Teamwork — The New Way

By MARTHA TWADDLE, MD, FACP, FAAHPM

Imagine a health care system that is truly dedicated to the patient and family. Imagine the patient and family recognized as the unit of care and seen as the epicenter of care planning and its delivery. Envision the health care team poised to serve, to integrate and collaborate with the patient and family in decision-making and care. This model of patient- and family-centered care is more than a dream; it is the focus and intent of our evolving health care systems. The best way to achieve it, and assure its success, is through the interdisciplinary team structure.

According to the nonprofit Institute of Patient- and Family-Centered Care, based in Bethesda, Md., patient- and family-centered care is an "innovative approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families."[1]

Core concepts are:

Respect and Dignity: Health care providers listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.

Information Sharing: Health care providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.

Participation: Patients and families are encouraged and supported in participating in the care and decision-making at the level they choose.

Collaboration: Patients and families are also included on an institution-wide basis. Health care leaders collaborate with patients and families in policy and program development, implementation and evaluation; in health care facility design; and in professional education as well as in the delivery of care.

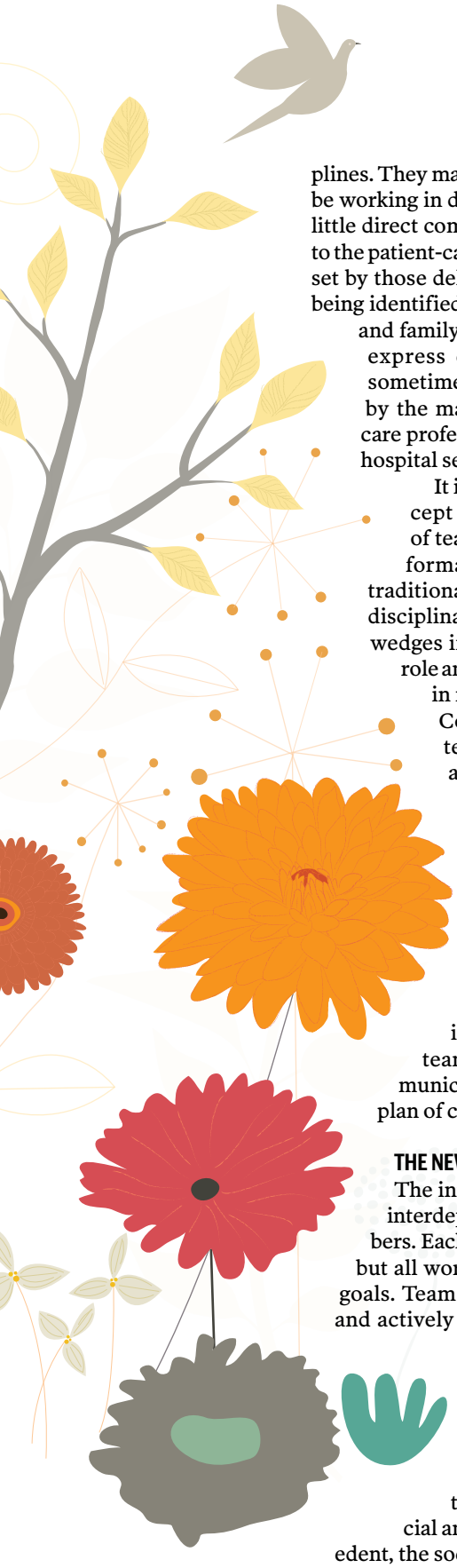
Patient- and family-centered care is receiving more emphasis as a welcome evolution from the purely medical model and its primary focus on disease management. In the latter model, the physician cares for the patient and bases treatment decisions on information gleaned from clinical experience, guidelines and data.

