Building Functional Rehab Teams (and How to Tell If You Are Part of a Dysfunctional Rehab Team)

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What is a Team, and Do We Really Need a Rehab Team?

Teamwork can be broadly defined as “a mechanism that formalizes joint action towards mutually defined goals.”

Rehabilitation

“A set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environment” (WHO)
Rehabilitation = Problem solving process
(WHO, Wade 2005)*

- Assessment
- Identify needs/modifiable factors
- Goal setting
- Measurement, planning & implementation of interventions
- Evaluation of change & effectiveness

*I'm All About That Bass (I mean Team)
or Why You Gotta Be So Rude?

“No matter who you are, where you are, what you’re doing or the level of your status, it will be the people who surround you that bring true meaning to your life.”

Keiza, 2009

Does This Apply to the Steelers?

“Teamwork calls for tolerance and respect among members. Some health professionals shy away from teams because they have been members of teams which were dysfunctional for a number of reasons, including a lack of leadership, interest, structure, and process.”

*From James J. Peters VA Bronx Medical Center, Geriatric Research, Education & Clinical Center Mount Sinai School of Medicine, Endowed Department of Geriatrics and Adult Development
Building Functional Rehab Teams

Eliminating (reducing) barriers:
Identifying/recognizing and managing “dysfunctional” components are crucial!

Definitions of Dysfunctional

- Not performing normally, as an organ or structure of the body; malfunctioning
- Behaving or acting outside the social norms
- Unable to function normally, properly, etc.
- Abnormal or unhealthy interpersonal behavior or interaction within a group

Definitions of Dysfunctional (Continued)

- Something that is flawed and doesn’t operate correctly or something that deviates from normal and accepted social behavior
- Of or characterized by abnormal or impaired psychosocial functioning
- Believing that the above definitions do not describe you
Rank Order of Dysfunction by Discipline
(Results from a facticious unpublished research study secretly performed at over 100 Rehab facilities from 1988 to 2014*)

1) Neuropsychologists/Rehab Psychologists
2) Physicians/Residents
3) Occupational Therapists
4) Nurses/Nurse’s Aides
5) Physical Therapists
6) Case Managers/Social Workers
7) Speech Language Pathologists
8) Rehab Aides
9) Unit Secretaries

*Funded by the Pan American Airlines Corporation

Rehab Models

• Medical
• Pseudo-Rehab
• Rehab Model (also the CARF Model)
• Insurance Model

Medical Model

Under this model, the physician is seen as the expert, and patients are expected to comply with his/her advice. The physician assumes an authoritarian position in relation to the patient. Because of the specific expertise of the physician, according to the medical model, this is necessary and to be expected.*

*Modified from Wikipedia
Rehab Model

Emphasis is on collaborative/integrative care to optimize functioning and recovery (if applicable) utilizing either a multidisciplinary or interdisciplinary team.

There is a “me” in Teams! Interdisciplinary vs Multidisciplinary vs Transdisciplinary*

- The terms multidisciplinary and interdisciplinary are often confused when referring to team structure and process in the healthcare setting.
- Members of a multidisciplinary team typically work together in caring for the patient, but only one team member, usually the physician, makes the treatment decisions.
- An interdisciplinary team’s decisions are made by the group.

What is an Interdisciplinary Team?*

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.
Transdisciplinary Teams*

- Recently there has been a growing emphasis on “transdisciplinary” (or “cross-disciplinary”) teamwork.
- In these teams, which are rooted in the research and business worlds, members of different disciplines are not only proficient in their own specialties but also, through cross-training and working on the team, become knowledgeable in other specialties as well, making team members' skills overlap.
- Transdisciplinary training and teamwork not only allow the provider to see a more complete picture of each patient, but also allow a single provider to assess and, in some cases, treat patients in an area other than his or her own.

