

Context is Critical: Supporting Interprofessional Teams in Primary Health Care

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Abstract

This paper is a preliminary outcome of a large research project led by the Association of Ontario Health Centres (AOHC) in Canada, exploring interprofessional team functioning in a community health centres. The findings indicate that the interprofessional team has great potential as a model for primary health care in community settings. It is also clear that there exist many challenges to this approach, and that the organizational context is critical to ensure success. Key determinants for support are systemic mechanisms to insure successful team functioning, including: understanding factors external to the CHC; attending to the impact of centre size; maintaining alignment; involving staff appropriately in decision-making; managing conflict effectively; valuing and allowing time for team meetings; clarifying role expectations; creating a positive emotional climate for interprofessional teams.

Introduction

Purpose of the Research

This paper is a preliminary outcome of a large research project led by the Association of Ontario Health Centres (AOHC), exploring interprofessional team functioning in a primary health care setting. The purpose of the overall study is to evaluate the processes and outcomes of primary health care teams in community health centres (CHCs) across Ontario. This research is partly informed by the work of Daniel Way and Linda Jones, who outline structured mechanisms for supporting the collaboration of the interprofessional team. Their model encourages the contributions of all members of the team, to create synergy based on shared knowledge. The model also focuses on the client as a partner in service delivery, and as an integral part of the care team (Way et al, 2001). However, these authors do not address workplace context as a potential support for or hindrance to effective team functioning. The segment of our study represented in this paper examines, through selected portions of the interview data, the positive and negative

impact of organizational structure and culture on the effective functioning of interprofessional teams in CHCs.

The Theoretical Framework

Since Peter Senge et al (1990, 2000) popularized Argyris' (1990) work on organizational learning, the concept has pervaded the lexicon of workplace learning and change. However, despite legions of related books, articles, films, and professional and academic programs, the concept of organizational learning remains difficult to define, and even more difficult to implement. Organizations face challenges in proceeding with such experiments, partly due to a lack of examples of how these complex concepts translate into daily workplace experience. Though recent research attempts to fill this gap (Laiken, Edge, Friedman & West, in press; Laiken, 2002), this work was conducted cross-sectorally, with only a minor focus on health care, within a hospital setting.

Currently, much of the health care literature on organizational learning focuses solely on training and professional development (Davidhizar, 2000) and there are few case studies, apart from those referenced above, of systemic organizational learning using a team-based model in health care settings (Lipshitz, 2000). Since the interprofessional team concept has been adopted by the CHCs in Ontario as the model of choice for primary health care in the community, these centres provide the current study with a rich arena to explore how this approach can best be supported, both within the health care setting, and potentially in many other organizational contexts.

Research Results: Systemic Barriers to and Supports for Interprofessional Collaboration

As promising as the model may be, our research indicates that there are a number of systemic barriers to, as well as supports for, working in primary health care through team collaboration. Following is a brief summary of our preliminary findings.

Understanding Factors External to the CHC

Traditionally, health care professional training and self-regulated professional associations recognize their own defined body of knowledge and skills through their certification processes. As a result, they have legitimized the pursuit of professional goals in isolation from other health care disciplines. Thus, the adoption of an interprofessional team model represents a major shift in philosophy and practice for most health care professionals. One of our research respondents, a health promoter, puts it this way:

For training of different disciplines, there has never been any integration - doctors got their clinical training, nurses got their clinical training ... so we're all trained... in our training we never touch the work of other people.

Attending to the Impact of Centre Size

Many of the CHCs have recently grown in size, which has both created barriers to effective team work, and in some cases has supported it. In a small centre, the feeling of “family” is commonly noted as a benefit – teams are smaller and more manageable, people meet each other informally in the hallways and deal with business as it comes up. Being in physical proximity creates less need for formalized structures to insure clear inter-team communication. Additionally, the complexity of a larger centre can cause confusion regarding team affiliation – especially in situations where the concept of working in interprofessional teams is not yet well understood.

I think being a small centre just breeds an informality about it. Where you are open to talk. Because, you know, you see the same person every day, and you get to build relationships that you might not necessarily get in a bigger organization.

