ONTARIO HEALTH CARE PROVIDERS’ PERSPECTIVES ON FAMILY HEALTH TEAMS: AN INTERDISCIPLINARY REVIEW

By

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Integrated Studies Final Project Essay (MAIS 700)

submitted to Dr. Nanci Langford

in partial fulfillment of the requirements for the degree of

Master of Arts – Integrated Studies

Athabasca, Alberta

April 2014
ABSTRACT

Family health teams, first implemented in Ontario in 2005, provide health care professionals from different disciplines with the opportunity to work as members of an interdisciplinary practitioner team to expand the scope and accessibility of services that are available to patients.

This interdisciplinary research paper reviews the literature in order to explore the perspectives of interdisciplinary health care providers in Ontario toward their role on an interprofessional team, the effectiveness of the team, and the collaborative experience. The studies reviewed reveal that the disciplinary perspectives most relevant to this subject area were interprofessional education, communication and organizational culture.

Health care providers need to learn about the roles and responsibilities of the members of the family health team so that their services can be adequately utilized; there needs to be processes in place to facilitate collaboration. Effective and consistent communication was seen as an important way to keep team members informed and engaged, and the organizational culture of family health teams was viewed as important to their development and performance.

Through education, communication, collaboration and leadership, Ontario health care providers are making significant and important contributions to the effectiveness of family health teams.
Ontario Health Care Providers’ Perspectives on Family Health Teams: An Interdisciplinary Review

Introduction

In 2004, Canadian provincial and territorial governments committed to implementing primary health care teams across the country with a projection that 50% of Canadians would have access to one these teams by 2011 (CFHI, 2012). A 2008 survey of Canadian experiences with primary health care found that about one third (32%) of Canadian adults had reported that they had access to care that involved a regular medical doctor who worked in practice with other health care professionals (Statistics Canada, 2009). To date, these interprofessional teams have been established to varying degrees in all Canadian provinces and territories, with British Columbia, Alberta, Ontario and Quebec having made the most progress towards implementation (CFHI, 2012).

In 2005, the Ontario Ministry of Health and Long-term Care (MOHLTC) initiated the implementation of family health teams across the province of Ontario in an effort to improve the recruitment and retention of health care providers, to improve patient care and outcomes, to provide more accessibility to healthcare, and to increase satisfaction among patients and health care providers (MOHLTC, 2005). These teams provide health care professionals from different disciplines with the opportunity to work as members of an interdisciplinary practitioner team to expand the scope and accessibility of services that are available to patients. According to the Health Council of Canada (2009), “Teams allow doctors to focus on medical diagnosis and management, while other health professionals (such as nurses,
dietitians, and social workers) provide other services and work with patients to help them improve their health habits and the way they manage their conditions” (p. 2). The working relationship among the members of each team takes into account the expertise and skills of individual providers. Over time, the teams develop their own individual working relationships, character and culture, with no two teams functioning exactly alike.

This interdisciplinary research project reviewed the existing literature to explore the perspectives of Canadian health care providers who work on interprofessional primary health care teams. The goal was to determine the perspectives of health care providers on factors such as their role on the team, the functionality of the team, and collaborative practice. As a research associate working with a family health team, and as a patient in one of these practices, I am interested in learning more about the dynamics of these interprofessional practices. As such, this paper focused on answering the following question: *What are the perspectives of Ontario health care providers on being a member of an interprofessional team, the effectiveness of the team, and the collaborative experience?* The results of this study could potentially contribute to the understanding of the dynamics of these teams, some of the challenges that team members encounter, and improvements that can be made to optimize team effectiveness.

**Ontario Family Health Team Studies**

A literature search on this subject was conducted utilizing keywords which were entered into the OVID Medline, PsycInfo, and PubMed databases, to search for relevant articles published in
the last 10 years. The search focused on research and evaluation studies involving family health teams in Ontario and revealed a number of pertinent studies. Some of the studies involved teams of health care providers while others involved practitioners from a specific discipline (e.g., pharmacists). The study designs included surveys, focus groups, case studies, in-depth interviews, and ethnographic methods such as the review of practice documents, field notes, interview transcripts, and provider-patient interaction observations.

