The Rewards and Challenges of Collaboration with Families and other Health Professionals

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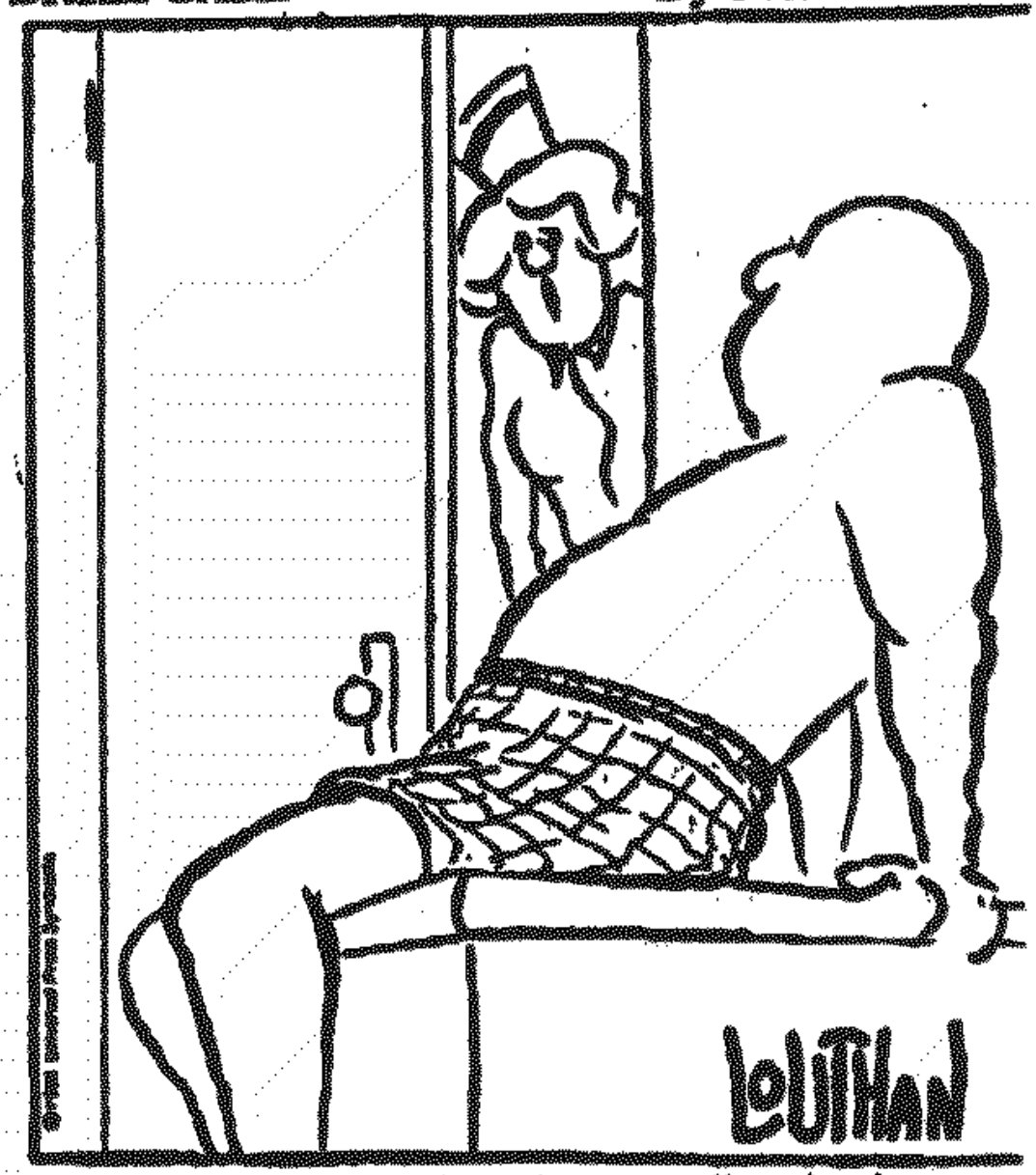
Toronto


CANADA
Lake Ontario
New York
Vt.
N.H.
Rochester
Lake Erie
Mass.
Conn.
Pennsylvania
N.J.
Atlantic Ocean

BRIEFCASE By John Louthan



"You can get dressed now — the doctor saw you when you weren't looking."

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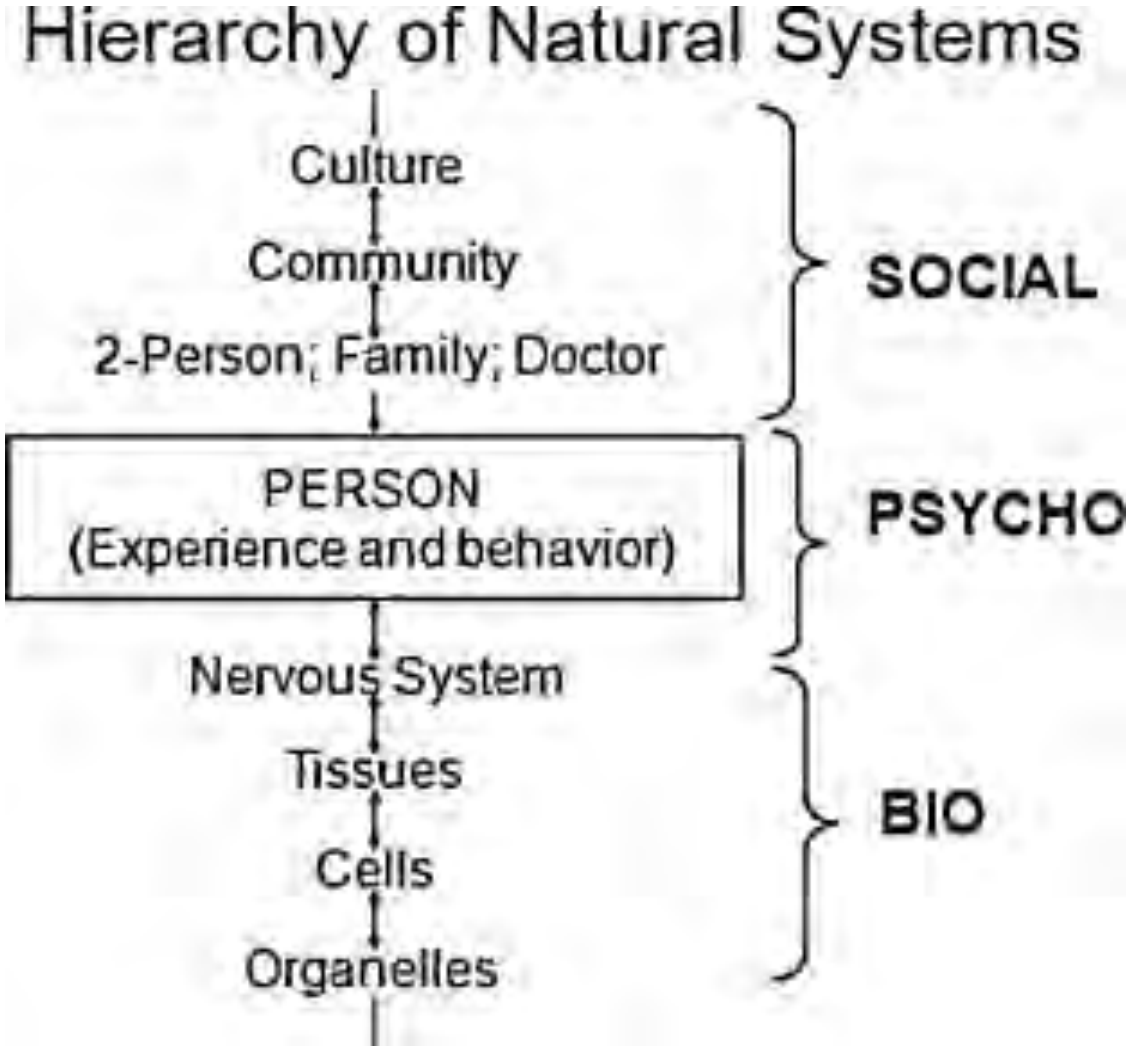
Disclosures

