TEAMWORKING IN PRIMARY HEALTH CARE pdf

1: Department of Health | Primary Health Care in Australia

Primary care in the UK changed enormously over the past two decades. [] The roles and demands on the primary healthcare team (PHCT) have increased and will continue to increase in a theoretically primary care-led NHS.

This is an open access article distributed under the terms of the Creative Commons Attribution License http: This article has been cited by other articles in PMC. Abstract Background The move towards enhancing teamwork and interprofessional collaboration in health care raises issues regarding the management of professional boundaries and the relationship among health care providers. This qualitative study explores how roles are constructed within interprofessional health care teams. It focuses on elucidating the different types of role boundaries, the influences on role construction and the implications for professionals and patients. Methods A comparative case study was conducted to examine the dynamics of role construction on two interprofessional primary health care teams. The data collection included interviews and non-participant observation of team meetings. Thematic content analysis was used to code and analyze the data and a conceptual model was developed to represent the emergent findings. Results The findings indicate that role boundaries can be organized around interprofessional interactions giving rise to autonomous or collaborative roles as well as the distribution of tasks giving rise to interchangeable or differentiated roles. Different influences on role construction were identified. They are categorized as structural characteristics of the workplace , interpersonal dynamics between team members such as trust and leadership and individual dynamics personal attributes. The implications of role construction were found to include professional satisfaction and more favourable wait times for patients. A model that integrates these different elements was developed. Conclusions Based on the results of this study, we argue that autonomy may be an important element of interprofessional team functioning. Counter-intuitive as this may sound, we found that empowering team members to develop autonomy can enhance collaborative interactions. We also argue that while more interchangeable roles could help to lessen the workloads of team members, they could also increase the potential for power struggles because the roles of various professions would become less differentiated. We consider the conceptual and practical implications of our findings and we address the transferability of our model to other interprofessional teams. Role boundaries, Interprofessional collaboration, Influences on role construction, Comparative case study Background Interprofessional collaboration is increasingly being promoted as a mechanism to respond to the challenges of the health care system by reducing costs, improving quality of care, and improving staff retention and job satisfaction [1]. Accompanying this trend towards teamwork are issues around the management of professional boundaries and the relationship among health care providers [2]. For example, Byrnes et al. In their review of team research, Mathieu et al. Our focus is on the types of role boundaries and the influences on role construction. Through the thematic content analysis of interview and observation data obtained from two primary health care teams, we have generated a model to reflect the elements of role construction. Primary health care has a mandate to provide services delivered by a collaborative team of professionals while emphasizing the quality of care and health status of patients [5]. According to Saba et al. In Canada, different primary care models offer an aggregation of health services within one organization e. As with team-based models in other settings, many challenges are encountered when trying to provide care across a diverse set of professionals. Difficulties include coordinating the roles of the different professionals to create a cohesive and complementary set of services for the benefit of the patients and the team members [7]; and overcoming a lack of trust and respect between team members [8]. These challenges are often experienced in micro-sites which are arenas for ongoing boundary work [9] through which professional roles are negotiated and constructed. In order to examine role construction, it is pertinent to consider literature on role boundaries. The roles performed by different members of interprofessional teams are subject to professional boundaries [12 , 13]. However, Bourgeault and Mulvale have highlighted the efforts of regulatory agencies to break down exclusive professional boundaries on health teams given that overlapping scopes of practice allow teams to be more responsive to changing conditions [12]. This stream of research has pointed to macro influences on role construction. Role boundaries can also be