The literature search revealed that a number of Ontario-based studies have evaluated the interdisciplinary collaborative care model in primary care, and these studies were reviewed for this research paper (Table 1). Goldman et al. (2010) used a case-study approach to examine family health team members’ perspectives on interprofessional collaboration and the potential benefits. Interviews were conducted with physicians, nurse practitioners and nurses, pharmacists, managers, social workers and dietitians. The results reflected five key issues: rethinking the roles and responsibilities of the team members; the essential role of a manager or executive director; shared time and space – to optimize opportunities for communication; the implementation of activities that would foster the team approach to care; and the value of interprofessional interactions with an increased focus on collaborative patient-centred care.

Delva and Jamieson (2005) surveyed team members from six Ontario family medicine practice teams to assess team functioning. Three factors were found to predict team effectiveness: 1) metacognition of team goals and performance – this relates to knowledge of team goals and operation and was the strongest predictor of team functioning; 2) team identification and
communication – the second strongest predictor of team functioning, “items in this factor reflect a personal sense of belonging to the team, good communication and utilization and valuing of team members and their roles” (p. 8); and 3) team potency – this factor also predicted team effectiveness and reflects the capacity for the team to work hard and be productive.

In another study, focus groups were conducted by Delva et al. (2008) with six Ontario family health teams to explore the views of health care providers on what constitutes a team, team effectiveness, and the factors that influence team effectiveness. The researchers identified twelve factors that had an impact on team effectiveness, based on comments from team members, including: educational and clinical obligations; purpose, motivation and team goals; team membership; an understanding of members’ roles; power differences; adjustment and problem-solving as a team; teamwork process; communication; recognition; support; overcoming barriers to effective teamwork; governance; and team meetings.

Results of a survey of 628 members in twenty-one Ontario family health teams on leadership and organizational predictors of team climate showed that leadership and the culture of interprofessional collaboration were more predictive of a well-functioning team than the composition of the teams (Howard et al., 2011). Larger, more diverse teams were associated with lower perceived team functioning; group and developmental cultures predicted higher team climate scores; and a hierarchical culture predicted lower team climate scores. The
utilization of a highly functional electronic medical record (EMR) was associated with higher team functioning.

Ragaz et al. (2010) conducted case studies with family health team members from five diverse communities in Ontario to investigate strategies for team leadership. Common themes were identified which resulted in fourteen lessons that were learned. Investments made early in team development were valuable in building a cohesive and effective team including: informing team members on how the family health team model will work, educating health care providers with regard to their role on the team, and communicating effectively and consistently. In order to achieve strategic balance, teams need to meet an early goal to fill a gap in patient services, negotiate with the ministry for resources, and to think beyond ministry guidelines to develop a family health team model that is suitable for the team. Team building was facilitated by the integration of nursing staff, the attributes of health care providers and other staff that were hired (flexibility, willingness to adapt, and leadership qualities), establishing effective human resources policies, implementation of the electronic medical record, and the development of patient care collaboration processes.

Additional studies focused on the perspectives of health care providers from specific disciplines including occupational therapists, and pharmacists. Donnelly et al. (2013) collected data from four family health teams that had employed occupational therapists to examine how they were being integrated into the team. According to the participants in the study, the key elements to integration included communication, trust, and an understanding of the discipline. Three
primary themes and eight secondary themes were identified by the researchers as having influenced the integration of occupational therapists into the family health teams. One of the main themes was to ensure that there was an understanding of the role of occupational therapists and the services that they can offer to patients. This could be accomplished by educating the team, engaging physicians through the identification of a physician champion, and increasing understanding through research and teaching. A second theme was the culture of collaboration which included the provision of program based care, and the ability to collaborate with other occupational therapists, both within and outside of the family health team. Collaboration and trust was the third theme which was seen as essential to integration; the electronic record was seen as critical to facilitating communication and collaboration; having the occupational therapists in the same location as other team members provided opportunities for them to interact with other team members which was seen as instrumental in developing relationships and building trust.