Ingredients for Effective Teams

- The majority of the team members are committed.
- Goals are realistic/achievable.
- Team members communicate and “tolerate” some disagreement.
- Roles do not significantly overlap and are not vague.
- Team members feel empowered (i.e., feel that their input matters).
- Teams members are flexible.
- Team members possess “adequate” problem-solving skills.

Spontaneous Recovery

For moderate and severe brain injuries, how much, other than keeping the patient safe, allowing the brain to heal and increasing blood flow to the brain via physical and mental activity, does the rehab team really contribute to the gains made during the pt’s rehab stay?
**Objectives:** To systematically investigate current scientific evidence about the effectiveness of multidisciplinary team rehabilitation for different health problems.

**Data Sources:** A comprehensive literature search was conducted in Cochrane, Medline, DARE, Embase, and Cinahl databases, and research from existing systematic reviews was critically appraised and summarized.

**Study Selection:** Using the search terms "rehabilitation", "multidisciplinary teams" or "team care", references were identified for existing studies published after 2000 that examined multidisciplinary rehabilitation team care for adults, without restrictions in terms of study population or outcomes. The most recent reviews examining a study population were selected.

**Data Extraction:** Two reviewers independently extracted information about study populations, sample sizes, study designs, rehabilitation settings, the team, interventions, and findings.

**Data Synthesis:** A total of 14 reviews were included to summarize the findings of 12 different study populations. Evidence was found to support improved functioning following multidisciplinary rehabilitation team care for 10 of 12 different study populations: elderly people, elderly people with hip fracture, homeless people with mental illness, adults with multiple sclerosis, stroke, acquired brain injury, chronic arthropathy, chronic pain, low back pain, and fibromyalgia. Whereas evidence was not found for adults with amyotrophic lateral sclerosis, and neck and shoulder pain.

**Conclusion:** Although these studies included heterogeneous patient groups, the overall conclusion was that multidisciplinary rehabilitation team care effectively improves rehabilitation intervention. However, further research in this area is needed.

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**Common “Dysfunctional” Personality Characteristics of Some Rehab Team Members**

- The know-it-all
- “I know how to handle the pt. I don’t need to follow the behavioral plan and/or the team’s consensus.”
- “I got the patient to do things that no one else could.”
- “I know secret information about the patient.”
- “I don’t need a license to practice psychology.”
Reality Testing (Perceptual Accuracy)

Behavioral Plans: Do they work?

TEAM BEHAVIOR PLAN

Behavior #____

Upon each occurrence of the preceding/antecedent behavior, staff will do the following (e.g., reduce stimulation, find out if patient is in pain or has to go to the bathroom):

1) _____________________________________________________
2) _____________________________________________________
3) _____________________________________________________

Upon each occurrence of the targeted/problematic behavior, staff will do the following (e.g., immediate and consistent feedback that the behavior is not appropriate, redirecting the behavior, controlling sources of inadvertent reinforcement such as staff or family laughing at the inappropriate behavior):

1) _____________________________________________________
2) _____________________________________________________
3) _____________________________________________________
Stressors Associated with Working on a Brain Injury Unit*

- Threats or actual episodes of physical assault
- Burnout
- Anger at patients and their families
- Fighting for power and control
- Frustration and helplessness of the pt can be mirrored by staff members who feel powerless to significantly alter the pt's condition.
- Perceive their own vulnerability
- Safety and other management techniques may produce anger or distress for the pt, which is hard on the caring healthcare professional.
- "Limited" or "undesirable" placement options (e.g., a particular SNF placement) can be an additional source of stress for staff.

*From Wilson et al., 2003

Needed Skills for Psychologists Working with Interdisciplinary Teams

(Delamater, 2012)

- **Understanding Disease** – Speaking the language of the pt’s illness (i.e., at least superficially knowing what the pt has, including lab values, tests, etc.)
- **Be Visible and Responsive** – Need to be in the clinic walking the halls, attend team meetings, want team to be accustomed to your input.
- **Communicate Concisely** – Get to the punch line; team members don’t have time for lengthy explanations or lengthy reports, which are often not read.
- **Teach and Train** – Can help teams resolve conflicts and coach team leaders; can advance understanding with seminars, journal articles, etc.
- **Promote Informal Bonding** – "Informal interpersonal relations are the glue of teams" Small talks, lunches, happy hours, and other relationship-building activities go a long way toward building functional, effective teams.
- **Respect Your Team Members** – Share concerns, brainstorm to problem solve.

