, and the community based, non-residential setting. It was anticipated that sanction for the interdisciplinary team might vary between each of the settings.

A bureaucracy in the classic Weberian sense of a clear hierarchy of power (Weber, 1947; Etzioni, 1969) with rules and

regulations governing activities, may countenance the existence of an interdisciplinary team but Merton argues that, while a bureaucracy is the ideal type of formal organization, it tends to be resistant to change. (Merton, 1968.) The strength of an interdisciplinary team lies in its flexibility and ability to challenge the status quo and, this being so, the team model is antithetical to the characteristics usually associated with bureaucracy. An interdisciplinary team, that seeks solutions to health care problems that cannot be easily categorized, may be threatening to a bureaucracy in which all activities are regulated and uncertainties anathema. An interdisciplinary team within this setting may be sanctioned only if the team leadership is authoritarian in nature. For even within organizations that exist to serve individuals, such as a hospital, the preservation and interests of the structure tend to take precedence over the interests of the patients. (Abramson, 1983.)

At the other end of the scale is the human relations organization. (Litwak, 1966). Such a model tends to stress primary group relations as well as organizational goals and is more likely to favor interdisciplinary teams. The interdisciplinary team is a decision making body, basing assessment and treatment decisions on the outcome of interdisciplinary discussion, and, as a result, the authority of the organization as a regulatory power is reduced. In a human relations organization, this ceding of decision making to its employees is congruent with its organizational personality.

Even more supportive of a team approach to care may be the

collegial organization. (Parsons, 1976.) Membership in the collegial organization is always self-selective and, while there is consensus concerning goals, there is also tolerance of individual differentiation and attainment. Community based health clinics or home care agencies may be of this type if they are organized as private partnerships. It might be assumed that an inter-disciplinary team will best flourish in such an organization, in which the total organization is based on collegial behavior and the absence of hierarchial authority.

The three settings in which team observations were made can be approximated to these three models. The acute care hospital, because of its size and the nature of its goal i.e., to react rapidly to treat acute health conditions, tends to function as a formal bureaucracy. There is insufficient time for variations of care and functioning to be countenanced. Within the long term care nursing home setting, the acute nature of the care needs has disappeared and the long-term goal is to provide care for frail and functionally disabled persons over time. This slower pace tolerates the development of a human relations model of organization. Finally the community based clinic, adult day center, or home care agency, may be administered by a partnership and approximate a collegial organizational model. If these differences are discovered in reality, it can be expected that the interdisciplinary team will receive the greatest sanction within the community clinic setting and the least within the acute care setting of the hospital. This is clearly a simplified schema, for

the community clinic may be an adjunct facility to an acute care hospital and subject to all its bureaucratic characteristics and the acute care setting may be a administered in small units by specialty which favor a human relations management style.

While a collegial or human relations organization, rather than a bureaucracy, is more likely to sanction and support an interdisciplinary team, it may also be adverse to the functioning of an interdisciplinary team. Smith notes, (Smith, 1965), that such an organization may evolve into a grouping of small units - an oligarchy - and while the units perform independently, there are obstacles to supervision and co-ordination of the small units. The interdisciplinary team, if it is to establish and implement a plan of care for each older patient, needs to co-ordinate activities of the various units. The key to such co-ordination is effective communication but this too may prove disadvantageous, for while good communication promotes problem solving it can also create a climate in which differences are so tolerated that consensus is hard to reach. (Blau and Scott, 1969.)

Thus the interdisciplinary team will be molded by the organizational structure of the organization in which it resides. Not only structure but ideology must also be considered. Strauss et al. in their study of a psychiatric hospital note how the staff of the hospital are bound in their work not only by the structural framework but also by the particular ideology of treatment that permeates their work. (Strauss et al., 1964.) In the preceding discussion of the interdisciplinary team, value has been laid on

the holistic care of the geriatric patient and the inter-relationship of professional knowledge and skills in providing the optimum care. This is the very rationale for the existence of the interdisciplinary team and if this ideology is not shared by the host health care organization, this will be reflected in the functioning of the team.

Hence an important factor in the study and classification of interdisciplinary teams, and the role of social workers as members of them, will be the level of administrative support and organizational sanction for the team approach.

The Professional Framework.

Each discipline has an unique organizational base, different levels of training and professional preparation, different monitoring bodies, different sets of regulations and expectations. There are varying reimbursement parameters and each discipline tends to follow different schedules and ways of structuring the work responsibilities.

Within the acute care setting, attending physicians with visiting privileges may make patient rounds in the mornings when the nursing shifts are changing or before the social workers have begun their day. In the nursing home facility, the speech language pathologist may only be on site for a few hours each week. These differences in professional schedules make the convening of a representative interdisciplinary team problematic. The differences in years of educational preparation between a physician and a

physical therapist, a dietician and a social worker, can also create artificial inequalities that must be overcome before interdisciplinary, collegial work can be accomplished.

Values and Terminology. Once the time restraints and professional educational differences are neutralized and ways found to bring the various disciplines together, the members of the interdisciplinary group must then recognize and interact within the different value systems held by each discipline. Autonomy of the patient/client, cherished by the social worker, may well clash with the value placed on curative treatment esteemed by the physician. The differing values, once recognized, may be subsumed by the shared commitment to interdisciplinary work.

Equally problematic, if less acknowledged as a difficulty, is the different jargon which each discipline favors. Not only does each discipline use its own terms and shorthand abbreviations but the same phrases may be used by different disciplines with widely different meanings. "Support systems" suggests different concepts to nurses than to social workers and 's.o.b.' to a nurse or a physician implies something altogether different than it does to an audiologist or activity therapist.

Knowledge as Power. Acknowledged by all as barriers to interdisciplinary teamwork are the battles that can ensue over ownership of knowledge. In an interdisciplinary setting, turf battles will be fought with greater or lesser intensity. Each

discipline is rightfully proud of its unique knowledge and skill base but therein lies the danger of assuming that others may not be as equally competent. Faulkner refers to this phenomenon as 'disciplinary ethnocentrism.' (Faulkner, 1985.)

Individual Differences

If team members overcome this ethnocentrism and seek to acknowledge and become familiar with the knowledge of other disciplines, another danger arises. There is a constant push-pull tension between members of interdisciplinary teams. On the one hand the individual team member both desires and needs the other disciplines to recognize and understand his/her special knowledge base but, on the other hand, too much familiarity can be threatening. For example, the social worker needs the non-social workers on the team to appreciate the importance of psycho-social dynamics within a patient's family but this area of knowledge is considered the preserve of the social worker and any non-social worker who presumes to detail the specific psycho-dynamics authoritatively, will be viewed competitively. Interdisciplinary team members may be alternately scorned for ignorance of own's own particular knowledge area and then rebuffed if they exhibit a competent grasp of the knowledge base. By doing so they are presuming ownership of territory which is the basis of one's own expertise and power within the team.

Individual differences in personalities, age differences, cultural and ethnic differences, may all create barriers to

effective team functioning. As in any group or team task, the interplay of the various individual personalities has a critical impact on the extent to which the team members function collaboratively.

Over Achievement.

Interdisciplinary teams may also create barriers for their work by becoming too successful as a team. The nature of geriatric care is such that additional members of the team may be needed, depending on the circumstances of each case. A successful team may become insular (a clique) and not able to integrate new members into the team. A we-them attitude may develop that effectively precludes the core interdisciplinary team from utilizing the skills of other disciplines. A group-think modality may also develop in which the interdisciplinary team becomes a working unit and, by its success as a cohesive unit, stifles the creativity and individual knowledge and skills of the individual team members. (Janis, 1971.) Rae-Grant and Marcuse warn that "team spirit is hazardous" for it may downgrade individual work. "Teamwork" they warn "need not be toxic; but it is no miracle drug either." (Rae-Grant and Marcuse, 1968.)

Social Workers as Members of the Interdisciplinary Team.

The nature of the social work role within the health care setting has been examined. Roberta Sands noted that the practice of focused treatment in a limited time frame, characteristic of the

acute care setting, is a crisis intervention model which is especially suited to social work practice. (Sands, 1983.) However, little interest has been shown in the specific role of the social worker within the interdisciplinary team. While it has been noted that social workers are often unprepared to function collaboratively within a health care setting (Mailick, Mildred, 1977; Feiman et al., 1975), little has been documented concerning the social worker's function as a member of the interdisciplinary team.

Social work knowledge and skills provide a specific contribution to the work of the interdisciplinary team, but beyond this, social workers are particularly suited to being team members because of the interpersonal and groupwork skills that are an inherent part of the social work profession. The social worker's experience with groupwork, knowledge of organizational theory, and familiarity with techniques of consensus building and conflict resolution, prepares the social worker to function well within the team setting.

Dana suggests that an interdisciplinary team member must have the ability to learn and the skill to educate others. (Dana, 1983.) Interdisciplinary team work, for the social worker, requires a reassessment of social work knowledge in the context of other disciplines, and the ability to translate social work practice into a language understood by these others, while simultaneously understanding the professional culture and cognitive style of the non-social work disciplines and interpreting their discipline

specific language.

The Study

The study, reported in the following chapters, included both field observations of interdisciplinary teams at their regular meetings and the role of the social worker as a team member, as well as a survey of the ongoing interdisciplinary work engaged in by the geriatric social worker throughout the workweek. The purpose of the study is to explore whether interdisciplinary work for the social worker in a geriatric health care setting is reality or illusion. The interdisciplinary knowledge and skill areas detailed above were used as guidelines to analyze the team observations and the social work role in interactions with representatives of other disciplines.

This study was undertaken in the hope that an examination of the reality of the interdisciplinary team and the interdisciplinary work activity carried out by geriatric social workers in health care settings, would provide guidelines for the professional education of social workers. In an address to the faculty of the Hunter College School of Social Work in 1989, Jane Parker, an Assistant Professor at the Tulane University School of Social Work, advised that:

> social workers must incorporate the knowledge of other disciplines while retaining their social work values and mission and seek, more aggressively, strategies for collaboration with physicians.

The health care settings and the tasks faced by social workers today in a rapidly aging society call for new directions in social work curricula.

CHAPTER IV

THE INTERDISCIPLINARY NATURE OF GERIATRIC SOCIAL WORK IN HEALTH CARE SETTINGS.

METHODOLOGY

Introduction

This chapter will discuss the purpose of the study, describe the variables being studied, and detail the three methods used to collect data. These include a survey administered to geriatric social workers in health care settings, site observations of interdisciplinary team meetings, and semi-structured interviews with the social workers observed in the team meetings. Methods of analyzing and reporting on the findings will be given.

Purpose of Study

Given the assumption that geriatric social work within the health care setting is characterized by interdisciplinary work, the study was designed to determine:-

- the amount of time that the geriatric social worker in

a health care setting spends in interdisciplinary tasks;

- the nature of the interdisciplinary tasks;
- the relationship between the type of health care setting and these interdisciplinary tasks
- the specific observed knowledge and skills that are needed to function within the interdisciplinary milieu;
- and the extent of educational preparation for this role.

In order to find the answers to these questions, the study utilized three data gathering approaches.

1. **A survey of geriatric social workers** was conducted to determine the interdisciplinary nature of the social worker's responsibilities and role, and the extent of educational preparation for these interdisciplinary tasks.

2. A series of **site visits** was undertaken to observe social workers in geriatric health care settings in interdisciplinary team meetings and, by doing so, to identify the knowledge and skills that are required in such a milieu.

3. **Informal interviews** with geriatric social workers were conducted to gain additional information regarding the required interdisciplinary knowledge and skills as well as social workers' own opinions about the interdisciplinary work in which they are engaged.

Survey of Geriatric Social Workers

A three and a half page survey questionnaire, consisting of sixteen (16) questions was designed and field tested. (Appendix II.) Three hypotheses underlay the questionnaire. These were;

- A geriatric social worker in a health care setting will spend up to a third of the work week in interdisciplinary tasks and activities, interacting with health care professionals from non-social work disciplines and engaging in team assessment and care management.
- The nature and extent of interdisciplinary contacts is related to the type of health care setting and the services provided.
- Social workers in health care settings have received little or no prior formal educational preparation for interdisciplinary geriatric social work.

Sample Selection & Data Collection

From the outset the goal was to gather a convenience sample of 60 completed surveys, twenty from each of the three major types of health care setting - the acute care hospital, the long term care facility, and the community health center/outpatient department or day center. An introductory and explanatory letter was written and this, along with a stamped self addressed envelope for easy return of the questionnaire, was mailed with the survey to almost 100 identified social workers (See Appendix I). Geriatric social workers were targeted by sending surveys to members of the New York

City Chapter and Committee on Aging of the National Association of Social Workers (NASW), and to social work members of the State Society on Aging of New York, Inc. Only those identified as working within health care settings were targeted.

Though the survey responses were anonymous, it was felt that potential respondents would be more likely to complete and return the survey if they were initially addressed by name. Each survey sent out was given an identifying number, marked on the return envelope and, on return, this number became the code number of the completed questionnaire. The relationship of code number to individual name was kept in a separate file and was only referred to in order to ascertain whether the first survey had been completed or whether a second mailing should be made. The final list of names of those who did respond was kept, no longer connected to the identifying number, so that a promised summary of the survey findings could be sent at the conclusion of the project.

The initial response rate was low (approximately 20%) and a second mailing was undertaken. This second mailing also had a low response rate of approximately 15%. In order to augment the number of respondents, the names and addresses of geriatric social workers found among lists of conference participants were collected and surveys were mailed to them. The collection of completed surveys became an ongoing task which extended over the life of the project. Several of the returned surveys, (7), on inspection, were found to have been completed by social workers either without a Masters Degree in Social Work or in the process of earning a MSW. Though

the responses from this sub-group were of interest, the thrust of the project is to clarify the extent and necessity for interdisciplinary education at the Masters in Social Work level and thus respondents with BSWs or other, non social work degrees, were excluded from the final data pool.

It should be noted that an easily accessible listing of geriatric social workers, involved in continuing education activities, was available through the researcher's work setting- the Hunter/Mount Sinai Geriatric Education Center. This federally funded geriatric education center is mandated to provide geriatric/gerontological education to health care professionals. A 51 hour continuing education program is offered, consisting of seminars, conferences and workshops. Social Work is one of the ten professions targeted by the center. At the time of the survey, the center had been in existence for seven years and established a network of geriatric social workers working within the health care system. However, this continuing educational program strongly promotes interdisciplinary care of the older person and it was felt that this philosophy and the educational experience itself might bias the responses. Accordingly, social workers involved with the Geriatric Education Center were not included in the sample surveyed.

Collection of the required 60 surveys, 20 from each of the three health care settings, was spread out over a period of 18-24 months. Most of the needed 60 questionnaires were collected in the first six months (43) and the remaining usable 17 questionnaires

were collected over a following fifteen month period. Surveys were mailed as potential respondents were identified and, in the latter stages of questionnaire collection, questionnaires were mailed only to social workers within those settings that were still underrepresented. In some cases, a further personalized letter was included along with the questionnaire and the standard cover letter. This second letter explained how the recipient had been identified as a social worker in a health care setting, noted that the survey was in its final stages, and requested that the recipient take time in completing the questionnaire. It was hoped that the extra, personalized approach would result in returned and completed questionnaires, and this proved to be so.

Survey Content

The survey included questions pertaining to the specific work setting and the percentage of the client group who were over the age of 65 years. This was to confirm that the respondents were working primarily with an older client population. Though surveys were sent only to social workers working within health care settings, this was not a guarantee that each specific respondent would be working with a geriatric population. For instance, long term care facilities are recognized as serving the elderly, but they are also used by a younger disabled population. It was important to exclude from the survey those social workers whom might be working within a nursing home but with a younger client group - perhaps AIDS or trauma victims. Similarly, 60% of the

patient caseload in acute care hospitals nationwide is over the age of 65 years but it could not be assumed that the questionnaire respondents from acute care settings were working with a mostly older patient/client caseload. Completed surveys from respondents who indicated that less than 50% of their patient/client caseload was over 65 years were excluded from the data pool.

As part of these identifying questions, the respondents were asked to give their title/position, as it was thought that the proportion of time spent in interdisciplinary work might be related to position. A social work supervisor or administrator might be involved in less, more, or different interdisciplinary tasks than a line caseworker.

Following these preliminary questions, the respondents were asked to list the activities they undertook in fulfilling their work. This was an open ended question, allowing the respondents to list those work activities that they felt were most frequent and central to their position. This was followed by a question which asked the respondent to indicate approximately how many hours he/she spent in each activity. It was expected that an examination of how a social worker divides the work week between the various tasks would illuminate how much time is spent in interdisciplinary activities. For this question, a list of possible activities were provided. The possible activities listed were selected after review of the social work literature concerning work within health care settings, from the researcher's own observations, and from knowledge gained in interviews with social workers in health care

settings.

These two questions served as an internal check on the reliability of the information gathered, for the answers could be compared. (Simon, 1978.) As advised by Babbie (Babbie, 1986, p.111), "there are a number of more technical methods for coping with the problem of reliability ... ask for the same information more than once, using either the same or a similar question." In addition, the first of the two questions was open-ended and provided the respondent with an opportunity to include work activities that were unanticipated by the researcher. The second question, which asked for amount of time spent on various work activities, listed the activities and thus provided an opportunity to check the reliability of the earlier responses. E.g., A respondent may fail to note that team assessment meetings are part of his/her activities but indicate, in the second question, that eight hours is spent weekly on this activity.

The next group of questions dealt with the categories of persons with whom the respondent interacted during work activities. A list of non-social work health care professionals was given and respondents asked to indicate those with whom they interacted. They were then asked to identify the professionals with whom they least and most interacted.

Finally, the questionnaire included a number of questions pertaining to the respondent's social work education and preparation for interdisciplinary work. Respondents were asked the year in which they received their MSW degree to test the assumption

that the more recent graduates may have experienced greater interdisciplinary education than those who graduated at an earlier date. Field of practice followed at graduate school was requested, as well as whether the respondents had taken courses in aging and/or health while in graduate school. This was to ascertain whether the extent of interdisciplinary preparation is linked to field of practice or courses taken.

The questionnaire utilized both closed and open ended questions. The closed questions facilitated coding and analysis of the data while, as noted above, the open ended questions provided a check on the general reliability of the responses and provided a more rounded picture of the work activities and type of interdisciplinary work undertaken.

A deliberate decision was made not to ask respondents, in the early questions, whether they engaged in interdisciplinary work but to approach this information obliquely, by asking respondents first to identify the nature of the work activities and the disciplines with which they interacted. In this way the centrality or, conversely, lack of importance, of the interdisciplinary work activities would emerge without the responses being biased in favor of interdisciplinary work.

Field Testing of Survey

This questionnaire was field tested by being administered to five social workers, known to the researcher, who were working in health care settings. In addition, it was reviewed by three

experienced social workers who were told the intent of the questionnaire and asked to assess whether it would capture the desired information. As a result, minor modifications were made.

A question was added concerning the percentage of the respondent's client group which was under the age of 50 years. It was expected that the answers to this question, along with the answers to the question of what percentage of the client group was over 65 years of age, would give a more accurate picture of the total client population being served. Many community settings, such as adult day care centers serving Alzheimer's Disease patients, or the developmentally disabled, serve not only an over 65 years population but a frail disabled younger population, a 50-65 year age group, that is considered, for all functional purposes, to be synonymous with the older aged group. On the other hand, health care settings, even when established to serve the older population, such as nursing homes, frequently serve younger persons - trauma victims, AIDS patients - and these younger persons often require different levels of care than the older population. A social work respondent from such a setting may be responsible for a caseload which is a mix of younger and older clients. In such cases, if more than 30% of the respondent's caseload fell within the under 50 year age category, the respondents were excluded from the study, as it brought into question whether they could be considered geriatric social workers.

A second part was added to the question dealing with whether the respondents had taken any aging or health care courses as part

of their graduate studies. In addition to indicating a positive or negative response, respondents were asked to state how many such courses were taken in graduate school. It was felt that there may be a difference, in interdisciplinary preparation, between those MSW graduates that took several aging and/or health care courses in school, perhaps as a concentration, and those who took only one such course as an elective. (A copy of the final questionnaire is found in Appendix II.)

Data Analysis

Using the initial five completed questionnaires from the pilot testing, a code book was established and categories selected for the responses to the two open ended questions. (A copy of the code book is included as Appendix III.) Once the surveys were completed, each one was coded and the data entered into a computer program (SPSS) for statistical analysis.

The frequencies of responses were tabulated by question and a series of cross tabulations were run. Cross tabulations were used in order to explore the relationships between:

1. <u>type of setting, and time spent in interaction with other health care professionals.</u> It was expected that geriatric social workers in the acute care setting would spend a greater amount of time in face-to-face interaction with physicians, nurses, and allied health professionals concerned with rehabilitation, than those social

workers in the nursing home facility or community setting. On the other hand, it was expected that social workers in the community setting would spend a greater amount of time with lawyers than those in acute and nursing home facilities. Little is known about type of setting and the specific health care disciplines with which a social worker interacts and there is no theoretical foundation on which to base this assumption. If a relationship is identified between setting and contact with specific health care disciplines, the information will provide guidelines for interdisciplinary educational preparation of the geriatric social worker.

2. professional level and time spent in interdisciplinary tasks/activities. It was thought that the survey might indicate that the more experienced and senior social workers within the workplace have more interaction with other health care disciplines, than do the less experienced social workers. The stage at which the social worker becomes involved in interdisciplinary tasks will have bearing on when interdisciplinary education might best occur. If entry level geriatric social workers are not involved in interdisciplinary activities, the educational preparation for this type of work may be safely established within the work setting and in continuing education after the MSW degree has been obtained.

3. extent of interdisciplinary educational preparation with type of setting and year that MSW was obtained. The concept of geriatric health care as an interdisciplinary team effort is relatively recent and it was anticipated that social workers graduating after

1984 would be more likely to have experienced educational preparation (knowledge and skills) for work within an interdisciplinary care model than those graduating prior to 1984. This year was selected as the watershed year, as it was in 1984 that the Council on Social Work Education published its Curriculum Guidelines for Gerontological Social Work Education. The mid-eighties also marked the appearance of a spate of articles on the centrality of interdisciplinary work in geriatric health care.

The educational setting in which the social workers received education for interdisciplinary work was also expected to be related to the extent of the interdisciplinary preparation. I.e., education in the fieldwork setting was expected to provide greater preparation than interdisciplinary education in the classroom setting.

Site Visits

Selection of Interdisciplinary Teams to Visit

The interdisciplinary work of the geriatric social worker is varied and includes contact with other disciplines for purposes of client care through telephone, individual face-to-face contact and participation in interdisciplinary group meetings, as well as activities of interpretation, reassurance and counseling with clients and their families concerning the services and assessments of non-social work disciplines. Of all these interdisciplinary

activities, it was determined that observation of the interdisciplinary team meeting would best provide an opportunity to view geriatric social workers' use of the knowledge and skills that are required to function interactively with other disciplines. Information might be obtained from geriatric social workers concerning their experience as team members, but it was felt that a more comprehensive and richer understanding of the social worker as a member of the interdisciplinary team would be developed through in vivo observation.

Accordingly, it was decided to visit six different facilities, two each from the three health care settings, i.e., acute care, nursing home care, and community based care. Babbie, in discussing this form of research as field research, describes a continuum from the complete participant, at one end of the continuum, in which others see the field researcher only as a participant, through the stages of participant-as-observer, observer-as-participant, to the other end of the continuum - the complete observer. (Babbie, 1986.) For this field research, the researcher filled a position somewhere between observer-as-participant and complete observer. The persons present at the team meetings knew of the researcher's observer status, and while the researcher did not participate in the team meeting, her presence was acknowledged and there was explanatory conversation at the beginning and end of the meetings. It was explained that the observer was interested in the role of the social worker within the interdisciplinary team and the knowledge and skills that were

needed. Permission to take notes during the meeting was requested and this was always readily granted.

At each of the six sites, a team meeting was observed on two consecutive occasions. Being present at two meetings of the interdisciplinary teams allowed the observer to verify and/or modify initial perceptions, thus increasing the reliability of the observations. It was also felt that team members might exhibit some discomfort with an observer in the room, in the initial observation, and that a follow up observation would provide an opportunity for the team members, becoming more comfortable with the presence of an outsider, to be more 'natural.' The expectation of discomfort due to an observer in the room proved unfounded. Many of the teams that were observed were accustomed to outsiders being present and did not appear to be constrained by having a stranger in their midst.

The second visit did, however, assist the observer in clarifying initial observations, and distinguishing patterns of team interaction from single occurrences of behavior. For example, the first observation of one of the team's meetings occurred when one of the two social workers present was also involved in dealing with problems concerning an imminent discharge of a geriatric patient. She was compelled to leave the meeting room for a few minutes on several occasions. A return visit and observation of a meeting when all members remained in the room for the hour long meeting, enabled the observer to discern whether the earlier, sporadic attendance of one of the social workers had substantially

altered the 'normal' level and patterns of social work involvement in problem solving and case analysis.

While team members showed no discomfort with the observer's presence at the first visit, the second observatory visit helped to identify the observer as credible and familiar. This resulted in team participants volunteering comments about their own perception of the team interaction and process, which greatly assisted the observer's own analysis.

Several steps were taken in arranging each specific visit. Six sites were selected, all within the Greater New York Metropolitan area. Selection was dependent upon a personal contact at each setting or an introduction, through a third party, to a member of the social work department. The initial contact was by phone to the Director of Social Services at each site, explaining the project and requesting permission to observe an interdisciplinary team meeting on two different occasions.

In all but one of the six sites, this initial phone call was followed by a letter, describing the project goals and the reason for the site visits. Care was taken to stress that identifying patient/client information discussed at the team meetings would be kept confidential and that the observation was in no way an evaluation of either the interdisciplinary functioning of the team or of the capabilities of the specific social worker, but a study of the role of the social worker within the team and the knowledge and skills required. (Sample letter sent as follow-up is included as Appendix IV.) At the sixth site, a telephone call, requesting

permission to visit a team meeting, proved to be all that was necessary.

For the other five sites, the explanatory letter was then followed by a second phone call to the Director of Social Services who, at this point, having presented the request within the Social Services Department, gave permission for site visits and identified the specific team meeting and the social worker(s) for observation. It should be noted that none of the sites contacted refused permission to visit and observe. On the contrary, every request was graciously and willingly met. Having received permission from the Director, a phone call was then made to the individual social worker for purposes of arranging the specifics of the site visits. Once again, it was emphasized that the observation was not an evaluation of the team or even of the social worker's level of functioning within it but an attempt to capture the interdisciplinary knowledge and skills that are required of the social worker in such a setting. When feasible, the two visits to the same site and team were planned for two successive weeks. This proved possible in all but one of the sites.

Field observations were planned and executed in the following sequence:-

1. Horseshoe Nursing Home (Long Term Care Facility) 7/91
2. Fenimore Cooper Home (Long Term Care Facility) 9/91
3. Rocky Hills Hospital (Acute Care) 10/91
4. V. Amway Center (Adult Day Care Center - Community Care) 12/91
5. Plainvista Clinic (Geriatric Outpatient Clinic - Community Care)

11/91 & 3/92

6. Two Partners Hospital (Acute Care) 3/92

The names of the facilities are fictitious to maintain confidentiality.

Site Observations

The possibility of utilizing a tape recorder during the observed team meetings was considered. (Simon, 1978.) Problems associated with the use of a tape recorder were weighed against the advantages of capturing the team member's deliberations, and led to the decision not to make audio tapes of the meetings. The promise of confidentiality of patient information shared in the team meetings might appear to be compromised by any sound recording, and it was further thought that taping the sessions would only serve to emphasize the presence of the observer, and influence the team member's interaction and behavior. In addition, it was apparent that a taped recording of the event would be of dubious assistance in reviewing the meeting afterwards. Interaction between the disciplines was of interest but, being an outsider, the researcher would be unfamiliar with the voices of the team members and might be unable to identify the speakers and their disciplines easily on replaying any tape. Furthermore, interaction between the disciplines is not confined to verbal interaction and it was believed that recording the sound might isolate verbal interaction from the visual and encourage the researcher to overlook many of the nuances of the team meeting, thus biasing the reporting.

At each site visit permission was requested to take notes and an ongoing record was kept of what was said and by whom. Notes were also made of the non-auditory content of the meetings. Seating patterns, visual interaction, movement of individuals into and out of the meeting room, and physical surroundings were also noted. To facilitate this note taking, as the researcher did not know all the team participants by name or discipline, each participant was assigned an identifying number. Notes were taken of what was said and by whom, arrivals and departures of staff, and time taken in the discussion of each topic. The discipline of each team member present was verified after the meetings with the host social worker.

After the site visits were concluded at each facility letters of thanks were sent to the social worker observed and to the Director of the Social Service Department who had been instrumental in granting permission for the visit. A copy of the written report and findings will be sent to each on completion.

Analysis of Site Visits

As soon as possible after each site visit, usually within a few hours, the field notes gathered during the observations were transcribed. These write-ups took two forms.

I. **A general description of the team meeting.** The description included number and characteristics of staff participating, (gender, age, ethnicity, discipline), topics discussed, physical

environment, seating arrangements, team leadership and responsibilities, and general meeting atmosphere.

II. **A Chart.** Secondly, with reference to the notes taken during the team meeting, the flow of the meeting, content and format, was charted. To do this, a list of 34 codes was developed which enabled each staff team member's participatory activity and statement to be categorized.

While the focus of this study is the role and function of the social worker and the knowledge and skills required, the charting of all the team participants provides a comprehensive view of the total team meeting, highlighting the particular interactions with the social worker, and providing a background against which to define the social work role. The 34 item code, utilized to chart the team meetings, became the basis for inductive examination and facilitated an analysis of the team observations and the social workers functions. The key to the code is outlined in Table 4-1.

Table 4-1

Key to Activities, Content and Conversational Exchanges Occurring in Interdisciplinary Team Meetings.

	Information concerning:	Question concerning:
Bureaucratic process =	IB	? B
Clinical aspects/needs =	I CL	? CL
Psycho-social aspects/needs =	I SOC	? SOC
Legal matters =	I LEG	? LEG
Financial matters =	I FIN	? FIN
Treatment =	I TR	? TR
Staff =	I ST	? ST
Patient's opinions =	I OPT	? OPT

Ask opinion/reaction = ?

