Team Dynamics in Collaborative Care

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Objectives of the presentation

- Providing in-depth view of internal dynamics of a mental health team involved in provision of care in collaboration with four family health clinics
- Discussing the enablers of and obstacles to collaboration by considering the experiences of a typical team
- Topics covered
  - Research approach
  - Team background: origin, objectives and processes
  - Dynamics of collaboration
  - Professional role changes
  - Dealing with professional and physical boundaries
  - Conflict
  - Leadership
  - Conclusion

The research study

- Study is part of a longitudinal, multi-province research project on interprofessional collaboration (IPC) in mental health teams
  - Funded by SSHRC
  - Overall research program objectives: Understanding a) macro-level influences on IPC and b) micro-level dynamics of teams in local settings
- This presentation
  - Reports on an Ottawa Hospital mental health team that works in collaboration with family physicians in four clinics
  - Focuses on micro dynamics of collaboration

Research approach

- Qualitative study aimed at an in-depth understanding of how interprofessional collaboration is practised and experienced
- Observation of team meetings
- Analysis of documents pertaining to the team
- In-depth interviews with all members of the team (8 members)

Participants	Total
Administrative assistant	1
Nurses (including team manager)	2
Psychiatrists (including clinical director)	3
Psychologist	1
Social worker	1
Total	**8**

Team background and objectives

- Team established in 2004, first as a pilot project and now with permanent funding
- Team objectives
  - To provide psychiatric services (of short-term duration) at the primary level
    - Family physicians see big number of cases of mental illness, but may have limited time and expertise
    - Providing mental health in primary care offers early detection, allowing patients to live better quality lives
    - Patients are more likely to go to family clinic for mental health care because of less stigma
  - To enhance the knowledge level of the primary health care team – especially physicians and residents
- Team objectives are compatible with members' personal commitment

Team evolution and process

- Initially, team met once a week to discuss admin issues and patient assessments
- Weekly meetings had to be cancelled due to
  - Restrictions on co-location for meetings
  - Time restrictions as more sites were added and number of patients increased
- Currently
  - Triage is done by two nurses
  - Meetings to discuss administrative matters are held once a month
  - Discussion of patient cases does not have a designated formal forum
    - It happens informally through face-to-face conversation, phone or email

Dynamics of collaboration

- Degree of collaboration between mental health team and family physicians (FHTs) varies from site to site and is influenced by
  - Physical emplacement and spatial arrangement: central vs. corner location
  - Hallway conversations with FHT members and rounds held by psychiatrists
    - The better FHTs know the members of the mental health team, the more trust and appreciation for capabilities of mental health team
  - Some FHT members prefer to connect with a psychiatrist
- Collaboration between the teams is affected by presence of residents, whose comings & goings reduce stability of FHTs & increase need for constant information sharing
- Many of these issues are prevalent among teams that need to collaborate

The paradox of collaboration

- Collaboration involves integration and separation mechanisms:
- Members learn from each other in discussions and meetings
  - Meetings and discussions are *integration* mechanisms
- Transfer of knowledge allows everyone to operate at a broader level of skill
  - Broader skills act as a *separation* mechanism by making other members of team more dispensable in making patient decisions
- Members read notes of other clinicians and write their own notes on patient records
  - The record is a substitute for clinicians' meeting with each other
  - The record acts as an *information integration* mechanism, but also allows *physical separation* of clinicians
- There is a paradox in IPC
  - A member's collaboration and learning from others increases his/her knowledge and confidence level
  - This increases the ability of the member to act in some respects independently
  - Effects of increased collaboration include increase in independence from other members of the team

Professional role changes

- Members were asked to describe how roles changed since joining the Shared Care team
- What members learned (or how knowledge was enhanced) as a result of work in Shared Care:
  - What other professions do
  - Different approaches (and styles) that can be incorporated in treatment
  - Behavioral aspects of a management plan
  - Resources that are available in the community and that can be used to help a patient
  - How medication and biochemicals influence the patient and their care
  - Bigger picture of mental health provision
    - Advocacy related to de-stigmatizing mental illness and health: working on the attitudes of others (e.g. FHTs)
    - Advocacy for the principles underlying shared care: desire to diffuse shared care model across organization or to diffuse information about shared care in the wider system

