

The Health Care Team Members: Who Are They and What do They Do?

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LEARNING OBJECTIVES

After completing this chapter, the reader will be able to:

1. Describe the importance of multidisciplinary teams as the primary vehicle for collaboration in health care.
2. Identify the specific healthcare professionals involved in a healthcare team and their professional roles.
3. Identify the main team functions that are necessary for the successful operation of any healthcare team collaboration.
4. Identify which healthcare professionals carry out which health team functions.
5. Describe key factors in designing future healthcare teams such as selection of team members as guided by team functions and goals.

KEY TERMS

Healthcare teams

Collaborative efforts in health care

Team member designations by healthcare profession

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Team member designations by team function
Intrateam/interteam communication
Professional interactions

INTRODUCTION

In its landmark report, *Crossing in the Quality Chasm: A New Health System for the 21st Century* (Committee on Quality, 2001), the Institute of Medicine of the National Academy of Sciences described the explosion of new scientific knowledge in all aspects of health care and suggested that “Making use of new knowledge may require that health professionals develop new skills or that their roles change.” The report went on to say that “Incorporating new knowledge requires skilled leadership to engage the participation of health professionals in collaborative teams,” and that “What is sometimes thought to be collaboration, may be in fact be uncoordinated or sequential action rather than collaborative work.” To have effective collaboration, the report suggests that “Effective working teams must be created and maintained,” but points out that “members of teams are typically trained in separate disciplines and educational settings, leaving them unprepared to practice in complex collaborative settings.” The report also stated “The work of each individual may be efficient from the perspective of his or her own tasks, but overall the efforts are suboptimal and may not serve the needs of patients” (Committee on Quality, 2001).

The purpose of this chapter is to examine the individual professional contributions to healthcare teams and to describe the functions that must be carried out to allow healthcare teams to work effectively, so that the maximum benefit to patients can be obtained.

CASE STUDY: A 43-YEAR-OLD MOTHER WITH EARLY STAGE BREAST CANCER

Linda Simmons (*name has been changed*) is a 43-year-old previously healthy woman, and wife and mother of two girls, ages 8 and 10. During the course of her regular breast self-examination, she discovered a suspicious lump in her left breast. She went to her family physician whose examination confirmed the presence of a suspicious mass. Her physician confirmed the diagnosis after Mrs. Simmons obtained a mammogram at the local hospital. Mrs. Simmons was then referred to a surgical oncologist on the staff of

a cancer center at a nearby teaching hospital who carried out a surgical biopsy. The biopsy revealed a localized early stage malignancy of the breast. The surgeon immediately brought in a medical oncologist and, together with the occasional involvement of a radiation therapist at the hospital, they developed a tentative treatment plan involving limited breast surgery, medical chemotherapy, and possible follow-up radiation therapy.

Mrs. Simmons was admitted to the hospital and the recommended surgery was carried out. This was followed by a course of chemotherapy over several months that involved regular visits to the medical oncologist's office for administration of the appropriate medication. Because Mrs. Simmons had had previous bouts of clinical depression and was showing signs of a possible repeat episode of depression as a result of her diagnosis and treatment, her family physician referred her to a mental health professional for possible intervention and medical treatment. Because the chemotherapy medicine was quite expensive and her husband's health insurance plan did not pay the full cost of treatment, Mrs. Simmons met with a social worker at the cancer center to see if there might be some way to offset the high costs of the proposed chemotherapy.

Throughout the course of treatment in the hospital and as an outpatient in the medical oncologist's office, Mrs. Simmons developed very close ties with the nurses who participated in various aspects of her care. Indeed, in both settings, Mrs. Simmons came to depend upon the nursing staff members for clinical services and, perhaps more importantly, for personal support and information. She believed that the nursing personnel were the strongest and most sustained durable link in her process of care.

At one point, a clinical pharmacist was consulted because the chemotherapy was having severe side effects of nausea and weakness, and a change of medication dosage was recommended; an additional new medication was ordered to relieve the side effects of the chemotherapy. Also, early in her treatment, Mrs. Simmons had a series of genetic tests to determine whether several specific breast cancer-related genes were present, because their presence or absence might influence the choice of chemotherapy. After discovery that she was positive for the presence of several of these genes, Mrs. Simmons was seen by a genetic counselor who explained the relevance of these findings to her care; this genetic counselor also helped her to review the appropriateness of testing her two daughters for these genes either now or at a later point in their lives.

