Interprofessional Collaboration in Action!
Building Teams for Science, Education and Practice

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Learning Objectives

- Discuss the components and impact of team-based pain care
- Analyze effective strategies for team building, skillful communication, and interprofessional collaboration to achieve quality outcomes in pain care
- Examine effective methods to resolve interprofessional discourse and work toward mutual goals for patient care

What is a Team?

"...a number of people with complementary skills who are committed to a common purpose, performance goals and approach for which they hold themselves mutually accountable."

From The Wisdom of Teams
Katzenbach and Smith, 1994
What kind of team do you want?

- Qualities of your "ideal" team
- How does it feel to be on the team?
- What does performance look like?
- What are people doing?
- How are they relating to each other?

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The Circle of Influence

**What I can't influence**

**What I can influence**

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Two Points of View

**Reactive P.O.V.**

- The world happens to me
- I am a powerless pawn in a game of chance
- The most I can do is hope, have lots of insurance, and buy emergency food supplies

**Proactive P.O.V.**

- I always have something to do with what happens to me
- I have authority, influence, and control over my life
- I see that by changing my attitudes & actions I can change what happens to me or at least my reaction to it.
The Reactive Posture

If only I had a boss who wasn’t such a dictator
If only I had more committed staff
If only I had more time to plan
If only I had less turnover
If only I had more patience
If only things didn’t change all the time
If only my people could just get along

The Pro-Active Posture

I can talk to my boss about how I feel
I can build a more committed staff
I can plan and involve my team in planning
I can focus on building team loyalty
I can work on my own behavior
I can anticipate and plan for change
I can build the unity of my team

Team Development

Creating the opportunity for people to come together to share their concerns, their ideas, and their experiences, and to begin to work together to solve their mutual problems and achieve common goals.

It is a process, not a single event.
Tuckman's Model of Group Development

- Sequential stages a group/team goes through
- Groups must deal with each phase before moving to next
- Performing
  - Storming
    - Can't be prevented, but can be managed
      - Requires awareness and pro-activity

Interpersonal Team Dynamics

- The Market
- Financial Pressures
- Technology

- Other Team Members
- Front Line Employees
- Partners
- Our Customers

- Forming
- Storming
- Norming
- Performing

Team operating principles
- Core Values
- Team Norms

What the leader can do

Belonging

Celebrating Your Team
- Naturally brings team members closer
- Celebrate the people and the events in their lives
- Involve those who value belonging highest
- Find reasons to celebrate and do it!
Contribution

Show Your Appreciation
- Catch someone doing something right
- Not complex, just often
- Words and actions from the heart
- Public and private
- It's free!
- You are a model to your team - it's contagious!

MANAGING CONFLICT

Causes of Conflict

Differences in:
- Personal style
- Values
- Perspective
- Goals
- Cultural background
Dynamics of conflict - focus of behavior science research

Five strategies for dealing with conflict have been identified

Strategies create different results

All have their time and place

Working together to overcome obstacles improves team strength

A Model of Conflict

Smoothing
Agreeing to Disagree

Bargaining
Splitting the Difference

Avoiding
Withdrawing from the Conflict

Forcing
Fighting a Win-Lose Battle

Problem Solving
Facing the Issues Together

Concern for Self

Concern for Other

Passive → Active

HIGH

LOW

Science and Practice is all Teams

Here is snapshot of some of my teams advancing education, practice and research.
In the United States, divisive battles between health care disciplines are far too common. Among leaders, such battles lead to disagreement about administrative, legislative, and funding priorities. But far too often the forces that incite such conflict operate at the ground level. Teamwork and collaboration are inhibited. The care of patients and communities is compromised. The discord is characterized by lack of respect for the capabilities of others, lack of recognition of value, inability to share a common vision, inability to communicate goals, and difficulty in setting priorities for more efficient and effective care. The educational chasms that isolate health care professions are immense. For example, there is a wide gulf between schools of medicine and schools of public health, and each health care discipline, including family medicine, has been on the giving and receiving end of this activity. We have allowed over competitiveness and one-upsmanship to shape the culture of training programs and thus perpetuate toxic practice and educational environments.” (Kruse, 2012)