- None

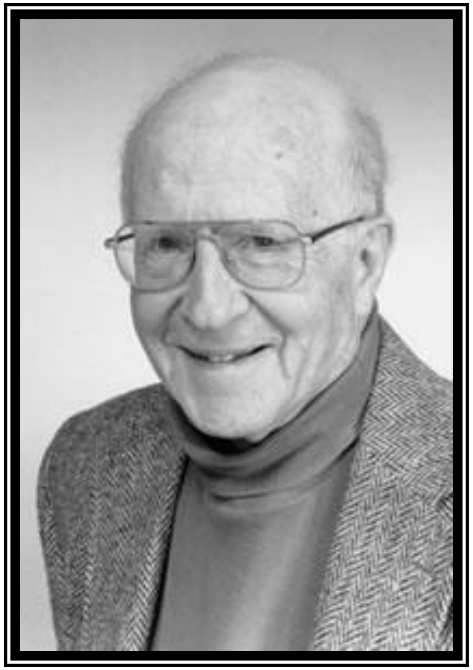
Goals of presentation

1. To present a rationale for why it is important to share care with families
2. To demonstrate family assessment that's relevant for clinical practice
3. To present challenges and best practices in sharing care with colleagues by collaborating across disciplinary cultures

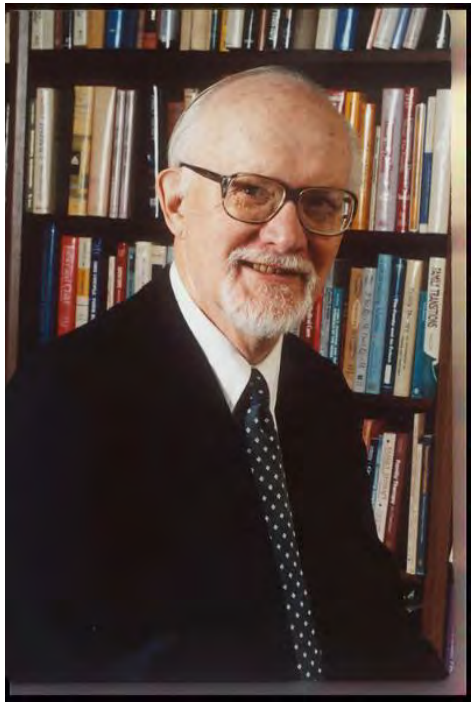


Biopsychosocial Model

University of Rochester Medical Center



George Engel MD



Lyman C. Wynne MD PhD

Why family?

- Families are a part of medical practice
- Impact of illness on families
- Influence of the family on health

Influence of the family on health

- Growing research on influence of the family on all aspects of health, especially:
  - Health behaviors or life style
  - Health care decisions
  - Compliance with medical treatments
  - Outcomes from chronic illnesses
  - Overall mortality

Health behaviors/life style

- 60% of deaths in US and Canada are due to health behaviors or lifestyle
- Most health behaviors (smoking, diet, exercise, alcohol use) are developed, maintained and changed within the context of the family
- Most healthy and unhealthy behaviors are shared by family members.

Couples and health

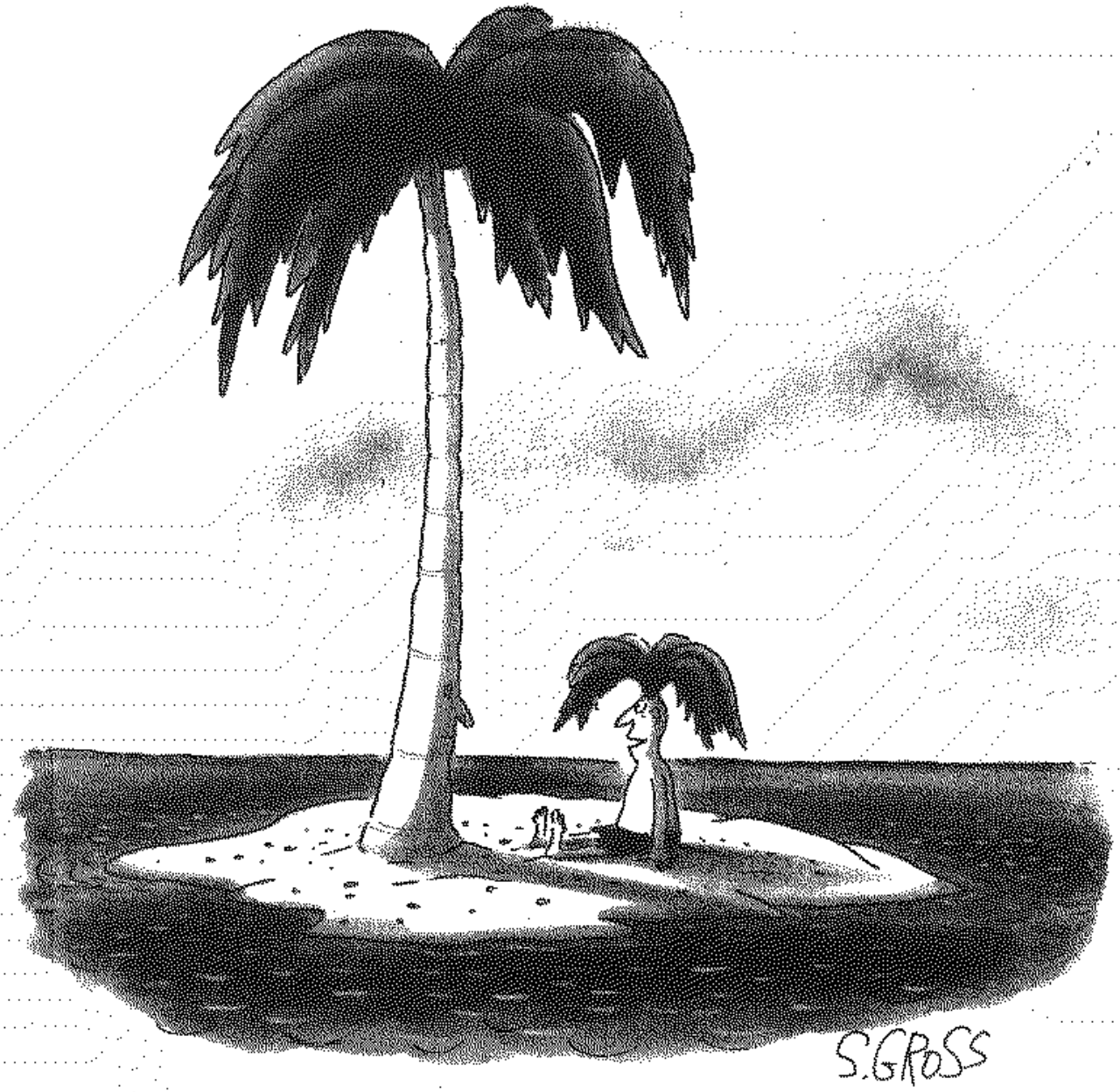
- Men have higher death rates in the 6 months after the death of their wives
- Divorced and unhappily married women have poorer immune function than happily married women
- Women in supportive marriages have improved survival after heart attack, cancer and kidney failure