At the present time, Mrs. Simmons has successfully completed her chemotherapy regime and is being followed as an outpatient by both the medical oncologist and her family physician, with occasional visits to the hospital for laboratory tests and x-rays. Fortunately, both physicians and the hospital maintain electronic medical record systems, but because they are not linked together into a single system, Mrs. Simmons must follow all

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three systems separately to get a complete picture of her care and prognosis. Her husband's health insurance carrier participates in a breast cancer case management program as well and has an electronic medical record system relating to her insurance-covered care, but Mrs. Simmons has found that less useful than the other three local systems.

MEMBERS OF THE HEALTH CARE TEAM BY PROFESSIONAL BACKGROUND

A review of Mrs. Simmons' medical care for her breast cancer suggests a very good standard of care, provided by a group of widely-varied health care professionals working together as a "team," sometimes in a formal fashion (during her inpatient hospital care, for example) and sometimes in a more informal, ad hoc way (during her care as an outpatient, for example). One way to better understand these "teams" and how they functioned is to examine the various members according to their professional backgrounds and professional designations to see how the individual professions contributed to the total process.

The first group of professionals was physicians, the professionals who had the responsibility for making important clinical decisions and carrying out many of those decisions in practice. However, within the general designation of "physicians" there were several subsets of the profession, each of which carried out different responsibilities and played different clinical roles.

Mrs. Simmons' family physician, for example, was the point of first contact for her when she realized that there might be a lump in her breast. This physician arranged the referrals to more specialized care and then served as a continuing point of contact and support for Mrs. Simmons, especially as the number of physicians involved in her care grew. This family physician provided Mrs. Simmons with a "medical home" before her illness, during her treatment, and after its completion.

The surgical oncologist provided specialized expertise in Mrs. Simmons' disease, brought in other medical specialists as needed, and also carried out direct interventions twice: once to conduct the surgical biopsy and once to carry out the surgical removal of the tumor itself. The medical oncologist provided expertise about appropriate chemotherapy and actually administered the chemotherapy itself over many months when that phase of treatment began. The radiation therapist provided specialized knowledge

in his area of expertise when asked and would have provided the appropriate therapy itself if it had been decided to include it in this phase of her treatment. Although all of these professionals were “physicians,” their professional backgrounds, training, and—more importantly—their roles in the overall treatment process were markedly different.

In addition to the physicians, many other healthcare professionals played a variety of essential roles as Mrs. Simmons’ process of care unfolded. Without their involvement at the proper time and in the proper way, the best efforts of the physicians simply might not have had the maximum effect possible. Various laboratory and x-ray technicians assisted with important diagnostic procedures when necessary. The mental health professional, a clinical psychologist, took on an important role in the diagnosis and treatment of a possible depressive illness arising at least partially from the primary diagnosis and its treatment. When significant side effects developed during the course of chemotherapy, the clinical pharmacist was able to suggest ways to continue effective primary treatment and cope appropriately with the side effects of treatment when needed.

Mrs. Simmons’ process of care also introduced two newer professional disciplines that will be increasingly important in the care of patients in the years ahead: the expert in clinical genetics and the expert in newer electronic information systems. The work of the clinical genetics expert has already been mentioned and was essential in two aspects of her care: assisting the medical oncologist in choosing the best course of chemotherapy by providing him with important genetic diagnostic information and assisting the patient to understand the role of genetics in breast cancer for herself, her daughters, and her other female relatives.

The services of the expert in electronic information systems were not overt and external in Mrs. Simmons’ case, but their impact was present throughout all phases of her care. Providing high-quality medical care for patients with a serious illness is now a very complex matter, often involving a staggering amount of information to gather, process, and make data available to all who need it, including patients and their families. Health information technology and its management have become critical to the success of high quality, collaborative health services delivery.