Opinion, not fact = OP

Empathetic statement, responding to family concerns etc. =

Explains decision, behavior, situation/teaching = EX

Reassuring = RS Problem solving = PS

Agree = A Disagree = D Summarize = S

Directs group in its discussion eg; 'let's get on' = DiGRP

Comments on team process = COM

Prescriptive statement = P

Analogous case = Anal

Report of professional meeting = Rept

Chit chat = CH Thanks = TH

Leaves meeting = L Returns to meeting = RET

Using this schema, the exchanges throughout each team meeting were transferred from the extensive notes taken during the interdisciplinary meetings to a chart format. (Chart I) This chart is an example of how data was organized and represents a small portion of an interdisciplinary team meeting. Each person attending the meeting was assigned a number and exchanges and activities for each person noted in code form, in sequential order. See Table I for explanation of the code used.

Analysis

The chart reflects the team activities and exchanges during a 20 minute period, midway through the meeting. Referring to the numbered key to the disciplines represented at the meeting, the chart reveals that the social worker (6) took responsibility for directing the group discussion and the physician (3) provided clinical information on the case being discussed. One of the medical residents (4) agreed. The social worker (6) gave information on psycho-social aspects of the case and the treatment being followed, to which the nurse (7) added information about financial aspects. The social worker (6) also commented on this aspect and the nurse (7) explained the situation and concerns, and gave information about other staff involved in the case. The social worker (6) summarized the case, offered problem solving directives and directed the team to the next case for review. The

number to the left of the chart indicates that this is the fourth case to be reviewed in the meeting.

The physician (3) provided clinical information, which was interrupted by the social work intern (8) who gave information concerning the bureaucratic process in the case. The physician (3) then asked about the case and one of the medical residents (4) gave an account of the clinical aspects and the treatment. The social worker (6) asked about psycho-social aspects and was answered by the medical resident (4), who agreed with the social worker's assessment. The physician (3) added to the psycho-social information on the patient and the treatment, at the same time as one of the nurses (9). The medical resident (4) offered a personal opinion and the other nurse (7) gave further psycho-social information and her opinion. The social worker (6) directed the group to the next case, the fifth to be reviewed, and as the physician (3) provided information about the patient's treatment, psycho-social and clinical aspects, a visitor (10) entered and joined the group.

Analysis of the charts reveals something of the role and nature of participation by the members, and the demands upon the social worker from the interdisciplinary viewpoint can be seen. The actual content of the case discussions is not evident but this is not necessary in order to gather a sense of the flow and type of participation by each of the disciplines. When specific content needs to be known, reference can be made to the original notes.

Chart I.

Chart for 20 Minute Segment of an Interdisciplinary Team Meeting

1	2	3	4	5	6	7	8	9	10
					DiGrp				
		ICL							
			A						
					ISOC/TR				
						?Fin			
					IFIN				
						EX			
						IST			
					S				
					PS				
					DiGrp				
4		ICL							
						IB			
		ICL							
		?	ICL						
			ITR						
					?SOC				
			ISOC						
			A						
		ISOC						ISOC	
		ITR						ITR	
			OP						
							ISOC		
							OP		
					DiGRP				
5		ITR							
		ISOC							
		ICL							Enters

Key. 1, 2 & 4 = Med.Resident, 3 = Physician,
5 = Util. Review Rep., 6 = Soc.Worker, 7 & 9 = Nurse,
8 = Soc.Work Intern, 10 = Visitor.

The goals of the team observations included identification of the knowledge areas that arose and about which the social worker was expected to be familiar, as well as the degree to which the social worker exhibited specific knowledge and skills. It should be reiterated that the observations were not a means of evaluating the social workers. A social worker might exhibit a low level of knowledge in a specific content area only because the knowledge area was not addressed or because leadership around the content area was delegated to another member of the team.

By using the charted flow of the interdisciplinary team meeting (as above), as well as the content notes, an analysis of the total meeting was possible. The knowledge and skill areas demanded of, and exhibited by, the social worker and his/her role within the interdisciplinary setting were assessed. As a framework for this, the knowledge, skill areas and roles, previously identified in the literature, were used.

Knowledge Areas

The knowledge content areas required of the social worker, in order to participate in the decision making and work of the interdisciplinary health care team, are the same knowledge fields demanded of all participating team members whatever their health care discipline. They are:-

Medical terminology, clinical procedures.

Community resources.

Setting ie; administration, relationship of the

organization's systems.

Rules and regulations governing care.

Entitlements of the older patient/client.

Family dynamics.

Psychosocial issues.

After each team meeting, a yes-no rating was made by the observer to indicate whether these knowledge fields featured during the team meeting. The rating was irrespective of whether the social worker actually possessed knowledge in these categories or to what degree.

Role

The role of the social worker was then assessed, again as either yes or no. In this instance the observed role(s) filled by the social worker in the team meetings were noted. Role definitions were drawn from the literature on group dynamics and team development. It was expected that the observed social workers might fill one or more of these roles during the team meeting. The roles were categorized as:-

Leader - chairs the meeting, controls level and flow of discussion, offers decisions for ratification by the team participants, is deferred to by others as leader.

Follower - responds to questions, offers opinions and assessments if asked.

Initiator - introduces new information, opens up new avenues of thought, discussion.

Group Maintainer - encourages input from team participants, assists reticent participants to enter the discussion and provide information, offers compromises, rephrases statements of others to make them acceptable to all.

Mediator - similar to group maintainer ie; the mediating role is part of that undertaken by a group maintainer, but it is also a distinct role in its own right. Takes the lead in finding common ground between opposing views, suggests compromises.

Informer - repository of information. Answers questions from other team participants, fills a teaching role.

Skills

Finally the level of skills as exhibited in each of the team meetings by the social worker was rated as low, medium or high by the observer. This evaluation was subjective and based on the observer's own concepts and expertise. A high rating was given when the social worker's contributions revealed in-depth skill/knowledge of a specific content area and/or exhibited expertise in a skill area, and when the social worker appeared to exhibit skills not held by other team participants; a low rating was assigned when the social worker exhibited little or no skill in a specific knowledge area or no expertise in a skill area; a medium rating was awarded when some skill was shown but which fell between the two extremes. A low rating should not be considered an indication that the social worker was deficient in the skill, for it might merely reflect the fact that the team discussion did not

demand a high level of knowledge or skill in this particular area during the observation of the team meeting.

Identification of the skills to be observed was compiled from the literature on the nature of interdisciplinary work and the skills required by a health care professional as a member of the team. (Kappelman et al., 1981; McPherson, Hasbrouck, Donneberg, 1985; Clark, Spence, Sheehan, 1987; Sheps, 1973; Baldwin and Tsukuda, 1984.) Varying terminology is employed in the literature, but there is general agreement as to what these skills are. (See Chapter 3 for further discussion.) For purposes of this study, the terminology used by Baldwin and Tsukuda is utilized, with some additions from other sources. The skills are categorized under three headings - cognitive, technical and interpersonal skills. They are:-

a) **Cognitive/knowledge skills.** To be a contributing/participating member of the interdisciplinary team, members need to be well versed in the following areas.

Care of the elderly. This encompasses an understanding of the bio-psycho-social aspects of the aging process and the type and form of health care that is available. It includes an appreciation of the impact of losses on an individual, the interaction of multiple health and age-related conditions, and the implications these hold for the selection of appropriate health care.

Family dynamics. This refers to a knowledge of family relationships (generational and sibling dynamics, the parent-child

and spousal relationships), including an appreciation of reciprocity between family members, and the particular stresses and benefits of caregiving.

Provider/patient relationship. This encompasses an understanding of the potential for poor communication, and the existence of an unequal power/control situation inherent in the care provider and patient relationship. It further includes an appreciation of the effect this may have on the outcome of any prescribed health care.

Ethics. This refers to an appreciation of the ethical component in health care decision making, and the potential for competing rights and wishes of patient, family and health care provider.

Organizational systems. Skill in this area of knowledge includes both an understanding of the major policy issues and trends that affect health and social services for the older population, and also how specific care provider systems are managed and interrelate. This includes, for example, an understanding of the relationship between acute care and nursing home care and means of accessing the systems.

In addition to possessing skill in the above knowledge areas, social workers, as all members of the interdisciplinary team, need to possess both **technical** and **interpersonal** skills.

b) Technical.

The first three listed technical skills arise from the

responsibilities of the interdisciplinary team which are identified as the tasks of identifying the patient/client problem areas, and developing care responses to manage the problems - clinical assessment, intervention and management.

Problem Identification. The ability to integrate the available information concerning an older person and identify the primary problem.

Decision making. The ability to synthesize the information and discussion within the team meeting and formulate a decision based on this information.

Problem solving. The ability to act as catalyst by asking questions, probing, and creating avenues of thought that lead the team towards problem solving. Note that filling the role of a problem solver is not necessarily equivalent to formulating the solution. The role of problem solver is an enabling role.

Role negotiation and differentiation of tasks must be accomplished by every interdisciplinary team in order to function successfully and, though the level of need for these skills will vary dependent on the stage of development of the team, the tasks are ongoing and a demand for the skills remain.

Role negotiation. The ability to define the appropriate care management roles (leadership, case manager, patient advocate etc.) of the disciplines in a particular case situation.

Task differentiation. Similar to above, this is the ability to define specific tasks of the team members in relation to each case, and facilitate team agreement, to avoid overlap of tasks.

Team maintenance, in the sense of resolving conflict, and communication abilities are also viewed as technical skills needed by team members.

Team maintenance. The ability to maintain and strengthen the team approach through use of interpersonal skills.

Communication. The ability to communicate clearly, explaining discipline specific terminology when necessary, so that all team members understand.

c) **Interpersonal.**

The interpersonal skills are self-explanatory. They refer to the skills required of all members of an interdisciplinary health care team, in order for the team to function as a team and carry out its goals.

Ability to listen.

Openness/trust.

Communication. Communication is also listed under technical skills. There is a distinction between the technical ability to communicate meaning clearly and the interpersonal skill of communicating with others, which skill rests upon the ability to empathize with others and be interactive in such a way that others become engaged and are receptive to the communication. It is this latter communicative ability which is rated under interpersonal skills.

Provide feedback.

Courage. This interpersonal attribute may be needed less

frequently as an interdisciplinary team strengthens its level of teamwork. In the formative stages of a team, individual members may require personal courage in order to provide feedback, offer what may appear to be unpopular care strategies, probe for further analysis etc.

Willingness to share power.

Commitment to functional advantages of collaboration.

Flexibility.

The interpersonal skills are the personal attributes held by the social workers and other team members that contribute to a functioning team.

Method of Analysis

After both visits to the same facility were concluded, written up and charted as explained above, and after all the site observations were accomplished, there was a review of the charts. A second assessment was then made of the knowledge areas required of the social worker, the social worker's role, and of the level of skills exhibited in each observed team meeting. This second analysis was undertaken without reference to the results of the first. Because this review did not take place until all the site observations were concluded, this second analysis occurred, in most instances, several months after the initial analysis. It was therefore anticipated that the second, latter analysis would be minimally affected by the undertaking of the first analysis. Once again, the analysis was necessarily subjective. This second

assessment was then compared with the first initial impressions, and were found to match.

Independent Assessment. To further validate the observations and assessments, the detailed notes of the interdisciplinary meetings, and the accompanying charts were given to an independent reviewer who agreed to assess the meetings and role of the social worker using the same categories and definitions of knowledge and skill areas. This independent reviewer is an authority on geriatric social work, an educator and writer on social work with the older population, and has been a member of an interdisciplinary team for several years. The independent assessments were then matched with those of the researcher. Differences in judgement in making the analyses were found to be minor. Only slight differences in opinion were recorded which did not alter the overall findings.

Use of an Index. Finally, numerical values were assigned to the ratings of yes and no (2 or 1); high, medium or low (3, 2 or 1); in order to create an index. It was decided to give each item an equal weight as the creation of an index was for the purpose of easily identifying trends and comparisons, rather than for measuring the overall level of interdisciplinary teamwork by the social workers. (Simon, 1978.) If this had been the intention, differential weighting of the roles and skills would have been indicated. (Babbie, 1986.) The assignment of numerical values resulted in a score on each category for each observed team

meeting, a composite score for both the team meetings at one site and a combined score on each item for all 12 team observations. Scores were then compared by setting in order to highlight both differences and similarities.

Use of an index further facilitated a comparison between the initial ratings and the second assessment, and became a means of testing the internal validity of the findings. It became evident that any differences in the two ratings by item tended to be minimal. More importantly, assessment across all 12 team observations by item revealed that any differences in ratings between the first and second analysis were only in the order of one to two points or tended to cancel each other out. This meant that the ranking of items according to how the items, or skills, were rated as yes/no, or high, medium and low, remained the same whether the first, second or independent analysis was utilized.

3. Interviews with the Geriatric Social Workers

In addition to the site observations, the social workers at each host site participated in semi-structured interviews. These were held, in most cases, just prior and after the initial site observation and served the purpose of explaining any content of the team meetings that was unclear to the researcher, identifying the disciplines of the team members and indicating what was usual and what fell outside the traditional form and function of the meeting.

Though the interviews were conducted informally, the same issues and questions were raised in each. The social workers were

questioned about the history and development of the interdisciplinary team being observed and how they perceived their own role and tasks as a member of the team. Each social worker also responded to questions about educational preparation for working with other disciplines in the health care setting and their own values and concerns regarding the social work interdisciplinary role. In several cases, the information gathered from these interviews was corroborated in brief interviews with the Social Service Director and/or Facility Director. The information collected was utilized to deepen the understanding of the team meeting under observation and is incorporated into the discussions of the team meetings.

Summary

This chapter has detailed the methodology used in collecting data. The goals of the study were identified and three methods of collecting information and testing the hypotheses were discussed - a survey of 60 geriatric social workers in health care settings, site observations of interdisciplinary team meetings at six sites, and semi-structured interviews with the geriatric social workers observed in the team meetings. Methods of analyzing the collected data were detailed. The information collected through the surveys and reports of the site observations will form the content of the following chapters.

CHAPTER V

SURVEY FINDINGS

Surveys were sent to social workers in health care settings providing care for older persons. The surveys collected information in four general areas. These were:-

* the setting and position held by the respondent;
* the nature of work activities undertaken by the respondent and the time spent in each identified activity;
* interaction with professionals from non-social work disciplines;
* the year of graduation and preparation for interdisciplinary work.

This chapter will report on the data collected.

Sixty survey questionnaires were collected from sixty graduate social workers, twenty from each of the three major categories of health care setting for the older person - the long term care facility, the acute care hospital, and the community setting. Several completed surveys were also received from social workers without a Masters degree in social work but these were not included in the final sample. It should be noted, however, that the type of work activities and level of responsibility of these non-masters level social workers was similar to that of the social

workers with Masters degrees.

Identifying Data

Setting of Respondents

Due to the selection process, the 60 respondents were evenly divided between those who worked within a long term care facility (nursing home), in an acute care setting (the hospital), and within a community setting. Community settings included adult day care centers, community health clinics, geriatric clinics attached to a medical center, home care agencies and geriatric case management agencies.

Little identifying data was collected in order to preserve the anonymity of the responses. The surveys were, however, initially mailed to social workers identified, by name, as working within a health care setting. Thus by matching names to the returned surveys it was possible, in most cases, to deduce the sex of the respondent. Thirty-nine responses were from women, eight from men. The sex of the remaining thirteen respondents is unknown.

Percentage of Client Group over 65 Years.

It was anticipated, due to the health needs of the older population, that each of the 60 settings represented in the questionnaires, would be serving mostly older persons. These older

persons would be the clients of the social work respondents. Seventeen respondents (over 28%) noted that all their patients/clients were over the age of 65 years and altogether 83% reported that three quarters or more of their client group were over 65. Only five respondents (8.4%) had fewer than half their client group over the age of 65.

Social Work Position/Title.

Surveys were sent to social workers regardless of their current position and title. Of the sixty social workers there was almost equal distribution between Executive Directors (31.7%), social work supervisors (26.7), and social workers (36.7%). Respondents were asked to state the title of their position and from the responses, it appeared that there were 19 Executive Directors, 1 Deputy Director, 16 Social Work Supervisors or Project Coordinators, and 22 Social Workers, and 2 who listed themselves as Consultants/Self-Employed. The respondents' work settings differ in size and complexity, so it would be misleading to equate the positions of all those with the same job title.

Nature of Work Activities

Work Activities

Respondents listed the work activities they engage in during the fulfillment of their job responsibilities. The percentages

noting each activity are listed below in rank order. (Table 5-1)

TABLE 5-1

NUMBER AND PERCENTAGE OF RESPONDENTS ENGAGED IN EACH OF THE LISTED WORK ACTIVITIES (n=60)

Work Activity	Number	Percent
Paperwork	57	95.0
Meeting Attendance	55	91.7
Interviewing	53	88.3
Administrative Duties	51	85.0
Counseling	50	83.3
Assessment	49	81.7
Info. & Referral/Advocacy	49	81.7
Supervision of students/staff	42	70.0
Groupwork	33	55.0
Home Visiting	16	26.7
Other*	33	55.0

* Other activities covered a range of job related tasks and responsibilities - training volunteers, teaching, fundraising, policy preparation, community education.

Amount of Time Spent in Specific Work Activities

To obtain a more precise understanding of the work activities, respondents were asked to estimate the amount of time spent each week on various job related tasks. (Table 5-2)

Educational tasks refers to reading of journal articles, ttendance at educational meetings, in-staff training etc. While it is to be expected that this activity will occupy a relatively small amount of time during the work week, 15 social workers, 25% of the respondents, indicated that no time at all was spent on this activity. Making home visits was also not part of the work activities for two thirds of the sample, and while 42 persons did

not respond when asked to state time spent in other work activity not listed in the questionnaire, this may only mean that they chose not to answer, rather than that no 'other' activity occupied their time during the work week.

TABLE 5-2

NUMBER OF HOURS SPENT IN AN AVERAGE WORK WEEK ON SPECIFIC TASKS

	Number of Hours Per Week						
Task	**0**	**1-5**	**6-10**	**11-15**	**16-20**	**21-25**	**Over 25**
Client Interview & Assessment	7	19	14	8	8	1	1
Development of Treatment Plans	14	33	7	2	1	2	1
Team Meetings							
a) Client Related	8	39	10	-	2	1	-
b) Organizational	14	38	4	4	-	-	-
Groupwork	27	30	3	-	-	-	-
Family Meetings	18	36	5	1	-	-	-
I&R/Access Services	10	34	8	1	3	2	-
Counseling	8	27	13	5	4	2	1
Commu./home visits	40	11	5	1	-	2	1
Filling out Forms	9	37	8	3	-	2	1
Supervising	21	22	14	2	1	-	-
Administrative Duties	4	30	16	2	4	2	2
Educational	15	42	3	-	-	-	-
Other	42	8	3	1	1	1	-

Of interest is the number of hours spent each work week in team meetings related to client/patient care and described in the questionnaire as treatment and care planning meetings. These are most likely to involve a number of disciplines and be considered an interdisciplinary activity. While 8 social workers (13.3%) did not participate in this activity, 39 or 65% spent 1 to 5 hours a week

in such meetings and a further 10 social workers (16.7%), spent up to 10 hours, substantially more than one fifth of the work week. Other activities that took up a considerable number of hours for many respondents were counseling, client interviews, supervisory responsibilities, and administrative duties.

Interaction with Other Professionals.

The next section of the questionnaire collected data concerning the estimated percentage of time spent each week with various categories of persons - clients/patients, family and friends of the clients, other social workers, and health care professionals other than social workers. (Table 5-3)

TABLE 5-3

PERCENT CONTACT TIME WITH OTHERS IN AN AVERAGE WORK WEEK

	Percentage of Work Week						
Contact Group	**0**	**1-10**	**11-20**	**21-30**	**31-40**	**41-50**	**Over 50**
Clients	2	9	11	13	8	10	7
Family/Friends	8	30	9	6	5	2	-
Other Soc. Wkrs.	4	31	9	3	3	5	5
Hlth. Care Profs.	-	18	17*	12	5	5	3
Other**	16	29	8	3	1	1	2

* Fourteen of these 17 respondents indicated that they spent a full 20%, equal to one day, of the work week in contact with health care professionals other than social workers.
** Other refers to landlords, religious leaders, office staff etc.

None of the sixty respondents indicated a lack of contact

with other health care professionals during the work week, and 25 (41.7%) spent over one fifth of their time with non-social work health care professionals. An additional 14 (23.3%) respondents estimated that they spent 20 percent of their time in this way. This means that 65% of the total number of respondents were spending seven hours or more per week in work contact with non-social workers.

When number of hours spent with other health care professionals is related to type of setting, it appears that the social workers in community health care centers and nursing home facilities were more likely to spend over a fifth of their work week in contact with other health care professionals than social workers in the acute care setting. (p .1, Chi-Square = 2.4771) Seniority and level of position had minimal bearing on time spent with non-social work health professionals. Whereas those at the level of 'social worker' and 'project coordinator' (25) were more likely to spend one fifth or less of their work week with other health care professionals, those at 'Executive Director' level (15) were equally divided between those who spent a fifth or less and those that spent more than a fifth of their time with non-social work health professionals.

Respondents were given a list of non-social work professions and asked to indicate which professions they interacted with in fulfilling their work responsibilities. (Table 5-4).

Almost all the respondents reported interacting with nurses and physicians, and over two thirds also responded that they

interacted with physical therapists and nutritionists/dieticians. Audiologists and dentists were the two professions that the respondents were least likely to interact with in the fulfillment of work responsibilities. Under a third (16 in each case) said that they interacted with these professions.

TABLE 5-4

INTERACTION WITH PROFESSIONS OTHER THAN SOCIAL WORK IN THE FULFILLMENT OF WORK RESPONSIBILITIES

Profession/Discipline	Yes	No	NA
Nurses	59 (98.3%)	1 (1.7%)	
Physicians	58 (96.7%)	2 (3.3%)	
Phys. Therapists	43 (71.7%)	17 (28.3%)	
Nutritionists	42 (70%)	18 (30%)	
Lawyers	39 (65%)	21 (35%)	
Occup. Therapists	38 (63.3%)	22 (36.7%)	
Psychologists	33 (55%)	27 (45%)	
Relig. Leaders	29 (48.3%)	31 (51.7%)	
Speech-Lang. Path.	22 (36.7%)	38 (63.3%)	
Audiologists	16 (26.7%)	44 (73.3%)	
Dentists	16 (26.7%)	44 (73.3%)	
Other*	26 (43.3%)	34 (56.7%)	

* Professions indicated under the category of 'other' included psychiatry (11 respondents or 18.3%), activity therapists (5), administrators (4), accountants, police, and educators (3 under each).

Almost two thirds of the respondents reported that they interacted with lawyers, and the likelihood of doing so appeared to have no relationship to the specific health care setting. Of the 39 social workers who reported interaction with lawyers, 14 worked

in an acute care setting, 13 in a long term care facility, and 11 in a community based setting.

When asked which profession the respondents interacted with the most in fulfilling work responsibilities, 34 (56.7%) answered nurses and 15 (25%) said physicians. (Table 5-5). Three answered administrators for this question and, of the remaining eight, five chose not to respond or mentioned variously - religious leader, home care worker, police.

TABLE 5-5

PROFESSIONS INTERACTED WITH THE MOST AND THE LEAST IN THE FULFILLMENT OF WORK RESPONSIBILITIES

Profession	Interact the Most	the Least
Nurses	34	1
Physicians	15	5
Administrator	3	1
Religious leaders	1	6
Home Care Worker	1	-
Police	1	-
Speech-Lang. Path.	-	9
Lawyers	-	8
Dentists	-	6
Nutritionists	-	5
Audiologists	-	4
Occup. Therapists	-	5
Psychologists	-	2
Phys. Therapists	-	1
Accountants	-	1
No Answer	5	6

Setting had an impact on which non-social work profession was

interacted with the most. Those in the acute care and community settings were just as likely to interact **the most** with non-nurses as with nurses, but those working in a long term care facility (nursing home) were overwhelmingly likely to interact **the most** with nurses rather than members of the other health care professions. Only one respondent from a long term care facility reported interaction most with an MD rather than a nurse. Those that reported interacting the most with an MD worked in the community and acute care settings.

Respondents were also asked which profession they interacted with the least. Six persons chose not to respond and the remainder offered a range of answers. Nine respondents (15%), indicated that they interacted the least with speech-language pathologists, 8 or 13.3% said lawyers, and 6 persons answered for each category of religious leaders and dentists. (See Table 5-5). It must be remembered that some respondents did not interact at all with some of the professions. For example, only four respondents reported interacting the least with audiologists but 44 others reported never interacting with members of this profession.

Preparation for Interdisciplinary Work

Of the sixty respondents, 57 answered yes when asked if they thought that knowledge of other disciplines and skills for working with persons from other disciplines is necessary in fulfilling the social work tasks in a health care setting. Two respondents answered no and one was unsure.

Year Receiving Master's Degree

The year, in which respondents received their Masters in Social Work, ranged from 1947 to 1990. Prior to 1974, there were one or two graduates each year, and after 1974, the numbers rose to two to four for each year. In all, 29 of the respondents reported that they received their MSW prior to 1981, and 28 since that time. Three did not answer this question. (Table 5-6)

TABLE 5-6

YEAR IN WHICH RESPONDENTS RECEIVED MSW DEGREE

Year	Number	Percent
1947-50	2	3.5
1951-55	4	6.7
1956-60	0	-
1961-65	3	5.0
1966-70	1	1.7
1971-75	7	11.6
1976-80	12	20.0
1981-85	16	26.7
1986-90	12	20.1
(No Answer	3	5.0)

Field of Interest/Concentration

Respondents were also asked what their concentration or field of interest was while in graduate school. (Table 5-7).

TABLE 5-7

CONCENTRATION/FIELD OF INTEREST WHILE IN GRADUATE SCHOOL

Field of Interest	Primary	Secondary
Casework	45	-
Groupwork	5	8
Comm. Organization	1	3
Administration	-	7
Research	1	-
Generic	7	-
No Answer	1	42

Courses in Aging and/or Health Care

While in graduate social work school, 32 or 53% said that they took a course in aging and 24 or 40% said that they took a course in health care. Eighteen respondents had taken both aging and health care courses but 22, over a third, had taken neither. (Table 5-8.) The year in which a respondent received the Master's Degree was related to whether a course in aging had been included in the graduate education.

TABLE 5-8

COURSE(S) IN AGING AND YEAR OF MASTERS DEGREE

	Aging Course(s)	No Aging Course(s)	Total
1947-1983	17	21	38
1984-1990	12	7	19
Year Unknown	3	-	3
Total	32	28	60

Graduates after 1984 were more likely to have taken a course in aging than those who graduated prior to 1984. This year, 1984, was chosen as the watershed year as it was in 1984 that the Council on Social Work Education published its curriculum guidelines for geriatric social work. Respondents who graduated before 1984 (n=38) were almost equally divided between those who had taken an aging course and those who had not (45% and 55%), but 74% of the post 1984 graduates (n=19) reported taking an aging course while in school. (Three did not respond to this question.)

Education in Interdisciplinary Knowledge and Skills

In terms of whether the respondents had received any education in understanding other professions or in interdisciplinary teamwork, 44 or 74% answered that they had received such preparation. (Table 5-9.) This preparation for interacting with other non-social work professions took place in the fieldwork setting only for 26 respondents (43%) and in the combined field setting and classroom for a further 18 respondents (31%). The remaining 16, (26%), received no preparation for interdisciplinary teamwork and interaction with other professions in fulfilling work responsibilities. Year of graduation appeared to have no relationship to whether interdisciplinary education was experienced or not.

TABLE 5-9

EDUCATIONAL PREPARATION FOR INTERDISCIPLINARY INTERACTION AND SETTING IN WHICH RECEIVED

	Educat. Prep.	No Educ. Prep.	
Class Setting	-	-	
Field setting	26	-	
Class & Field	18	16	
Total	44	16	60

It was anticipated that preparation for interdisciplinary work might be related to taking aging or health courses as part of the Master's curriculum. Of the 32 respondents who indicated that they had taken at least one course in aging, seven reported that they received no preparation for interdisciplinary work, and 16 that the preparation was only received in the fieldwork setting. (Table 5-10.) Only 9 respondents who had taken an aging course noted that both field and classroom contributed to interdisciplinary preparation.

Those respondents who reported taking at least one course in health fared slightly better in receiving educational preparation for interdisciplinary work from the class setting. Of the 24 respondents, 3 indicated that they had received no education regarding interdisciplinary practice, 9 that the education was received from the fieldwork setting only, and 12 that it was received from both the field and classroom setting. On the other hand, 12, of the 20 respondents who reported taking neither aging nor health courses, indicated that they also received educational preparation for interdisciplinary work either in the fieldwork

setting (8) or in both field and class (4). Taking aging and/or health courses as part of the Master's degree curriculum appears to be no guarantee that preparation for interdisciplinary work is received in the classroom and, conversely, not taking such courses has little bearing on whether a geriatric social worker will receive educational preparation.

TABLE 5-10

EDUCATIONAL PREPARATION FOR INTERDISCIPLINARY TEAMWORK AND RELATIONSHIP TO COURSE AND FIELD WORK

	Received Educational Preparation in				
	Class Only	Field Only	Both Class & Field	No Prep.	Total
Aging Course(s)	-	9	1	4	14
Health Course(s)	-	2	4	0	6
Both Aging/Health	-	7	8	3	18
No Course(s)	-	8	4	8	20
Total	0	26	17	15	58*

*Totals do not add to 60 as 2 respondents indicated that they had taken neither health nor aging courses but did not answer the question regarding educational preparation and are not included in this table.

As a final question, respondents were asked if their social work education had prepared them sufficiently in the necessary interdisciplinary knowledge and skills. (Table 5-11). Thirty six or 60% noted that it had, eight fewer than those who indicated that interdisciplinary education had been experienced. Three respondents were unsure and 9 respondents did not answer this question.

TABLE 5-11

EDUCATIONAL PREPARATION FOR INTERDISCIPLINARY WORK RESPONSIBILITIES

	Yes	No	Unsure	NA	Total
Receive any Education?	44	14	-	2	60
In Classroom Only?	-	58	-	2	60
In Field Setting Only?	26	32	-	2	60
Both Class & Field?	18	40	-	2	60
Did Educ. Prepare You?	36	12	3	9	60

On completing the questionnaire, 19 respondents added personal comments. These can be categorized under four different headings.

