The Use of Interdisciplinary Teams to Improve Communication in Rural Community Mental

Health Clinics: Facilitators, Barriers, and Lessons Learned

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Abstract

In the past 15-20 years, interdisciplinary teams have become more widely used in inpatient care settings. Unfortunately, not all outpatient mental health settings have emphasized interdisciplinary teams for care provision and thus, communication between providers caring for the same patient can be fractured and inconsistent (Flin et al., 2003). The purpose of this project was to implement a formal interdisciplinary team meeting in a rural community mental health clinic (CMHC) so as to improve communication that occurs between various disciplines. By doing this, the focus was to be placed on providing safe patient-centered care with the goal of improving patient outcomes over time. Due to unforeseen factors, the scope of the project required a change. Therefore, the purpose shifted to evaluate facilitators and barriers to implementing an IDT in a rural outpatient CMHC. To do so, semi-structured interviews were conducted with key stakeholders from two different agencies (one without a formal IDT and an agency with a thriving IDT), as well as a questionnaire sent out via Survey Monkey. Primary facilitators to formal IDT implementation included: administration's support, autonomy, changes in culture as needed, and a strong facilitator/leader. Primary barriers included: culture (including politics and lack of support), competing demands, fear around losses, and expense. Overall it was found that creating a short-term patient centered disruption has long-term benefits such as improved productivity, efficiency, attitudes, and client care. Recommendations include: ongoing education, generative lines of questioning to amplify positivity, decreased productivity expectations, establishing an IDT mentor, training prior to IDT implementation, and identifying a strong leader/facilitator and specific IDT parameters once formalized.

Introduction: The Clinical Problem

Description of Clinical Problem

According to the Quality and Safety Education for Nurses (QSEN) initiative, teamwork and collaboration is one of the core competencies that nurses should become effective at during schooling (Batalden et al., n.d.). The purpose of this project was to implement a formal interdisciplinary team meeting in a rural community mental health clinic (CMHC) so as to improve communication that occurs between various disciplines. The immediate outcomes sought by this project were improving provider-to-provider communication, as well as acting as a forum for providers to debrief during critical incidents. The conduction of this project and its outcomes ideally served as a model for other rural community mental health clinics.

The problem. In the past 15-20 years, interdisciplinary teams have become more widely used in inpatient care settings. An interdisciplinary team (IDT) is a group of healthcare providers from different fields that work together to accomplish a treatment goal for a single patient ("Interdisciplinary team", n.d.). Unfortunately, not all outpatient mental health settings have emphasized interdisciplinary teams for care provision and thus, communication between providers caring for the same patient can be fractured and inconsistent (Flin et al., 2003). Fractured communication can critically affect patient care outcomes. If team members do not effectively communicate, patient safety is at risk (Sutcliffe, Lewton, & Rosenthal, 2004). Causes for lack of communication can be attributed to "social, relational, and organizational structures" (Sutcliffe et al., 2004, p. 186). The end result can be decreased continuity of care, decreased patient satisfaction, and decreased provider job satisfaction (Flin et al., 2003).

Population and epidemiology. According to the Center for Disease Control's National Center for Health Statistics (2012), there were over 1,109,544,000 visits by individuals to an

outpatient setting in 2010. Outpatient healthcare settings are treatment facilities that provide care

to a patient who is not hospitalized ("Outpatient", n.d.). Of those people who seek healthcare,

25% (about 61.5 million) have a mental health disorder for which they may also be receiving

treatment. Approximately 6% (13.6 million) of people in the US have a serious and persistent

form of mental illness (National Alliance on Mental Illness, 2013). A mental health disorder is

defined as any condition that affects one's thoughts, behavior, or mood (Mayo Clinic Staff,

2014), whereas a serious and persistent mental illness is defined as a long-term mental health

disorder that greatly affects one's ability to maintain social or occupational function and requires

long-term treatment (Spollen, 2003). The majority of patients with a mental illness in the United

States receive ongoing care in outpatient settings, such as community mental health clinics

(CMHCs), primary care clinics, and public health clinics.

A mental health patient in a CMHC often sees a prescribing provider, a

therapist/psychologist, and occasionally specialized care providers (a case manager or drug and

alcohol specialist). In 2009, 30 million adults were receiving care for a mental illness; 32% of

these persons were receiving both outpatient therapy and medication management (Kaiser

Commission on Medicaid and the Uninsured, 2011).

Review of the Literature

Searches were performed in GoogleScholar, Ovid, and PubMed using and combining

search terms such as "interdisciplinary team, patient care team, community mental health,

outpatient setting, collaboration, communication". Related words such as "interprofessional,

inpatient setting, collaboration, team work, effectiveness" were then used to widen the search.

Over 3,000 studies resulted. Limiters refined the search results to less than 500 articles. Articles

were selected if offered free in full text, in English language, and studied human subjects only, as

well as if the article was comprehensive and had pertinence to this project's purpose.

   Relevant literature. In a healthcare setting, there are multiple types of team make-ups. The different types of teams are: multidisciplinary teams, interdisciplinary teams, transdisciplinary teams, interprofessional teams, and collaborative care. Often these terms are used interchangeably in literature. However, the focus of this project is specifically interdisciplinary teams. It is also important to note the terms interdisciplinary, interprofessional, and collaboration are used synonymously in this project.

   An interdisciplinary care team (IDT) can occur in any setting (though most often seen in an inpatient setting) and consists of many professions caring for the patient. Leadership is shared in an IDT (Cooper & Fishman, 2003). Within an IDT, the care providers' skills complement one another and their goals for the patient's treatment are aligned. However, each member of the team works independently to achieve the goals (Cooper & Fishman, 2003). While members of the IDT use their own skills to treat the patient's problem area, the group is seen to be responsible for the overall outcome (Peters, n.d). The essential purpose of an IDT is to develop a comprehensive plan of care by including all of the providers currently caring for a patient in one setting. The care plan should follow the biological, psychological, and social form of thought. By doing so, it encompasses all of the patient's needs.

   In a 2013 study, a researcher aimed to find out what collaborative practice looks like within 18 Romanian community mental health centers, as well as understand the ways in which contact between staff usually occurs (Sfetcu). Sfetcu (2013) found that 95% of those surveyed worked in teams with two or more disciplines, yet 67.5% of respondents reported that these teams had no formal team meetings to discuss patient cases. For those that reported the team meetings did occur, it was on a monthly basis. Surprisingly, 32.5% said that their team meetings

lasted less than 30 minutes (Sfetcu, 2013). Overall, 65% of respondents stated that teamwork is important or necessary, yet it was not occurring consistently in their work settings.