Throughout the entire course of Mrs. Simmons’ care, the one professional group that was continuously present and essential to the success of that care was the profession of nursing. At all stages of her care, a clinical nurse played a central part in keeping the process moving forward,

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delivering specific services and support, and providing the substance and structure of the entire caring process itself. Professional nurses were ubiquitous throughout her course of care. Without them, there simply would have been no unified process and direction for Mrs. Simmons' care.

It should be pointed out that there are also subsets within the nursing profession as there are with physicians. All nurses are not the same in what they do, nor do they fulfill the same roles as all other nurses; sometimes the differences in their individual roles are more important than their similarities. Mrs. Simmons, for example, encountered nurses in the operating theater, on the wards of the hospital postoperatively, and in the delivery of chemotherapy and follow-up care in the medical oncologist's office. All were in the same professional grouping, but each was fulfilling a different role.

It should be obvious from this brief summary of one patient's process of care that a wide variety of healthcare professionals is needed to provide high-quality health care today. As this care becomes increasingly complex and challenging, the proper "mix" of professional talents and resources becomes broader and broader, and the difficulty of putting together effective teams becomes greater. It is becoming increasingly apparent that 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.

This lack of skill in making healthcare teams work well to some extent reflects badly on the early formative training of healthcare professionals in general. As a rule, each professional group, whether it is medicine, nursing, pharmacy, or any other group, trains the future members of their professions in their own professional enclaves. There is relatively little cross-training or interaction with the other professional groups with which a particular discipline must eventually work. There is also little transition or flow between and among the professional groups; the majority of the training time is spent in developing the unique skills necessary for one particular professional body. This results in professionals who are highly competent in the specifics of their own field and, at the same time, virtually unaware of the specifics of others. This lack of integration and exposure to the fields of others in early training leads to highly trained individuals in each professional group but poorly prepared members of interprofessional teams or collaborative groups.

To design better healthcare teams, the first steps are to identify the professional skills that are necessary to deliver the health team's ultimate

product, and understand the cultures and values of the specific healthcare professional groups who can deliver the needed care. Understanding how each professional group works and what that group needs for the maximum effectiveness of its contributions is essential to creating effective collaboration in health care.

Successful health care collaboration also depends upon organizational structures (i.e. teams) that have rules and roles of their own. No amount of understanding and knowledge about the other professionals in a healthcare team will make a collaboration successful if the organization and structure of the team is flawed. Therefore, it is important to look at the organization of healthcare teams from the point of the organizational roles and functions within any effective healthcare team.

MEMBERS OF THE HEALTH CARE TEAM BY ROLE AND FUNCTION

Collaboration between and among health professionals usually takes place around team efforts of a formal or informal nature, particularly in the care of illnesses that are complex or chronic in nature. It involves interaction between and among different types of professionals and is enhanced when the members of a collaborative understand each others cultures, values, and methods.

Another way to understand healthcare collaboration is to view health care as a system or an organizational process that involves many different functions that must be accomplished if the overall process of care is to be maximally effective. This approach examines whether the key functions are specified and carried out and, if so, by which professionals. Analysis of collaboration from a systems perspective is as important as the understanding of the clinical roles played by each individual professional contributor.

What are the roles and functions that are important to identify in any collaborative team effort? There seem to be seven key functions that must be carried out in any effective team activity:

1. Process access/entry point/referral guide
2. Clinical leader/clinical decision maker
3. Technical expert/consultant
4. Support service(s) provider
5. Process coordinator/point of continuing contact

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6. Resource manager/coordinator
7. Information coordinator/communicator

Not every healthcare collaboration requires all these individual roles and functions, but in those circumstances where the illness involved is serious, complex, or chronic in nature, these functions will certainly need to be considered.

Process Access/Entry Point/Referral Guide

The first step in seeking or obtaining care is to find an entry point to the needed healthcare process; then, if necessary, the patient and provider can move on to more elaborate and specialized points of service and care. Although in this age of improved and intensified communication there may not seem to be any challenges related to entering the healthcare process, entry in truth may be quite complicated. Lack of a usual healthcare provider or medical home, lack of financial resources or insurance coverage, and lack of language capacity of understanding, all can influence where, when, and how a person can enter into the healthcare process.