Family relationships have a powerful influence on health

"The evidence regarding social relationships and health increasingly approximates the evidence in the 1964 Surgeon General's report that established cigarette smoking as a cause or risk factor for mortality and morbidity from a range of diseases." (House et al. 1988)

Couples grow to look alike, study say.

New York Times



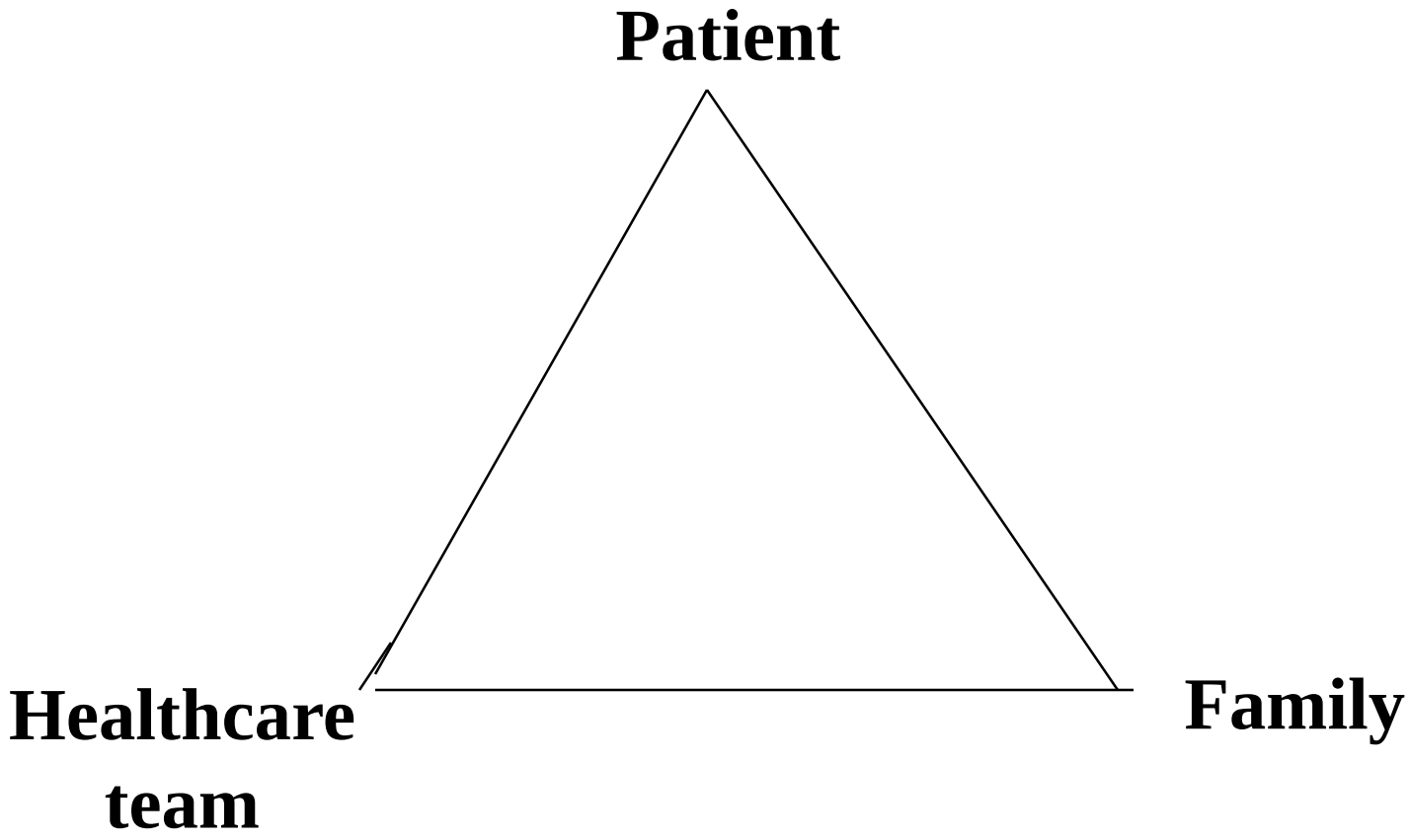
"I read somewhere that when two people live together for a long time they start to look like each other."

When must family issues be addressed?

- family caregiving with chronic illness*
- managing end of life, especially decision making*
- family violence
- genetic counseling*