"The fact is we’re much better able to meet treatment goals when we work on functioning teams as opposed to alone in silos."

Strategies for Managing Problems on the Brain Injury Rehab Unit
Impaired Consciousness States

• Treatments are limited
• ABC (Antecedent-Behavior-Consequence)
• Manipulate environment (e.g., low-stim, quiet environment)
• Family education/training (requires a very “delicate” mixture involving communicating realistic expectations and maintaining hope)
• Neurostimulants
• Keeping the pt safe with the right mixture of stimulation and rest to allow PTA progression

Inappropriate Behaviors

• Not always easy to determine what is emotional versus cognitive and often it is an interaction between the two
• Neurological, psychological and psychosocial changes need to be addressed.
• Reducing anxiety (individually and/or in groups)
• Reducing repetitive behaviors by “requiring” them
• Therapist-aided self-monitoring training
• Structured environment; less-demanding tasks

Disruptive Behaviors

• Irritability and “agression” are common in the early stages of brain injury recovery.
• Fear, confusion and frustration can manifest as “aggression.”
Disruptive Behaviors

- Antecedent controls (e.g., decreasing stim, increasing predictability, reducing element of surprise)
- Consequent controls (e.g., reinforcing “good behavior,” differential reinforcement, time out)
- Self-management techniques (self-monitoring, relaxation, mindfulness, problem-solving, anger-management)

For verbal outbursts, interruptions, nonsensical talk, type of feedback makes a big difference regarding management:
- Attention and interest by family and staff (-)
- Systematic ignoring
- Verbal correction (+)

Resistance to Treatment

- Various reasons for “refusals” (e.g., cognitive, impaired insight/awareness, pain, fatigue, depression/anxiety/learned helplessness, “control” issues)
- Must target the “cause”
- Treatment is often multi-modal (providing choices, bargaining, written goals, positive feedback, meds can be helpful if mood problems)
- “Rapprochement” between the pt’s goals and the team’s goals
Impaired Insight/Awareness

- Insight and awareness are similar but not the same (lack of awareness usually has a more “direct” neurologic etiology).
- Components of impaired insight: lack of information, inability to integrate information and inability to make appropriate inferences with that info.
- Intervention will depend on which component (s) is (are) impaired.
- Will usually require repetitive attempts and intervention from the team, family, peers.
- “Gently challenging” the pt by having him/her predict how they will perform a certain task.

Mood Disturbance

- Apathy, depression and anxiety are common.
- Helpful to know etiology (i.e., CNS versus adjustment-related).
- Supportive, behavioral and/or medication interventions are helpful and require multi/interdisciplinary team efforts.
- Rehab/clinical neuropsychologist can help.
- The impact that individual team members have when providing support and encouragement is a significant factor in successful outcomes!

Family Issues

- Hope for a full recovery (high expectations)
- Denial
- Anger/frustration directed at staff
- Unreasonable demands (not perceived as unreasonable to the family)
- Uncertainty regarding temporary vs. permanent
- Crisis mode
Family Issues (Continued)

- Team members should provide education (re: diagnosis, prognosis, skills required to be caregiver and services available at the time of discharge).
- It is important to communicate with other members of the team regarding family issues (e.g., how to best help the family and not let a family’s non-rehab “issues” “play out” and create havoc on the unit).
- If a team member questions a team decision, he/she should do so in private with the team.
- Support team decisions with family.

Strategies for Reducing Stress Associated with Working on a Rehab Unit

- Using humor
- Positive thinking
- Taking the “good” with the “bad”
- Recognizing burnout
- Pizza
- Incentives (e.g., employee of the month)

Questions