“When multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care.” (WHO, 2010)

http://www.aacn.nche.edu/education-resources/ipereport.pdf

Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel


http://www.aacn.nche.edu/education-resources/ipereport.pdf

Interprofessional Collaborative Practice Domains

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Interprofessional Collaborative Practice Competency Domains

- Domain 1: Values/Ethics for Interprofessional Practice
- Domain 2: Roles/Responsibilities
- Domain 3: Interprofessional Communication
- Domain 4: Teams and Teamwork

Interprofessional Teamwork and IOM Core Competencies

- EBP Project
- Work in Interprofessional Teams
- Core Competencies
- Provide Patient-Centered Care
- Employ Evidence-Based Practice
- Apply Quality Improvement
- In class simulation

Interprofessional Team-based Care

- Intentionally created
- Usually relatively small work groups in health care
- Recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or group of patients, e.g., rapid response team, palliative care team, primary care team, operating room team
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Defense and Veterans Center for Integrative Pain Management (DVCIPM)

Research in the Battlefield

• A Survey of Military Healthcare Professionals' Perceptions of an Acute Pain Service at Camp Bastion, Afghanistan
• Impact of an Acute Pain Service on Pain Outcomes with Combat-Injured Soldiers at Camp Bastion, Afghanistan


Principal Investigator: COL Chester “Trip” Buckenmaier III, MD, Defense & Veterans Center for Integrative Pain Management (DVCIPM), Walter Reed National Military Medical Center, Bethesda, MD
Co-Investigators:
* COL Peter Mahoney, MD, Royal Centre for Defense Medicine, Birmingham Research Park, Birmingham, UK
* Rosemary C. Polomano, PhD, RN, FAAN Associate Professor of Pain Practice, University of Pennsylvania School of Nursing, Philadelphia, PA
Research Coordinator: Kyung “Nancy” Kwon, CRNP, MNS, Henry Jackson Foundation & DVCIPM
Camp Bastion, Afghanistan

- British military base in Afghanistan, constructed in 2006
- Helmand Province, southern Afghanistan
- Inhospitable/dangerous region
- Largest overseas British military installation since World War II
- > 2000 personnel

Acute Pain Service Far Forward

- US Army Acute Pain Service deployed to Camp Bastion, Afghanistan during 23 April to 13 July 2009
- Support British efforts to implement APS at CSH
- What did health professionals think of the APS?

Soldiers asked to quantify Pain Intensity and Pain Relief at 3 different time points

- RECALL of pain intensity and pain relief at point of injury - prior to arriving at CSH (within 0 to 3 hrs of injury)
- Post primary analgesic intervention (4 to 6 hrs after injury)
- Prior to evacuation (7 to 24 hrs after injury)
**Numeric Rating Scale**

Extremely 
Not at all

*Statistical difference between physician and nurse perceptions (Mann-Whitney U tests)

**Frequencies for Responses to 5 of the Items (N=70)**

- Patients managed by the APS report decreased levels of pain: 65.8%
- Patients managed by the APS obtain greater levels of pain relief: 73.9%
- Overall, APS has a significant impact on patient outcome: 70.1%
- APS pain management protocols differ markedly from what I usually do: 39.1%
- Patients managed by APS are able to be transported sooner: 30.0%

**Perceptions of an APS**

*Statistical difference between physicians and nurse perceptions (Mann-Whitney U tests)
A Qualitative Analysis of Perceptions and Experiences Following Battlefield Injury and Evacuation: A Survey of Casualties from the Iraq and Afghanistan Wars

Principal Investigator: COL Chester “Trip” Buckenmaier III, MD, Defense & Veterans Center for Integrative Pain Management (DVCIPM), Walter Reed National Military Medical Center, Bethesda, MD

Co-Investigators:
* Rosemary C. Polomano, PhD, RN, FAAN
* Christine Rupprecht, RN, MSN, Clinical Nurse Specialist, Army Regional Anesthesia Pain Management Initiative

Research Coordinator: Kyung “Nancy” Kwon, CRNP, MNS, Henry Jackson Foundation & DVCIPM

This project is sponsored by the Tri-Service Nursing Research Program, Uniformed Services University
The specific aims of this investigation are to:

1. Systematically quantify and characterize the short-term and long-term effects of traumatic extremity injuries during combat on post-injury pain, chronic pain, health-related quality of life (HRQoL), functional status, social reintegration (e.g., level of disability) and psychological adjustment (PTSD and depression) in a soldier cohort injured in the Afghanistan and Iraq wars.

