THE INTERPROFESSIONAL HEALTH CARE TEAM

LEADERSHIP AND DEVELOPMENT

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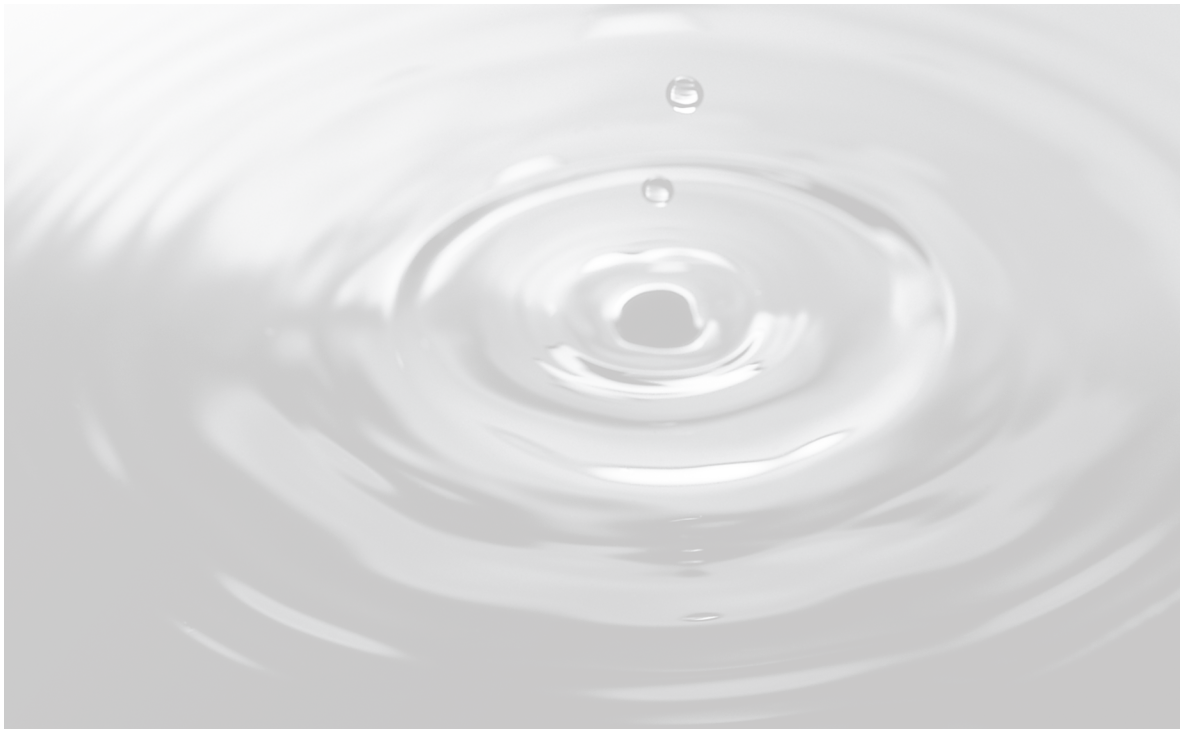

To my husband, Leigh, for his optimism, energy, and love and my granddaughter, Madeline Paige Broome, for her wide-eyed wonder.

— Donna Weiss

To my spouse, Trudi Sippola, for all of her unwavering support and to my loving parents, Sonya Tilin and in memory of my father Edward Tilin, who both taught me that developing relationships is the secret to a happy and healthy life.

— Felice J. Tilin

To the memory of my parents, Al and Alice Morgan. What more can I say?