Farrell et al. (2013) used ethnographic methods to describe the role of pharmacists on family health teams, the pharmacists’ perceptions of their role, and the perceptions of other health care providers toward the inclusion of pharmacists on their interprofessional team. Researchers visited six Ontario family health teams, over a fifteen month period, to conduct interviews, observe provider-patient interactions, and to analyse practice documents. The two principal roles of the pharmacist that emerged from the analysis was 1) to provide information and respond to project requests; and 2) to engage in patient-centred medication management activities, which includes direct patient care, providing education, and collaborating with team
members. Pharmacists’ perceptions of their roles and their routines differed across family health teams however there were some similarities across the teams:

They all appeared committed to the concept of evidence-based care and indicated that they would benefit from improved skills in accessing and evaluating relevant clinical literature. Similarly, they all indicated the need to have better patient assessment skills, even those pharmacists who did not regularly see patients. All were challenged by lack of space in the practices, although they dealt with this challenge differently (Farrell et al., 2013, p. 294).

Based on the criteria for identifying relevant disciplines in interdisciplinary research studies, as described by Repko (2008), the disciplinary perspectives most relevant to this subject area are interprofessional education (IPE), communication, and organizational culture, based on their theories, concepts and assumptions. Significant insights from the relevant disciplinary perspectives were identified and integrated in order to produce an interdisciplinary understanding of Ontario health care provider perspectives on the functioning of family health teams.

**Interprofessional Education (IPE)**

There has been much discussion in Canada about changing how health care professionals are educated so that they will have the knowledge, skills and confidence to work collaboratively and share their expertise in a team setting. According to the World Health Organization (2010):
Interprofessional education occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. Collaborative practice in healthcare occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings (World Health Organization, 2010, p. 13).

Soklaridis et al. (2007) used focus groups to examine the views of educators across primary care health professions on the development of family health teams and interprofessional education within primary care. Three main themes emerged from the discussions. First, there was a lack of understanding of interprofessional education, with confusion in defining and differentiating between the terms *interprofessional, interdisciplinary* and *multidisciplinary*. “Through this discussion we discovered that defining and understanding the role of each health care professional was not something that came naturally. It had to be taught, and when it was not, there was confusion and discomfort when people tried to collaborate on initiatives and patient care” (p. 2001:e.2).

Participants expressed that there needed to be a process in place that would facilitate collaboration in order for the health care providers to work together; they required assistance to understand how to teach, learn and collaborate interprofessionally. Secondly, the participants expressed that there was a lack of interprofessional education programs at higher learning institutions, or variance in IPE initiatives, with some universities providing more
opportunities than others. Thirdly, there was a lack of agreement that family health teams could play a role in teaching IPE. Educators in the study stated that there was a need for faculty development courses so that health care providers could learn how to work collaboratively in family health teams (Soklaridis et al., 2007).

Accreditation bodies have been urged to include standards for interprofessional practice as a requirement for approval of programs. This approach means the established providers who are teaching must have the skills and desire to teach, model and mentor interprofessional care. As well, practitioners in the field will require ongoing professional development programs to learn about collaboration (Oandasan et al., 2006, p. 17).

Health care providers who participated in the studies that were reviewed also expressed the need for additional interprofessional education. Learning about the roles of all of the team members early in the development of the family health team is important to program development (Ragaz et al., 2010). Nurse practitioners and pharmacists indicated that it was difficult to educate other health care providers on their team about their role, their expertise, and their capacity to contribute to the team and to the care of patients (Goldman et al., 2010). Not fully understanding the roles of the health care providers could affect their integration, as was the case in the study by Ragaz et al. (2010) which described the challenge of integrating nurse practitioners into the team as their role was not clearly understood by other health care providers.
Many of the participants in the studies reviewed had developed strategies and educational activities to combine education with team building. Some family health teams organized retreats, educational rounds, and interprofessional journal clubs (Goldman et al., 2010). Other health care providers used presentations at grand rounds on a regular basis to inform other team members about their roles on the team as well as the skills and services that they can provide (Ragaz et al., 2010). Occupational therapists also used a number of strategies to educate team members on their profession and the services that they offer including presentations, educational rounds, information booths, ‘meet and greets’, as well as informational brochures and letters. The occupational therapists in the study felt that when team members had a good understanding of their profession they were more likely to make referrals; when their role wasn’t understood their services were underutilized (Donnelly et al., 2013).

