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RELATIONSHIP COMPONENTS NEEDED FOR MARRIAGE AND FAMILY THERAPISTS TO WORK COLLABORATIVELY WITH HEALTH CARE PROFESSIONALS: A NATIONAL DELPHI STUDY

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RELATIONSHIP COMPONENTS NEEDED FOR MARRIAGE AND FAMILY THERAPISTS TO WORK COLLABORATIVELY WITH HEALTH CARE PROFESSIONALS: A NATIONAL DELPHI STUDY

By

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ABSTRACT

RELATIONSHIP COMPONENTS NEEDED FOR MARRIAGE AND FAMILY THERAPISTS TO WORK COLLABORATIVELY WITH HEALTH CARE PROFESSIONALS: A NATIONAL DELPHI STUDY

By

Laura Ann Myer-Mohr

The purpose of this study was to identify the relationship components needed for Marriage and Family Therapists (MFTs) to work collaboratively with Health Care Professionals (HCPs). The study focused on four major objectives: 1. to identify core components needed for MFTs to work collaboratively with HCPs; 2. to validate by obtaining consensus of MFT practitioners working in collaborative practice (Delphi procedure) those components that are VERY IMPORTANT and IMPORTANT for collaborative work; 3. to identify demographic factors which differentially affect the reported significance of components; and 4. to propose a **Collaboration Inventory** (CI) for use in further development of evaluative measures of collaborative practice.

A four-phase methodology was used to attain the stated objectives. Phase 1 identified core components of the collaborative relationship from a review of literature relevant to collaboration. In phase 2 a Collaboration Inventory was constructed. The inventory consisted of three sections. 1. Background Information (four demographic variables and two qualitative items); 2. A list of Collaborative statements (99 items); and 3. Rank Order section (five general components and 26 sub-components questions). Phase 3 pilot tested the instrument. The Delphi procedure for obtaining opinions of a panel of experts was used in phase 4 to empirically validate the CI by obtaining

consensus of therapists working collaboratively regarding VERY IMPORTANT and IMPORTANT components on the CI revised from phase 3. Marriage and Family Therapists who belong to the Collaborative Family Healthcare Coalition composed the panel. Opinions were obtained in two rounds, using two CIs: Round 1 response rate was 49% (42) and Round 2, 58% (23). Feedback from Round 1 was given as frequencies of responses in each of the inventory items. Descriptive statistics included frequency, medians, and Leik's Formula to report the findings.

Major Findings of the Study

Panelists identified Domain Orientation and Interactive Process as VERY IMPORTANT with consensus rates of 58% and 63%, respectively. Components identified as IMPORTANT included Stakeholder and Shared Rules, Norms, and Structure with agreement levels of 55% and 75%. Finally, panelists agreed at a high level of consensus (80%) that Professional Autonomy was Not Important to the success of the collaborative relationship. In addition, panelists agreed at a high level of consensus (greater than 70%) that Mutual Respect, Common Purpose, and Frequency of Communication are VERY IMPORTANT, Orientation and Mode of Communication are IMPORTANT, and Action/Decision, Shared Support Staff, and Hierarchy within the Relationship are Not Important.

Implications of this study are for improved skills for MFTs working with HCPs and for the initial steps towards the development of an instrument that will enable the further understanding and validation of the Collaborative Healthcare process.

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CHAPTER 1

Introduction

The intention of this study is to identify the key components of a collaborative relationship among marriage and family therapists (MFTs) with health care professionals (HCPs). Over the last few decades, more MFTs and HCPs have been working together, or collaborating, to better serve individuals and families. To successfully accomplish the work in this new dimension of healthcare, it has been necessary for mental and physical healthcare professionals to strengthen existing knowledge and skills plus learn new collaborative knowledge and skills. A comprehensive collaborative model that identifies the necessary components for working together would provide much needed information for these individuals who are forging a new professional path. The findings from this study will assist individuals currently engaging in collaborative practices and provide a useful tool for emerging professionals with an interest in collaborative healthcare. A collaboration model would, in addition, allow for further development of collaboration in healthcare by facilitating research about the impact of collaboration on patient care.

This chapter will cover the need and significance of this study, the purpose and research questions, and definitions for this study. The next section presents a brief overview of the background on collaborative family healthcare and establishes the need for further investigation of the key components of a collaborative relationship.

Background Information

Medical family therapy, or what is now known as Collaborative Family Healthcare, is a sub-speciality of marriage and family therapy. Collaborative Family Healthcare is considered by many as the 'third wave' of interest in this area. This sub-speciality is understood best within the context of its historical evolution.

The first wave of interest occurred in the 1920's and 1930's which primarily began with a recognition of the importance of the family and social context in individual healthcare (Ransom, 1981). The second wave of collaborative family healthcare, occurring between the 1950's and the 1970's, included several significant developments. Primary developments included both family therapy and family medicine evolving as independent disciplines and the advent of community health centers (Seaburn, Lorenz, Gunn, Gawinski, and Mauksch, 1996).

The third, and considered by some to be the most productive wave, has included several advancements. One of the most significant advancements of this time was the identification and explanation of the biopsychosocial model by George Engel (1977). This model provided a broader way of looking at individuals, acknowledging that biology, psychology, and social environment all contribute significantly to an individual's well-being. This model moved the health care paradigm beyond the traditional reductionistic biomedical model. In addition, family focused professional organizations were integrating some of the previous developments into their professions. In medicine, the Society of Teachers of Family Medicine held the first "Family in Family Medicine"

conference in 1981 and identification of the 'family as patient' became a professional theme (Alper, 1994). The journal entitled "Family Systems Medicine" began publication in 1983. This journal, now called "Families, Systems, and Health" was a journal representing the "confluence of family therapy, systems theory, and modern medicine" (McDaniel, Hepworth, Doherty, 1992, p. 21). Within MFT, professionals began emphasizing the integration of physical and mental well being. In 1992, McDaniel, Hepworth and Doherty coined the phrase 'Medical Family Therapy', which began a new, clearly identified sub-speciality within marriage and family therapy.

Although more recent developments have been significant, a "new wave" has yet to be identified. These developments are represented by a notable shift in terminology. Although in 1992 'Medical Family Therapy' was identified as a unique professional emphasis that joined medicine and therapy to better serve individuals and families, the current phrase 'Collaborative Family Healthcare' was not proposed until 1996 (Seaburn et al., 1996). Collaborative Family Healthcare is a term that expands beyond joining two professions together and moves into a more integrative paradigm. This paradigm suggests a broader, more holistic perspective regarding health and wellness. Collaborative Family Healthcare also expands beyond the partnership of physicians and therapists to include other healthcare professionals as well as families (Seaburn et al., 1996).

Recently, several areas of research have been identified within the collaborative family healthcare movement as necessary to the advancement of the field. General research areas include "refining and operationalizing models of collaborative care,

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conducting outcome research on collaborative approaches, expanding collaboration with medical specialities and sub-specialities beyond family medicine, and on influencing decision makers in health care policy and managed care " (Bischof, 1999, p. 7). This project is the first step in an effort to further some of the objectives identified above.

This project strives towards operationalizing a model of collaborative healthcare. A professionally validated Collaboration Inventory will help to refine and operationalize a comprehensive model of collaboration. It will begin the process of developing a tool for conducting outcome research on collaborative approaches and allow for application of the model to other medical specialities and sub-specialities. This inventory can be used in research outcome studies of collaborative healthcare to influence decision makers and to affect the growing potential of marriage and family therapy as a profession.

Significance

The primary aim of this project is to identify key components of the collaborative relationship of MFTs with HCPs. As there is no standardized model of collaborative healthcare, there is tremendous variety in the way individuals engage in this process. Students in MFT or health care training programs, professionals engaging in collaborative clinical practices, and university instructors have begun to incorporate collaborative healthcare into their respective programs. The presence of collaboration within both physical and mental health care is no longer a small sub-speciality but for many the image of tomorrow (McDaniel, 1993).

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Existing literature emphasizes many concepts surrounding the collaborative relationship, however it is not focused on actually examining the relationship between practitioners. Research studies dating back to 1967 explored the impact of mental health services on patient well being and health care utilization (Follette and Cummings, 1967). Some of the impetus for interest in the mental and physical health care partnership comes from the visibility of mental health problems in medical care practices (Shemo, 1985; 1986). A further discussion of cost off-set studies and the connection with mental health problems in medical settings is developed in Chapter 2.

More recent studies have begun to examine collaboration and its impact on patient health care. Collaboration in these off-set effect studies, however, is still limited to a dichotomous variable, present or absent (Belar, 1995). Much descriptive writing has also been done in order to share different collaborative models in different settings, however little empirical research has been conducted around this professional arena. Finally, a few qualitative studies have begun to explore the complexity of the collaborative relationship (Bischoff, 1999; Bischof, in press).

This project utilizes the Delphi methodology. This methodology allows experts in the field to identify and validate components and sub-components considered very important or important to the success of a collaborative relationship. These components and sub-components will form a model of collaboration. This model of collaboration will result in an inventory for future use in measuring the impact of collaboration on patient and family well being.

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Purpose

The intent of this project is twofold. First, this project will identify the very important and important components of collaborative practice among marriage and family therapists with health care professionals as perceived by practicing experts. Second, this verification process will result in a more comprehensive collaboration model that can be used to develop an inventory in the future to evaluate collaborative practice. The following objectives will be accomplished by this study:

1. To identify core components needed for MFTs to work collaboratively with HCPs.
2. To validate by obtaining consensus of MFT practitioners working in collaborative practice (Delphi procedure) those components that are VERY IMPORTANT and IMPORTANT for collaborative work.
3. To identify demographic factors which differentially affect the reported significance of components.
4. To propose a **Collaboration Inventory** (CI) for use in further development of evaluative measures of collaborative practice.

Research Questions

The following research questions were developed to accomplish the identified objectives and achieve the project purpose. The questions are divided by subject category.

Collaborative Components (Objectives 1 and 2)

1. What are the VERY IMPORTANT **components** of a collaborative relationship of an MFT with an HCP?

2. What is the *degree of consensus* regarding VERY IMPORTANT components of collaborative practice?

3. What are the IMPORTANT **components** of a collaborative relationship of an MFT with an HCP?

4. What is the *degree of consensus* regarding IMPORTANT components of collaborative practice?

Collaborative Sub-Components (Objectives 1 and 2)

5. What are the VERY IMPORTANT **sub-components** of a collaborative relationship of an MFT with an HCP?

6. What is the *degree of consensus* regarding VERY IMPORTANT sub-components of collaborative practice?

7. What are the IMPORTANT **sub-components** of a collaborative relationship of an MFT with an HCP?

8. What is the *degree of consensus* regarding IMPORTANT sub-components of collaborative practice?

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Collaborative Items (Objectives 1 and 2)

9. What are the VERY IMPORTANT **items** of core components of a collaborative relationship of an MFT with an HCP?

10. What is the *degree of consensus* regarding VERY IMPORTANT elements of core components of collaborative practice?

11. What are the IMPORTANT **items** of core components of a collaborative relationship of an MFT with an HCP?

12. What is the *degree of consensus* regarding IMPORTANT elements of core components of collaborative practice?

Demographic Factors (Objective 3)

13. What demographic factors are associated with consensus regarding VERY IMPORTANT and IMPORTANT **components**?

14. What demographic factors are associated with consensus regarding VERY IMPORTANT and IMPORTANT **sub-components**?

15. What demographic factors are associated with consensus regarding VERY IMPORTANT and IMPORTANT **items** of core components?

Definition of Conceptual Terms

Marriage and Family Therapists: includes members of the mental health care profession self-identified as primarily practicing therapy from a systemic paradigm

Health Care Professionals: includes physicians, nurses, nurse practitioners, and physicians assistants

Collaborative Healthcare: includes members of the mental health and physical health care professions working together regarding patient wellness

Components: broad categories of relationship characteristics identified as relevant to the process of collaboration

Sub-Components: dimensions of components further identified for clarification

Inventory items: individual factors that contribute to the understanding and definition of the sub-component

Collaboration Inventory: a list of items identified by practicing Marriage and Family Therapy experts as important or very important to the success of collaborative practice with Health Care Professionals

Very Important: those items ranked by panelists as Very Important on the Collaboration Inventory

Important: those items ranked by panelists as Important on the Collaboration Inventory

Delphi Study: methodology used to produce convergence of group consensus through a series of questionnaires regarding a topic of interest

Consensus: the extent panelists concur in their ranking per inventory question is considered degree of consensus

Demographic Factors: includes gender, primary work function, current employment setting and years in collaborative practice

For a more thorough discussion of terms and for operational definitions, see Chapter 3 Methodology.

Overview of Subsequent Chapters

Chapter one has described the need and significance of this study. It has identified the purpose of this study and defined relevant research questions. Chapter two provides a review of the relevant literature regarding the integration of mental and physical health, empirical support for this partnership, collaborative healthcare models, the theoretical perspectives and models for this project and a review of the research methodology and its appropriateness for this project. Chapter four reviews the findings of the study and Chapter five provides a summary of the project, discussion of the findings, implications, researcher observations, limitations, and recommendations for future research.

CHAPTER 2

Literature Review

Introduction

A major initiative in the Marriage and Family Therapy field is the development of alliances with health care professionals as a means of improving client well-being and reducing healthcare costs (Rinaldi, 1985). This association has come about for a variety of reasons. The affiliation first began as a result of the recognition of the integration of physical and mental health. Research studies followed the recognition and explored the impact of psychotherapy services provided within the medical arena. Present day health care services often provide some level of collaborative care between physical and mental health care professionals. This care is the result of the previous initiatives in research and practice as well as a product of third party managed care.

This project is an effort, in keeping with the evolution of health care, to further explore the relationship of Marriage and Family Therapists collaborating with Health Care Professionals. The following discussion expands upon the empirical and theoretical components relevant to the development of this study. The review begins with an exploration of the integration of mental and physical health, including the presence of mental illness in medical care. The literature on the changing primary care climate and the need for psychotherapy in the medical world provides some of the background on this integration. Next, a review of empirical studies provides insight into the evolution of research in the field of collaborative health care. This section looks at traditional off-set effect studies as well as collaborative off-set effect studies, including

the few existing studies that explore the complexity of the collaborative relationship. The next section focuses on the development of Collaborative Healthcare models including the most recent and influential model to date. Following that section is a discussion of the theoretical paradigms that influence this study. The conceptual model for this study is then presented. This model evolved from an integration of Collaborative Healthcare models with Wood and Gray's (1991) Theory of Collaboration. Finally, a review of the literature on the research methodology used for this study is included.

Integration of Mental and Physical Health

Mental illness in medical care

Individuals with mental illnesses have always required assistance from the medical field. Years ago, mental illness was considered an illness only if a neurological disorder was present (Engel, 1977). As time passed, psychiatrists, psychologists and other professionals within the mental health field began recognizing the full realm of psychosocial disorders that existed. Despite the fact that professionals both in and outside the medical field were recognizing a distinction between neurological and psychosocial disorders individuals struggling with various mental illnesses continued to be treated predominately within the medical field (Baughman, 1994; Mauksch & Leahy, 1993; Shemo, 1985). In a survey conducted in 1975 by the National Institute of Mental Health, for example "800,000 patients with mental illness were treated in mental hospitals while 900,000 were treated in general hospitals, 300,000 in VA facilities, 200,000 in nursing homes, and **13,000,000** (emphasis added) in the offices of

non-psychiatric physicians." (Shemo, 1985, p. 21). Although these figures are twenty years old, mental health treatment is still primarily provided by physicians through the use of psychotropic medications (Baughman, 1994; Mauksch & Leahy, 1993).

Health care has changed in the last two decades. Health care has moved from an era of medical specialization to an emphasis on preventative general health care (Belar, 1995). This has affected the role of the general practitioner who has become increasingly important (Alper, 1994). In 1985, 67% of hospitalized patients had diagnosable mental illnesses (Shemo, 1985). Currently, the percentage of individuals within hospitals who are diagnostically mentally ill has decreased, but mental illness diagnoses has surged within primary care facilities (Baughman, 1994). As recently as 1994 "77% of all mental health visits are to primary care physicians." (Baughman, 1994, p. 374). Mental illness has shifted to predominantly presenting in primary care instead of within hospitals. This shift reflects the current change in healthcare.

The Primary Care Climate and Managed Care

Health care managed by a third party payor (e.g. insurance companies) is increasingly becoming the form of healthcare delivery (Alper, 1994). Managed health care is quickly changing the role of primary care (Sandy, 1995). Primary care physicians are heavily relied on to treat larger, more varied populations in shorter spans of time (Emanuel & Duhler, 1995). Primary care physicians are expected to manage the total health of their patients, including physical and psychosocial "wellness" (Glasser & Sterns, 1994). Time constraints make it difficult for these physicians to spend quality time with their patients. Communication and rapport building are not reimbursable acts

and consequently difficult for the physician to accomplish (Emanuel & Duhler, 1995; Glasser & Sterns, 1994). Primary care physicians have become "gatekeepers" to their patients' health care, therefore most medical care needs, regardless of the illness, must be funneled through the primary care physician (Alper, 1994; Emanuel & Duhler, 1995).

Today, mental illness is highly present in primary care practice but not well addressed (Fogel, 1993; Glasser & Sterns, 1994; VonKorff, 1992). According to Miranda et al. (1991) 40-60% of individuals presenting for primary care visits present symptoms with no biomedical issue, 5-34% have actual mental health diagnoses. The change in the management of health care necessitates patients viewing their primary care physician as an overall "wellness" doctor, ultimately placing too heavy a burden on the primary care physician (Marcus, 1989). Primary care physicians struggling to balance the high demands of managed care companies with quality patient care sometimes results in the neglect of psychosocial disorders. Recognizing and/or treating psychosocial issues is difficult for primary care physicians due to limited training and time constraints (Fogel, 1993; Russell & Roter, 1993; Hepworth & Jackson, 1985; Katon, et al., 1990; Tomson, 1990). Primary care physicians manage to accurately recognize patients with mental illnesses and/or psychosocial disorders only about 50% of the time (Glasser & Sterns, 1994; Mauksch & Leahy, 1993). These changes in health care open up a variety of opportunities for mental health specialists, especially for marriage and family therapists (Patterson & Scherger, 1995; Crane, 1995a; Crane, 1995b).

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The Need for Psychotherapy in the Medical World

The face of health care is changing. Preventative care and wellness are becoming common themes (Alper, 1994; Emmanuel, 1995). Alternative and holistic medicine are more commonplace domains in medical school (Marcus, 1989). The recognition of the mind/body connection is an obvious step in the direction of holistic medicine. An integration of psychiatric care can occur within primary care (Belar, 1995; Shemo, 1985). According to Fogel (1993), a very complex relationship exists between physical and psychological illness. To distinguish between the physical and psychological, especially in primary care, is arbitrary (Glasser & Sterns, 1994). Within the range of "normality," there is an association for most individuals between physical complaints and emotional well-being (Dworkin, VonKorff, & LeResche, 1990).

Empirical Support

There have been various empirical studies relevant to the union of the mental and physical health care fields. These can be categorized into three groups: traditional off-set effect research, collaborative off-set research and the most recent research on the collaborative relationship. The following sections will explore further these three groups.

Off-set Effect Research

The strong presence of mental illness in primary care settings has initiated studies exploring the impact of a referral by a physician to psychotherapy on health care utilization. A few studies have been conducted regarding the effectiveness of therapy or counseling on medical care utilization. This research has been called 'offset' effect

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research, defined as "an offset effect occurs when the use of mental health services leads to a reduction in the use of other health or social services, thereby potentially defraying some portion of the cost of the provision of the mental health services by the savings realized in other components of the health care system" (Shemo, 1985 p. 19-20).

Off-set effect research began with Follette and Cummings' (1967) ground breaking study suggesting that a medical care utilization decrease would follow psychotherapeutic services. Recent studies continue to demonstrate a decrease in utilization of medical care following psychotherapy (Budman, Demby, & Randall, 1982; Katon, et al., 1990; Mumford, et al., 1984; Shemo, 1985). Forester, Kornfeld, Fleiss, and Thompson (1993) studied the effects of psychotherapy and recognized a decrease in both emotional and physical symptoms.

Collaborative Off-set Effect Research

A few research studies have begun to look at, or at least label, the physician/therapist relationship as a collaborative effort (VonKorff, et al., 1998). Collaborative care, however, is more often than not identified as a dichotomous variable, present or absent. VonKorff, et al. (1998) found that a model of collaborative care that includes either physician care accompanied by a psychiatric visit, or physician care accompanied by brief psychotherapy reduced health care utilization for patients diagnosed with major depression. The findings included a greater decrease in utilization than patients treated only by their primary care physician (VonKorff, et al., 1998). Finally "the cost per patient successfully treated was lower for Collaborative Care than

for Usual Care patients" (VonKorff, 1998, p. 143). This study is one of the few to date that examines the complexity of collaborative care.

Collaborative Relationship Research

Most studies of collaborative health care are outcome studies that focus on cost and psychotherapy benefit to the patient. A few studies (Bischof, 1999; Bischoff & Brooks, 1999) have emerged that take a qualitative look at the dynamics of the collaborative relationship. Recently, Bischof (1999) conducted a phenomenological study exploring the experiences of several mental health providers working collaboratively in non-academic health care settings. This study qualitatively identified perceived pros and cons of working collaboratively, ethical and reciprocal issues of working collaboratively and collaboration in rural settings. Bischof (1999) also included recommendations for mental health providers interested in working collaboratively.

A second qualitative project (Bischoff & Brooks, 1999) is exploring issues around training and education of individuals interested in medical family therapy. This ongoing study utilizes a Delphi methodology with a data collection method using open ended questions. These authors are seeking "to determine the knowledge- and skill-based competencies that mental health practitioners need for successful collaborative practice" (Bischoff and Brooks, 1999). Bischoff and Brooks (1999) are focused on constructing a training model for mental health practitioners. This dissertation project is timely in that it takes the much needed step of quantitatively explicating the collaborative relationship to the next level.

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Collaborative Healthcare Models

Understanding and exploration of the collaborative health care relationship has evolved in several different ways, from emphasis on off-set effect studies to initial exploration into the collaborative relationship. This evolution has also produced an abundance of literature, much of which is anecdotal in nature, describing collaborations throughout the country. While many marriage and family therapists are working collaboratively with physicians, and sharing this experience within the field, very little is empirically based. A few models have been put forth in an attempt to capture the dynamics of this relationship. Three of the most influential models will be discussed in this section, including: The Medical Family Therapy Model, The Level of Collaboration Model, and The Collaborative Healthcare Model. These models are progressive models as each builds on the previous one, and are presented chronologically.

The Medical Family Therapy Model

This first attempt at categorizing types of collaboration provided many necessary tools, including introducing the phrase Medical Family Therapy and introducing the concept of 'bump-in-the-hall' conversations. Medical Family Therapy as the first of these models suggested three types of collaboration: indirect consultation, co-therapy, and limited referral (Hepworth & Jackson, 1985). Indirect consultation involves brief interactions between physician and therapist offering "suggestions, support, or supervision" (Hepworth & Jackson, 1985, p. 124). This type of collaboration categorized the "in-the-hallway" interaction common in the medical profession (McDaniel, Hepworth, & Doherty; 1992). The second type of collaboration,

co-therapy, is the least common and involves both physician and therapist present during a family consultation (Hepworth, 1985). Finally, limited referral is said to be the most common form of collaboration, even today (Seaburn et al., 1996). Limited referral involves the process of one professional referring patients to another professional. This model is often used when professionals are physically separate in location, and usually results in each professional providing "parallel" services (Hepworth & Jackson, 1985). The contributing factors of this model would be the recognition of Medical Family Therapy as a speciality within Marriage and Family Therapy, and suggesting different types of relationships between physician and therapist.

