Team Approaches: Working Together to Improve Quality

By Camille Catlett and Anita Halper

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The team approach is not unique or new to the discipline of human communication sciences and disorders. Models for teaming and the dimensions for team effectiveness have been in place for many years; they derive from the human relations model of management. This article presents two perspectives on team approaches; one from health care, the other from education. Team approaches are defined, benefits and challenges of team-based approaches are identified, and tools and strategies for facilitating more effective teaming are introduced.

Team Approaches in Healthcare Settings

Anita Halper

There are a number of different ways to define rehabilitation, but a common one is Melvin's (1989). He describes it as "that process which maximizes the physical and psychological health, and the social, economic and vocational or educational status of an individual" (p. 273). Although this description delineates the wide scope and complexity of rehabilitation, it does not provide a framework for delivering rehabilitative services. Given the scope and complexity of rehabilitation, team approaches provide the most logical solution to service delivery. Teams, however, are seldom defined or understood clearly.

The terms multidisciplinary, interdisciplinary, and transdisciplinary often are used interchangeably. But they do have distinct meanings. A multidisciplinary approach to service delivery means that persons from several disciplines are involved in the delivery of services. The approach, however, is discipline-oriented with each team member responsible only for the activities related to his or her own discipline (Melvin, 1989; Rothberg, 1981). One team member is affected very little by the efforts of the other team members. In reality, this may be the easiest way to deliver services. But it is not always in the best interest of the patient.

An interdisciplinary approach to service delivery presupposes interaction among the disciplines. Not only are individuals from several disciplines working toward a common goal, but the team members have the additional responsibility of the group effort (Rothberg, 1981). This approach necessitates effective communication among the various individuals involved in the patient's rehabilitation (Melvin, 1989). The team includes not only the professionals but the patient and his or her family and significant others as well.

A transdisciplinary approach is based on the premise that one person can perform professionals' roles by providing services to the patient under the supervision of the individuals from the other disciplines involved. Representatives of various disciplines work together in the initial evaluation and care plan, but only one or two members actually provide the services. This model is often used in high-risk neonatal and early-intervention programs. It should be noted that regardless of who is providing the service, professionals are still accountable for areas related to their specific discipline and for training the team member

who is delivering the service (Connor, 1981; Bailey & Wolery, 1989).

It is my contention that the interdisciplinary approach to rehabilitation is the most effective for the patient. The end product of a true interdisciplinary approach is an integrated plan of care that involves effective collaboration between the team members (Bailey & Wolery, 1989). This can be a difficult thing to achieve, and there are some issues that have to be considered in the deliver of services under this model. Each facility has to determine whether these factors will impede its ability to implement and sustain interdisciplinary rehabilitation. The benefits and challenges of this approach must be weighed carefully.

Benefits and Challenges

The benefits of teamwork are obvious. Team practice has led professionals to see clients and their families as whole persons, not as parts of a whole (e.g., mouths, brain, arms, legs). An appreciation of other disciplines allows professionals to accommodate larger functional goals and integrated interventions, instead of working on isolated tasks. From the patients' and families' point of view, it is easier to communicate with a cohesive team, rather than numerous practitioners who work in isolation. It is also less overwhelming if information related to intervention is synthesized across disciplines, rather than presented separately from each practitioner. Teamwork brings together diverse knowledge and skills and can result in quicker decision making. As a result of professional collaboration, redundancy or fragmentation of service can be reduced or eliminated, thereby increasing the cost efficiency of service.

But there are drawbacks to teaming as well. Certain economic and professional factors must be considered. A substantial amount of time can be spent by team members from various disciplines in communicating. Think, for example, of the salary costs of a team conference or rounds. In addition, most professionals have a productivity standard that must be met. This can impose a limitation on the time such individuals have for participating in these and other interdisciplinary activities. As a further complication, there are personnel shortages in many of the rehabilitation professions. Costs combined with staff shortages can certainly affect the ability to deliver rehabilitation services under an interdisciplinary model (Melvin, 1989).

Some team members and professional groups are threatened by the notion of giving up some of their autonomy to the group effort. There is a lack of confidence and trust in the opinions and decisions of individuals from other disciplines. In addition, team members' perceptions of their respective roles and contributions to the team may clash. This may lead to individuals feeling that others are usurping their domain. This issue of territorialism can destroy a functioning team (Rothberg, 1981).