In the patient- and family-centered model, the patient/family unit is an active participant in an interdisciplinary team structure. The assessment of illness and its impact is more holistic, taking into account not just the physical aspects of disease, but also the psychological, social and spiritual ramifications of illness. The patient's family — biological or chosen — is central to care and incorporated into assessment and decision-making. Treatments are determined with greater consideration for the patient's individual needs and preferences; this approach leads to much greater satisfaction from all involved in care.[2]

Establishment of the team and teamwork are essential to the effective delivery of patient- and family-centered care. An interdisciplinary health care team, which exemplifies the concept of teamwork, collaborates to facilitate a more comprehensive assessment and treatment plan, leading to superior outcomes.[3]

THE OLD MODEL

Health care professionals working together in patient care historically have considered themselves a team. However, this loosely structured group is more often made up of professionals working in ways specific to their disci-



plines. They may be working in parallel, they may be working in duplication of each other. There is little direct communication and collaboration as to the patient-care goals. These goals typically are set by those delivering medical care rather than being identified after discussion with the patient and family. Patients and families frequently express dismay at sorting through the sometimes conflicting messages provided by the many physicians and other health care professionals they see, particularly in a hospital setting.

It is essential to understand the concept of teamwork and the definition of team in order to ensure its effective formation and function. Health care traditionally has been based on the multidisciplinary team model best described as wedges in a pie. Members have a specific role and place on the team, but they work in relative isolation from each other. Communication tends to be written — letters between physicians and specialists, notes in a patient chart. Within institutional health records, different disciplines may not even record their written assessments in a manner that allows others to see their input — as in the common practice of separating nursing and therapy notes from physician notes — further impairing communication. "Pie-wedge" team structure can lead to miscommunication and even conflicts as to the plan of care.

THE NEW MODEL

The interdisciplinary model is based on interdependent interaction of team members. Each may have a particular expertise, but all work synergistically towards shared goals. Team members work closely together and actively communicate, regardless of discipline. Leadership is often need-driven — for example, if patient and family priorities are physical, such as when symptoms of illness are not controlled, the physician and nurse may lead the plan of care. When psychosocial and spiritual issues are taking precedent, the social worker and chaplain will take more of a leadership role.

In truth, however, the patient and family function as the true leaders in the team because they set the overarching goals through stated preferences and descriptions of what, to them, constitutes meaningful care. A hand analogy often describes an interdisciplinary team: The individual fingers of the hand have different functions, abilities and dexterity, but as the fingers work together toward a common goal, the hand has much greater capacity than any one finger alone.[4]

Hospice and palliative care demonstrate the best example of the interdisciplinary team structure and function. Dame Cicely Saunders, founder of the modern hospice movement, called this team structure essential to care of the terminally ill. Trained as a nurse, social worker and physician, Saunders embodied the concept of interdisciplinary practice.

As the field of hospice and palliative care grew and developed, the interdisciplinary construct has continued as its inherent structure. It is mandated within the Medicare Hospice Conditions of Participation. The National Consensus Project for Quality Palliative Care and the National Quality Forum[5,6] identify the interdisciplinary team as a core element.

Increasingly, the interdisciplinary team is recognized as the most effective model for delivering patient- and family-centered care and for improving patient care outcomes and health care safety in general. The Joint Commission requires that long-term care patients receive care delivered by an interdisciplinary team, and the 2006 American Geriatrics Society position statement endorses interdisciplinary care as central to providing the best care to older adults.[7]

Interdisciplinary care improves clinical outcomes in stroke, myocardial infarction, congestive heart failure and geriatric syndromes, as well as in general symptom management. The effective communication within an interdisciplinary model has led to reductions in hospital length of stay as well as hospital cost.

In geriatrics, interdisciplinary care facilitates favorable outcomes in decreasing depression, delirium and loss of functionality. It enhances medication adherence while better preventing drug side effects, duplicate therapies and unnecessary hospital re-admissions. Interdisciplinary teamwork also has been shown to improve patient safety, particularly in decreasing the incidence of falls in the elderly.