— Marlene J. Morgan

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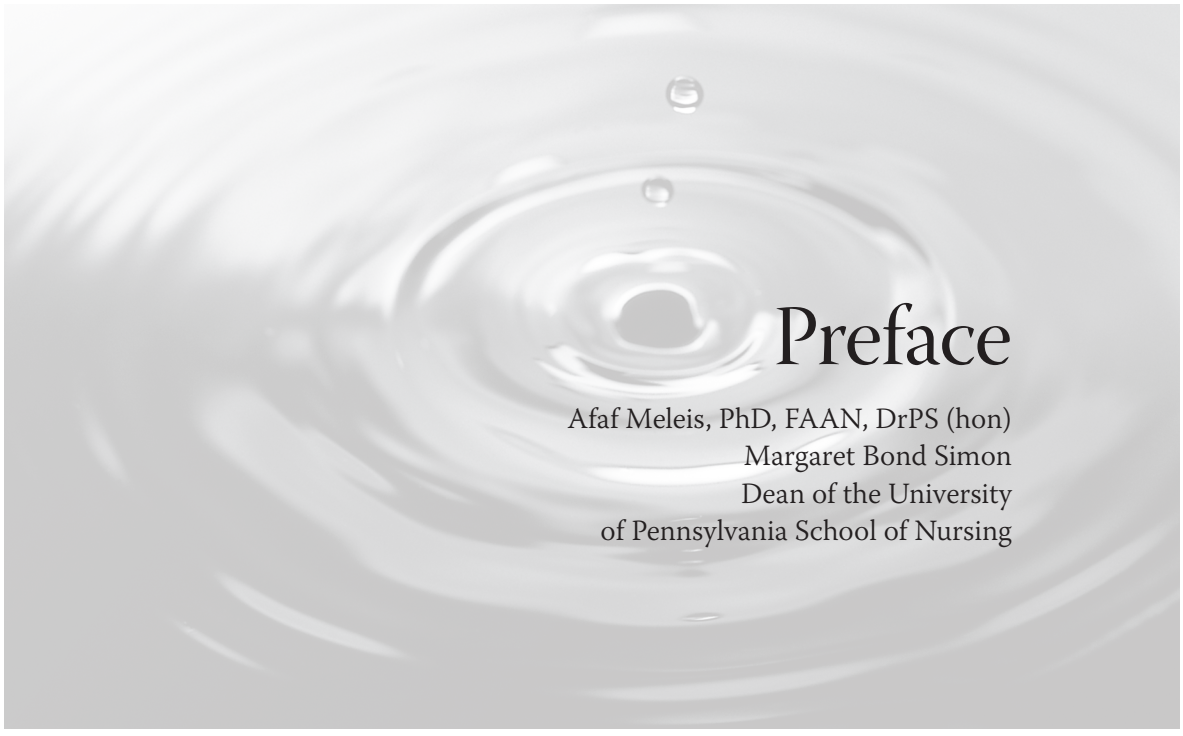

Preface

Afaf Meleis, PhD, FAAN, DrPS (hon)
Margaret Bond Simon
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Quality health care requires teamwork. Putting individuals together to teach across disciplines or to provide healthcare never guarantees the creation of a team with the synergy needed for a shared vision, an agreed upon mission, and a system of collaboration. To form productive and efficient teams requires a knowledge base, the use of best practices, interprofessional leadership, and individuals who are well prepared to be collaborative and effective members of the team.

It has become apparent, as evidenced in many policy reports and through much research, that teamwork is the hallmark of positive outcomes for the health and wellbeing of patients, families, and communities. Collaboration and partnership are equally as important and must be forged within and between organizations to advance well-being and enable institutions to function at their full capacities. However, it also has become apparent through many thoughtful dialogues and reports such as the *Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World,* written by the independent Lancet Commission on Education of Health

Professionals for the 21st Century, and *The Initiative on the Future of Nursing*, authored by the Institute of Medicine (IOM) Committee on behalf of the Robert Wood Johnson Foundation, that partnership, collaboration, and the formation of teams requires a paradigm shift in educational programs as well as in institutional function (Bhutta, Chen, Cohen et. al, 2010 and IOM, 2011).

Paradigm shifts occur through deliberate and systematic dialogues and debates. Productive dialogues and debates depend on knowledge of a field, willing participants, environments that promote such dialogues, diversity of opinions, respect of different voices, and trust in the value and principles that promote partnership and collaboration. Whether this paradigm shift is needed for crossing the boundaries of professions and developing interprofessional education, moving the silos of different disciplines toward interdisciplinarity or the ethos of independence toward interdependence, it fundamentally depends upon and requires the use of a well-organized and comprehensive evidence-based knowledge foundation and tools for implementation.

This book provides the much-needed knowledge base for developing a relational leadership style that promotes interdisciplinarity, interprofessionalism, and productive teamwork. It describes possibilities and options, theories, exercises, rich references, and stimulating questions that will inspire both novices and experts to think differently about their roles and styles as leaders or members of a team. I venture to suggest that this book will become a very important resource that will lead to more constructive actions for the development of a collaborative culture. The authors provide many tools to empower readers and facilitate the fostering of productive teamwork. It is an inspiring book with easily operational principles. My gratitude goes out to the authors for having the wisdom, the knowledge, and the experience to invest in writing this book. As teaching faculty members, students, clinicians, leaders, and managers read it and discuss its ideas, they will be as grateful to the authors as I have been after reviewing and using its content. It is written for many audiences and to achieve many goals all centered on best practices to attain quality care, particularly during this time of reinventing and transforming health care.

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Introduction: Interprofessional Leadership in the Health Care Environment

Learning Objectives

1. Understand the interprofessional health care team as a broadly inclusionary concept.
2. Describe how an interprofessional orientation can enhance patient care.
3. Explain the importance of relationship-centered care to patient outcomes.
4. Understand the concept of members as leaders.