2. Evaluate the effectiveness of early aggressive (within 72 hours of the injury) advanced regional anesthetic interventional techniques, including one or more nerve blocks or infusions, continuous peripheral nerve block, or other specialized procedures on outcomes listed above.
Methods

Design: A prospective, longitudinal repeated measures design was used to obtain participant-reported outcomes collected over a 2-year period.

Sample:
- Eligible participants:
  - Sustained a combat injury to one or more extremities in the OEF/OIF conflicts
  - Required initial U.S. hospitalization at the Walter Reed Army Medical Center (WRAMC), Brooke Army Medical Center, or National Naval Medical Center
  - Soldiers were excluded for major head trauma and diagnosis of moderate or severe traumatic brain injury (TBI)
  - Data are presented for a total of cohort of 277 patients at various time points during the study

Procedures:
- Participants were recruited at the WRAMC by research nurses or by phone contact at the Philadelphia VA Medical Center by research staff
- Baseline data (Time 0) were collected immediately following acute care hospitalization for initial combat injury when rehabilitation was initiated
- Data collection occurred at regular intervals and continued up to 2 years post-acute care

Study Schema

The sampling plan allowed participants to enter the study at anytime within 2 years of their initial injury.

Preliminary Validation of the Defense and Veterans Pain Rating Scale (DVPRS) in a Military Population

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Disclaimer: The views expressed in this presentation are those of the authors and do not necessarily reflect the official policy of the Department of the Army, the Department of Defense, or the United States Government.
Objectives

- Background on developing DVPRS
- DVPRS v.1.0
- DVPRS v.2.0
- Study validating DVPRS was conducted at the former Walter Reed Army Medical Center (WRAMC)
- Methods and Results
- Future Implementation

Introduction

In 2008, the Army Surgeon General chartered a 22-member Pain Task Force charged with examining pain assessment and standardizing pain practices across the Department of Defense (DoD) and Veterans Health Administration (VHA) settings.


DVPRS

- Enhance the existing NRS with visual cues and word descriptors to anchor pain ratings with perceptual experiences and limitations imposed by pain
- Provide supplemental questions on general activity, mood, level of stress and sleep to help quantify the impact of pain
Due to copyright restrictions, a new faces scale has been designed for the sole purpose to be used into the DVPRS v2.0. Pain experts made recommendations on the faces. Focus groups were conducted with inpatients and outpatients at WRNMMC.
Participant Characteristics

* 350 subjects
  * Inpatient = 224
  * Outpatient = 126
  * Chronic noncancer pain: 38%
  * Acute postoperative pain: 25%
  * Neuropathic pain: 33%

Results for Reliability and Validity

* Reliability:
  * Internal consistency reliability (Cronbach’s alpha) was high for the 5 items for both inpatients (0.903) and outpatients (0.866)
  * Alternate forms reliability established for the Supplemental Items using the Brief Pain Inventory Interference Subscale
* Construct validity:
  * A principal component factor analysis (Varimax rotation) revealed one item grouping or factor accounting for 72.35% of the variance in the measure
  * Hospitalized patients had significantly less pain (mean 3.40 ± 2.5) than patients surveyed in the outpatient pain clinic (5.29 ± 1.7) (P<0.001)
* Content validity:
  * Word descriptors matching by respondents showed high agreement (Intraclass Correlation Coefficient-ICC > 0.90) in the correct placement or one deviation from the correct placement

Percent of Respondent Agreement in Placing the Appropriate Word Descriptors by the Numeric Value for Pain Intensity
Questions