Education

Eight respondents commented on their educational experience, one stating that the education prepared him/her well for interdisciplinary work. However, five of the social workers noted that they had taken or were currently taking additional geriatric education for, as one respondent said, "my preparation in school was inadequate."

Interdisciplinary Practice

Five respondents observed that interdisciplinary knowledge and skills were developed through practice and work experiences after the completion of the Master's degree.

Work

Two respondents commented on the geriatric social worker's

practice today. The amount of paperwork was judged too great and it was suggested that the social work status has diminished as a result.

Need for Interdisciplinary Education

Eight respondents expressed the importance of geriatric education and the need for education concerning interdisciplinary skills and knowledge. "There is a need for developing skills to work in teams ..." and "knowledge of interdisciplinary relationships are very important."

Finally five respondents made positive comments about the survey, thanking the researcher for undertaking the project or indicating approval of the focus on interdisciplinary factors in geriatric social work.

CHAPTER VI

SOCIAL WORK AND THE INTERDISCIPLINARY TEAM IN THE COMMUNITY HEALTH SETTING

This chapter and the two following chapters contain descriptive reports of interdisciplinary teams and the role and function of social workers within team meetings. The descriptive data and analyses are based on observation and conversations with the social workers concerning their work within the interdisciplinary team.

V. Amway Center - Day Care

This facility is located within New York City in an area which has traditionally been a blue collar working class area - an area to which new immigrants moved, as the first stop before moving further north and away from the city. In fact, many of the residents remained in the area, which was first a center for European Jews and Irish Catholics, giving way to the newer immigrant Latino and South American families. The main avenues are

lined with small stores, businesses and apartment buildings with the occasional hospital complex intervening, while the side streets contain low, 4 floor apartment buildings and rows of small homes, with gardens in front.

Setting

The facility is a large long term care facility for the elderly. Most of the building is used as a skilled nursing home but the facility also administers home care programs and operates a geriatric day care program for the neighborhood. The facility has been in existence for many years and enjoys a sound reputation within the community and with professionals in the field of geriatric care. Most of the elderly that use the home and its services are long-time residents of the community and reflect the surrounding population--white European Jewish, Irish Catholic and Latino.

Permission was granted for observation of the weekly interdisciplinary team meeting of the geriatric day care program. The meeting was held in the activity room of the area set aside for the day care program. The entrance is reached through the nursing home. A receptionist's desk and office space is opposite the day care area doorway and beyond the desk is the main area which has a number of tables scattered around, chairs around the edge of the room, posters and stereo equipment. It is a multi-purpose room, adaptable for dance, arts and crafts, music, conversation etc. and

the team meeting, on the days of the visits, was scheduled for a 9.00 am. start so that it might end by 10.00 am. in time for the beginning of the program day, when the space was needed for activity sessions. The Center has 93 members, with a daily attendance of about 45 persons.

Meeting One

Purpose of Meeting

The purpose of the interdisciplinary meetings was for ongoing review of case activities as mandated by the state. Case activity notes for each individual are reviewed and the necessary forms completed, thus providing a written update which confirms or revises the case plans. These requirements are imposed by the external state regulatory body and the center must show compliance in order to remain licensed and eligible for reimbursement. The stated goal of this particular meeting was to review three cases but before beginning this work, the team looked over the list of center participants and recognized that the team was behind in its reviews. This recognition added a sense of urgency to the meeting.

Team Participants

Five staff were present at the meeting, (all female) - the Director of Nursing, the floor nurse, a recreational therapist, a social worker and the Director of the Center, who is also a social worker. An additional team member, another recreational therapist,

was missing on this day. The Director, herself, is not always present at these meetings. There are other staff recognized as members of the interdisciplinary team but they do not attend, writing up their reports for inclusion in the discussions and conveying information to the team members on an individual basis. These other staff include a nutritionist, a physical therapist, and occupational therapist, but no physician.

As the day care participants are all living in the community, they tend to have their own physician in the community and contact is made with these by the Center staff. When a Center participant has a medical appointment, the physician is expected to report to the Center regarding treatment but this does not always happen. At this first meeting there was some discussion regarding follow-up and the need to obtain a report from a physician in the community in regard to one of the cases being reviewed. It was not clear which team member would take responsibility to make sure that this happened.

Content of Meeting

Three cases were identified for review. Medical history and past case notes on a white male were shared and the team members entered into a discussion about the current status of his health problems and extent of participation in the center activities. There was some concern regarding medical treatment and the need for an assessment, complicated by compliance issues. The social worker noted that the participant did not follow up when appointments were

made for him and this precipitated a discussion as to the probable reason for this, and whether it was due to gender, age, or cultural factors. Team members also agreed that the participant appeared anxious, perhaps due to his health problems and perhaps a symptom of depression, and different opinions were shared concerning whether the anxiety ought to be viewed as a normal reaction or whether it warranted recommendations for counseling. A treatment goal was determined.

The second case was a white female, spouse of the previous case. The team members briefly queried whether the two cases should be reviewed as one but agreed to see the cases as separate for purposes of developing treatment plans, as the two individuals presented differently in response to their situations. The medical history was reviewed and discussion centered on a weight problem. It was suggested that this might be linked to depression and team members all contributed information about the client's background and current activities in an attempt to understand the situation and perhaps pinpoint a cause for depression. Care was taken to develop a treatment plan which adequately represented the views of all members of the team and the objectives of which would be measurable.

Discussion of these two cases occupied a full hour. The meeting ended when the recreation therapist was called away to lead a program and center members entered the room, needing the use of the table for a craft activity.

Meeting Dynamics

The team members have been working together for many years and were comfortable with each other, feeling free to differ in their opinions and challenge each other as needed. The meeting atmosphere was informal but goal directed. The Director of the Center led the meeting, asking questions and managing the discussion. The Director of Nursing and the floor nurse maintained the case records and were responsible for reading the past case histories and recording the assessment and treatment plans, that were developed during the meeting. All five staff persons participated in the discussion on each case and contributed to the decisions to affirm or revise the treatment plans. During the first few minutes of discussion for both cases, the Director tended to pose questions which were answered by the floor nurse, but once the current information was shared, all team members offered their opinions and contributed further knowledge of each case.

There were a few interruptions--a member left the room briefly to find a sweater, a phone message was relayed by the secretary to the Director--but the team remained focussed on the case reviews. Great care was taken in selecting the most appropriate phrasing for the written record to define any problems and develop treatment goals that were realistic and accepted by all. Differences of opinion frequently surfaced in the fulfillment of this task as team members held contrary views in many instances over the reasons for the perceived problems. The differences were argued in an amicable manner and continued until a consensus was

reached.

Meeting Two

Team Participants

This meeting was held at the same time a week later in the same room. This week, six staff members were present. The Director was absent, leaving four of the original team participants --the social worker, the Director of Nursing, the floor nurse and the recreational therapist. These four formed the nucleus of the meeting. Also present this week was a social work intern/student, supervised by the social worker, and a therapeutic recreation specialist. This specialist had been a teacher but discovered, since working at the center, that she works well with Alzheimer's patients and has thus become the recreation specialist working with this group. All six team members were female. In the absence of the Director of the Center, the social worker was the acknowledged chair of the meeting and she took responsibility for leadership.

Content of Meeting

This morning, the receptionist was unexpectedly absent and there were several interruptions of the meeting by other staff persons regarding work details and decisions that needed to be made re later appointments. The social worker, chairing the meeting, was called away at intervals to make decisions.

As during the previous week's meeting, three cases were scheduled for discussion. The first case was that of a female

Center member who presented with behavioral problems. The team members were all in agreement over the issues but unsure of the treatment, as various strategies had been tried in the past with little success. The case notes from the psychologist were reread and considered. After restating the problem, treatment goals were rephrased to everyone's satisfaction.

The second case concerned a male who had suffered a foot amputation and discussion dealt with the need to secure appropriate shoes to enable him to participate in the Center activities and to adjust to his limited mobility. During the writing of the case notes on this Center participant there were a number of interruptions as telephone messages were relayed to the team members and informal, non-work focussed conversation between team members while the two nurses wrote up the treatment goals.

Discussion of the third case commenced with the statement that the female participant under review had been in infrequent attendance at the Center recently. The reason for this was discussed and it was clear that one of the team members knew the details of the participant's life quite well and was able to explain the reasons for the infrequent attendance. A previous behavior problem, noted in the records, was no longer apparent but it was determined that this was due to recent anxiety on the part of the participant. This anxiety altered her usual manner of interaction with others which had been identified as problematic. Thus the prior treatment goal to change the antisocial behavior had been achieved but this was due to external conditions and could not

be credited to the care provided by the Center staff. A new treatment goal was identified, incorporating the new information and the meeting ended.

The team expressed anxiety that it was behind with the case reviews. There was no available time to continue the reviews as one staff member was scheduled to lead a group activity. All agreed to meet again later in the day to catch up.

Meeting Dynamics

The meeting atmosphere was comfortable, even though there were a number of interruptions and some confusion due to the unexpected absence of the receptionist. Several decisions had to be made concerning later appointments and reorganization of staff, and direction was sought from the social worker at intervals by staff not involved in the team meeting. As noted earlier, this resulted in the social worker leaving the meeting for a few moments on two separate occasions.

In spite of this, the meeting atmosphere was relaxed with every member contributing to the discussion. It was clear that each staff member felt comfortable in the setting and there was laughter and teasing of each other. The light atmosphere, notwithstanding, the task, of developing statements that could be recorded as treatment goals for the client cases being reviewed, was taken seriously and care was taken to phrase the written statements appropriately. Sometimes, in the struggle to reach agreement on the perceived treatment goal, a team member would

offer a phrase that was intentionally flippant and which was greeted with amusement. On one occasion, when this occurred, the observer was asked not to record "that statement." In turn, the author of the statement expressed her belief that a sense of humor was a necessary attribute of a well functioning team and that the observer should certainly note this in any analysis.

Unlike the first observed meeting the previous week, the student intern was present at this team meeting. She did not, nor was expected, to contribute much but her opinions were respected by the others. There was the added dynamics of the teaching role filled by the social worker who frequently spoke, on the side, to the intern, providing background on the cases under discussion and engaging in general chit-chat.

Impressions of Meetings/Social Work Role

The team members have worked together for a long time and this was evident by the comfortable atmosphere, the teasing and acceptance of each other. This atmosphere permitted the members to challenge each other and while everyone's views were respected, there were some strong disagreements in both meetings over the analysis of the case situations. For example, team members disagreed as to whether the sadness of one client was attributable to normal concern about a close friend or was an indication of clinical depression. Team participants were divided in their assessment and, by challenging and then listening to each other, sufficient information was contributed by the team members so that

agreement could be reached.

A major issue in the meetings and one which the team members discussed with me, concerned the state's prescribed format for the patient/client records, which is viewed as an obstruction to the work itself. The forms, while providing a structure for work, are also constrictive in that it proves difficult to find the words which capture all the salient issues without overlooking important areas and simultaneously indicate suitable care plans. There was much discussion over the exact wording and disputes as to the meaning being conveyed in the records. The task of writing the case notes, while irksome, did seem, however, to cause the team to examine the assessments and intervention plans more carefully than might otherwise be the case.

Because the Center participants live in the community, the level of knowledge by the team members about some parts of the clients' daily existence is necessarily limited. Background knowledge of a client and understanding of family and psychosocial dynamics was exhibited by the staff person who related best to the specific Center participant, rather than by any particular discipline. The issues and problems varied widely and the team members were often powerless to control them, being unable to intervene easily or manage the client's activities outside the day care setting. Systems negotiation with, for example, community health care professionals, landlords, and lawyers, was part of the ongoing work with each client.

Both the observed meetings were chaired by a social worker.

At the first meeting, the senior social worker present was the Center Director and she directed the meeting, with the other social worker deferring the leadership to her and assuming a secondary role. In her absence from the second meeting, the interdisciplinary meeting was both chaired and directed by the social worker. As chair, it was the social worker's responsibility, in both team meetings, to make sure that all relevant information on each client was shared with the team and that this information was then reflected in the case notes. The nurse kept the logs and wrote up the notes but the input was a team effort with everyone contributing, so that the final agreed upon statements were a product of all.

At the conclusion of the second meeting, the team members spent a few minutes sharing their own analysis of the team experience with the observer. All agreed that the most important thing that was needed to enable the team to function was the ability to work with each other and allow a team member to "go off on a tangent" and then build on this with everyone contributing their thoughts. The special knowledge of each member was respected. The team members have worked together for a number of years and acknowledged that they all liked and respected each other, and while they might have differences this was infrequent, "unlike some teams."

Plainvista Center - Community Clinic

The geriatric community clinic is housed in a large city hospital which serves an indigent urban population of all ethnic and cultural backgrounds. Comprised of a vast network of acute care floors, specialty wings, research laboratories and clinics, the medical center enjoys an international reputation, and is viewed as an excellent training ground for medical internists and health care professionals of all disciplines. The geriatric clinic is the only department that deals exclusively with the older population even though, as at all hospitals, the majority of the overall patient caseload is over the age of 65 years.

Setting

The geriatric clinic serves mostly the local older population, assessing and managing its health care and providing a range of social and psychiatric services. Many, but not all, of its patients/clients are members of the NYC street population or verge on the edge of homelessness, who view the clinic and its staff as their family and support network.

The clinic staff, consisting of all disciplines, provide care and services as an interdisciplinary team. General meetings are held once weekly during the lunch-hour. These are educational meetings and the various disciplines within the clinic take turns in being responsible for the 45 minute program. The program may be a speaker on a topic of general interest, a report on the latest

research or conference proceedings, or the presentation of a case for general discussion.

Plans were made to attend two of the regular meetings, both of which were to be led by the social work department in its usual rotation. Each discipline takes turns in being responsible for the content of the meetings.

A medium sized room at the side of the second floor clinic offices is set aside for these meetings. The room contains a table with two to three chairs behind it along one wall, and a second table and an assortment of wooden and metal folding chairs around the edges of the room.

Meeting One

It is recognized that the meetings must begin and end promptly to accommodate the busy schedules of the staff and the room quickly filled up as staff members arrived promptly. Some staff brought their lunch to eat as they listened.

Purpose of Meeting

The agenda for this first meeting included presentations by the two assistant social workers, who, under the direction of the Social Work Supervisor, were to present a case and report on a recent conference and its content. (The Social Work Department was responsible for planning the content of the forty-five minute period and had selected to use the time in this way.) The case to be presented was chosen for educational purposes, for

interdisciplinary feedback and intervention planning, and additionally to provide an opportunity for one of the two assistant social workers to gain experience in case presentation.

Team Participants

The meeting began with nine persons present. Four others arrived shortly thereafter and a little later two more persons entered. I was told that the 15 staff persons represented all the disciplines among the clinic staff, and I was able to identify the three social workers, a dietician, two psychiatrists, three physicians, a psychologist, and four nurses. The fifteen staff persons represented all age groups and ethnic backgrounds. Nearly all were female. The two social work presenters, both women, sat behind the table to the right of the doorway, and those attending sat around the edges of the room, facing them.

Content of Meeting

The meeting was called to order by the Director of Social Services who announced the agenda for the meeting and then handed over the proceedings to one of the assistant social workers for presentation of the selected case.

The situation presented was of a male in his sixties with psychiatric problems. The full chronological history of the case was shared and included not only the psycho-social history and assessment but the medical care, and issues of counseling, referral to additional community based services, and non-compliance with the

prescribed drug regimen. Staff attending the meeting interrupted with questions and a full description was given of the client's home environment, interests, and typical behavior patterns. This included the past history and information about the patient/client and his family dating over a number of years. Chosen because of its complexity and the issues that it raised, the case history engendered much discussion and comment. The social worker offered the history and facts pertaining to the case, avoiding any analysis of the case situation except in response to questions about changes in treatment goals and suggestions for current care. Team participants were particularly interested in 1) the patient's relationship with family members, and in 2) suggesting possible reasons for the non-compliance with medical care.

The case was rich in detail and created so much discussion and comments that only a few minutes of the 45 minute session remained for the report, prepared by the second social worker, on a conference on death and dying. This was noted briefly and the sharing of further details was postponed for a later meeting.

Meeting Dynamics

The atmosphere was cordial. There were no immediate tasks that had to be completed by the end of the meeting so there was no sense of urgency. Those attending listened attentively to the presentation but were free to interrupt with questions and comments, as the case unfolded. Several staff persons sat and listened only, while about six persons (two physicians, the

psychiatrists, the dietician and the Dircetor of Social Work) were engaged in active dialogue concerning the case, and at times became so involved in discussion that the social worker's chronological account of the case suffered. One of the physicians, filling the role of educator, used the case information to illustrate various facets of geriatric care and understanding.

There was only one interruption to the meeting when a patient came to the door (which was left open), accompanied by a staff person. One of the physicians left the room to speak to the patient. The meeting came to an abrupt end as staff left to keep appointments, leaving the observer with the impression that the interdisciplinary meeting offered a brief respite from the immediate tasks of the day, beyond its educational and informational purpose.

Meeting Two

The meeting room was the same one used previously. An assortment of chairs around the room served as seating, while the Director of Social Work, who was leading the session, took her place behind the table on one side of the room, facing the team participants.

Purpose of Meeting

This meeting was held almost four months after the meeting previously observed. Once again, the Social Work Department had been scheduled to lead the meeting, and this time the Director of

Social Services planned to use the time to provide information on resources and to present a case for discussion.

Team Participants

The meeting commenced with only five persons in the room, but by the time the 45 minute session was over, a total of 15 staff persons were present. Nearly all were the same as those who had attended the earlier meeting and, again, the disciplines represented were medicine, psychiatry, nursing, nutrition, social work, psychology. All except three were female. The males were a senior physician--a respected geriatrician--and two medical internists.

Content of Meeting

The session began with information about new phone devices for the elderly and a note about an upcoming conference and a training session regarding senior entitlements. These announcements were a prelude to the presentation of a case history.

The case, as the one discussed at the earlier meeting, included a wealth of clinical information as well as psychosocial material and behavior problems. The case was that of a female patient/client who had a long history of involvement with the hospital and clinic. Her medical history was detailed and a chronology of contacts with the social work department at the clinic was given. The past history of the patient was colorful and engaged the interest of the team participants. Staff added

comments and attempted analyses but in a somewhat detached manner as the case was the responsibility of the social work department and the discussion was in the nature of an informational, intellectual exercise. No immediate crisis of care was presented.

Attention focused on the nature of the worker/patient relationship and a psychological explanation of the patient's tendency to mobilize help by exhibiting hysteria. There was a difference of opinion here between those staff persons who judged that the patient/client was dependent on ill health and was using the clinic staff and those who felt that there was genuine cause for concern and that the patient might be suicidal. The time available did not allow for more detailed information to be given so a definitive case assessment by this interdisciplinary group was never a real consideration. The meeting ended when the forty five minutes of allotted time had passed and several staff persons got up to leave.

Meeting Dynamics

As at the earlier observed meeting, the atmosphere was both casual and respectful towards the presenter and the information provided. There were a number of questions and comments but the presenter was able to provide much of the case history with few interruptions. Some of the information caused amusement and, at one point, when the details appeared similar to the personal experiences of one of the staff persons present, there was laughter and teasing comments directed to this staff person. Staff clearly

felt comfortable with each other.

As at the previous meeting, several staff persons listened but contributed little to the discussion while others participated more actively. These were two of the physicians, a medical internist, a psychologist and the social work director. While theories were suggested to explain past physical complaints of the patient/client, most interest was reserved for the behavior patterns that were reported. The psychologist asked a number of questions regarding the psychosocial assessment and offered theories regarding the motivating factors for the behavior and coping mechanisms of the case subject. The senior physician used the case presentation to teach the staff and drew analogues with other cases and situations.

Impressions of Meetings/Social Work Role

These clinic meetings were both structured, in that there was a definite planned agenda, led by one of the clinic departments, and also informal, in that staff entered at any time through the 45 minute period and felt free to interject, ask questions and comment. The sessions were used as an educational forum in that the senior physician used the cases to illustrate some fundamental truths about working with the older population, and drew analogies to other cases. In addition, staff from all the disciplines provided information from their respective fields to shed light on the case and offer possible theories and treatment suggestions. This information was of a nature that would be useful in other

contexts and with other clients/patients.

Some of the staff remained silent but there was a general air of interest and attentiveness. There was also a collegial atmosphere. Staff shared concern over the welfare of the clients, sadness over the reported death of a patient, and amusement, when appropriate, concerning references that were viewed as 'in-jokes.' At the same time, there was respect for each of the disciplines' special expertise and differences of opinion regarding analyses of the two cases were accepted.

As both these meetings were the responsibility of the social work department, the social workers necessarily took a leadership role. At the same time, due to the fact that the social workers were presenting cases for general discussion, the presenting social workers held back their own insights and case analyses until other staff views were expressed. Only when the views given were contrary to the social work determination did the social workers counter these views with their own judgements. Thus the social workers were initiators and informers but also acted as mediators (due to their superior familiarity with the cases being presented) and filled the group maintenance role. The social work role, when the social work department is not responsible for the meeting, is likely to be somewhat different.

While both these sites, in which interdisciplinary group meetings were observed, were community based settings, they differed in a number of respects. A discussion of these differences, including the impact they have on the work of the

social workers, follows.

Interdisciplinary Team Meetings in the Community Care Setting

Differences Between the Sites

The two community care settings, the V. Amway Center and Plainvista Clinic, differed markedly in their interdisciplinary team structure and focus. At the first site, the V. Amway Center, the meetings were task focused and held for the purposes of fulfilling mandated requirements for record keeping and the development of treatment plans and care goals. The meetings at the second site, Plainvista Clinic, were convened for a totally different purpose - general education and information.

The V. Amway Center team meetings were attended by persons representing a limited number of the disciplines involved in the cases being discussed. Due to programming and time constraints, several key members of the interdisciplinary care group were not present. These provided input and gained needed information through interdisciplinary contacts outside the team meeting. Participants at the Plainvista Clinic meetings represented all the various disciplines but they, too, exchanged information and consulted on an interdisciplinary basis outside these meetings. In this case, the meetings were in the nature of departmental educational gatherings.

Similarities Between the Sites

In spite of these major differences, a number of similarities existed. The members of both team groups knew each other well and respected each other's views. The regular meetings had been part of the settings' cultures for a long time and were accepted as part of the established routine. In addition the staff members, with few exceptions, had been in their staff positions for a number of years and were comfortable with each other. In informal discussion after the meetings, the team members identified the length of time that they had worked together as one reason why they felt comfortable with each other and were able to collaborate easily. They had developed meeting formats that were predictable and allowed for discussion, disagreements, and shared laughter in an atmosphere of informality even while there was adherence to the objectives of the meetings.

The team meetings at both the sites occurred in an institutional setting where community care was not the primary function. One of the groups was located within a nursing home facility and the other in an acute care hospital. Thus both Center and Clinic were part of a larger institution but the staff's work with the community living elderly lay outside the institutional procedures which were focused on care and treatment of persons in the residential setting. Being part of a larger setting enhanced access to additional resources but at the same time the community care clinic/day care center was perceived as separate from its host

institution, allowing it the freedom to establish its own norms and culture. In addition, the older persons using the day center and clinic facilities were possessed of another world outside the facility and were visitors only to the institution, not bound to most of the institutional regulations which affect those living there.

Element of Time

The team meetings were constrained by time. It is clear that there was a limited amount of time available for discussion, which resulted in abbreviation of the interdisciplinary consideration of the presented cases in the meetings held at Plainvista, which held an educational focus. On the other hand, at V. Amway Center, in spite of lack of sufficient time, the team members did not compromise or develop case management plans without full consideration of the issues. The meetings were task oriented and when the desired work was not accomplished in the time available, the team was able, on at least one occassion, to schedule an additional meeting later in the workday to complete the tasks before the group.

From another perspective, time might be viewed as plentiful. The community setting provided the framework for a different pace than was found elsewhere. Except for the need to complete records and forms-which was real, there was little perceived urgency to make decisions regarding treatment and care. The time available to those caring for older persons in the community was more generous

than for those in the acute care setting and this allowed the members of the interdisciplinary teams the luxury of testing various forms of treatment or of postponing treatment until additional reports/assessments were received from other disciplines as needed. There was a sense of distance from the issues but this might also be due to the fact that the health care teams held limited authority over the treatment regimens and limited control over the outcomes of their work. They had to contend with the external influence of the community on each patient/client and the other, 'outside' services utilized by each older person.

The Social Worker as Member of the Interdisciplinary Team in the Community Setting

The Social Worker's Role

In both sites and at all four team meetings attended, the team meetings were led by social workers. At Plainvista, the two meetings observed were those for which the social work department was assuming its regular turn of responsibility for leadership of the meetings. At the V. Amway Center, it was the recognized, ongoing role of the social worker to take the chair and lead the meeting, although at the first observed meeting, the Director of the Center, also a social worker, assumed the leadership position in her capacity as Center Director. (See Table VI-1)

In the leadership role, the social workers were initiators and took a major part in offering information for discussion. This information was not limited to psychosocial information but also covered medical, clinical issues, diagnoses, and treatment modalities. The social workers also undertook to explain the diagnoses and treatment when needed--both the psychosocial diagnoses as well as the medical ones, although the nurses and physicians, when present, often provided the explanations for these. The social workers also offered opinions and involved other members of the interdisciplinary teams in sharing their own professional expertise. In the role of team/meeting leader, the social workers assumed a lesser responsibility for group maintenance and mediation, sharing these roles with others. When differences of opinion arose, the social worker acted as mediator, but if the social worker, herself, was promoting one viewpoint or analysis, the role of mediator was then filled by another member of the team as being more neutral on the issue under discussion.

Knowledge Areas Demanded of the Social Worker

All of the seven knowledge areas, identified in the literature as needed by members of an interdisciplinary team, were required by the social workers in the community care settings. The social workers needed to know not only medical terminology and procedures but, further, the expected course of clinical procedures, the potential outcomes, and implications of specific actions.

Knowledge was required in all the identified areas though it was apparent that more knowledge was needed, and displayed more frequently, in the categories of medical procedures, community resources, family dynamics and psychosocial dynamics than in the areas of entitlements, rules and regulations and the specific setting and its administration. This is not to say that the observed social workers held less knowledge in these areas but that less was required of them in the specific meetings that were observed.

Skills Exhibited by the Social Workers

A similar caveat must be used when reflecting on the observed skills of the social workers, i.e., the noted skills were those that were used by the social worker and the fact that other skills were not evident might be due to the absence of need for them.

Cognitive Skills

The cognitive skills displayed follow the pattern of the knowledge areas that were required. The social workers, at both sites and in all four meetings, exhibited high cognitive skills in the realm of family dynamics and ethics. Cognitive skills in provider/patient relationships were present but not always apparent, while knowledge of care of the elderly and organizational systems were the areas in which cognitive skill was least exhibited. This is hardly surprising as the interdisciplinary team discussions that were observed demanded less knowledge in these two

areas.

Technical Skills

Problem identification, problem solving, and communication were technical skills exhibited at a high level. Decision making and team maintenance were utilized, almost as a logical extension of the team leadership role. Least apparent were the skills of task differentiation and role negotiation, perhaps due to the fact that there was little need for such skills among collegial peers that were used to meeting together to discuss client/patient care.

Interpersonal Skills

The identified interpersonal skills were all observed. All the social workers exhibited a strong commitment to interdisciplinary collaboration. This was evident, both in their demeanor in the team meetings and in conversations outside the environment, in which they reflected on their part in an interdisciplinary team.

Displayed at an equally high level were the interpersonal skills of clear communication, courage, openness and trust. The ability to listen to other members of the team, to provide feedback as needed and to share power with others if necessary were also common traits. Flexibility was a less observable skill, perhaps because the team leadership role filled by the social workers tended to preclude these skills from emerging. As team leaders, the social workers held responsibility for refocusing discussions

and moving the team members towards decisions within the time available. Flexibility was rated at a high level only in the one meeting in which the social worker was not filling the leadership role.

Further discussion and comparison between settings, concerning the geriatric social workers' roles and skills, follows in Chapter IX.

TABLE VI-I

Knowledge, Role and Skills of Geriatric Social Workers as Members of Interdisciplinary Teams in the Community Setting

	Community Care Setting I		Community Care Setting II	
	Team Meeting 1	Team Meeting 2	Team Meeting 1	Team Meeting 2
Knowledge Areas Required				
Medical Terminology/Procedures	X	X	X	X
Community Resources	X	X	X	X
Setting--admin./procedures	O	O	X	O
Entitlements	X	X	X	X
Family Dynamics	X	X	X	X
Rules, Regulations	O	O	O	O
Psychosocial Dynamics	X	X	X	X
Role of Social Worker				
Leader	X	X	X	X
Follower	O	O	O	O
Initiator	X	X	X	X
Group Maintainer	X	O	X	X
Mediator	X	X	X	O
Informer	X	X	X	X
Skills Exhibited				
Cognitive				
Care of the Elderly	M	M	M	H
Family Dynamics	H	H	H	H
Provider/Patient Relationship	M	M	H	H
Ethics	H	H	H	H
Organizational systems	M	M	H	M
Technical				
Problem Identification	H	M	H	H
Decision Making	M	H	M	M
Problem Solving	H	H	H	H
Role Negotiation	M	M	M	M
Task Differentiation	M	M	M	M
Team Maintenance	H	L	H	H
Communication	H	M	H	H
Interpersonal				
Ability to Listen	H	M	H	M
Openess/trust	H	H	H	H
Clear Communication	H	M	H	H
Provide Feedback	H	H	H	M
Courage	H	H	H	H
Share Power	H	H	H	M
Commitment to Collaboration	H	H	H	H
Flexibility	H	M	M	M

X=Yes O=No H=High M=Medium L=Low

CHAPTER VII

SOCIAL WORK AND THE INTERDISCIPLINARY TEAM IN THE RESIDENTIAL CARE FACILITY SETTING

As with the observations of team meetings in the community care settings described in the preceding chapter, two long term care sites were selected for the purpose of observing interdisciplinary team meetings and the role and function of the social workers within them. Two visits were made to each site.

Horseshoe Nursing Home

Horseshoe Nursing Home is a large, skilled nursing home facility in New York City. It is situated on a tree lined side street, a few blocks away from a main commercial thoroughfare. Taking up almost the entire length of one side of the block, it is surrounded by residential brownstones, churches and small, privately owned apartment buildings.