* Should include family members in interview

The Therapeutic Triangle



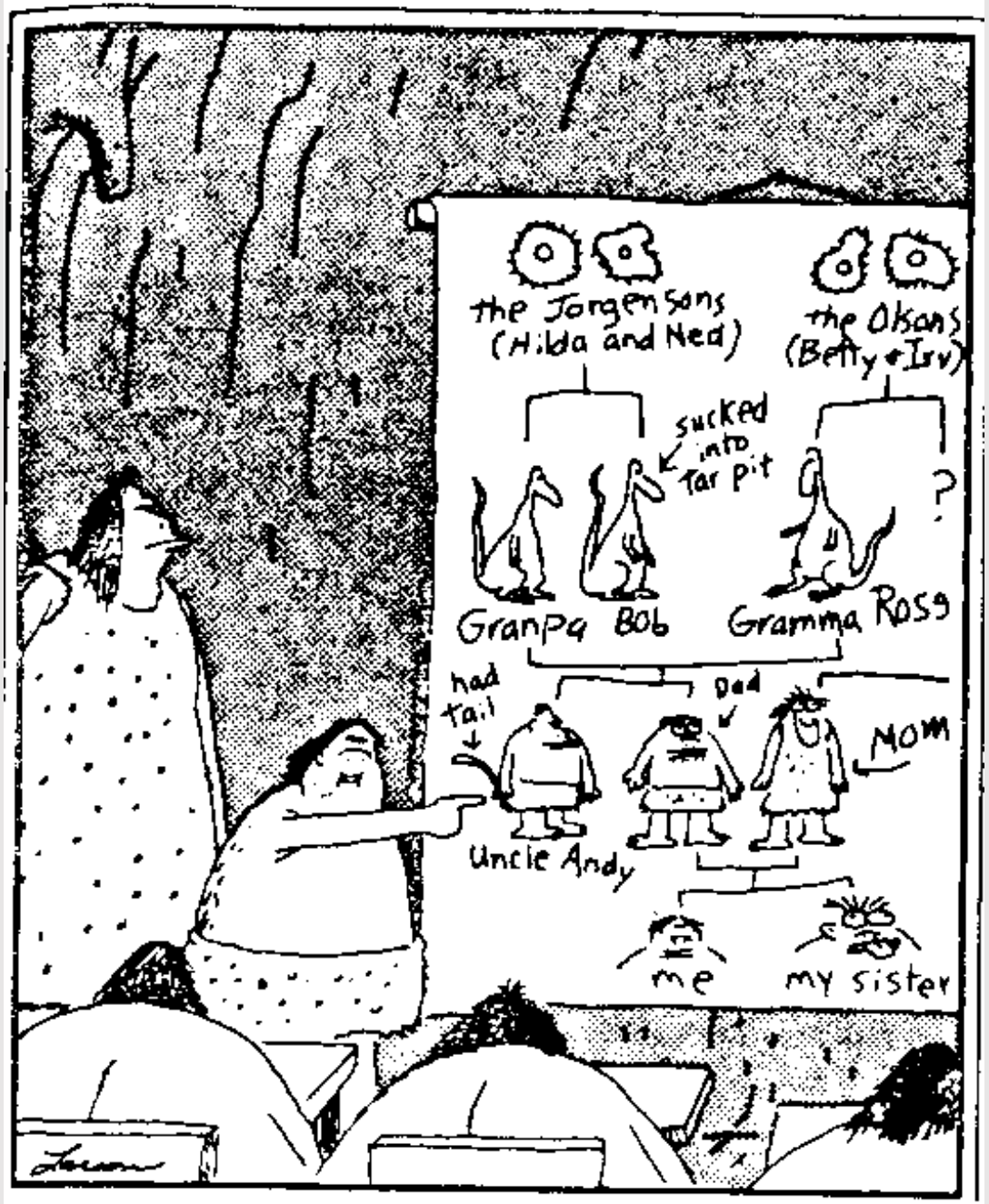
Working with Families:

Collaborate, Assess, and when relevant, Intervene

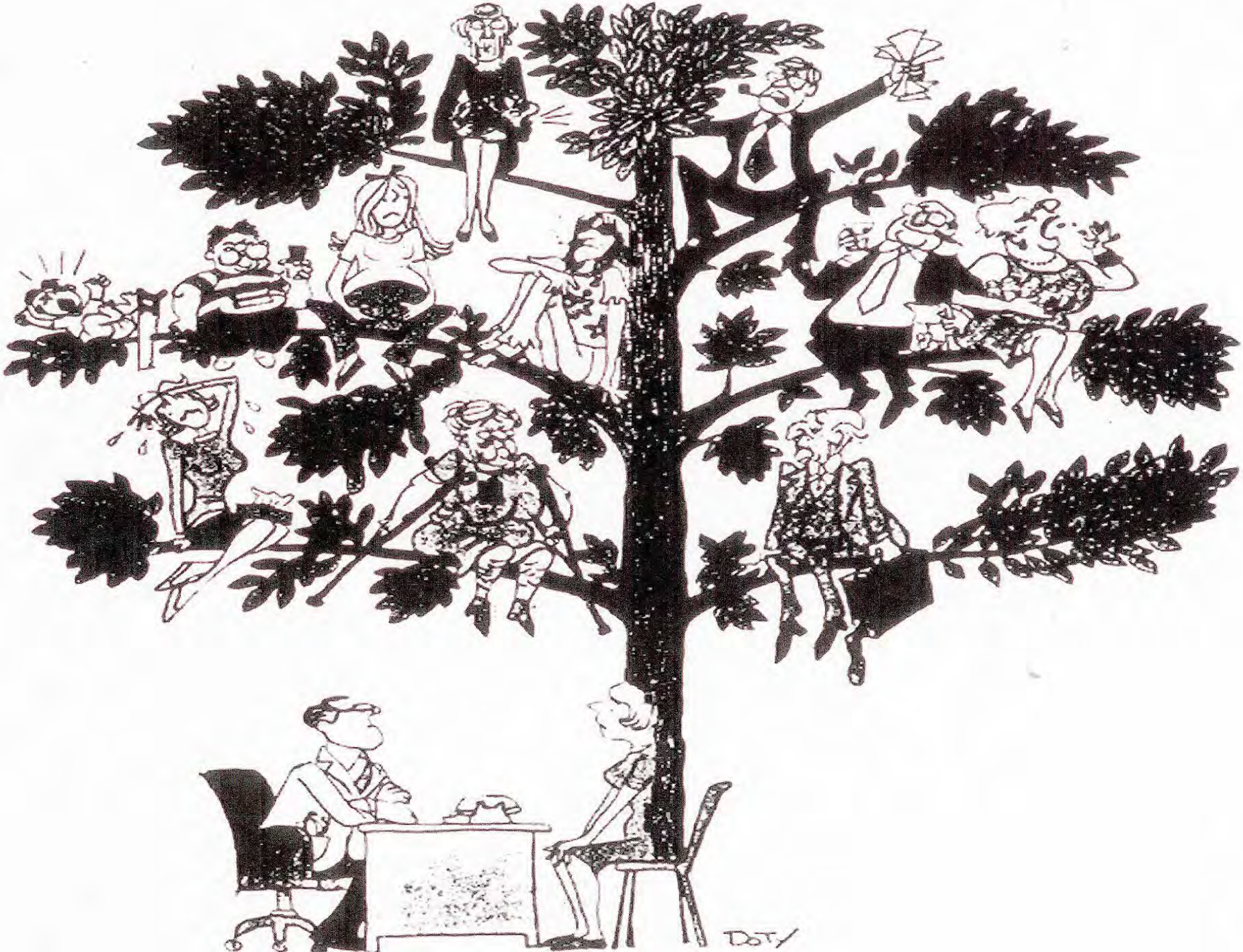
1. Connect with each family member
2. Empathize without taking sides (multi-partial alliance)
3. Gather views & opinions of family members
4. Educate family members and involve them in treatment plan