(receptionist)

Research on team development (Katzenbach and Smith, 2003; Lencioni, 2002) supports the concept that team size is critical, and that teams of 8-12 people are most effective in accomplishing their goals. A larger CHC can support many teams of this size, comprised of professionals who interact with each other directly in relation to patient care. The challenge here is to coordinate for effective inter-team communication, so that the overall work of the centre is aligned, without attempting to hold meetings of forty people for decision-making purposes.

The membership composition of the CHC teams also seems to have a significant impact on the team's ability to operate effectively and efficiently, according to our research. Interviewees repeatedly mention the advantage of having team members who have been together over many years. This provides stability and an opportunity for the team to develop over time. However, it was noted that turnover has recently increased, and the centres are faced with the additional challenge of incorporating many part-time staff. While this allows for increased flexibility, it also destabilizes the team. Part-timers are not able to attend team meetings on a regular basis, and understandably, bring a different degree of commitment to the work of the centre. A community developer notes:

... and so how to loop them in... There might not be enough hours in their contract to pay them to come to all these different team meetings. So that's an on-going challenge for us ... how to incorporate them as part of our team - they're more like on a periphery of the team and yet the work that they're doing is pretty vital.

CHCs that describe themselves as successful in overcoming some of these challenges employ a number of strategies. Team building is considered a priority, and is accomplished in a variety of ways. These include ensuring protected time for the teams to meet on a regular basis, both for task accomplishment and to acknowledge successes, or simply to celebrate and socialize together. Team members working directly with each other meet regularly, on a day-to-day or week-to-week basis, whereas larger groupings of

staff meet once a month for updates and information sharing, to insure inter-team coordination.

Maintaining Alignment

The interprofessional model of primary health care in the CHCs, along with increased growth and demand for services, has required adaptation to significant change for team members in the various centres. The CHCs that have been successful in overcoming people's natural resistance to change have employed several strategies which seem common to all, as follows.

Developing a Shared Philosophy and Set of Values. Earlier research (Chawla & Renesch, 1995; Laiken 2002, 2005) emphasizes the importance of developing a shared philosophy or vision for team and organizational alignment. This activity is highlighted in our current research as a key step in enabling high performing interprofessional teams. Though the overall goals for the centre are usually set by the management team and Board of Directors, input from staff is deliberately solicited and incorporated into a shared philosophy, which then becomes the guide for all important decisions. Of the outcome, a community team manager says:

One (factor in sustaining high performance) is a clear sense of purpose that the team has. A clear sense of what our role is, as having this responsibility for being, in many ways, mediators between the health centre and the community that we serve, and in valuing that role.

Hiring for "Fit". A significant factor in contributing to a supportive organizational culture is having the centre philosophy or vision inform hiring policies and practices. On the one hand, diversity of all kinds is valued, as that adds richness to the team experience and capability. On the other hand, our research results repeatedly emphasize the importance of making hiring decisions within the framework of a shared philosophy to insure a values "fit" with the centre. New members are expected to embrace the concept

of interprofessional primary health care, and be prepared to learn how to function well within this model.

Because everybody has the same philosophy, and like I said, they were hired on their philosophy as well as their credentials. The people that we didn't call back for a second interview, we got the feeling during the interviews that they weren't going to be a fit. (nurse practitioner)

One way of successfully insuring “fit”, is to employ multi-disciplinary hiring teams, in which every member has a say in the selection process. The outcome of such collaborative efforts is evident in the number of staff who have sustained their committed employment in the CHCs over many years, and in the satisfaction that was repeatedly expressed regarding the hiring process itself. One administrative support staff member notes:

So it's good... they have a good process for hiring, that's for sure, because they've hired really good people. I couldn't think of one person in the 25 years that I've been here that did not fit with this team.

Involving Staff Appropriately in Decision-Making

Given the numerous changes with which CHC staff have needed to cope, a natural resistance to change surfaces when people feel uninvolved in making decisions that will directly affect their work (Taylor, Lillis & LeMone, 2005). In the CHCs reporting successful interprofessional team functioning, there appears to be a concentrated effort to insure that staff are involved, in some appropriate way, in critical decisions. This does not always imply consensus. There seems to be a recognition that some decisions require broad-based input, while others (such as ministry policy decisions, etc.) are “givens”, and are not necessarily discussable. At times, staff are given choices from among selected options, at other times they are invited to invent the options themselves, and in some cases they are simply given information about why a decision has been made. However, the management professionals we interviewed seemed keenly aware of the impact of each

of these styles, and were thinking strategically about when to implement them effectively – usually in conversation with their staff.