In spite of these economic and professional factors, the interdisciplinary approach can improve the delivery of services to patients. All team members are working toward common goals and not in isolation.

Team Approaches in Education Settings
Camille Catlett

Prior to the passage of Public Law 94-142 (the Education for All Handicapped Children Act of 1975, subsequently reauthorized as IDEA, the Individuals with Disabilities Education Act), children with disabilities were typically served by a single

representative of a single discipline, most frequently a classroom teacher. Other "specialty services professionals" were recommended on the basis of the child's "primary presenting problem" or "primary handicapping condition." Speech-language pathologists and audiologists treated most children in settings isolated from educational programs.

The multidisciplinary team evaluation and the related services mandated in P.L. 94-142 were products of a growing understanding by parents and professionals of the compound effects of developmental delays and disabilities. In accordance with the law, speech-language pathologists and audiologists working in educational settings began to "join" educational teams.

But the nature and function of educational teams differ widely across educational settings. In some service delivery models, the speech-language pathologist serves as a member of a multidisciplinary team composed of educators and parents, working independently with little or no collaboration (Peterson, 1987). In other models, the speech-language pathologist serves as a member of an interdisciplinary team whose members meet and discuss findings regarding each student, often with little collaboration beyond discussion. A variation of the interdisciplinary model that operates in secondary education environments may feature teams that include community members, such as employers. Another approach that has evolved as teachers, therapists, medical professionals, human services professionals, and family members have worked together, discussing child needs and planning programs that integrate efforts across developmental domains and disciplinary boundaries, is called transdisciplinary. Services provided by transdisciplinary teams are often characterized as collaborative services (ASHA, 1991).

In the transdisciplinary/collaborative model, it is assumed that "no one person or profession has an adequate knowledge base or sufficient expertise to execute all functions (assessment, planning, and intervention) associated with providing educational services for students (ASHA, 1991). Thus all team members contribute to the coordinated approach (educational program, IEP, IFSP) designed for each child (and family), although each team member's responsibility for implementation may vary.

As members of effective transdisciplinary teams, speech-language pathologists and audiologists can be involved in the total education program. For example, if a child with a communication disorder needs to be provided with simple directions in the classroom, the speech-language pathologist can assist the classroom teacher in implementing specific techniques and strategies. Similarly, an audiologist might work with a classroom teacher to coordinate seating and environmental modifications for a child with a hearing loss. Or a speech-language pathologist, social worker, classroom teacher, and parent might work together to improve the self-image of a child with multiple disabilities.

Benefits and Challenges

There is an abundance of literature and anecdotal information extolling the virtues of different styles and approaches of teaming (ASHA, 1991; Garland & Linder, 1988; Hoffman, 1990). In fact, most effective teams probably operate through the judicious use of several approaches. However, the legislative and practical considerations remain that children with disabilities and their families are best served

through well-coordinated team approaches. And effective team members must, first and foremost, be committed to the concept that the most effective way of providing effective intervention is through a service delivery model conducted by a team (Durbin & Dodson, 1990).

Although there are many benefits to teamwork (for professionals, family members, and children), it should be recognized that well-functioning teams require attention, time, and support. Time is needed for team members to get to know each other and learn about each other's professional philosophies, work styles, attitudes about change and innovation, and approaches to conflict and conflict resolution. Team members must assess themselves and explore strategies for improving teamwork. This, too, takes time. More time is needed to allow for team meetings to discuss student, family, and programmatic issues, as teams are more likely to be successful and work together effectively if they are allowed to develop their relationships, expertise, and program (Hoffman, 1990). Professional "turfism," differences in treatment approaches, lack of time, staff turnover, lack of administrative support, and distance are a few of the practical variables that confound educational teaming. Yet a larger issue is that few speech-language pathologists and audiologists have been trained in negotiation, conflict resolution, collaborative goal setting, or other areas that are essential for serving as effective team members or team leaders.

Tools and Strategies for Effective Teaming

If effective teams require attention, time, and support, and the skills for accomplishing team development are now widely held among speech-language pathologists and audiologists, how can we take leadership roles in facilitating team development? Many answers may be found within the business, psychology, and organizational development communities, where approaches that can foster team building and team leadership skills have been developed. Knowledge of existing tools and approaches can facilitate productive team building in both old and new teams.