The Levels of Collaboration Model

At the first annual conference of the Collaborative Family Healthcare Coalition in July 1995, William Doherty introduced a model that highlighted the new concept of collaboration. This concept focusing on collaboration, broadened the understanding of the relationship between physician and therapist in several ways. One of the most significant ways that was identified was to include a variety of health care professionals, no longer limited to physicians, encompassing nurses and other health care workers. Doherty's model (1995) suggests different levels for working collaboratively; "the levels refer both to the extent to which collaboration occurs and to the capacity for collaboration in a given health setting as a whole" (p. 277). Five different levels of collaboration that increase hierarchically are part of this model from minimal collaboration at level one to greater systemic collaboration at level five.

Level 1: *minimal collaboration*. This level is characterized by professionals working at separate sites providing separate services with little to no interaction regarding patient care. This form of collaboration is most often seen in private practice and is similar to the limited referral model above.

Level 2: *basic collaboration at a distance*. This level is similar to Level 1 in that professionals practice at separate locations however communicate occasionally regarding patient care. Active referrals occur and recognition of the other professional as a resource is present at Level 2.

Level 3: *basic collaboration on site*. This level is distinguished primarily by proximity; professionals are often located in the same physical location. Professionals maintain separate management systems, such as charting, billing, and so forth. The two professionals, however, experience regular communication via phone/letter or 'bumps-in-the-hall' due to their physical location.

Level 4: *close collaboration in a partly integrated system*. This level is characterized by the beginnings of an allegiance to a biopsychosocial paradigm; professionals engage in regular face-to-face meetings, coordinate treatment plans, and develop the beginnings of an understanding of each other's culture. Finally, some systems are shared, such as charting and scheduling. Levels 3 and 4 are similar to the indirect type of collaboration mentioned previously.

Level 5: *close collaboration in a fully integrated system*. This level is rare, however a suggested "vision for the future" (,Doherty, 1995, p. 279). Physical and mental health professionals share a biopsychosocial vision of shared services, systems

and treatment plans. Mutual conscious effort is made to attend to professional relationship issues such as balance of power and influence based upon professional expertise. Level 5 is similar to the co-therapy type of collaboration initiated by Hepworth and Jackson (1985). Doherty (1995) acknowledges this level as rare in actual practice, but providing a goal for future collaborators.

Doherty's levels of collaboration provided much need expansion into the complex relationship of collaborative healthcare. These groundbreaking levels of collaboration remain one of the most predominant collaborative models in the field of collaborative healthcare. Doherty's levels of collaboration were the foundation for the most recent and thoroughly developed model of collaboration to date, described below. The relationship components that Doherty identifies as key include: physical location, physical facilities, communication patterns, professional culture, paradigm, and attention to the professional relationship. The most recent model, Collaborative Health Care, is based upon Doherty's key components (Seaburn et al., 1996).

Collaborative Health Care: The Rochester Model

One of the most visible and published groups that work collaboratively in mental/physical health care is the Rochester group, located at the University of Rochester, New York. This group published a text "Models of Collaboration; A Guide for Mental Health Professionals Working with Health Care Practitioners" (Seaburn et al., 1996) that reveals their comprehensive model of collaboration. The breadth and depth of collaborative relationships is presented similar to Doherty's (1995) levels with significant additional factors relevant to collaborating. Seaburn et al. (1996) further

define health care professionals and include patient/family into their definition of collaboration.

Relevant to this study, the text also includes the "best current thinking" (Seaburn, et al., 1996, p. 92) elucidating what this group considers to be the core components of a collaborative relationship. This text reviews much of the existing literature and identifies six core components of a successful collaborative relationship. The components are communication, common purpose, paradigm, relationship, location of services, and business arrangement, see **Figure 1** (Seaburn, et al., 1996). The following are summaries of the ingredients of these components with breakdowns according to areas of emphasis.

- Communication. Understanding of cultural norms regarding rules for and forms of communication (e.g. mode, frequency, confidentiality, language, content)

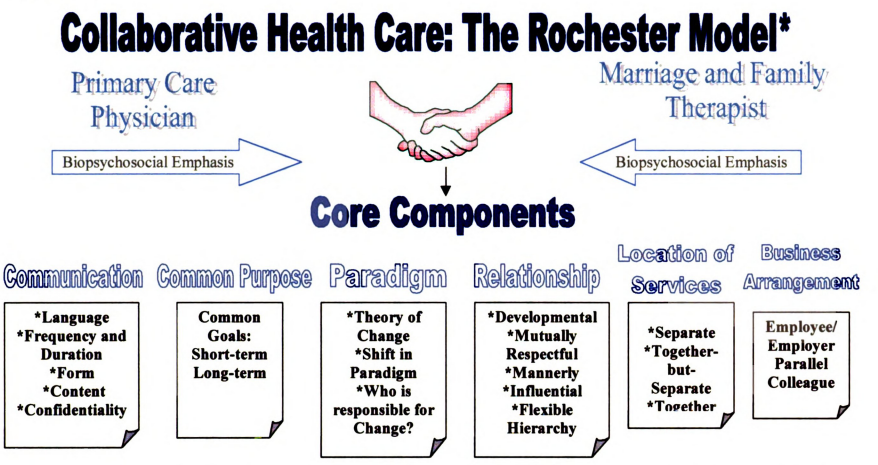
  Mode: the method for communication (phone calls, e-mail, letters, face-to-face meetings)
  Frequency: how often Therapist and Health Care Professional communicate regarding patient care
  Confidentiality: clarified understanding of professionally dictated code of ethics around confidentiality
  Language: degree of shared jargon/language; breakdown of communication/lack of understanding
  Content: development of an understanding regarding what information will be shared

- Common Purpose. Professionals unite around common goal; at the heart of collaboration is the desire or need to solve a problem, create or discover something; short term goals may differ, however each contributes to overarching collaboration goal

- Paradigm. Respective paradigms may not be shared, however cannot be mutually exclusive; may evolve or *shift* as time passes (biomedical/psychosocial to *biopsychosocial*)

Figure 1:

Figure 1:



*Core components identified as 'Rochester model' as discussed in Seaburn et al (1996) "Models of Collaboration" Basic Books, New York, NY.

*Illustration of Core Components designed by Laura A. Mohr, 11-3-97

- Relationship. Basic relationship issues are relevant to collaboration. Specifically included are trust and mutual respect. The relationship is developmental in nature and individuals also value interpersonal processes.

  Developmental: building trust as relationship matures, increased personal communication
  Value Interpersonal Processes: professionals place value on the process of interaction with others
  Mutual Respect: respect validity of each participant's perspective; value each participant's expertise

- Location of Services. geographic location of providers; close proximity enhances collaboration. Three models are proposed:

  Separate - separate locations, separate systems (office, charts, staff, etc.)
  Together-but-Separate: shared location, separate systems
  Together: shared location, shared systems

- Business Arrangement. Recognition of the financial arrangement is relevant as issues of hierarchy and power can impact a collaboration. Three types of business arrangements are suggested:

  Employer/Employee: includes one individual employed by another; hierarchy is often traditional and potentially impedes collaborative process; this situation is also rare
  Parallel: professionals have separate facilities and have parallel financial arrangements; currently the most common arrangement, expected to change as managed health care continues to evolve
  Colleague: professionals are part of a larger managed care system; financial differences may exist, however mismatch of power is not present as with employer/employee

Seaburn et al. (1996) suggest the aforementioned as key aspects of a collaborative relationship. It is important to note that these are derived from their collective experiences and have not been validated through research. Seaburn et al. (1996) call for further research in this area.

Theoretical Perspectives and Models

Several models and frameworks contribute to the integrated theory of collaboration for this research. The ecological and biopsychosocial perspectives serve as background theories. The theory of collaboration used in this study is partially based on aspects of negotiated order theory (Gray, 1989). All three theories, human ecology, biopsychosocial, and collaboration are integrated into the overall theoretical model guiding this project. These theories, as applied to collaborative health care, are reviewed in this section. Finally, an overview of the conceptualization of this project concludes this section.

Ecological perspective

Several of the basic premises of the human ecology theory provide a background or macro theory of this project. Human Ecology theory (Buboltz & Sontag, 1993) looks at humans as biological as well as social beings in constant interaction with the environment; humans as a product of their environment and heredity. Early development of ecology theory recognized the importance of holistic and interdisciplinary approaches that linked science and theory to practice and the improvement of human lives (Buboltz & Sontag, 1993). Present day ecology brings with it an expansion of the scope of environment to include broader systems, such as health care (Buboltz & Sontag, 1993). Edgar Auserwald (1968) stated "Rather than starting with the perspective of separate disciplines or service agencies, an ecological perspective starts with the whole; thus it has the potential to avoid fragmentation of knowledge, service, and support" (p. 424).

The collaborative health care movement emphasizes several points congruent with human ecology theory. Collaborative health care is based upon the premise that individuals are products of both physiological as well as psychological traits, or a biopsychosocial approach (see below for further discussion of the biopsychosocial model). As an interdisciplinary approach, collaborative healthcare strives to bring together members of the physical and mental health care professions both in theory as well as in practice. Finally, a key aspect of human ecology theory is the interaction between individual and environment; physical, social and cultural environment. This paradigm is congruent with the philosophy of both marriage and family therapy and family practice. It is no coincidence that the majority of providers who practice collaborative health care operate within these professions.

Several factors influence our present day understanding of health and well being. These factors include human ecosystems theory, interdisciplinary approaches to problem solving and the evolved understanding of the interaction between individual and environment. The interplay of these factors is further articulated by George Engel in the biopsychosocial approach to healthcare.

Biopsychosocial model

The biopsychosocial model, first formalized by Engel in 1977, demonstrates the initial steps towards an integration of the mind/body paradigms. The biomedical model has been defined as "a model of the workings of natural phenomena" and the biopsychosocial model as "a blueprint for how to think about natural phenomena" (Blount & Bayona, 1994, p. 174). It was originally thought that disease or physical

illness had only a biomedical root with molecular biology as its basic discipline. This perspective assumes that illness and wellness can be impacted primarily by medically treating deviations from the biological norm. This perspective does not allow for the impact of psychological, social or behavioral dimensions on physical well being. Engel (1977) in his groundbreaking paper, proposed a new paradigm; a new way of looking at physical wellness: "To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which (the individual) lives, and the complementary system devised by society to deal with the disruptive effects of illness" (p. 132). Engel called this new medical perspective 'biopsychosocial.'

The theory of human ecology and the biopsychosocial model provide broad background theories that contribute to present day attention to professional emphasis on pooling resources to manage increasingly difficult problems, or collaborating.

The Concept of Collaboration

Collaboration, or the coming together of organizations or systems to address and/or resolve a problem, is a workable application of a dimension of an ecological perspective to explain human behavior. As the professional arenas in our society struggle with issues such as economic and technical change, declining productivity growth, increasing competitive pressures, and shrinking federal revenues for social problems, (Sharfman, Gray, & Yan, 1991), the notion of collaboration is becoming very popular. Research on this phenomenon, however, is in its infancy. The notion of collaboration has been investigated in many fields, including education, business, and

within the medical profession. One of the most recent developments in research and literature that transcends any one profession is attention to collaborative relationships.

Collaboration is being examined and viewed as applicable to a wide variety of professions (Fishbaugh, 1997; Friend & Cook, 1992; Gray, 1989; Schrage, 1990; and Schrage, 1995). Barbara Gray (1989) has done some of the most notable research on the process of collaborating. Gray addresses the notion of collaboration in its broadest sense as applicable to many different professional arenas in her book Collaborating (1989). In addition, Warren Bennis (1997) in his book discusses the "secrets of creative collaboration" primarily in business/management fields. Finally, Michael Schrage in his first book Shared Minds (1990), (revised as No More Teams! (1996)) also examines the collaborative process as applied to business/management environments. Some scholarly works recount the process of developing a collaborative relationship (Medalie & Cole-Kelly, 1993; Hepworth & Jackson, 1985). Some scholars speaks to the process of working collaboratively (Muchnick, Davis, Getzinger, Rosenberg, & Weiss, 1993). Some other work recognizes the need for developing a collaborative relationship (Blount & Bayona, 1994; McDaniel, 1995).

Most of this work is individual and anecdotal with on-site descriptions. Individuals in healthcare and other professions are making more collaborative efforts yet an understanding and evaluation of this phenomenon remains unexplored.

Negotiated Order Theory

Several authors, with specialities ranging from organizational behavior to health care, have attempted to develop a full conceptualization of collaboration. Gray (1989) made one of the first attempts at developing a theory of collaboration, based upon the theory of negotiated order.

Negotiated order theory examines the process by which individuals in organizations determine how things are accomplished (Day & Day 1977). Strauss, Scatzman, Bucher, Ehrlich, and Sabshin (1963) explored the relationship between doctors and nurses working in a psychiatric hospital setting. They found that many individuals did not adhere to company policies and manuals (rational bureaucratic theory), nor did they adhere to simply adhere to the writings of their individual professions (theory of individual professions). Rather "an informal structure emerges in which the involved parties develop tacit agreement and unofficial arrangements that enable them to carry out their work" (Strauss et al., 1963, p. 130). These informal negotiations often supercede the formal structure of the organization.

Day and Day (1977) further address the notions of negotiated order theory. In organizations individuals bring with them many different aspects of themselves, including- but not limited to- training, professional socialization, experience, and personal backgrounds. Negotiated order was found to be a means of bringing together these differences to enable individuals to work together and resolve conflict- via informal, or negotiated, means.

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Negotiated order theory furthers the understanding of the collaborative relationship between MFT's and HCP's. Much of the literature suggests that collaborative relationships are both a formally and an informally negotiated relationship as well as far from permanent arrangements (Hepworth & Jackson, 1985; Medalie & Cole-Kelly, 1993; Seaburn, et al., 1996).

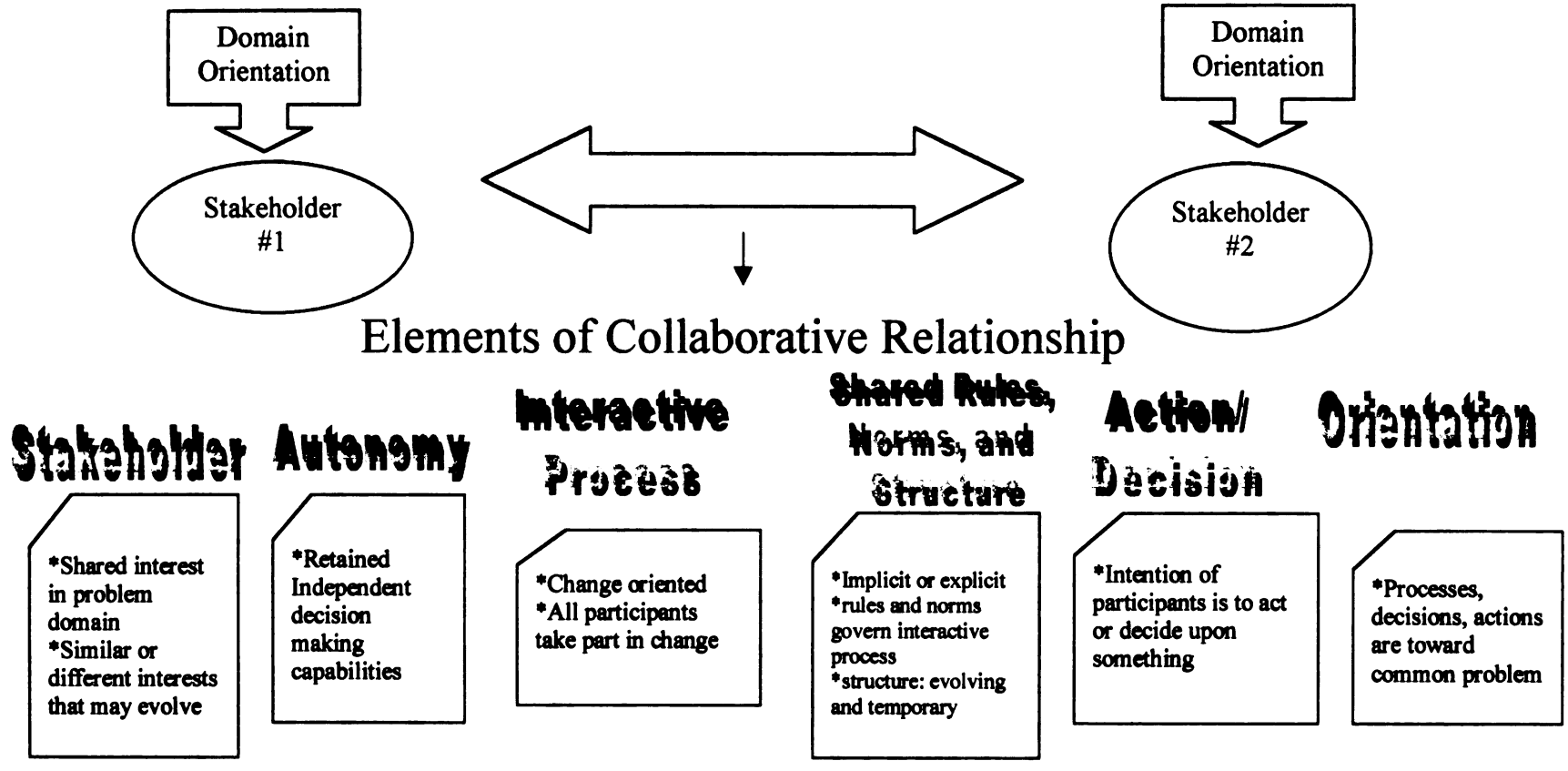
A Theory of Collaboration

In the development of a theory of collaboration, Gray states that "no single theoretical perspective provides an adequate foundation for a general theory of collaboration" (Gray & Wood, 1991 p. 3). In 1991, Gray and associates explored collaboration to develop "a deeper, more systematic understanding of the theoretical issues involved in forming and maintaining collaborative alliances" (p. 4). A comprehensive review of case research and theoretical analysis to date is provided by Gray and Wood (1991) in their paper in the special issue of the Journal of Applied Behavioral Science on collaborative alliances. The result is a definition of collaboration that includes suggested core components: *"Collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structure, to act or decide on issues related to that domain"* (Wood and Gray, 1991 p. 146).

This broad definition of collaboration includes several components (see **Figure 2**). The following are summaries of these concepts (Wood & Gray, 1991).

Figure 2: *A Theory of Collaboration** Wood and Gray

Figure 2: A Theory of Collaboration* Wood and Gray



*Collaboration theory as discussed in Wood & Gray (1991). Toward a comprehensive theory of collaboration. Journal of Applied Behavioral Sciences, 27 (2), 139-162.

*Illustration of Collaboration theory designed by Laura A. Mohr, 9-4-99

- Stakeholders: groups or organizations with an interest in the problem domain both may have common or differing interests in beginning, however they may evolve or be redefined as time, and the life of the collaboration, pass

- Autonomy: stakeholders retain their autonomous, independent decision making capabilities

- Interactive: a process; change-oriented relationship; all participants take part in the change

- Shared rule, norms and structures: can be implied in collaboration; usually, however stakeholders explicitly agree in rules and norms that govern interactions; shared structures; evolving

- Action or Decision: participants intend to act or decide, as a collaboration is directed toward an objective

- Domain orientation: participants orient processes, decision, and actions toward issues relating to the problem area that brought them together

These components will provide the structure and foundation for measuring and evaluating the collaborative relationship between health care professionals and marriage and family therapists. These components will be integrated with terms relevant to the health care setting using collaborative health care literature. The identification of this theory is central to being able to operationalize a study of collaborative relationships. The components provided in the collaboration literature, although not empirically based, are similar in nature to those suggested in the collaborative health care literature. This facilitates a smoother translation from broad, organizational terminology into relevant health care terminology.

The Integrated Model: Collaborative Relationship Components

The conceptualization of this study includes a background of both human ecology and biopsychosocial theory. The prominent, or foreground, theories for this study are a negotiated order based Theory of Collaboration put forth by Wood and Gray (1991) integrated with the Collaborative Health Care model put forth by Seaburn et al. (1996). Collaborative theory (Wood & Gray 1991) subsumes the core components of the collaborative health care model (Seaburn et al., 1996). The core components used in this study are:

- **Stakeholder**
- **Professional Autonomy**
- **Interactive Process**
- **Shared Rules, Norms, and Structure**
- **Action or Decision**
- **Domain Orientation**

The following section provides definitions for this study of the integrated core components and breaks the components down further into sub-components. An illustration of these components can be found on the conceptual map (**Figure 3**).

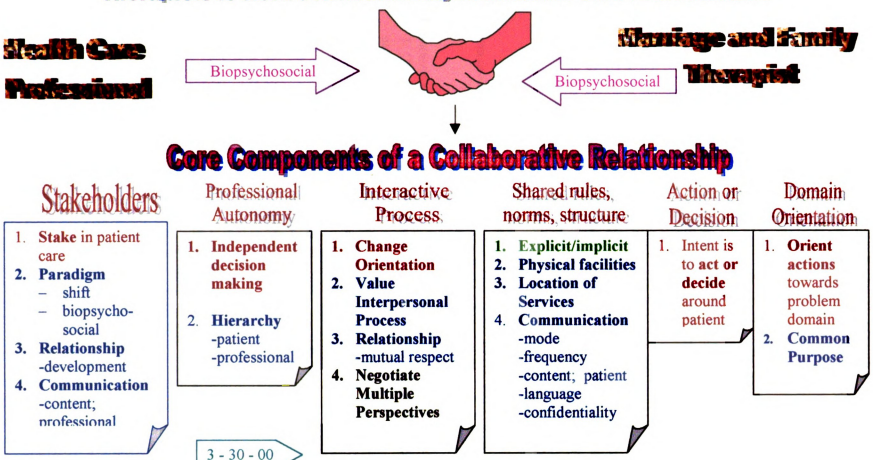
List and Definitions of Core Components for this Study

- **Core Component:** **Stakeholder:** The extent to which individuals have a stake in the patient care issues.

  Sub-components:

  1. Stake: Groups or organizations with an interest (*stake*) in the problem domain
  2. Paradigm: May evolve or *shift* as time passes (biomedical/psychosocial to *biopsychosocial*)

Figure 3: **Relationship Components Needed for Marraige and Family Therapists to work Collaboratively with Health Care Professionals**



*All visual illustrations compiled and designed by Laura A. Mohr

3. Relationship that develops:

-developmental: building trust as relationship matures, increased personal communication (see communication: professional)

-communication content: professional relationship begins with initial self disclosure (primarily indirect and through discussion of cases); discussion turns more often toward what is going on with the providers

- **Core Component:** **Professional Autonomy**: The skills and knowledge related to maintaining professional autonomy within the relationship.

Sub-Components:

1. Independent Decision Making: Stakeholders retain their autonomy
2. Flexible Hierarchy - Differential sharing of power, fluid hierarchy;

patient focus: professional with most expertise given the situation exerts most influence

professional focus: professional arrangement; one is employee of another, versus shared, equal power

- **Core Component:** **Interactive Process** The skills and knowledge related to the interaction between professionals.

Sub-Components:

1. Change Orientation: Relationship exists as participants intend to engage in some change
2. Value interpersonal processes: Professionals place value on the process of interaction with others
3. Relationship

Mutual Respect: respect validity of each participants perspective; value each participants expertise

4. Negotiate multiple perspectives: Process of negotiating a variety of perspectives

- **Core Component:** **Shared Rules, Norms, and Structure**: The extent to which individuals understand cultural rules and norms and the structure of the collaboration.