Setting

The nursing home has over 500 beds, including an Alzheimer's Disease Patient unit. The building is old with high ceilings and

long corridors, though brightly decorated and modernized where possible. The ethnic and cultural characteristics of the residents reflect the surrounding community - white, African American, Jewish and Catholic. Staff are from all ethnic/cultural backgrounds.

On entry a visitor is immediately struck by a sense of involvement and activity on the part of residents, staff, family visitors and volunteers. There is much chatter and laughter in the lobby as people come and go, older volunteers and residents sell crafts, residents wait for transportation for day trips or just take in the scene, and younger volunteers help with wheelchairs and run errands. The walls are hung with art by the residents and notices of upcoming activities.

The team meetings that were observed were two of the regular team meetings held each week on each of the floors. The purpose of the meetings is to discuss each resident, agree on care plans, and meet as a team with family members when the resident is newly admitted or when a change in care or treatment is being made. Family members might also request permission to meet with the team or the social worker may suggest that a family member does so, dependent upon the circumstances. The meetings are also used administratively to maintain the written case reports and obtain the necessary staff signatures on the records for each resident. This is mandated by the New York State Department of Health as part of the surveying process and licensing of every nursing home facility. A written plan of care must be developed, agreed to by each discipline and updated at intervals.

Two meetings were observed, on consecutive weeks, on one of the facility's floors. The meetings on this floor were held mid-morning and mid-week in an unoccupied resident's room. The room was empty except for a bed, night stand, a few chairs and the closet. Additional chairs were brought in as needed as the meeting members assembled, and were placed in a rough oval in the available space between the bed and the closet.

Meeting One

Purpose

The purpose of this meeting was to review the treatment goals and care plans for the residents on the floor. This is done for each resident on a regular basis and the cases for several residents are considered at each of the weekly meetings. At this first meeting, family members of two residents had been invited to join the staff for discussion of their relative's care plans. The remaining cases to be discussed were those that were due for review.

The NYS Department of Health requires the completion of standard forms and these have to be signed by each of the disciplines to indicate agreement and to show that each discipline represented on the care team is familiar with the care plan to be followed. The meetings, with all relevant staff gathered together, become a means for the efficient collection of the required signatures. The records are kept in large bound folders at the nurses station and are the responsibility of the nurses on the

floor.

Team Participants

Eight staff persons attended the entire one hour meeting and four others attended for a portion of the time. One of these, a nurse's aide, joined the group for the case discussion of one of the residents under her care. The other three came and went as work responsibilities allowed. Two family members also joined the meeting at appropriate points when their family members were being discussed.

The disciplines represented in the meeting were medicine, nursing (including nurse's aides), social work, speech language, dietary/nutrition, and recreational therapy. All the staff were female, except for the physician, and represented a variety of ethnic and cultural backgrounds.

The social worker took responsibility for alerting the staff on the floor that it was time for the meeting. It is held at the same time each week but may be convened in a different location depending on the space available. The atmosphere was cheerful with members greeting each other and there was some minutes of small talk and interaction informally while everyone assembled, some bringing in additional chairs to accommodate everyone. One of the nurses was responsible for bringing the resident records to the meeting from the nurses' station at the end of the hallway. This nurse 'managed' the meeting by keeping a record of which cases were

to be discussed, making sure that the team participants did discuss the correct cases, and collecting the necessary signatures from staff for each record when it was updated. The physician sat at the head of the oval of chairs, facing the doorway, and initiated the formal proceedings by asking for information on the first scheduled case.

Content of Meeting

This first observed meeting at Horseshoe covered 9-10 different cases, including a transfer case to another facility and a new admission. Staff reviewed cases that were due for review, (not necessarily because of any specific problem), as well as those cases requiring the mandated quarterly review. In those situations in which staff judged there to be no need for change or when a former care problem had been resolved and no longer existed, little time was spent in discussion. These case reviews occupied two to three minutes at most.

The transfer and new admission cases were routine and consisted mostly of the opportunity for the family member, in each case,to meet with the staff and ask questions, and be informed of the procedures. Little team discussion was held but time was taken to explain procedures to the family member and convey the message that the nursing home staff were caring and available. The family members had been informed of the meeting time ahead of the meeting and were waiting in the hallway to join the group at the appropriate moment. The social worker brought them into the

meeting room, introduced them to staff with whom they were unfamiliar, and escorted them out at the conclusion of the discussion.

Two cases involved greater discussion and evoked interest. In one of these the written records appeared to be contrary to staff observations regarding the care problem. Problem behavior recorded in the past had been forgotten and was no longer apparent, while weight loss that was being exhibited appeared to be causing the resident no difficulty and there was some debate as to whether these changes even meant anything worthy of being recorded. Once placed on record, care management goals would have to be identified and yet there seemed no need for any change in care. Staff were divided over whether the weight loss was significant or not.

The second case that prompted a lengthy exchange of information, was of a female resident, fairly new to the nursing home facility. The resident was exhibiting some confusion and persistently voiced a request for a specific recreational activity. While some staff saw this as a manifestation of her confusion, several staff present at the team meeting confirmed that this recreational activity was a major part of the resident's former life and that the family was arranging for her to continue this interest. In light of this information, the requests and comments of the resident were reevaluated as appropriate.

Throughout the hour, as the treatment plans were confirmed or new treatment goals established and updated, the nurse wrote up the team decisions and circulated the case records for the appropriate

signatures. Much attention was paid to this task of "signing off" on the cases, and discussion of the next case was delayed until all the required disciplines had signed, indicating their knowledge of and agreement with the treatment goals.

The meeting concluded after one hour. Details were given regarding the cases to be reviewed the following week, and staff returned to their responsibilities on the floor. A few remained for a last minute sharing of information concerning one resident and then, they too, hurried away.

Meeting Dynamics

There was a welcoming, cheerful atmosphere. Staff arrived over a period of several minutes at the beginning of the meeting. Though the meeting time was established by past routine, the meeting location was likely to change from week to week and so several team members entered the room to confirm that this was the meeting place and then left to find a chair for themselves and/or to alert other staff that they would be in this particular room for the period of the meeting. While the staff gathered in this fashion, those in the room waiting for everyone to assemble, engaged in cheerful, informal conversation.

Throughout the hour, there was a sense of ease. While the work was accomplished, team participants treated the activity as a pleasant routine, serving as a respite from the tasks awaiting them outside the door. The cases under review were treated seriously

but the meeting was viewed as a means of completing the necessary forms in a timely fashion rather than as an opportunity to assess a resident's welfare in depth or to solve problems. Problems were identified and long term solutions were placed on one side for further consideration outside this particular meeting time. Respect was shown to the family members that joined the group at the appropriate times and team members expressed empathy and support for the concerns of these family members.

Discussion and conversational exchanges were conducted in an informal manner. Frequently several staff persons spoke at once, indicated agreement with what someone might be saying, or became involved in handing the recording forms back and forth in the process of collecting the required signatures for each case being reviewed. There were a great many comments concerning these forms. Staff went in and out of the meeting as necessitated by activities outside the room, and, for one case, a specific nurse's aide was asked to join the group. Thus there was a constantly shifting group of persons in attendance with a total of fourteen persons being involved at one time or another.

Meeting Two

This second meeting was held on the same day of the following week. Regularly scheduled for the same time each week, the purpose also remained the same--that of reviewing resident's case records on a cyclical basis and affirming or altering assessment and treatment goals. Once again, the meeting was held in an unoccupied

resident's room, with chairs grouped in the available space between bed and closet.

Team Participants

A total of ten staff persons were present for all or some of the meeting. Of these only the physician, the social worker and the dietician were the same persons as had attended the previous week. The remaining seven staff persons were substituting for members of their departments who were either absent, on vacation, or involved in care responsibilities and tasks that could not be postponed. Apart from medicine, social work and nutrition, the disciplines represented were recreational therapy, occupational therapy and nursing. A Physical Therapist also attended which was identified as an unusual occurrence, due to work responsibilities which generally resulted in her absence.

The meeting commenced with seven staff persons and the others arrived a few minutes later. A nurse, substituting for the nurse from the previous meeting, arrived fifteen minutes into the meeting time in response to a request by the physician. All were female except for the physician.

Content of Meeting

A total of twelve cases were reviewed, including some additional quarterly review cases. The impetus for this was due to the fact that there was to be no meeting the following week when some quarterly reports fell due, and so an effort was made to

review these cases now. Thus most of the formal meeting was taken up with reaffirming the existing treatment plans and not on specific issues and residents' problems.

The physician chaired the meeting in that he opened the proceedings by asking for information on the first case to be considered and moved the discussion from one case to the next. The nurse, in charge of the case folders and forms, facilitated the order of the cases to be discussed.

Little time was afforded each case record but when changes were identified between that recorded in the past and present observations, discussion followed. A previous report of bedsores experienced by one resident led to a detailing of the treatment that had been inititated and carried out successfully by the dietary, occopational therapy, and nursing departments. There was discussion over the use of restraints for another resident. The evaluation forms "triggered" the need for restraints but staff felt this was not needed. Alternate care plans were defined. A review of another resident's case revealed that the resident was losing weight but that there appeared to be no clear reason for this and, contrary to the former case, the forms did not "trigger" for a nutritional evaluation. Time was spent in discussing the efficacy of the required assessment and treatment forms themselves.

Meeting Dynamics

There was an air of frustration that pervaded this meeting, due to two considerations. Firstly, as the majority of those

participating were substituting for others from their departments, many of the participants were not familiar with the forms that had to be completed and there was some confusion. The nurse who was responsible for the records did not usually fill this role and while she and others struggled with what was required, debating how to complete each form, other team participants engaged in background conversation.

Secondly, there was a lack of leadership as participants tended to defer to the physician to take responsibility for how the meeting progressed and, while he did lead discussion on the individual cases, the task of moving the meeting from one case to the next was not readily assumed by any person.

In spite of this general frustration, the participants were comfortable with each other, able to question case assessments and to accept being questioned. There was a feeling of camaraderie and participants teased each other, discussing vacation needs, and comparing their style of resident care with that of other facilities.

Informally and outside the task of completing the forms, staff took the opportunity of being together to request and receive feedback from other departments regarding cases that needed attention, and to secure the physician's signature on care orders. When the meeting ended, most of the participants returned quickly to their responsibilities on the floor but several remained to clarify and determine care plans with each other.

Impressions of Meetings/Social Work Role

Staff did not find it easy to find time in the day to meet together and the social worker took the part of shepherding the team members together. However the meetings were not resented. Staff appeared to enjoy being together, though it was clear that they were present for a purpose and there was little wasted time. The meetings were seen less as a chance to discuss issues and residents' problems but rather as a means of meeting the reporting regulations.

The necessity of completing the required forms and signing off on the treatment plans dominated the meetings. The observations of the meetings occurred soon after the introduction of 'new' forms and the staff were still becoming familiar with them. The forms involve a number of evaluative categories which are designed to identify potential problem areas that need to be addressed. There was general agreement and frustration among team members that the forms did not always trigger the problems that the staff knew were present and, on other occasions, suggested problems that were not real. The meetings were often focused on the successful completion of the forms and time was taken in passing the forms around to each team member to gather the required signatures. This was exacerbated in the second team meeting as several of the team members were substituting for others and were not always familiar with the forms. After the team meetings, staff reiterated to the observer their frustration with the forms and reporting procedures.

The predominance of the forms meant that the keeper of the forms, the nurse, was the acknowledged leader of the meetings. It was she who determined the content and order of discussion. Once a resident's case was offered for review, the physician took the lead in reviewing the treatment plan and was deferred to in this regard.

The discipline specific knowledge of each staff person was respected and, conversely, when a discipline was not represented but it's expertise was needed, staff were comfortable in filling the specific role and providing information to each other. On occasion, the team agreed that a missing staff person should be consulted in regard to a particular issue. Team participants showed confidence in each other's abilities.

The social worker filled a variety of roles, some of which conflicted. In the first meeting, the social worker's chief responsibility was with the family members who attended while their relative's situation was under review. The social worker 'hosted' the family member, bringing him/her into the room at the appropriate time, introducing them to the team members, and seeing that their concerns were aired. The recommended procedures and decisions were interpreted to the family by the social worker if necessary and the social worker briefly left the meeting with the family members to answer any further questions they might have and assist in any follow-up plans such as arranging for transportation.

Attention to this responsibility towards the family members took precedence over the other roles of the social worker in

relation to the team meeting. These roles included the initial convening of the team group and assisting the nurse facilitator in the overall facilitation of the content and flow of the meetings. In the second meeting it was the social worker who went in search of the nurse, who was absent at the start, and who, later, again left the meeting room to fetch needed charts so that a resident's past history could be verified. The social worker took a proactive role in encouraging, through questions, the input of team members and making sure that the opinions and evaluations of the nurse's aides were given a hearing.

Fenimore Cooper Nursing Home

This large long term care facility is situated in New York City and is sited between a wealthy residential area of large apartment buildings and established homes on one side and an area of new immigrants, poverty, and decaying apartments on the other. The building occupies half of the block and acts as a stabilizing force in the community.

Fenimore Cooper Nursing Home has almost 500 beds, both skilled nursing and health related, and administers a variety of ancillary programs - home care, adult day care, rehabilitation programs etc. The facility is closely tied to a large teaching hospital for purposes of education, research, and shared resources. It holds a strong religious affiliation which is reflected in its administration but its doors are open to members of all faiths and backgrounds. The residents are white European, African American and Latino, mostly Puerto Rican.

Setting

Each floor of the nursing home operates as a distinct unit with its own activity/day room and a team of staff to provide the necessary services for the residents. Each floor holds interdisciplinary team meetings on a weekly basis. The observer was assigned to one of the floors.

The team to be observed met weekly in the late morning on a regular basis. The meeting was held in the day room. This was a

large room with a doorway in the middle of one long wall leading out to the central corridor. Just outside the door was the nurse's station and focus of the floor, around which both residents and staff congregated. The day room, itself, was furnished with easy chairs, bookshelves, and a television. Windows ran the length of one wall. One half of the room was left as open space and in the other half there were tables and chairs.

Meeting One

On arrival at the facility, I was met by the social worker, a member of the interdisciplinary team on this floor, and escorted to the day room to await the beginning of the meeting. It was indicated that the meeting would take place around one of the tables at one end of the room, and the social worker left to alert the other team members of the time. A few residents were seated in the room but left at this point. The Rehabilitation Specialist arrived moments later and took responsibility for bringing sufficient chairs over to the table. Every team member had a "special place" at which to sit and I was invited to take a chair placed at one of the table corners. Almost immediately the remaining team participants arrived and took their positions around the table, and I found I was seated next to the social worker's usual seat.

Purpose of Meeting

The reason for the weekly meetings was to review the care and

treatment plan for each resident on the floor. Regulations require that care plans be drawn up and reviewed on a regular basis for each person living at the nursing home, and that a team approach be taken in developing the care plans, with representatives of the various disciplines "signing off" on the written care goals.

Team Participants

There were seven staff present at the first meeting. These were a physician, nutritionist, nurse, social worker, rehabilitation specialist, psychiatrist and pharmacist. All the participants, save the psychiatrist, were female. The physician, who was to chair the meeting, sat in the center along one side of the table.

The meeting began promptly with all present except for the pharmacist. After a few minutes the psychiatrist left to deal with a work related issue but returned after a few minutes. The pharmacist arrived a little later. She was substituting for another staff person and not a regular member of the team. There was one other interruption when a resident came to the doorway to see the physician and the physician left to stand in the corridor and speak with the resident. The team meeting was put on hold and all discussion ceased until the physician returned after a couple of minutes.

Content of Meeting

The meeting's content was to be a review of a number of

residents' case records. Before this formal part of the meeting began, there was a review and explanation of the new forms for my benefit. This was to assure that I understood the regulated process of review, as mandated by the NYS Department of Health. There was general agreement by all the staff that the new forms were too structured, tended to confine the handling of each case and were frequently misleading. The forms were designed not only to facilitate planning for care but also to alert care providers to potential problems. The pitfalls in this were borne out during the meeting when the information entered on the form for one resident indicated (flagged) that the resident was in danger of falling. This idea was greeted by surprise and derision by the team participants as none of them, knowing the resident, judged this to be valid. The resident's scores on a variety of items pointed to a risk of falling but staff believed that the resident was in no peril.

The meeting was structured. It was the responsibility of the nurse to be in charge of the records and she brought in all the large ringbinders containing the charts and case histories of the residents to be discussed at the meeting. The physician led the meeting. The nurse identified each case to be discussed and then the physician briefly reviewed the case history, giving both the medical and the psychosocial histories, and referring to current problems, if any. After completing this precis, she asked questions of the team participants and they responded accordingly and offered their own opinions. Five cases were reviewed in this

fashion.

At this meeting there was little problem solving except in relation to the case of one resident. This one resident was showing signs of dementia and there was much discussion concerning the cause of this and whether the dementia justified the use of a health proxy. Medications, nutrition, and general activities were considered in an attempt to evaluate the extent and cause of the dementia. Much of the discussion on this case was led by the psychiatrist who was clearly most familiar with the situation.

Meeting Dynamics

The team participants were comfortable in their roles and in the team setting. The meeting was conducted quite formally with staff following the lead of the physician and waiting for the formal review of each case before reacting and raising new issues. Participants were courteous to each other and there were few interruptions when one person was speaking. There was a sense of equality, with each person's opinions being valued. Little disagreement was in evidence.

The pharmacist, not usually in attendance, contributed little, but most of the team participants were vocal and each, at various points, filled the role of teacher, explicating either a specific treatment or symptom of a resident under discussion. The meeting time was an opportunity for the team members to explain their assessments and treatment plans to each other.

The door to the day room was open throughout and occasionally

residents came in to speak to members of the staff who were involved in the meeting, but, on the whole, it appeared that residents were used to the regularity of the weekly meeting and were used to leaving the staff uninterrupted and the day room free for this time period.

Meeting Two

The second meeting observed at this site took place one week later. The same room was used and chairs were pulled up to a table at one end of the room as in the previous meeting. This time a few residents remained in the room throughout the meeting, sitting at the sides of the room and, perhaps, listening to the discussion. Several other residents in wheelchairs clustered in the open doorway, watching the proceedings for a few moments and then moving away.

Purpose of Meeting

As at the earlier meeting, the purpose was to review resident's cases, updating treatment plans where needed, and to complete the required forms on schedule. This week also both the social worker and the psychiatrist took the opportunity of having the team participants together to raise specific questions and concerns they held in regard to specific residents. The meeting was to be a forum for discussion and the sharing of information.

Team Participants

This week there were eight staff persons present. Five of them had participated the week earlier--the physician, social worker, psychiatrist, rehabilitation specialist, and nurse. In addition to these returning participants, there was a nutritionist, an occupational therapist, and pharmacist. Once again, all, save the psychiatrist, were female.

The occupational therapist arrived a few minutes after the beginning of the meeting and had to leave before it ended. The psychiatrist arrived about a third through the time allotted for the meeting.

Content of Meeting

As a week earlier, five cases were identified for review. The nurse was in charge of keeping the case records and forms up to date and she took responsibility for indicating which case should be discussed. The social worker assisted in collecting together the pertinent ringbinders on each of the residents to be discussed.

The structure was less formal than the week earlier. The physician began each discussion by giving a synopsis of the resident's record and then all staff members gave input as needed. The nurse took charge of securing the staff signatures on the treatment/care plan as mandated. There was greater problem solving in this meeting and participants shared detailed information on resident's behavior in order that staff might understand the dynamics fully. One case focused on the relationship between a resident under review and her roommate and the impact this was

having on the resident. Another situation involved a resident who was screaming and calling out, bothering other residents and staff, and there was a lengthy discussion over the optimum means of controlling this behavior while not harming the resident in any way.

Questions about two additional residents, whose care plans were not scheduled to be reviewed, were raised by both the psychiatrist and the social worker respectively. In both situations, information was requested from the team participants to assist in the development of an appropriate plan of care.

Meeting Dynamics

A similar format was followed to that of the first meeting, i.e., the physician presented the medical and social history of the particular resident being reviewed and then the other team participants added information and their opinions. Several of the cases discussed in this meeting posed problems needing solutions and the team members spent time in seeking answers and determining the most appropriate care to be offered.

Though all team members participated, the discussion tended to be dominated by the physician, social worker, nurse and rehabilitation specialist. These four formed the nucleus of the team. The psychiatrist contributed only to the discussion dealing with residents in which he held an immediate concern and direct knowledge. The occupational therapist was only able to be present for part of the meeting but she contributed as needed and after she

left, when an issue arose that required her specific knowledge, the team noted that her input should be sought. It was unclear which team participant would take responsibility to inform her regarding the case decision and elicit her suggestions, but it was clear that the social worker enjoyed a close working relationship with her and would be the most likely person to follow up.

Team participants respected each other's viewpoints and information was shared freely. Individual staff tended to hold close relationships with specific residents, regardless of the staff member's own discipline. In such situations the staff member closest emotionally to a resident would offer an assessment of the needed care and be listened to even when the knowledge and personal assessment covered areas usually dealt with by another discipline. There were no turf battles.

Impressions of Meetings/Social Work Role

The staff on this floor of the Fenimore Cooper Nursing Home had been meeting as an interdisciplinary team for some time, and the social worker, physician, and rehabilitation specialist had worked together for a number of years and so knew each other well. They respected each other's expertise and this contributed to a smooth functioning of the team. The team participants were glad to be with each other. The physician was acknowledged as the leader but everyone felt comfortable about bringing concerns and raising issues.

There was a businesslike atmosphere to the meetings and staff

wasted no time in general conversation but began, immediately, to focus on the case records to be reviewed. Genuine concern was shown for each of the residents being discussed and when problems were identified that were not immediately solved, agreement was reached concerning what further information was needed.

The physician, in reporting on each case record, described the psychosocial aspects of the resident's life at Fenimore Cooper and the relationship with the family, as well as the medical, clinical history. And throughout the following discussion, the physician and other team members, as well as the social worker, would include analyses of the psychosocial dynamics in their comments. This would appear to usurp the role of the social worker but, as an indication of the mutual respect between the team participants, this was not viewed as competitive.

The social worker, in addition to providing information concerning the social aspects of each resident's history, also asked questions of the team participants in regard to specific psychosocial dynamics, thereby eliciting the necessary information on which an appropriate care plan could be based. For instance, discussion of one case centered on the demands by the community living spouse for special care of her husband and the impact this had on the husband as a resident. The social worker first provided information, then analysed it to explain the demanding nature of the spouse, and followed up by asking questions of team participants regarding the resident's ability to relate to others at specific times. This discussion generated sufficient

understanding of the psychosocial dynamics so that an informed treatment plan could be established. In this and similar discussions in both team meetings, the social worker also filled the role of teacher, by analyzing the known psychosocial aspects of a case situation and explaining the implications for care.

Interdisciplinary Team Meetings in the Residential Care Setting

Differences Between the Sites

The two nursing home sites of the interdisciplinary teams were very similar but, nevertheless, there were some differences which affected the manner in which the interdisciplinary team meetings were conducted and impacted upon the role of the social worker.

The team meetings at Horseshoe Nursing Home were viewed as a means of bringing together the staff on one floor of the nursing home on a weekly basis but they were also used as an opportunity to meet as a team with family and friends of the residents. Thus an additional element was introduced with family members being included in the meetings for short periods when the care of their relative was being discussed. This added to the tasks of the social worker who was responsible for arranging with the family member to be present and then making sure that the family member was brought into the meeting at the appropriate time and, after the discussion ended, escorting the family member out of the room and answering any follow up questions and issues that might be raised. Though the family member might be familiar with most of the team

participants, there were generally a few staff members that were unknown and entering the room to be faced by a group of persons tended to be intimidating. At the Fenimore Cooper Nursing Home, meetings between staff and family members took place at other times, outside the interdisciplinary meetings, and the social worker was able to remain in the room for the period of the meeting without being drawn away.

On the other hand, the Horseshoe Nursing Home meetings were held privately in an empty room, and interruptions by other staff and residents were minimized. There was the disadvantage of not owning a regular meeting space and staff had to be informed of the whereabouts of the meeting each week but, once convened, the meetings were private. The team meetings at the Fenimore Cooper Nursing Home were open to the life of the nursing home floor and subject to interruption. Though the interruptions were minimal, the potential existed and team members could be distracted by what was happening around them. Conversely, the meetings interfered with the residents' choice of where they spent this time period. This lack, in both nursing homes, of a delineated space for the team meetings did not appear to be indicative of low prestige and importance granted the interdisciplinary team but was due to a real lack of space. Both nursing homes are housed in fairly old structures that, when built, made no accommodations for staff meeting areas on the same floors as the residents' rooms.

Similarities Between the Sites

In spite of the privacy sought by the Horseshoe Nursing Home team, both sites were similar in that the team meetings were held amidst the life of the nursing home in which the staff worked. A time was set aside for the team meetings but because the life of the nursing home facility could not be placed on hold, it proved difficult for the team members to guarantee that they could attend each meeting. Each team member was subject to being called away from the meeting or being prevented from attending due to a work situation that required immediate attention.

The team meetings were all dictated by the necessity to establish treatment goals and complete care plans on a regulated basis. During the period of the team observations, the required forms issued by the NYS Department of Health had only recently been introduced. Staff were still not completely familiar with them and were uncertain of their usefulness. This created some confusion and much frustration and, at both of the sites, team participants complained about the forms and spent time in critiquing them.

Universal acceptance of the mandatory nature of the record keeping meant that the case records themselves tended to take a central role in the team meetings and to interfere with a focus on each case situation. This tendency was clearly illustrated in the meeting at the Horseshoe Nursing Home in which the team participants decided not to record certain information on one resident because no justifiable treatment goal could be identified to correspond to the information. The interdisciplinary meetings

were viewed as a means of accomplishing the required paperwork, rather than of problem solving, and much time was spent in gathering the necessary signatures from the various disciplines regarding the treatment plans. This activity took time away from interdisciplinary discussion. However, when disagreement surfaced over the exact treatment goal to be specified, the disagreement led to interdisciplinary discussion, sharing and decision making. Thus, even if a discussion was motivated initially by the record keeping mandates, the result was an interdisciplinary focus on the older resident/client.

Element of Time

Interdisciplinary meetings in the nursing home setting operated under two different time dimensions which dictated the intensity and flow of the deliberations. The differing time elements created different frameworks for the meetings and these were frequently contradictory. In the first place, the immediate objective for each meeting was the completion of treatment plans and goals of care for the residents being reviewed. The external mandate called for the completion of these records on a regular basis and state surveyors, when visiting the nursing home facilities to evaluate the level of care, were expected to monitor the case records and treatment plans. There was a sense of urgency regarding the timely processing of each record which moved the team deliberations forward.

In contrast to this sense of limited time in which to

complete the team tasks, there was the extended time which is afforded to members of an interdisciplinary team within a nursing home setting. In most instances, the issues and problems presented by residents do not require crisis interventions. The issues are not acute. The team participants were dealing with persons within long term care and had the luxury of time in which to collect further information on any specific issues, to "wait and see" in situations that were perplexing, or to attempt a treatment plan that could be altered at some point in the future if the original goal appeared ineffectual.

Connected to this perception of time available and adding to a diminished sense of urgency, were two advantages held by staff within a nursing home facility. One of these was that the residents in the nursing home were known to the staff. The residents had been observed in all aspects of their daily routines, their interests and family backgrounds were known, and for each resident's case under review, one or more of the team participants was close to the resident, knowing intimate details to an extent that is rarely possible for team participants working with older persons in a non-residential setting.

The staff in a nursing home facility are also able to control the treatment and care without being subject to the vagaries of an external home environment or unknown, outside forces. The residents were living within an institution and, however much independence and individual freedom was promoted, the staff were necessarily in a position of power in relationship to the

residents. This ability to manage and control what happened to the residents and the knowledge that there was time for orderly planning, was reflected in the interdisciplinary team discussions.

The Social Worker as Member of the Interdisciplinary Team in the Nursing Home Setting

The Social Worker's Role

At all four interdisciplinary meetings observed in the nursing home setting, the physician took the leadership role. The nurses were responsible for managing the case records, writing up the treatment goals, obtaining the necessary signatures, and identifying which residents' cases were scheduled for review and the position of chair of the meetings was filled by the physicians. However the social workers were recognized as core members of the teams and were not seen as followers. It was the social worker at the Horseshoe Nursing Home that determined where the meetings would be held and both at Horseshoe and at Fenimore Cooper it was the social workers who gathered the team participants together.

In both sites, the social worker acted as an initiator, raising pertinent questions, and eliciting information from team participants that was needed in the development of treatment goals

and care plans. This role was accompanied by the role of informer, as the social workers elaborated on the information being discussed and explained the implications of the psychosocial histories and the family relationships for care planning. At the Horseshoe Nursing Home, the social worker was also the informer to family members, acting as interpreter between the team participants and the family as needed. The social worker made sure that the concerns and questions of the family members were stated, rephrasing the issues if necessary, and, also, repeating the team decisions to the family member, ensuring that they were understood.

The roles of group maintainer and mediator were less observed. At both sites, the social worker had been a member of the interdisciplinary team for some time and had a history of working with the other core participants. The team rarely required a mediator or needed to be maintained.

Knowledge Areas Demanded of the Social Worker

Knowledge areas demanded of the social workers were similar at both nursing homes visited. The social workers required knowledge of psychosocial and family dynamics, and medical procedures and terminology. The history of each resident was presented and contained information on prior as well as current medical care. Likewise, knowledge of the administrative practices and procedures of the specific nursing home setting was necessary in order to develop the varying plans of care.

Knowledge of entitlements was not required in the four team

meetings that were observed. The financing of nursing home care might involve Medicaid/Medicare knowledge but this is generally dealt with prior to admission to the nursing home. Once a resident, there is little added utilization of entitlements and this might account for the fact that this knowledge area was absent from the meeting deliberations. Knowledge of community resources was noted at one of the nursing homes only. This arose in connection with a discussion regarding the transfer of a resident to another level of care.

Skills Exhibited by the Social Workers

Use of skills by the social workers was observed at the four interdisciplinary team meetings. A low rating does not indicate lack of proficiency so much as that the social worker did not exhibit the specific skill--perhaps because of a lack of need or because another team participant did so.