In 2009, Zwarenstein, Goldman, and Reeves performed a systematic review of the literature using five studies regarding interprofessional collaboration and efficacy related to health outcomes. Variability was found as to whether interdisciplinary rounding on an inpatient unit affects total length or cost of the stay. Yet another study found that for an IDT that met on a monthly basis, fewer prescriptions were written for antipsychotics, antidepressants, and benzodiazepines (Schmidt, Claesson, Westerholm, Nilsson, & Svarstad, 1998). A second systematic review focused on community mental health teams (CMHTs) as compared to standard care (Malone, Newron-Howes, Simmonds, Marriot, & Tyrer, 2007). Interestingly, individuals in the CMHT group reported slightly lower satisfaction with care than those who received standard care. Despite the findings, admission rates to hospitals were much lower in the CMHT group and, when hospitalized, hospital stays were shorter (Malone et al., 2007).

A randomized controlled trial from 1998 indicated that a shorter length of stay and decreased cost of care for patients occurred when inpatients had rounds by an IDT (Curley, McEachern, & Speroff). Furthermore, Peters (n.d.) identifies benefits that IDTs lend to both patients and providers: 1) Accountability between team members may develop; 2) Consistent team meetings offer a place for discussion of client's care to take place, even if a specific case is not listed on the agenda; 3) Regular meetings allow team members to conveniently access and connect with each other; and 4) Care provided by the IDT may actually reduce costs due to cost-effectiveness of the bundled care provided (Curley et al., 1998; Zwarenstein et al., 2009; and Memmott, Marett, Bott, and Duke, 2000).

It must be noted that continuous communication is essential to an IDT, as well as

discussion and re-examination of the shared goal progression and obstacles of achieving the

patient/provider goals (Peters, n.d.). Thus, regular meetings are crucial to success of the IDT

(Cooper & Fishman, 2003). When interdisciplinary teams meet regularly, all care team members

remain up-to-date on a patient's status - goals can be more easily met or barriers to goals

addressed and workarounds developed. Over time, this may reduce costs of care due to decreased

length of hospital stays and reduced readmissions (AHC Media, 2014). A recovery-oriented

services framework may help to do the same (Menefee, 2014). The use of an interdisciplinary

forum has also been shown useful to decrease caregiver strain by allowing providers to work

through their emotions (Hanna & Romana, 2007), as well as foster problem solving and

communication (Salas et al., 2008).

   While IDTs may meet on a regular basis formally, the team member's communication

practices may still not advance care toward a patient's goal(s). The IDT needs to consistently

evaluate this. If failure has occurred, identifying the underlying communication pattern is needed

for success. Additionally, the IDT needs to frequently assess whether their team meetings are

truly collaborative in nature and focused on the patient's abilities and desires related to treatment

rather than each discipline's/the organization's desires for that patient's treatment (Bokhour,

2006).

   Following this same form of thought is recovery-oriented services. Recovery oriented

services (ROS) focus on patient strengths, health, home, purpose, and community and patient

choices are respected (Buboltz, n.d.). ROS also places the patient as the 'driver' of the treatment

planning process (Buboltz, n.d.). Assertive Community Treatment (ACT) teams are one form of

an IDT that provides wrap-around services to high-risk individuals with severe mental illness to

improve outcomes. A study by Kidd et al. (2011) found that the use of ROS in an ACT improved

outcomes related to legal involvement, re-hospitalization, and self-promoting activities (education and employment). A crucial aspect in adding ROS to an established process is educating involved staff on ROS (Farkas, Gagne, Anthony, & Chamberlin, 2005; Jacobs, Davidson, Steiner, & Hoge, 2002). Jacobs et al. (2002) also highlight the use of IDT conferences related to recovery.

Gaps in literature. Currently, there is a lack of information surrounding what a formal IDT looks and acts like, as well as the benefits in a rural community mental health setting. Information related to funding and the cost effectiveness of a formal IDT in a CMHC or the use of a ROS framework to guide communication in IDT meetings are also needed.

Other sources of evidence. No clinical guideline exists related to use of interdisciplinary teams or communication between team members. Yet, there is a 2013 international guideline by the Registered Nurses' Association of Ontario (RNAO) about how to develop and sustain interprofessional care within a system. It offers recommendations on competent communication, which includes formal meetings. Unfortunately, the levels of evidence for this practice guideline are mainly level B or lower.

Relation of literature to clinical problem. As the literature review reveals, IDTs have been effective in various settings to facilitate frequent and effective communication between disciplines and improve patient outcomes. Of note, in May 2013 an information brief was released related to the collaborative care model, which is what healthcare has been moving toward. This release indicated that Medicaid's goal is to move towards a Health Home model of care, where all services are provided under one roof thereby allowing communication to flow between providers and patient (Unutzer, Harbin, Schoenbaum, & Druss, 2013). While Medicaid's end goal is a collaborative care model using Health Homes, not all outpatient settings

(especially in rural areas) are currently designed for this. In order to provide a like level of care,

an IDT approach can be utilized to reach a similar effect.

     Summary of proposed project. Agency P's unstructured IDT did not function to its

fullest capacity. Members and roles needed to be clarified and formal meetings implemented to

allow for effective communication, team-based treatment planning, and continual assessment of

patient/provider goals. Furthermore, on average, an Agency P prescriber had one to two no

shows per day, which equaled 30 minutes to one and a half hours of unproductive time. If the

time were spent in an hour-long weekly IDT meeting, time may have been used more efficiently

and downstream cost-savings seen.

     Agency P's mission was to serve individuals with serious and persistent mental illness

with high quality, integrated care. Improving communication between disciplines theoretically

would have improved care for patients. When the project was conceived, Agency P supported

trialing a formal IDT. The Doctor of Nursing Practice (DNP) student's goal was to evaluate how

effective a change in IDT structure was, as well was to coordinate the IDT meetings.

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Approach to the Conduct of the Project

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Setting

     Agency P was a community mental health clinic in rural, western Oregon. The estimated

population of the county this town resided in was 77,916 in 2014 (United States Census Bureau,

2015). Approximately 18.3% of this county's population was financially below the federal

poverty line and 16.9% of those under the age of 65 were uninsured (United States Census

Bureau, 2015). According to Agency P's electronic medical record in December 2015, Agency P

was serving 1,873 clients across a multitude of programs including medication management,

therapy, drug and alcohol therapy, case management, and other programs; approximately 40% of

the patients served by Agency P were in one or more programs, most commonly therapy and

medication management. Within the adult outpatient services there were four medication

prescribers, 14 therapists, and five case managers, not including drug and alcohol or disability

services. All providers were co-located in one building.

Function of the setting. The county health department was one of the main veins

through which people living in Agency P's county received their mental health care. The IDT in

place at Agency P was informal and was not living up to its potential. Communication occurred

via hallway conversations, emails, or a provider reading another's note.

Organizational readiness to change. At the outset of this project, it appeared that there

were mixes of individuals in the contemplation and preparation phases. Many adult providers

and the adult behavioral health supervisor had voiced the need for a better avenue for provider-

provider communication and had expressed excitement at the opportunity of an IDT. From June

to September 2015, there were many programmatic changes within Agency P's clinics. Because

of these co-occurring changes, it was thought that modification to communication channels

between IDT members may have be welcomed. Thus, practice of formalizing the adult

behavioral health IDT was to be used as a pilot test for an organization wide change.