Now what's the decision process is a very important thing. Is it one person deciding for the others? Or is it sort of the common decision, And I think that is why we are such a good team, because we work together and a decision is made ... again, we sort it out either on consensus or majority. (dietician)

Managing Conflict Effectively

To make consensus decision-making possible, managing conflict that is caused by difference in opinion is a critical team and organizational value (Lencioni, 2000; Laiken, 2002, 1994). The CHC culture must be one of “no blame” – a challenging stance for health care professionals who have often been taught to fear making mistakes that could, in the end, be life threatening. Thus, embedding the practice of surfacing concerns and making them discussable in order to manage conflict, has been a significant step in supporting interprofessional teams in the CHCs. Many of our research participants describe successes in this realm:

... if she senses that there is something that needs to be problem-solved, she would call another special meeting, or something like that. I think that's her style - she'd never do it individually, but she wants it to be the whole group doing it openly. Sometimes it can be difficult - but we do it. (health promotion staff)

Valuing and Allocating Time for Team Meetings

One of the key barriers to effective team functioning, described by our interviewees, is a perceived lack of time to meet on a regular basis. Though time is always framed as a scarce resource in organizations, the CHC context raises particular challenges in this respect. Several of the points previously outlined contribute here. Consensus decisions

made with open input from all are necessarily more time-consuming for the team. When CHCs are attempting to make such decisions in teams of forty people or more, as is the case in some of the larger locations, the task becomes impossible. People become frustrated with lack of “air time”, and success in reaching good decisions in this context is limited. As a result, staff meetings are deemed a waste of time, and clinical staff, in particular, are anxious to get back to serving their clients more directly.

More significant, however, is the issue raised repeatedly during our research, of staff generally not framing team meeting time as the “real work”, but as an “add-on” to their work day. With limited numbers of hours at their disposal, and growing lists of clients waiting for attention, the clinical staff struggle with this dilemma.

As one astute receptionist notes:

... so unless the system works out how they're gonna manage this dichotomy of the anxiety producing “number crunching” for the government, but at the same time, they want to work in an interprofessional team format, which will take hours away from that primary function.

However, the solution seems not to be to simply work harder on the front line, and limit meeting times. An outcome of this strategy, as noted by a physician, is an experience of being isolated from one's colleagues. He says:

...it also starts to interfere with, you know, communication things, because you become more and more isolated, the harder you're working. The less time you have to exchange information, or work collaboratively, or really enjoy the company of your colleagues ...so I think it fosters isolation on a team.

Our research suggests that a supportive organizational response to this dilemma is to demonstrate a valuing of time in meetings as a legitimate and critical part of effective team-work. Thus, encouraging such meetings during work hours, providing the needed support and resources, booking blocks of meetings well ahead to allow part-timers and

others to schedule their attendance, defining the tasks in meetings so that staff see them as contributing in tangible ways to their work with clients, all go a long way in helping to reframe meetings as key to establishing high performing teams in the CHC.

Clarifying Role Expectations

In a “family-sized” unit, there is the opportunity to interact regularly and to fully understand one another’s roles. In the larger CHCs, or those that are geographically dispersed - for instance, through the use of “satellite” units - such day-to-day intimacy is precluded. It is incumbent on the organization, then, to insure more formal structural coordination among all of its teams. This calls for increased clarity regarding roles and accountability, particularly in decision-making, where power imbalances come into play. Staff at all levels are conscious about how differences in educational background, professional training, pay rates, etc. create a hierarchy of power relationships – despite the centres’ honest intention to work collaboratively.