Cognitive Skills

The social workers both revealed a high level of skill in the area of family dynamics, as discussion often centered around the residents' past family history to explain current concerns or focused on current relationships. Less evident were the cognitive skills in the realms of care of the elderly and provider/patient relationships, although these were present. Skill in knowledge of organizational systems and ethics was least observed.

Technical Skills

The social workers at both sites and in all four team meetings exhibited a high level of skill in the areas of problem identification, problem solving and communication. Skill in team maintenance was less clear, perhaps because this skill was not required. The teams at both nursing home facilities have been in existence for some time and with the same core members, and little work is needed to maintain the viability of the team approach. For the same reasons, skills in role negotiation and task differentiation were not practiced at a high level. The work of differentiating tasks between the team participants had already occurred in the past and team members appeared comfortable in their own roles and, if needed, in exchanging roles.

Interpersonal Skills

Connected to the same factor of comfort between participants and longevity of the teams that were observed, is the fact that among the interpersonal skills, the social workers revealed a high level of openness and trust, and the skill of sharing power within the team environment. At both sites, the social workers permitted the non social work participants to provide information and offer explanations on issues that might be considered the preserve of the social worker themselves. There was no sense of exclusionary ownership of information. This followed from the high level of commitment to interdisciplinary collaboration, which was both evident in the meetings and confirmed by the social workers in

their comments on the team process.

Skill in communication was also exhibited, whether this was in communicating with the team participants or with family members. Skill in communicating in different areas and at different levels of clinical expertise was noted.

Courage, flexibility, and the skill of providing feedback to others in the team setting were not always observed. Perhaps this was because the teams had both functioned for a lengthy period of time with most of the same core staff in attendance. Under these circumstances, a routine had been established and there was little need for these skills.

Additional discussion of the role, knowledge and skill areas demanded of the social worker in the nursing home setting and a comparison with other settings is contained in Chapter IX.

TABLE VII-I

Knowledge, Role and Skills of Geriatric Social Workers as Members of Interdisciplinary Teams in the Nursing Home Setting

	Nursing Home Setting I		Nursing Home Setting II	
	Team Meeting 1	Team Meeting 2	Team Meeting 1	Team Meeting 2
Knowledge Areas Required				
Medical Terminology/Procedures	X	X	X	X
Community Resources	X	X	O	O
Setting--admin./procedures	X	X	X	X
Entitlements	O	O	O	O
Family Dynamics	X	X	X	X
Rules, Regulations	X	X	X	X
Psychosocial Dynamics	X	X	X	X
Role of Social Worker				
Leader	O	O	O	O
Follower	O	O	O	O
Initiator	X	X	X	X
Group Maintainer	X	X	O	X
Mediator	X	O	O	O
Informer	X	X	X	X
Skills Exhibited				
Cognitive				
Care of the Elderly	M	M	H	H
Family Dynamics	H	H	H	H
Provider/Patient Relationship	H	M	M	H
Ethics	M	M	M	L
Organizational systems	M	M	M	M
Technical				
Problem Identification	H	H	H	H
Decision Making	H	M	H	H
Problem Solving	H	H	H	H
Role Negotiation	M	M	M	M
Task Differentiation	L	M	M	M
Team Maintenance	H	H	M	M
Communication	H	H	H	H
Interpersonal				
Ability to Listen	H	H	M	H
Openess/trust	H	H	H	H
Clear Communication	H	H	H	H
Provide Feedback	M	M	H	H
Courage	M	M	H	H
Share Power	H	H	H	H
Commitment to Collaboration	H	H	H	H
Flexibility	M	H	M	M

X=Yes O=No H=High M=Medium L=Low

CHAPTER VIII

SOCIAL WORK AND THE INTERDISCIPLINARY TEAM IN THE ACUTE CARE SETTING

As with the community and nursing home health care settings, two acute care sites were selected and interdisciplinary team meetings observed at both the sites. This chapter offers a descriptive report of the interdisciplinary team meetings and an analysis of the role and function of the social workers who participated in them.

Rocky Hills Hospital

The Rocky Hills Hospital is a large urban hospital in New York City. The hospital consists of a number of buildings, spread over a two block area. The surrounding area presents two very different images of the city. On one side, there are wealthy apartment buildings, embassies, and private clubs occupying some of the most expensive real estate in the city, while on the other side there is a bedraggled area now in a transition stage between inner

city decay and gentrification. This side of the hospital features small restaurants, synagogues and churches, decaying brownstones and new, high rise apartments which are filled with young single working persons. The displaced poor are being pushed a few blocks further away into an area traditionally recognized as a center for the Puerto Rican community.

Setting

Heavily endowed, the Rocky Hills Hospital has recently added new buildings and renovated others. It is a nationally known medical center, recognized not only for its patient care but for its research and medical school. It serves both an affluent, white patient population, as well as the low income, mostly Latino community that is its neighbor.

Arrangements were made for observation of the interdisciplinary team on the geriatric acute care floor. This unit is housed in one of the older buildings in the hospital complex. Patients are assigned to the unit either on arrival at the emergency room or are transferred from other parts of the hospital as need dictates. The patients are in need of acute care but present with numerous age-related medical conditions that indicate a need for geriatric assessment and care. As the hospital is also a teaching hospital, the unit provides student physicians with an opportunity to learn about geriatric care.

An interdisciplinary team meeting is held weekly during the middle of the day. The room used for the purpose is the dayroom,

a square lounge area, furnished with a sofa, a few chairs, a long table against one wall and a television set. The room is placed at one end of the geriatric unit which has a central nursing station and office with patient rooms leading off on all four sides. The meeting is held at the same time each week and attendance by the staff is part of the established routine.

Meeting One

Purpose

The social worker, physician and head nurse of the floor meet three times at intervals during the work week to review patients and their care, and this team meeting was viewed primarily as an information sharing opportunity and review of current care, rather than a time for problem solving and decision making. The cases of each of the patient's on the geriatric unit were discussed at this weekly meeting.

The team members were assigned to the geriatric unit and worked with each other on a daily basis. They were familiar with each of the patients. Non-unit staff might also attend the meetings. The weekly gathering provided a forum for discussion to which staff from other units could be invited on a consultative basis, or they could invite themselves if one of their clients/patients had been admitted to the unit.

Team Participants

For the initial observation of the team meeting, the observer

arrived a little early and was invited to wait in the dayroom for the team participants to gather. One of the hospital patients was in the dayroom, sitting in a wheelchair and watching a soap opera on television. Presently a staff member entered and asked the patient to leave so that the room could be used for the meeting. The patient was wheeled back to his room.

Nine staff were present at this first meeting. These were the physician in charge of the geriatric floor, a second physician, attending in order to discuss one of his patients with the group, the Head Nurse, two other nurses, social worker, psychiatrist, and two Medical students, who were experiencing their first day on the geriatric floor. A tenth person was, like myself, a silent observer. The second physician, the psychiatrist and two of the medical students were the only male staff present.

Most of the participants arrived within a few minutes of each other. The physician in charge of the floor who was to lead the meeting sat in one corner, facing the door, which was kept closed while the meeting was in progress. The remaining participants sat on the sofa or pulled up the chairs around the walls to form a rough semicircle. The psychiatrist arrived after the meeting was in progress and the two medical students entered about halfway through. There was some discussion regarding whether the students were expected to join the meeting on this their first day on the unit and it was agreed that they should. A nurse, not usually in attendance at the meeting, was invited into the room at one point when the discussion was focused on one of her patients.

Content of Meeting

A total of nine patient cases were reviewed during the one and one-half hour meeting. A pattern of case review emerged. The medical officer on the unit gave the clinical report, which was followed by a full care report from the nurse based on the written records which included ADL scores, assessment of skin, food intake, attitude of patient, and progress of patient towards self-care. The social worker then gave her report on the psychosocial assessment of the patient, family/patient dynamics and concerns, and a report on family meetings. Any issues needing team discussion were highlighted as these three individual reports were given.

Just as the meeting began with a review of a patient who was ready to be discharged home, the visiting physician left the room in response to a beeper call. On his return, a few minutes later, the meeting participants turned to an extensive discussion of his patient. This case situation posed a number of problems concerning both medical issues and in regard to discharge planning. It was unclear whether the patient could care for herself in the community even with assistance and there was a difference in wishes between the patient and her family regarding placement in a nursing home facility. The physician requested input from the staff regarding the clinical status of the patient and their impressions of the patient/family relationships. Of particular concern was the possibility of legal ramifications. The psychiatrist joined the

group during this part of the meeting and entered fully into the deliberations, making reference to similar situations in the past. Approximately 40 minutes was spent on this particular case, and when the discussion concluded, the visiting physician left the meeting.

During the remainder of the one and half hour meeting, the seven other patient cases were reviewed. Discussion focused on the extent of the immediate presenting problem, the need for further assessment, or specific plans for discharge, depending on the patient's stage in the hospitalization process. Issues included the appropriateness of hospice care, the treatment of bedsores after discharge, and symptoms of mental illness. In some cases the initial assessments and/or interviews with family members had not occurred so that there was a paucity of information, and decisions centered on what information needed to be gathered.

Meeting Dynamics

Team participants knew each other and had already been interacting during the morning, so there was little preliminary conversation. Participants entered and were ready to begin the patient reviews. There was an air of informality in spite of the routine that followed a consistent pattern in the discussion of each patient case. The informality was heightened by the fairly constant movement in and out of the room. Some participants arrived late, another was invited in during the meeting because she held expertise needed by the team participants in their

deliberations, the visiting physician left midway through the meeting period, and several team participants left the room at intervals for a few minutes to respond to beeper calls or to incidents on the floor that required attention.

The team participants listened to each other's opinions with respect and tended to minimize discussion during the formal presentations by medicine, nursing, and social work, although questions were asked. The team member giving a formal report might raise specific issues and pose certain questions during it. If the solutions were contained in a report to follow, they were not offered at that point but provided in due course as part of the following reports.

Most of the discussion, after the formal reports were given, consisted of conversation between the physician, nurses, and the social worker. The psychiatrist contributed to an understanding of several of the cases, explaining and demystifying the behavior or responses of some of the patients being reviewed. The students, new to the floor the day of this meeting, were mostly silent until the end of the meeting when some of their assigned patients, whom they had already met, were discussed. Throughout the deliberations, considerable caring and appreciation of the geriatric patients as individuals, was demonstrated by the team participants.

The physician in charge of the geriatric unit chaired the meeting and summarized any decisions at the end of each review, confirming which team participant was to take responsibility for

the agreed upon follow-up.

Meeting Two

This meeting was held at the same time the following week and took place in the dayroom, as formerly. Once again, ambulatory patients, watching a television program, were asked to vacate the room to enable the meeting to occur.

Purpose of Meeting

As at the team meeting held a week earlier, the purpose of the gathering was to review the cases of all the patients on the geriatric unit. The number of patients hospitalized varies from week to week and, at this meeting, twelve cases were due for review.

Team Participants

This week, twelve persons were in attendance. This number included mostly the same staff persons that had been present the previous week. Present were the physician in charge of the geriatric floor, a geriatric fellow and three medical students, the head nurse, the social worker, the psychiatrist, accompanied by a non-participating colleague, and a Bio-ethicist who was present as an observer. Two additional nurses attended, each for one-half of the session, planned so that they might be present when the patients for whom they were responsible were being discussed.

With twelve persons, the room was full and the late arriving

medical students sat on the table. Two of the medical students, the psychiatrist and his colleague were male. All others female.

Content of Meeting

There was a considerable variation in the amount of time given to each case, depending on the need for discussion. For the most part the review of the newly admitted cases identified what further information was needed, while discussion of the ongoing cases focused on progress of the patient's physical situation and analysis of the family caregiving situation.

The case, that had created so much discussion at the earlier meeting, was updated. The clinical situation had altered in the intervening days, and new understanding of the family relationships had been obtained, changing the discharge plans. A new patient had been admitted because of frequent falls and discussion centered not only on this patient's care plan but on falls in general and the multitude of possible causes. Similarly, the side effects of a medication being experienced by another patient led to shared information on drug reactions in general.

Some time was given to the legal process required to assure that the 'best' discharge plan was followed, and there was discussion concerning the administrative procedures when a patient was transferred from a nursing home facility onto the hospital's geriatric unit. Concern was also shown over the administrative procedures for admitting patients to the geriatric floor. This latter conversation grew out of the review of a new patient whose

admittance onto the acute care floor was considered unwarranted.

Meeting Dynamics

Team members were familiar with each other and the atmosphere was relaxed at the same as it was businesslike. The meeting was a little more formal than the meeting the week earlier, possibly because of the greater number attending, of which three were in the role of observer, and which included the students. There was a sense of limited time and the discussion was kept focused and methodical, by mutual agreement, with very little informal chatter.

The physician in charge of the floor was also in charge of the meetings. As in the meeting observed a week earlier, the physician introduced each patient's case, providing the medical history and other pertinent information. The nurse responsible for the case being discussed reviewed the chart information, concerning ability with ADLs, weight, food intake, sleeping patterns, skin condition, and muscle tone etc., and this was followed by the social worker reporting on the psychosocial aspects. A description of the home living arrangements and family situation was included in this.

Though this was the formal format of the meetings, team members were free to interject with questions and observations, and participants would frequently disagree among themselves over the evaluations of the patients. The participants enjoyed differing degrees of personal interaction with each patient, and when a participant held a close relationship with the patient being

discussed, his or her opinion was respected. The two nurses who split attendance at the meeting, so they would each be present when their specific cases were being discussed, tended not to offer opinions or ask questions. They both presented the formal nursing reports and responded to questions, providing their personal assessments of each case if asked and when appropriate, but were less likely to initiate discussion. This was left to the Head Nurse. The psychiatrist, in sharing his evaluations of the cases, took the opportunity to explain the theory of any perceived behavior manifestations, in order to assist the staff in understanding.

Impressions of Meetings/Social Work Role

The interdisciplinary team meetings were held at the same time each week and the team participants all gathered at the assigned time. Though there were often interruptions from outside the meeting and participants were called away to deal with patient situations or respond to phone calls, it was clear that attendance at the meeting took priority. The participants knew each other well and worked alongside each other during the day so they were comfortable with each other and yet they appeared to appreciate the opportunity to discuss each case as a staff team in the semi-formal setting of a team meeting.

These weekly meetings were viewed primarily as a time for sharing information, with any specific problem solving occurring during the thrice weekly meetings between the physician, nurse, and

social worker. However, a certain amount of problem solving did take place within the team meeting and though specific treatment plans were rarely defined, my impression was that these weekly discussions informed and fueled the decisions that would be later confirmed in the smaller, problem-solving meetings. When there was disagreement over the assessment or care plan for a particular patient, there was little attempt to gain a team consensus within the meeting format. Any disagreement usually resulted in a decision to gather more detailed information. The team discussion and the increased information, when gathered, would then be expected to lead to a resolution within the smaller meeting between the three core disciplines.

The social worker's contribution to the discussion of each patient was related to the stage of hospitalization reached by the patient. If it was a recent admission, the social worker had not always completed the patient and family interviews, and under these circumstances would contribute little to the discussion, taking direction from the physician and psychiatrist. Both the physician and the psychiatrist tended to suggest potential family and social dynamics that might be relevant to a patient's presenting situation. The physician, in summarizing the outcome of the discussion, would then note that the social worker was to complete the appropriate interviews.

If the patient being reviewed had been on the floor for some time, the social worker was able to take a more assertive role as more facts were available to her. The social worker had been in

her position for only a few months and was considered the junior to the physician, head nurse, and psychiatrist, but this newcomer status did not prevent the social worker from stating her views even when they might be contrary to that of other team participants. An example of this occurred in the second of the two observed meetings when there was disagreement over the timing of a care plan. The discharge plan for a patient was agreed to by all the team participants but the social worker argued that the family needed time to accept the decision. The social worker emphasized the need for process while the psychiatrist advised prompt disposition of the situation and a quick discharge of the patient. In spite of the sharp contrast in views, the atmosphere of the meeting was cordial and the social worker and psychiatrist were accepting of each other's opinions. No resolution of this difference occurred during the meeting and the responsibility for a final decision was left to the physician and nurse to make later.

During the meetings it was the social worker, more than the other team participants, who received beeper signals and had to leave, on occasion, to take phone calls. In general the acute care setting of the hospital meant that the social work assessment had to be completed within a short time limit, and interviews with family members had to be scheduled with dispatch. The acute care situations of the patients also meant that family and friends of each patient sought contact with the social worker on an emergency basis. These time constraints resulted in the phone calls to the social worker that required an immediate response.

Two Partners Hospital

The Two Partners Hospital is an acute care facility specializing in orthopaedic surgery. Patients may enter the facility as emergency cases following accidents or enter for care for a long term, chronic condition, requiring surgery and pain management. Due to the nature of the specialty, the patients' hospital stay may be lengthy and includes a stage of rehabilitation. All ages are served by the hospital but there is a preponderance of older patients.

The Two Partners Hospital is situated in New York City in a mixed residential and commercial area. There are a number of other medical facilities in the near vicinity. Population of the area is mixed - second and third generation immigrants (mid-European-Jewish, Irish-Catholic) and new immigrants (Asian, Latino). The hospital patients come from all areas of the city.

Setting

In planning the visit to this hospital site, a visit was arranged to two different interdisciplinary team meetings, one on each of two floors of the 12 floor building. There are 20 to 22 patients on each floor. Each floor holds interdisciplinary meetings to review the patient cases. Each floor operates as a unit with its own staff team, the members of which have their

offices on the floor.

As the building is new, the structure and furnishings are modern and clean. Each floor has a large square room in one corner which is divided diagonally into two smaller areas. Entrance from the corridor is into the day room/waiting room which contains chairs and bookshelves and an array of magazines. The room is used as a meeting room and lounge. A door in the partition leads to a conference room which is equipped with a conference table and chairs. This pattern is repeated on each of the patient floors.

Meeting One

The first visit was to a team meeting on a rehabilitation floor. On this floor, meetings take place every day, Tuesday through Friday and generally last for two hours each, in the late morning. Patients generally spend two weeks on the floor (on average) and each patient is reviewed each week during the course of the four meetings per week. Each patient has an entry interview and a discharge interview and, if remaining in the hospital beyond two weeks, will participate in a regular care interview. In this way, each patient's situation is discussed and reviewed every week, with four to five patients being reviewed each day. Not all patients are geriatric patients but the majority are.

The meeting was held in a small room, leading off the patient dayroom, which was equipped with a large conference table, chairs and a wall telephone. The team was assembled by the social worker, whose responsibility was to convene and organize the meeting. The

social worker scheduled which patients were to be reviewed on each day, creating a list for each week, and bringing the relevant charts from the nursing station to the meeting.

Purpose of Meeting

The purpose of this meeting was to undertake the weekly review of four patient cases. The four cases had been scheduled in advance, and staff were prepared for which cases would be discussed. The meetings are a time for sharing progress notes and each case review concludes with the patient joining the team whereupon case management plans are relayed and the patient has the opportunity to ask questions, express concerns or raise other issues with the team as a whole.

Team Participants

Seven staff members were present at this meeting. These were a physician (a physiatrist), two nurses - the primary and the charge nurse - a physical therapist, an occupational therapist, the social worker, and a music therapist. After the first two cases were reviewed, the physician and one of the nurses working with these cases left, relinquishing their seats to a second physician and another nurse who were responsible for the next two patient cases to be reviewed. All the team members were women except for one of the physicians.

There was some movement in and out of the room as each of the patients were escorted into the room when it was time for them to

join the team. The social worker or nurse left the meeting room to fetch them at the appropriate time and, at one point, the team was joined by a Spanish speaking nurse who acted as an interpreter for a Latino patient. Patients were often accompanied by a relative or friend.

Content of Meeting

This team meeting was structured and routinized in that each team member sat in the same place each day and the team meeting was directed by whichever physician was present, following an established pattern in the order in which the disciplines reported.

For each of the four cases under discussion, the physician who was present, introduced the case history and reports were heard from the nurse, the physical therapist, occupational therapist, music therapist and social worker, in that order. The social work report came at the end as it was the social worker who was responsible for the discharge plan, based on the preceding reports. The reports were formal, providing information on functional ability and range of motion, giving the chart and assessment scores and data and, in the case of the music therapist's report, commenting on degree of participation. The social worker concluded the reports with any plans for discharge and follow-up care.

When decisions needed to be made concerning change in rehabilitation care or for discharge, the decision was made at the meeting through group discussion. The patient was then invited into the room and the presiding physician explained the purpose of

the meeting and introduced the staff members in those instances where the patient did not know them. The physician then gave the patient a precis of the reports that had been previously shared, ending with the decisions that had been taken and asking for input. Of the four patients, one was in her sixties, two in their seventies and one mid-eighty. Three were female and one male.

Three of the four patients were preparing for discharge after surgery and the reports and discussion centered on whether the patient being reviewed was functionally able to return home and the extent of the follow up services and assistive devices that would be needed. In discussing one case, it appeared that the patient's family members had made conflicting statements regarding what family care would be available to assist the patient and a decision was made to clarify this. The fourth case was somewhat different in that the patient was reported as being functionally capable but suffering great pain, the immediate cause of which was unclear. Some time was taken in discussing both the possible physical and psychological aspects of the pain and determining whether the patient was a candidate for pain control education.

The specific decisions and recommendations of the team were repeated to the patient and the relative or friend that might be accompanying each patient. In addition, on this day, the physician used the time with one of the patients to demonstrate correct movements and one of the family members asked about obtaining the necessary home equipment.

Meeting Dynamics

The team members knew each other and there was an easy familiarity in their discussions. However, at the same time, the format of the meeting was structured and there was little wasted time. The physician chaired the discussion on each patient in turn and as each team member was asked to report, the other team members listened without interruption. At the conclusion of the formal updates and reports, it was the role of the physician to focus on any contradictions or to raise the issues regarding care planning and/or discharge. Once the physician commented on the reports, then other team members added to the general discussion. There were no major disagreements regarding interpretation of the facts.

In general, the patient whose case was under discussion was waiting in the dayroom outside and, at the appropriate time, was led into the meeting room by the nurse or social worker. On occasion, the staff escort had to search for the patient in his/her room or elsewhere on the floor and there were one or two minutes of waiting. During these pauses, the team members were generally silent, engaged in writing up the necessary records or reviewing the casenotes on the next scheduled patient. A break to the meeting also occurred when the first physician and nurse left to be replaced, after a few moments, by others. During this lull, the waiting team members engaged in general conversation concerning their social life outside the workplace.

The team members were welcoming to the patients and those who accompanied them, defusing the necessarily intimidating situation.

One patient took the opportunity to thank all the staff for their care and others asked a few questions concerning their discharge plans, but in general, they were silent and accepting of the team's decisions and assessments as summarized to them by the physician.

Meeting Two

The following week I returned to visit another interdisciplinary team on another floor of the facility. The layout was similar - the meeting taking place in the room leading off the dayroom. The room, in this instance, contained, in addition to a conference table and chairs, a few lockers for the staff.

On this floor - a rehabilitation unit - the interdisciplinary meeting was held once weekly. Grand Rounds were also held on a weekly basis and I was told that these were held mainly for educational/informational purposes, and that problem solving and care planning takes place mostly during the informal day-to-day interaction of the team members who work together on the unit.

Purpose of Meeting

The team meeting, itself, was an opportunity to review the cases and was also used to satisfy discharge planning mandates. The staff work as a team on the floor and the team members knew many of the patients from hospital visits over time, so it was unusual for new or unexpected information to be shared at the team

meetings. The purpose of the meeting that I attended was to review six cases.

Team Participants

The meeting was attended by ten staff persons. These were the physician (a Rheumatology Fellow), three medical house staff, a nurse from the floor, a nurse from the clinic, (to assure continuity of care after discharge), a Utilization Review representative, the social worker and a social work intern, and a Physical Therapist. The four physicians were all male, the others female.

The team members had been meeting as a group for some time, with the exception of the social work intern, and the house staff who rotate through the hospital and so change every few months. The house staff did, indeed, take a secondary role, responding with information and comments when their own cases were under discussion, but leaving the leadership to the physician and the social worker.

This meeting was held without the presence of the patients under discussion. About 60% of the patients were considered elderly and many of them had been under the care of the hospital for many years, suffering from chronic joint conditions.

Content of Meeting

Six cases were presented for review. Some of the cases warranted only a few words while discussion of others was lengthy.

The social worker chaired the meeting. She had scheduled the patient cases to be reviewed and began the meeting by listing which cases would be discussed.

Management of pain was a major area for discussion as the team members assessed a patient's pain threshold. In one instance the patient's report of pain appeared unjustified by the physical findings and time was taken in reviewing the medical history and exploring options. The patient had been readmitted by an attending physician but the house staff were at a loss to determine the necessity for it.

A second major theme was the administrative processes used to move patients between surgery, rehabilitation, and clinic care after discharge. Within the hospital setting, the movement from the surgery floor to rehabilitation was sometimes delayed or thwarted by lack of beds. After discharge, concern was centered on the need for continuing rehabilitative care as part of the discharge plan. Much of this discussion hinged on the nature of the patient's insurance coverage and whether, if clinic care was not covered, private care was feasible. Decisions made by the team were specific and included such tasks as informing a patient's family physician regarding appropriate follow-up, and educating a patient about anticipated length of recovery.

Meeting Dynamics

The physician, in theory, chaired the meeting but the social worker, who had been in the position for several years, was the

convener and organizer of the meeting, listing the agenda at the outset, noting the cases to be reviewed and moving the group discussion from one case to the next. It was the social worker who used the phone to locate one of the team members who was missing and it was the social worker who managed the flow of the discussion.

An informal and relaxed atmosphere existed with the team members comfortable with each other and respectful of each other's views. It was clear that the team members not only knew each other as colleagues and were used to working together as a team but that they liked each other. There was a sense of the team as a unit which encompassed even the newer members - the physicians who rotated through the hospital units and the social work intern.

Though the meeting had been described as a forum and a formality to meet the discharge planning requirements, consisting of reports from the team members, the meeting did, in fact, include some exchange of new information. Problem solving, task identification and the apportioning of distinct responsibilities, did occur.

Impressions of Meetings/Social Work Role

As indicated, both the social workers were responsible for co-ordinating the interdisciplinary team meetings, and assuring that the staff were present and the patient records available. In the first team meeting that was observed, the social worker held a formal organizing role, with the task of scheduling the cases to be

reviewed on a weekly basis and administratively arranging for the presence of patients and family members. This task meant that the social worker needed to be in and out of the room, escorting patients and meeting with family members, while also carrying the responsibility to report on the discharge plans for each case.

The team meeting was chaired by the physician and the format was structured. Reports on each patient case under review followed a specific order and were given in turn with minimal interruptions by the listening team members. Questions and comments were expressed at the completion of the reports.

The second team meeting was also coordinated by the social worker. In theory the physician was in charge of the team meeting but the social worker had unofficially taken upon herself the task of convening the group, and making sure that the team members attended. The social worker had also assumed the role of unofficially chairing the meeting, indicating the agenda for the meeting and moving the discussion along, summarizing the decisions and specifying the agreed upon tasks and which member would undertake each of these.

Interdisciplinary Team Meetings in the Acute Care Setting

Differences Between the Sites

Though both acute care settings, there were a few differences between Rocky Hills and the Two Partners Hospital that affected the characteristics of the interdisciplinary team meetings, and, in turn, the role and expectations of the social workers participation in the teams.

The emphasis on acute care meant that there was a sense of immediacy surrounding the staff/patient relationships in both hospitals but this differed due to the differing foci of the settings. At the Rocky Hills Hospital, the patients had been admitted to hospital for a variety of reasons and generally in crisis situations. The interdisciplinary team was faced with the need to make assessments rapidly and determine care plans within a short time frame for patients with a range of diagnoses and presenting symptoms. Offsetting this was the fact that the team was located on a geriatric floor and all the team members were steeped in geriatric knowledge and viewed the patients as older persons with a multitude of interlocking needs related to age.

At the Two Partners Hospital, the care was also acute but not usually life threatening. Further, because it was a specialized hospital, all the patients presented with similar symptoms. There

was a similarity to the care plans and discharge plans that were made by the two teams that were observed, and a rhythm to the hospital experience of each patient that was reflected in the work of the team. In general, a patient entered for surgery and remained two weeks for post operative rehabilitation before discharge to the community and extensive post discharge therapy. While most of the patients were older persons, they were not clustered by age and the interdisciplinary team participants did not acknowledge old age as a primary factor. Though some of the team discussions of individual patients did include an examination of their age related health conditions, this was not universal and a holistic approach to care, favored for geriatric care, was not always evident.

This difference between the two settings, in the nature of the acute care provided, affected the conduct and climate of the team meetings. At Rocky Hills Hospital, there were interruptions throughout the meetings. The social worker, in particular, was frequently called out of the meetings to respond to phone calls and the physician and nurses were also likely to be called away to deal with some situation developing on the patient floor. At Two Partners Hospital, there was some movement of team members in and out of the meeting, but these were generally related to the needs of the meeting itself i.e., escorting patients, securing pertinent records etc., and did not detract from the immediate team tasks.

Rocky Hills also tended to bring 'guest' professionals into the team meetings to assist in care planning on individual

patients. This brought additional resources and expertise to the team and extended the nature of the team deliberations. For the two different teams observed at Two Partners, this was not customary. When information or direction was needed from others outside the regular team membership, the need to contact such persons was recognized as a specific task, assigned to one of the team, and contact occurred outside the team setting.

Similarities Between the Sites

The interdisciplinary team meetings were similar at both sites in that the meetings were viewed as a regular part of the work schedule. Meetings were scheduled for an established time and staff expected to attend as part of their work routine. In addition, the team members all worked with each other on the specific floor with the patients that they were reviewing at the meetings and so a great deal of planning and interaction around each case occurred outside the meetings, both prior and after the meetings. Perhaps because of this, the team members all knew each other and appeared to have developed comfortable working relationships. Thus a sense of team went beyond the immediate meeting and contributed to the familiarity and ease with which the team discussions were conducted.

In the acute care setting, the physician was the recognized chair of the interdisciplinary team meetings. It is true that one of the Two Partners team meetings was co-ordinated and led by the social worker but, in theory, the physician was in charge of the

meeting. The acute clinical aspects of each case were the major concern in determining treatment and therefore decision making regarding care lay primarily with the physician.