Anticipated barriers and facilitators. Facilitating factors included the enthusiasm that

many providers had voiced in regards to a formal IDT meeting, the change climate of the

organization, a meeting space that was provided and consistent, and a DNP student passionate

about teamwork. On the other end of the spectrum were barriers such as staff's possible view of

the meeting as loss of time, no existing meeting structure into which the IDT could be added, and

meeting hours were non-billable. A final perceived project barrier was not having a specific

individual in the organization that agreed to be a champion for the project.

Participants

  Inclusion and exclusion criteria. Inclusion criteria included: all of Agency P's main branch adult mental health professionals (non-acute, non-EASA/ACT) and exclusion criteria included: mental health professionals that worked primarily at another branch, non-direct care staff, and any primarily child mental health professional.

  Size and rationale. The sample in this project was to be a convenience sample of the providers of Agency P (at least 20-30 separate participants, plus data from 10 IDT meetings).

  Recruitment plan. Because this was a multidisciplinary team meeting backed by the county, attendance was expected. All disciplines were to attend the entirety of the meeting, except prescribers who would have joined for the second half of the meeting.

  Protection of participants. None of the collected data from pre/post questionnaires was individually identifiable. Any data collected was stored on a password-protected computer.

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Proposed Implementation and Outcome Evaluation

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Proposed Implementation Procedures

  The DNP student designed a pre- and post-intervention questionnaire, as well as IDT/ROS training for the project. Results of the pre-intervention questionnaire were to be incorporated into the IDT training to facilitate staff buy-in. The goal was to hold 10 to 12 60-minute formal IDT meetings facilitated by the DNP student. At each meeting, challenging patient cases or issues were to be discussed, as well as patients from each prescriber's past week and upcoming week's schedules.

Measures/Outcomes

  Data collection sources, processes, and procedures. The data collection method was to be via a pre/post questionnaire gathering quantitative and qualitative data. The questionnaires to

be used in this project were based on communication/collaboration questionnaires used in other

studies, as well as the literature itself. Data was also to be collected at each IDT meeting. The

questionnaires were to be distributed to employees via Agency P's email system. All respondents

would remain anonymous. While demographics were to be collected, none of the 18 HIPAA

identifiers would be collected. Furthermore, IP address and email address tracking was to be

disabled prior to sending the questionnaire to participants. No further contact with participants

was to be had after collection of the post-intervention questionnaire.

Implementation of Project

Prior to implementing the project as described in the previous section, Agency P declined

continuing with the DNP student's formal IDT implementation citing a lack of

resources/finances that were needed to proceed. The DNP student learned agencies may agree

with a proposed idea, but if the organization is not ready for change, a project can be stopped at

any juncture. Due to this interruption in the project, the scope of the overall project was shifted.

The goal of the revised initiative was to evaluate facilitators and barriers to implementing an IDT

in a rural outpatient CMHC to answer the question: "What factors/barriers caused one agency

(Agency P) not to proceed with implementing a formal IDT while a similar rural agency

(Agency L) supported a formal IDT, which was running successfully?"

Setting

Agency L was located in a small town in Eastern Oregon. The population of the town

was just over 17 thousand in 2014 (United States Census Bureau, 2016). In 2010, the majority of

the population (74%) identified as Caucasian, while a much smaller portion of the population

identified as Hispanic (United States Census Bureau, 2016). Approximately 20% of the

population was said to have no health insurance and 20.5% of individuals lived in poverty in

2014 (United States Census Bureau, 2016). Agency L (a CMHC) has many branches, one of

which was located in this small rural town. A range of services was offered such as counseling,

medication management, skills training, and case management. There was also a walk-in clinic

for patients in crisis. Drug and alcohol services were not available, but rather contracted out. The

CMHC also participated in a lot of community outreach with other agencies and had contracts

and liaisons with the local hospital, corrections, Department of Human Services, developmental

disabilities, and the school district.

Participants, Recruitment Plan, and Protection of Participants

An invitation was sent via email to the supervisors of the behavioral health programs in

both Agency P and L, which asked the respective agencies to participate in this initiative. Once

each agency agreed, the DNP student requested that each supervisor identify and select six key

informants (consisting of both supervisory staff, management, and clinicians) who could speak to

the topic of IDTs. Once these individuals were identified, each was contacted by email, given

background information on the project, and asked to participate in the interview process. A

calendar of potential interview openings that spanned the course of up to a month's time was sent

to each participant. Each individual contacted responded positively, but without confirmation ("I

will try") or affirmatively ("Yes I will participate"), which provided 12 total participants (see

Appendix A, Table 1). At the beginning of each interview, participants were notified their

information would remain confidential and would not be accessible by anyone other than the

DNP student. All interviews were recorded and stored on a password-protected device that only

the DNP student had access to. Because the interviewer knew the individual participants,

identifying data was collected but was de-identified and collectively analyzed.

Near the end of the project period, the DNP student spoke with Agency P's finance

department related to the real costs behind implementing an IDT. However, little information

was obtained. An individual in the finance department of Agency L was unable to be reached.

Changes Made to Implementation Procedures

Rather than implement an IDT, semi-structured interviews were conducted with two

agencies after IDT implementation was refused by Agency P. Key informants from Agency P

were interviewed to better understand the barriers that prevented them from making change

within their organization by using the IDT model of care, as well as to determine factors that

may act as facilitators to change in the future. Key informants from Agency L were also

interviewed, as the organization had successfully implemented a formal IDT in their outpatient

CMHC. Questions concerned why the team chose to implement an IDT, challenges faced, and

facilitators to the process. The responses from both agencies were compared to determine

facilitators and barriers to communication and IDT implementation.

Each individual was interviewed either by phone, in person, or emailed the written

interview questions. Phone and in person interviews were 30-60 minutes in duration and

conducted individually. Participants were provided with a written copy of the interview

questions when asked of the interviewer. Once the interview was complete, there was no further

contact related to interview questions. The DNP student also attempted to gather additional data

via the original pre-intervention questionnaire. The questionnaire was sent to 10 of the 12

participants (see Appendix A, Table 2). Results were not viewed until the responding period

ceased. After all interview and questionnaire data was gathered, all interview recordings were

transcribed into one document. Data was reviewed and coded. Codes were grouped and analyzed

for themes. Recordings and transcriptions were deleted after project termination.

Measures

The interview questions for both agencies were designed using an appreciative inquiry

(AI) framework. Appreciative inquiry is a method of facilitating change in a system with an

assets-based approach (Coghlan, Preskill, & Catsambas, 2003). The basic tenet of AI is to

discover information about the system being studied that is successful and positive. AI attempts

to develop this information to move the system forward "to create a better future" (Coghlan et al.,

2003, p. 5). Barriers or negative processes are not the focus of the AI framework, as when

problems are the sole focus of inquiry only more will be learned about the problem rather than

productive solutions. The idea is to take what is working well and amplifies the result so that it

trickles in other facets of the system (Coghlan et al., 2003). However, because identifying

barriers was important to this project, interview questions about barriers were included and

framed from a positive AI point of view.