**Communication**

Communicating effectively with other health care professionals has been identified as one of the core competencies for practice collaboration (Oandasan et al., 2006). In the studies reviewed, participants stated that all forms of communication were important to keeping team members informed and engaged whether they were emails, faxes, meetings, or hallway conversations (Ragaz et al., 2010; Delva et al., 2008). Consistent communication was thought to be critical to building trust and a sense of accomplishment (Ragaz et al., 2010). “Effective teamwork relied on team communication based on respect and feelings of comfort with other
team members. Good relationships among team members not only aided communication but facilitated the degree to which team members could help each other” (p. 603).

Participants in the study conducted by Delva et al. (2008) indicated that there were barriers to communication including conflicts in schedules and roles, inconsistent sharing of information or incomplete information from team meetings. The team secretaries were seen as central to facilitating communication as they interact with all members of the team in terms of distributing minutes, providing electronically accessible documents, and communicating immediately when problems arise. Other health care providers indicated that they practiced in areas that were separate from other team members which made it difficult to communicate and collaborate (Goldman et al., 2010).

Health care providers in several of the studies stated that the electronic medical record (EMR) was an effective tool for communication. “The EMR enabled both formal and informal communication with physicians and other team members through the messaging system and patient records. The instant messaging function served as an internal communication system” (Donnelly et al., p. 8). Using the EMR to share patient information helped to facilitate interprofessional collaboration (Goldman, et al., 2010).

Organizational Culture

Theorist, Edgar Schein (2004) defined organizational culture as:
the pattern of shared basic assumptions learned by a group as it solved its problems of external adaptation and internal integration, which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems (Schein, 2004, p. 17).

In recent years, there has been an increasing interest in the organizational culture of medical group practices and it is considered to be an important factor in the performance of these practices. Zazzali et al. (2007) surveyed 1,593 physicians in 52 medical groups across the US to assess the influence of organizational culture on physician satisfaction with how the groups are organized and managed. The study results showed that physicians’ ratings of group culture (e.g., teamwork and cohesiveness) were positively associated with most of the satisfaction measures, suggesting that culture is an important element of group practice in influencing the attitudes of professionals toward their organizations.

Leadership is seen as one of the elements of organizational culture that is required for effective teamwork:

Teamwork is influenced by organizational culture. A clear organizational philosophy on the importance of teamwork can promote collaboration by encouraging new ways of working together; the development of common goals; and mechanisms to overcome resistance to change and turf wars about scopes of practice. Teams need training to learn how to work together and understand the professional role/responsibility of each
They also require an effective administrative structure and leadership (Oandasan et al., 2006, p. i).

Health care providers indicated that working to their full scope of practice was a rewarding aspect of being in a family health team. Ragaz et al., (2010) described the effortless integration of registered nurses (RNs) into the family health team and the expansion of their role on the team which was seen as invaluable in terms of improving patient access to services and relieving some of the pressure on the team physicians. “One RN described how her role in the practice quickly developed from taking blood pressures and patient histories to participating in chronic disease management, patient education, preventive care and more complex physical examinations and procedures” (Ragaz et al., 2010, p. 42).