Sub-Components:

1. Explicit/Implicit: Can be explicit or implicit; usually explicitly agree on rules and norms that govern their behavior

Structure is usually temporary and evolving

2. Communication: Understanding of cultural norms regarding rules for and forms of communication (e.g. mode, frequency, confidentiality, language, content - patient focus)

Mode: the method for communication (phone calls, e-mail, letters, face-to-face meetings)

Frequency: how often Therapist and Health Care Professional communicate regarding patient care

Confidentiality: clarified understanding of professionally dictated code of ethics around confidentiality

Language: degree of shared jargon/language; breakdown of communication/lack of understanding

Content - patient focus: developed norm for communicating about individual patients' care; communication includes conversation regarding professional relationship dynamics

3. Provision of Services: Therapist and Health care professional provide services together or apart; separate services to joint comprehensive care

4. Location of Services: Geographic location of providers

5. Physical Facilities: Shared facilities (charts, support staff)

- **Core Component:** **Action or Decision**: The extent to which professionals intent to act or decide

Sub-component

1. Action/decision: process of collaboration is engaged in with the intent of resulting in an action or decision

- **Core Component:** **Domain Orientation**: Actions and decisions are oriented toward the patient's health care.

Sub-Components:

1. Orientation: Participants orient processes, decisions, and actions toward issues relating to the problem area that brought them together

2. Common Purpose: Professionals unite around common goal; short term goals may differ, however each contributes to overarching collaboration goal

These are the components suggested throughout the healthcare and organizational behavior literature (Seaburn, et al., 1996, Wood & Gray, 1991) as facilitating a successful collaborative relationship between health care professionals and marriage and family therapists. It has been suggested that "explorations of possible answers (to what the core components are) through experimentation with rigorous designs, both qualitative and quantitative, need to continue" (Seaburn, et al ., 1996, p. 92).

This project will examine each of these collaborative relationship components. Experts practicing in the field of collaborative health care will evaluate a collaborative inventory that itemizes each of the above components and sub-components. It is through feedback from practicing experts that the final product will emerge. As this is a new field with many individuals in collaborative practice but little existing research, the most appropriate methods for further examination into the core components are the Survey and Delphi methodologies. Literature discussing these methodologies is presented in the next section.

Use of the Survey and Delphi Methodologies

A review of the methodologies appropriate for this project is included in this section. The primary method of research is the Delphi Technique. The Delphi Technique involves obtaining a consensus of opinions about a topic from experts in the field (Stone Fish & Busby, 1996). the technique involves surveying panelists to obtain the consensus, a brief review of survey methodology is included.

The following is a discussion of both Survey research and Delphi research methodologies. Each topic address such issues as a general overview, historical roots, research questions appropriate, validity and reliability issues, and strengths/weaknesses of the methodology. Finally, the appropriateness of fit with this particular project will be included throughout the discussion. As this project primarily uses the Delphi methodology, a more developed discussion of this methodology will be provided.

Survey Methodology.

Warwick and Lininger (1975) define survey as "a method of collecting information about a human population in which direct contact is made with the units of the study (individuals, organizations, communities, etc.) through such systematic means as questionnaires and interview schedules" (p. 2). Survey research is a method of collecting data from or about a group of people, asking questions for the purpose of generalizing to a population represented by the group or sample. The sample is a subset of a population thought to represent the population. The variables for survey research are those areas of interest to the researcher. The questionnaire or survey is a list of questions that are given to individuals in the sample.

Warwick and Lininger (1975) noted that survey research is the most appropriate and useful methodology under the following three conditions:

1. When the data that are necessary to meet for the project objective is quantitative

2. When information is reasonably specific and familiar to respondents

3. When the researcher has considerable knowledge regarding the topic of interest and potential responses from participants

Babbie (1983) stated that survey research is probably the best method available to the social scientist interested in collecting data on a population too large to observe directly. Further, survey instruments provide mechanisms for additional data analyses later on (Babbie, 1983). In the case of this project, the inventory is created with the intention of further development into a survey instrument for use in future research projects.

Historical roots. Survey research is one of the oldest and most commonly used methods of research known. The 1930's and 1940's saw the beginning of survey research and sampling in the social sciences (Warwick & Lininger, 1975). Early scientist Rensis Likert was one of the individuals pioneering survey research into areas such as individuals' attitudes, beliefs, and behaviors (Likert, 1932). Likert is the scientist who originated the Likert scale so commonly used in research today.

Research questions/purposes. Research questions appropriate for survey research include inquiring about characteristics or descriptions of a certain population as well as questions related to behavior, beliefs, influences on behaviors or beliefs, attitudes, values, and/or the relationship between the variables. This project will inquire into opinions regarding influences on collaborative behavior. Survey research can move

to a higher level of investigation. Often when modes of inquiry are complex, a survey can be coupled with additional surveys or research methods to draw inferences or additional information. As this project's objectives include an examination of the complex relationship between two professionals, a sophisticated survey style, the Delphi Technique, was implemented.

Validity and Reliability. A discussion of reliability and validity issues is warranted with the survey methodology. Kerlinger (1996) recommends using statistical means to determine survey data's reliability. This project used statistical methods appropriate with the Delphi Technique (see Chapter 3 for a further discussion of the data analyses). Methods for enhancing reliability include clear, unambiguous questions and a good number of questions for all sub-sets of the questionnaire. The most significant factor regarding validity is that the questions are asking what the researcher is attempting to learn about (face validity). As mentioned, unambiguous, clear questions can impact this. Finally, response rates affect validity. The presence of systematic bias affecting which individuals do not respond, as well as individual factors among respondents such as mood, time of day, and so forth can impact the responses received.

Strengths and weaknesses. The greatest strength of survey research is the ability to gather large amounts of data from a large population (Nelson, 1996). Survey research, however, has significant weaknesses. The most significant weakness is that through each step of the process, error can be made thus resulting in invalid data. Researchers must cautiously and carefully conduct survey research. In addition, survey research is difficult to replicate, as there are many unknowns. Finally, survey research

often yields a good amount of data regarding statistical information, descriptions, distribution, and so forth, however, it is often up to the researcher, and/or reader to assign meaning to the findings. This is a significant area to proceed into with caution.

Delphi Methodology

The Delphi method is an opportunity to obtain the opinions and/or thoughts of individuals considered experts in a particular field (StoneFish & Busby, 1996). The Delphi method takes surveying to a higher level. This is done by not only surveying for opinions, but then sharing responses in a recursive manner, until hopefully some consensus is reached among the experts.

The process involves providing a forum of communication where experts respond with their opinion and/or knowledge regarding the topic of interest. The panelists are then provided feedback from other panelists, anonymously, and given an opportunity to adjust their viewpoints. The goal is to come to a group consensus regarding the topic of inquiry.

Underlying assumptions of the methodology. The primary assumption of the Delphi method is that "*n* heads are better than one" (Dalkey, 1972). This is evident in the distinction between basic surveys and the Delphi method. This process allows for more interaction and, ideally a consensus, whereas a survey of opinions might result in individual thoughts without the richness of the reciprocal process. The second assumption of the Delphi method is that of a greater concern with "the application of useful knowledge than with the attempt to define the truth"

(StoneFish & Busby, p. 470). This is the perspective that the Delphi method takes on the positivist versus post positivist argument. The Delphi method recognizes the changing realities as panelists adjust their thoughts, opinions, or realities, throughout the process, however is primarily interested in providing knowledge that is useable rather than taking a stance on the issue.

Historical roots. The Delphi method has a rich and interesting history. Initially, the word Delphi was taken from the name of the site of the famous Greek oracle and is rich with Greek mythology. Initially intended to predict the future, the Delphi method was used for either research in horse racing (Quade, 1967) or defense and military issues (Dalkey & Hemler, 1963). More recently, the Delphi method has been used in a variety of fields, including health, environment, education, and transportation. The Delphi method has also been used throughout the social sciences including psychology, sociology and political science. The Delphi method began emerging in the field of family therapy in the early 1980's, yet very little research has been conducted utilizing this method. In fact, StoneFish and Busby (1996) suggest as few as five separate studies in MFT have implemented the Delphi method for research. The level of interest in the methodology is increasing, as evidenced by a resurgence of projects currently underway (Bischoff, in progress, Mamalakis, in progress).

Research questions/purposes. The Delphi method is useful for questions that can be addressed by obtaining a consensus of opinions from experts in the field. As the collaborative healthcare is a field wrought with unanswered questions and unchartered

waters, the Delphi provides a natural fit. The Delphi method can also be useful in developing policies or regulation in a new field or with relatively new phenomena (StoneFish & Busby, 1996). Finally, the Delphi method can often simplify or bring to consensus those thoughts or opinions that are somewhat scattered throughout the literature, so as to make them more user friendly for the readers. A review of these aforementioned purposes of the Delphi Technique suggest a fit with further research into the field of collaborative healthcare.

Panel Selection. Sampling for the Delphi method is primarily based upon the individuals' expertise in the area of interest. Individual expertise is the best method of obtaining a quality outcome with the Delphi Technique (Dalkey, 1972). Randomly selecting individuals as panelists is therefore not the ideal process. Criteria that the researcher utilizes to identify experts can vary. Some criteria may include publications, clinical experience, teaching experience, national convention participation, and/or degrees earned. It is up to the researcher to identify methods for identifying experts for the panel. Obtaining demographic information regarding panelists may be useful for future reference.

Data collection. The collection of data for the Delphi method generally consists of a questionnaire with approximately two to three rounds. Questionnaires are sent out several times (often about three), first for initial responses and thereafter for changes and/or alterations based upon others panelists' responses. Hemler (1976) describes the following steps in collecting data. First, the researchers inquire of the panelists and

allow expression of thoughts ideas and/or information regarding the subject. Second, the researchers pull together the information so as to get an image of how the group views the topic. The third phase involves any differing opinions expressed by the individual panelists; (this is the phase where panelists receive anonymous information received by the research team and are given opportunities to adjust their own responses). The final phase involves the gathering of general consensus, this occurs after the team receives final revisions of responses from the panelists. This project will include two mailings of the inventory, one for general response and feedback, the second a feedback of initial responses to panelists for re-response.

Issues of validity and reliability with this method. Traditional means of assessing reliability and validity are difficult to apply to the Delphi method. Specifically, the test-retest reliability measure could possibly be reconstructed with the same panelists regarding the same topic, however it is unlikely that, if the panelists took time to participate, they will be very tolerant of participating again, for testing reliability (StoneFish & Busby, 1996). Validity is directly related to the selection of the panelists. It is important to carefully select the panelists using clearly specified criteria. As it is expert opinions that are being sought, the individuals answering the questionnaires have often thought a great deal on the subject and can include information in the open ended questions that do not really address the topic at hand.

Strengths and weaknesses of the methodology. Strengths of the Delphi model include its usefulness for new, unexplored areas, and for developing a consensus among a panel of experts. "Anonymity in the Delphi technique reduces the effect of dominant individuals, controlled feedback reduces irrelevant communication, and the use of statistical procedures reduces group pressure for conformity" (Dalkey, 1972). These are often considered drawbacks of traditional pooling of opinions. Several potential weaknesses do exist. One potential weakness is that panelists, repeatedly asked questions, may tend to provide answers that move closer and closer to the mean. Stone Fish and Busby (1996) recommend providing the panelists information regarding the mean only on the last questionnaire. A second potential weakness is that diversity may be sacrificed to the desired outcome of consensus. A third potential weakness may be that as the panelists are experts in some area, their time is probably in demand and the questionnaires for the Delphi project may be quite lengthy. The required time commitment can be a potential problem. Fourth, consensus may be difficult to obtain as the panelists are experts within their respective field, and have often developed very specialized, narrow perspectives. Finally, as the goal is to reach a consensus, the categories may be broadened so that all parties agree, however the categories are so broad that the information is useless.

Conclusion

Chapter two has reviewed the relevant literature exploring the evolution of collaborative health care. The literature review included the integration of mental and physical health, empirical studies, the most current Collaborative Healthcare model, a discussion of human ecology theory, biopsychosocial model, and the theory of collaboration, the conceptual model for this study, and concluded with a review of the literature on Delphi research methodology.

The new model of health care is 'collaborative health care.' It stands to reason that the exploration of the collaborative relationship would be crucial to the successful marriage of the mental and physical health care fields, yet minimal research examining this particular relationship has been conducted. Gray and Wood (1991) suggest specific elements of a successful collaborative relationship. Seaburn et al. (1996) aid us in translating these broad concepts into terminology applicable to the health care field. Missing from the literature is an identification of specific collaborative components, sub-components and operationalized statements and an empirical validation of their significance. This study will address this missing dimension. Chapter three will delineate the research methodology specific to this study.

CHAPTER 3

Methodology

The purpose of this study is to verify the levels of importance of components in a collaborative relationship of an MFT with an HCP as perceived by practicing experts. This chapter introduces the methodology used to fulfill the purpose by including a reiteration of the project objectives, related research questions, the research design, including the four phases of the methodology, sample, and the data collection and analysis procedures. Images in this dissertation are presented in color.

Objectives

The following are the objectives of this study:

1. To identify core components needed for MFTs to work collaboratively with HCPs.

2. To validate by obtaining consensus of MFT practitioners working in collaborative practice (Delphi procedure) those components that are VERY IMPORTANT and IMPORTANT for collaborative work.

3. To identify demographic factors associated with the reported significance of components.

4. To propose a **Collaboration Inventory** (CI) to use in the future to evaluate collaborative practice.

The following research questions were generated from these objectives. This study is guided by research questions rather than hypotheses. This is due to two reasons: one, the nature of this study is exploratory. Secondly, the data analysis is primarily descriptive. Research questions are presented in the order of the objectives. Operational definitions that apply to each research question follow by section.

Research Questions # 1-12

Collaborative Components (Objectives 1 and 2)

1. What are the VERY IMPORTANT **components** of a collaborative relationship of an MFT with an HCP?

2. What is the *degree of consensus* regarding VERY IMPORTANT **components** of collaborative practice?

3. What are the IMPORTANT **components** of a collaborative relationship of an MFT with an HCP?

4. What is the *degree of consensus* regarding IMPORTANT **components** of collaborative practice?

Collaborative Sub-Components (Objectives 1 and 2)

5. What are the VERY IMPORTANT **sub-components** of a collaborative relationship of an MFT with an HCP?

6. What is the *degree of consensus* regarding VERY IMPORTANT **sub-components** of collaborative practice?

7. What are the IMPORTANT **sub-components** of a collaborative relationship of an MFT with an HCP?

8. What is the *degree of consensus* regarding IMPORTANT **sub-components** of collaborative practice?

Collaborative Items (Objectives 1 and 2)

9. What are the VERY IMPORTANT **items** of core components of a collaborative relationship of an MFT with an HCP?

10. What is the *degree of consensus* regarding VERY IMPORTANT **items** of core components of collaborative practice?

11. What are the IMPORTANT **items** of core components of a collaborative relationship of an MFT with an HCP?

12. What is the *degree of consensus* regarding IMPORTANT **items** of core components of collaborative practice?

Operational Definitions

For the purposes of this study, VERY IMPORTANT will be the median score of questions identified by panelists as essential or absolutely essential (3.5 - 5). The numbers indicate a ranking on the response scale in the Collaboration Inventory.

For the purposes of this study, IMPORTANT will be those questions identified by panelists as somewhat or minimally essential (1.5 -3.4). The numbers indicate a ranking on the response scale in the Collaboration Inventory.

For the purposes of this study, *consensus* will be defined as the extent panelists concur in their ranking per inventory question. Consensus will be measured using Leik's formula for Ordinal consensus ranging from a score of 0 (no consensus or 0%) to 1 (perfect or 100% consensus).

Consensus will be reported in this study as *degree of consensus* or a percentage range of consensus. Ranges will be broken down into three groups: less than 50% concurrence (< 50%), between 50 and 74% concurrence (50 - 74%), and greater than or equal to 75% concurrence (>75%) per inventory question.

Research Questions # 13-15

Demographic Factors (Objective 3)

13. What *demographic factors* are associated with the ranking of VERY IMPORTANT and IMPORTANT **components**?

14. What *demographic factors* are associated with the ranking of VERY IMPORTANT and IMPORTANT **sub-components**?

15. What *demographic factors* are associated with the ranking of VERY IMPORTANT and IMPORTANT **items** of core components?

Operational Definitions: The demographic variables that describe the panelists are identified in the following four categories:

1. Gender:
   - 1 = Female
   - 2 = Male

2. Primary Work Function:
   - 1 = Physician
   - 2 = Physician Assistant
   - 3 = Nurse
   - 4 = Marriage and Family Therapist
   - 5 = Other

3. Current Employment Setting:
   - 1 = Academic setting
   - 2 = Clinical, inpatient
   - 3 = Clinical, outpatient

4. Years in Collaborative Setting:
   - 1 = 5 years and less
   - 2 = 6 - 10 years
   - 3 = 11 - 15 years

Research Objective 4

Research objective 4: to propose a **Collaboration Inventory** (CI) to use in the future to evaluate collaborative practice, does not warrant any research questions. As discussed, this project will identify a list of questions based on the literature review as descriptive of a collaborative relationship (Objective 1). Following this list, confirmation of the importance of the inventory questions will be explored (Objective 2). Final analysis of the Collaboration Inventory will include a list of this inventory items or subjects more or less important to the success of a collaborative relationship. This information may then be used for further exploration and analysis (eg. factor analysis) in the continued development of more empirical tools for future research studies.

Research Design

A four-phase Delphi methodology was used to accomplish the objectives of this study and address the research questions. Each phase and the relevant objectives are described below.

Phase 1: (Objective 1: Identify components)

The purpose of this phase was to identify core components of collaboration. This was accomplished by reviewing literature relevant to collaboration. Writings on collaboration included literature from business (Schrage, 1995), collaborative healthcare (Seaburn, et al., 1996), education (Fishbaugh, 1997), human services (Dluhy, 1990) and organizational behavior (Wood & Gray, 1991). The review of literature is described in chapter 2. The identification of the core components and breakdown of components into sub-components is further discussed in chapter 2. A list of identified Core components and sub-components can be found in Appendix A.

Phase 2: (Objective 1, 4: Develop components and inventory)

The purpose of this phase of the research was to construct an inventory of core components of collaboration. This process involved developing questions exploring the various aspects of the collaborative relationship and identifying the importance of each aspect. The Collaboration Inventory consists of three parts: components, sub-components, and individual items. As developed in phase two, collaborative components address five broad categories of the relationship. On the inventory, panelists are asked to rank the importance of each component relative to the other components (rank 1-5).

Collaborative sub-components are smaller categories under each of the components. The five components each have a number of sub-components, ranging in size from for example three sub-components (for the Domain Orientation component) to ten (for the Shared Rules, Norms, and Structure component). On the inventory, panelists are again asked to rank the importance of the sub-components relative to the other sub-components within the same component (ranking ranges from 1-3 for Domain Orientation sub-components to 1-10 for Shared Rules, Norms and Structure sub-components).

Inventory items were then generated from the collaboration literature. Once components were broken down into sub-components, individual questions were developed regarding each sub-component inquiring about the various aspects of the sub-component. The majority of item derivation developed out of the collaborative healthcare literature. As reviewed in chapter 2, several collaborative healthcare models included various aspects relevant to the collaboration process. These differing aspects

were incorporated into the inventory under the appropriate sub-component as individual questions. Panelists were asked to rank the importance of each item (1-3; Very Important, Important, Not Important) to the success of the collaborative relationship. The list of items generated from the review of literature is included in Appendix A.

The inventory is designed with the inventory items listed first. Inventory items are the most specific questions and an inverted funnel sequence was thought to be clearer for panelists. Headings that include the appropriate descriptive component and sub-component are provided with the items. The last section of the inventory includes the ranking questions; first, ranking of the general components followed by ranking of the individual sub-components.

Finally, at the end of each section, panelists are provided space to write in any additional components, sub-components or items thought absent from the existing inventory. This is in keeping with the Delphi methodology.

Phase 3: (Objective 1, 4: Pilot test the inventory)

The purpose of this phase was to pilot test the instrument. A copy of the original Collaboration Inventory can be found in Appendix B. The pilot test included three Michigan therapists practicing collaboratively who evaluated the instrument and offered suggestions for thoroughness, clarity, and specificity (breath and depth). A copy of correspondence for the pilot phase can be found in Appendix B. Pilot panelists were not included in the research sample. Several significant changes resulted from the pilot study. Pilot participants unanimously agreed on the following points:

1. Components 'Act or Decide' and 'Domain Orientation' should be collapsed into one category.

2. Additional questions, such as 'Did this Occur?' should proceed the ranking of Importance for clarity.

3. A 3-point scale, rather than a 5-point scale, would be clearer.

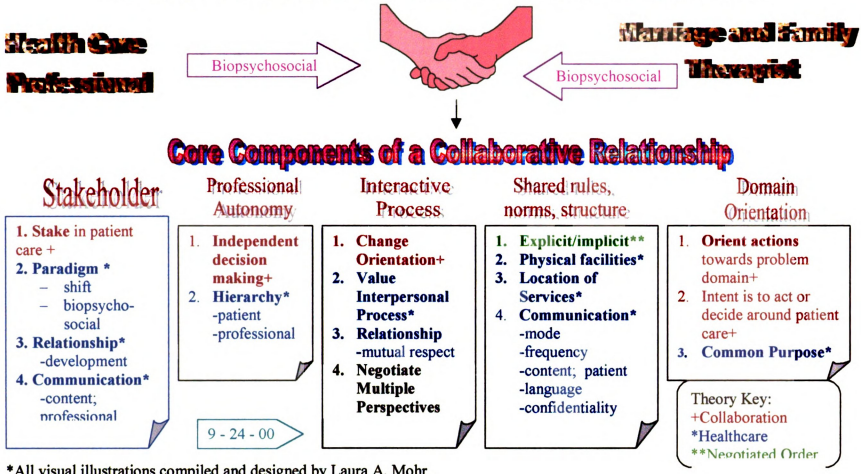
Figure 4 is the final conceptual map illustrating the collapse of the previous component 'Act or Decide' into the 'Domain Orientation' component. Questions such as "Did or Did Not Occur" and "Which most accurately describes your experience?" were added prior to the ranking questions in the inventory for clarity. The most complicated change was the shift in the scale from 5-points to 3-points. As a result of the scale change, operational definitions had to be changed. Operational definitions could no longer be based upon a 5 point scale.

In order to maintain consistency throughout the survey analysis, with scales of differing ranks (all items with 3 point scale, components with a 5 point scale and sub-components ranging from 3 levels to 10 levels), operational definitions were converted to percentage form from point form. Three categories (Very Important, Important, and Not Important) will be identified. In chapter four, each research question will specify the point breakdown congruent with the percentage definition. Revised Operational definitions are as follows:

Pre-Pilot Study: For the purposes of this study, VERY IMPORTANT will be those questions identified by panelists as essential or absolutely essential (3.5 - 5). The numbers indicate a ranking on the response scale in the Collaboration Inventory.

Post-Pilot Study: For the purposes of this study, VERY IMPORTANT will be those questions identified by panelists in the top one third (< .333) of their ranking category. The ranking categories appear on the response scale in the Collaboration Inventory.

Figure 4: **Relationship Components Needed for Marraige and Family Therapists to work Collaboratively with Health Care Professionals**



*All visual illustrations compiled and designed by Laura A. Mohr

Pre-Pilot Study: For the purposes of this study, IMPORTANT will be those questions identified by panelists as somewhat or minimally essential (1.5 -3.4). The numbers indicate a ranking on the response scale in the Collaboration Inventory.

Post-Pilot Study: For the purposes of this study, IMPORTANT will be those questions identified by panelists in the middle one third (.34 - .70) of their ranking category. The ranking categories appear on the response scale in the Collaboration Inventory.