In Mrs. Simmons' case, when she first discovered a possible lump in her breast, she spoke with a female friend of hers who told her that a family relative had encountered a similar problem and had received care from a general surgeon in the community. Mrs. Simmons was told that, although this surgeon was not known as a cancer specialist, he was well-regarded as a general surgeon and had provided good care as far as she knew.

Because Mrs. Simmons had a good relationship with her family physician, a young female physician recently trained in family practice and specializing in women's health care, she related to her doctor how her friend had mentioned this general surgeon in the community. The family physician responded that she would be more comfortable if Mrs. Simmons sought surgical care at a nearby teaching hospital that had an organized cancer program. The doctor had referred several patients to a surgical oncologist there and had had good experiences with him. The physician's opinion was that the cancer program had a higher volume of breast cancer patients, offered a wider range of services, and generally had more expertise available for Mrs. Simmons' care.

The family physician related that she was also pleased with that particular surgical oncologist at the nearby teaching hospital because he always re-

ported back to the referring physician in detail about his findings and about the progress of the case. The family physician mentioned that this was not always true with her referrals to other specialists. She believed it was important that she continued to be involved with Mrs. Simmons' care over the course of her illness. Mrs. Simmons was convinced to follow her family physician's recommendations.

However, other types of access/entry/referral points could be just as effective, if operated correctly. Mrs. Simmons' family physician described another successful entry. One of her patients was a child with a genetic condition whose parents had gone to one of the referral services sponsored by the national organization connected with this condition to find an expert in their local area. On the other hand, the doctor revealed that she also had patients who had gone online to unauthorized and unsupervised Web sites for information and possible referrals. These patients had found themselves inundated with high-pressure sales pitches for unauthorized, unproven, and possibly dangerous treatments and medications.

The access/entry/referral activity is a critical function for any collaborative team effort, because the point of entry may determine the eventual major source of care coordination and future care, and, to a great extent, the ultimate outcome of that care for the patient.

Clinical Leader(s)/Clinical Decision Makers

Mrs. Simmons was referred to an expert surgical oncologist who quickly involved a medical oncologist in her care. They had worked together on many occasions, had quite a good understanding of each other's roles, and had no problem in deferring to the other's opinion when it was appropriate. They continued to jointly manage the clinical aspects of Mrs. Simmons' care, with the surgical oncologist taking the major initiative early in the process and the medical oncologist taking the major role after the surgical interventions were carried out. Mrs. Simmons' family physician continued to keep track of her progress through her contact with the surgical oncologist and found him to be more communicative than the medical oncologist, although both responded well when she asked for follow-up reports. Unfortunately, this type of personal cooperation and close communication is seemingly less common in these days of extremely busy medical specialty practices. This is probably not due to any lack of interest in communication, but rather to increasingly busy schedules and demands on physicians' time.

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There is occasional uncertainty about leadership in clinical collaborations that can be traced to the involvement of many specialists, each of whom believe (with some good reason) that they are experts in their particular area and should be actively consulted in the collaborative process. In Mrs. Simmons' case, no less than five clinical experts were directly involved in her care (the family physician, the surgical oncologist, the medical oncologist, the radiation therapist, and the clinical psychologist) and the situation could have easily led to confusion, conflict, and lack of coordination. Fortunately, it did not for this case because of the professional strengths of the two leading oncologists and their willingness to work together for a common purpose, as well as the established relationship with the family physician and her coordination and facilitation of communications.

The function of clinical decision-making and leadership is central to the entire collaborative team process, so the focus of that decision-making authority and responsibility should be clearly identified and recognized by all team members. As will be pointed out later, however, this does not mean that the clinical decision-maker(s) must also operate or manage all of the details of the team effort, as that management organizational role can perhaps be best done by others.

Technical Expert/Consultant

In any collaborative effort, a number of technical experts also may be involved, and their roles and functions are important to identify and integrate into the larger process. It is essential to plan how best to involve them in a timely and appropriate fashion and perhaps to actually assist them in their participation in the overall process.