There are four stages of appreciative inquiry: discovery, dream, design, and destiny.

Stage one attempts to decipher "the best of what is" in relation to the subject of inquiry (Bushe,

2011, p. 2). Stage two encourages reflection – to think of a time when the system was

functioning its best, then characterizes the commonalities individuals shared in relation to goals

(Bushe, 2011). The third stage is where a common organizational/system dream is developed via

brainstorming, design statements, proposals, and more (Bushe, 2011). Finally, stage four is

where implementation of the consensual plan occurs. After there has been an agreement on the

design, the changes within the organization are self-directed and follow the overall design.

Leaders then magnify the processes of their choosing to gain momentum in structure change

(Bushe, 2011).

The DNP student designed the semi-structured interview. The semi-structured interview asked specific questions of each individual yet if further inquiries arose during the interview it was within the fidelity of the framework to inquire. Examples of previous appreciative inquiry proposals with questionnaires were examined in order to adapt valid questions for the interview. An interview matrix was developed for each agency based on those adaptations in order to best fit the scope and intent of this project (see Appendix B-C). The second design measure was the Survey Monkey pre-intervention questionnaire (see Appendix D). This questionnaire was sent out to participants two weeks prior to the close of the data collection period. These additional data points were meant to elicit feedback on how each agency's team functions specifically in relation to communication.

Outcomes

12 individuals were approached for an interview. However, only 10 individuals submitted data to the DNP student. Two approached individuals did not respond to the DNP student at all. Data from seven individuals was analyzed - a 58.5% response rate overall and 70% response rate for those interviewed. Three interviews were not used in the initiative due to being incomplete. See Appendix A, Table 1 & 3 for specific interview and demographic details.

Survey Monkey Questionnaire

The Survey Monkey questionnaire was sent to 10 of the 12 individuals (83%) asked to complete the interview. Of those 10 individuals two completed the survey, which is a 20% response rate. Agency P employs both individuals as supervisors. Both respondents are graduate-prepared and had worked in the mental health field for over 10 years each. Both respondents reported feeling well-informed of the happenings with their clients between appointments, either agreed or strongly agreed that their informal IDT has effective

communication strategies to discuss clients, it is clear who's responsible for portions of the treatment care plan, and reported the ability to routinely communicate with team members about patient care decisions.

Agency P Outcomes

Six clinicians from Agency P were interviewed. The data from four clinicians (see Appendix A for explanation) was analyzed for themes. Fifty percent of clinicians acknowledged the climate for change being at the precontemplation stage, while the other 50% believed the agency to be in contemplation stage. One individual reported, "There is some thinking in terms of leadership having some appreciation for the [IDT] model" while another reported, "there is some controversy over whether that is necessary." Participants identified strengths of Agency P as: client centeredness, a high level of access to services, timely services, a sense of community, a dedicated team with a caring environment, and "we all have the same end goal." When questioned about the benefit of an adult outpatient IDT one participant stated, "an IDT could conceivably improve access to services within medication management."

Facilitating factors for effective communication. According to Agency P participants, elements of effective communication are: respect, ethical behavior, the ability to give and take, open-mindedness, willingness to engage in conversation and understand others' perspectives, transparency, adequate documentation, non-reactivity, self-awareness and self-care, timeliness, active listening, and ensuring communication occurs. Participants identified ways in which their communication could improve such as communicating with less reactivity, talking less and listening more, providing context to a discussion, and thoughtfulness. Stating expectations and knowing when to reframe a situation can also open up lines of communication. One supervisor reported she is pushing her team to "bridge those gaps in communication."

Facilitating factors to IDT implementation. It was reported that Agency P has "an appreciation and buy-in for evidence-based practices", which could help to facilitate discussions around formal IDT usage. If an IDT was implemented, expected behaviors from individuals include: professional courtesy, respect for others, coaching/modeling for others, collaboration, lack of hierarchy, clear definition of roles, and administration's support for a culture shift and team autonomy (a top down approach). "Having their [administration's] blessing" would reduce worry and could help to increase investment in the IDT. According to respondents, communication between IDT members should be: respectful, ethical, with the ability to give and take, honest/transparent, professional, patient, collaborative, open-minded, and supportive. A skilled meeting facilitator was also identified as a necessity for success.

Barriers to effective communication. It was identified that when working with those outside one's own specialty, skepticism can occur in relation to the success of the relationship or a joint project outcome, which can hinder communication channels. Furthermore, multiple participants identified that departments are segregated and siloed, both in culture and also physically. "That sends a pretty strong message…when you cannot even use your keycard to get into another area of the building!" When considering IDT implementation, Bronstein (2003) suggests that structural characteristics of the agency (size of caseloads, autonomy, culture, supervisory support, and material space) must be considered. 50% of participants also noted, "Face-to-face communication is discouraged." Hierarchy and territorial behavior can prove challenging, as well. Another individual reported a barrier in her own communication was a feeling unapproachable and stated, "having support administratively to allow that time [to communicate]…would make it easier for me to be more approachable." "You are so busy working that the communication piece gets puts to secondary instead of primary" (participant 4).

Participant 5 also voiced difficulty in connecting with other disciplines, "…Not even counting med management…we cannot get any of their time!"

Barriers to IDT implementation. Being in a low service provider area and "a recurring crisis shortage of staff" contributes to culture and affects ability to implement an IDT. One participant noted, "I think the barrier is internal" with others reporting that a culture of collaboration would need to be developed by leadership, as well as a shared vision between the various disciplines for a formal IDT to be successful. "I don't believe there is buy-in across leadership…so that sometimes increases tension and frustration, which ripples out." Additionally, at least 50% of the participants also cited unavailability of funding or resources as a main reason for lack of IDT implementation. Mindset can also become a barrier. According to respondents, leadership may have the fear that an IDT meeting could become a place for clinicians to chat or talk about clients in an unprofessional manner, thereby wasting time, money, and becoming no more effective. Thus, the status quo is maintained. 50% of providers also listed variances in provider's schedules (8 hr. vs. 10 hr. work days, part-time vs. full-time) and billing matrixes as barriers to holding a formal IDT meeting regularly.

Agency L Outcomes

Four clinicians from Agency L were interviewed. The data from three clinicians was analyzed for themes (see Appendix A for explanation). These clinicians acknowledged the climate that spurred initiating a change from informal to formal IDT was related to a lack of structure due to confusion and chaos, as well as limited communication and coordination of care between team members that led to ineffectually serving clients. Support and push from the county's Coordinated Care Organization toward integrated treatment also supported the formal IDT framework.

Facilitating factors for effective communication. Active listening skills, openness (including honesty and expressing one's needs), and boundaries (including assertiveness, confidence, and a calming presence) were all identified as perceived traits of effective communication. Specifically on an IDT, the participants report that communication needs to be respectful, transparent without judgment, professional, efficient, and show appreciation for the other disciplines. The RNAO (2013) identifies many of these as traits to promote effective communication. To communicate more effectively, participants noted that slowing down, recognizing what is not said, striving to realize what one does not know, and timely responses are helpful.