The shift to percentage allows all Components, Sub-components, and items to be analyzed on a similar scale (top one third = Very Important, middle one third = Important, lower one third = Not Important). A copy of the revised Collaboration Inventory (CI) can be found in Appendix C.

Phase 4: (Objective 2, 3, and 4: validate by obtaining consensus, identify demographics, and derive Collaboration Inventory)

The purpose of this phase was to empirically validate the CI by obtaining consensus of therapists working collaboratively regarding VERY IMPORTANT and IMPORTANT components on the CI revised from phase two. The Delphi methodology was used. Two rounds were used to survey therapists. A copy of correspondence with the sample and the revised CI can be found in Appendix C.

Sample

Panelists for a Delphi study are chosen based upon expertise rather than via a random process (Dalkey, 1969). The membership of the Collaborative Family HealthCare Coalition was chosen as an appropriate group to invite to participate in the Delphi process. The Coalition has 500 subscribed members.

"The Collaborative Family Healthcare Coalition, founded in 1993, is a diverse group of physicians, nurses, psychologists, social workers, family therapists, and other healthcare workers..... .who study, implement, and advocate for the collaborative family healthcare paradigm." (Mission Statement, CFHcC, 1993). Members of the Coalition are dedicated to the advancement of the collaborative paradigm. Additional selection criteria included: individuals who are currently, or have within the last calendar year, practiced collaboratively; physical healthcare workers; and mental healthcare specialists who identify themselves as Marriage and Family Therapists, either by training, license or primary practice. Mental Health care providers who did not claim to engage in any form of marriage and family therapy were not included in the panel. These criteria are in place to ensure that respondents are individuals with an interest in the further development of collaborative healthcare and its integration into MFT.

Data Collection

The Collaboration Inventory (CI) consists of three sections. The first section, CI-1: Background Information includes four demographic variables and two qualitative items regarding collaborative experiences. The second section, CI-2: Collaborative Experiences includes an Explanation and Definition sheet, and 99 collaboration items (ranked Very Important, Important and Not Important). The third section, CI-3: Rank Order includes two sections asking panelists to rank order the general components (rank 1-5) and sub-components (depending on the size of the sub-component, rank 1-3, 1-4, 1-5, or 1-10). The survey form is a total of 11 pages, one page is informational. A copy of the survey can be found in Appendix C.

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A Likert-type rating scale of 1 to 3 was be used to score inventory items CI-2. Panelists responded to the items based upon the following statement: "Respond regarding your most successful MFT/HCP professional collaborative relationship within the past five calendar years (1995 - 2000)." The rankings are as follows:

1 - Very Important
2 - Important
3 - Not Important

A rank order scale was used to identify which of the different components and sub-components was more or less Important. Section 3 of the CI includes the rank order questions. Panelists were asked to rank order each component and sub-component based upon the total number possible. For example, for the Components: 'Rank the following *five* Components in order of Importance (1-5)" and for the component Professional Autonomy (that has 3 sub-components) "Rank the following *three* Sub-components in order of Importance (1-3)."

The inventory was sent to all members of the CFHcC, together with a cover letter requesting each eligible person to be a panelist and complete the CI. Eligibility was finally determined by including those individuals who were identified as Marriage and Family Therapists either in the CFHcC directory or self-identified. From the eligible panelists, 42 responses were returned (49%) in Round 1 and 23 responses were returned (58%) in Round 2.

The Collaboration Inventory for Round 2 was similar to the CI from Round 1. In order to simplify and clarify for the second round, the questionnaire demographic and descriptive (Did it occur? Which most accurately describes your experience?) questions that did not require consensus along with those that did reach consensus at more than

75% were removed. In accordance with the Delphi methodology, feedback was provided to the panelists regarding the frequency of each response. The section of the inventory with the items, CI-2 included percentage breakdowns of the frequency of responses in Round 1. Due to the complexity of the data gathered in CI-3, the ranking of Components and Sub-Components, bar graphs were provided to report frequency of responses from Round 1. A cover letter was included with Round 2. A sample of the cover letter and CI for Round 2 can be found in Appendix D. Follow-up e-mails were sent to the CFHcC Listserv for both rounds. Each was done approximately two weeks after the mailing of the surveys. A return postage paid envelope was included in both rounds to encourage completion of the CI. Round 1 was mailed on July 13, 2000; Round 2 was mailed on August 26, 2000 (see Table 3.1).

Table 3.1. Timetable for obtaining and analyzing the data.

Action	Date
Pilot testing	April 2000
Round 1 Mailed	July 13, 2000
Follow-up E-mails sent	August 7, 2000
Round 1 Analyzed	August 2000
Round 2 Mailed	August 26, 2000
Follow-up e-mails sent	September 11, 2000
Round 2 Analyzed	September 2000

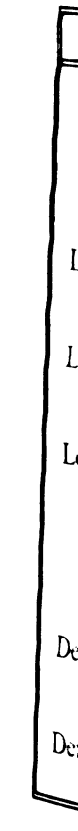
Data Analysis

Delphi data are primarily concerned with obtaining consensus, therefore are primarily analyzed using medians and interquartile ranges (Stone Fish & Busby, 1996) or other measures of Ordinal consensus (Leik, 1966). This study utilized median scores as they are most accurate when describing ordinal data and Leik's (1966) measure of ordinal dispersion to determine consensus. This formula allows the data to be analyzed free from limitation based upon sample size, choice options, central tendency (bell curve) and assumptions about intervals between choice options. The following formula provides an appropriate measure of ordinal consensus.

$$D = \frac{2 \Sigma d_1}{m - 1} - 1$$

D is a percentage, a measure of ordinal dispersion; when subtracted from 1 (complete consensus) it becomes a percentage of consensus. Σd_1 equals the cumulative frequency of responses; m equals the number of options in the scale. Convergence to consensus indicates the degree to which the respondents reach unanimity on a given item. Complete consensus would be 1.0 (or 100% consensus), according to Leik, and 0 (or 0% consensus) would be complete dispersion of responses. For the purposes of this study, degree of consensus will be reported in ranges: less than 50% concurrence (< 50%), between 50 and 74% concurrence (50 - 74%), and greater than or equal to 75% concurrence (>75%) per inventory item.

For both Round 1 and 2 Collaboration Inventories, data were entered into a survey software program. Random checking by the researcher and an assistant was done to maintain accuracy. Frequency distributions were provided to panelists in



Round 2 as it is a statistical measure easily understood by those reading the inventory. Medians were used to report the identified levels of importance for components, sub-components, and items. Frequency was provided to describe demographic characteristics. Chi-square tables were done to determine difference between group means on all the CI elements. Table 3.2 illustrates the statistical tools used for the data analysis.

Table 3.2: Summary of Data Analysis

Exploratory Variable	Scale of Measurement	Data Used	Survey Items	Analysis
Feedback to Panelists	Ordinal	Round 1	all items	Frequency
Level of Importance for Components	Ordinal	Round 1	S3: 1- 5	Median, Frequency
Level of Importance for Sub - Components	Ordinal	Round 1	S3: 6 - 30	Median, Frequency
Level of Importance for Survey Items	Ordinal	Round 1	S2: 1 - 50	Median, Frequency
Convergence to Consensus	Ordinal	Round 1 and 2	all items	Leik's Formula
Describe Demographics	Nominal	Round 1	S1: 1, 4-7	Frequency
Association of Demographic factors on Consensus	Nominal	Round 1 and 2	S1: 1, 4-7	Chi-Square

Conclusion

This chapter has delineated the research methodology specific to this study. The chapter has included research objectives identified by this project and related research questions. An explanation of the Delphi procedure was presented. How the sample was recruited, how data was collected and how data was analyzed were then addressed. Chapter 4 will present the findings of the study.

CHAPTER 4

Research Findings

This chapter contains the results of the analysis of the responses from the panelists who participated in this study. The objectives of this study were accomplished in four phases. Phase one consisted of identifying core components of collaboration by reviewing the literature relevant to collaboration. A list of the core components and sub-components identified can be found in Appendix A. Phase two consisted of constructing an inventory of components, sub-components and items of collaboration. The list of items generated for the inventory can be found in Appendix A. Phase three consisted of pilot testing the Collaboration Inventory (CI) and making the appropriate changes as recommended by the pilot participants. A complete discussion of results and changes can be found in chapter 3. A copy of the revised Collaboration Inventory can be found in Appendix C. Phase four included the data analysis. In this chapter the research findings will be given for each research question.

Response Rate - Round 1 and Round 2

Table 4.1 contains a summary of the rate of response to each of the two rounds of survey.

Table 4.1: Survey Response Rates

	Surveys Eligible	Surveys Returned	Response Rate
Round 1	85	42	49%
Round 2	40	23	58%

Survey eligibility was determined by the sample inclusion criteria reviewed in chapter 3. Based upon insufficient response rates for HCPs, data analysis was conducted only on data for Marriage and Family Therapists. Health care professionals numbers (n=11) were too low for analysis. Seven panelists returned incomplete surveys with notes stating they were ineligible and were dropped from the eligible list. Two responses returned in Round 1 were unidentifiable as no name or postage information allowed for identification and therefore were not re-surveyed. The demographic data which describes the characteristics of the sample which responded to Round 1 is given in Table 4.2.

Table 4.2: Demographic Summary

Total Respondents		**Employment Setting***			
MFT	**HCP**	**Academic**	**Clinical**	**Inpatient**	**Outpatient**
42	11	31	40	4	36
Years in Collaborative Practice*			**Gender***		
0 - 5	**6-10**	**11 - 15**	**Male**	**Female**	
11	13	16	14	28	

* Marriage and Family Therapists only

Use of Round 1 and Round 2 Data

The Delphi technique was employed in two rounds. This technique encourages participative decision making by allowing input and re-evaluation on the inventory items. Round 1 included demographic and ranking questions. Participants were invited to contribute any additional items thought missing. No additional items were provided. As required by the methodology, response rates were provided to panelists in Round 2.

Due to the nature of the questions, most items could have been ranked Very Important, or at the high end of the scale. This ranking compromises the parametric assumptions of interval and normal distributions. Therefore, non-parametric measures were used throughout the analysis.

Leik's measure of ordinal consensus was used to determine the level of consensus of each item. Since minimal change was noted in the overall ratings of the items from Round 1 to Round 2, data from Round 1 was used as the principal source of information for determining which Collaborative components, sub-components, and items were considered Very Important and/or Important. Round 1 provided the demographic information.

Summary of Findings

Overview

The following discussion is structured in order of the research questions. Research questions are grouped by Components, Sub-Components, and Items. Three general types of questions were posited throughout this study. The first is a series of questions regarding the ranking of each inventory question (VERY IMPORTANT and IMPORTANT). These ranking questions are Research Questions #1, 3, 5, 7, 9, and 11. The second is a series of questions regarding consensus, or the degree to which panelists agree with the respective ranking. Consensus questions are Research Questions #2, 4, 6, 8, 10, and 12. Finally, a series of questions is posed regarding demographic association with ranking and consensus. Demographic questions include Research Questions #13-15.

Ranking questions. Median scores were utilized to determine level of importance for all inventory questions. The scales used for analyzing the median scores for each inventory question vary based upon the size of the category (component, sub-component, item all have different category sizes). Scales are depicted below within each category. The VERY IMPORTANT components, sub-components and items are those questions identified by panelists within the top one third (< .33) of their ranking category. The IMPORTANT components, sub-components, and items are those questions identified by panelists in the middle third (.34 - .70) of their ranking category.

Consensus questions. For the purposes of this study, *consensus* is defined as the extent panelists concur in their ranking per inventory question. Consensus is measured using Leik's formula for Ordinal consensus ranging from a score of 0 (no or 0% consensus) to 1 (perfect or 100% consensus). Leik's formula provides a percentage of agreement in decimal form for each inventory question. Consensus is reported in this study as *degree of consensus* or a percentile range of consensus. Ranges are divided into three groups: less than 50% concurrence (< 50%), between 50 and 74% concurrence (50 - 74%), and greater than or equal to 75% concurrence (>75%) per inventory question.

Collaborative Components

Table 4.3 summarizes findings related to Collaborative Components. Median scores for both Round 1 and Round 2 are provided. Median scores from Round 1 are used to determine level of importance using the following scale:

Very Important: 1.00-2.33
Important: 2.34-3.67
Not Important: 3.68-5.00

Components are listed in order of score on Leiks formula of consensus, beginning with the component with the highest degree of consensus. A discussion of individual research questions and respective findings follows the table.

Table 4.3: Collaborative Component Data

Collaborative Components	Degree of Consensus	Leik's formula	Level of Importance	R1 Median	R2 Median
Professional Autonomy	> 75% range	0.805	Not Important	4.4	4.86
Shared Rules, Norms, and Structure	> 75% range	.75	Important	3.33	3.06
Interactive Process	50-74% range	0.6385	Very Important	2.07	1.5
Domain Orientation	50-74% range	0.583	Very Important	2.04	1.93
Stakeholder	50-74% range	0.5555	Important	3.25	3.64

Research Question #1: What are the VERY IMPORTANT **components** of a collaborative relationship of an MFT with an HCP?

Findings: Two components were found to be Very Important. These components include: 1. Interactive Process and 2. Domain Orientation.

Research Question #2: What is the *degree of consensus* regarding VERY IMPORTANT **components** of collaborative practice?

Findings: Both Interactive Process and Domain Orientation reached consensus in the 50-74% range. Interactive Process reached 63.8% consensus and Domain Orientation reached 58.3% consensus.

Research Question #3: What are the IMPORTANT **components** of a collaborative relationship of an MFT with an HCP?

Findings: There are two components that have median scores within the Important range. These components include: 1. Shared Rules, Norms, and Structure and 2. Stakeholder.

Research Question #4: What is the *degree of consensus* regarding IMPORTANT **components** of collaborative practice?

Findings: Shared Rules, Norms, and Structure reached 75% consensus or within the >75% range. Stakeholder reached 55.5% consensus or within the 50-74% range.

Collaborative Sub-Components

Due to the extensive nature of the information for sub-components, tables for sub-components are provided in two different forms. Table 4.10, provided at the end of the chapter, summarizes all of the data related to Collaborative Sub-Components. This chart is similar in structure to Table 4.3 (Collaborative Components Data, above). Table 4.10 includes median scores for both Round 1 and Round 2, level of importance determined using Round 1 medians, scores on Leik's formula of Ordinal consensus, and degree of consensus.

Tables 4.4 and 4.5 are included within the text. These tables summarize sub-components' levels of importance and degrees of consensus, including scores on Leik's formula for addressing research questions. Level of importance scales vary for each group of sub-components. Scores range from ranking 1-3 for Domain Orientation sub-components, to 1-10 for Shared Rules, Norms, and Structure sub-components. For analysis, all scales are then divided into thirds to determine the levels of importance. The breakdown of the individual scales is provided on Table 4.10, at the end of the chapter.

Sub-Components are listed in order of the level of consensus achieved and are listed with their Collaborative Component heading.

Table 4.4: Sub-Components Ranked Very Important sorted by Degree of Consensus

Respective Component	Sub-Components ranked Very Important	Degree of Consensus	Leik's Formula
Domain Orientation	Common Purpose	> 75% range	0.952
Autonomy	Hierarchy regarding patient care	>75% range	0.9
Interactive process	Mutual Respect	> 75% range	0.8195
Shared Rules, Norms and Struture	Communication frequency	> 75% range	0.7502
	Communication content	50-74% range	0.7222
	Communication language	50-74% range	0.542
Stakeholder	Stake	< 50% range	0.474
Total	**7 of 25 (28%)**		

Research Question #5: What are the VERY IMPORTANT **sub-components** of a collaborative relationship of an MFT with an HCP?

Findings: A total of seven of the possible 25 sub-components (28%) ranked within the Very Important range. Table 4.4 lists the sub-components that ranked within the Very Important range. Table 4.10 includes median scores and scale ranges for each sub-component.

Research Question # 6: What is the *degree of consensus* regarding VERY IMPORTANT **sub-components** of collaborative practice?

Findings: There are four sub-components ranking as Very Important that reached consensus in the >75% range; Common Purpose reached 95.2% consensus, Hierarchy Regarding Patient Care reached 90% consensus, Mutual Respect reached 82% consensu,; and Communication Frequency reached 75% consensus. Two sub-components ranking as Very Important reached a consensus in the 50-74% range. Communication Content reached 72.2% consensus and Communication Language reached 54.2% consensus. One sub-component Location of Services ranking Very Important, did not reach consensus of 50%. It reached only a 26.4% consensus.

Table 4.5: Sub-Components Ranked Important sorted by Degree of Consensus

Respective Component	Sub-Component ranked Important	Degree of Consensus	Leik's formula
Domain Orientation	Orientation	50-74% range	0.714
Shared Rules, Norms and Structure	Communication mode	50-74% range	0.7084
Professional Autonomy	Independent Decision Making	50-74% range	0.65
Interactive Process	Value Interpersonal Process	50-74% range	0.647
Shared Rules, Norms and Structure	Communication confidentiality	50-74% range	0.6111
Stakeholder	Shift in Paradigm	50-74% range	0.5787
Interactive Process	Negotiate Multiple Perspectives	50-74% range	0.559
Shared Rules, Norms, and Structure	Provision of Services	50-74% range	0.5416
Stakeholder	Relationship: Trust	50-74% range	0.5087
Shared Rules, Norms and Structure	Location of Services	< 50% range	0.2638
Total	**10 of 25 (40%)**		

Research Questions #7: What are the IMPORTANT **sub-components** of a collaborative relationship of an MFT with an HCP?

Findings: A total of 10 sub-components from a possible 25 sub-components (40%) ranked within the Important range. Table 4.5 lists the sub-components that ranked within the Important range. Table 4.10 includes median scores and scale ranges for each sub-component.

Research Question #8: What is the *degree of consensus* regarding IMPORTANT **sub-components** of collaborative practice?

Findings: There are nine sub-components ranking as Important that reached consensus in the 50-74% range. These include: Orientation at 71.4% consensus; Communication Mode at 70.8% consensus; Independent Decision Making at 65% consensus; Valuing Interpersonal Processes at 69.6% consensus; Communication Confidentiality at 61.1% consensus; Shift in Paradigm at 57.9% consensus; Negotiate Multiple Perspectives at 55.9% consensus; Provision of Services at 54.2% consensus; and Relationship: Trust at 50.9% consensus. One sub-component ranking Important did not reach consensus of 50%. Location of Services reached only 26.4% consensus.

Collaborative Items

As with collaborative sub-components, tables for collaborative items are provided in several different forms. Table 4.11, provided at the end of the chapter, summarizes all of the findings related to Collaborative Items. This chart is similar in structure to Table 4.3 (Collaborative Components Data, above). Table 4.11 includes median scores for both Round 1 and Round 2, level of importance determined using Round 1 medians, scores on Leik's formula of Ordinal consensus, and degree of consensus.

Tables 4.6 and 4.8 are included within the text. These tables summarize collaborative items' level of importance for addressing research questions. Median scores from Round 1 are used to determine level of importance using the following scale:

Very Important:	1.00-1.66
Important:	1.67-2.33
Not Important:	2.34-3.00

Tables 4.7 is also included within the text. This table summarize the degree of consensus for Collaborative Items ranked both as Very Important and Important. Collaborative Items are grouped by the respective Collaborative Component heading. Due to the large number of Collaboration items reported findings of items will be limited to summary statistics. Individual Item rankings can be found on Table 4.11.

Table 4.6: Number of Items sorted by Component ranked Very Important

Respective Component	Items ranked Very Important
Professional Autonomy	3 of 4 (75%)
Shared Rules, Norms, and Structure	9 of 15 (60%)
Interactive Process	4 of 6 (66%)
Domain Orientation	3 of 4 (75%)
Stakeholder	15 of 21 (71%)
Total	**34 of 50 (68%)**

Table 4.7: Number of Items ranked Very Important and Important sorted by Degree of Consensus			
Degree of Consensus	**Number of Items ranked Very Important**	**Number of Items ranked Important**	**Total Items by Degree of Consensus**
> 75% range	11	0	**11**
50 - 74% range	12	12	**24**
< 50% range	11	4	**15**
Total	**34**	**16**	**50**

Research Question #9: What are the VERY IMPORTANT **items** of core components of a collaborative relationship of an MFT with an HCP?

Findings: A total of 34 items from a possible 50 items (68%) ranked within the Very Important range. Table 4.6 lists the number of items by their respective Component, that ranked within the Very Important range. Table 4.11 includes median scores and scale ranges for each item.

Research Question #10: What is the *degree of consensus* regarding VERY IMPORTANT **items** of core components of collaborative practice?

Findings: There are eleven items ranking as Very Important that reached consensus in the >75% range. There are twelve items ranking as Very Important that reached a consensus in the 50-74% range. Eleven items ranking Very Important did not reach consensus of 50%. Table 4.11 includes Leik's formula scores with individual consensus percentage for each item.

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Table 4.8: Number of Items sorted by Component ranked as Important

Respective Component	Items ranked Important
Domain Orientation	1 of 4 (25%)
Interactive Process	2 of 6 (33%)
Stakeholder	6 of 21 (29%)
Shared Rules, Norms, and Structure	6 of 15 (40%)
Professional Autonomy	1 of 4 (25%)
Total	**16 of 50 (32%)**

Research question #11: What are the IMPORTANT **items** of core components of a collaborative relationship of an MFT with an HCP?

Findings: A total of 16 items from a possible 50 items (32%) ranked within the Important range. Table 4.8 lists the number of items by their respective Component, that ranked within the Important range. Table 4.11 includes median scores for each item.

Research Question #12: What is the *degree of consensus* regarding IMPORTANT **items** of core components of collaborative practice?

Findings: None of the items ranking as Important reached consensus in the >75% range. There are twelve items ranking as Important that reached consensus in the 50-74% range. Four items ranking Important did not reach consensus of 50%. Table 4.11 includes Leik's formula scores with individual consensus percentage for each item.

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Demographics

The demographic questions seek to determine if additional variables, such as gender or years in practice, play a significant role in how individuals rank the importance of Collaborative components, sub-components and/or items. Chi-square (χ^2) cross tabulations were selected as the statistical approach to use used to analyze this data. In consultation with a statistical consultant, chi-square tables were selected for two reasons. First, the data in this project required non-parametric analyses, as it does not meet the assumption of normal distribution required of parametric measures. Ordinal data in this study are positively skewed. Second, Chi-square analysis was selected over analysis of variance as Chi-square analyses compare entire distributions of variables rather than the means. In the case of this survey several of the scales are three points, making comparison of means less discriminating than comparison of entire distributions. The significant value was set at $p < .05$.

Research Question #13: What *demographic factors* are associated with consensus regarding VERY IMPORTANT and IMPORTANT **components**?

Research Question #14: What *demographic factors* are associated with consensus regarding VERY IMPORTANT and IMPORTANT **sub-components**?

Research Question #15: What *demographic factors* are associated with consensus regarding VERY IMPORTANT and IMPORTANT **items** of core components?

Findings: Contingency tables were developed for all of the demographic relationships with the variables (components, sub-components, and items). Due to the limited size of the sample, N = 42, contingency tables could not be completed. A basic assumption of Chi-square tables is the continuity of expected frequencies (a continuous increase/decrease in the number of expected frequencies). When expected frequencies of any of the cells is small (less than 5 cases), the distribution departs from continuity and the distribution of the χ^2 poorly fits the data (Hinkle, Wiersma, & Jurs, 1994). The recommended method addressing the problem of cells expected size < 5 is to collapse or eliminate individual rows (variables) to increase the size of the cell. This suggestion is not recommended with this data set, as the rows are limited to only two or three. Due to the size of the sample, Research Questions 13 - 15

cannot be addressed.