In Mrs. Simmons' case, four technical experts or consultants were successfully brought in to deal with various aspects of her care and one additional expert was approached but could not be successfully included. The four successful consultants were the radiation therapist, the clinical psychologist, the clinical pharmacist, and the genetics counselor. The one unsuccessful involvement was a neurologist who was contacted to appraise some severe headaches that Mrs. Simmons was having during the course of her chemotherapy. Unfortunately, his office could not provide an appropriate appointment for almost a month and by that time, the headaches had subsided and the consultation was no longer thought to be necessary.

In any complex or chronic illness, not only are first-line clinical experts and decision-makers necessary, but usually there is a need for technical

expertise and consultations about more limited and specialized aspects of care. Blending these specialized technical reviews and interventions into the overall care process can be difficult and sometimes damaging to the smooth and timely operation of the broader process; this can be facilitated by the medical home or care coordinator.

Support Service(s) Provider

Just as there is need for technical expertise and consultants in the collaborative team effort, frequently individual support services that enhance and expand the primary clinical services are necessary. These are services such as x-ray and laboratory, physical and occupational therapy, social work and social support services, home nursing care and long-term care, transportation services for the disabled, meals-on-wheels and other home assistance services, and support groups and individual counseling for patients and family members. These services are not aimed at the primary disease entity itself, but rather are focused on the damages and aftermath of the disease and its treatment.

In Mrs. Simmons' case, there was need for x-ray and laboratory services provided by the hospital, social work assistance in dealing with her prolonged absence from work and her possible job loss, and nutritional advice and supplements when her chemotherapy interfered with her usual food intake. She had been referred to and took an active part in a breast cancer survivor group sponsored by her local church, and she visited a physical therapist when she thought that some shoulder muscles were weaker after surgery and were hampering her ability to return to her previously active swimming routine.

Very often, in the heat of active treatment for the primary illness, these secondary support services are overlooked or underappreciated because they do not necessarily deal with urgent life and death matters. However Mrs. Simmons probably would be the first to say that the support of her church pastor and her breast cancer survivor group members were extremely important in helping her and her husband deal effectively with the stresses of her primary cancer treatment events.

Coordination of Effort/Point of Continuing Contact for Providers and Patients

It is clear that many healthcare professionals take part in any process of care, ranging from those who are continuously and intensely involved to those

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who play more of a “cameo” role, coming in as needed for a brief (and perhaps critical) technical role and then moving off the scene. Often there is no central point of coordination of all these efforts in an organizational (and not necessarily clinical) sense. From the patient’s point of view, it also may be very difficult to keep track of the involvement of all the separate individual specialists as well as confusing to know where to go to get a complete picture of what is going on.

The role of organizational coordination of the efforts of all the individual team players therefore becomes critical and essential to the smooth functioning of the collaborative effort. The coordinator helps all those involved in the patient’s care process to know what is happening, what is expected of them, and what their activities should be in relation to the activities of others. The organizational coordinator is not necessarily the clinical decision-maker, although clinical decision-makers can take on the coordination role if he, she, or they are willing and capable.

In Mrs. Simmons’ case, this role was assumed by a staff member at the hospital’s cancer program, where both the surgical oncologist and medical oncologist were on staff. In this well-organized cancer care program, there was a specific nonclinical person (designated a “care process coordinator”) who served as the central point of contact for Mrs. Simmons and all her various clinical specialists. This care process coordinator was assigned to Mrs. Simmons’ case early in the process and became responsible for making the patient’s appointments with consultants, laboratory, and x-ray services as well as for ensuring that these appointments and all other aspects of Mrs. Simmons’ care were proceeding smoothly. The coordinator was also the person who would retrieve any needed medical records or test reports, and who would remain the point of continuing contact for Mrs. Simmons and everyone else involved with her care.

Simply having a group of highly-skilled professionals working for the same patient does not guarantee an effective collaboration and team effort. The coordinator helps individual skills and services mesh together in an operational way that increases efficiency, quality, and patient and provider satisfaction. It is often a poorly recognized, underpaid, and underappreciated role and function, but it is central to effective and successful collaboration.