The health care providers in the Ontario-based studies that were reviewed for this study stressed the importance of leadership and management; participants in some family health teams who did not have an executive director or manager felt that there was a lack of team development. Leadership by family physicians was also seen as important in facilitating the development of the family health team (Goldman et al., 2010). Participants indicated that key issues that need to be addressed were the implementation of activities that will facilitate collaboration and promote a team approach to patient care such as establishing interprofessional committees and working groups, and organizing case conferences and retreats (Goldman et al., 2010).
Organizational structure is another element that can influence organizational culture. In some family health teams the perception is that physicians hold more power on the team as compared to other health care providers, and that they need to relinquish this power (Delva et al., 2008; Goldman et al., 2010). Effective human resources policies were seen as essential to a well-functioning team environment as they provide structure, help to resolve disputes, and reduce the effect of the power hierarchies within the team (Ragaz et al., 2010).

Working as a team can be challenging and health care providers in the reviewed studies articulated some of the barriers to team building. Challenges included conflicts with scheduling, lack of understanding of team members’ roles which can lead to infrequent interaction, insufficient time for team building, and the inadequate recognition of transient or peripheral staff members. Other barriers to team building were absenteeism, disorganization, and lack of cooperation (Delva et al., 2008). Family health team members who worked in different locations from other team members felt that this was a barrier to team development (Goldman et al., 2010).

Despite the challenges, the health care providers in the studies that were reviewed, valued effective teamwork and described their teams as functioning in a positive way. As a team, they could find better ways of doing things and improve on the systems that were already in place (Delva et al., 2008).
Conclusion

The body of literature that focuses on the functioning of Ontario family health teams is expanding. This interdisciplinary research paper examined a number of studies in order to explore the perspectives of health care providers in Ontario with regard to their role on an interprofessional team, the effectiveness of the team and the collaborative experience. A review of the literature revealed that the challenges most relevant to this subject area are in the disciplinary realms of interprofessional education, communication, and organizational culture.

The most important characteristics of team members were flexibility, being comfortable in a fluid environment as the team changed and developed, and the willingness to take on a leadership role. Health care providers need to learn about the roles and responsibilities of the members of the team so that their services can be adequately utilized; and processes should be implemented to facilitate collaboration. Effective and consistent communication was seen as an important way to keep team members informed and engaged, and the organizational culture of family health teams was viewed as important to their development and performance. Through education, communication, collaboration and leadership, Ontario health care professionals are making significant and important contributions to the effectiveness of family health teams. Higher learning institutions should offer training in communication and collaboration, so that health care professionals can learn how to work effectively as members of an interprofessional team. Future research should include the perspectives of all members
of family health teams across Ontario to assess their views on how well these teams function and where improvements can be made.
References


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<td>Delva &amp; Jamieson (2005) High performance teams in primary care: The basis for interdisciplinary collaborative care</td>
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<td>Delva et al. (2008) Team effectiveness in academic primary health care teams</td>
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| Goldman et al. (2010) Interprofessional collaboration in family health teams: An Ontario-based study | Qualitative case study using semi-structured interviews | • Members of 14 family health teams in urban and rural Ontario  
• 32 family physicians, nurse practitioners, nurses, dietitians, social workers, pharmacists and managers | • Focused on the importance of defining and understanding changing roles and scopes of practice  
• Documented strategies and initiatives to support Interprofessional care |
| Howard et al. (2011) Self-reported teamwork in family health team practices in Ontario | Cross-sectional study using a mailed survey | • 413 team members from 21 family health teams | • Larger, more diverse teams were associated with lower perceived team functioning; group and developmental cultures predicted higher team climate scores; and a hierarchical culture predicted lower team climate scores |
| Ragaz et al. (2010) Strategies for family health team leadership: Lessons learned by successful teams | Case studies                 | • Team members from 5 diverse Ontario family health teams                     | • Common themes were identified which resulted in 14 lessons that were learned |
| Soklaridis et al. (2007) Family health teams: Can health professionals learn to work together? | Focus groups                 | • 36 participants from nursing, pharmacy, speech language pathology, occupational and physical therapy, social work and family medicine from 6 higher education institutions across Ontario | • Lack of understanding of interprofessional education  
• Need assistance in learning how to model Interprofessional learning, teaching and collaboration  
• Train the trainer model  
• Clarification of roles and responsibilities |