We recognize that clinicians are extremely difficult to find and to be recruited into the CH sector, and so their time and their opinion is valued quite differently from other team members’, I think. You know, that’s probably inevitable, but I don’t think that has to define the state of partnership within the centre. (community team manager)

Indeed, the “state of the partnership” is influenced significantly by how the CHC acknowledges and works with these differences. In terms of decision-making power and accountability, we repeatedly heard a plea for transparency. A pretence of “equality” is much less appreciated than explicit clarity which recognizes power differences and allows these to be made discussable. What staff crave, and what seems to work, is a planful approach to decision-making, where it is *collaboratively decided how the decision will be made* (whether by consensus, voting, sub-committee, etc.), with related clarity about responsibility and accountability for the decision. As one nurse practitioner so eloquently expresses it:

I think if you acknowledge where the power lies, if it's brought out on the table and set forward, and say you know we're all going to talk about this, but the ultimate decision is going to be in so-and-so's hands ... then people know what's going on, and, you know ... that can be very liberating, and people feel freer to express themselves.

An additional problem surfaced by our research, is a general lack of knowledge about role differences among staff, which sometimes leads to mistaken assumptions regarding workload expectations.

... They may not understand each others' role very well, so you might have a perception that this person does not appreciate what I do - when it's really not that - you know that person doesn't quite understand what you do. (program manager)

Orientation processes that help staff learn about each of the roles across professions has helped in some of the CHCs. However, what seems to have most impact is the opportunity for people in different roles to interact with each other within collaborative projects – which are very much supported by the interprofessional team model. The extent to which the CHC values such collaboration and encourages it, by providing time and resources for team meetings, full-day retreats, etc. seems to contribute a great deal to eliminating potential conflict caused by unclear role expectations. Some of the most successful attempts to address this issue have included retreat opportunities where inter-team communication and role clarification have been the main focus.

Creating a Positive Emotional Climate for Interprofessional Teams in the CHCs

The picture produced by our research results is of an extremely dedicated, committed group of professionals across all of the CHCs, who recognize that they are part of change journey, which will inevitably produce challenges. There are many ways, some of which have been outlined in this paper, that the CHCs can create a culture of support for interprofessional primary care teams. In addition to those, there are less formal actions that appear to help increase morale and sustain employee commitment. Repeatedly, we heard about the importance of socializing together, avoiding favouritism, rewarding achievements, celebrating together, and generally supporting the mental health of professionals who are daily confronted with the challenges of illness, loss and death. Though these strategies may sound self-evident, our research clearly identifies that it is the concerted attention to these issues which seems to make all the difference.

Conclusion

It seems evident that the interprofessional team has great potential as a model for primary health care in community settings. It is also clear that there exist many challenges to this approach, often involving a steep learning curve for team members in the CHCs. However our data indicate that they seem up to the task. Some of the key determinants in supporting this learning, named by the researchers and described by our interviewees, are the systemic mechanisms, outlined in this paper, to insure successful team functioning. These include:

- understanding factors external to the CHC
- attending to the impact of centre size
- maintaining alignment
- involving staff appropriately in decision-making
- managing conflict effectively
- valuing and allowing time for team meetings
- clarifying role expectations
- creating a positive emotional climate for interprofessional teams

Is the effort worth the time and energy involved? Ultimately, it must be the CHCs' clients who answer that question, and this will be the focus of a different paper. However, if one believes the impressive amount of research (Slater & Narver, 1995; Crossan, Lane & White, 1999; Jackson, 1999) empirically demonstrating that an environment of continuous learning and improvement is most likely to provide exceptional service, the following words would indicate that the interprofessional team model for primary health care has much to commend it:

Wow! The interprofessional approach... how much I learned from that! From listening to people from another profession, from working with them, hearing their perspectives on things ... piecing it together... I really felt that made me a much better practitioner, because I wasn't doing tunnel-vision. I had a much broader scope. It also helped me have a much better understanding and respect for other professions, and what they do and what they have to put up with. (social worker)

Acknowledgements

The authors wish to acknowledge the financial support of the Ministry of Health and Long Term Care – Primary Health Care Transition Fund. The views expressed in this paper are those of the authors, and do not necessarily reflect those of the Ministry of Health and Long Term Care.

We also acknowledge the Association of Ontario Health Centres, the Centre for Studies in Family Medicine, The University of Western Ontario, and The Department of Adult Education and Counselling Psychology at The Ontario Institute for Studies in Education, University of Toronto.

In particular, we gratefully acknowledge the 78 research participants – the interprofessional team members of the 13 participating CHCs, as well as the CHC Advisory Committee for all of their input throughout this project.

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