Human beings are social by nature and bond together in families, small groups, and tribes. As we attempt to navigate from childhood through adulthood, our behaviors tend to mirror those of our family groups, peer groups, and professional groups. As we mature, our sense of self is created, in part, by our interactions with and feedback from these groups. Over the millennia, interaction with a variety of other people has been necessary to fulfill primary needs like love and affection but also to accomplish the work inherent to community building and survival. With the evolution

of societies from the Stone Age through the Information Age, the complexity of the challenges that individuals and organizations face has increased, as well as the need for well-functioning, diverse groups who can meet those challenges. Solving complex problems requires diverse information sets that are not the purview of a single person or a single profession. This is true in all modern endeavors but most apparent in the healthcare industry.

The concept of health incorporates a complex and holistic system where biological, psychological, physical, socioeconomic, cultural, and environmental factors function as interconnected and interacting determinants of one another. Rowe (2003) has noted that health issues are characteristically broad and complex and are most appropriately examined from an interdisciplinary perspective. Reports from the Pew Health Professions Commission (1998), the Institutes of Medicine (2001, 2002, 2003), and the World Health Organization (WHO, 2010) have repeatedly supported the notion that educational programs for health professionals can only be considered complete if they include experiences working in interdisciplinary teams. The literature regarding higher education is replete with references to research, as well as, interdisciplinary, interprofessional, and integrative studies. External funding sources for research identify evidence of interdisciplinary collaboration as a key criterion for grant eligibility (Bray, Adamson, & Mason, 2007; García & Roblin, 2008; Palincsar, 2007). Evidence of interdisciplinary team experiences is included in the accreditation standards for many health professional education programs with the expectation that health professionals will be educated with an interdisciplinary orientation and will develop an ability to leverage the power of teams to solve complex problems (Frenk et al., 2010; IPEC Report, 2011; NIH, 2008; Royeen, Jensen, & Harvan, 2009).

Members of interdisciplinary healthcare teams have multiple reporting relationships and value systems. Finding themselves working in increasingly complex organizational and political structures. The competitive healthcare market presents professionals with a variety of leadership challenges—not the least of which is learning to leverage the power of interdisciplinarity. Drinka and Clark (2000) define an interdisciplinary healthcare

team (IHCT) as "a group of individuals with diverse training and backgrounds who work together as an identified unit or system" (p.6). Disciplinary expertise is maximized when members of the interdisciplinary healthcare team can routinely employ strong relational skills and effectively coordinate their work with others. Relational coordination in the form of high-quality communication, mutual positive regard, trust, and active engagement are associated with a stronger collective identity, reduction in status differential, increased ability to respond to pressures with resilience, job satisfaction, and retention of staff. Most importantly, organizations that institutionalize the consistent communication strategies associated with relationship-centered organizations are high performing and profitable, demonstrating low employee turnover, better clinical outcomes, reduction in length of stay, and enhanced patient-perceived quality care (Gittell, 2009; Suchman, Sluyter, & Williamson, 2011).

The trend toward specialization in the health professions may lead to a less inclusionary interpretation of Drinka and Clark's definition of interdisciplinarity. It may be interpreted as the inclusion of persons who have the same basic training but have a specialty. For instance, some people may consider an internist, gynecologist, and a physiatrist to be an interdisciplinary team. The term *interprofessional* connotes a broader perspective and may include persons who have professional licensure or certification in nursing, occupational therapy, physical therapy, speech and language pathology, social work, and other health-related professions in addition to physicians (Hammock, Freeth, Copperman, & Goodsman, 2009). In literature and in practice, the terms are often used interchangeably.

Health care evolved from a hierarchical process dominated by physicians to an inclusionary team of professionals. Recently, the team was broadened to include patients and caregivers. The conceptual shift regarding the focus of health care occurred in tandem with the recognition of health care as a complex system of relationships. Neither term—*interdisciplinary* nor *interprofessional*—reflects the importance of the patient and other important constituencies/contexts in the achievement of good patient outcomes. The more cogent term seems to be *relationship-centered*.

The notion of relationship-centered healthcare teams reaches beyond the traditional core of physicians, nurses, and therapists; it incorporates all the constituencies who impact patient outcomes. It implies that the construction of healthcare teams is unique to the individual patient needs. The breakdown of traditional professional boundaries is necessary to meet the challenge of providing quality and cost-effective health care that is accessible to increasing populations (Grant & Finocchio, 1995). Skills in team building, team membership, and the understanding of the group dynamics are foundational and indispensable for the next generation of healthcare leaders.

Whether teams are called interdisciplinary, interprofessional, or relationship centered, each member of the healthcare team needs to ask these important questions:

- Who needs to be involved in order for the best patient outcomes to be achieved?
- How can we work together to achieve those outcomes efficiently and effectively?
- What is my unique professional and personal contribution to the team?
- How can I facilitate the optimum functioning of the team and the best client outcomes?