When working as a team with individuals that do not share one's own opinions, collaboration and understanding other's values and using those to work toward the shared goal is invaluable to the process. Participants identified past experiences where they accomplished this and reported valued attributes both they and their counterparts displayed as: actively listening with an open mind, a willingness to learn, self-introspection and acceptance, growth and improvement, along with adaptability and flexibility to achieve shared goals.

Facilitating factors to IDT implementation. Participants reported that one of the primary facilitators for Agency L's IDT implementation was administration allowing management the autonomy to reduce clinician productivity expectation. A manager reported that leadership had to "make the commitment to protect their [clinician's] own time…it has to happen from the management down." Agency L also changed culture related to productivity norms – the expectation was adjusted. To increase clinician's time, the productivity expectation was pro-rated and unique to all clinician's schedules as a whole, but also to the individual clinician. Participant 3 said, "What it cost us was the reduction in revenue (the opportunity cost), [but] it is

made up with improved processes and productivity." 66% of respondents agreed with this statement citing eventual increased productivity, time, and efficiency. One hundred percent of Agency L participants agreed that a strong leader and meeting facilitator is needed to effectively operate an IDT – one with vision, knowledge, and teaching ability. This facilitator should have strong skills in setting boundaries and practicing transparency, which includes gentle and direct coaching when the meeting derails. Participants reported expectations of the team members include: introspection, accountability, professionalism, transparency, brevity and clarity of speech. Set guidelines were established at the outset of IDT formation to help maintain consistency, such as order of the meeting and who attended the meeting at certain times. However, it was found that fluidity in the meeting is also vital. Participants reported that early in the course of the team, a template was designed for clinicians to use when staffing cases, which caused meetings to run more effectively, efficiently, and reduced confusion. Literature echoes this finding. Kilgore & Langford (2009) and Bronstein (2003) recommend emphasizing the absence of hierarchy, problem-solving skills, respect for other's opinions and contributions, as well as setting and assessing goals as a team. IDT meetings should focus on patient debriefing, coming to an agreement on treatment plan modifications, and should not be rigid, in the event crucial information is omitted (Bokhour, 2006).

      Barriers to effective communication. In an IDT there can be barriers to communication. Participants from Agency L report these as fears of one's idea being rejected or fear of hurting another individual's feelings, vulnerability, and culture of the agency. Communication was also noted to be less effective if team members were not able to separate personal opinions from clinical opinions.

Barriers to IDT implementation. One of the primary barriers that Agency L had to overcome was one of competing demands – the idea of never having enough time, as well as the fear of loss in productivity. Other identified barriers included the expense and commitment to the process, which was a unanimous theme. Organizational politics and lack of support by leadership were also recognized as initial barriers. A final barrier was variation in team member's backgrounds, training, and experience. Kilgore & Langford (2009) suggest focusing on professional role descriptions to foster collaboration and interdependence at the outset of IDT implementation.

Overall response to an IDT. Participants from Agency L report that implementing a formalized IDT has been overall beneficial for their organization and for clientele, especially in regard to forward thinking in client planning and maintaining client centered treatment. There were other unanticipated benefits, which were "the staff's attitudes and their confidence…it was a relief of stress in response to the support of the IDT…staff started expressing their needs more, in a good way."

Observations. Agency L participants recommended that if possible when forming an IDT, all clinical outpatient staff should be included on this team, as well as community partners (law enforcement, clergy, etc.) should be invited to the meeting, as the meeting serves as a "group think" activity. Furthermore, participant 3 reported that three things would help improve the team: omniscience (as at times there can be a disconnect between what team members are thinking or in perspectives), infinite time (for everyone to get their needs met) and rewards (in appreciation for participation). While these suggestions are based on wishful thinking, the concept is important. The respondents from Agency L also advised that change (especially if shifting an entire culture) may take time and require multiple attempts, especially to gain buy in

from stakeholders due to resistance. Persistence and helping others to recognize the strengths

inherent in change is critical. Participants unanimously agreed that adapting to and moving with

change is the key to success as it is a continual process of refining and improvement.

Common Themes

The analyzed data produced multiple common themes between Agency P and L (Figure 1).

Figure 1. Commonalities (Themes) Between Agencies	
Facilitators to Communication	**Barriers to Communication**
Active listening skills	Segregated departments/disciplines
Respect and ethical behavior	Lack of time
Transparency and honesty	Culture (including territorial behavior and hierarchy)
Professionalism	Lack of support
Facilitators to IDT Implementation	**Barriers to IDT Implementation**
Administration support	Culture (including politics & lack of support)
Autonomy	Competing demands
Change in culture	Fear around losses
Strong facilitator/leader	Expense

Discussion

Lessons Learned and Practice-Related Implications

The outcomes of this quality improvement initiative provide many implications for

practice. It is widely known that every project or initiative has its pitfalls. Yet, it is how these

hiccups are navigated that is telling. Appreciative inquiry attempts to look at the strengths of a

situation and build from those strengths. However, during these interviews it was found that

when individuals do not feel their needs are being met, negativism could become the norm. If the

culture is not one that adopts change readily, it can be difficult to engage the individual from

negative to positive talk even when asking positively slanted or strengths-based questions.

Individuals or organizations that come from a negative framework can become stuck in that

framework. It will require additional shaping by leadership and others within the organization to create and amplify positivity and ability to see change as a benefit.

Research suggests that lack of communication can lead to decreased job satisfaction and creation of a formal IDT can increase said job satisfaction (Flin et al., 2003). The lack of communication can be resultant to organizational structure (Sutcliffe et al., 2004). This is an accurate representation of sentiments shared during the interviews conducted during this initiative. Through analysis of Agency P's data, it appears that the agency's culture is based on siloes; the view of patient treatment being under an umbrella with shared care is known, but has not been embraced as standard practice among the organization. When talking with clinicians from Agency P, it was reported by non-supervisory clinicians there is a culture of communicating by only email or "to-dos", rather than in person. Yet, supervisory staff indicated that communication occurs readily and effectively. This is an apparent disconnect between staff and supervisor's view of culture. Despite disconnect, on the whole each individual interviewed reported a desire for an increase in interdisciplinary communication and participation. Unfortunately, desires do not change that the organization's stated views do not align with their current practice. In turn, this lack of encouragement to readily communicate reduces job satisfaction. One individual reported that if administrators allowed creation of an IDT, providers might feel more satisfied with their job and thus, increase productivity. An overall theme voiced by participants from both agencies is management's support must be gained, short-term consequences (such as loss of revenue) and long-term benefits (increased productivity due to efficiency, continuity of care) of IDT implementation must be realized; once a formal IDT is implemented, it must be a firm commitment long-term. By the same token, if a formal IDT is

implemented it is important to ensure the team is efficient and effective in order to responsibly use resources.

Applying change theory. In this project, it was revealed that agency dynamics could prevent change despite many of the individuals in the organization desiring a change (for instance, an unsupportive culture, productivity expectations, lack of mid-level management freedom in decision-making, and segregation). It was also discovered that change takes time, especially in a public agency. It may take much more education and training than at a private agency. One reason for that may be related to fear of the unknown as related to financial burden.