negotiated and constructed in micro sites where they are shaped by local forces and the interactions among members [15 , 16]. In this study, we focus on the construction of role boundaries in micro-sites but acknowledge that this phenomenon takes place within macro-level constraints. As part of our focus on role construction at the team level, we are examining boundaries that form around team member interactions and around role distribution between professions. Collaboration is an interpersonal process that entails joint involvement in intellectual activities [17] whereas autonomy suggests independent and self-determined practice [18]. Although these two concepts may appear by definition to be opposed to each other, in practice professional work involves both independent and interdependent elements [19]. A study by Rafferty et al. In other words, autonomy can be complementary to team work and enhance collaboration by promoting collegial relationships between team members [18]. While some findings have pointed towards the potential for a positive association between collaboration and autonomy, researchers have also raised the issue of silos, where members of a team operate in separate and unconnected roles. This concept suggests a more profound form of detachment and autonomy between professions that goes beyond the boundaries around tasks. Thus, collaboration and autonomy have been suggested as complementary aspects that can enhance health service delivery although, in extreme forms the latter may inhibit team functioning. Boundaries between professions on a team can form not only around interactions, but also around the distribution of responsibilities of different professionals. The construction of these boundaries in interprofessional settings may result in a separation of responsibilities or a decrease in formal role demarcations [21] role blurring between professions. Hall discusses the possibility that role blurring will occur because of overlapping competencies [21]. Role blurring is considered beneficial by some while others oppose it and link it to role strain and confusion [21]. For example, certain professionals on the team might believe that their role is being encroached upon and that their sense of professional identity is eroding [21 , 22]. Others may be overwhelmed because they are trying to do everything and are experiencing uncertainty about the limits of their responsibilities [8 , 21 , 22]. While some professionals may perceive role blurring as a threat, others may see an opportunity to expand their responsibilities or to make the team more flexible and responsive to its client population [21]. Research describing role distribution and interactions between team members can be complemented by knowledge about within-team dynamics and how these may contribute to shaping role boundaries. Different elements can influence how professional boundaries are constructed. At the micro-level our level of analysis , these influences include structural elements the characteristics of the workplace such as workload [21 , 23] and physical space [24 , 25]; interpersonal elements dynamics between team members including leadership [26] and education [25]; and individual attributes dynamics that individual practitioners bring to the interprofessional team such as attitudes and values [4 , 6]. On different teams, certain influences may be more significant than others, leading to different manifestations of role distribution and interdependency between team members. The manner in which role boundaries are manifested may have implications for teams and their clients. Several authors have provided insights into the implications around collaborative endeavours and sharing of responsibilities for professionals and patients. These include easing workloads [23]; shorter wait times [27]; and continuity of care [28]. Although much of extant research looks at themes related to interprofessional collaboration, few studies have focused specifically on roles or proposed integrative models of role boundaries and influences on role construction. The reviewed literature, while mentioning phenomena such as role overlap [7] and role clarification [5] does not specifically consider the elements of role construction as a main focus. More research is needed to study methods of promoting collaboration in the workplace [17], to understand the complex relationship between collaboration and autonomy [20 , 29], and to further examine the implications of interprofessional collaboration for professionals and patients [30]. Investigation into micro-level processes of boundary work can provide insights that may aid in improving interprofessional collaboration and the integration of roles [31]. In this study we help respond to these gaps by exploring how task roles are constructed on interprofessional teams. We consider the types of roles boundaries that are present, the influences on the construction of these boundaries, and the implications for practitioners and patients. In doing so, we provide an integrated overview of the elements of role construction rather than a detailed examination of one component over another. The following question guided this study:

How are roles constructed within interprofessional health care teams? More specifically, we ask: What types of role boundaries are present within an interprofessional team? What are the influences on the construction of roles and role boundaries? Methods This research uses a holistic, comparative case study approach to explore the dynamics of role construction. Comparative case studies may generate more compelling evidence than single case studies because they allow for the analysis of patterns between cases and the derivation of more robust results [32 , 33]. Our case selection strategy was based on purposive sampling [34]. The two cases allowed us to generate rich information [34 , 35] for our study of role construction on interprofessional primary health care teams. We chose teams composed of multiple professions working together to deliver health services to patients so that we could collect data on the interactions and distribution of responsibilities between team members and in so doing, help respond to our research questions. Purposive sampling is also used to gather a diversity of opinions [36]. The selected health care teams offer similar services in primary health care but also have diverse characteristics allowing our findings to be extended across more than one case. These points of divergence include the origins of the two teams, the models of primary health care and the age of the teams. Both teams â€” located in different provinces in Canada but operating within similar regulatory frameworks - provide primary health care services including consultations, diabetes care, hypertension management and blood monitoring INR reviews. These two cases also show similarities in the types of professions found on their teams for example, nurse practitioners NPs , registered nurses RNs , registered practical nurses RPNs , dieticians, social workers and pharmacists, and in the size of the teams that were studied. As Eisenhardt suggests, the health care teams also have diverse characteristics, so that our findings could be extended across more than one type of team [32]. Team 1 transitioned from a group of independent physicians working in the same clinic to an interprofessional team model Family Health Team. Team 2 is an NP-led team with physician consultants and was created specifically to respond to the underserviced primary health care needs of the community in which it is situated. Further, Team 2 is a recently-established team, which compares to Team 1 that has been in operation for several years. Data collection Data was collected through interviews, observations and written documents. The questions explored roles distribution, overlap, expansion , team member interactions, influences on role construction, and implications for practitioners and patients. Team 1 is a subset of a larger organization. Similar to Team 2, it includes a variety of professionals who collaborate â€” with varying intensities â€” in the delivery of health care services. A cross-section of professions was sampled through the help of the manager and through snowball technique. All members of Team 2 were interviewed. Non-participant observations of 2 team meetings at each site were recorded to learn more about roles and interprofessional collaboration among team members. These meetings were attended by most participants in the study and covered topics such as program updates, new initiatives e. Written documentation - organizational charts, meeting agendas with supplementary information about projects , program templates and websites - provided additional background information on the origin, evolution, objectives and types of services for each team.