Summary of Research Findings

This chapter has included the research findings to each of the research questions presented. Table 4.9 provides a summary of the results and research questions #1-4 for Collaborative Components. Table 4.10 provides a summary of the results and research questions #5-8 for Collaborative Sub-Components. Table 4.11 provides a summary of the results and research questions #9-12 for the Collaborative Items. The next chapter presents the overall summary of the study, discussion and conclusions followed by implications and recommendation.

Table 4.9: Collaboration Components Research Question Summary

Collaborative Components Research Questions
R1: What are the VERY IMPORTANT components of a collaborative relationship of an MFT with an HCP?
R2: What is the degree of consensus regarding VERY IMPORTANT components of collaborative practice?
R3: What are the IMPORTANT components of a collaborative relationship of an MFT with an HCP?
R4: What is the degree of consensus regarding IMPORTANT components of collaborative practice?

Collaborative Component Data					
Collaborative Components	**Level of Importance**	**Round 1 Median**	**Round 2 Median**	**Degree of Consensus**	**Leik's formula of Consensus**
Domain Orientation	Very Important (1.00 - 2.33)	2.04	1.93	50 - 74% range	0.583
Interactive Process		2.07	1.5	50 - 74% range	0.6385
Stakeholder	Important (2.34 - 3.67)	3.25	3.64	50 - 74% range	0.5555
Shared Rules, Norms, and Structure		3.33	3.06	> 75% range	0.75
Professional Autonomy	Not Important (3.68 - 5.00)	4.4	4.86	> 75% range	0.805

Table 4.10: Collaborative Sub-Components Research Question Summary

Collaborative Sub-Components Research Questions
R5: What are the VERY IMPORTANT sub-components of a collaborative relationship of an MFT with an HCP?
R6: What is the degree of consensus regarding VERY IMPORTANT sub-components of collaborative practice?
R7: What are the IMPORTANT sub-components of a collaborative relationship of an MFT with an HCP?
R8: What is the degree of consensus regarding IMPORTANT sub-components of collaborative practice?

Collaborative Sub-Component Data					
Collaborative Sub-Components	**Level of Importance**	**Round 1 Median**	**Round 2 Median**	**Degree of Consensus**	**Leik's formula of Consensus**
Domain Orientation (3 point scale)					
Common Purpose	Very Important (1 - 1.66)	1.29	1.02	> 75% range	0.952
Orientation	Important (1.67 - 2.33)	1.92	2.13	50 - 74% range	0.714
Act or Decide	Not Important (2.34 - 3.00)	2.75	2.84	> 75% range	0.762

Collaborative Sub-Component Data					
Collaborative Sub-Components	**Level of Importance**	**Round 1 Median**	**Round 2 Median**	**Degree of Consensus**	**Leik's formula of Consensus**
Interactive Process (5 point scale)					
Relationship: Mutual Respect	Very Important (1.00 - 2.33)	1.12	-	> 75% range	0.8195
Value Interpersonal Process	Important	2.44	1.27	50 - 74% range	0.647
Negotiate Multiple Perspecitves	(2.34 - 3.67)	2.69	2.29	50 - 74% range	0.559
Change Orientation: Initial	Not Important	3.97	2.71	50 - 74% range	0.618
Change Orientation: Ongoing	(3.68 - 5.00)	4.31	3.17	50 - 74% range	0.6875
Stakeholder (4 point scale)					
Stake	Very Important (1.00 - 2.00)	1.56	1.29	< 50% range	0.474
Shift in Paradigm	Important	2.27	2.35	50 - 74% range	0.5787
Relationship: Trust	(2.01 - 3.00)	2.33	2.4	50 - 74% range	0.5087
Relationship: Personal Communication	Not Important (3.01 - 4.00)	3.71	3.82	50 - 74% range	0.6487

Collaborative Sub-Component Data					
Collaborative Sub-Components	**Level of Importance**	**Round 1 Median**	**Round 2 Median**	**Degree of Consensus**	**Leik's formula of Consensus**
Shared Rules, Norms, and Structure (10 point scale)					
Communication: Content		2.93	4	50 - 74% range	0.7222
Communication: Frequency	Very Important	3.43	4	> 75% range	0.7502
Communication: Language	(1.00 - 4.00)	3.43	3.5	50 - 74% range	0.542
Communication: Mode		4.4	4.7	50 - 74% range	0.7084
Provision of Services	Important	4.88	2.25	50 - 74% range	0.5416
Location of Services	(4.01 - 7.00)	5.25	6	< 50% range	0.2638
Communication: Confidentiality		6.2	5	50 - 74% range	0.6111
Explicit/Implicit Rules and Norms		8.12	8.5	50 - 74% range	0.4569
Shared Record Keeping	Not Important	8.25	8.25	50 - 74% range	0.5104
Shared Support Staff	(7.01 - 10.00)	8.95	8.9	50 - 74% range	0.7322
Professional Autonomy (3 point scale)					
Hierarchy: Patient Focus	Very Important (1.00 - 1.66)	1.23	1.06	> 75% range	0.9
Independent Decision Making	Important (1.67 - 2.33)	1.92	2.12	50 - 74% range	0.65
Hierarchy Relationship Focus	Not Important (2.34 - 3.00)	2.8	2.83	> 75% range	0.75

Table 4.11: Collaboration Items Research Question Summary

Collaborative Items Research Questions
R9: What are the VERY IMPORTANT items of a collaborative relationship of an MFT with an HCP?
R10: What is the degree of consensus regarding VERY IMPORTANT items of collaborative practice?
R11: What are the IMPORTANT Items of a collaborative relationship of an MFT with an HCP?
R12: What is the degree of consensus regarding IMPORTANT items of collaborative practice?

Collaborative Items Data					
Collaborative Items (3 point scale)	**Level of Importance**	**Round 1 Median**	**Round 2 Median**	**Degree of Consensus**	**Leik's formula of Consensus**
Domain Orientation					
Common Purpose	Very Important (1.00 - 1.66)	1.35	1.11	> 75% range	0.818
Act/Decide: HCP		1.41	1.23	50 - 74% range	0.591
Orientation		1.45	1.11	> 75% range	0.818
Act/Decide: MFT	Important (1.67 - 2.33)	2.1	1.23	50 - 74% range	0.591
Interactive Process					
Relationship: Mutual Respect (MFT)	Very Important (1.00 - 1.66)	1.07	-	> 75% range	0.878
Relationship: Mutual Respect (HCP)		1.1	-	> 75% range	0.829
Value Interpersonal Process		1.25	1.22	50 - 74% range	0.696
Negotiate Multiple Perspectives		1.63	1.64	< 50% range	0.478
Change Orientation: Ongoing Interaction	Important (1.67 - 2.33)	1.68	1.91	50 - 74% range	0.696
Change Orientation: Initial interaction		1.8	2.03	50 - 74% range	0.696

Collaborative Items Data					
Collaboration Items (3 point scale)	**Level of Importance**	**Round 1 Median**	**Round 2 Median**	**Degree of Consensus**	**Leik's formula of Consensus**
Stakeholder					
MFT initially concerned with both psychosocial and physical well being	Very Important (1.00 - 1.66)	1.09	-	> 75% range	0.85
MFT-HCP developed trusting relationship		1.09	-	> 75% range	0.85
HCP initially concerned with both physical and psychosocial well being		1.12	-	> 75% range	0.805
With progression, MFT concerned with both psychological well being		1.15	-	> 75% range	0.769
With progression, HCP concerned with both physical and psychological well being		1.17	-	> 75% range	0.75
MFT provided care/treatment for patient		1.25	1.18	50 - 74% range	0.696
MFT contacted HCP regarding referral		1.27	1.22	50 - 74% range	0.609
MFT continued care after referring patient		1.27	1.18	50 - 74% range	0.609
HCP continued care after referring patient		1.28	1.11	> 75% range	0.826
HCP provided care/treatment for patient		1.35	1.14	50 - 74% range	0.74
HCP referred patient to MFT		1.37	1	> 75% range	1
MFT referred patient to HCP		1.42	1.23	50 - 74% range	0.591
HCP contacted MFT regarding referral		1.44	1.55	< 50% range	0.435
MFT-HCP exchanged information		1.5	1.73	< 50% range	0.479
MFT-HCP shared information		1.62	1.91	< 50% range	0.479
MFT-HCP disclosed more information	Important (1.67 - 2.33)	1.73	2.11	50 - 74% range	0.609
MFT initially concerned with only psychosocial well being		1.75	2.44	< 50% range	0.429
With progression, HCP concerned with only physical well being		1.82	2.32	50 - 74% range	0.55
With progression, MFT concerned with only psychosocial well being		1.85	2.4	50 - 74% range	0.5
HCP initially concerned with only physical well being		1.88	2.58	50 - 74% range	0.5
Relationship: Personal Communication		2.1	1.81	50 - 74% range	0.727

Collaborative Items Data					
Collaborative Items (3 point scale)	**Level of Importance**	**Round 1 Median**	**Round 2 Median**	**Degree of Consensus**	**Leik's formula of Consensus**
Shared Rules, Norms and Structure					
HCP and MFT had Informal face-to-face	Very Important (1.00 - 1.66)	1.22	1.19	50 - 74% range	0.636
Communication: Language		1.31	1.32	< 50% range	0.479
HCP and MFT had formal arranged meeting		1.4	1.94	< 50% range	0.348
Location of Services		1.41	1.32	< 50% range	0.435
MFT phoned		1.5	1.46	< 50% range	0.335
MFT sent letter/e-mail		1.55	1.55	< 50% range	0.435
HCP phoned		1.57	1.57	< 50% range	0.305
Communication: Frequency		1.65	1.82	50 - 74% range	0.609
Provision of Services		1.65	1.58	50 - 74% range	0.545
Communication: Content	Important (1.67 - 2.33)	1.67	1.73	50 - 74% range	0.652
Shared Record Keeping		1.68	2.45	< 50% range	0.305
Communication: Confidentiality		1.92	1.92	50 - 74% range	0.565
HCP sent letter/e-mail		2	2.14	< 50% range	0.305
Explicit/Implicit Rules and Norms		2.2	2.29	50 - 74% range	0.636
Shared Support Staff		2.23	2.54	< 50% range	0.435
Professional Autonomy:					
Hierarchy: Patient Focus	Very Important (1.00 - 1.66)	1.55	1.71	50 - 74% range	0.571
Hierarchy: Relationship Focus		1.62	2.28	< 50% range	0.409
Independent Decision Making: HCP		1.66	1.88	50 - 74% range	0.728
Independent Decision Making: MFT	Important (1.67 - 2.33)	1.73	1.88	50 - 74% range	0.728

CHAPTER 5

Summary and Recommendations

This chapter presents the overall summary of the study, a discussion of the findings, the implications of the findings, the contribution this study has made to the field of Collaborative Healthcare, researcher observations, the limitations of this study, and recommendations for future research.

Summary

A change in how our society defines health and well being has precipitated a shift in how helping professionals view themselves. Mental and physical health care workers have begun forging professional relationships in efforts to better serve individuals. Marriage and Family Therapy, as a field, embraces the notion of synergy among people: the whole of groups is more useful and valuable than the sum of the individuals. This respect and appreciation for the impact of working with others has motivated MFTs to look beyond the scope of traditional mental health private practice. Marriage and Family Therapists have begun developing professional relationships with health care professionals. Many health care professionals have welcomed the opportunity to better serve patients with the inclusion of mental health services as part of routine care.

An examination into the various aspects of this new collaborative relationship is warranted as the occurrence of such partnerships increases in number. The intention of this study was to identify the relationship components needed for marriage and family therapists (MFTs) to work collaboratively with health care professionals (HCPs). Presently, several professional writings exist illustrating the various different collaborative relationships of MFTs working with HCPs. A few studies have begun to

qualitatively explore this new phenomenon. The present study is an attempt to move the current research in collaborative healthcare in a more quantitative direction. The following objectives were identified for this study:

1. To identify core components needed for MFTs to work collaboratively with HCPs.
2. To validate by obtaining consensus of MFT practitioners working in collaborative practice (Delphi procedure) those components that are VERY IMPORTANT and IMPORTANT for collaborative work.
3. To identify demographic factors which differentially affect the reported significance of components.
4. To propose a **Collaboration Inventory** (CI) for use in further development of evaluative measures of collaborative practice.

A four-phase methodology was used to accomplish these objectives. Phase 1 was to identify core components of the collaborative relationship. This was accomplished by reviewing literature relevant to collaboration. This review of literature is described in

chapter 2. The identification of the core components and breakdown of components into sub-components is further discussed in chapter 2. A list of identified Core components and sub-components can be found in Appendix A.

The purpose of phase 2 was to construct an inventory of core components of collaboration. This process involved developing questions exploring the various aspects of the collaborative relationship. Broad relationship components, then components further divided into sub-components, and finally individual items were generated for the inventory. Panelists were then asked to rank the importance of each aspect of the

collaborative relationship. A list of items generated from the review of literature is included in Appendix A.

The purpose of phase 3 was to pilot test the instrument. A copy of the original Collaboration Inventory can be found in Appendix B. The pilot test included three Michigan therapists practicing collaboratively who evaluated the instrument and offered suggestions for thoroughness, clarity, and specificity (breath and depth). A few significant changes resulted from the pilot study. A copy of the revised Collaboration Inventory (CI) can be found in Appendix C.

Finally, the purpose of phase 4 was to empirically validate the inventory by obtaining consensus of therapists working collaboratively regarding VERY IMPORTANT and IMPORTANT components on the CI revised from phase 3. The Delphi methodology

was used. Two rounds were used to survey therapists. A copy of correspondence with the sample and the revised CI can be found in Appendix C.

The inventory was sent to members of the Collaborative Family Healthcare Coalition (CFHcC), together with a cover letter requesting each eligible person participate as a panelist and complete the CI. Eligibility was finally determined by including those individuals who were identified as Marriage and Family Therapists either in the CFHcC directory or self-identified. From the eligible panelists, 42 responses were returned (49%) in Round 1 and 23 responses were returned (58%) in Round 2. The time needed for completing data collection was three months. Follow-up e-mails were distributed approximately two weeks following initial mailings.

Data was analyzed focusing on 15 research questions. Descriptive and nonparametric testing was used in the analysis. The primary goal of the study was to describe what collaborating experts reported. In adhering to the Delphi methodology, no attempt to generalize findings to a population was made. Depiction of levels of importance for various inventory items employed descriptive statistics. Since the nature of the scaling for level of importance did not adhere to parametric assumptions, the Leik formula was incorporated into this study to measure ordinal consensus among respondents on their response to items. Descriptive statistics were also utilized to describe the degree of consensus panelists reached regarding each inventory item.

Discussion

A discussion of the findings for each of the four research objectives follows.

Research Objective 1

To identify core components needed for MFTs to work collaboratively with HCPs.

Research Objective 2

To validate by obtaining consensus of MFT practitioners working in collaborative practice (Delphi procedure) those components that are VERY IMPORTANT and IMPORTANT for collaborative work.

Five collaborative components were identified in the literature. These broad components were derived from the general collaboration literature, Gray's (1989) most recent effort at defining the process of collaboration. Collaborative healthcare literature aided in the explanation and application of these components to the healthcare field. These explanations took on the forms of both elucidation of the components and further clarification of the categories in the form of sub-components. The following discussion

is in regards to objectives one and two: identification core components and validation by obtaining consensus and will examine each of the five collaborative component with the corresponding sub-components. The components will be discussed in the order of degree of consensus reached: the extent panelists agreed upon the ranking of the inventory question. The discussion will begin with the component reaching the highest level of consensus.

Professional Autonomy. Professional Autonomy was the components to reach the highest level of consensus at 80% agreement, and the only component ranked Not Important. This component is best understood by further examining the respective sub-components. Professional Autonomy includes the following sub-components: 1. Patient Focused Hierarchy: the professional with the most expertise given the situation exerts the most influence; 2. Relationship Focused Hierarchy: the professional or business arrangement; and 3. Independent Decision Making: professionals retain their independent decision making capabilities. Professional Autonomy ranked Not Important with a very high level of consensus: 80% of panelists agreed that this component was not important to the success of the collaborative relationship. The level of consensus for the sub-components is high relative to other sub-components. Two of the three sub-components reached consensus at a high level. Hierarchy around patient care issues ranked Very Important with 90% agreement, Hierarchy around the professional relationship ranked Not important with 75% agreement, and Independent Decision Making ranked Important with 65% agreement. Table 5.1 represents the relevant findings of this component and corresponding sub-components.

Table 5.1: Professional Autonomy and Sub-Components			
Name	**Leik's Formula**	**Degree of Consensus**	**Level of Importance**
Professional Autonomy	0.805	> 75% range	Not Important
Hierarchy: Patient focus	0.9	> 75% range	Very Important
Hierarchy: Relationship focus	0.75	> 75% range	Not Important
Independent Decision Making	0.65	50 - 74% range	Important

The high level of consensus lends validity to the ranking of Not Important for this component. The high levels of consensus for the sub-components lend further validity to panelists' agreement on this particular subject area and it's importance to collaboration.

The rankings of the sub-components corresponding to Professional Autonomy are in keeping with one of the common threads of this study. This theme defies the tenor of the predominant collaborative healthcare relationship literature. Panelists have agreed that aspects of the professional relationship, care and treatment of patients are most important, and personal aspects of the professional relationship, those aspects independent of the patient are less, or not important.

Findings in this component are incongruent with the dominant literature regarding another aspect of collaborative writings. The existing literature suggests that collaborations that occur primarily around individual patients are lower, or lesser, levels of care. Current writings also suggest that as collaborative care continues, independent relationships between professionals often characterized by emphasis on professional hierarchy become increasingly more important. It is possible that collaborations between MFT and HCP that remain at the level of converging around a particular

patient are most effective. Further examination is needed of the assumption that higher levels of collaboration, including increased professional intimacy between collaborators, means better care for patients.

Shared Rules, Norms, and Structure. The largest of the components, Shared Rules, Norms, and Structure is the extent to which individuals understand cultural rules and norms, and the structure of the professionals involved. Shared Rules, Norms, and Structure reached consensus at 75% and ranked Important. This indicates a high level of consensus regarding the level of importance of this item: 75% of panelists agreed that this component is Important relative to the other components.

Shared Rules, Norms, and Structure includes ten sub-components. Only one, Communication Frequency, reached consensus at a high rate of 75%. Frequency of communication is a subject often addressed within the Collaborative literature; It is recognized as significant, but is perhaps not imperative, to the success of collaboration. Panelists agreed with moderate levels of consensus that Communication Content, and Language (72% and 54%, respectively), ranked Very Important. Panelists also agreed with moderate levels of consensus that Mode of Communication (71% agreement), issues of Confidentiality (61% agreement), and Provision of Services, or who is providing what services (54% agreement), are Important to the collaborative process. Finally, Sharing of Support Staff and Sharing of Records ranked Not Important with moderate levels of consensus (73% and 51%, respectively).

Location of Services provided ranked Important, however with only 26% agreement. Rules and Norms being explicitly stated ranked Not Important with 45% agreement. Table 5.2 represents the relevant findings of this component and corresponding sub-components.

Table 5.2: Shared Rules, Norms and Structure and Sub-Components

Name	Leik's Formula	Degree of Consensus	Level of Importance
Shared Rules, Norms, and Structure	0.75	> 75% range	Important
Communication: Frequency	0.7502	> 75% range	Very Important
Shared Support Staff	0.7322	50 - 74% range	Not Important
Communication: Content	0.7222	50 - 74% range	Very Important
Communication: Mode	0.7084	50 - 74% range	Important
Communication: Confidentiality	0.6111	50 - 74% range	Important
Communication: Language	0.542	50 - 74% range	Very Important
Provision of Services	0.5416	50 - 74% range	Important
Shared Record Keeping	0.5104	50 - 74% range	Not Important
Explicit/Implicit Rules and Norms	0.4569	50 - 74% range	Not Important
Location of Services	0.2638	< 50% range	Important

Some of the most interesting findings of this study are within this component. Several of the findings are congruent with the Collaborative Healthcare literature, including Doherty's Levels of Collaboration (1995) and the Rochester Model (Seaburn, et al., 1996). Doherty suggests that a few of the aforementioned communication sub-components are positively correlated with the level of collaboration; as communication frequency, mode, language and content increase, the extent of the collaboration increases. In this study, panelists have agreed that these sub-components are all either

Very Important or Important. In addition, Issues of Confidentiality, and Provision of Services are considered significant relationship ingredients within the existing literature. In this study, panelists agreed with moderate levels of consensus (61% and 54%) that these items are also Important.

Several other sub-components within this component are also dominant themes in both Doherty's (1995) and Seaburn et al.'s (1996) writings. A unique finding of this study is that Shared Support Staff ranked Not Important with a relatively high rate of consensus (73% agreement). Shared Record Keeping also ranked Not Important, yet with slightly less agreement (51%). Much of the collaborative healthcare literature encourages sharing of support staff and records, whenever possible (Bischoff & Brooks, 1999). The low ranking of these sub-components may have several explanations. First, these are some of the more rare circumstances that occur in collaborative relationships between MFTs and HCPs. Panelists may not have ranked these as important as they may not occur within their respective settings. Panelists were, however, encouraged to respond to questions that had components that did occur in their individual settings. It is possible that panelists ranked these sub-components as Not Important as they did not appear to contribute to the success of the collaborative relationship.

One of the more interesting findings of this component is the final sub-component ranked Not Important. Explicit/Implicit Rules and Norms, defined as the extent to which rules and norms are overtly discussed, ranked Not Important, with agreement of 46%. This finding is congruent with the theory of Negotiated Order. Day and Day (1977) suggest that it is the unwritten, covert rules and norms that most significantly influence behavior. The theory of Negotiated Order states that "an informal

structure emerges in which the involved parties develop tacit agreement and unofficial arrangements that enable them to carry out their work" (Strauss et al., 1963, p. 130).

Finally, Location of Services while ranking Important, was agreed upon by only 26% of panelists. This may suggest that panelists are ambiguous about the role physical location plays in the success of the collaborative relationship. Sharing physical space with HCPs is reported throughout the literature as one of the more rare circumstances. This finding may be attributed to the low rate of occurrence for this sub-component. Doherty (1995) suggests shared Location of Services is also positively correlated with higher levels of collaboration. Further investigation into this subject is warranted.

Interactive Process. This component, defined as the skills and knowledge related to the process of interacting between professionals, ranked Very Important with a 64% rate of consensus. One of the sub-components of Interactive Process, Mutual Respect was the only sub-component in the entire inventory to reach a high level of consensus in the first round. More than 80% of respondents agreed in the first round that this sub-component is Very Important to the success of collaborative relationships.

The remaining sub-components reached consensus at moderate levels. Two sub-components: Valuing Interpersonal Processes and Negotiating Multiple Perspectives were ranked as Important, with 65% and 56% levels of agreement, respectively. The remaining two sub-components of Interactive process are a Change Orientation during the Ongoing Interaction and during the Initial Interaction. Panelists agreed that both Change Orientation during the Ongoing Interaction (69% agreement), and during the Initial Interaction (62% agreement), were Not Important. Table 5.3 represents the relevant findings of this component and corresponding sub-components.