Case records and reports were visible at the team meetings but the completion of these was not viewed as the overarching concern. Meetings were held to review patient cases and care plans and this goal remained the focus of discussion, with the written records being used as a tool and reporting mechanism. This was the case even at the one meeting that was identified by the staff as being held primarily to satisfy the state discharge planning mandates. It is important to note this characteristic in relationship to the acute care settings, since as was noted in Chapters VI and VII, this focus on patient care planning, rather than on the mandated forms, was not necessarily true of the team meetings in the non-acute care settings.

Element of Time

The acute care setting was accompanied by a distinct sense of time passing. There was an urgency to the interdisciplinary team deliberations due to the nature of the hospital setting. Patients entered the facility often under emergency conditions, in a crisis situation, and the staff had little time in which to gather information for assessment before interventions needed to be initiated. Even in the Two Partners Hospital, which is a specialist hospital dealing with patients all with similar care needs, there was an urgency. Some patients were hospitalized due

to an emergency and others were there for elective surgery, but the normally prescribed time for the patient to remain in the acute care setting was limited. The interdisciplinary team did not have the time to explore many avenues of enquiry or debate, thoroughly, alternative care arrangements for each individual case. This urgency meant that the team meetings tended to be structured efficiently in terms of number of cases reviewed and it is possible that potential differences of opinion between the team members never had an opportunity to surface.

While a team that must make decisions quickly may overlook important factors, it is also possible that the demands associated with the development of an appropriate care plan in a minimum amount of time may prove advantageous. Time constraints may encourage decision making and prevent needless vacillation or delays while further data is collected and evaluated. This small study of the interdisciplinary teams at work does not include enough information for any judgement to be made regarding this. What is evident, however, is the fact that the time factor in the acute care setting strongly influences the work of the social worker.

The realm of information that the social worker is responsible for gathering deals with the psychosocial aspects of the geriatric patient and the family and home environment from which the patient has come. It is precisely these areas of information that require time to gather. The other members of the interdisciplinary team may collect information from observation of

the patient within the acute care setting i.e., the data is readily available, but the social worker has to make contact with persons outside the acute care setting and/or develop a relationship with the geriatric patient to gather the needed information and this requires time. The social worker, perhaps more than any other discipline in the acute care setting, is affected most by the extraordinary time pressures.

The Social Worker as Member of the Interdisciplinary Team in the Acute Care Setting

The Social Worker's Role

The observed team meetings were all chaired, either actually or nominally, by a physician. The social workers at Two Partners Hospital filled the role of coordinator, identified the cases to be reviewed, convened the team members, led the meeting in one instance, and were initiators in discussion. At the Rocky Hills meetings, the physician was in charge and the social worker took a subsidiary role. While filling the role of 'follower,' this should not be construed to mean that the social worker did not offer contrary opinions or evaluations as appropriate.

The role of informer was a key role for the social workers. In each team meeting, the social worker possessed information gathered in interviews with the patient and family members which

was required before the team could fully develop a care plan. In this sense, the social workers were viewed as core members of the team.

The role of group maintainer and mediator were not generally filled by the social workers. At both sites, the teams had been in existence for some time and required little maintenance. As coordinators, the social workers at Two Partners might be judged to fill a maintenance role, and at Rocky Hills, the social worker took a mediating role in one instance only. The interdisciplinary teams had evolved as groups and followed a format which required little attention. The fact that the team members knew each other and worked with each other on a daily basis outside the meetings, also meant that any disagreements were not viewed as threatening and were tolerated. Under these circumstances, little mediation of maintenance of the group was required.

Knowledge Areas Demanded of the Social Worker

It was no surprise that within the acute care setting, a knowledge of medical terminology and procedures was required for full participation in the team discussions. Also required of the social worker in all the four meetings that were observed, was knowledge of psychosocial dynamics and of the procedures and administrative workings of the host setting. This latter knowledge was needed in the development of care plans and discussions of the additional resources that were available in the care of each geriatric patient.

A knowledge of family dynamics, generally recognized as a key element in a social worker's knowledge base was required in only three of the four interdisciplinary meetings. In the one meeting in which this knowledge was not needed, the focus was on patient's experience within the acute care setting and reaction to hospital care. This was probably a reflection of the specific cases under review, rather than a usual characteristic of the meetings in general.

Entitlement knowledge and familiarity with community resources were also not always needed or exhibited. In three of the team meetings, these areas of knowledge were not featured at all. This is noteworthy as one would expect community resources to be discussed, considering that the cases being reviewed included planning for discharge. It may well be that interdisciplinary team participants view this area of expertise as belonging to the social worker and that the social workers, themselves, confine their knowledge of entitlements and community resources to work outside the team setting.

Skills Exhibited by the Social Workers

As in the other health care settings, the level of skills exhibited by the social workers was observed. A low rating does not mean that the social worker was not proficient in the skill but may only indicate that no occasion to exhibit such a skill arose in the observed meeting.

Cognitive Skills

Except for the one team meeting in which the patient cases being reviewed did not feature family relationships, the social workers all exhibited a high level of cognitive knowledge concerning family dynamics. For the other knowledge areas, no pattern emerged. The social workers revealed a high level of cognitive skill in specific areas that were related to the individual circumstances of each of the cases that were reviewed at the team meetings. For instance the high level of skill in ethical knowledge was related to a lengthy discussion by the interdisciplinary team regarding the rights and wishes of a patient when these wishes were in opposition to a family member, and a high rating regarding care of the elderly knowledge was connected to a discussion regarding problems of care that had arisen for one patient during rehabilitation.

Technical Skills

The social workers in all the team meetings indicated a high proficiency in problem identification. As the setting is acute care, the patients were all facing some acute care health problems and the social workers took part in defining and identifying the problem areas. Also generally exhibited at a high level was the skill of communication and that of task differentiation. Once a problem was identified, the next step was task differentiation and an appropriate division of labor and the social workers were skilled in this task.

Decision making and problem solving were practiced at a lesser level. In many cases the necessary information that would lead to decision making had not been collected by the social worker, due to the time factors of the acute care setting, and the decisions were in the nature of agreeing to gather more information before problem solving regarding care could occur.

Team maintenance and role negotiation were also lesser skills but, as indicated earlier, this was related to the fact that the teams that were observed were of long standing and required little maintenance by any member of the team, and nor was role negotiation required.

Interpersonal Skills

It was clear that all the social workers were committed to collaboration and felt comfortable in their participation within an interdisciplinary team. The ability to listen, openness and trust, and skill in sharing power, were all exhibited skills. These are key skills in functioning as an interdisciplinary team member.

All the other interpersonal skills were present but no specific pattern emerged from the four observed team meetings. A high level of communication skills was apparent for the social workers who filled the role of co-ordinating the meetings, and the ability to provide feedback to other members of the team was a feature in all but one of the meetings. The one meeting in which this was exhibited at a low level was the one in which the team members appeared to be most comfortable with each other and there

was little need for feedback in order for the teamwork to be accomplished.

Further discussion of the role, knowledge and skill areas of the social workers within the acute care setting as compared to the other two health care settings, is the subject of the following chapter.

TABLE VIII-I

Knowledge, Role and Skills of Geriatric Social Workers as Members of Interdisciplinary Teams in the Acute Care Setting

	Acute Care Setting I Team Meeting 1	Acute Care Setting I Team Meeting 2	Acute Care Setting II Team Meeting 1	Acute Care Setting II Team Meeting 2
Knowledge Areas Required				
Medical Terminology/Procedures	X	X	X	X
Community Resources	X	X	X	O
Setting--admin./procedures	X	X	X	X
Entitlements	X	X	O	O
Family Dynamics	X	X	X	O
Rules, Regulations	O	X	O	X
Psychosocial Dynamics	X	X	X	X
Role of Social Worker				
Leader	O	O	O	X
Follower	X	X	O	O
Initiator	O	O	O	X
Group Maintainer	O	O	X	X
Mediator	O	O	O	O
Informer	X	X	X	X
Skills Exhibited				
Cognitive				
Care of the Elderly	M	M	H	M
Family Dynamics	H	H	H	L
Provider/Patient Relationship	M	M	H	M
Ethics	M	H	M	L
Organizational systems	M	H	M	M
Technical				
Problem Identification	H	H	H	H
Decision Making	M	M	M	M
Problem Solving	M	H	M	M
Role Negotiation	M	M	M	L
Task Differentiation	H	M	H	H
Team Maintenance	M	M	M	M
Communication	H	H	H	M
Interpersonal				
Ability to Listen	H	H	H	M
Openness/trust	H	H	H	M
Clear Communication	M	M	H	H
Provide Feedback	H	H	H	L
Courage	M	H	M	M
Share Power	H	H	M	H
Commitment to Collaboration	H	H	H	H
Flexibility	M	H	M	M

X=Yes O=No H=High M=Medium L=Low

CHAPTER IX

SOCIAL WORKERS AND THE INTERDISCIPLINARY TEAM

Site visits to observe meetings of interdisciplinary teams were made to six different facilities and in all but one of the sites the same team was visited on two consecutive occasions. At the sixth site, two different teams were each visited once. However, some of the interdisciplinary teams had more than one social worker participating and this resulted in a total of ten social workers and two social work interns being observed as members of the interdisciplinary teams.

Characteristics of the Social Workers

All twelve social workers were women. Of the ten social workers with a Master's level degree, eight were white, one Latino, and one Black - West Indian. Neither gender nor ethnicity appeared to have any relationship to their participation or role within the team setting, although this cannot be stated unequivocally as no male social worker was included in the observations.

The gender composition of all the observed teams was tilted

heavily in favor of women. Only among the disciplines of medicine and psychology were men to be found as members of the teams. However these disciplines were not the sole province of males as, across the teams visited, six female physicians and medical students were in attendance, half as many as the male physicians and psychologists.

The age and experience of the social workers varied widely. Social workers included recent graduates working in their first health care setting position as well as those who had been in geriatric social work for many years with a wealth of experience in the field. Except for one, most had also been at the specific setting for a considerable length of time, and all enjoyed a solid reputation with their colleagues.

This last factor is not surprising due to the fact that the teams to be observed were not randomly selected. At each setting, the Director of Social Services or a Social Work Supervisor, had determined which interdisciplinary team and social workers in the facility would offer the 'best' opportunity for observation and then these social workers were approached to determine if they would permit such observations. It was to be expected that the selected social workers would be those who enjoyed a positive role within the interdisciplinary team and a respected relationship with members of the other health care disciplines.

Team Leadership

The interdisciplinary teams were chaired by either a

physician or a social worker. Seven of the twelve meetings were led by a physician and the remaining five by a social worker. It was clear at all the team meetings that medicine, social work, and nursing were always the major disciplines represented and filled an important role in the team deliberations, regardless of what other disciplines were present. Nurses did not, however, feature as team leaders, for this position appeared to be reserved exclusively for a physician or a social worker.

Setting had some influence on which of these two disciplines filled the leadership role. Physicians were not participants in the interdisciplinary team in one of the community care settings visited and the two observed meetings were led by a social worker. As emphasis in the acute care setting is on medical aspects, it can be expected that the meetings will be physician dominated and led, while social work might play a more central role in the residential setting. In this study, there was no such delineation. Clinical health care of the older persons was the central focus in both the acute care and residential settings but, at the same time, the psychosocial aspects of each situation shared the spotlight, offering a major role to the social workers. Of the eight meetings in these two settings, three of the four meetings in the acute care setting were led by a physician and all four held in the residential setting were physician-led.

In determining which discipline took the leadership role in the acute care and residential care settings, gender did not appear to be a factor. In the acute care setting in which the social

worker chaired the interdisciplinary meeting, staff verbally recognized the male physician as leader but, in reality, the social worker took this responsibility. The remaining seven meetings were led by physicians. In regard to gender, of these seven meetings chaired by physicians, four and a half of the meetings were led by a female physician, and at two of these meetings, male physicians were also present. The other two and a half meetings were led by male physicians and no female physicians were present. It seems that discipline rather than gender is thus the determining factor in team leadership. When a physician is present, the leadership position is likely to be filled by that physician.

Team Meetings

At all six sites, the interdisciplinary team was a recognized entity with regularly scheduled meetings and was part of the culture of the specific facility. The interdisciplinary teams had been meeting for a long period of time and attendance at the meetings had become part of the weekly rhythm of work for the team members. The time of the meetings was known by both the team participants themselves as well as by non-participating staff. The meetings can be described as institutionalized.

Connected to this view of the team meeting as a fixture in the life of the health care setting, is the fact that in most cases the team participants had been meeting together for a considerable length of time, and the individual staff members felt comfortable with each other and within the interdisciplinary team setting.

This was particularly true of the teams observed within the community health care settings but in all the meetings, a high level of comfort was observed. Team participants both respected and enjoyed the company of each other, and there was often laughter and a teasing camaraderie.

The Element of Time

Different aspects of the health care settings create conditions which impact upon the nature of the social worker's job. Perhaps one of the most stressful pressures is that of time available to accomplish the work-related goals. The sense of time and the pressures it created was heavily dependent upon the setting itself.

The **acute care hospital** exists to care for those in health crisis situations. Patients are admitted in acute stress, suffering from health problems that have often been precipitated by an acute episode. Assessment and treatment is required immediately to stabilize and reverse the specific health problems. For the interdisciplinary team, this sense of immediacy means that decisions have to be made quickly. Teams observed in the acute care settings made far more decisions as a team than teams in other settings. In the acute care setting, team participants tended to deliberate much more rapidly than did the other teams and discussed a great number of cases at each meeting. Frequently the necessary information was not always available at the time decisions were needed.

This paucity of information was particularly true for the social workers who, in these settings, suffered an additional handicap relative to the other team members. The social workers' responsibilities included an assessment of the geriatric patient's home environment and family dynamics but this information existed outside the acute care setting and required interviews and telephone contacts with collaterals. Other team members needed to gather data only on the patient, who was more available within the acute care facility at whatever time was convenient to the team member.

Perhaps because of this, the social workers were less in control of how their time was managed than the other team members and were often interrupted during the meetings, called to respond to phone calls or to meet with family members. Representatives of the other health care disciplines also experienced interruptions but were better able to postpone dealing with them until a more convenient time. This movement in and out of the meetings by the social workers was accepted, by both the social workers and the other team participants, as part of the social work modus operandum or culture.

In the **community care settings**, the concept of time available was altogether different. The pace was less urgent and the only time pressure was generally that surrounding the completion of the required forms in a timely fashion. Treatment plans and evaluations were developed for older persons living in the community. The situations and problems faced by these

patients/clients were chronic and not expected to alter much in the weeks ahead and this meant that the interdisciplinary team members had the luxury of debating and discussing the many variables connected with each situation. Written reports might be required but there would always be opportunities in the future to revisit and revise the evaluations and care plans. For the social worker, the long term relationship with each client which either already existed or would be developed over the time available, meant that a great deal of psychosocial information was known and could be factored into any decision making. The input of the social worker was given a central role in the discussions on each client.

The **nursing home setting** also experienced a slower time-frame. Again there was the pressure of deadlines for the mandated reporting but, as in the community care setting, there would always be reports to prepare in the future, affording an opportunity to alter the care plans. Each case could be discussed in depth and over time, and the urgency to make decisions delayed until further knowledge or thought had been given to the specific case. The input of the social worker to the team deliberations was central and if any disagreement existed between staff concerning resident/client assessment in relation to matters other than clinical health care, there was time for the social worker to take responsibility and schedule further interviews with the family or friends as well as with the resident.

Access to Knowledge

The interdisciplinary team meetings in all three settings were held for the purposes of sharing patient/client information, developing treatment plans and completing the mandatory reports. In all the settings, the social worker was expected to be responsible for gathering information concerning the patient's family and home environment, and reporting on the psychosocial aspects of each case. There was, however, a variation in the degree of access and control of the needed knowledge, dependent on the specific setting, and this did affect the tasks of the social workers.

Within the **acute care** setting there was generally insufficient information about recently admitted patients for consideration at the team meeting. As noted above, this occurred due to the time factor in acute care in which decisions have to be made rapidly and the social workers had little time to gather the necessary information. With gaps in the psychosocial information, discussion on a case often ended with requests by the team for further knowledge, and decisions concerning treatment were predicated on the discovery of particular facts eg; the availability of a family caregiver to provide emotional and/or physical support.

In essence, the interdisciplinary team's discussions in the acute care setting established the parameters of the social worker's follow-up interviews with the patient and family members, by detailing what information was needed. It must be remembered

that the social workers, themselves, contributed to the team discussions and were equally responsible, with the other team participants, for suggesting which areas of information were to be gathered.

The **community care** teams faced other difficulties in accessing the necessary knowledge. The social workers established strong relationships with the patients/clients over a period of time and were familiar with each individual. There was, however, a great many factors outside the treatment setting that impinged strongly on each client, and could alter individual situations and affect the focus of the care. There was no guarantee that the patients/clients would attend the community care settings on a regular basis and there were frequently long periods in which an individual might be absent from the center or clinic. When this occurred, the social worker, as well as the other team participants, needed to reassess the individual and adjust treatment plans as indicated. In the community care setting, it was the role of the social worker to gather pertinent information from outside the center setting, which would then direct the care given by all members of the team. The team participants had no control over the external influences and there was sometimes a degree of frustration that then became the task of the social worker to dissipate through collection of 'new' information.

In contrast the **nursing home** setting provided continual access to the daily life and experiences of each resident. Not only was each resident known to the members of the team but the

team members controlled the implementation of the chosen care plans. Living in the institutional setting, the residents of the nursing home facility experience Goffman's "lack of autonomy," and are subject to the authority of the staff. This authority of the team and the fact, that each team member tended to know each of the residents from interaction on a daily basis, resulted in a blurring of the roles of the disciplines to a greater degree than among the teams in the other settings. Knowledge and understanding of the psychosocial profiles, generally the preserve of the social worker, was shared by many of the team participants.

Critical Knowledge

This last observation concerning the blurring of the social work role within the nursing home setting is linked not only to the extent of knowledge about each resident that was known to the team participants but also to the type of knowledge that is critical in each of the three settings.

In the **nursing home**, the residents are frail and functionally disabled but physical health problems are generally chronic in nature and not acute. Clinical, medical knowledge is factored into the treatment plans but most often is concerned with nutrition issues, or control of decubiti, prevention of falls and depression, and monitoring of dementia. All of these issues are necessarily linked to psychosocial factors and concerns. The psychosocial aspects of each resident's care becomes the major focus and there is a melding of the interests and responsibilities of the social

worker and the medical and nursing roles, which impacts upon the social worker's interdisciplinary experience and role.

This was evident in the team meetings that were observed. After one team meeting in which the physician had presented and evaluated the psychosocial aspects of each case discussed, leaving little for the social worker to add, this was raised later by the observer with the social worker in question. The social worker commented that initially she had felt some resentment over this usurping of her traditional role but believed that it was beneficial for the physician to include this area of knowledge in the assessment as it modelled a true team approach to all the team participants. The social worker had adjusted her team responsibilities to adding pertinent information if necessary and interpreting and explaining the psychosocial information to the team if this appeared needed.

The critical knowledge in the **community care** setting is also the psychosocial information and understanding. Whereas the community care settings deal with health care, this care is generally focussed on psychological and emotional well-being. At the day care center (V. Amway Center) at which team meetings were observed, the center participants used their own family physicians in the community for their medical care and physicians were not participants in the team meetings at all. Nurses were members of the team and provided ongoing health care and monitoring to the center participants but the focus remained on psychological well-being. This resulted in the social worker taking a leadership role

in the team deliberations.

The **acute care** setting is altogether different and this, too, affects the social worker's role. In acute care, as noted earlier, the emphasis is on dealing with the immediate health crisis and the clinical aspects of care. The psychosocial aspects of each case were considered important in all the team meetings that were observed but only featured in decision making in reference to discharge planning. The responsibility for this was lodged firmly with the social workers. The representatives of the other disciplines accorded the psychosocial body of knowledge some respect, recognizing its impact on the clinical aspects, but left the gathering of this information and the assessment of it to the social workers. The acute care setting is dominated by the physical health problems of the patients and, accordingly, focus in the meetings was on the clinical knowledge and decisions of the physicians. Role blurring seldom occurred in the acute care setting.

Family Interaction

The social worker expects to interact with the older client and the family members but involvement in the interdisciplinary team can add a particular slant to the nature of this interaction. All the social workers interviewed and observed noted their role as mediator between the physician and the family/client and as interpreter of the medical/clinical assessments and treatment plans. As members of the interdisciplinary teams, the social

workers were privy to the medical decisions, and the other team participants expected them to assist in relaying and explaining the care decisions to the patients and families.

Family members also expected this type of interaction from the social worker. Furthermore as one social worker explained, family members and patients tend to hold the physician in some awe and expect that he/she will be exceedingly busy and not available to be bothered with enquiries. The social worker is not viewed in the same light, being seen as more approachable and filling a less time-demanding position. As a result, family and patients tend to contact and question the social worker, rather than the physician, for needed information.

Mandatory Reporting Forms

No discussion of the interdisciplinary team and the role of the social worker can avoid mentioning the burden of forms and reports that must be completed for each patient/client. The social worker, as well as the other members of the interdisciplinary teams, must take responsibility for keeping the reports up-to-date.

The centrality of the reporting and the specific role of the social worker in relation to it varied and was dependent on the health care setting. Team meetings in both **nursing home** facilities and one of the **community care** settings were driven by the mandate to complete the forms. The meeting discussions revolved around the forms and there was a constant danger that the act of completing

the specific reports would become more important than the development of the most appropriate care plan for the individual patient/client.

A great deal of frustration was shared with the observer by all disciplines concerning the inadequacies and pressures of the structured report forms. Much time and care were taken with developing the correct wording and "signing-off" on each record. While the nurses on each team were responsible for maintaining the records, the social workers took a major responsibility in making sure the records for the cases under review were brought to the team meeting, in providing social work reports and in assisting with the wording of the developed care plans. The act of completing the reports did serve to highlight aspects of the cases that might otherwise have gone unremarked and did lead to sharing of information between the disciplines.

Mandated reporting was not the guiding principle in the acute care team meetings. While case records were required and used to monitor the patients progress and note the team decisions regarding care, the necessity of completing the records took a secondary place to the patient assessments. This was due to the fact that the acute care team meetings were task oriented and operated under a sense of urgency. Assessments and care decisions were required quickly. For the social worker, the maintenance of written case records occurred outside the team meeting.

Social Work Role Dependent on Setting

In all the observed team meetings the social worker's role was similar. The social worker was an informant, contributing to the knowledge of each case and participating in the decision making and interacting with the other disciplines. Informational contributions were focussed, as expected, on the realm of psychosocial issues and family relationships, but were not confined to these.

The specific role taken by the social workers was molded by the nature of the health care setting. (See Table IX-I). In the **community care** settings, the social worker took the leadership role, establishing the agendas and chairing the meetings. At the V. Amway Center, there were no physicians present, and the social worker was responsible for convening and leading the meetings. This was also true of the two observed meetings at the Plain Vista Clinic, although here the leadership was rotated between disciplines and social work leadership was not a result of the specific setting.

In the community settings, the day center and community clinic were housed within larger institutions but maintained a separate individual identity. This characteristic gave a sense of independence and freedom to the team deliberations and, for the social workers as for the other team members, enabled decision making and allowed a sense of autonomy, while offering a wealth of additional, available resources. Most community health care settings are likely to enjoy this type of advantage as part of a

larger institutional facility.

The **nursing home** setting also resulted in a central role for the social worker in the team meetings. In both nursing home settings, the social worker was responsible for convening the meetings, gathering together team participants and assuring that the necessary records and case files were available. This also occurred in one of the **acute care** settings and seemed to be related to the belief that group happenings is the province of the social worker and so it is appropriate for the social worker to fill this role. At the other acute care setting, the social worker participated as a key team member but was neither the convener nor team co-ordinator. This role was filled by the physician, in keeping with the central position of medicine in the acute care setting.

Knowledge Required by Social Workers as Members of the Interdisciplinary Team

Based on the issues raised and the nature of the discussions that occurred in the observed interdisciplinary team meetings, an assessment was made of the knowledge areas that are required by the social workers in order for them to function within the interdisciplinary team in a geriatric health care setting. (See Table IX - I). Using the seven content areas that are noted in the literature, one point was scored for each team meeting in which the particular knowledge area was required by the demands of the team discussions. A maximum of twelve points indicates that all twelve

team meetings required the knowledge area under scrutiny.

The content areas of both **medical knowledge** (clinical medical assessments and procedures) and **psychosocial dynamics**, were universally required. All the observed team meetings included discussions concerning medical procedures, even in the community care team in which no physician was present. All team meetings also became involved in analysis and discussion of the psychosocial aspects of individual cases. The patients/clients emotional reactions to health problems, tolerance of medical care, and compliance with prescribed treatment were perceived as impacting upon the viability of the care plan and were frequent subjects of discussion. The team deliberations were not limited to recognizing that specific psychosocial issues existed but went beyond this to seek out the possible causes of the related problems and to determine how care might be provided that would minimize or alter any existing dysfunctional psychosocial factors.

Knowledge dealing with **relationships between an older person and the family** was also an important knowledge area for the social workers and other members of the teams. In nearly all the cases under review at the meetings, attention was given to the family-patient relationships. Only in one of the acute care team meetings was discussion on family relationships not included. This team meeting focused on six patient cases, three of which were discussed at some length in terms of post-operative recovery and pain management. Family relationships did not surface as a critical issue.

Most, but not all, of the team meetings dealt with **service resources in the communities** of the patients/clients and required knowledge of the specific **facility setting** in order to determine care plans. The patient/client cases reviewed at the team meetings frequently dealt with discharge plans and it was generally in this context that knowledge of community resources was needed. It is not surprising, therefore, that of the three team meetings that did not utilize knowledge of community resources, two of them were held within a nursing home facility - a setting in which discharge is less frequent. In contrast, all three of the meetings that did not touch upon knowledge of the actual health care setting were held in the two community care centers. The fact that the inter-disciplinary team discussions in the community care centers did not include references to the larger facilities in which they were placed, heightened the sense of the community care centers as being separate from their host facilities and operating as independent bodies.

The final two knowledge areas were only apparent in half of the team meetings. A knowledge of **entitlements** of the older person only surfaced in the community care settings and one of the acute care settings. This is noteworthy as many of the patient cases under review in the meetings did deal with discharge planning and needed resources. Entitlements are generally perceived as a complicated and variable body of knowledge and perhaps the team participants left this aspect of planning to others to deal with outside the team meetings. This is an area which needs looking at

more fully, as one would expect the subject of entitlements to be factored into any health care plan of an older person. It would appear to be a proper subject for inclusion in the interdisciplinary team decision making, as eligibility and/or access to entitlements are important variables in the viability of care plans.

Rules and regulations, which set the parameters of care, also surfaced as a topic for discussion or reference in only half the team meetings i.e., those within the nursing homes and in two of the acute care facility meetings. It is possible that there existed an unspoken recognition of the existing regulations and there was no need to specify regulations and facility rules in discussing potential options for care.

Skills Required to Function as an Interdisciplinary Team Member

As in the case of the knowledge areas, the various skills identified in the literature as required by the interdisciplinary team participant, were rated for the lead social worker in each of the observed meetings. Ratings of high, medium, or low were assigned, dependent on the degree to which each skill was exhibited. A low rating cannot be accepted as an indication that the social worker performed poorly in the skill area. It may merely indicate that the skill was not required to any degree during the meeting under observation and was not displayed.

A numerical weighting was assigned to each rating. High was given a score of 3, Medium - 2, and Low - 1. Using these numbers,

an overall score for each specified skill was obtained. The maximum score across all 12 team observations was 36, (See Table IX - II), while a minimum score was 12.

Cognitive Skills

Skill in understanding **family dynamics** in the care of an older person was the highest rated cognitive skill, (34). Focus on the older person as a member of a family unit and understanding of the specific familial relationships and dynamics is considered the province of the social worker and it was to be expected that the rating would be high. The social workers contributed a great deal to the team discussions in this area of family dynamics but it is interesting to note that team participants, representing the other disciplines, also made strong contributions in this area. This was especially true for the physicians and nurses and, when present, the psychologists. However the social workers tended to not only identify specific family dynamics but to link the family dynamics to the patient/client's symptoms and care needs. In this way the social workers used their cognitive skill in this area to educate the other team members and to establish the rationale for the assessments and decisions regarding care.

Also rated high were the cognitive skills of **provider/patient relationships** (29), **care of the elderly** (28), and **organizational systems** (28). The social workers were sometimes responsible for bringing the older person and their families into the interdisciplinary team meeting to discuss the patient/client care

and under these circumstances, exhibited a high degree of understanding of the relationship between a patient and the health care providers. In other instances, the social workers were the team members who took responsibility for relaying the team decisions to the patient/client and, in their remarks, indicated a strong recognition of the relationships that can exist between the patient as supplicant and provider as healer. Along with the other members of the interdisciplinary teams, the social workers revealed knowledge and skills in regard to health care of the older person and the organizational systems within which the health care occurs.

The cognitive skill that rated the lowest score was that of **ethics and human values** (27). In most of the team meetings, care situations were discussed and decisions made that rested on ethical judgements and values but, in general, these values were not discussed in any depth nor were they questioned. At one of the acute care setting meetings, a case was discussed which involved recognition of values but it was only within the community care settings that the interdisciplinary team members (the social workers among them) found themselves consistently involved in discussions regarding ethical values in developing treatment plans. This may have been because the team in the community care setting holds less power to enact treatment decisions and the older patient/client is less compliant, than in the acute or residential care settings, where their autonomy is reduced. As a result, any suggested care plan or intervention in the community care setting was considered by the team from the perspective of the

patient/client's own cultural and ethical values, as these would certainly be a factor in acceptance of the proposed care.

Technical Skills

The purpose of the interdisciplinary team meetings was generally to review patient/client cases and develop treatment plans, and skill in **problem identification** rated a high of 34. Social workers, along with all members of the teams, exhibited skill in defining problem areas.

Communication was also a highly developed and utilized skill. In discussion of their team roles, the social workers often indicated that as social workers they hold a responsibility to interpret the treatment decisions to the patient/client and, within the meeting environment, to express the psychosocial aspects of a case situation in a language that is intelligible to all members of the team. Psychosocial explanations make frequent use of social work "jargon" but it was clear that these social workers were able, and did, demystify the jargon and communicate clearly with the other members of the teams.

The social workers scored high in the skill of **problem solving.** They were seen as key members of the interdisciplinary team in all twelve meetings and participated fully in the problem solving tasks. The one arena where this skill was not quite as evident was in the acute care setting which, as noted earlier, is focussed on the clinical aspects of care and solutions to the identified problems tend to be medical, and emanate from the

physicians.