TEAMWORKING IN PRIMARY HEALTH CARE pdf

2: Primary Care Teams - www.enganchecubano.com

Health care, by definition, is a multidisciplinary profession in which doctors, nurses, health professionals from different specialties must work together, communicate often, and share resources. Health teams are often made up of a variety of professionals - called cadres in health care - each with specialized knowledge and responsible for.

Blog Home Why It Matters Optimized team-based primary care improves the quality, safety, and reliability of care; reduces waste; and better addresses the needs of chronically ill patients. In this blog post, she answers some common questions about team-based care and describes its advantages for patients and providers. What is team-based care? State of the Science. American Board of Internal Medicine Foundation; Is team-based care a new approach? For at least 15 years, IHI has been incorporating the team-based care approach as a high-leverage change in our work related to primary care. It started with the Chronic Care Model in the late s. It is an integral part of not only patient-centered medical home recognition, but also imperative to attaining advanced access to help work down a backlog of appointments , and of primary importance when working on flow , improving chronic care management , and addressing preventive screening and follow-up. IHI has seen optimized care teams have a positive impact on a range of measures, including office visit cycle time, access to care, preventive screening, self-management goal setting and action planning, and medication reconciliation. For hundreds of organizations across the country, IHI has offered solid change concepts and ideas on the selection and development of a care team, multiple well-tested methods to optimize the care team, and more recently, how that care team might extend beyond the traditional four walls of the clinic through community health workers, public health nurses, in schools, and elsewhere. What are the advantages of the team-based approach for providers as well as for patients? The attributes of quality in which physicians are most interested â€” as clearly outlined in the IHI white paper, Engaging Physicians in a Shared Quality Agenda â€” include patient outcomes and personal muda waste , particularly wasted time. The use of a well-organized and optimized care team addresses both of those issues. In my experience, the people who benefit the most â€” the patients and physicians â€” are often the biggest proponents for this approach once they understand and experience it. I know of physicians who were skeptical at first and then became strong proponents of the approach once they saw the impact on both patient outcomes and efficiencies. Physicians understandably want to ensure that their high standards are being met. Until they trust that their care team members have the same focus and high standards they do, there will likely be pushback on the team-based model. It takes time and positive experiences to develop that trust. An effective clinical care team learns from regular practice to fine tune their skills, has shared goals, struggles with learning new approaches, has clear roles and responsibilities, and learns to rely on and trust their team members. The best teams also communicate effectively. While not all teams are at the same level of competence and effectiveness â€” assuming that the care team is well developed and optimized â€” there are many potential advantages for patients. They include enhanced access to care and services with a consistent care team; improved quality, safety, and reliability of care; enhanced health and functioning in those who have a chronic condition; and more cost-effective care. Patient and family experience also tends to improve with a high-functioning primary care team. Optimizing the care team is critical to maximizing the supply of the clinic and improving the daily flow of work. Organizations are encouraged to assess the current needs of their patient population and identify the ideal composition for the care team. The specific mix of staff number of physicians, nurses, assistants, technicians, clerks, etc. This approach begins with understanding the demand and adjusts supply to meet the demand within the limits of clinic resources. This is different from an approach that develops an arbitrary care team mix and then tries to fit the demand into the supply. After identifying the composition of the care team, we encourage organizations to ensure that all staff members are working to the highest level of their expertise and ability. Does a physician need to do their foot exam? No, a nurse can do the initial assessment. Does a physician need to be the one to discuss their dietary requirements and restrictions? No, in fact, a dietitian â€” given the specialization of their training â€” might be a more effective educator. By reassigning these responsibilities to other care team members, the physician can then spend more time focusing on what matters