Table 5.3: Interactive Process and Sub-Components			
Name	**Leik's Formula**	**Degree of Consensus**	**Level of Importance**
Interactive Process	0.6385	50 - 74% range	Very Important
Mutual Respect	0.8195	> 75% range	Very Important
Change Orientation: Ongoing	0.6875	50 - 74% range	Not Important
Value Interpersonal Process	0.647	50 - 74% range	Important
Change Orientation: Initial	0.618	50 - 74% range	Not Important
Negotiate Multiple Perspectives	0.559	50 - 74% range	Important

These inventory questions all reached consensus at a reasonably high level. At least 50% of respondents concurred with the rankings. This component has a more pragmatic quality as it emphasizes the back-and-forth nature of the relationship; a common characteristic of many relationships. The common nature of this component may explain the high ranking. Individuals may have recognized these terms more easily. Also, the respondents are Marriage and Family Therapists who, in many cases, emphasize process over content. This may further explain the high ranking of this component. Finally, it is important to note the high concurrence of ranking mutual respect as very important. As professionals dedicated to the advancement of successful relationships, MFTs are likely to place a high level of importance on a sub-component such as Mutual Respect. Bischoff and Brooks (1999) recognize the necessity of mutual respect in order for collaborations to exist.

Domain Orientation. This component, defined as 'actions and decisions between individuals are oriented toward patient health care' ranked the highest of the five components for level of importance, with an agreement rate of 58%. Three sub-components were identified as further characterizing this component: Common purpose, Orientation, and Act or Decide. Common purpose, or professionals uniting around a common goal, was agreed upon by panelists at a very high rate. Panelists reached 95% consensus regarding the ranking of Common Purpose as most important of these three sub-components. Orientation: professionals orient processes, decisions and actions around patient care issues, was ranked Important, with 76% agreement, and Act or Decide: interaction results in an action or decision, was ranked Not Important, with 71% agreement. Table 5.4 represents the relevant findings of this component and corresponding sub-components.

Table 5.4: Domain Orientation and Sub-Components

Name	Leik's Formula	Degree of Consensus	Level of Importance
Domain Orientation	0.583	50 - 74% range	Very Important
Common Purpose	0.952	> 75% range	Very Important
Act or Decide	0.762	> 75% range	Not Important
Orientation	0.714	50 - 74% range	Important

These inventory questions all reached a relatively high level of consensus regarding the rankings. At least half of individuals surveyed agreed that this collaborative component, Domain Orientation, was the most important aspect of the relationship. This is a less pragmatic, more paradigmatic component than some of the others. This can be interpreted in several ways. This may be due to the complex nature

of the subject matter, several pilot study participants found this particular category complex. It may be, however, that one of the more crucial aspects of a successful collaborative relationship is the intent of each participant in the forming and maintaining the relationship. This finding is in keeping with recommendations by Bischof (1999) to support an action-oriented approach to collaboration.

The rank of Domain Orientation is supported by the ranking of the sub-component Common Purpose. A very high consensus (95%) was reached regarding the importance of individuals engaging in a relationship united around a common goal. All sub-components of Domain Orientation reached a high level of consensus. This supports the congruence of thoughts regarding these relationship characteristics.

Stakeholder. This component, defined as the extent to which an individual, or individuals have a stake or investment in patient care issues, ranked Important at a moderately high level of consensus, 55%. This component acquires the lowest level of consensus among panelists. The namesake of this component-- sub-component Stake-- ranked Very Important, but with rather low consensus (47%). Trust in the relationship and Shift in Paradigm ranked Important with reasonable consensus (51% and 48% respectively). Finally, also with at least 50% consensus, Personal communication within the relationship was ranked Not Important. Table 5.5 represents the relative findings of this component and corresponding sub-components.

Table 5.5: Stakeholder and Sub-Components			
Name	**Leik's Formula**	**Degree of Consensus**	**Level of Importance**
Stakeholder	0.5555	**50 - 74% range**	**Important**
Relationship: Personal Communication	0.6487	50 - 74% range	Not Important
Relationship: Trust	0.5087	50 - 74% range	Important
Shift in Paradigm	0.4787	50 - 74% range	Important
Stake	0.474	< 50% range	Very Important

This component, identified as a stakeholder, is a term that is used throughout the Collaborative Healthcare field as well as the Organizational behavior field. Individuals engaging in a professional relationship with common goals are often referred to as 'stakeholders.' This component ranks as Important, however with a low level of consensus. As this is a term that is often used as a label to describe individuals, participants may not place value on the role of stakeholder as much as the processes that occur when one becomes a stakeholder. Within the component--sub-component Stake--which bears a similar definition, ranks Very Important, yet panelists are also ambiguous about the ranking. Consensus is low (47%), which may be due to some of the same reasons Stakeholder does not get a higher rating.

Panelists agree at a relatively high level of consensus (65%) that Personal Communication is Not Important. Panelists moderately agree that Trust within the relationship (51% agreement) and Paradigm shift, or a change in one's conceptualization of patient wellness/illness to include both physical and psychosocial issues (48% agreement), are important to the relationship.

Professional conceptual and relational issues are ranked Important, and are consistent with findings in the previous components. While various relationship aspects are Important or Very Important, such as Trust, Respect, and Valuing Interpersonal Processes, the prevailing theme is that the emphasis is on the professional interactions. Personal interactions are not, according to panelists, important in the success of collaborations.

Collaborative Items and Consensus. Collaboration inventory items provided several interesting findings. Inventory items were all ranked on the same three point scale: Very Important, Important, Not Important. One of the more notable findings is that none of the inventory items were ranked as Not Important. This finding can be interpreted to mean several things. First, panelists may not be discerning regarding individual items. The components and sub-components included forced ranking; rankings relative to each other. Inventory items were not ranked relative to each other, rather ranked separately on a three point scale. Secondly, inventory items demonstrate this data as being positively skewed, therefore not meeting assumptions of normal distributions. Finally, the scale is only three points so that the distinction between responses is minimal, which suggests the need for a larger number of categories. This point will be further discussed in the Limitations section of this chapter.

Another relevant finding of the inventory items data is the relatively low level of consensus. The assumption would be that with fewer options to choose from (a three point scale) that consensus would occur at a higher rate. As demonstrated in Table 5.6, the percent of inventory items (30%) that reached consensus at a low level is higher than for Components or Sub-components (0% and 8% respectively). Table 5.6 demonstrates

the percent of inventory questions divided by style (component, sub-component, item) reaching consensus at high, moderate, or low levels.

Table 5.6: Levels of Consensus reached by Percent of Inventory Questions			
	High Consensus (> 75%)	**Moderate Consensus (50 - 74%)**	**Low Consensus (< 50%)**
Components	40%	60%	0%
Sub-Components	24%	68%	8%
Items	22%	48%	30%

The significant diversity regarding consensus of inventory items may be attributed to several points. First, consensus may be more difficult to reach when the questions at hand are more specific in nature. There is a difference between agreeing on how important the role of Mutual Respect is to the success of a relationship and how important is the role of a phone call. Second, it may be more than just the nature of the questions. This finding may confirm one of the gaps within the collaborative healthcare field mentioned earlier in this study: the lack of converging ideas within the field. As mentioned, several individuals in areas of the United States contribute to the literature by sharing their respective collaborative experiences. What is missing, however, may still be a merging of thoughts and experiences into a collective model.

This study suggests that individuals with an interest in the field of collaboration may not be working together to maximize the understanding and facilitation of collaborative healthcare. This project is the first of, hopefully many, that begins to pull together thoughts, experiences, successes, and failures, to benefit professionals beyond their current location.

A closer look into the content of the inventory items is also warranted. One of the most significant findings is that, as illustrated on Table 4.12, several inventory items delineating Paradigm (part of Stakeholder component) reached a high level of consensus in Round 1. More than 75% of panelists agreed that both collaborative parties' (MFTs and HCPS) concern with physical and psychosocial well being of patients is Very Important. These were the only items that obtained such high consensus in Round 1. The overall sub-component, Shift in Paradigm, ranked only Important with moderate consensus (48%). Inventory items portraying mutual respect ranked Very Important with high levels of consensus. This is in keeping with the rank of the sub-component Mutual Respect. The inventory items regarding Common Purpose and Orientation both ranked Very Important with high levels of consensus (82% for both). This is congruent with sub-component findings. Finally, panelists are ambiguous regarding how professionals initiate contact. Most inventory items examining initial contact reached minimal levels of consensus. This is also in keeping with some of the significant findings regarding communication of this study which have been incongruent with the dominant literature.

Finally, it is important to recognize that panelists provided no additional questions to the inventory in either round, suggesting the inventory included an exhaustive list of collaborative dimensions. A significant goal of this project was to facilitate the move of Collaborative Healthcare research in a quantitative direction, eventually producing for a Collaborative measurement tool. This project is the first attempt to itemize relationship characteristics. The lack of additions from 'experts' suggests that this project is timely in that the vast majority of relationship characteristics

considered important to the success of the relationship is discussed in the literature, however few have been empirically tested. This project attempts to provide additional groundwork for future studies of relationships of MFTs working collaboratively with HCPs. The recommendations section will further this discussion.

Research Objective 3

To identify demographic factors which differentially affect the reported significance of components.

Research questions regarding demographic factors were generated. Specifically, demographic factors that were examined included gender, employment setting and years of collaborative practice. This project was not able to examine in a meaningful way the demographic factors in relation to the data. Chapter 4 addresses the statistical limitations of analyzing these questions. Statistically, limitations were due primarily to an inadequate sample size (N = 42) and potential cell size in regards to the demographic factors. A look at the inability to explore these questions conceptually is also warranted. The first demographic factor, gender, is included to inquire about any differences between males and females regarding the perceived value of relationship characteristics. Currently, the literature in collaborative Healthcare does not include any gender-related findings. It should be noted that similar to most mental health professions, Marriage and Family therapy is predominately female. The sample for this study, limited to MFTs, in terms of gender as a demographic, is congruent with the MFT population in that it is predominately female. Due to this limited diversity, rigorous analysis and correlation are not possible.

Employment setting is a demographic factor that is peripherally addressed in the collaborative literature. Throughout collaborative healthcare writings there is a recognition of the different 'work settings' and the influence on collaborative practices (Seaburn et al, 1996). For the purposes of this project, employment settings included academic, clinical, inpatient and outpatient. One interesting finding is the significant overlap of individuals working in several different contexts. Marriage and Family therapy is applicable in such a broad range of contexts, few practicing MFTs work in any one setting. This may contribute to the difficulty in addressing this objective.

Statistically, the limitation is due primarily to the inadequate sample size. This, along with potential reasons for the limited sample size, will be further addressed in the Limitations section of this chapter.

Research Objective 4

To propose a **Collaboration Inventory** (CI) for use in further development of evaluative measures of collaborative practice.

A list of inventory items, broad characteristics and sub-characteristics provided in the form of the Collaboration Inventory in Appendix C. Panelists added no additional items, components or sub-components suggesting that at this stage, the CI is reasonably thorough in exploring various relationship elements. The existing inventory is timely in that it takes the initial steps towards bringing together thoughts and opinions of many different practicing 'experts' in the field of collaborative healthcare. Pilot participant suggestions were incorporated into the final inventory improving the quality and potential for future developments.

Future research is required to continue the development of the CI. Findings of this study will contribute to the further development of a quantitative instrument available for individuals to examine the extent of collaborative relationships in various settings. Several strategies exist as a result of this study for consideration in future developments. First, it is clear that components, sub-components, and even inventory items are more or less important in the process. Future developments should take into consideration the varying degrees of importance, and include this into the measurement process. The difference between the presence of one component, sub-component, or item, over another may be significant and scoring should be weighted accordingly. Second, as sub-components and inventory items are embedded within broader groupings, further exploration into the relationship between components and sub-components, sub-components and items, and finally items and components is warranted. There is potential for scores on inventory items to infer information regarding the corresponding sub-component, and the corresponding component, as well as scores of sub-components being utilized to make inferences about collaborative components.

These additional developments rely heavily on statistical processes, primarily factor analysis. Factor analysis involves "classifying large numbers of interrelated variables into a limited number of dimensions or factors" (Frankfort-Nachmias and Nachmias, 1992, p. 442). Factor analysis includes exploring the relationships between inventory items (factor loading) as well as determining the 'weight' of each inventory item, to most accurately represent what the author hopes to identify or explain.

The Collaboration Inventory requires further development in the aforementioned areas. These areas are primarily quantitative in nature. It is equally important to further the understanding of the subject areas included within the inventory. Interpretation of the various relationship characteristics by panelists, and future participants, is key to the usefulness of the inventory. Qualitative studies, including interviews, focus groups and additional Delphi studies can strive towards developing terminology with shared meaning throughout the field, thereby enhancing the validity of reported answers.

Implications

As Marriage and Family Therapy is a clinical practice, and Collaborative Healthcare is something individuals engage in, practical implications of these findings are relevant. The findings of this study can be applied to three broad areas: 1. training, 2. initiating collaborative relationships, and 3. further facilitating collaborative relationships. Efforts and energies should be placed in areas that practicing experts recognize as more important to the success to the relationship.

This study found that the professional orientation (Domain Orientation) was very important to panelists. In interacting or initiating interactions with health care professionals, MFTs should emphasize their orientation towards patient care, discussing it overtly with the HCP. Clearly identifying specific goals related to patient care to HCP may further facilitate collaborative practice. Acknowledging the importance of mutual respect, and modeling the respectful behavior may go a long way in furthering collaborative relationships. Recognizing the importance of the process of interacting with the HCP (Negotiating Multiple Perspectives, Valuing Interpersonal Processes) and how HCPs are in a way clients as much as the patients. Some communication

characteristics, such as frequency of communication appear important as opposed to others such as formal meetings or sharing of patient charts or support staff, which may not be as useful. Overt, explicit discussions around daily tasks may be unnecessary as they will often evolve out of the process. The development of a personal relationship with the HCP may be beneficial, but is certainly not required for successful collaboration. Finally, the professional structure or hierarchy, may not warrant a great deal of attention. These implications are primarily drawn from the findings around the rankings of components, sub-components, and items.

Marriage and Family Therapists hone and practice many skills with clients. It is often the case, however that those skills are limited to the therapy room. It may also be the case that professionals are limiting their application of collaborative skills to collaborations with on-site professionals. The low levels of consensus suggest that MFTs are not working on collaboration with each other in ways that maximize potential for collaborative efforts. It may be helpful to examine skills utilized within both the therapy room and within the healthcare setting and consider the greater impact those skills may have on the field of Collaborative Healthcare as well as Marriage and Family Therapy.

Potential Contributions to the field of Collaborative Healthcare

The current state of collaborative healthcare research was discussed in chapter 2. Many individuals contribute to the collaborative healthcare literature in a more anecdotal form based upon their clinical experiences. Several models or spectrums have been suggested to aid professionals in their conceptualization of this process. A few studies have begun to take a more empirical view of the collaborative relationship. This study

has attempted to make two significant contributions. The first of these contributions is to bring together ideas and concepts from a variety of origins into a more comprehensive collaborative model. Second, this study has made an attempt to quantify the relationship components. The goal is to further this process and allow for more specific and rigorous ways and means of looking at this process of providing care. The profession should continue to explore collaborative healthcare both qualitatively and quantitatively. The field has made enormous strides in the development of the journal, Families, Systems and Health, and the establishment of the Collaborative Family Healthcare Coalition. Both of these advances are resources with great potential for further use in this ongoing process of understanding, measuring, and defining Collaborative Healthcare.

Researcher Observations

This sections provides the opportunity to include information that does not belong in any of the existing areas. This section includes information potentially helpful for future projects and general information relevant to this study.

The process of completing the survey deserves some attention. Several panelists commented that the survey was long, complicated or confusing. Individuals were often confused by the ranking portions of the survey. Several had either incomplete or incorrect responses to this section and were dropped from the study. Future surveys may need to explore other ways of gathering this information. This supports recommendations for future research, discussed below. Several panelists commented on how the standing relationship with the HCP made several questions moot. Panelists felt that some questions were 'obvious' for their respective situation. It would behoove

future surveys to take into further consideration the length of time individuals have been participating in the collaborative relationship.

A few interesting points surfaced when exploring the data. Significant diversity in what kind of work MFTs do was very present. Work settings had tremendous diversity and should be further explored. In addition, while few HCPs responded to the survey, levels of consensus did not change regardless of the inclusion of the HCP. Data including the HCPs was not included for this study, however some analyses were run for curiosities sake. It would stand to reason that members of a single profession, such as MFT, would tend to agree more around a particular topic, than if professions were combined. This study did not find this to be the case. Perhaps the distinction by paradigm (biopsychosocial or not) is more significant than the title of the profession.

Finally, this researcher had the opportunity to work in a new collaborative setting throughout the duration of this project. Several relationship characteristics identified in this study as Very Important, however incongruent with the dominant literature, were observed in the clinical setting. Location of Services was thought, per the dominant literature, to be of extreme importance. Clinical work was done within a particular HCP's office. Referrals and collaboration, however, were greater from HCP's beyond the physical office of the MFT clinical work. The findings of this study suggest that paradigm, primarily through inventory items, and not the sub-component, is a Very Important component. This finding is congruent with the experience of the researcher. HCPs who embrace a biopsychosocial paradigm engage in collaboration far more frequently than those who do not. General findings of this study suggest paradigmatic relationship components as more important than pragmatic components.

This researcher's clinical experience in collaborative healthcare is congruent with this finding. While more difficult to observe and measure, it may be of significance for the field to take a closer look at these abstract relationship components over those that are more easily quantified.

Limitations of this Study

This project has several limitations. The most significant limitation is the sample size. This study included a sample size of 42 of a possible 85 panelists. This was 49% of the eligible panelists. The response rate was limited for many reasons. Potential reasons may have included the time of year the surveys were mailed. As many of the members of the CFHcC work in an academic environment, many may have been on summer leave during the mailing of Round 1 (July). Round 2 was mailed in August. This time of year is also difficult for professionals affiliated with academic settings as it is the beginning of the academic year. Efforts were made to increase response rate. Two weeks following each of the mailings, follow up e-mails were sent to respondents to encourage completion of the survey. Finally, one half of the collaborative relationship includes health care providers, often physicians who are frequently the target of many individuals seeking to gain some of their time. This culture may have contributed to a low response rate for physicians.

Another limitation includes the respondent perspective. Several issues are relevant. Respondents were asked to complete the survey based upon their 'most successful collaborative relationship around a particular patient within the past five years.' If respondents experienced a successful collaborative relationship between rounds, the second round may have been completed based upon a different experience

than the first. In addition, it is possible that different relationship characteristics are important depending upon the presenting patient. A look into different types of patients warrants further investigation.

An additional limitation was the three point scale provided to panelists for ranking the importance of inventory items. Pilot participants unanimously agreed that a three point scale was more conducive to responding to the questions, however a five point scale would have provided richer data. A five point scale may have provided more discrimination among inventory items.

The inventory was constructed by a therapist and therefore may include a strong therapist focus. The respondents for the survey were therapists and therefore may be in keeping with a 'therapist' perspective. Further exploration into use of the inventory with Health Care providers is warranted. Finally, the terminology for the inventory may be cumbersome and terms may not have had shared meaning. This could alter the interpretation and subsequent response of participants.

Recommendations for Future Research

Research into the field of Collaborative Healthcare is new and therefore full of future opportunities. Based upon this study and the existing literature a need for a plethora of future research exists. Demographic findings in this study, or lack of findings, suggests further qualitative studies are warranted. A close examination into how employment settings, managed care contexts, and particular collaborative partners all bear significance in furthering this process. Focus groups exploring additional relationship characteristics would be beneficial. Issues of consensus and the level of importance would warrant focus groups. Finally the nesting structure of the inventory

deserves a closer look. As demonstrated by Shift in Paradigm (sub-component ranked Important with moderate consensus, yet, inventory items ranked Very Important with high consensus), often inventory items lend a different ranking than the sub-component they attempt to clarify.

Quantitative research studies are also merited. Further development of the Collaboration Inventory, including factor analysis, bears significant potential for future research. An instrument equipped to measure the extent of collaborative practice would allow for examination of maximizing collaborations and care for patients. In addition, an instrument of this nature would allow for communication of the benefit of collaborative healthcare to managed care companies interested in efficiently and cost-effectively managing patient care.

Enormous potential exists for increased qualitative understanding of the process, practice and impact of collaborative healthcare. As mentioned previously, qualitative examination of the terminology and development of shared meaning would make significant contributions to the development of the instrument. Exploration into the impact different patients have on the relationship, and perceived importance of corresponding relationship characteristics warrants closer examination. In addition, this study explored successful collaborative relationships. Results may vary significantly if MFTs considered an unsuccessful relationship. Finally, inventory content areas worth exploring rose from this study. A closer look into the assumption that increased collaboration means better patient care should be explored. Increased collaboration in the literature is characterized by high levels of shared record keeping, shared staff, and relationship between MFT and HCP independent of the patient. Findings in this study

are incongruent with these characteristics. Further investigation into these areas might prove fruitful.

Practical application of the qualitative understanding of this relationship into quantitative studies can lead to improved patient care, cost savings and job satisfaction for practitioners. As a field specializing in interactive processes and relationship dynamics, it is appropriate that Marriage and Family Therapy lead the way in forging collaborations with other helping professionals to create a new definition of health and well being.

Appendix A: Identification of components, sub-components and items

- A-1: Components and Sub-Components
- A-2: Item Derivation

Appendix A-1

Components and Sub-Components

Component #1: **Shared rules, norms, and structure**:

Definition: The extent to which individuals understand cultural rules and norms and the structure of the collaboration

Sub-components include: communication
location of services provided
provision of services
physical facilities utilized
rules and norms are implicit or explicit

Component #2: **Interactive Process:**

Definition: The skills and knowledge related to the interaction between professionals.

Sub-components include: individuals value interpersonal processes
mutual respect within the relationship
relationship has a change orientation
individuals negotiate multiple perspectives

Component #3: **Professional Autonomy:**

Definition: The skills and knowledge related to maintaining professional autonomy within the relationship

Sub-components include: independent decision making capabilities
flexible hierarchy

Component #4: **Stakeholder:**

Definition: The extent to which individuals have a stake in the patient care issues

Sub-components include: Paradigm shift
development of trust in the relationship
content of communication
individuals with a stake in services provided

Component #5: **Action or Decision:**

Definition: The extent to which professionals intent to act or decide

Sub-component includes: The extent to which professionals intent to act or decide

Component #6: **Domain Orientation**:

Definition: Actions and decisions are oriented toward the patients health care.

Sub-components includes: common purpose and action orientation

Appendix A-2

Item Derivation

HCP: Health Care Professional (Physician, Nurse, Physician Assistant)
MFT: Marriage and Family Therapist

1. Component: Shared Rules, Norms and Structure

Sub-Component: Communication: *(mode)*:
1. HCP sent **letter/e-mail** to MFT regarding patient
2. MFT sent **letter/e-mail** to HCP regarding patient
3. HCP **phoned** MFT regarding patient
4. MFT **phoned** HCP regarding patient
5. HCP and MFT had an **informal face to face** (bump in the hallway) meeting regarding patient
6. HCP and MFT had **formal arranged meeting** regarding patient

Sub-Component: Communication: *(frequency)*:
1. On average, **how often** did the HCP communicate with the MFT regarding patient issues.
2. On average, **how often** did the MFT communicate with the HCP regarding patient issues.

Sub-Component: Communication: *(confidentiality)*:
1. Issues of confidentiality were **not discussed nor implied** between MFT and HCP
2. Issues of confidentiality differences **not discussed,** MFT and HCP
3. Issues of confidentiality differences **were discussed and were explicit** between MFT and HCP

Sub-Component: Communication: *(language)*:
1. MFT had **little/no understanding** of **medical terminology** which led to some communication breakdown
2. HCP had **little/no understanding** of **therapeutic terminology** which led to some communication breakdown
3. MFT and HCP **shared some medical and therapeutic terminology**, however some communication breakdown still occurred
4. MFT and HCP developed a **shared language** (a basic understanding of medical and therapeutic terminology) which minimized communication breakdowns.