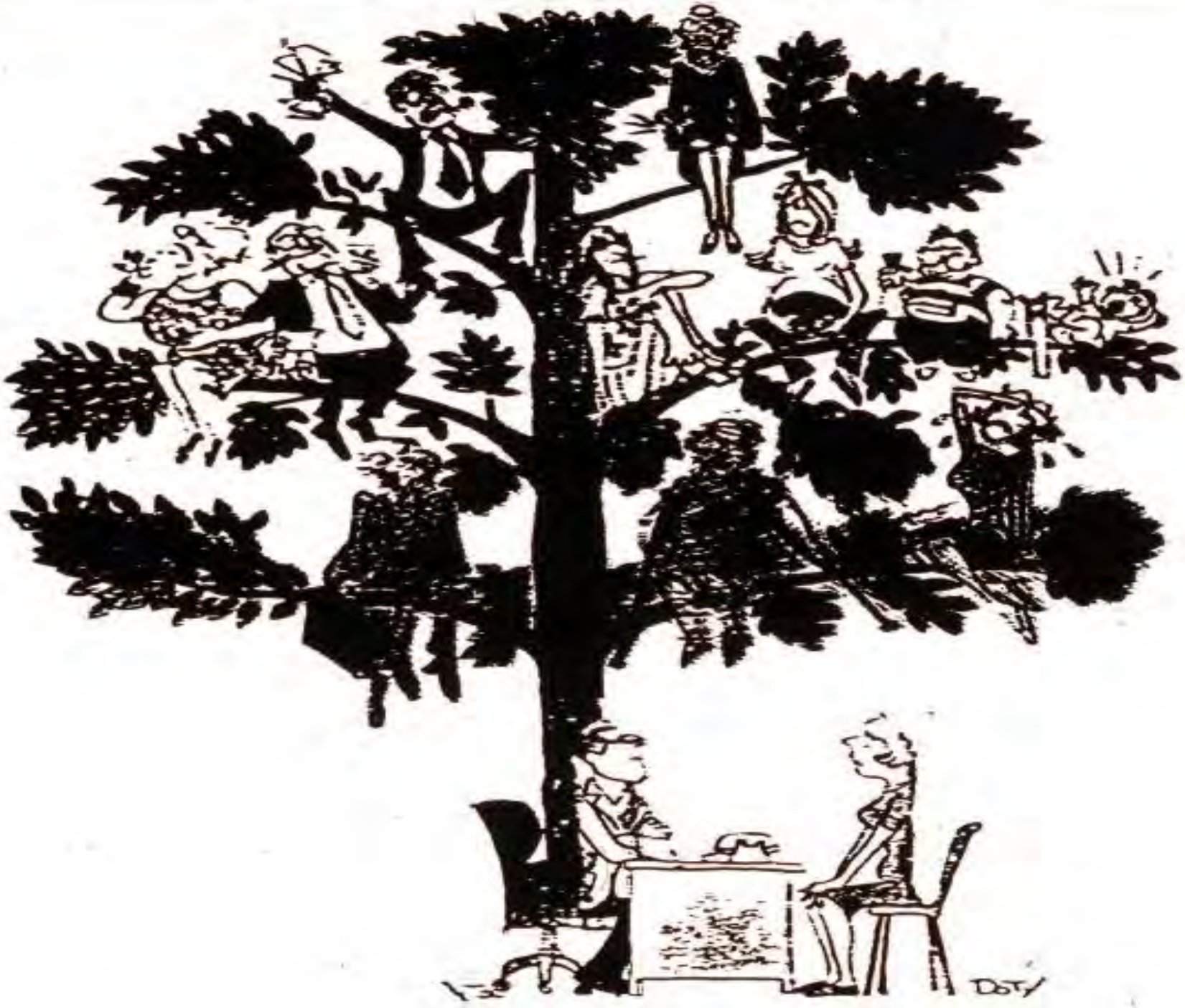
The genogram or family tree

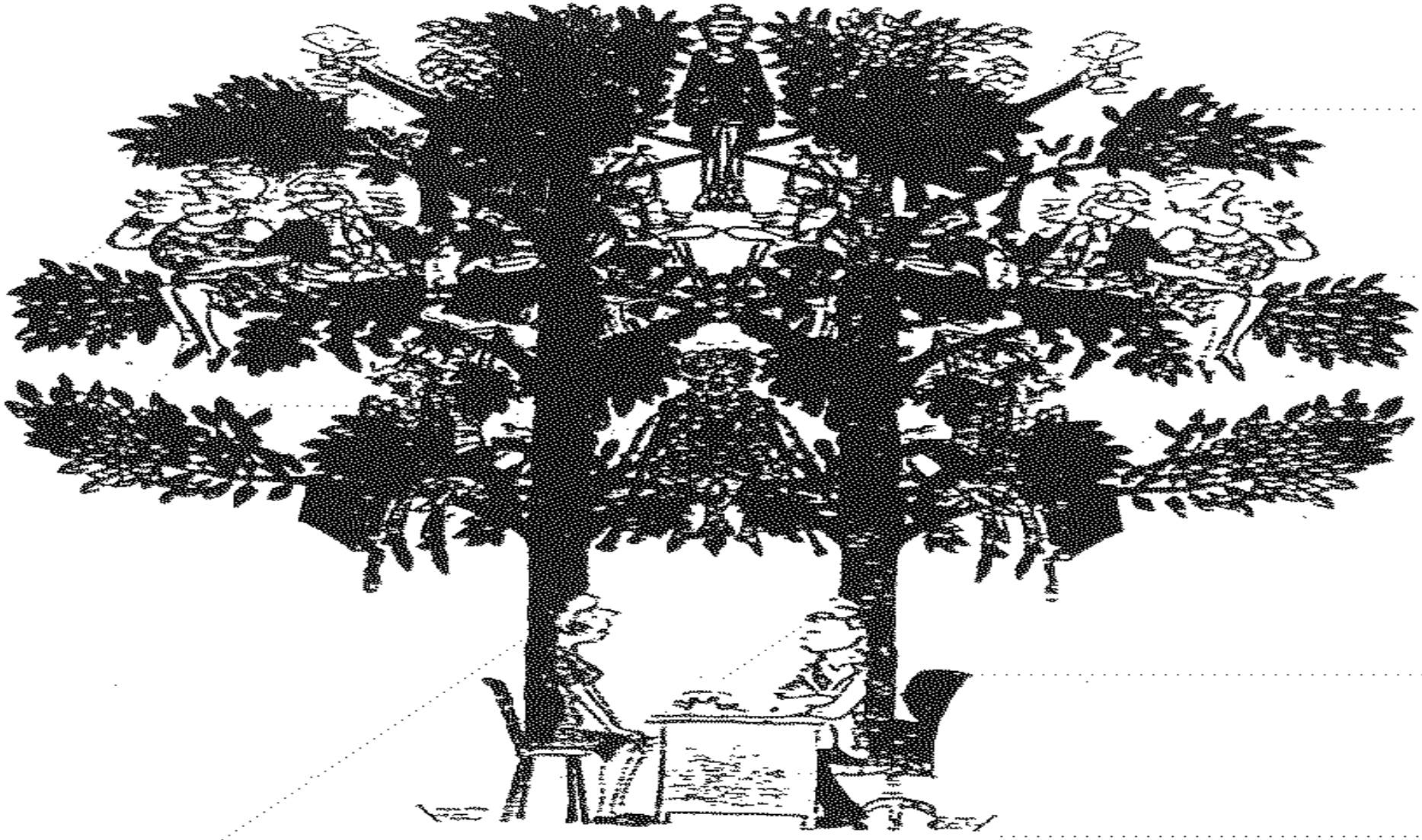
- biopsychosocial photograph: includes genetic, other medical, and relationship information
- most efficient record keeping



Dirk brings his family tree to class.