Change can take on two patterns – linear or non-linear. Linear patterns of change are often stable, deterministic, appear to have a "top down" mechanism, are simple and predictable, orderly, and designed (Crowell, 2011, p. 30). Furthermore, within linear thinking, change is seen as a scary, troubling thing that can lead to chaos. Linear patterns of change may play out through Lewin's three Freeze Phases. Agency P seems to be in a frozen state where the key players (managers, administration) are in the "safe zone" – they are established in the current way that communication occurs. While the organization states they value communication and evidence-based practice, suggesting change from the frozen to an unfrozen state and introducing transition to a new structure, causes pain and discomfort. Agency L also experienced this. However, to move forward Agency L's administrators moved with their fears and demonstrated "non-physical push methods" (such as engaging in appreciative inquiry and offering an announcement that the behavioral health umbrella would trial a new communication structure based on current research). By doing so, it destabilized members out of their comfort zone and forced a change in behavior (ChangingMinds.Org, 2014). To continue the process, the same individuals need to use "pull methods" such as continuing to engage in appreciative inquiry to garner support

(ChangingMinds.Org, 2014). After making change, in order to find the correct balance of what

works for the organization it will take time to orchestrate a structure that will best serve the

organization's needs. Once this is established, refreezing can take place until needs (or evidence-

based practice) change. The goal is to create a culture that is readily able and willing to change

when evidence and practice dictate it is necessary – the ability to see what is working and what

could be improved upon (Crowell, 2011).

An agency's ability to see the need for change, as well as cope and adapt once change

occurs is highly dependent on the agency's culture. Agencies such as these are able to move

beyond fear, apply future-oriented thinking, and find both small and large workable solutions to

issues (such as developing flexible productivity levels, coaching/modeling behavior from the top

down, team empowerment, and developing workable parameters and templates). In a complex

system, mechanisms are unpredictable, but are adapted to. To be adaptive, behavior must be

changed in order to best match values. Agency L places focus on adapting to and moving with

change especially the changes that required modifying company culture, which is a cornerstone

of complexity theory.

Figure 2. Preventative Dynamics and Workarounds	
Dynamics that may Prevent Change	**Workarounds to Promote Change**
Unsupportive culture	Flexible productivity levels
Productivity	Coaching/modeling
Lack of freedom in decision making	Team empowerment
Segregation	Parameters and templates

Recommendations

Ongoing education to administrators and leadership regarding why an IDT is necessary is essential. When presenting to leadership, discuss the most common barriers and facilitators to implementation and provide ideas for workarounds to give leadership a sense of hope. Involve leadership in building a new productivity level that works for everyone. However, education alone does not cause change. Appreciative Inquiry should be used to generate questions and discussion about when the organization was at its best and experienced successes. This method should be used to assist the organization in realizing their potential. Ensure a forum is available where staff can have open discussions with administrators to avoid disconnectedness. As well, when considering implementing an IDT, it may be helpful to find an "IDT mentor" at another agency with a successful formal IDT to lessen the fear involved in creating a disruption to the status quo. This may also help to create reassurance as the agency goes through the process of refinement.

Prior to implementation of a formal IDT, the facilitator for the meeting should conduct training on agency values and expectations, effective communication, individual's roles and potential differing points of view, the IDT process, and staffing a case. Once an IDT is formalized, finding a balance for the meeting is necessary. For instance, having all clinical staff involvement with medical providers coming in for half of the meeting with specific intentions for their time. The team should build a case presentation format so that the needs of each case are fully discussed and addressed succinctly. Furthermore, it could be beneficial for the team to identify its own mission and goals (separate from the agency). Finally, administration/leadership may want to define what productive, constructive, and efficient use of time looks like so that effectiveness can be measured.

Limitations to this Initiative

Printed handouts of the questions were not given to each participant. For those that are

visual learners, it proved somewhat difficult to focus and understand each question. In future

projects, handing out the questions in print to each participant is necessary in order to receive

succinct, relevant responses. In this project, time was a limiting factor for both organizing the

logistics with each agency, scheduling interviews, and gathering and analyzing data. It would be

prudent to plan, schedule interviews, and send out questionnaires as far in advance as possible (at

least double the amount of time one would think it could take). Furthermore, there was a definite

lack of response to the online questionnaires. It would be useful to utilize Survey Monkey's

Email Invitation Collector to send follow-up emails to those who have not responded within the

allotted time frame, allowing another short period of time for slow responders. Finally, it was

noted that the pool of participants was small. Because of the nature of this quality improvement

initiative, a small sample pool is generally acceptable. However, because a supervisor selected

the participants there is potential for selection bias.

Conclusions and future directions. The facilitators of communication and for the

process of IDT implementation may be transferable to another like setting. It has the potential to

provide background and context for agencies that are uncertain about change. It should be noted

after this quality improvement initiative had commenced, Agency P informed DNP student that

the agency is moving from contemplation to preparation phase in related to implementing a

formal IDT. Administration and middle management are gathering information and beginning to

have open discussions.

<div align="center">

Summary

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This project's goal was to implement regularly scheduled, formal IDT meetings into a

rural community mental health clinic with an emphasis on the recovery-oriented services model.

Due to unforeseen barriers, the scope of this project was changed to evaluate barriers and

facilitators to communication and formal IDT implementation in two rural CMHCs. During this

project, it was learned that primary facilitators to formal IDT implementation included:

administration's support, autonomy, changes in culture as needed, and a strong facilitator/leader.

Primary barriers included: culture (including politics and lack of support), competing demands,

fear around losses, and expense. Overall it was found that creating a short-term patient centered

disruption has long-term benefits such as improved productivity, efficiency, attitudes, and client

care. Recommendations include: ongoing education, generative lines of questioning to amplify

positivity, decreased productivity expectations, establishing an IDT mentor, training prior to IDT

implementation, and identifying a strong leader/facilitator and specific IDT parameters once

formalized. By completing this project, information may have been provided that may be

relevant to other rural community mental health clinics also considering implementation of a

formal IDT.