The skill of **decision making** rated a 28 and, for the same reason, was not higher only because the acute care setting is focussed on health care decisions which are the province of physicians. Decision making skills were more evident in the nursing home settings where the care decisions tended to center on psychosocial issues.

Team maintenance, (28), and **task differentiation** (26), were also rated at this level because, in most of the meetings, there was a low level of need for either of these skills. Team maintenance skills were highest in the nursing home facility in which there was a changing body of team members between the two observed meetings, and at the Plain Vista Hospital where the participating numbers were large and the resulting discussions promised to lead away from the case under review, unless refocussed by the social worker chairing the meeting.

Role negotiation (23), scored the lowest rating. This is a skill recognized as necessary for interdisciplinary team members but little attention has been given to the fact that this skill is required most during the early formative stages of a team. The social workers in these observed meetings did not exhibit a higher use of this skill simply because it was not needed. In general the teams that were observed had been meeting over a lengthy period of time and had developed role patterns that were acceptable to all.

Interpersonal Skills

Social workers are expected to be highly skilled in interpersonal relationships and the social workers observed in these meetings exhibited high levels of skill in those specific areas that are viewed as necessary for functioning as a member of an interdisciplinary team.

The ability to **be open and to trust others** was rated at 35, and a **willingness to share power** at 34. These interpersonal skills of trust and being willing to share power are necessary for team functioning. As one social worker remarked "if teams don't work, it's because of personalities." It was clear that all twelve teams "worked" and this required that every member of the teams, not just the social workers, were willing to work with each other and share power. **A commitment to team collaboration** (rated at 32) was also evident. It should be noted that it was most unlikely that a non-collaborative team would have been selected for observation.

The comment of one of the social worker's, quoted above, is a frequently heard opinion. There is always the temptation to blame a poorly functioning team on personality issues. An explanation based on individual behavior can mask the fact that the team members, social workers among them, may lack knowledge of organizational functions and knowledge of the other disciplines. This study observed only teams which were functioning and in which the personality differences made little difference to the work of the teams. The members had an understanding and respect for each other's professional roles and had worked together for some time,

so were familiar and tolerant of each other's individual, behavioral characteristics. To determine whether poorly functioning, interdisciplinary teams are due to lack of understanding of each discipline's function, (rather than personality differences), requires a parallel study of non-functioning teams.

Skills related to a commitment to team collaboration - **clear communication** (33), **ability to listen** (32), and **willingness to provide feedback** (31) - were also rated as strong. For the social workers, the skill of being willing to give feedback would have been higher except that in some of the team meetings, the social workers were engaged in going in and out of the meetings to escort patients and family members or to retrieve records. It is possible that by adopting the role of team convener and co-ordinator, the social worker may forfeit opportunities to provide relevant feedback to other members of the team?

Lowest rated of these interpersonal skills was **courage to take risks** (29), perhaps because there was little need to take risks as team discussions were uniformly open and accepting of each discipline's contributions, and **flexibility** (27). Flexibility rated as low as this due to the fact that the teams had been in existence for some time and each had developed a structure and customary format. Flexibility was not needed and social workers, as the other team members, displayed comfort in their behavior and in fulfilling their designated team roles. There may be a danger in this as familiarity breeds routine which, in turn, stifles

creativity.

Insights of the Social Workers on their Interdisciplinary Work

The social workers observed in the interdisciplinary team meetings shared their opinions and thoughts about the social work experience within an interdisciplinary health care team. Their comments and insights were remarkably similar, regardless of the specific facility setting in which they each worked.

The Social Worker's Function

There was universal agreement about the function of the social worker in regards to the team. The social worker was responsible for helping to develop patient/client assessments and care plans with other team members, and for discharge planning. In addition, there was a general belief that the role of team facilitator was a task that belonged to the social worker.

The social workers tended to feel responsible for whether the team "was working." To make sure that the team functioned smoothly, the social workers had assumed the tasks of making sure that team members were present, that the appropriate cases were discussed, that each team participant was involved in the discussions and care planning, and that the discussions remained focussed. The social workers also felt that it was important that a social worker use "non-social work jargon" within the team meetings. Psychosocial aspects of a case needed to be explained in

terms which were "useful" to all members of the team.

Why a Team "Works"

The social workers also shared their opinions about which factors were needed to ensure that a group of health care professionals from a variety of disciplines would function as a team. The single most important reason given for the smooth functioning of a team was length of time that the team participants had been meeting as a group. All the social workers spoke of the fact that the team participants in "their" teams knew each other well and were used to working together. This was seen as necessary to establish the necessary respect between the different disciplines. The social workers noted that the team participants did experience differences at times but because the participants knew and liked each other, these differences did not compromise the functioning of the group as a team.

It was also felt that, in order to reach a team decision, the participants must allow each other to add to the discussions and "go off on a tangent." The contributions of each could then be built upon and added to until the knowledge and interests of each discipline were joined in a consensus. An overly formal and structured review of the cases under discussion resulted in reduced sharing of each discipline's special knowledge.

Another aspect of an interdisciplinary group that was seen as contributing to its functioning as a team was the presence of

humor. It was suggested that the team participants needed to laugh together. By not assuming too serious a perspective on their individual roles, the team participants were more open to each other's contributions, and fashioned decisions in which all disciplines participated.

While these were general attributes seen as necessary to team functioning, there were also suggestions in regard to those interdisciplinary teams which were chaired by a physician. Under these circumstances, it was felt that the smooth functioning of the team depended upon the individual team participants feeling comfortable with the physician in charge. Furthermore, it was felt that the social worker, in the role of facilitating the team meetings, should adapt to the specific physician's style. It was pointed out that each physician possessed an individual style which impacted on the nature of the team meeting and that there was no one correct way for an interdisciplinary team meeting to be conducted.

Social Work Responsibility for the Team

Adapting to the style of the team leader and feeling comfortable in the team setting was connected to the initial factor noted i.e., the team participants needed to know and like each other as individuals. That this was the key to a smoothly functioning interdisciplinary team was borne out by the statements that if a team was malfunctioning, this was due to the personalities involved, which created an atmosphere of discomfort.

The social workers perceived their professional role as enabling individuals to work together and understand each other, and thus saw social work as the discipline that was most responsible for a smoothly functioning team by assisting the interdisciplinary team participants to overcome personality differences and learn to like each other.

Impact on the Social Worker of the Interdisciplinary Setting

Working in an interdisciplinary setting within health care was viewed by the social workers as a very different experience than working either just with other social workers or with other disciplines within the mental health setting. Working totally with other social workers, the individual social worker was immersed in social work culture and beliefs, which had its own advantages. Working within a mental health setting, the social worker was working with other disciplines (psychologists, psychiatrists) but these were usually involved together in counseling and therapy, so that the professional cultures and languages did not differ a great deal. It is only when the social worker experienced work within the interdisciplinary health care arena, that real differences were felt.

Within the health care setting and its accompanying work with a number of other disciplines, the social worker required knowledge of these other disciplines - their language, their objectives, and their discipline specific cultures. Conversely, the social worker was forced, by the interdisciplinary interaction, to identify the

social work parameters. Working with colleagues from other disciplines, the social worker was called upon to represent the social work profession and to define the boundaries of the social work role. It was this that led one social worker to remark that social workers in an interdisciplinary team setting "need professional self-esteem and assurance."

In light of the heavy responsibility the social workers in this study had assumed for the functioning of the interdisciplinary teams, ownership of professional confidence, understanding of the social work role and function, and a firm belief in the contributions of social work were essential.

Educational Needs

The social workers were asked if they had received any education or training in order to function within an interdisciplinary setting, and what knowledge and skills should be taught to social work students regarding interdisciplinary work. The social workers, themselves, had received little or no interdisciplinary training as part of their graduate studies in the classroom, learning the necessary skills on-the-job, and, in some instances, through fieldwork experiences. All, save one, felt that education was needed in the schools of social work to prepare a social worker for work with an interdisciplinary team in the geriatric health care setting.

The specific knowledge areas that were identified included medical/clinical information, the aging process, inter-

relationships of health problems and treatment plans, and family dynamics. As one social worker observed, "it requires knowledge to know what is important" in the team discussions regarding patient care. The skill areas that were mentioned focused on general team participant skills as well as the skills required to fulfill the special role of the social worker as a member of a team.

It was noted that schools of social work might include discussion about the physician-social work roles within a health care sequence, but that teaching about the other disciplines and the variety of discipline systems within a health care facility, was absent. Furthermore, social workers in the health care settings also worked with the other disciplines outside the relatively structured team meetings, and it would be helpful if the schools offered an introduction to the interdisciplinary process as a whole.

Closely linked to the social worker's observations regarding their interdisciplinary work, was the recommendation that education focus on defining the social work role within a non-social work setting. Identifying the nature of social work - "how to define our expertise" - and skills needed to establish the social worker's position within the team, need to be included in the curriculum.

TABLE IX-I

Role and Knowledge Areas Required of the Social Workers as Members of the Observed Interdisciplinary Teams

	Acute Care				Comm. Care				Nrsg.H. Care				
	1		2		1		2		1		2		
	1	2	1	2	1	2	1	2	1	2	1	2	Total
Role of Soc. Wkr.													
Leader	-	-	-	X	X	X	X	X	-	-	-	-	5
Follower	X	X	-	-	-	-	-	-	-	-	-	-	2
Initiator	-	-	-	X	X	X	X	X	X	X	X	X	9
Grp Mainten.	-	-	X	X	X	-	X	X	X	X	-	X	8
Mediator	-	-	-	-	X	X	X	-	X	-	-	-	4
Informer	X	X	X	X	X	X	X	X	X	X	X	X	12
Knwldg. Areas													
Med. Termim.	X	X	X	X	X	X	X	X	X	X	X	X	12
Comm. Resour.	X	X	X	-	X	X	X	X	X	X	-	-	9
Setting/Admin.	X	X	X	X	-	-	X	-	X	X	X	X	9
Entitlements	X	X	-	-	X	X	X	X	-	-	-	-	6
Family Dynam.	X	X	X	-	X	X	X	X	X	X	X	X	11
Rules & Regs.	-	X	-	X	-	-	-	-	X	X	X	X	6
Psy/soc. Dyn.	X	X	X	X	X	X	X	X	X	X	X	X	12

TABLE IX-II

Level of Cognitive, Technical and Interpersonal Skills Exhibited by the Social Workers in the Observed Interdisciplinary Team Meetings

	Acute Care				Comm. Care				Nrsg.H. Care				
	1		2		1		2		1		2		
	1	2	1	2	1	2	1	2	1	2	1	2	Total
Cognitive Skills													
Care of Elderly	2	2	3	2	2	2	2	3	2	2	3	3	**28**
Fam. Dynamics	3	3	3	1	3	3	3	3	3	3	3	3	**34**
Provider/Pt.Rel.	2	2	3	2	2	2	3	3	3	2	2	3	**29**
Ethics	2	3	2	1	3	3	3	3	2	2	2	1	**27**
Org. Systems	2	3	2	2	2	2	3	2	2	2	2	2	**27**
Technical Skills													
Problem Ident.	3	3	3	3	3	2	3	3	3	3	3	3	**35**
Decis. Making	2	2	2	2	2	3	2	2	3	2	3	3	**28**
Prob. Solving	2	3	2	2	3	3	3	3	3	3	3	3	**33**
Role Negot.	2	2	2	1	2	2	2	2	2	2	2	2	**23**
Task Differ.	3	2	3	3	2	2	2	2	1	2	2	2	**26**
Team Maint.	2	2	2	2	3	1	3	3	3	3	2	2	**28**
Communic.	3	3	3	2	3	2	3	3	3	3	3	3	**34**
Interpersonal Skills													
Abil.to Listen	3	3	3	2	3	2	3	2	3	3	2	3	**32**
Openess/Trust	3	3	3	2	3	3	3	3	3	3	3	3	**35**
Clear Comm.	2	2	3	3	3	2	3	3	3	3	3	3	**33**
Will. Feedback	3	3	3	1	3	3	3	2	2	2	3	3	**31**
Courage/Risks	2	3	2	2	3	3	3	3	2	2	3	3	**31**
Share Power	3	3	2	3	3	3	3	2	3	3	3	3	**34**
Comm. to Coll.	3	3	3	3	3	3	2	3	3	3	3	3	**35**
Flexibility	2	3	2	2	3	2	2	2	2	3	2	2	**27**

CHAPTER X

STUDY FINDINGS AND THE IMPLICATIONS

Summary of Survey and Team Observations Findings

In this chapter, findings from both the survey of geriatric social workers in health care settings and from the observations of social workers in interdisciplinary team meetings, will be compared and discussed. Implications drawn from the findings will be identified and examined.

This study, of the extent and nature of interdisciplinary work carried out by social workers in a geriatric health care setting, was undertaken to test firstly whether interdisciplinary work is a reality or an illusion. If such work proved to be a reality, as was anticipated, the second objective was to determine which specific knowledge areas and skills are required for social workers to function in an interdisciplinary capacity.

Interdisciplinary work did prove to be a reality of the work setting. It was found that a substantial amount of time was spent in interdisciplinary activities, both within and outside the team meeting activities, which were viewed by all staff as an

important part of their weekly schedules. Characteristics and differences amongst the three categories of health care settings were observed and these did have an impact on the interdisciplinary work of the social workers within each setting

Factors Impacting on the Interdisciplinary Work

Characteristics of the various settings that are relevant to the social work role can be categorized as follows:-

Organizational.

It was expected that the general nature of the three different settings would impact on the interdisciplinary health teams in distinctive ways, creating differences in the way the interdisciplinary teams, and hence the social workers, functioned. The acute care setting, as the most hierarchial of the three settings, was expected to encourage structured interdisciplinary teams; the nursing home facility, viewed as a human relations model, was thought to place the social worker in a central role within the interdisciplinary team; and the community care setting was seen as a collegial model of organization in which a health care team might be most truly interdisciplinary in its activities.

While these differential characteristics were found to exist to a certain degree, they were not as evident as expected and the interdisciplinary role and function of the social workers were more similar than different in all three health care settings. All six organizational settings that were visited

recognized the legitimacy of the interdisciplinary team and supported an interdisciplinary approach to care. In addition, all the observed teams were of long standing and the participants respected and liked each other as individuals. All the observed teams were collegial in nature.

The Dimension of Time

The nature of time was a crucial variable in each setting. The amount of time available for accomplishing the necessary tasks and the time frame, in which the team members operated, impacted on the work of the social workers. Though pressures were felt in every setting regarding the development of care plans and the recording of same in the written records and forms, the nursing home facility offered a milieu of extended time frame in which to assess and arrive at team decisions. At the other end of the scale, the acute care setting demanded immediate care decisions and this lent urgency to the social worker's tasks, as it did for all members of the interdisciplinary team.

Focus of Knowledge

The type of knowledge needed by the social workers was similar in each of the health care settings but with varying emphases. The acute care setting is a medical model and the emphasis was slanted towards clinical applications of medical, health care issues. The nursing home facility, with its client caseload of frail elderly, also required medical knowledge on the

part of the social worker, but psychosocial concerns and the older person and family issues were of greater prominence. This was also true for the community care setting and was especially evidenced in site observations at the one community center where interdisciplinary meetings were led by the social worker and physicians did not participate.

Control Over Patient/Client Care

Within each setting a different degree of control over the geriatric patients/ clients was exercised by the interdisciplinary team participants, including the social workers. There was the least amount of control within the community care setting, in which the focus of the clients' lives was outside the setting and its work.

In the acute care setting, there was control over the care to be given but much was dictated by the nature of the acute health episode that was the cause of the hospitalization in the first place. The social workers, as well as the other team participants, needed to react to the immediate presenting issues. As the emphasis was necessarily on medical care, the physicians held a position of leadership and authority, and social work, along with the other non-medical disciplines, must tailor their work to the medical model.

It was within the nursing home facility that the greatest control over the geriatric population was felt. The time frame of the care being provided, the relative incapacity of the

nursing home residents, and the residential setting, all gave the social workers and other staff greater control in implementing the care decisions and managing the treatment. Goffman's work on the loss of autonomy of the institutionalized individual finds a clear expression within the nursing home facility, in which the residents' independence is weakened. This loss of decision making for self means increased power for the staff of the institution. In this study, the higher degree of control by staff in the residential facilty was reflected in team confidence in the decision making process.

The Social Work Responsibility for the Team

An unexpected finding from the team observations, which will be discussed more fully later in this chapter, was the discovery that the social workers felt responsible for the smooth functioning of the interdisciplinary teams, and that frequently this belief was supported by the other team participants. This responsibility was felt even when the social workers were not acting as leaders or chairpersons of the team meetings. In these circumstances there was an accepted, but unofficial, recognition that the social workers had a role to play in insuring that the team meetings were productive and remained interdisciplinary in focus.

Educational Preparation

A second major finding, to be discussed later, was the fact

that one third of the social work respondents to the survey had taken neither an aging nor a health care course while in graduate school, even though they were now engaged in geriatric health care. Almost one third had also received no formal preparation for interdisciplinary work and, for those that had, the preparation was mostly gained in the fieldwork setting. This finding has implications for the education of social workers who anticipate working within the health care arena with the older population.

Discussion of the Anticipated Findings

In undertaking this study, it was anticipated that several general beliefs about the interdisciplinary nature of the social worker's role in the geriatric health care setting would be confirmed. Furthermore, the existing literature on the knowledge and skill areas demanded in interdisciplinary work was expected to be supported by the experiences of the social workers who responded to the survey or were willing to be observed within the interdisciplinary team meetings. Findings that were anticipated and thus brought few surprises are discussed in this section.

Interdisciplinary Interaction and Educational Preparation

Interdisciplinary Interaction

Interaction between the social worker and other non-social

work disciplines takes place frequently and is not confined to the team meetings. Sixty-five percent of the survey respondents noted that they spent a total of one day or more during the work week in work contact with representatives of other disciplines. Over four-fifths of the respondents were involved in interdisciplinary team meetings regarding client/patient care and a number of other interdisciplinary activities were noted as taking up several additional hours each week. These activities included the development of treatment plans and accessing services for the patient/client.

The social workers observed in team meetings also spoke of the considerable amount of time that is spent outside the actual interdisciplinary meetings in interacting with other disciplines, discussing care management and sharing information. In some instances, these interactive opportunities were structured in the form of regularly scheduled meetings but mostly took the form of informal contact via telephone or in face-to-face contact in casual meetings during the course of the normal workday.

The amount of interdisciplinary interaction was a little higher in the community care and nursing home facility than in the acute care setting. There was no obvious reason given for this though it can be surmised that in the community care setting, the social worker is required to effect access to services for the client/patient to a greater degree than in the other settings and this involves much interdisciplinary interaction; and that within the nursing home, there is almost

continual interaction with the discipline of nursing, as it is the nurses and nursing aides that provide the bulk of care to the residents.

There was no attempt to measure the venue of the most effective interdisciplinary interaction but it is possible that this occurs outside, rather than within, the team meetings. The social worker at one of the acute care sites reported the use of additional meetings between herself and the nurse and physician, on a regular basis each week, in which care decisions were made.

All the social workers who were interviewed viewed their direct contact with health care professionals from other disciplines as occupying a major part of their work hours.

Required Knowledge of Other Disciplines

Not surprisingly, the social workers reported that the disciplines with which they interacted the most were the disciplines of nursing and medicine. Only one or two respondents had no interaction with these disciplines. The other disciplines with whom the majority of the social workers interacted during an average work week were the disciplines of physical therapy, nutrition, law, occupational therapy, and psychology. Considering the health care needs of the social workers' clients, the interaction with these health care disciplines is to be expected. However, it is noteworthy that interaction with lawyers (65% of the survey respondents said they interacted with lawyers in fulfilling their work responsibilities) is experienced

by such a large proportion of the social workers. One might anticipate this within the community care setting when interaction with lawyers is possibly required when dealing with housing issues, access to entitlements, guardianship and decisions of competency. But in the acute care setting and the nursing home facility, many of these issues can be considered either irrelevant or already determined. In actuality, interaction with lawyers did not have any relationship to setting. The high percentage of respondents interacting with lawyers may be taken as a symptom of our litigious society and the close relationship that exists between health care and law.

Considering the reported interaction with representatives of these non-social work disciplines, it is not surprising that the social workers acknowledged the need to know about these other disciplines. Knowledge about nursing and medicine is essential as so much time each week is spent in interacting with them and the social work care of the client/patient is interdependent with the nursing and medical care each client/patient is receiving. The social workers also noted the need to know about the other disciplines. Even if not a great deal of actual time was spent in interaction with each of these disciplines during each work week, the social workers who were interviewed stressed the need to understand the role and capabilities of each discipline. One social worker explained that interdisciplinary knowledge is critical as it enables the social worker to know not only what questions to ask in the

interdisciplinary team meetings but also how to evaluate the care plans that are developed for each client/patient.

Educational Preparation

Nearly all the respondents (57) felt that there was a need to be prepared educationally for interdisciplinary work within the geriatric health care setting. One third of the respondents had taken neither an aging nor a health course while in social work school but, in spite of this, seventy-four percent of the respondents said that they had received some education for interdisciplinary work. Most of this preparation had taken place during the fieldwork experience and not in the classroom. Only sixty percent of all those responding to the survey felt that this educational preparation had been sufficient and prepared them adequately for the interdisciplinary work.

The most recently graduated social workers were most likely to have taken aging courses while in graduate school but this was no guarantee that interdisciplinary preparation was included in such courses. Taking a health course while in school seemed to provide a slightly better chance that some classroom attention would be given to interdisciplinary knowledge and work but there was no significant correlation between taking either aging or health courses and receiving educational preparation in this area.

Though 60% reported sufficient preparation, a full forty percent felt that educational preparation had been absent or

inadequate for what they faced when working with other disciplines. Even among those that felt prepared, a number noted that they had or were taking additional courses and training to assist them with the interdisciplinary aspects of their work. Of the social workers observed within the interdisciplinary team meetings, all, unanimously, reported that their educational preparation had been inadequate.

Analyzing the nature of the content of the interdisciplinary team meetings and speaking with the social work participants of these teams, it was clear that there is a strong need for knowledge of medical terminology and procedures, psychosocial dynamics, and of the older person and the family. Without competence in these knowledge areas, the social worker is excluded from participating productively in much of the team discussions and decision making. Psychosocial dynamics may be the trademark of the social worker and all social work graduates will have received educational preparation in this area. Family relationships are also standard curriculum content in social work schools although, unless a course in aging has formed part of the social worker's education, the family and older person interrelationships might be overlooked. Medical knowledge is less likely to have been received, even if a health course has been taken. It is clear that knowledge of medical language and procedures is essential and if this is not owned prior to working within a geriatric health care setting, this is a content area with which the social worker will need to become familiar as

speedily as possible. As interpreter and counselor to the family and older patient/client and as a core participant in team decisions concerning overall care, in-depth understanding of the medical profession and its language and tools is necessary.

The Interdisciplinary Team Experience

The Interdisciplinary Team Setting

All the interdisciplinary teams that were observed functioned smoothly. There were variations in involvement in the discussions and decision making by the various disciplines and there were differences in degree of formality and conduct of the meetings, but all proved to be interdisciplinary forums. This is not surprising as the specific teams to be observed where identified by the directors of social work in each organization and it was unlikely that a poorly functioning team would have been suggested for observation. It was not, however, the intent of this study to evaluate interdisciplinary team meetings. The focus was on the role and expectations of the social worker within the interdisciplinary team milieu. It is possible that social workers, as participants in less successful or malfunctioning interdisciplinary teams, might have even greater demands placed upon their knowledge and skills and might, therefore, require an even greater amount of educational preparation and interdisciplinary expertise.

Social Workers as Interdisciplinary Team Participants

All the social workers that were observed reported that they felt comfortable as a team participant. However, they also remarked on either the difficulties that were faced when the team was first formed and was "new' or when they themselves first experienced participation in a team as a social worker, just entering the geriatric health care field for the first time. It was these memories that prompted the unanimous belief that educational preparation is a necessity.

Differences Between the Settings

The differences between the three settings, in the manner of the interdisciplinary work and the way in which the team meetings are conducted, do not alter the educational preparation that is suggested above. But these differences are of sufficient importance that they require recognition and incorporation into the social worker's preparation for working within any one of the three settings.

An understanding of the organizational/institutional mores and characteristics better informs the work to be carried out. An understanding of the differing time frames, in which the health care is provided in each of the different health care settings, may alleviate stress and assist the social worker in successful management of the work load. By understanding the focus of care in each of the health care settings, social workers

can identify the knowledge areas that are most critical in each setting. Finally, through recognition of the degree of control that interdisciplinary team participants possess in regard to prescribed treatment plans and client/patient outcomes, social workers gain increased empathy both towards the clients/patients and towards the other health care disciplines. This, in turn, translates into a better quality of care.

Discussion of the Unanticipated Findings

While this study uncovered few surprises there were some findings that had not been anticipated and were of sufficient frequency that they should be addressed and their implications considered.

Degree of Interdisciplinary Interaction

Interdisciplinary Interaction and Seniority

It was expected that the amount of interdisciplinary interaction, between social workers and representatives of other disciplines within the geriatric health care setting, would be extensive and a constant feature of the work responsibilities. What was not expected was the finding that level of seniority of the social worker bore no relationship to the amount and extent of the interdisciplinary interaction. In this study those who were at the level of social worker or project co-ordinator were

marginally less likely to spend over a fifth of their work week in interdisciplinary interactions. Social workers at the Executive Director level spent slightly more time in interdisciplinary interactions but the differences were not statistically significant. Social workers entering the health care facility at the junior beginning level found themselves immediately interacting with representatives of other health disciplines on matters of patient/client assessment and care.

This means that on first entering the health care setting, there is no grace period in which the beginning social worker might learn about the other disciplines or receive training in effective interdisciplinary interaction from more senior level social workers. Interdisciplinary interaction is a given of the setting and the functions of the social worker and interdisciplinary demands commence from the first day. It is not a task that one takes on as one develops as a professional.

It was preparation for this interdisciplinary interaction that was referred to by those respondents who reported that they had received educational preparation in their fieldwork placement. Those social workers who do not experience a fieldwork placement in a health care setting, in which interdisciplinary interaction is the norm, are faced with the need to learn quickly and immediately when they enter a health care setting. Social work interns were present at two of the team meetings that were observed. In both these cases, the social worker remarked that part of the intern's training was experiencing the team modality

and learning to work with other non-social work disciplines.

Interdisciplinary Interaction and Setting

In regard to amount of interdisciplinary interaction, it seemed incongruous that extent of interdisciplinary interaction for the survey respondents tended to be higher for those social workers in the nursing home or community care setting and lower for those in the acute care setting. In general the acute care setting employs a greater number of different health care professionals on a full-time basis than does the nursing home or community care center where the non-social work professionals are more likely to operate on a visiting, part-time basis or as consultants only. Thus one would expect a greater degree of interdisciplinary interaction in the acute care setting.

That this is not so may be due to the fact that in the acute setting, the work is crisis centered and just because representatives of all disciplines are in evidence there are fewer attempts to schedule opportunities for interaction. Leaving the interaction to casual contacts may be insufficient. Conversely, in the other settings, specific time may be set aside for interdisciplinary interaction as, without this structure, it is recognized that no interaction would take place. This is an area which intrigues and is worthy of additional study.

Educational Preparation.

Education Concerning the Social Work Profession

Whereas it was anticipated that a finding of the study would be that social workers lack educational preparation for interdisciplinary work within the geriatric health care setting, the nature of the needed educational content transcended the expected. In addition to the need to receive preparation by learning about the non-social work disciplines - their bodies of knowledge, their procedures and their philosophies - and learning how to function as a member of the interdisciplinary team, social workers also indicated a need for preparation in a third content area.

This third content area deals with the parameters of the social work profession itself. Social workers observed in the interdisciplinary team meetings, remarked that to be a functioning team participant, it is necessary to understand fully the role of the social worker, the nature of the social work profession and the possibilities and boundaries afforded the social worker. This understanding is needed not only so that the social worker can then reflect this to the non-social workers but also that the social worker may own a sense of professional confidence and credibility. Without this sometimes intangible base of knowledge, the social worker lacks professional strength. The social workers, that articulated the need for education regarding the discipline of social work, did so in reference to a perceived lack of preparation in this area.

Time Spent in Educational Activities

A second unanticipated finding in regard to educational preparation holds implications for future remedies. This finding is that little time is spent by social workers in geriatric health care settings in educational activities. Of the survey respondents, one quarter (25%), i.e., 15 persons, spent no time during the work week in educational activities and a further 70% (42 persons) spent less than 5 hours a week on this activity. While it is not expected that educational activities will occupy a major part of a social worker's weekly work, it is dispiriting to note the low amount of time devoted this activity by the individual social worker, given the number of journals, written articles, professional conferences, and educational opportunities afforded by staff meetings, that are generally available. This finding holds implications for determining how interdisciplinary knowledge might best be imparted.

The Interdisciplinary Team Meetings

The Team as a Focal Point.

All the interdisciplinary teams that were observed fulfilled stated objectives. The meetings were scheduled and specific work tasks, dealing with the assessment of care needs and the development of treatment plans, were established for each meeting's agenda. Observation of the meetings revealed that the value of the team meeting goes beyond this. The team meetings also filled a function for the participants unrelated to the

stated goals. Even when time was limited, which was nearly always the case, and even when the team participants exhibited pressure to accomplish the meeting's agenda, the actual convening of the participants as a group was, in itself, a form of respite. Admittedly, the teams that were observed were all functioning teams with participants who respected each other and were comfortable in their interactions, but there was a sense of respite for the participants from the pressures of the patient/client issues that waited beyond the doors of the meeting rooms.

The meetings provided a formal, legitimate means of coming together to share insights and frustrations and to gather strength from each other in the form of professional support and recognition. The meetings were a time for some laughter and a reaffirmation of direction. Is it possible that the team milieu itself enriches the overall quality of interdisciplinary work? This, too, is an area which deserves more study. The finding underscores the work of Campion, whose study found that health care professionals who were members of an interdisciplinary team possessed higher levels of morale and job satisfaction than those who were non-team participants. (Campion, Jette, & Berkman; 1983.) For an organization that is non-supportive of the team format, this may be the very justification that is needed to change the attitude of the administration.