most to patients, such as communicating with patients, collaboratively setting goals, or using their expertise for more serious conditions. Optimizing care teams is not only about giving time back to physicians. This is also an issue for nurses. If we free nurses from tasks traditionally assigned to them but for which their skills are not necessary, they can have more time to do the work they find more challenging and satisfying as professionals and that is ultimately more important to patients. To illustrate the idea of optimizing the care team, we often run an exercise with our primary care teams using cups [see photo above] to represent the typical ambulatory care team. The potential overuse of the physician is represented by the cup on the far left, filled with jelly beans. Can the team-based approach help organizations pursue the Triple Aim of improving health, enhancing the care experience, and reducing costs? An optimized care team will provide the expertise and resources tools and time to jointly plan and customize care and provide support for individuals and families to better manage their own health. By redesigning primary care services and structures to work effectively and efficiently on prevention, health promotion, and chronic disease management, you can improve outcomes and the care experience in a cost-effective way. What would you say to skeptical patients who might view team-based care as a way to cut costs or who worry that it will mean spending less time with their primary care physicians? It requires a shift in thinking for some people to understand the value and benefit of the team approach. However, by limiting the time physicians spend on activities that other care team members can effectively manage either prior to or following their office visit, effective and efficient team-based care can enhance the time patients spend with their provider. Having said that, it is important to acknowledge that patients might be concerned that someone with less training and expertise than their physician might assume responsibility for their care and worry that this is driven primarily by a desire to cut costs. We need to get better at explaining to patients that we are instead utilizing different medical professionals to the full extent of their training and experience, and assure patients that when they need to see a physician they will. Providing care is indeed a team approach and the physician will be involved in decision making along with the other members of the team. How does team-based care help address the challenges facing primary care physicians today? Team-based care can help primary care physicians address a variety of their biggest challenges. As noted earlier, it helps physicians use their time more effectively, for example. Team-based care is also the only way to address the needs of an expanding patient population in the US with a simultaneous shortage of primary care physicians. The advantages to team-based care can extend into the community, especially when combined with some form of case management or care coordination, home visits, or other strategies. Care providers from a variety of disciplines on the team can help people better manage their conditions at home and in their community and avoid long and costly ED visits. Community health representatives and public health nurses from the community work collaboratively with the care team from within the clinic, making home visits and aligning their strengths and services in the best interest of the persons they serve. Optimizing the care team might also mean creating alternatives or supplements to one-on-one physician visits, such as group visits. Why is primary care in need of not just change, but transformation? The current infrastructure for primary care in the US is not sufficient to meet the population management needs of a primary care patient panel. Researchers have estimated that it would take 7. If you include the estimate that it takes 4. It is not possible to achieve improved population health without substantial versus incremental change. You may also be interested in:

TEAMWORKING IN PRIMARY HEALTH CARE pdf

3: Team working in primary health care : a review of its effectiveness (Book,) [www.enganchecubano.com]

The development of teamworking and multidisciplinary communication across organizational settings, and particularly in healthcare, reflects a growing awareness of the benefits to be derived from this way of working. These benefits, in the form of improved healthcare delivery and better member well.