Team members working in the context of an

interdisciplinary team are more productive, and they experience improved job satisfaction and decreased rates of burnout.[8]

MAKING TEAMS EFFECTIVE

The effective function of an interdisciplinary team relies on several factors including team composition and structure, organizational structure and interpersonal relationships. Who is on the team and how they interact with one another is vitally important, as the most critical factors for effective team outcomes are communication and collaboration. The organizational culture and structure also will have a direct impact on the team's effectiveness and success.

Communication is the main element in effective teamwork. Formal communication occurs through the active exchange of information in interdisciplinary team meetings. Although they take a commitment in time and resource, structured interdisciplinary team meetings are important, not only for the active discussion of patient and family assessments, but in order to promote positive interpersonal relationships, resolve interteam conflict and promote further teamwork and communication.

In the patient- and family-centered model, the interdisciplinary team meets regularly and formally with the family, either in bedside rounds or in arranged family meetings. Team discussion that actively includes the patient and family is most effective in goal-directed collaboration and patient-centered outcomes.

Just as important as formal discussions in team meetings are the informal exchanges of information in hallways, at work stations and over the phone. These focused exchanges of individual assessments and active collaboration regarding the next steps in care are what truly drive timely processes and outcomes.

Team discussions typically begin in this informal manner, and the formal team meetings serve to consolidate and document the active planning. The active collaboration is founded on trust and mutual respect between team members, key components that are intrinsic to the most successful teams. Trust leads to effective cooperation, and respect facilitates the open communication necessary for excellent outcomes. A high level of team commitment to goals and to the team itself, as well as an environment of friendliness, optimism and humor, will facilitate the best team outcomes.

Team size and composition are also very important to success. Smaller groups of around five to seven members are associated with greater team member participation and more effective, efficient team function. Occupational diversity on the team also is associated with better outcomes, likely from the more comprehensive assessment provided by differing perspectives.

Teams with full-time members who have worked together longer are the most effective, but when new members join a team, creativity and innovation can be the result. Answering the question "Why do you do it this way?" can lead a team to re-evaluate and improve.

Increasingly, the interdisciplinary team is recognized as the most effective model for delivering patient- and family-centered care.

The organization that supports the individual team is critical to its success. An organization that makes administrative support and team innovation a priority will foster highly effective teams. Similarly, providing timely, effective feedback to a team through outcomes data, satisfaction of patients/families and intra-organizational satisfaction allows teams to optimize their performance. For teams to function effectively, they need an organizational structure that effectively manages change, is flexible and decentralized and demonstrates commitment to continuous performance and quality improvement.

BARRIERS AND CHALLENGES

Even the most highly functioning teams must be diligent to address the challenges and systems-based barriers inherent in any health care system. Communication breakdowns, hierarchical organizational structures and muddied team-member roles all can impede a team's effective outcomes. Communication breakdown is the most significant issue; not only does this interfere directly with effective team function, but miscommunication has direct impact on patient care and outcomes. Lack of communication is cited as responsible for 70 percent of adverse events reported in health care and is the leading cause of patient-care errors.[9]

Communication breakdown interferes with the team's ability to collaborate and undermines

the delivery of patient- and family-centered care. Insufficient time, high clinical demands and geographic constraints are contributing factors. Team members disperse to attend to their individual patient care priorities, and they may not have sufficient time to re-connect to discuss their assessments or to create a holistic care plan. The goal to achieve a short length of stay in the hospital setting may confound a team's ability to provide a holistic assessment, coordinate an effective family meeting or even collaborate as to a plan of care prior to discharge.