Resource Manager/Resource Coordinator

With the growing complexity of medical and hospital billing, health insurance requirements and processes, and economic pressures on both patients

and providers in recent years, a new role has developed: the financial resources coordinator or manager. This role and function is often critical for patient's access to care, for the providers' reimbursement, and for all participants in the healthcare process to have some sense of satisfaction and peace of mind with regards to the economic aspects of health care.

In Mrs. Simmons' case, she was fortunate that she had adequate health insurance coverage through her husband's employer and initially believed that all her expenses would be covered by that plan. While it was true that most of her expenses were covered to some degree, it sometimes took considerable effort to get certain newer treatments and medications approved for treatment by the plan. Additionally, she and her husband had to pay a significant share of the total cost, and experienced confusion about what was owed.

In the past, Mrs. Simmons' financial issues probably would have been assigned to a billing clerk in the hospital's accounting office and to an office manager in the different physicians' offices. Each of these people dealt primarily with bills in their sector of health care and had little interest in the finances of any other areas of care, even though all the individual areas overlapped and interacted with all the others in many significant ways. In addition, each of these individuals was usually dealing with difficult matters (i.e. bill paying) and sometimes had bad news to give and unpleasant actions to take. These often difficult and unpleasant transactions were handled by staff who were completely untrained in dealing with people in a cooperative way, which led to the perception of the financial staff as the "bad guys" by both providers and patients.

In Mrs. Simmons case, the care process coordinator at the hospital's cancer center understood all the challenges of financing complex health care from her own personal family experience and she felt determined to do all she could to minimize the negative aspects of each patient's experience. Based on her own family's experience, she had often said, "It is bad enough that our patients have cancer; we should not handle the billing process in such a harsh and unpleasant way that it only makes matters worse."

As a result, she asked for permission to work with one specific billing clerk in the finance office and requested that they work together to handle all aspects of patient billing for all cancer center services. Whenever billing problems arose, either with the providers, patients, or insurance plans, this coordinator advised her patients and providers to call her or her colleague in the finance office and they would work together to find the best solution.

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They were not always able to solve individual billing and financial problems, but they made it clear to patients and providers that solving billing and insurance issues were important parts of the cancer center's total program.

The important point here is that financial and insurance issues in health care are increasingly complex and difficult, and sometimes involve determining where and how patients receive care in a timely and supportive fashion. In any collaborative team effort around complex patient care, there is an important function of financial resource management that needs to be included in any good team process.

Information Coordinator/Communicator

A final important function for any collaborative team effort is the coordination and management of information from a wide variety of sources. It includes making that information available to the people for whom it has significance and importance, such as providers and patients.

In the past, information about a person's health care was gathered at a variety of sites and in a variety of ways. Its assemblage was often the result of random circumstances and opportunity, not intention. As a result, the information available to patients and providers was often located in many sites and separate information systems, was inadequate or incomplete, and was not easily viewed in its totality by anyone. Communication of this information was even more individual and opportunistic, and no participant in the healthcare collaboration could ever be sure that they had a complete and current picture of the case. As a result, tests and examinations were often repeated by each individual provider, so that each one would have the information at hand that he or she needed.

Information is a vital and even essential resource for the provision of excellent patient care. It should be complete, well-integrated into the patient's overall record, and easily available for review and discussion by multidisciplinary teams. The challenge is how best to make this wide variety of information and resources available to everyone who needs it in a timely and appropriate fashion. To perform this information coordination function effectively, this new professional role is still developing.

For the present, the information coordination role and function is played, not by an individual healthcare professional, but by an electronic medical record or, more correctly, by a series of electronic medical records kept by individual providers and institutions. The function is fulfilled not by one

person who continuously reviews and updates an individual patient's complete health record, but by an information system specialist, usually at a distance. This professional assesses the effectiveness of the broader system beyond an individual patient record and determines whether important pieces of information have been entered in timely and accurate manners.

The creation of the care process coordinator role was valuable in Mrs. Simmons' case, because the coordinator was able to follow her care process and could intervene if needed information was not forthcoming. However, the care process coordinator is not an information systems specialist or expert, and cannot serve as an expert information coordinator and communicator. For that reason, this role and function will belong to a more active member of healthcare collaborative teams in the future.