DOTY





“Dad”:
a case example from a film

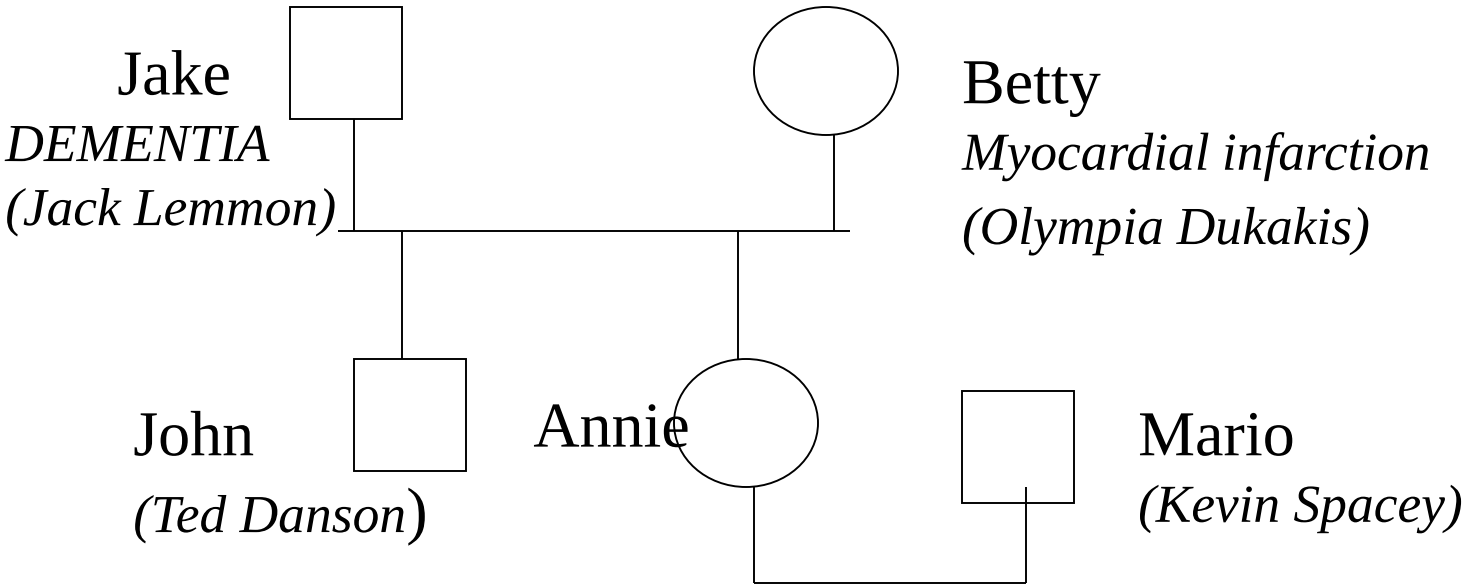
From a popular US movie in the 1990s with several famous US actors

Illustrates how an illness affects a family, especially family roles, and how a family can influence the outcome from an illness

Imagine that you are a member of the health care team caring for this family

Dad

The Tremont family




1:54:06
Dad

First scene

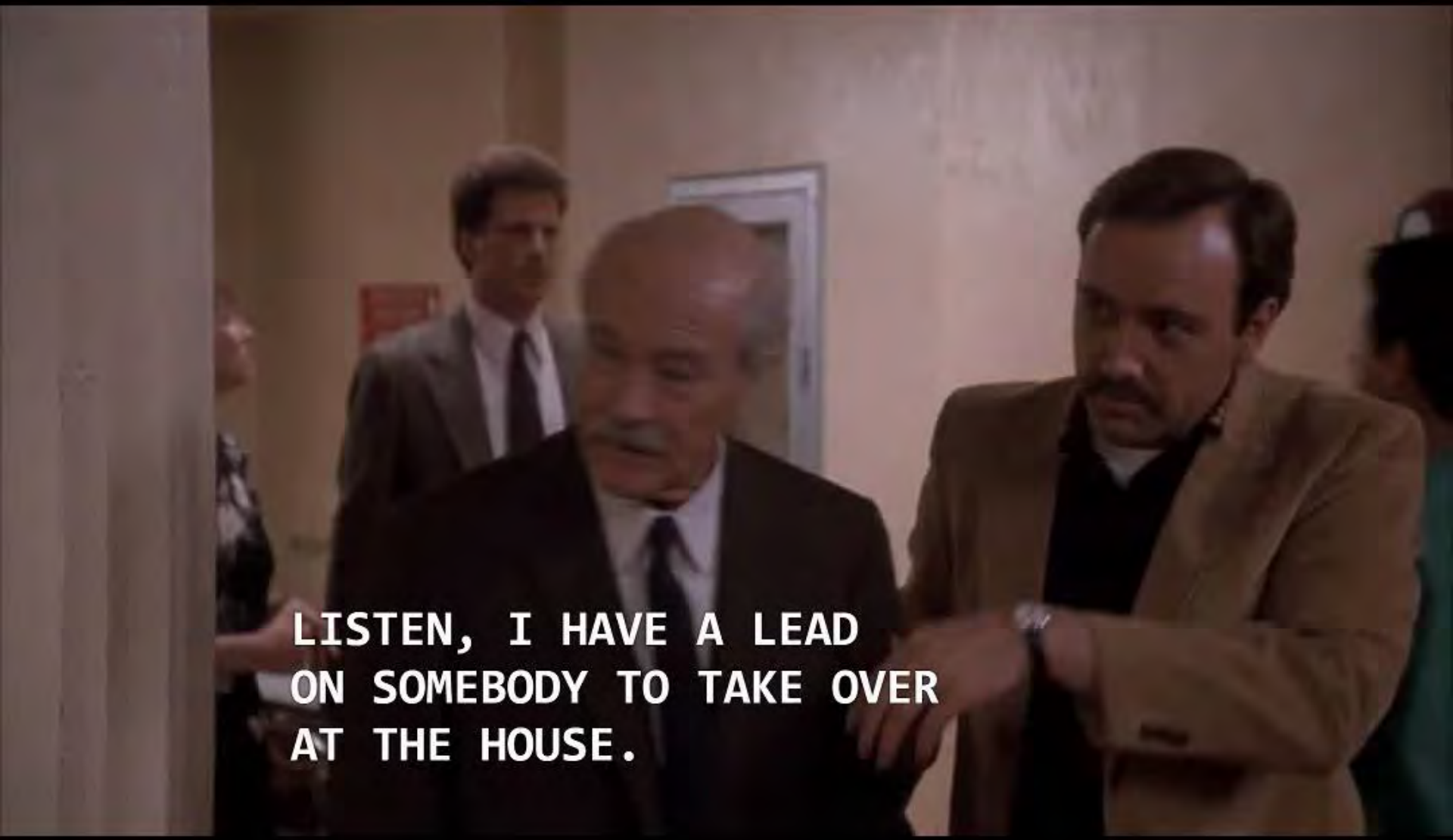
John (son) returns home and explains to his father that Betty (mother) has had a heart attack and can no longer care for him in the way that she has been doing.


THEN YOU'VE SEEN HIM
MORE THAN I HAVE.

Second scene: visit to the hospital

Family - Dad, John (son), Annie (daughter) and Mario (son-inlaw) visit Betty in the hospital.