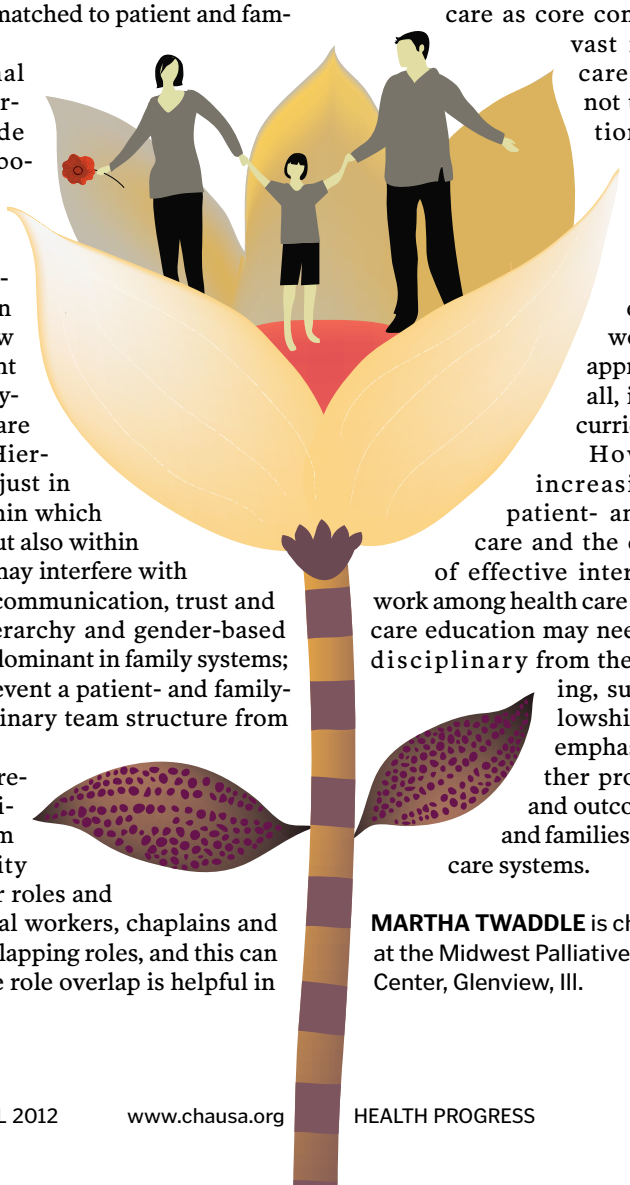
Communication within the team is influenced by the team leader. When nurses or physicians are the primary leaders of the team, the biomedical model will typically take precedence and psychosocial and spiritual issues may not be fully assessed, discussed or integrated into the care plan. This can lead to an incomplete plan of care that may not be well matched to patient and family needs.

An organizational structure that is hierarchical will impede effective team collaboration and function and have a negative impact on patient care outcomes. A rigid chain of command will slow processes and prevent the patient- and family-centered model of care from functioning. Hierarchy may exist not just in the organization within which the team functions, but also within the team itself. This may interfere with effective inter-team communication, trust and respect. Cultural hierarchy and gender-based roles may also be predominant in family systems; this dynamic may prevent a patient- and family-centered interdisciplinary team structure from happening.

One of the most frequently noted barriers to effective team function is ambiguity around team member roles and responsibilities. Social workers, chaplains and nurses may have overlapping roles, and this can lead to conflict. Some role overlap is helpful in an interdisciplinary team, but when it isn't clear who is responsible for what part of the care, the result can be misunderstandings, resentment and hurt. Effective conflict resolution skills and regular team meetings focused on the team's internal well-being rather than on patient care are very important to maintaining clear lines of communication and working out misunderstandings before they fracture critical team relationships.

THE FUTURE

Interdisciplinary teamwork is continually demonstrated to be the best way to facilitate care for patients and families. This model supports and promotes the patient- and family-centered approach and leads to the best outcomes of care. Hospice and palliative medicine as a medical subspecialty recognizes and promotes communication skills and the team-based delivery of care as core competencies, but the vast majority of health care professionals are not taught how to function within an interdisciplinary team as part of their primary training. The opportunities to learn effective teamwork and practice the approach occur late, if at all, in most educational curricula.



However with the increasing emphasis on patient- and family-centered care and the critical importance of effective interdisciplinary teamwork among health care personnel, all health care education may need to be more interdisciplinary from the very start of training, supplemented by fellowships in the field. This emphasis will serve to further promote the best care and outcomes for the patients and families served by our health care systems.

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NOTES

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