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Appendix A
Tables 1-3

Table 1

Demographic Data

Agency P

Administrative staff	1 (14%)
Mid-level managerial or supervisory staff	3 (43%)
Therapist/counselor	2 (29%)
Prescriber	1 (14%)
Total number of proposed participants	**7**
Average number of years at the agency	6 years*

*Excludes one non-respondent

Agency L

Administrative staff	0
Mid-level managerial or supervisory staff	1 (20%)
Therapist/counselor	4 (80%)
Prescriber	0
Total number of proposed participants	**5**
Average number of years at the agency	4 years*

*Excludes one non-respondent

Table 2

Survey Monkey Questionnaire Data

Agency P

Number of questionnaires sent out*	6
Number of returned questionnaires	2 (33.3%)

Agency L

Number of questionnaires sent out*	4
Number of returned questionnaires	0 (0%)

*Two potential interviewees were suggested after the questionnaire window
closed; neither participated in the interview or survey questionnaire

Table 3

Interview Data

Agency P

Total number of propositioned interviewees	7
Total number of respondents	6
Total number of entirely unanswered interviews	1
Total number of unused interviews*	3
Total interviews analyzed for data	**4 (57%)**
Number of in-person interviews	5
Number of phone interviews	1
Additional feedback via email	1

Agency L

Total number of propositioned interviewees	5
Total number of respondents	4
Total number of entirely unanswered interviews	1
Total number of unused interviews*	2
Total interviews analyzed for data	**3 (60%)**
Number of phone interviews	2
Number of paper/written interviews	2
Additional feedback via email	0

*Interviews were not included if incomplete (i.e. none or few questions answered)

Appendix B
Agency P Semi-structured Interview Format

Protocol:
I appreciate you taking the time to meet with me today. I'd like to begin by letting you know that this session is being recorded in order to best capture what is said and later to best analyze the data. All information shared in this interview is confidential and will not be accessed by anyone other than myself. By participating in this interview and survey, you are giving your consent for the information you provide to be used in this project.

Prior to asking you questions, I want to give a bit of background as to why I'm conducting these interviews. The purpose of my initial DNP project was to implement regular, formal interdisciplinary meetings into a rural community mental health center. By definition, an IDT is a group of healthcare providers from different fields that work together to accomplish a treatment goal for a single patient. In my initial project, the idea was to create an outpatient IDT that consisted of therapists, prescribers, alcohol and drug counselors, crisis team members, and potentially representatives from any specialty team such as EASA or ACT. Unfortunately due to certain constraints, my original project was deemed not possible. The purpose of my modified project is now to identify both barriers to and facilitators of communication and implementing an IDT. In order to discover this information, both an agency without a formal IDT and an agency with a formal IDT will be interviewed. Many questions between the two interviews will be the same or similar, while others will differ due to the two agencies being in different stages of change. A survey will also be sent out to gather additional data points. By completing this project, new information about changes in communication/teamwork as related to IDTs may arise. I also have sent a survey to you to complete that complements the interview data.

Demographic questions:
1) Current occupation or profession:
        A) Nurse
        B) Social Worker
        C) Physician
        D) Nurse Practitioner
        E) Therapist
        F) Case Manager
        G) Other (Specify): _____

2) Years employed with this agency: _____years

Facilitators/Appreciative Inquiries:
3) In mental health agencies stages of change are often focused on. What stage of change do you believe your organization (or department) is in, as a whole and why? As a reminder, the stages of change include: precontemplation, contemplation**,** determination, action, maintenance, and termination.

4) What do you perceive as strengths of the behavioral health program at Agency P (the things that most attract and excite you)?

4a) How do these apply to communication & implementation of an IDT?

5) What do you perceive as traits of effective communication?
   5a) In what ways would you change your own communication, if at all, to make it more effective?

6) Think of a time when you were inspired by working with another person or a group where you may not have had the same ideas or opinions as the others, but you really worked together and valued each other (ever in career). Can you describe this time?
   6a) What did you value about yourself in this experience?
   6b) What did you value of others?

7) Imagine a time in the future where an IDT was implemented in AOP at Agency P. What behaviors would you expect from individuals on the team, as well as leadership?
   7a) What would you expect communication to look like?
   7b) What kinds of organizational systems, norms, or practices would you see making it possible?

8) If you could wave a magic wand that created three special gifts, gifts that would help this team be its very best and move towards improved communication or IDT implementation, what gifts would you wish for?

Barriers:
9) What are your current perceived barriers to effective communication between team members at Agency P?

10) In your opinion, what are the biggest (overarching) barriers to implementation of an adult outpatient interdisciplinary team at Agency P? (i.e. cultural barriers, competing demands, lack of support by management, resources)
   10a) When thinking about implementing a formal IDT at Agency P, are there **specific aspects** of this that make it seem more difficult to implement? (i.e. expenses, time commitment, etc)
   10b) Do you question the need for an implementation like this?

11) Think back to the barriers you just identified. In what ways would you adjust the organization or team in order to overcome these barriers when making changes to the program as a whole in the future?

Questions adapted from:
Coghlan, A.T., Preskill, H., & Catsambas, T.T. (2003). An overview of appreciative inquiry in evaluation. *New Directions for Evaluation, 100*(2003), 5-22.
Glasgow, R.E., and Emmons, K.M. (2007). How Can We Increase Translation of Research into Practice? Types of Evidence Needed. The Annual Review of Public Health, 28:413–33. doi: 10.1146/annurev.publhealth.28.021406.144145
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Torres, C. (2003). AI community leadership project. Retrieved from
        https://appreciativeinquiry.case.edu/practice/toolsQuestionsDetail.cfm?coid=4845

Appendix C
Agency L Semi-structured Interview Format

Protocol:
I appreciate you taking the time to meet with me today. I'd like to begin by letting you know that this session is being recorded in order to best capture what is said and later to best analyze the data. All information shared in this interview is confidential and will not be accessed by anyone other than myself. By participating in this interview and survey, you are giving your consent for the information you provide to be used in this project.

Prior to asking you questions, I want to give a bit of background as to why I'm conducting these interviews. The purpose of my initial DNP project was to implement regular, formal interdisciplinary meetings into a rural community mental health center. By definition, an IDT is a group of healthcare providers from different fields that work together to accomplish a treatment goal for a single patient. In my initial project, the idea was to create an outpatient IDT that consisted of therapists, prescribers, alcohol and drug counselors, crisis team members, and potentially representatives from any specialty team such as EASA or ACT. Unfortunately due to certain constraints, my original project was deemed not possible. The purpose of my modified project is now to identify both barriers to and facilitators of communication and implementing an IDT. In order to discover this information, both an agency without a formal IDT and an agency with a formal IDT will be interviewed. Many questions between the two interviews will be the same or similar, while others will differ due to the two agencies being in different stages of change. A survey will also be sent out to gather additional data points. By completing this project, new information about changes in communication/teamwork as related to IDTs may arise. I also have sent a survey to you to complete that complements the interview data.

Demographic questions:
1) Current occupation or profession:
      A) Nurse
      B) Social Worker
      C) Physician
      D) Nurse Practitioner
      E) Therapist
      F) Case Manager
      G) Other (Specify): _____

2) Years employed with this agency: _____years

Facilitators/Appreciative Inquiries:
3) What do you perceive as traits of effective communication?
      3a) In what ways would you change your own communication, if at all, to make it more effective?

4) Think of a time when you were inspired by working with another person or a group where you may not have had the same ideas or opinions as the others, but you really worked together and valued each other (ever in career). Can you describe this time?
   4a) What did you value about yourself in this experience?
   4b) What did you value of others?

5) What was it about your organization or what was the "climate" that spurred initiating the process to implement a formal IDT with weekly meetings?

6) What do you perceive as strengths of the behavioral health program at Agency L?
   6a) What traits does your organization have that allowed a formal IDT process to be
   successful?