Betty objects to John’s efforts to make Dad more independent.


LISTEN, I HAVE A LEAD
ON SOMEBODY TO TAKE OVER
AT THE HOUSE.

As Betty's health care team

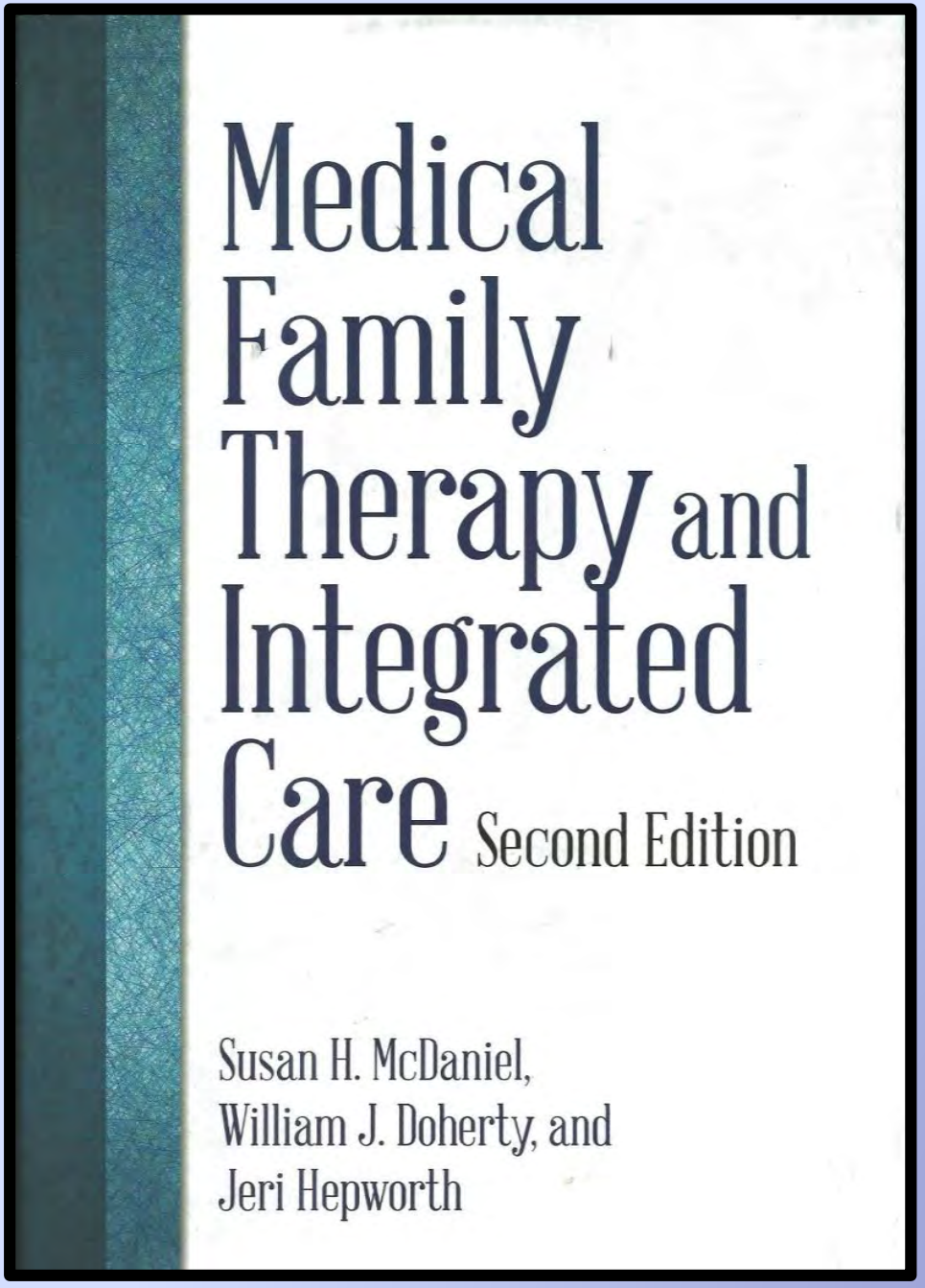
Consider how you would convince Betty not to resume all the housework after discharge from the hospital and continue to do everything for Dad.

How would you conduct an interview with the family to arrange a safe discharge plan for Betty.

SHARED CARE WITH COLLEAGUES

Best Practices and Challenges
Collaborating across Disciplinary Cultures


Lindsay
Peterborough
Campbellford
Napanee
Kingston
Belleville
Trenton
Clayton
Newmarket
Cobourg
Picton
Oshawa
Newcastle
Port Hope
Bowmanville
Markham
Ajax
Scarborough
Toronto
Port Credit
LAKE ONTARIO
Pulaski
Oswego
Fulton
Olcott
Niagara-on-the-Lake
Albion
Greece
Lockport
Medina
Brockport
Irondequoit
Wolcott
Rochester
Grimsby
St Catharines
Niagara Falls
North Tonawanda
Batavia
Canandaigua
Waterloo
Auburn
Syracuse
Seneca Falls
Geneva
Welland
Port Colborne
Buffalo
Cheektowaga
Genesee
East Aurora
Warsaw
Hamburg
Arcade
Dansville
NEW YORK
Cortland


Medical Family Therapy and Integrated Care
Second Edition
Susan H. McDaniel,
William J. Doherty, and
Jeri Hepworth

COLLABORATION ACROSS DISCIPLINES

*Recent research regarding interprofessional teamwork in healthcare

*Clinical applications, such as integrated primary care

NEW MODEL OF PRIMARY CARE

from physician-centered care
to
collaborative, team-based care

The complexity of healthcare in the Information Age means that no one person can know everything

RELATIONAL SKILLS

*building trust and psychological safety that allows for resolution of inevitable conflicts

*role clarity, while also providing back-up behaviors when needed

*clear communication

-reflective listening

-check for understanding

*managing anxiety without triangulation

DISTRIBUTED LEADERSHIP

*Rotate roles in team meetings

*Adopt 360 degree evaluations of all team members

EDUARDO SALAS PHD

Professor & Chair of Psychology, Rice University
Houston, TX

35 years studying Teams & Teamwork

AMERICAN PSYCHOLOGIST

Journal of the American Psychological Association
May–June 2018 Volume 73 Number 4 ISSN 0003-066X ISBN 978-1-4338-9173-1

Special Issue: The Science of Teamwork

Nashville Roller Derby Justin Hamel

126th Annual Convention, August 9–12, 2018
San Francisco, California

TEAMS are now commonplace

Our safety, security, comfort, and innovation depend on good teamwork and collaboration

TEAMS

are more effective than

the sum of the work of individuals

TEAMS

manage complexity and produce more than individuals because team members

*combine their diverse, complementary capabilities
*monitor one another to reduce errors
*shift the workload as needed.