Sub-Component: Communication: *(content)*:
1. Interaction between MFT and HCP focused on **patient issues only**
2. Interaction between MFT and HCP focused **primarily on patient issues**, however included some **relationship dynamics**
3. Interactions between MFT and HCP included a **mixture of patient care and relationship dynamic issues.**

Sub-Component: Provision of Services:
1. The MFT and HCP provided **separate care and treatment**
2. The MFT and HCP provided **primarily separate** care and treatment, with **occasional joint comprehensive** care and treatment
3. MFT and HCP provided **consistent joint comprehensive** care **and treatment.**

Sub-Component: Shared Facilities:
1. The MFT and the HCP had **separate** support staff
2. The MFT and the HCP **shared some** support staff
3. The MFT and the HCP **shared most** support staff

Sub-component: Record Keeping:
1. The MFT and the HCP kept patient records **separately**
2. The MFT and the HCP kept **primarily separate but occasionally shared** patient records.
3. The HCP and the MFT **share** patient records.

Sub-Component: Location of Services:
1. MFT and HCP provide services in **separate locations (separate buildings)**
2. The MFT and HCP provided services in **shared location with separate offices.**
3. MFT and HCP worked in the **same office**

Sub-Component: Explicit/Implicit:
1. The **majority of rules and norms** for behavior between MFT and HCP were **implied**, but not explicitly discussed.
2. **Some of the rules** and norms for behavior between MFT and HCP **were explicitly identified** while others remained implied.
3. **Most rules and norms** for behavior between MFT and HCP were **explicitly identified.**

2. Component: Interactive Process

Sub-Component: Relationship: (*Mutual Respect*):
1. MFT had **little/no regard** for HCP perspective or expertise
2. HCP had **little/no regard** for MFT perspective or expertise
3. MFT **demonstrated some regard** for HCP perspective or expertise
4. HCP **demonstrated some regard** for MFT perspective or expertise
5. MFT **showed clear regard** for HCP perspective and expertise
6. HCP **showed clear regard** for MFT perspective and expertise

Sub-Component: Value interpersonal process:
1. MFT/HCP interactions indicated that patient treatment outcome was dependent on separate efforts of **either** the MFT or HCP
2. MFT/HCP interactions indicated that patient treatment outcome was dependent on **parallel efforts** of the MFT and HCP
3. MFT/HCP interactions indicated that patient treatment outcome was dependent on **joint/shared efforts** between MFT and HCP

Sub-Component: Change Orientation; (*initial interaction*):
1. MFT/HCP relationship developed with **no intent to modify** existing patient care
2. MFT/HCP relationship developed with **clear intent to modify** existing patient care

Sub-Component: Change Orientation; *(ongoing interaction)*:
1. Ongoing interactions between MFT and HCP indicate **no intent to modify** existing patient care
2. Ongoing interactions between MFT and HCP indicate **clear intent to modify** existing patient care

Sub-Component: Negotiate Multiple Perspectives:
1. HCP trained perspective of patient was **shared with** MFT
2. MFT trained perspective of patient **shared with** HCP
3. HCP and MFT **dialogued** about both professional perspectives
4. HCP and MFT negotiate a **mutual (shared) professional perspective** about patient

3. Component: Professional Autonomy

Sub-Component: Hierarchy (*patient focus*):
1. HCP/MFT interactions regarding patient care reflect **HCP as dominant**; regardless of the situation
2. HCP/MFT interactions regarding patient care reflect **MFT as dominant**; regardless of the situation.
3. HCP/MFT interactions regarding patient care reflect **flexible shifts** in professional roles, depending on the situation.

Sub-Component: Hierarchy (*relationship focus*):
1. HCP is **supervisor of** the MFT.
2. MFT is **supervisor of** the HCP.
3. MFT and HCP are **peers/colleagues.**

Sub-Component: Independent Decision Making:
1. HCP **reports to** MFT regarding patient treatment
2. MFT **reports to** HCP regarding patient treatment
3. HCP **does not report to** MFT regarding patient treatment

4. MFT **does not report to** HCP regarding patient treatment
5. HCP **dialogued with** MFT regarding patient treatment
6. MFT **dialogued with** HCP regarding patient treatment
7. HCP **provided suggestions** to MFT regarding therapeutic treatment of patient
8. MFT **provided suggestions** to HCP regarding physical treatment of patient

4. Component: Stakeholder:

Sub-Component: Relationship: *(developmental/trust)*:
1. Initially, the MFT - HCP providers **shared** personal and professional information
2. As the collaboration progressed, the MFT - HCP providers **disclosed more** personal and professional information
3. As the collaboration evolved, the MFT - HCP providers **exchanged** personal and professional information
4. As the collaboration matured, the MFT - HCP providers **developed a trusting** relationship.

Sub-Component: Relationship: (*personal communication)*:
1. Personal disclosure shared between MFT and HCP is **indirect**, through patient care.
2. **Some** personal disclosure shared between MFT and HCP occurs directly, and some occurs through patient care.
3. Personal disclosure is shared openly between MFT and HCP in clear and direct ways.

Sub-Component: Stake:
1. The HCP **referred** patient for therapy
2. The MFT **referred** patient to HCP
3. The HCP **contacted** the MFT regarding the referral
4. The MFT **contacted** the HCP regarding the referral
5. The HCP **provided care/treatment** for the patient
6. The MFT **provided care/treatment** for the patient
7. The HCP **continued care** after referring patient for therapy
8. The MFT **continued care** after referring patient to the HCP.

Sub-Component: Shift in Paradigm: (*biopsychosocial*):
1. The HCP was **initially** concerned with only the physical well-being
2. The MFT was **initially** concerned with only the psychosocial well being
3. The HCP was **initially** concerned with physical and psychosocial well being
4. The MFT was **initially** concerned with physical and psychosocial well being
5. **With the progression** of the collaboration, the HCP was concerned with only the physical well-being of patient
6. **With the progression** of the collaboration, the MFT was concerned with only the psychosocial well being of the patient
7. **With the progression** of the collaboration, the HCP was concerned with physical and psychosocial well being of the patient
8. **With the progression** of the collaboration, the MFT was concerned with physical and psychosocial well being of patient

5. Component: Action or Decision

Sub-Component: Act/Decide:
1. MFT **never shared** with HCP any decision or plan of action regarding patient care, as a result of the collaboration.
2. HCP **never shared** with MFT any decision or plan of action regarding patient care, as a result of the collaboration.
3. MFT **shared** with HCP a **vague** decision or plan of action regarding patient care, as a result of the collaboration.
4. HCP **shared** with MFT a **vague** decision or plan of action regarding patient care, as a result of the collaboration.
5. MFT **expressly stated** to HCP a decision or plan of action regarding patient care, as a result of the collaboration.
6. HCP **expressly stated** to MFT a decision or plan of action regarding patient care, as a result of the collaboration.

6. Component: Domain Orientation

Sub-Component: Common Purpose:
1. The goal of collaboration between MFT and HCP was **not stated,** nor made clear
2. The goal of collaboration between MFT and HCP **was implied,** vague understanding
3. The goal of collaboration between MFT and HCP was **explicitly stated** and understood by both HCP and MFT

Sub-Component: Orientation:
1. MFT - HCP collaborative processes, decisions, and actions are general with **little focus** on general patient care and health promotion
2. MFT - HCP collaborative processes, decisions, and actions include **some focus** on general patient care and health promotion.
3. MFT - HCP collaborative processes, decisions and actions are **primarily focused** on generalized patient care and health promotion.

Appendix B: Pilot Study Correspondence

- B-1: Letter to Pilot Reviewers
- B-2: Original Collaboration Inventory
  - Section 1: Background Information
  - Section 2: Explanation, Inventory Items
  - Section 3: Rank Order From
- B-3: Critique form for Pilot Reviewers

March 15, 2000

Department of Family and Child Ecology
107 Human Ecology
East Lansing, MI 48824

Dear Colleagues:

I am a doctoral student at Michigan State University and I have reached the dissertation stage. With a strong commitment to the growth and development of the field of collaborative health care, I have chosen a dissertation topic which will contribute to this field. My topic is **A Collaboration Inventory generated from a National Delphi Study of Collaborative Relationships of Marriage and Family Therapists and Health Care Professionals.** The goal of my project is to develop an instrument for measuring the extent of collaboration between therapists and health care professionals to determine the collaborative practices necessary to maximize benefits to patients and professionals alike.

The Inventory which is included with this letter contains components which I have identified through a review of:

1. Seaburn et al, (1996) Models of Collaboration
2. Wood and Gray (1991) "A Theory of Collaboration"
3. Additional literature related to Collaborative Healthcare

Based on your experience in working with physicians, I would appreciate it if you would review this survey instrument and offer any suggestions or comments. Please complete the survey and the additional Pilot review form. Based upon your response and those of others, I will modify the questionnaire and send it to individuals registered as members of the Collaborative Healthcare Coalition.

Please return the survey to me by April 1, 2000. Thank you very much for your assistance in this important research project.

Sincerely,

Laura A. Mohr, M.S.
Michigan State University

Collaboration Inventory
Section 1: Background Information

Personal Data: please complete the following:

Name: _____

Gender: _____ Female
_____ Male

Primary Work Function:
_____ Physician
_____ Physician Assistant
_____ Nurse
_____ Marriage and Family Therapist
_____ Other (Please describe _____)

Current Employment Setting:
Check one:
_____ Academic setting
_____ Non-Academic

Check one:
_____ Inpatient
_____ Outpatient/Ambulatory Care

Years in Collaborative Practice:
_____ 5 years and less
_____ 6 - 10 years
_____ 11 - 15 years

Below, please describe how you initially began working in a collaborative health care setting.

Please describe below **your most successful collaborative experience (around a particular patient) in the past five (5) years.**

Please check on of the following:
_____ I agree to have my name appear in the study summary
_____ I would rather not have my name appear in the study summary.

THANK YOU

Collaboration Inventory
Section 2: Collaboration Experience

Explanations and Definitions

Collaboration Inventory:

The goal of this inventory is to identify the elements of a collaborative relationship between health care professionals and mental health care professionals and determine the level of importance to collaboration.

Panelists:

- Health Care Professionals (HCP): individuals who primarily identify themselves as, and work as, a member of the medical health care profession (physicians, nurses, physician assistants)
- Marriage and Family Therapists (MFT): individuals who primarily identify themselves as, and work as, marriage and family therapists

Major Components to be Reviewed:

There are six (6) major components identified as key to successful collaborative relationships. Each component includes sub-components which are identified in the explanation and throughout the inventory.

- Shared rules, norms, and structure: The extent to which individuals understand cultural rules and norms and the structure of the collaboration
  Sub-components include: communication, location of services provided, provision of services, physical facilities utilized, extent to which rules and norms are implicit or explicit.

- Interactive Process: The skills and knowledge related to the interaction between professionals.
  Sub-components include: individuals value interpersonal processes, mutual respect within the relationship, relationship has a change orientation, individuals negotiate multiple perspectives.

- Professional Autonomy: The skills and knowledge related to maintaining professional autonomy within the relationship
  Sub-components include: independent decision making capabilities, flexible hierarchy

- Stakeholder: The extent to which individuals have a level of investment in the patient care issues
  Sub-components include: Paradigm shift, development of trust in the relationship, content of communication and individuals with a stake in services provided.

- Action or Decision: The extent to which professionals intend to act or decide

- Domain Orientation: Actions and decisions are oriented toward the patients care.
  Sub-components include: common purpose and action orientation

Collaboration Inventory
Section 2: Collaborative Experience

Directions: Please read each statement and determine to what degree each statement was essential to the success of **the most successful collaborative experience** you have had around a particular patient within the past five calendar years (1995 - 2000). In other words, how important were the following items to the success of the collaboration.

HCP: Health Care Professional (Physician, Nurse, Physician Assistant)
MFT: Marriage and Family Therapist

Please rank each of the statements according to this scale:

5 - Absolutely Essential (AE)	*Absolutely essential* to the success of your collaborative experience
4 - Essential (E)	*Essential* to the success of your collaborative experience
3 - Somewhat Essential (SE)	*Somewhat essential* to the success of your collaborative experience
2 - Minimally Essential (ME)	*Minimally essential* to the success of your collaborative experience
1 - Useful, but not Essential (U)	*Useful*, but not essential, to the success of your collaborative experience
0 - Not Applicable (NA)	*Not applicable*, did not occur during the collaboration

1. Component	**AE**	**E**	**SE**	**ME**	**U**	**NA**
Shared Rules, Norms and Structure						
Sub-Component: Communication: *(mode)*:						
1. HCP sent **letter/e-mail** to MFT regarding patient	5	4	3	2	1	0
2. MFT sent **letter/e-mail** to HCP regarding patient	5	4	3	2	1	0
3. HCP **phoned** MFT regarding patient	5	4	3	2	1	0
4. MFT **phoned** HCP regarding patient	5	4	3	2	1	0
5. HCP and MFT had an **informal face to face** (bump in the hallway) meeting regarding patient	5	4	3	2	1	0
6. HCP and MFT had **formal arranged meeting** regarding patient	5	4	3	2	1	0

	AE	E	SE	ME	U	NA
Sub-Component: Communication: *(confidentiality)*:						
1. Issues of confidentiality were **not discussed nor implied** between MFT and HCP	5	4	3	2	1	0
2. Issues of confidentiality differences **not discussed, nor explicitly stated, but were implied** between MFT and HCP	5	4	3	2	1	0
3. Issues of confidentiality differences **were discussed and were explicit** between MFT and HCP	5	4	3	2	1	0
Sub-Component: Communication: *(language)*:						
1. MFT had **little/no understanding** of **medical terminology** which led to some communication breakdown	5	4	3	2	1	0
2. HCP had **little/no understanding** of **therapeutic terminology** which led to some communication breakdown	5	4	3	2	1	0
3. MFT and HCP **shared some medical and therapeutic terminology**, however some communication breakdown still occurred	5	4	3	2	1	0
4. MFT and HCP developed a **shared language** (a basic understanding of medical and therapeutic terminology) which minimized communication breakdowns.	5	4	3	2	1	0
Sub-Component: Communication: *(content)*:						
1. Interaction between MFT and HCP focused on **patient issues only**	5	4	3	2	1	0
2. Interaction between MFT and HCP focused **primarily on patient issues, however included some relationship dynamics**	5	4	3	2	1	0
3. Interactions between MFT and HCP included a **mixture of patient care and relationship dynamic issues.**	5	4	3	2	1	0

	AE	E	SE	ME	U	NA
Sub-Component: Provision of Services:						
1. The MFT and HCP provided **separate care and treatment**	5	4	3	2	1	0
2. The MFT and HCP provided **primarily separate** care and treatment, with **occasional joint comprehensive** care and treatment	5	4	3	2	1	0
3. MFT and HCP provided **consistent joint comprehensive care and treatment.**	5	4	3	2	1	0
Sub-Component: Shared Facilities:						
1. The MFT and the HCP had **separate** support staff	5	4	3	2	1	0
2. The MFT and the HCP **shared some** support staff	5	4	3	2	1	0
3. The MFT and the HCP **shared most** support staff	5	4	3	2	1	0
Sub-component: Record Keeping:						
1. The MFT and the HCP kept patient records **separately**	5	4	3	2	1	0
2. The MFT and the HCP kept **primarily separate but occasionally shared** patient records.	5	4	3	2	1	0
3. The HCP and the MFT **share** patient records.	5	4	3	2	1	0
Sub-Component: Location of Services:						
1. MFT and HCP provide services in **separate locations(separate buildings)**	5	4	3	2	1	0
2. The MFT and HCP provided services in **shared location with separate offices.**	5	4	3	2	1	0
3. MFT and HCP worked in the **same office**	5	4	3	2	1	0
Sub-Component: Explicit/Implicit:						
1. The **majority of rules and norms** for behavior between MFT and HCP were **implied**, but not explicitly discussed.	5	4	3	2	1	0
2. **Some of the rules** and norms for behavior between MFT and HCP **were explicitly identified** while others remained implied.	5	4	3	2	1	0
3. **Most rules and norms** for behavior between MFT and HCP were **explicitly identified.**	5	4	3	2	1	0

	AE	E	SE	ME	U	NA
2. Component: Interactive Process						
Sub-Component: Relationship: (*Mutual Respect*):						
1. MFT had **little/no regard** for HCP perspective or expertise	5	4	3	2	1	0
2. HCP had **little/no regard** for MFT perspective or expertise	5	4	3	2	1	0
3. MFT **demonstrated some regard** for HCP perspective or expertise	5	4	3	2	1	0
4. HCP **demonstrated some regard** for MFT perspective or expertise	5	4	3	2	1	0
5. MFT **showed clear regard** for HCP perspective and expertise	5	4	3	2	1	0
6. HCP **showed clear regard** for MFT perspective and expertise	5	4	3	2	1	0
Sub-Component: Value interpersonal process:						
1. MFT/HCP interactions indicated that patient treatment outcome was dependent on separate efforts of **either** the MFT or HCP	5	4	3	2	1	0
2. MFT/HCP interactions indicated that patient treatment outcome was dependent on **parallel efforts** of the MFT and HCP	5	4	3	2	1	0
3. MFT/HCP interactions indicated that patient treatment outcome was dependent on **joint/shared efforts** between MFT and HCP	5	4	3	2	1	0
Sub-Component: Change Orientation; (*initial interaction*):						
1. MFT/HCP relationship developed with **no intent to modify** existing patient care	5	4	3	2	1	0
2. MFT/HCP relationship developed with **clear intent to modify** existing patient care	5	4	3	2	1	0
Sub-Component: Change Orientation; *(ongoing interaction)*:						
1. Ongoing interactions between MFT and HCP indicate **no intent to modify** existing patient care	5	4	3	2	1	0
2. Ongoing interactions between MFT and HCP indicate **clear intent to modify** existing patient care	5	4	3	2	1	0

	AE	E	SE	ME	U	NA
Sub-Component: Negotiate Multiple Perspectives:						
1. HCP trained perspective of patient was **shared with** MFT	5	4	3	2	1	0
2. MFT trained perspective of patient **shared with** HCP	5	4	3	2	1	0
3. HCP and MFT **dialogued** about both professional perspectives	5	4	3	2	1	0
4. HCP and MFT negotiate a **mutual (shared) professional perspective** about patient	5	4	3	2	1	0
3. Component: Professional Autonomy						
Sub-Component: Hierarchy (*patient focus*):						
1. HCP/MFT interactions regarding patient care reflect **HCP as dominant**; regardless of the situation	5	4	3	2	1	0
2. HCP/MFT interactions regarding patient care reflect **MFT as dominant**; regardless of the situation.	5	4	3	2	1	0
3. HCP/MFT interactions regarding patient care reflect **flexible shifts** in professional roles, depending on the situation.	5	4	3	2	1	0
Sub-Component: Hierarchy (*relationship focus*):						
1. HCP **is supervisor of** the MFT.	5	4	3	2	1	0
2. MFT **is supervisor of** the HCP.	5	4	3	2	1	0
3. MFT and HCP are **peers/colleagues**.	5	4	3	2	1	0
Sub-Component: Independent Decision Making:						
1. HCP **reports to** MFT regarding patient treatment	5	4	3	2	1	0
2. MFT **reports to** HCP regarding patient treatment	5	4	3	2	1	0
3. HCP **does not report to** MFT regarding patient treatment	5	4	3	2	1	0
4. MFT **does not report to** HCP regarding patient treatment	5	4	3	2	1	0
5. HCP **dialogued with** MFT regarding patient treatment	5	4	3	2	1	0
6. MFT **dialogued with** HCP regarding patient treatment	5	4	3	2	1	0

	AE	E	SE	ME	U	NA
7. HCP **provided suggestions** to MFT regarding therapeutic treatment of patient	5	4	3	2	1	0
8. MFT **provided suggestions** to HCP regarding physical treatment of patient	5	4	3	2	1	0

4. Component: Stakeholder:

Sub-Component: Relationship: *(developmental/trust)*:

1. Initially, the MFT - HCP providers **shared** personal and professional information	5	4	3	2	1	0
2. As the collaboration progressed, the MFT - HCP providers **disclosed more** personal and professional information	5	4	3	2	1	0
3. As the collaboration evolved, the MFT - HCP providers **exchanged** personal and professional information	5	4	3	2	1	0
4. As the collaboration matured, the MFT - HCP providers **developed a trusting** relationship.	5	4	3	2	1	0

Sub-Component: Relationship: *(personal communication)*:

1. Personal disclosure shared between MFT and HCP is **indirect**, through patient care.	5	4	3	2	1	0
2. **Some** personal disclosure shared between MFT and HCP occurs directly, and some occurs through patient care.	5	4	3	2	1	0
3. Personal disclosure is shared openly between MFT and HCP in clear and direct ways.	5	4	3	2	1	0

Sub-Component: Stake:

1. The HCP **referred** patient for therapy	5	4	3	2	1	0
2. The MFT **referred** patient to HCP	5	4	3	2	1	0
3. The HCP **contacted** the MFT regarding the referral	5	4	3	2	1	0
4. The MFT **contacted** the HCP regarding the referral	5	4	3	2	1	0
5. The HCP **provided care/treatment** for the patient	5	4	3	2	1	0
6. The MFT **provided care/treatment** for the patient	5	4	3	2	1	0
7. The HCP **continued care** after referring patient for therapy	5	4	3	2	1	0

	AE	E	SE	ME	U	NA
8. The MFT **continued care** after referring patient to the HCP.	5	4	3	2	1	0
Sub-Component: Shift in Paradigm: (*biopsychosocial*):						
1. The HCP was **initially** concerned with only the physical well-being of patient	5	4	3	2	1	0
2. The MFT was **initially** concerned with only the psychosocial well being of patient	5	4	3	2	1	0
3. The HCP was **initially** concerned with physical and psychosocial well being of patient	5	4	3	2	1	0
4. The MFT was **initially** concerned with physical and psychosocial well being of patient	5	4	3	2	1	0
5. **With the progression** of the collaboration, the HCP was concerned with only the physical well-being of patient	5	4	3	2	1	0
6. **With the progression** of the collaboration, the MFT was concerned with only the psychosocial well being of the patient	5	4	3	2	1	0
7. **With the progression** of the collaboration, the HCP was concerned with physical and psychosocial well being of the patient	5	4	3	2	1	0
8. **With the progression** of the collaboration, the MFT was concerned with physical and psychosocial well being of patient	5	4	3	2	1	0
5. Component: Action or Decision						
Sub-Component: Act/Decide:						
1. MFT **never shared** with HCP any decision or plan of action regarding patient care, as a result of the collaboration.	5	4	3	2	1	0
2. HCP **never shared** with MFT any decision or plan of action regarding patient care, as a result of the collaboration.	5	4	3	2	1	0
3. MFT **shared** with HCP a **vague** decision or plan of action regarding patient care, as a result of the collaboration.	5	4	3	2	1	0

	AE	E	SE	ME	U	NA
4. HCP **shared** with MFT **a vague** decision or plan of action regarding patient care, as a result of the collaboration.	5	4	3	2	1	0
5. MFT **expressly stated** to HCP a decision or plan of action regarding patient care, as a result of the collaboration.	5	4	3	2	1	0
6. HCP **expressly stated** to MFT a decision or plan of action regarding patient care, as a result of the collaboration.	5	4	3	2	1	0
6. Component: <u>Domain Orientation</u>						
Sub-Component: <u>Common Purpose</u>:						
1. The goal of collaboration between MFT and HCP was **not stated,** nor made clear	5	4	3	2	1	0
2. The goal of collaboration between MFT and HCP **was implied,** allowing for vague understanding	5	4	3	2	1	0
3. The goal of collaboration between MFT and HCP was **explicitly stated** and understood by both HCP and MFT	5	4	3	2	1	0
Sub-Component: <u>Orientation</u>:						
1. MFT - HCP collaborative processes, decisions, and actions are general with **little focus** on general patient care and health promotion	5	4	3	2	1	0
2. MFT - HCP collaborative processes, decisions, and actions include **some focus** on general patient care and health promotion.	5	4	3	2	1	0
3. MFT - HCP collaborative processes, decisions and actions are **primarily focused** on generalized patient care and health promotion.	5	4	3	2	1	0

Directions: Please select the most accurate response regarding frequency of communication during **the most successful collaborative experience** you have had around a particular patient within the past five calendar years (1995 - 2000).