The full potential of the interprofessional healthcare team is realized when each member assumes a leadership stance. The member as a leader recognizes the power of his/her unique professional expertise and personal qualities. He/she accepts the responsibility of actively contributing relationship-centered, safe, effective, and quality health services. The designated leader is responsible for drawing out the leadership stance in all team members by modeling self-awareness, self-regulation, empathy, and positive communication and encouraging these behaviors in others (Boyatzis & McKee, 2005). Leaders who are successful in facilitating a proactive leadership stance throughout their teams realize that their own perspective is incomplete and recognize the value of engaging the wisdom and power of the collective. In doing so, they create sustainable, relationship-centered, and highly productive

team cultures that are creatively resilient in the face of change and thrive over time.

Leadership in the interprofessional healthcare team means that both the designated leader and members must be willing to share the responsibilities of team leadership and be cognizant of group dynamics in order to work with widely diverse skills, values, and interests (Lee, 2010). Appropriately addressing these issues requires a strong leadership that has a broad and integrative perspective. The leadership should be embraced by a cadre of professionals who leverage their own disciplinary knowledge base and integrate it with those of other related disciplines in order to develop advanced understanding and competence in patient-centered and relationship-centered practice. The accountability for this type of leadership is shared by health professionals at all organizational levels who engage in research, teaching, health administration, and health policy development, as well as direct patient care.

The challenge that faces health professionals is that while most health professionals work in interprofessional teams and recognize their value, the majority have been professionally acculturated into their respective professional guilds rather than seeing themselves as members of an interprofessional team. Until recently, professional training in most of the health disciplines did not emphasize collaboration, group decision making, or shared leadership (Calhoun et al., 2008; Lee, 2010). The Institutes of Medicine reported that a lack of effective collaboration among disciplines was most often identified as the cause of medical errors (IOM, 1999, 2003). For example, a boy dies of a treatable infection or pain reducing palliative care is withheld from a terminally ill patient for want of interprofessional collaboration (Dowd, 2012; Brown, 2012). On the other hand, effective interprofessional collaboration is linked to improved patient outcomes (Wheelan, Burchill, & Tilin, 2003). "It is becoming increasingly apparent the effort to produce high quality care is not hampered by lack of clinical expertise in the individual professions but rather by lack of appropriate knowledge and experience among these groups as to how to make these multidisciplinary teams work well" (Freshman, Rubino, & Chassiakos, 2010, p. 6).

As health systems increase in complexity, health professionals need to develop confidence in group problem solving, successful conflict management and resolution, efficient and effective information exchange, and boundary management (Gray, 2008). These competencies are dependent upon an understanding of the stages of group development and what makes teams effective. An effective team shows high levels of reflectivity and self-management skill, the ability to develop and maintain reciprocal relationships, and the willingness to empower others (Goleman & Boyatzis, 2008). The most successful and productive healthcare teams are those in which the concept of the collective as leader is applied. This means that all members, regardless of status, are self-aware and committed to assuming leadership and responsibility for the continued development of the group.

This text is designed to help all health professionals realize their capacity for leadership and develop the knowledge, skills, and attitudes that are requisite to becoming a positive agent of change and growth in themselves, others, and their organizations.

This text is comprised of three parts: Teamwork and Group Development, Relationship-Centered Leadership, and Building and Sustaining Collaborative Interprofessional Teams. Each part is divided into chapters that introduce theoretical concepts, provide case stories, and active teaching/learning experiences that are appropriate for in-class, online, or personal reflective learning environments.

Part I: Teamwork and Group Development introduces groups as complex systems and includes models of group dynamics, the developmental stages of groups, and how to optimize teamwork throughout the group life span. Activities provide practice in differentiating personal from group goals, analyzing the developmental levels of groups, and applying strategies that individual leaders/members can employ to foster and sustain highly functional teams.

Part II: Relationship-Centered Leadership provides a detailed discussion of leadership behaviors, emotional intelligence, and how self-awareness, self-management, and an understanding of positive psychology can facilitate team development and productivity. Activities will help the reader analyze

competencies required for health professions leadership; analyze leadership behaviors in real-life situations; identify personal leadership characteristics, challenges, philosophy, and behaviors; and conceptualize strategies for successful personal and health professional leadership for members as well as leaders of healthcare teams.

Part III: Building and Sustaining Collaborative Interprofessional Teams focuses on spanning professional boundaries, facilitating the development of a team culture, and generative practice. Practices that include appreciative inquiry and positive communication can facilitate the development of affiliative environments and help sustain the productivity and effectiveness of relationship-centered healthcare teams. Real-world profiles provide examples of these concepts in action. Activities will focus on helping the student develop interpersonal sensitivity and attentiveness, utilize empathic communication strategies, provide and receive feedback, use positive influence to build trust, manage conflict, and leverage the creativity and energy inherent to diverse healthcare teams.

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