7) What was the process the organization went through to plan and implement the IDT?
   7a) Who are the members of the IDT? How long does a meeting last?
   7b) Was there a fear related to loss in "productivity" of clinicians due to the
   meeting?

8) Think about your current IDT at Agency L. What behaviors do you expect from individuals on the team, as well as leadership?
   8a) What do you expect communication to look like?
   8b) What kinds of organizational systems, norms, or practices make it possible?
   8c) What factors or qualities are needed to **run** a successful IDT team **meeting**?

9) If you could wave a magic wand that created three special gifts, gifts that would help the team be its very best and move towards improvement, what gifts would you wish for (if any)?

Barriers:
10) What are your current perceived barriers to effective communication between team members at Agency L, if any?

11) In your opinion, what were the biggest (overarching) barriers to implementation of an adult outpatient interdisciplinary team at Agency L? (e.g. cultural barriers, competing demands, lack of support by management, resources/finances)
   11a) When thinking about implementing the formal IDT at Agency L were there **specific**
   aspects of this that made it seem more difficult to implement? (E.g. expenses, time
   commitment, etc)
   11b) How is the IDT funded?
   11c) Did or do you question the need for an implementation like this?

Wrap-Up
12) Were there unanticipated benefits to implementing a formal IDT? Were there unanticipated burdens to implementing a formal IDT?

13) What did you or the organization learn from the process of implementing a formal IDT?

Questions adapted from:

Coghlan, A.T., Preskill, H., & Catsambas, T.T. (2003). An overview of appreciative inquiry in evaluation. *New Directions for Evaluation, 100*(2003), 5-22.

Glasgow, R.E., and Emmons, K.M. (2007). How Can We Increase Translation of Research into Practice? Types of Evidence Needed. The Annual Review of Public Health, 28:413–33. doi: 10.1146/annurev.publhealth.28.021406.144145

Samuels, N.D. (2005). Teambuilding. Retrieved from https://appreciativeinquiry.case.edu/practice/toolsQuestionsDetail.cfm?coid=7514

Torres, C. (2003). AI community leadership project. Retrieved from https://appreciativeinquiry.case.edu/practice/toolsQuestionsDetail.cfm?coid=4845

Appendix D
Survey Monkey Questionnaire

Please help us learn how we can improve communication between team members and implementation of IDTs at rural community mental health clinics by completing an anonymous online survey about communication and interdisciplinary teamwork. Your responses will help inform practice.

The survey will take approximately 5-10 minutes to complete, and your responses will not be linked to your email or any other identifying information. The collection window for this survey closes 05/07/2016 at 1159pm.

If you have any questions, or if you would prefer to complete a pen-paper version of this survey, please contact Erin Schmidt, RN, PMHNP-BC at 503.475.1283 or schmieri@ohsu.edu.

If you would like to be entered into a **drawing for a giftcard**, you will receive information at the end of this survey.

Thank you for your participation in this important effort and for all you do for your organization!

Sincerely,

Erin Schmidt, RN, PMHNP-BC
OHSU Doctoral Student, Class of 2016

Note: Please do not forward this email as its survey link is unique to you.

Demographic questions:
Thank you for participating in our questionnaire. Your feedback is important. Please take some time to answer the following 6 demographic questions prior to answering the 10 survey questions. This entire survey should take approximately 5-10 minutes to complete. Your help in furthering the use of interdisciplinary teams in rural mental health clinics is much appreciated!

1) What is the highest level of education you have completed?
      A) Did not attend school
      B) Graduated from high school
      C) 1 year of college
      D) 2 years of college
      E) 3 years of college
      F) Graduated from college
      G) Some graduate school
      H) Completed graduate school

2) Which of the following best describes your current occupation or profession?
      A) Nurse
      B) Nurse Practitioner

C) Social Worker
D) Physician
E) Therapist
F) Case Manager
G) Other _____

3) About how many years have you been working in the MENTAL HEALTH field?
A) Less than 1 year
B) At least 1year but less than 3 years
C) At least 3 years but less than 5 years
D) At least 5 years but less than 10 years
E) 10 years or more

4) What is your age?
A) 18 to 24
B) 25 to 34
C) 35 to 44
D) 45 to 54
E) 55 to 64
F) 65 to 74
G) 75 or older

5) What is your gender?
A) Female
B) Male

6) Primary language used at work, if other than English:
Specify_____

Interdisciplinary Quantitative Questions:
Thinking about your current interdisciplinary team at your organization (whether formal or informal), please answer the following questions. If you feel a question does not apply, please respond N/A.

On a scale of 1 to 5 (1 being strongly disagree to 5 being strongly agree), rate the following questions with one number that best fits your experience.

1) Team members are not well-informed regarding events that happen between appointments.
----------N/A----------1----------2----------3----------4----------5

2) Our team has developed effective communication strategies to share patient/client treatment goals and outcomes of care.
----------N/A----------1----------2----------3----------4----------5

3) I am able to [routinely] communicate with others to ensure common understanding of patient care decisions between colleagues and myself.
----------N/A----------1----------2----------3----------4----------5

4) Our team responds well to emergencies, both during and after the event.
----------N/A----------1----------2----------3----------4----------5

5) It is clear who is responsible for aspects of the patient/client care plan.
----------N/A----------1----------2----------3----------4----------5

6) In most instances, the time required for team meetings could better be spent in other ways.
----------N/A----------1----------2----------3----------4----------5

7) I feel comfortable speaking out within the team when others are not keeping the best interests or desires of the client in mind.
----------N/A----------1----------2----------3----------4----------5

Short Answer Qualitative Questions:
Please respond as thoroughly as possible to the below questions. If you feel a question does not apply, please respond N/A.

8) What is an interdisciplinary team? What are the benefits/drawbacks of a formal IDT?

9) What methods of communication do you currently use to communicate with team members?

10) What would you consider important to discuss during an hour-long weekly IDT meeting?

Questions adapted from:
Heinemann, G. D., Schmitt, M.H., Farrell, M.P., & Braillier, S.A. (1999). Development of an
        Attitudes toward Health Care Teams Scale. *Evaluation & the Health Professions, 22*(1),
        123- 142.
King, G., Shaw, L., Orchard, C. A., and Miller, S. (2010). The interprofessional socialization and
        valuing scale: A tool for evaluating the shift toward collaborative care approaches in
        health care settings. *Work, 35*(1), 77‐85.
Registered Nurses' Association of Ontario. (2013). *Developing and sustaining interprofessional
        health care: Optimizing patients/clients, organizational, and system outcomes*. Toronto,
        Canada: Registered Nurses' Association of Ontario.
Schroder, C., Medves, J., Paterson, M., Byrnes, V., Chapman, C., O'Riordan, A., Pichora, D.,
        and Kelly, C. (2011). Development and pilot testing of the collaborative practice
        assessment tool. *Journal of Interprofessional Care, 25*(3), 189-195.
Temkin-Greener, H., Gross, D., Kunitz, S.J., & Mukamel, D. (2004). Measuring interdisciplinary
        team performance in a long-term care setting. *Medical Care, 42*(5), 472-481.