In Mrs. Simmons' case, there was no central repository of all information relating to her illness and progress. To determine her complete picture, she had to access four separate electronic information systems and put their sometimes disparate information formats and items together for herself. This situation will be reduced in the near future to two separate systems, one for all hospital-connected physician and hospital services and one for her family physician. But in this case study, Mrs. Simmons still had to piece her record together on a day-to-day basis and serve as her own information system coordinator, relying on her connection with the care coordinator for those items of information that she could not find herself.

Table 1-1 presents an overview of the teams, roles, and functions involved in Mrs. Simmons' care.

CONCLUSION

All patient care involves some degree of collaboration and teamwork between and among individuals of various professions and disciplines. Not all interactions between healthcare personnel need to be considered as part of a formal team effort, because much of health care involves personal interactions taking place between only a few individuals on a one-time, short-term basis.

For more serious, more complex, and/or chronic illnesses and conditions, however, the model of collaborative team-related efforts becomes increasingly crucial to ensure efficient, effective, and high-quality care. The days of

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Table 1-1. Mrs. Simmon's Case Example: Teams, Roles, and Functions

Team Member's Professional Area	Roles and Functions	Case Example
Clinical decision-maker	Leadership, manages clinical aspects of care	Family physician Surgical oncologist Medical oncologist Radiation therapist Clinical psychologist
Technical expert/ Consultant	Consultant, provides information about specialized aspects of care	Radiation therapist Clinical psychologist Clinical pharmacist Genetics counselor
Support services	Enhance, support, and expand the primary care services	X-ray Laboratory Physical therapy Occupational therapy Social work Social support services Home nursing care and other home services Long term care Transportation Support groups Counseling
Coordination point	Organizes all efforts; central point of setting timely appointments with appropriate specialists and other service providers	Care process coordinator
Resource manager	Handles the economic aspects of care	Care process coordinator Billing clerk
Information coordinator	Coordinates and manages information from a wide variety of sources	Electronic medical records Information specialist

an individual healthcare professional working alone or in a very small group are rapidly waning and are being replaced by organized multidisciplinary team efforts. Learning how to promote improved collaboration between and among various healthcare professionals and learning how to create and support capable healthcare teams are critical strategies for the long-term success and cost-effectiveness of modern health care.

The seminal report from the Institute of Medicine, *Crossing the Quality Chasm* quoted at the beginning of this chapter, provides a template for this evolution towards broad-based successful collaboration. The Committee on Quality of Health Care in America (2001) identified four characteristics of effective healthcare teams in the future:

These characteristics include

1. team makeup, such as having appropriate size and composition and the ability to reduce negative effects of status differences between, for example, physicians and nurses;
2. team processes, such as communication structures, conflict management, and leadership that emphasizes excellence and conveys clear goals and expectations;
3. the nature of the team's tasks, such as matching roles and training to the level of complexity and promoting cohesiveness when work is highly interdependent; and
4. environmental context, such as obtaining needed resources and establishing appropriate rewards.

In review, two ways were presented of understanding the professions and the professionals who comprise today's (and tomorrow's) healthcare teams. One way is to understand the professions themselves: what they do, how they do it, and what they think about what they are doing. The other is to understand the roles and functions that need to be carried out in any team effort, quite separate from the individual professionals taking part. The first understanding focuses on healthcare professionals as individuals and as members of professional groups; the second understanding focuses on organizational structures—formal and informal—and what it takes to make them work. Consideration of both these points of view in collaborative facilitation will lead to improved care, higher quality, and lower costs over time, which is an important set of objectives for all healthcare professionals and consumers.

DISCUSSION QUESTIONS

1. Why is it important to understand health team members' professional backgrounds and their individual clinical roles in the collaborative healthcare process?
2. Why is it important to know the specific team functions that take place in healthcare teams and to know which healthcare professional is carrying them out?
3. How might individual health professions change their educational programs to better prepare their graduates for improved collaboration in the future?
4. How might you design healthcare teams to enhance and improve collaboration?

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