

***Improving Patient-Centered Care: Optimal Strategies for
Interprofessional Communication and Collaboration
Question & Answer Session***

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How can we better integrate mental health issues with medical needs; there seem to be cross-discipline issues here?

We need to ensure that there are trained mental health professionals on every team to assess and intervene with patients and families who have mental health issues. It is not enough to screen for depression, we must have professionals on the team that are devoted to addressing psychosocial and psychiatric issues. While doctors and nurse practitioners can treat mental health issues medically, a social worker, psychologist or trained psychiatric nurse is needed to provide a comprehensive assessment of the patient's current and past mental health, provide the needed support and counseling, and address the social determinants of health that are impacting the patient's situation.

Do you recommend a "pre-family-meeting" get-together with the team to get team members on the same page before the actual family event?

Absolutely. It might even be good to role-play a family meeting in advance if it is expected to be challenging. The team should have clear goals for the meeting and should discuss any issues that might be problematic. They might even discuss where everyone should sit during the meeting to ensure that all family members feel supported and included.

Mark Earnest, MD, PhD, FACP, Professor of Medicine, Division Head, General Internal Medicine, University of Colorado School of Medicine, Former Director, Interprofessional Education, University of Colorado Anschutz Medical Campus; Aurora, Colo.

What is the best way to deal with the egos of those on the team?

I would offer up a couple of suggestions for this:

- 1) Build and maintain a data-driven, goals-focused culture that emphasizes the common work of caring for patients. While this doesn't eliminate the challenge of ego, it does provide a way of moving the conversation toward the things that matter most and provides an objective way to assess the effectiveness of attitudes and behaviors that may be becoming problematic. A group that is clear about their goals, regularly monitors their progress towards those goals, and is clear about the roles and responsibilities of members will create and maintain a culture that can help contain and prevent some of the bigger personality challenges.

- 2) Ensure the organization supports and enforces a culture of collaboration. Teams can do a lot to self-regulate (as described above), but most teams are nested within a larger organization. Optimally, that organization sets behavior standards and provides mechanisms through which problems can be surfaced and addressed. Our organization has an anonymous reporting system wherein problematic behavior can be reported. We have an office of professionalism and an ombudsman's office, which monitor those reports and intervene when necessary. Having a system like this work requires that the entire organization support it and that every person in the organization be aware of the expectations for professional behavior and of the resources available for addressing lapses.

Although we may not practice within an interprofessional collaborative practice (IPCP), many of us are functioning as team members on a regular basis with nurse care managers, social workers, pharmacists, physicians, etc.; however, we are limited to telephonic-only contact. Are there more specific points relevant to large telephonic-only (virtual) teams that can enhance effective communication?

Many of the issues are the same in telephonic communication as they are in face-to-face conversation. Clarity of communication is critical. Working on conventions to avoid and resolve ambiguity is important because that is where most errors and conflicts occur. The lack of an affective aspect of communication is often where trouble arises in written communication, as well as at times with verbal communication that is not modulated by facial expressions and other cues as to the speaker's intent. This can be particularly true if the conversation turns personal or if humor is part of the dialogue. My belief is that personal relationships matter a great deal and can go a long way towards reducing some of the friction and challenges that happen among dispersed and asynchronous teams. Looking for opportunities to occasionally meet face to face or to come to know one another through other means may be time well spent.

Please, comment more about the need to build up the process of definitions of roles in the team with regard to the development of procedures, policies, and processes that could help to establish a real change in practice and won't remain just the "isolated practice" of one specific group of professionals.

Ideally, there is a dynamic process that occurs between the local team and, through the organization of which they are a part, other analogous teams. Such a process would allow local innovation and improvement that can be disseminated to other teams as they all engage in continuous improvement. Achieving this requires some standardization of roles, policies, and procedures so that changes can be defined, described, and discussed. A key issue is how the teams are connected such that innovation leading to positive deviance can be identified and any learning from that can be shared.

Hogai Nassery, MD, Atlanta Medical Director, Harken Health; Atlanta, Ga.

Does extra time need to be allotted for communication and reflection with the team?

If you have a team that works together consistently, then yes, this would be a best practice. How often and for how long could vary.

How does our traditional method of charting help us, and how does it interfere with integrated care?

I think the real issue is that using an electronic health record (EHR) can either be helpful or hinder us. I remember speaking with an inpatient physician who said that it took several clicks to get to nursing notes on the wards with the EHR, whereas with a paper chart, it was very easy to just flip to that part of the chart.

I'd also suggest finding consistent terminology and perhaps agreeing to highlight the key parts of the note. With EHRs and the use of templates, there is often "note bloat," or inadvertent redundancy of information, which can obscure the key parts of a clinical encounter.

Do you have recommendations for communication among teams — for example, between a case-management and/or health-coaching-focused team and a direct-care team — such as primary care/medical home?

The key part of communication is building a relationship, if possible, and trust. This is facilitated by continuity of care, i.e. an inpatient team could work with the same case management team consistently. Any opportunity to actually meet face to face and visit each other is priceless.