GEOGRAPHICALLY- DISPERSED HEALTHCARE TEAMS

*ambiguous roles with re to teamwork

*loosely coordinated

*low task interdependence

ON-SITE HEALTHCARE TEAMS

*well-functioning in terms of teamwork
*interdependent
*reciprocal coordination

TEAMS NEED PSYCHOLOGICAL SAFETY TO PROSPER

when leaders admit their own mistakes,
others feel they too can safely communicate errors

Goal of Team-Building

to create an environment where psychological safety can flourish, and the team can develop processes to resolve conflicts, mitigate errors, learn together, & improve performance

DEBRIEFING

Improve team functioning through reflection

Contributes even more than huddles to effectiveness

TEAM SKILLS

*Coordination
*Communication
*Adaptability

Team Skills

COORDINATION

*Shared Goal-Setting

*Shared Mental Model

(eg, the biopsychosocial approach)

Team Skills

COMMUNICATION SKILLS

*Quality more important than frequency

*No jargon

Team Skills

ADAPTABILITY

to adjust behaviors and strategies in response to change in order to be efficient and functional

A TEAM OF EXPERTS

DOES *NOT* NECESSARILY MAKE

AN EXPERT TEAM!

Team Member Selection

How Do We Select for “Team-ness?”

*we don’t know for sure!

*it’s about how team members complement each other

TEAM TRAINING WORKS!

It improves:

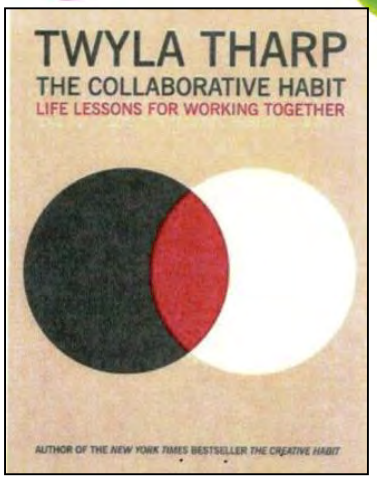
teamwork competencies

leader capabilities

interpersonal relationships

team processes

COLLABORATION
&
TEAMWORK



Like creativity, collaboration is a habit—and one I encourage you to develop.

….

Collaboration may be a practice—a way of working in harmony with others—but it begins with a point of view.

--Twyla Tharp, *The Collaborative Habit—Life Lessons for Working Together, 2014*

Integration=
the outcome

*integrate of health and mental health care

*provide comprehensive biopsychosocial care

*heal the mind-body split

Collaboration=

the process to achieve integration

*working together with the patient and the family

*working together as a team of health professionals.

A Continuum of Working Together

Social and Structural Issues that get in the way of Collaboration

*Financial barriers

*Practice style

*Cultural barriers

Physicians

- Cold, insensitive
- Rigid, Controlling
- Egotistical, arrogant
- Obsessive compulsive
- Pressed for time
- Technician, counterdependent
- Somatically-fixated

Psychologists

- Too cerebral, impractical
- Touchy-feely, wishy-washy
- Impotent, neurotic
- Weird, flaky
- Not real docs!
- Right-brained & left-winged
- Psychosocially-fixated

A REFERRAL BY A PHYSICIAN TO A THERAPIST

THOMAS L. CAMPBELL, M.D.
SUSAN H. McDANIEL, Ph.D.

PSYCHOLOGIST

PRIMARY CARE PHYSICIAN

I'M OKAY AND YOU'RE NOT!

Cultural Differences Between Behavioral Health Professionals and Primary Care Physicians

- Working styles
- Theoretical paradigms
- Languages
- Beliefs about confidentiality

Overcoming Stereotypes & Disciplinary Tribalism

*Professional training to developing a strong identity in the discipline

*Interprofessional training to collaborate

--using principles for effective teamwork

--learning what each discipline is good for

--developing respectful, personal relationships across disciplines

TABLE 3.1
Levels of Systemic Collaboration Between Therapists and Other Health Professionals

Level	Description	Location	Handles adequately	Handles inadequately
1. Minimal collaboration	Separate facilities and systems Rarely communicate	Private practice, most agencies	Routine medical or psychosocial problems	Refractory problems or those with biopsychosocial interplay
2. Basic collaboration, off-site	Separate facilities and systems Periodic communication about patients, linkages, treatment planning	Setting with active referral linkages	Patients with moderate biopsychosocial interplay (e.g., diabetes, depression)	Problems with significant biopsychosocial interplay
3. Basic collaboration, on-site	Separate mental health and other health care systems in the same facility Regular communication and appreciation of each other's work Ill-defined teams, no common language Physicians have more power and influence than other providers, who may resent this	Some HMOs, rehabilitation settings, medical clinics, without systemic approaches to collaboration, mutual consultation, and team building	Patients with moderate biopsychosocial interplay who require occasional face-to-face interactions among providers and coordinated treatment plans	Problems with significant biopsychosocial interplay and ongoing, challenging management problems
4. Close collaboration in a partly integrated system	Shared site and systems Regular interaction, mutual consultations Shared systemic and biopsychosocial paradigm Routines difficult, some attention to team building Unresolved tensions over physicians' greater power and influence on the team	Some HMOs, CHCs, rehabilitation settings, hospice, family medicine, and other clinical settings that systematically build teams	Problems with significant biopsychosocial interplay and management problems (e.g., chronic illness, somatization)	Complex patients with multiple providers and multiple systems, especially with conflicting agendas among providers or triangulation by patients or families
5. Close collaboration in a fully integrated system	Shared site, systems and biopsychosocial vision Shared expectations for team-based prevention and treatment Regular team meetings Conscious effort to balance power and influence among providers, according to patient need and provider expertise	Some large, closed health systems, primary care clinics, hospice, etc.	The most difficult and complex biopsychosocial problems with challenging management issues	Patients with insufficient team resources or breakdowns in collaboration with larger systems

Note. Data from Doherty (1995).
CHC = community health center.

Ill patients are an existential reminder of our humanity, our vulnerability, our ultimate lack of control,
often stimulating strong emotions in patients, families, and health professionals.

Collaboration

*stimulates hope

*results in acts of generosity

*can mitigate against the epidemic of clinician burn-out

Clinician Satisfaction

one of the most important outcomes
of integrated healthcare
for both health and mental health
professionals

BIOPSYCHOSOCIAL APPROACH

*Self-awareness
*Self-calibration
*Self-regulation
*Self-care

KNOW
OUR OWN FAMILY HISTORY
OF
HEALTH & ILLNESS

Behind every health professional is
a person with a family who has
a history of medical and mental health issues

How do you take care of yourself?

A biopsychosocial approach to genetic conditions

is

humanizing


obrigado
Dank U
Merci
mahalo
Köszi
спасибо
Grazie
Thank you
mauruuru
Takk
Gracias
Dziękuję
Děkuju
danke
Kiitos

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

20th ANNUAL CFHA CONFERENCE

INNOVATIONS in INTEGRATION

Solutions for Healthcare Reform

Rochester is just **four hours** from Toronto!

Highlighted Material at this Conference: Interprofessional Teams (plenary speaker, **Eduardo Salas, PhD**); Opioid/Substance Management; Health Disparities (plenary speaker, **Dayna Matthew, JD**); Across the Lifespan (plenary speaker: **Carol Podgorski, PhD**); and Collaborative Care

More Information at **www.integratedcareconference.com**