Changes for Improvement Cross-Train Staff Cross-training enables staff to assume different duties as needed. The ability of a clinic to respond to expected or unexpected surges in demand or unexpected, yet predictable events depends to a large extent on the flexibility of the staff to adjust their responsibilities during these periods. It provides another option to smooth the flow and support the providers. To develop a flexible and effective care team, provide some degree of cross-training so that the team as a whole can respond quickly to minute-to-minute variations in demand and supply, or to unexpected events. A float team that is trained to cover responsibilities throughout the clinic when needed. Scheduling staff that can clean instruments and set up rooms for procedures. Nursing staff that can do scheduling, if necessary. Scheduling or reception staff that can obtain patient information and assign patients to exam rooms. Check-in and check-out staff that can fill in for each other. Reduce Variation in Provider Styles Variation in how office visits are conducted by different providers e. An open discussion about how the "work gets done" can help identify opportunities for standardized approaches that promote efficiency across the larger care team. The creation of communication short-cuts and flexible cues and sequencing can also optimize team communication. For example, use a large board in the clinic workroom to note daily patient appointments including special needs by provider along with nursing staff assignments. Flexible cues and sequencing are a type of communication that keep a practice flowing smoothly without the need for verbal or face-to-face communication. Here are some examples: A chart in the blue basket means that the patient has arrived and is ready for rooming, and a chart in the red basket means that the patient has gone for testing. Flags on the room indicate which member of the care team is in the room, or if the patient is ready for the next stage of the visit. It is important to research the scope of licensing with the state regulatory agencies to be sure that staff are not inadvertently asked to work beyond the scope of their license. Establish Standard Protocols to Move Work Away from the Provider One way to optimize staff abilities is to establish protocols for conditions and processes that can be clearly delineated. The following are some examples: Develop a standard process for flu and pneumococcal vaccinations so that a nurse or other appropriate provider can administer shots according to established guidelines. Develop nurse-run or pharmacist-run hypertension, allergy, or INR clinics based on protocols. Ask physicians to sign off on standard advice protocols for home care. Write protocols for ordering an initial lab or radiology for certain symptoms such as urinary tract infection, strep throat, or suspected broken bone at the office visit, or to replace a physician visit with a nurse visit. Limit Interruptions Interruptions create unnecessary variation in the flow of tasks, disrupt the coordination of work among staff, and contribute to patients waits for services or treatment. For example, when a provider is interrupted during a patient visit for a phone call, or when patient information or exam room supplies and equipment are missing, all can lead to delays. To decrease these common types of interruptions, have physicians track the number of times and reasons why they leave the exam room for missing items to identify what equipment is needed in the room at all times. Clinics can also establish telephone call policies to mitigate interruptions by phone. Manage Contracted Supply Some practices discover a gap between the expected amount of time providers have on their schedules for direct patient care and the time stipulated in contracts. Correcting this mismatch can often result in increased supply. Lack of clarity around roles and responsibilities results in time wasted.

4: Team-Based Care: Optimizing Primary Care for Patients and Providers

Background. A team approach in primary care has proven benefits in achieving better outcomes, reducing health care costs, satisfying patient needs, ensuring continuity of care, increasing job satisfaction among health providers and using human health care resources more efficiently.

TEAMWORKING IN PRIMARY HEALTH CARE pdf

5: Primary health care nursing

7 Concepts Of Health 8 Primary Health Care 8 Primary Health Care in New Zealand 9 Table 2. The Structure Of The Health And Disability Sector 49 Teamworking in.

6: Optimize the Care Team

Instead of the primary care physician trying to do everything in a minute appointment, a whole team of health care providers is responsible for the patient's care - from nurses to doctors to community health workers to mental health specialists to pharmacists.

7: Team work in primary health care

Primary health care is the frontline of Australia's health care system. It can be provided in the home or in community-based settings such as in general practices, other private practices, community health, local government, and non-government service settings for example, Aboriginal Community Controlled Health Services.

8: Improving Primary Care Team Guide | A practical guide for enhancing quality through team building

the Ministry of Health recommended that teamworking was the way in which primary care could best be delivered, when its committee proposed that general practitioners (GPs) should work in teams with other healthcare professionals in health centres (Milne.

9: Teamworking guide for primary care | Evidence search | NICE

With the arrival of the National Plan, this timely paper presents preliminary findings from a major survey of multidisciplinary team working and effectiveness. The three-year study covered primary, secondary and community health care teams.

TEAMWORKING IN PRIMARY HEALTH CARE pdf

WeddingShape Diet and Fitness Guide for Brides The Big Banana Hunt (Safari Friends (Safari Friends) The machine by Peter Marginter Post-chapter 11 performance Do you know where your water has been? El abanico de seda La campanella sheet music violin A note about food labels You have a friend, Pietro. Engineering economy eighth edition solution Posh pancakes fancy fritters The medicine of ER, or, How we almost die Islam: challenges in twenty-first century European revolution Llamas, weavings, and organic chocolate Careers for Extroverts Other Gregarious Types A Teachers Guide to Natures Food Chain Heat, lights, and action! Event management and planning John Patricks casino poker Between dictate design Value theory and economic progress Common job curses Certificate of birth blank russia translation Old New Kent County, Virginia Carl Rogers and the culture of psychotherapy Martin Lakin The basis of my forecasting method Sir Thomas More on the U.S. Constitution History of public health Introduction by Paulynn P. Sicam On the economical acquisition of royal ancestry. V. 6. Power, gender, and technology. Ninth International Conference on Metering and Tariffs for Energy Supply (Mates 99 (Conference Publicatio Centers for medicare for medicaid services cms report Labour and the Benn factor Papers read before the Synthetic Society. Hannah arendt the banality of evil book Tanks of the World 1915-1945 Heavens Register The Paintings of Van Gogh