Professional boundaries and boundary management

- Professions define values, knowledge bases, and scope of practice for their members
- This creates boundaries within which members practice their roles
  - "Boundaries" denote demarcations that delimit the scope of a certain domain
- Professional boundaries delimit structural/hierarchical and knowledge/practice domains
- In IPC, boundaries have to be properly managed, at times crossed and at times maintained in order to achieve the team's objectives

Hierarchical boundaries

- The sociology of professions indicates that physicians occupy the top of the hierarchy of occupations in the health care field
- How are hierarchical boundaries drawn in the Shared Care team at TOH?
- Participants' accounts:
  - The medical model, which places physicians in a position to issue directives to other health care workers, follows a traditional, "old school model" that is waning
  - The views of professionals coming into practice, the Colleges, the Ministry of Health, and the Canadian Medical Protective Association have changed over last decade
  - More physicians are open and trained to work in IP environments, and residents are evaluated for their skills in teamwork and respect for others' opinions

Hierarchical boundaries

- My study of the Shared Care team indicated that psychiatrists
  - Described themselves – and were described by others - as being open to other perspectives, as moving away from operating autonomously
  - Requested that team members address them by first name
  - Some components of psychiatrist role cannot be replicated by others (e.g. doing psychiatric diagnoses, prescribing medication, sending patients to hospital)
    - This still leaves much room for others to participate and take responsibility for patient care

Physical boundaries

- Physical co-presence (or co-location) of professionals is not necessary, but is desirable for facilitating collaboration

- The TOH Shared Care model is intended to remove boundaries for patients
- But the model creates boundaries among mental health team members who provide services in four different primary care clinics
- The physical boundaries are managed by sharing notes in patient records and holding informal conversations
- Dealing with work stations that vary from one day to the next also requires that members be highly flexible in order to cope with a “nomadic” work life
  - Files and work tools need to be carried to different locations
  - Support available at different locations varies
  - Relationships and workplace cultures also vary
  - The configuration of the team differs from one day to the other in the week

Conflict

- Research on teams (including IP teams) indicates that conflicts are a normal occurrence
- In the Shared Care team:
  - "We get along very well, and we like each other and respect each other."
- When members disagree on diagnosis/treatment, they resolve issue through discussions, digging deeper into patient situation, or referring patient to more specialized services
- Absence of conflict was attributed to
  - Flexibility of team members – willingness to adapt to different situations
  - Respect for each other
  - The nature of the work where members have some autonomy: it is up to each team member to decide whether and how to help the patient
- Other possible explanations
  - Patient diagnoses and treatments lend themselves to different interpretations
  - Therefore members have a tolerance for ambiguity and for multiple views

Leadership

- Leadership helps facilitate collaboration

- In the case of TOH's Shared Care, the model is *distributed* or *shared* leadership
  - Program manager: Nurse, MHA, responsible for overall management and operational matters
  - Clinical director: Psychiatrist, responsible for the direction that the program takes
  - Leadership also provided by other members of TOH and sites where Shared Care operates

- Program manager and clinical director
  - Share good relationship with each other and with other members of team
  - Inclusive of other perspectives; other members mentioned possibility of taking lead on projects
  - Committed to model of Shared Care, and to providing mental health care at early stages of need
  - Highly mindful of whom to hire for Shared Care work

- One shortcoming is the amount of responsibility each of these two leaders holds
  - This limits amount of time available

Conclusion

- Collaborative care works best when team dynamics are positive

- Important dynamics that should be given consideration include
  - What type of collaboration is required and how do different types affect
    - Degree of access that is offered to patients
    - Quality of care
  - How much learning are members of shared care achieving, and how can a higher level of skills be achieved by diffusing knowledge?
  - How are professional/hierarchical boundaries drawn and managed?
  - How can physical boundaries be minimized?
  - What are the sources of conflict?
    - How can differences in opinions be managed so that they enhance discussion among members and quality of care for patient?
  - How is leadership provided, and what does leadership do to facilitate collaboration?