Social Work Responsibility for the Team.

An additional finding in regard to the interdisciplinary team was the strong sense of responsibility held by the social workers towards the team functioning. In some cases the social worker was appointed as co-ordinator of the meetings with responsibility to convene the participants and establish the agenda, whether or not the social worker also assumed the leadership of the meetings. At other facilities, the social worker was not formally charged with responsibility but took this upon herself. Furthermore, the other non-social work participants informally acknowledged this unspoken role of the social worker, perhaps viewing this role as something that a social worker does.

In discussions with the social workers after observing the interdisciplinary meetings, the social workers frequently remarked on the actions they took as social workers, to ensure that the meetings would function smoothly. These actions ranged from carrying the case record binders to the meetings to rephrasing technical statements into more generic language accessible to all participants or posing specific questions in the meetings that would draw the non-participant team member into the ongoing discussion.

The social workers often acted as mediators or advocates on behalf of the quieter, less aggressive members of the interdisciplinary teams. A pattern that repeated itself in several of the observed team meetings was that of a white

physician (male or female), a white, female social worker and female nurses who were Asian. When this pattern occurred, the social worker often took an advocacy role on behalf of the nursing participants during the case discussions, asking specific questions designed to elicit comments and opinions from the nurses who were less culturally inclined to participate aggressively in discussion. This social work role also occurred when nurses aides were invited to participate in the meetings. On these occasions, both the nurse participant (supervisor of the nurse's aide) and the social worker acted as mediators and encouraged input. In these situations, this protective role was assumed regardless of the particular cultural background of either the social worker or the aide. In such instances the social worker was seeking to overcome and compensate for differences in authority.

The means employed to ensure smooth functioning of the team varied from one social worker to the next, but what was universal was the sense that being the social worker, participating in the team, carried with it a responsibility for the whole. Is this an integral part of the social work culture? This is an area for which social workers entering the health care field may not be prepared, and which needs to be acknowledged. There are unspoken expectations by the interdisciplinary team members of the participating social worker. Whether justified or not, this was a reality in the team meetings that were observed.

Knowledge and Skill Areas

Knowledge Area - Entitlements

While the expected knowledge areas, as noted in the literature, were in evidence, the low use of entitlement knowledge was unexpected. Social workers only used entitlement knowledge in the two community care team settings and one of the acute care team meetings. In the other meetings, a need for such knowledge was sometimes demanded in which case the social worker needed to gather the required information and a note was made of this, but generally inclusion of entitlements in the case discussions was absent. Only twelve team meetings were observed so that no firm conclusion can be reached from this finding, but it would appear that entitlement knowledge could play a larger part in the discussions of treatment plans. The fact that it does not may either be due to a real lack on the part of the team participants or else an acceptance that entitlements is the purview of the social workers and does not need to be included in an interdisciplinary discussion, but can be safely left for the social worker to deal with outside the team meeting.

Skill Area - Ethics

Unexpected too was the comparatively low level of cognitive skills in ethics and human values. The team participants were often engaged in case discussions that involved matters of ethics and differences in values regarding care and quality of life issues. In spite of this, the discussions tended to focus on the

clinical aspects or psychological aspects of care and, in most cases, neither the social workers nor the non-social work participants pursued an issue from an ethical viewpoint.

There were notable exceptions to this as in one of the team meetings at Rocky Hill Hospital. At this meeting, there was a lengthy discussion concerning discharge plans for an older patient which centered around the competing wishes and rights of the patient and a family caregiver. In general, however, the ethical aspects of each case were left unquestioned. This may be due to the time constraints faced by all of the team meetings or may be due to a genuine lack of skill or familiarity with the "soft" content area of ethics and values. Ethics in health care has only recently enjoyed a resurgence as a popular topic and a proper field of enquiry and it is probable that as fashions and foci change, the use of cognitive skills in ethics will be granted a greater platform in the interdisciplinary team discussions.

Major Findings and Their Implications

Need for Knowledge and Skills for Interdisciplinary Work

An overwhelming 95% of the survey respondents affirmed the need for knowledge of other disciplines and skills for working

with non-social workers within the geriatric health care setting. Though 74% indicated that they had received some preparation in these areas, only 60% said that the education was sufficient and five of the social workers noted that they had taken or were currently taking courses to rectify their lack of preparation. All of the social workers observed in the team meetings reported that their own education for interdisciplinary work was insufficient.

There is a clear need for educational preparation for social workers in the geriatric health care settings. While there is some existing educational preparation, there is a need to increase the opportunities for this. Social workers require education regarding interdisciplinary work as well as about the non-social work disciplines with which they interact. Judging by the findings of the survey, these disciplines include not only the health care disciplines normally found within a health care setting but also the discipline of law. Education is also required concerning the nature of the various health care settings and the manner in which the specific setting impacts on the social work role. Social workers also need education regarding social work as a profession.

Site of Educational Preparation

The majority of the survey respondents who had received educational preparation for interdisciplinary work had done so within the fieldwork setting only. (43% of the total number of

respondents.) Thirty-one percent had received education within both the fieldwork setting and the classroom, though the classroom learning seemed unrelated to participation in either aging or health courses. The remaining 26% had received no educational preparation at all. Thus most of the interdisciplinary preparation was rooted within the fieldwork setting.

An increase in educational preparation of social workers entering the geriatric health care arena in regards to interdisciplinary work, could occur within the classroom setting but should not be limited to this. The fieldwork setting appears the most logical and appropriate location for interdisciplinary educational preparation for it offers the opportunity to witness and participate, first hand, in interdisciplinary work activities. If the classroom setting becomes the locus of educational preparation for interdisciplinary work, it is unclear in which part of the curriculum, this content should be included. Of the survey respondents, 32 social workers, (53%), reported taking an aging class while in graduate school, 24 (40%) had taken a health class but 22 social workers, (37%), answered that they had taken neither courses in aging nor courses in health while in graduate school. Unless there is a closer link between courses taken in the classroom and eventual work in a health care setting, there will be no guarantee that those who need educational preparation in interdisciplinary work will participate in those courses which include the necessary content.

Knowledge and Skills Required by the Social Work Interdisciplinary Team Participant

The seven knowledge areas identified in the literature as required by the participant of an interdisciplinary team are all required by the social work participant. Of most importance, judged by the frequency and depth that these knowledge areas are needed in team discussions, are knowledge of medical assessments and procedures, psychosocial dynamics and older person and family relationships. Marginally less important is knowledge of community resources and the specific facility setting. And least important appear to be knowledge of entitlements and rules and regulations governing care in each setting.

Educational preparation concerning these knowledge areas is vital. If it is not feasible, due to time constraints, to include all seven knowledge areas in an educational program, then focus should be on those that are required to the greatest extent. Entitlement knowledge and an understanding of the rules and regulation governing care in a specific setting are content areas that can be more readily learned from written manuals and as needed.

All the identified skill areas were also found to be needed and used by the social workers participating in the interdisciplinary teams. The extent to which the skills were exhibited and called for in the course of the team meetings indicates their educational importance. Family dynamics rated the highest of the cognitive skills. Problem identification and

communication skills were the most used technical skills, and the only interpersonal skills that were rated as less utilized than the others were the skills of courage to take risks and flexibility. These skills, as discussed in Chapter IX, were least exhibited as the teams were of long standing and functioned smoothly, thus providing little or no opportunity for utilization of these interpersonal skills. For those teams that are newly constituted or for those social workers participating in an established team as a 'new' member, these skills would be required.

Any preparation of social workers for interdisciplinary work needs to focus on the listed skill areas. Educational preparation in the fieldwork setting could focus on the practice of these skill areas and a conscious evaluation of the social work student's abilities in each category.

Social Work Responsibility for the Interdisciplinary Team

The finding, that social workers who participate in an interdisciplinary team assume a responsibility for the successful functioning of the team, holds important implications. The social workers observed in the team meetings felt responsible for the cohesion and productivity of the interdisciplinary team and the non-social work participants of the team also viewed the social worker as fulfilling a co-ordinating and maintenance role in respect to the team. This responsibility was formally recognized at only three of the six sites visited, but in the

follow-up interviews, all but one of the observed social workers verbalized their sense of responsibility for the effective functioning of the team.

Educational preparation is needed for the social workers in a geriatric health care setting in group facilitation and group dynamics. This is true for those social workers whose chosen field of concentration is casework as well as for the group workers and community organizers.

Paucity of Professional Educational Activities

The finding, that social workers in geriatric health care settings spend little or no time during the workweek in educational activities, must be considered when developing educational opportunities. Though, as professionals, social workers bear a responsibility to remain abreast of knowledge in their field, this does not always occur. If the needed education concerning interdisciplinary work is not provided as part of the graduate education, in either the classroom or the fieldwork setting, then other mandates may be needed to assure that the necessary educational preparation is received. Such mandates could be in the form of required continuing education credits or for the social work departments within geriatric health care settings to be providers of interdisciplinary education through in-service training.

Systems Implications

The implications of the findings of this study may also be viewed from the perspective of the various "players" in this arena of social work and geriatric health care.

The Social Worker in the Health Care Setting

Interdisciplinary Preparation

Social workers involved in geriatric health care can expect to find themselves participating in interdisciplinary teams and engaged in a range of interdisciplinary activities. This can prove to be a difficult and challenging aspect of the work for a social worker who has received no conscious educational preparation. The interdisciplinary nature of the work needs to be recognized at the outset and adequate education and skill training undertaken.

An understanding of the other non-social work disciplines - the terminologies, the philosophies, the organizational and professional cultures - is needed for recognition of what is possible in the care of the geriatric patient/client and in order that the geriatric care might not be impeded through professional misunderstandings leading to poor co-operation.

Responsibility for the Team Functioning

The social worker is required to become more than merely one of the interdisciplinary team participants. Expectations of

both the non-social work team members and of the social workers themselves are that the social work member of the team will assume responsibility for the functioning of the team. To fulfill these expectations, whether they are outwardly or inwardly imposed, requires that the social worker needs to be skilled in group and interpersonal skills. The social worker becomes not only an advocate for the individual geriatric patient/client as each case is discussed but is also an advocate for the individual team participant, ensuring that each discipline is engaged in assessment and development of treatment plans.

Geriatric Health Care Facilities

Organizational Support for Interdisciplinary Work

The organizations involved in geriatric health care - the acute care hospitals, the community health centers and day care centers, and the nursing home facilities - are settings in which interdisciplinary geriatric care becomes more than the sum of the parts. A recognition of the value of interdisciplinary work, whether via interdisciplinary team meetings or through informal contact between different disciplines, can only lead to organizational support and encouragement of the interdisciplinary approach. The six organizations, sites of the team observations, all did acknowledge and sponsor an interdisciplinary milieu.

Hidden Value of the Interdisciplinary Team

What may not be fully recognized by any geriatric health care setting is the crucial aspect of the interdisciplinary team culture itself. Though this study was of the social work role and function in the interdisciplinary team setting, it was clear that every team participant, whatever discipline they represented, received a level of satisfaction and recognition by being a participant of a team. The respite from patient/worker issues and the opportunity for collegial support and interaction that the meetings afford would appear to add immeasurably to work satisfaction and, by implication, to quality of care and staff morale. If this is indeed true, geriatric health care facilities would be advised to ensure that every staff person is provided with the opportunity to participate in interdisciplinary team work.

Graduate Social Work Schools

Curriculum Development

In light of the survey findings and the comments of the observed social workers, graduate schools do not, currently, offer sufficient educational preparation for interdisciplinary work. The fieldwork setting may be arguably the optimum arena for interdisciplinary education and the development of the necessary interdisciplinary skills but it is the graduate schools which define the overall curriculum. The graduate schools can do much to further the educational preparation of social workers in

geriatric health care settings by enumerating the interdisciplinary aspects and specific educational objectives to be met by the individual fieldwork setting. Such objectives can be used as a guide for the fieldwork supervisor in directing a student's learning.

Within the classroom, an increased acknowledgement of the interdisciplinary aspects of geriatric health care is required and can be integrated into existing courses. There being no guarantee that social workers who enter the health care field enroll in aging or health courses and given the fact that interdisciplinary work is integral to social work in many fields of practice, this body of knowledge and skills could be included in the existing methods courses.

Possible Solutions and Strategies

Discovering or confirming a need, for increased educational preparation for geriatric social workers in the area of interdisciplinary work, may be a necessary first step, but does not take into account the feasibility of possible solutions. The study undertaken here confirmed much about the knowledge required by the geriatric social worker and discovered some unexpected factors involved in the interdisciplinary nature of the work. It did not, however, point the way to the correct means of ensuring adequate educational preparation. As a conclusion to this

account, the following potential educational strategies are offered.

1. **Interdisciplinary Curriculum.** The interdisciplinary nature of geriatric social work in a health care setting involves sufficient knowledge areas to form the content of an entire fifteen week graduate course. With the increase in the frail geriatric population in the coming years, the graduate schools will be preparing an increasing number of Master level social work students for work in geriatric health care settings. All of these students might be required to take a course on the interdisciplinary nature of health care, as part of an aging or health specialty.

The initial difficulty with this approach is the fact that social work graduate students do not necessarily know or identify the field of practice which they will enter after graduation. Even if the linking of eventual work setting and classroom studies was obtained, more serious obstacles stand in the way of adding a new course to the graduate school curriculum. All academicians recognize the administrative difficulties and issues involved in adding new courses to an overburdened graduate curriculum. Time and funding constraints mean that any new course can generally only win approval if it is substituted for another, and this requires agreement by administrators and faculty that some other course is no longer needed or is of lesser importance. As long as the social work graduate schools

remain with a two year degree program consisting of both class and fieldwork learning, it will be difficult to secure sufficient time to introduce a new course.

In lieu of an entire course, interdisciplinary curriculum segments might be integrated into existing courses on aging and/or health, or, as noted earlier, into the methods courses. This is already the accepted practice in some schools but needs to be extended to all.

2. **Team Teaching.** The study confirmed the need by geriatric social workers in the health care setting to know about other disciplines, in particular to be familiar with the medical profession. Opportunities for team teaching is an option open to graduate social work schools. Courses might be taught with leadership from a Social Work professor and from a physician. In such a scenario, both instructors would teach the content together, reacting to the specific curriculum content from their own professional perspective. In this manner they will not only teach the required interdisciplinary content but also model the interdisciplinary team approach.

This educational strategy also faces obstacles. Once again there are cost issues as team teaching means double the cost of offering a course and, for faculty, there are problems concerning work loads. While it might be argued that two faculty to teach one course translates into each faculty person taking responsibility and giving time for half a full course, this is

not so in practice. Team teaching requires a great deal of skill and preparation time in which both the identified faculty must participate.

As an alternative, if an entire team taught course is not feasible, guest lecturers might be utilized as part of a specific course. Another solution, though requiring administrative creativity, is for faculty from schools of social work and medicine to be paired for purposes of exchange lectures, each acting as guest lecturer for the other during an academic semester. Differences in salaries, workloads, lecture expectations, and physical locations would all need to be considered for this teaching modality to be successful.

3. **Fieldwork Learning Opportunities.** If Master's level social work students are placed in health care settings for their fieldwork assignment, they will experience the interdisciplinary climate. For these students, care needs to be taken both in defining the specific learning opportunities concerning interdisciplinary work and in structuring what content is to be taught.

The schools of social work need to take responsibility for identifying the learning objectives and assisting the fieldwork supervisors in placing a focus on interdisciplinary learning. Participation, under the supervision of a senior social worker, in an interdisciplinary team and a conscious teaching, as part of the supervisory process, of the demands and issues involved in

the interdisciplinary modality, will assist the graduate student in the development of the necessary skills and knowledge.

4. **Continuing Education.** Continuing education courses are suggested as an alternative to offering classroom education for interdisciplinary work as part of the Master's degree program. Post graduate courses, given at times that are convenient to persons already employed, can focus on the interdisciplinary skills and knowledge required of the social worker in a geriatric health care setting. These continuing education courses can be included among the various continuing education courses that academic institutions already offer to their alumni and other interested persons. Using this format to disseminate knowledge holds the added advantage of providing an extra source of income to the academic institution offering the continuing education course(s), as well as identifying those who complete the course as accredited owners of interdisciplinary knowledge and skills. This identification provides a competitive edge in the job market.

The difficulty, with assigning the teaching of necessary educational content to a continuing education modality, lies in the timing of the offered education. For social workers in the geriatric health care setting, learning the theory and practice of interdisciplinary teamwork after graduation and initial employment, may be too late. Entering geriatric health care without the advantage of interdisciplinary knowledge and skills

may be a cause for work related stress and a rejection of interdisciplinary work. On the other hand, once involved in the geriatric health care field, social workers may find their job interests validated and, with an experiential base in interdisciplinary teamwork, be more receptive to this body of knowledge, and more understanding of the practical applications of what is being taught.

5. **In-service Training.** Social work departments within geriatric health care facilities can be the locus of education to prepare the incoming employees for the interdisciplinary milieu and tasks they will be expected to perform. Social work departments can offer interdisciplinary orientation workshops and in-service training to entering social workers who have not already received educational preparation in their classroom or fieldwork experience. In addition, the newly appointed staff might be paired with an experienced social worker who will act as a mentor responsible for providing guidance specific to interdisciplinary activities and team functioning.

On-the-job training exists and social workers entering the health care setting no doubt learn quickly, by necessity, the skills needed to function within the setting. It would, however, be a danger to leave the acquisition of knowledge and skills solely to this informal method. Difficulties and misunderstandings can be avoided if on-the-job training is structured to ensure that the intuitive learning is related to

theory. The larger health care facilities with established social work departments hold an advantage here as they possess the resources to provide in-service training. Smaller facilities, with fewer social workers and resources, may find this strategy not feasible.

For the social worker in a geriatric health care setting, interdisciplinary knowledge and skills form a crucial part of the social worker's arsenal of expertise and ability. While much is still not fully understood or documented concerning the interdisciplinary work demands, a great deal is recognized and acknowledged regarding the specific knowledge areas and skills that are needed. It is time for schools of social work, social work departments in the work-place, and the social workers themselves, to all take responsibility for an adequate educational preparation for the interdisciplinary aspect of geriatric care.

APPENDIX I

Cover Letter Accompanying Survey Questionnaire

Dear Colleague

In the next few years the social work profession will experience an increase in the need for qualified geriatric social workers in health care settings to meet the needs of the growing population of frail elderly. The schools of social work, offering Masters degrees in Social Work, hold the responsibility to provide the necessary education and training to ensure that social workers are equipped to meet the demands of geriatric social work.

A study is currently being carried out to gather information about the nature of geriatric social work. With this information, schools of social work will be better able to provide the education needed for the available jobs. You have been identified as a social worker in the health care system and I'm writing to request your help in this study. Please will you take a few minutes to complete the enclosed questionnaire and return it to me within the next two weeks. A stamped, addressed envelope is included. Your help will be most appreciated as the information that you can provide will be invaluable and lead to a better understanding of the nature of the social worker's tasks and responsibilities in working with the frail elderly.

The information that you provide will be kept confidential and neither your name nor place of work identified in the written report. A copy of the finished report will be sent to you when it is completed.

Thank you so much for taking the time to complete the questionnaire. If you have any questions, please call me at (212) 481-5142. Thank you.

Sincerely,

M. Joanna Mellor

APPENDIX II

The Nature of Social Work in Health Care Settings

The purpose of this questionnaire is to determine the nature of the social worker's tasks when working with the frail elderly in a health care setting. Your answers to the following questions will provide a clearer understanding of the social worker's role. The findings will be used as a guide for the education of geriatric social workers.

1. Type of work setting. Please check.

   Acute care hospital _____

   Long Term Care facility _____

   Community health center _____

   Other (please specify) _____

2. Approximately what % of your client group is over the age of 65? _____

3. Under the age of 50?_____

4. Your title/position _____

5. What activities do you undertake in fulfilling your work? Please list eg:interviewing, advocacy etc.

   _____

   _____

   _____

   _____

6. In fulfilling your work responsibilities you are engaged in a variety of tasks. Please indicate approximately how many hours in an average work week is devoted to each of the tasks listed below. (Total number of hours may add up to more than a full work week as some tasks overlap.)

Client interview and assessment _____

Development of treatment plans _____

Team/committee meetings:

a) Client related eg:treatment and care planning ___
b) Organizationalmeetings eg:Budget,PRO mtgs.etc ___

Groupwork eg:support groups,group therapy etc.___

Family meetings ____

Accessing services, Info.& Referral, etc. ____

Counseling _____

Community/home visits _____

Filling out forms _____

Supervising students, staff _____

Administrative details _____

Journal reading, attending educational mtgs. ____

Other (Please list and give approximate no. of hours spent in each task.)

_____

_____

_____

7. In an average work week, approximately what percentage of your time is spent in contact with:

Clients _____

Family and friends of clients _____

Other social workers _____

Health care professionals (other than social workers) _____
Other eg:landlords, religious leaders, office staff, etc. _____

(Percentages may add up to more than 100%)

8. Other than social workers which professions do you interact with in fulfilling your work responsibilities? Please check all that apply.

Nurses _____ Physicians _____ Nutritionists ____

Audiologists _____ P.T. _____ O.T. _____

Psychologists_____ Dentists _____ Speech Lang._____

Religious Ldrs.____ Lawyers _____

Other (Please specify)_____

_____

9. Which profession do you interact with a) the most? _____

b) the least? _____

10. Do you feel that knowledge of other disciplines, and skills in working with other disciplines, are needed for you to fulfill your social work tasks? Yes_____ No_____

Unsure_____

If your answer is yes, please explain why _____

_____

_____

Now a few details about your own educational background.

11. In which year did you receive your MSW? _____

12. What was your method(s) of concentration when in graduate school?

Casework _____ Groupwork _____ Comm.Organizing _____

Admin._____ Research_____ Other(Please specify)_____

13. While in graduate school did you take any courses in:

Aging Yes _____ No _____ If yes, how many? _____

Health Care Yes _____ No _____ If yes, how many? _____

14. While in graduate school did you receive any education in understanding other disciplines/professions or in interdisciplinary teamwork, either in the classroom or as part of fieldwork ?

Yes_____ No _____

15. If you answered yes to Question 14, was this education provided as:

Classroom education, part of a course _____

Fieldwork supervision/education _____

Both of the above _____

(Check which applies.)

16. Did this education prepare you for the interdisciplinary knowledge and skills you require in your work?

Yes_____ No_____ Unsure_____

If you have any additional comments that you would like to share, please note them below.

Thank you for your time in completing this questionnaire.

APPENDIX III

Survey Code Book

Variable Name	Q.#	Variable Label	Card	Col.	Categories/Codes
V1	-	ID#	1	1-2	Code ID
V2	-	sex	1	3	M=1, F=2, Unknown=9
V3	1	wkstg	1	4	Acute Care=1 LTC Facility=2 Community Clinic/Home Care=3; Senior Center=4 Other=5 Unknown=9
V4	2	over65	1	5-7	Code % given Unknown=999
V5	4	title	1	8	Director/Exec. Dir.=1 Ass/dep. Dir.=2 Soc. Wk. Superv. & Proj. Coord.=3 Soc. Wker.=4 Other=5; Unknown=9
	5	wkact	1	9	Yes=1, No=2, Unkn.=9
V6		int.			
V7		assess	1	10	" "
V8		mtgs	1	11	" "
V9		counsel	1	12	" "
V10		group	1	13	" "
V11		IR/advoc	1	14	" "
V12		homev	1	15	" "
V13		super	1	16	" "
V14		papwk	1	17	" "
V15		admin	1	18	" "
V16		other	1	19	" "
	6	wkrestm			
V17		int	1	20-21	Code no. of hours 99=unknown.
V18		trtpl	1	22-23	" "
V19		mtgcli	1	24-25	" "
V20		mtgorg	1	26-27	" "
V21		grp	1	28-29	" "
V22		fam	1	30-31	" "
V23		IR	1	32-33	" "
V24		couns	1	34-35	" "
V25		chmvis	1	36-37	" "
V26		form	1	38-39	" "
V27		supr	1	40-41	" "
V28		admin	1	42-43	" "
V29		educ	1	44-45	" "

Var. Name	Q#	Var. Label	Card	Col	Code
V30		oth1	1	46-47	" "
V31		oth2	1	48-49	" "
	7	Contact			
V32		cli	1	50-52	Code % time given 999=unknown.
V33		fam	1	53-55	" "
V34		socwk	1	56-58	" "
V35		hcpro	1	59-61	" "
V36		oth	1	62-64	" "
	8	Profint			
V37		N	1	65	Yes=1, No=2, Unk.=9
V38		A	1	66	" "
V39		Psy	1	67	" "
V40		Reg	1	68	" "
V41		MD	1	69	" "
V42		PT	1	70	" "
V43		Den	1	71	" "
V44		Law	1	72	" "
V45		Nut	1	73	" "
V46		OT	1	74	" "
V47		SL	1	75	" "
V48		Oth1	1	76	" "
V49		Oth2	1	77	" "
CARD II					
V50		ID	2	1-2	Code ID #
V51	9	Intmo	2	3-4	Nurse=01, Audio=02, Psych=03, Reg. ldrs=04, MD=05, PT=06, Dent=07, Law=08, Nut.=09, OT=10, Sp.Lang=11, Other=12, Unknown=99
V52		Intlst	2	5-6	" "
V53	10	Intknec	2	7	Yes=1, No=2, Don't know & Unsure=3, Missing=9
V54	11	YrMSW	2	8-9	Code last 2 digits
V55	12	Methconc1	2	10	Casework=1, Group=2, Comorg=3, Admin=4, Res=5, Other=6, Not by meth=7, Unknown=9
V56		Methconc2	2	11	" "
V57	13	Agingco	2	12	Yes=1, No=2, Don't know=3, Unknown/Missing=9
V58		Hlthcaco	2	13	" "
V59	14	Inted	2	14	" "
V60	15	Provinted	2	15	Classroom ed=1, Fieldwork=2, Both=3, Unsure=4, Missing/NA=9
V61	16	Edprep	2	16	Yes=1, No=2, Unsure=3, Unknown/NA=9.

APPENDIX IV

Letter to health care sites, requesting permission to observe interdisciplinary team meetings. Sent as follow-up to initial telephone contact.

Dear ,

It was a pleasure speaking with you and I thank you for the opportunity to explain a little more about the study I am undertaking.

The aim of the study is to gather information about the interdisciplinary nature of geriatric social work practice in health care. In my work with the Hunter/Mount Sinai Geriatric Education Center, which emphasises the value of interdisciplinary health care for the older person, and as a social worker myself, I have become interested in how little of an interdisciplinary nature is included in the social work curriculum and yet how much of interdisciplinary knowledge and skills is required once a social worker is in practice. Now, as a doctoral candidate at Hunter College, I am looking at the interdisciplinary knowledge and skill base used by social workers in health care settings where a large proportion of the patient population is elderly. Hopefully the findings can be translated into curriculum within the schools of social work, so that the schools can better prepare social work students to meet the demands of working within today's health care system.

The study consists of two parts - a survey of social workers in health care, and a study of interdisciplinary team meetings. It is with this second part of the study that I am requesting your help. I hope it might be possible for me to "sit in" and observe a team meeting at _____ on two separate occasions. My objective is not to evaluate the team meetings in any way but to observe the knowledge and skills required of the social worker to function within this situation.

Information regarding patient care that is discussed at the meetings will be kept confidential and I will not identify the facility or the social workers themselves by name. It is the cumulative information, that I can gather from all the site observations, that will form the final report.

I do hope that I may "sit in" on a team meeting. Please call if you need further information. I will call you next week to follow up with this request. Thank you for your help and consideration.

Sincerely,

GLOSSARY AND EXPLANATION OF USE OF TERMS

Community Based Care. Health and/or social service care delivered within the community, either in the home or in an ambulatory setting, eg., outpatient clinic, adult day care center.

Geriatrics. The practice of medicine concerned with the diseases associated with old age.

Geriatric Social Work. The practice of social work within a host health setting in which the diseases associated with old age are treated.

Gerontology. The branch of science concerned with aging.

Health Care Setting. A setting which provides health and/or social services to patients/clients who are functionally vulnerable. Hence an adult day center, which does not provide direct medical care but is planned on a social model, is included under the definition of health care setting as the center clients utilize the services on account of their vulnerable health status.

Interdisciplinary Team. A group of persons representing a variety of disciplines and interacting as a group for purposes of assessing patient/client situations, planning and implementing care.

A variety of terms are used in the literature to describe interdisciplinary teamwork. Often these terms are used synonymously but they frequently also imply different shades of meaning. (See below.) For the purposes of this study the nomenclature - **interdisciplinary** and **team** - will be employed.

Interdisciplinary not Interprofessional. Not all members of the geriatric health care team may be members of a recognized profession even though their role on the team is important and necessary. In its narrowest sense, profession refers to medicine, law, and the church, while discipline, by indicating training or education in a specific field, holds a broader connotation. An interdisciplinary team encompasses the health aide and the recreational therapist more readily than one defined as a team of professionals, which is frequently used to indicate persons with postgraduate training.

Interdisciplinary not Multidisciplinary. A distinction is needed between multidisciplinary, in which different disciplines function independently, and interdisciplinary, in which the various disciplines work interdependently. Too often it appears that the characteristic of interdisciplinary is attributed to what is, in reality, merely different disciplines working alongside each other but independently. Petrie makes the

distinction that the multidisciplinary team requires everyone to do "his or her thing with little or no awareness of the other disciplines work' while the interdisciplinary team process demands that the participants take into account the contributions of other team members." (Clark et al., 1986.)

Teamwork not Collaboration. These two terms are used in the literature almost interchangeably. However there is some indication that the use of 'collaboration' implies the act of collaboration on the part of one member of the team and does not necessarily extend to all the team membership. Hence the study conducted by Feinman et al. in the seventies stresses the need for the social worker to learn collaborative techniques in order to work with other disciplines, and there is a sense of the collaborator adjusting to other disciplines without a corresponding adjustment on the part of others. "Teamwork," however, suggests that all members of the team are involved in collaborative activities and that the work of the team is something greater than the sum of its parts.

Long Term Care. Health and/or social service care provided for chronic, not acute, health conditions which affect functional abilities. Long term care may be provided in a community or an institutional setting.

Residential Care Facility. A nursing home, providing long term residential care within an institutional setting.

The Interdisciplinary Nature of Social Work Practice in the Geriatric Health Care Setting

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