One approach, developed by David W. Miller (1992) of Phoenix International, is the use of clarifying questions. These questions can be used singly or collectively for independent reflection, followed by group (team) brainstorming). Some clarifying questions Miller suggests include:

1. What are the characteristics of an effective team? How do you know (a named characteristic) when you see it, i.e., What happens? What do others on the team say and/or do?

2. How do you negotiate the creation of a team when team members vary in the value they perceive in teamwork?

3. What problems do you encounter in team meetings that you would like to resolve? (As you think about this question, consider team meetings to plan meetings with family members, team meetings with family members, team meetings to review/revise the implementation of a sequence of intervention, and any other team situations you can think of.)

4. What individual team member behaviors do you find it most difficult to deal with? What have you tried? What has worked?

5. What team meeting behaviors have you tried or observed that help a team to be effective? What behaviors do you exhibit that don't help (or even hinder the group)? How does the way you typically deal with conflict affect teamwork?

6. What does it mean to lead a team? What is ineffective leadership? What can you do about it, either as a team leader or as a team member?

7. What types of team meetings do you have? What's the shape of a well-managed meeting of each type? What happens during the meeting and in what order? How do you get an off-track meeting back on track?

An annotated list of additional tools for team building is provided in the *Tools for Team Building* section that follows. Approaches to the use of these tools for team building have been as unique as the teams. Some teams have elected to prioritize a set amount of team development time into regularly scheduled meetings. Other teams have found it helpful to bring in a nonteam member to facilitate discussion. And yet others have wanted to limit participation to the members of the team.

Whatever strategy or approaches are selected should be well thought out and, like good team work, coordinated. While it may seem impossible to fit more time for teaming into the competing priorities of healthcare and educational professionals, the time spent working on more effective approaches may actually save time in the long run.

Summary

Effectively functioning teams are essential for delivering effective services to children and adults with disabilities, as well as their families. As important as it is for professionals from different disciplines to work closely and cooperatively together, efficient team functioning is often difficult to achieve. Administrators must allow time for the team to plan, practice, and critique their work together, while simultaneously encouraging a sharing of information and skills. When team leaders and team members commit their time and professional expertise, the results have been shown to be effective. Henry Ford summarizes the challenges and benefits of teamwork succinctly: "Coming together is the beginning, keeping together is progress, working together is success."

Tools for Team Building

Analyzing Teamwork. David W. Miller. (1991). A tool for examining the goals, roles, procedures, interpersonal relationships, and systems of a team. Available from Phoenix International, 17 Pipestem Court, Potomac, MD 20854.

BRASS TACKS: Part I – Program Policies and Practices. P. J. McWilliam & Pam Winton. (1990). An instrument to assist early intervention programs and teams in determining the extent to which practices reflect a family-centered approach and to identify specific areas for change. Available from Carolina Institute on Infant Personnel Preparation, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill, CB No. 8180, Highway 54 Bypass West, Chapel Hill, NC 27599-8180.

Dyer's Team Building Checklist. W. Dyer. (1987). A single-page tool for assessing group preparedness for a team-building program. Available from Team building: Issues and alternatives (2nd ed.). Reading, MA: Addison-Wesley.

Managing Quality Through Teams: A Workbook. L. Miller and J. Howard. (1991). A skills training workbook for team leaders and members who are working toward continuous improvement. Included are such topics as customer focus, process management, decision making, action planning, planning and managing team meetings, facilitating participation, and problem solving. Available from GOAL/QPC, 13 Branch St., Methuen, MA 01844-1953 (Telephone: 508-685-6360).

The Family Report: Consumer Opinion in the Quality of Services in Early Intervention Programs. P. J. McWilliam (1991). An instrument for determining family reactions to the services they receive and their desires for program changes related to family-centered practices. Available from Carolina Institute on Infant Personnel Preparation, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill, CB No. 8180, Highway 54 Bypass West, Chapel Hill, NC 27599-8180.

The Team Handbook. P. R. Scholtes. (1991). A "how to" book to help teams succeed in improving quality and productivity, and in their efforts to improve work processes. The approach focuses heavily on the work of W. Edwards Deming and on the understanding and application of data. These databased methods draw from the discipline of statistics and classical logic, which characterize Deming's teaching. Available from Joiner Associates, Inc. (Telephone: 1-800-669-TEAM).

Team Effectiveness Rating Scale. R. Neugebauer. (1983). A tool for examining team functioning in 10 different areas, including clarity of goals, openness of communications, and handling of conflict. Available from Child Care Information Exchange, November 1983.

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