Communication: *(frequency)*:

1. On average, **how often** did the HCP communicate with the MFT regarding patient issues.
    a. 0 - 2 times/month
    b. 3 - 5 times/month
    c. 6 - 10 times/month
    d. more that 11 times/month
2. On average, **how often** did the MFT communicate with the HCP regarding patient issues.
    a. 0 - 2 times/month
    b. 3 - 5 times/month
    c. 6 - 10 times/month
    d. more that 11 times/month

Collaboration Inventory
Section 3: Rank Order of Importance

Directions: Please rank order the following components in order of significance to a successful collaborative relationship. (1 = most significant 6 = least significant)

_____ Shared Rules, Norms, and Structure: the extent to which individuals understand cultural rules and norms and the structure of the collaboration
_____ Interactive Process: the skills and knowledge related to the interaction between professionals
_____ Professional Autonomy: the skills and knowledge related to maintaining professional autonomy within the relationship
_____ Stakeholder: the extent to which individuals have a stake in the patient care issues
_____ Action or Decision: the extent to which professionals intent to act or decide
_____ Domain Orientation: actions and decisions are oriented toward the patients health care.

Please note below any additional components you believe should be added to the inventory:

Directions: Please rank order the following sub-components in order of significance to a successful collaborative relationship. *Note: Please do not rank order the components. (1 = most significant)*

Example: Professional Autonomy
3 Hierarchy: patient focus
1 Hierarchy: relationship focus
2 Independent Decision Making

1. Shared Rules, Norms, and Structure
_____Communication: mode
_____Communication: frequency
_____Communication: Confidentiality
_____Communication: Language
_____Communication: Content
_____Provision of services
_____Shared Facilities
_____Record Keeping
_____Location of Services
_____Explicit/Implicit

Example: **Professional Autonomy**

3 Hierarchy: patient focus
1 Hierarchy: relationship focus
2 Independent Decision Making

2. Interactive Process

_____ Relationship: Mutual Respect
_____ Value Interpersonal Processes
_____ Change Orientation: initial interaction
_____ Change Orientation: ongoing interaction
_____ Negotiate Multiple Perspectives

3. Professional Autonomy

_____ Hierarchy: patient focus
_____ Hierarchy: relationship focus
_____ Independent Decision Making

4. Stakeholder

_____ Relationship: trust
_____ Relationship: personal communication
_____ Stake
_____ Shift in Paradigm

5. Action or Decision

_____ Act or Decide

6. Domain Orientation

_____ Common Purpose
_____ Orientation

Please note below any sub-components you believe should be added to the inventory. Please include what component you feel it falls under.

Form for Critique of
Collaboration Inventory
by Pilot Test Reviewers

Directions: Please respond to these questions regarding the Collaboration Inventory.

1. How long did it take you to complete the inventory?
   _____ less than 1 hour
   _____ 1 - 1 ½ hours
   _____ 1 ½ - 2 hours
   _____ 2 - 3 hours

2. Was the format easy to follow?
   _____ very easy
   _____ somewhat easy
   _____ difficult: if so, why: _____ (please specify)

3. Were the directions for responding to the inventory clear?
   _____ yes _____ no

4. Are there other demographic questions that should be asked?
   _____ yes _____ no

If so, please list: _____

5. Is the terminology clear?
   _____ yes _____ no

If no, please make suggestions below or on the survey form.

General comments:

Are there any other suggestions you would make to encourage participation in completion of this study?

Are there any other suggestions you have for improving the understanding of the inventory?

Any additional comments:

Appendix C: Survey Correspondence - Round 1

- C-1: Invitation to Participate
- C-2: Revised Collaboration Inventory:
  - Section 1: Background Information
  - Section 2: Explanation, Inventory Items
  - Section 3: Rank Order Form

July 12, 2000

Department of Family and Child Ecology
107 Human Ecology
East Lansing, MI 48824

Dear Colleagues:

I am a doctoral student at Michigan State University and I have reached the dissertation stage. With a strong commitment to the growth and development of the field of collaborative health care, I have chosen a dissertation topic which will contribute to this field. My topic is **A Collaboration Inventory generated from a National Delphi Study of Collaborative Relationships Between Marriage and Family Therapists and Health Care Professionals.** The goal of my project is to develop an instrument for measuring the extent of collaboration between therapists and health care professionals to determine the collaborative practices necessary to maximize benefits to patients and professionals alike. The Collaboration Inventory contains components which I have identified through a review of literature related to Collaborative Relationships, including, but not limited to Seaburn, Lorenz, Gunn, et al, (1996) Models of Collaboration and Wood and Gray (1991) "A Theory of Collaboration."

In order to realize the contribution which this study will make to collaborative efforts between health care professionals and marriage and family therapists, I need your assistance. As a new field, the identification of these components will rely on expert opinion, such as yours. Since this is a Delphi study which uses a panel of experts to provide opinions about specific items, I would like to invite you to accept the role as panelist. *Eligible panelists include individuals who identify themselves as either health care providers or marriage and family therapists.* You will receive **two rounds** of Collaboration Inventories.

In Round **One**, panelists will give their opinions regarding the presence and the importance of each item based upon *your most successful collaborative professional collaborative relationship within the past five (5) calendar years (1995 - 2000)* and add items or topics to the list. In Round **Two**, you will receive the revised inventory and have the opportunity to rate the items again. The goal is to obtain consensus on the importance of components for successful collaboration.

To summarize, you can assist me in the following ways:

1. Complete the Collaborative Healthcare Inventory by giving your opinion about the components importance and adding to the list
2. Completing the background information sheet
3. Returning the completed Inventory to me no later than July 25.
4. Repeating the Inventory in Round 2 which will be sent to you in August.

Please be assured that confidentiality will be maintained regarding your responses. Research findings will be reported in all write ups as averages and/or achievement of consensus, therefore no specific responses will be known. A list of all panelists will appear in the final study summary. If you do not wish to have your name included, you can indicate so on the Background Information sheet. Your privacy will be protected to the maximum extent allowable by law. Please note that you indicate your voluntary agreement to participate by completing and returning this questionnaire. If you have any further questions, please feel free to contact me at 517-699-1069 or Marsha T. Carolan at 517-432-3327. You may also contact David E. Wright at 517-355-2180 for questions about your rights as a human subject of research. Thank you in advance for your support of this study and the advancement of the profession.

Sincerely,

Laura A. Mohr, M.S.
Doctoral Student
Michigan State University

Marsha Carolan, Ph.D
Dissertation Chairperson
Michigan State University

Collaboration Inventory
Section 2: Collaboration Experience

Explanations and Definitions

Collaboration Inventory:

The goal of this inventory is to identify the elements of a collaborative relationship between health care professionals and mental health care professionals and determine the level of importance to collaboration.

Panelists:

- Health Care Professionals (HCP): individuals who primarily identify themselves as, and work as, a member of the medical health care profession (physicians, nurses, physician assistants)

- Marriage and Family Therapists (MFT): individuals who primarily identify themselves as, and work as, marriage and family therapists

Major Components to be Reviewed:

There are five (5) major components identified as key to successful collaborative relationships. Each component includes sub-components which are identified in the explanation and throughout the inventory.

- Shared rules, norms, and structure: The extent to which individuals understand cultural rules and norms and the structure of the collaboration
  Sub-components include: communication, location of services provided, provision of services, physical facilities utilized, extent to which rules and norms are implicit or explicit.
- Interactive Process: The skills and knowledge related to the interaction between professionals.
  Sub-components include: individuals value interpersonal processes, mutual respect within the relationship, relationship has a change orientation, individuals negotiate multiple perspectives.
- Professional Autonomy: The skills and knowledge related to maintaining professional autonomy within the relationship
  Sub-components include: independent decision making capabilities, flexible hierarchy
- Stakeholder: The extent to which individuals have a level of investment in the patient care issues
  Sub-components include: Paradigm shift, development of trust in the relationship, content of communication and individuals with a stake in services provided.
- Domain Orientation: Actions and decisions are oriented toward the patients health care.
  Sub-components include: common purpose, action/decision and action orientation

Collaboration Inventory
Section 1: Background Information

Personal Data: Please complete the following:

Name: _____

Gender:

- ❑ Female
- ❑ Male

Current Employment Setting: (check all that apply)

- ❑ Academic setting, university
- ❑ Academic setting, residency training program
- ❑ Clinical, medical inpatient
- ❑ Clinical, medical outpatient
- ❑ Clinical, mental health inpatient
- ❑ Clinical mental health outpatient

Age:

- ❑ under 25
- ❑ 26 - 35
- ❑ 36 - 45
- ❑ 46 - 55
- ❑ 56 - 65
- ❑ over 65

Primary Work Function:

- ❑ Physician
- ❑ Physician Assistant
- ❑ Nurse
- ❑ Other: _____
- ❑ Marraige and Family Therapist

Ethnicity:

- ❑ Caucasian
- ❑ Hispanic
- ❑ African American
- ❑ Asian
- ❑ Native American

Professional with whom you primarily collaborate with:

- ❑ Physician
- ❑ Physician Assistant
- ❑ Nurse
- ❑ Other: _____
- ❑ Marraige and Family Therapist

Years in Collaborative Practice: ..... ❑ 5 years and less ❑ 6 - 10 years ❑ 11 - 15 years

Below, please describe how you began working in a collaborative health care setting.

_____

_____

How do you definfe a 'successful collaborative experience?' _____

_____

_____

Describe your most successful collaborative experience (around patient care) in the past five (5) years.

_____

_____

_____

Please check one of the following:

- ❑ I agree to have my name appear in the study summary.
- ❑ I would rather not have my name included in the study summary.

Collaboration Inventory
Section 2: Collaborative Experience

Please read each statement and respond regarding your most successful MFT/HCP professional collaborative relationship within the past five calendar years (1995 - 2000) around patient care.

MFT: Marriage and Family Therapist
HCP: Health Care Professional (physician, nurse, physician assistant, etc...)

Section One:

Directions:
1. Check the appropriate box to identify if each activity occurred during your collaborative relationship;
2. If the activity occurred, identify the level of importance to collaboration.

Communication: Mode	Did Occur	Did Not Occur	Very Important	Important	Not Important
HCP sent **letter/e-mail** to MFT regarding patient care issues.	❑	❑	❑	❑	❑
MFT sent **letter/e-mail** to HCP regarding patient care issues.	❑	❑	❑	❑	❑
HCP **phoned** MFT regarding patient care issues.	❑	❑	❑	❑	❑
MFT **phoned** HCP regarding patient care issues.	❑	❑	❑	❑	❑
HCP and MFT had an **informal face-to-face** (bump in the hallway) meeting regarding patient care issues.	❑	❑	❑	❑	❑
HCP and MFT had **formal arranged meeting** regarding patient care issues.	❑	❑	❑	❑	❑

Relationship: Developmental/Trust

	Did Occur	Did Not Occur	Very Important	Important	Not Important
Initially, the MFT - HCP providers **shared** personal and professional information	❑	❑	❑	❑	❑
As the collaboration progressed, the MFT - HCP providers **disclosed more** personal and professional information	❑	❑	❑	❑	❑
As the collaboration evolved, the MFT - HCP providers **exchanged** personal and professional information	❑	❑	❑	❑	❑
As the collaboration matured, the MFT - HCP providers developed a **trusting** relationship	❑	❑	❑	❑	❑

Stakeholder

	Did Occur	Did Not Occur	Very Important	Important	Not Important
The **HCP referred** patients to MFT .	❑	❑	❑	❑	❑
The **MFT referred** patients to HCP □	❑	❑	❑	❑	❑
The **HCP contacted** the MFT regarding the referrals	❑	❑	❑	❑	❑
The **MFT contacted** the HCP regarding the referrals	❑	❑	❑	❑	❑
The **HCP provided care/treatment** for the patients	❑	❑	❑	❑	❑
The **MFT provided care/treatment** for the patients.	❑	❑	❑	❑	❑
The **HCP continued care** after referring patient to the MFT	❑	❑	❑	❑	❑
The **MFT continued care** after referring patients to the HCP.	❑	❑	❑	❑	❑

Shift in Paradigm	Did Occur	Did Not Occur	Very Important	Important	Not Important
The **HCP was initally** concerned with *only the physical* well-being of patients	❑	❑	❑	❑	❑
The **MFT was initally** concerned with *only the psychosocial* well-being of patients.	❑	❑	❑	❑	❑
The **HCP was initially** concerned with *both physical and psychosocial* well-being of patients.	❑	❑	❑	❑	❑
The **MFT was initally** concerned with *both psychosocial and physical* well-being of patients.	❑	❑	❑	❑	❑
With the progression of the collaboration, the HCP was concerned with *only the physical* well-being of the patients.	❑	❑	❑	❑	❑
With the progression of the collaboration, the MFT was concerned with *only the psychosocial* well-being of patients.	❑	❑	❑	❑	❑
With the progression of the collaboration, the HCP was concerned with *both physical and psychosocial* well-being of patients.	❑	❑	❑	❑	❑
With the progression of the collaboration, the MFT was concerned with *both physical and psychosocial* well being of patients.	❑	❑	❑	❑	❑

Section two:

Directions:
1. Please identify the statement that most accurately describes your MFT/HCP collaborative relationship;
2. Identify the level of importance of that statement to collaboration

Communication: Confidentiality

Which statement most accurately describes your experience?

- ❑ Issues of confidentiality were **not discussed nor implied**
- ❑ Issues of confidentiality were **not discussed nor explicitly stated, but were implied**
- ❑ Issues of confidentiality **were discussed and were explicit**

How important was **confidentiality** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Communication: Language

Which statement most accurately describes your experience?

- ❑ MFT and HCP had **little/no understanding** of medical/therapeutic terminology which led to some communication breakdown.
- ❑ MFT and HCP **shared some** medical and therapeutic terminology, however some communiction breakdown still occurred.
- ❑ MFT and HCP **developed a shared language** (a basic understainding of medical and therapeutic terminology) which minimized communication breakdowns.

How important was **language** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Communication: Content

Which statement most accurately describes your experience?

- ❑ Interaction between MFT and HC P focused on **patient issues only.**
- ❑ Interaction between MFT and HCP focused **primarily on patient issues,** however included some discussion of **relationship dynamics.**
- ❑ Interactions between MFT and HCP included a mixture of patient care and relationship dynamic issues.

How important was **the content of communication** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Provision of Services

Which statement most accurately describes your experience?

❑ The MFT and HCP provided **separate care and treatment.**
❑ The MFT and HCP provided **primarily separate** care and treatment, with occasional joint comprehensive care and treatment.
❑ The MFT and HCP provided **consistent joint comprehensive** care and treatment.

How important was **the provision of services** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Shared Support Staff

Which statement most accurately describes your experience?

❑ The MFT and HCP had **separate** support staff
❑ The MFT and HCP **shared some** support staff.
❑ The MFT and HCP **shared most** support staff.

How important was **sharing support staff** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Record Keeping

Which statement most accurately describes your experience?

❑ The MFT and HCP kept patient records **separately.**
❑ The MFT and HCP kept **primarily separate but occasionally shared** patient records.
❑ The MFT and HCP **shared** patient records.

How important was **shared record keeping** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Location of Services

Which statement most accurately describes your experience?

❑ The MFT and HCP provided services in **separate locations (separate buildings).**
❑ The MFT and HCP provided services in **a shared location with separate offices.**
❑ The MFT and HCP worked in the **same office.**

How important was **the location of services** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Explicit/Implicit Rules and Norms

Which statement most accurately describes your experience?

- ❑ The **Majority** of rules and norms for behavior between MFT and HCP were **implied**, but not explicitly discussed.
- ❑ **Some** of the rules and norms for behavior between MFT and HCP were **explicitly identified** while others remained implied.
- ❑ **Most** rules and norms for behavior between MFT and HCP were **explitily identified.**

How important were **explicit rules and norms** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Relationship: Mutual Resepct (MFT)

Which statement most accurately describes your experience?

- ❑ The MFT had **little/no regard** for the HCP perspective or expertise.
- ❑ The MFT **demonstrated some regard** for the HCP perspective and expertise.
- ❑ The MFT **showed clear regard** for the HCP perspective and expertise

How important was **the MFT's respect for the HCP** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Relationship: Mutual Respect (HCP)

Which statement most accurately describes your experience?

- ❑ The HCP had **little/no regard** for the MFT perspective or expertise.
- ❑ The HCP **demonstrated some regard** for the MFT perspective or expertise.
- ❑ The HCP **showed clear regard** for the MFT perspective and expertise.

How important was **the HCP's respect for the MFT** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Value Interpersonal Process

Which statement most accurately describes your experience?

- ❑ MFT/HCP interactions indicated that patient treatment outcome was dependent on **separate efforts of either MFT or HCP.**
- ❑ MFT/HCP interactions indicated that patient treatment outcome was dependent on **parallel efforts of both MFT and HCP.**
- ❑ MFT/HCP interactions indicated that patient treatment outcome was dependent on **joint/shared efforts between MFT and HCP.**

How important was **valuing interpersonal processes** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Change Orientation: Initial Interaction

Which statement most accurately describes your experience?

❑ MFT/HCP relationship developed with **no intent to modify** existing patient care.
❑ MFT/HCP relationship developed with **clear intent to modify** existing patient care.

How important was **a Change Orientation during the initial interaction** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Change Orientation: Ongoing Interaction

Which statement most accurately describes your experience?

❑ Ongoing interactions between MFT and HCP indicated **no intent to modify** existing patient care.
❑ Ongoing interactions between MFT and HCP indicated **clear intent to modify** existing patient care.

How important was **a Change Orientation during the ongoing interaction** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Negotiate Multiple Perspectives

Which statement most accurately describes your experience?

❑ MFT/HCP trained perspective of patient care was **shared** with HCP/MFT, respectively.
❑ MFT and HCP **dialogued** about both professional perspectives.
❑ MFT and HCP **negotiated a mutual professional perspective** regarding patient care.

How important was **negotiating multiple perspectives** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Hierarchy: Patient focus

Which statement most accurately describes your experience?

❑ MFT/HCP interactions regarding patient care reflected **HCP as dominant**; regardless of the situation.
❑ MFT/HCP interactions regarding patient care reflected **MFT as dominant**; regardless of the situation.
❑ MFT/HCP interactions regarding patient care reflected **flexible shifts** in professional roles, depending on the situation.

How important was **hierarchy around patient care issues** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Hierarchy: Relationship focus

Which statement most accurately describes your experience?

❑ **MFT is the supervisor** of the HCP.
❑ **HCP is the supervisor** of the MFT.
❑ The MFT and HCP are **peers/colleagues**.

How important was **hierarchy around the relationship** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Independent Decision Making: MFT

Which statement most accurately describes your experience?

❑ The MFT **reported to** the HCP regarding patient treatment issues.
❑ The MFT **did not report to** the HCP regarding patient treatment issues.
❑ The MFT **dialogued with** the HCP regarding patient treatment issues.
❑ The **HCP provided suggestions** to the MFT regarding *therapeutic treatment issues.*

How important was **the MFT's independent decision making** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Independent Decision Making: HCP

Which statement most accurately describes your experience?

❑ The HCP **reported to** the MFT regarding patient treatment issues.
❑ The HCP **did not report to** the MFT regarding patient treatment issues.
❑ The HCP **dialogued with** the MFT regarding patient treatment issues.
❑ The **MFT provided suggestions** to the HCP regarding *physical treatment issues.*

How important was **the HCP's independent decision making** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Relationship: Personal Communication

Which statement most accurately describes your experience?

❑ Personal disclosure shared between the MFT and HCP was **indirect**, through patient care issues.
❑ **Some** personal disclosure shared between the MFT and HCP **occured directly**, and some occured through patient care issues.
❑ Personal disclosure was **shared openly** between the MFT and HCP in clear and direct ways.

How important was **personal communication between MFT and HCP** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Act/Decide: MFT

Which statement most accurately describes your experience?

- ❑ The MFT **never shared** with the HCP any decisions or plans of action regarding patient care, as a result of the collaboration.
- ❑ The MFT **shared** with the HCP **vague** decisions or plans of action regarding patient care, as a result of the collaboration.
- ❑ The MFT **expressly stated** to the HCP decsions or plans of action regarding patient care, as a result of the collaboration.

How important was **the MFT stating explicitly any decisions and/or plans of action regarding patient care** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Act/Decide: HCP

Which statement most accurately describes your experience?

- ❑ The HCP **never shared** with the MFT any decisions or plans of action regarding patient care, as a result of the collaboration.
- ❑ The HCP **shared** with the MFT **vague** decisions or plans of action regarding patient care, as a result of the collaboration.
- ❑ The HCP **expressly stated** to the MFT decisions or plans of action regarding patient care, as a result of the collaboration.

How important was **the HCP stating explicitly any decisions or plans of action regarding patient care** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Common Purpose

Which statement most accurately describes your experience?

- ❑ The *goal of the collaboration* between the MFT and HCP **was not stated,** nor made clear.
- ❑ The *goal of the collaboration* between the MFT and HCP **was implied**, allowing for vague understanding.
- ❑ The *goal of the collaboration* between the MFt and HCP **was explicitly stated** and understood by both the MFT and HCP.

How important was **a common purpose** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Orientation

Which statement most accurately describes your experience?

- ❑ The MFT/HCP collaborative processes, decisions, and actions were **general, with little focus** on overall patient care and health promotion.
- ❑ The MFT/HCP collaborative processes, decisions, and actions included **some focus** on overall patient care and health promotion.
- ❑ The MFT/HCP collaborative processes, decisions, and actions were **primarily focused** on overall patient care and health promotion.

How important was **an orientation focused on overall patient care and health promotion** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Communication: Frequency

On average, how often did the MFT and HCP communicate regarding patient issues

- ❑ 0 - 2 times/month
- ❑ 3 - 5 times/month
- ❑ 6 - 10 times/month
- ❑ More than 11 times/month

How important was **the frequency of communication** to the collaboration?

❑ **Very Important** ❑ **Important** ❑ **Not Important**

Collaboration Inventory
Section 3: Rank Order of Components

Please Rank order the following five ***Collaboration Components*** *in order of importance to a successfull collaborative relationship.*
Place your ranking in the box to the right: 1= most important 5=least important.

Interactive Process: the skills and knowledge related to the *process of interacting* between professionals. ..... ☐

Shared Rules, Norms, and Structure: the extent to which individuals understand *cultural rules and norms and the structure* of the professionals involved. ..... ☐

Professional Autonomy: the skills and knowledge related to each individual *maintaining professional autonomy* within the relationship. ..... ☐

Stakeholder: the extent to which an individual, or individuals, have *a stake, or investment* in patient care issues. ..... ☐

Domain Orientation: actions and decisions between individuals are *oriented toward* patient health care. ..... ☐

Please note below any general **components** you believe should be added to the inventory.

_____

_____

_____

Directions: Please rank order the following Collaborative Sub-components in order of importance to a successful collaborative relationship. Note: Please do not rank order the components. Place your ranking in the box to the right beginning with 1 = most important.

Interactive Process:
Rank the following *five* sub-components 1 = most important 5 = least important:

Relationship: Mutual Respect - individuals respect the validity of each participants perspective .....

Value Interpersonal Processes - professionals place value on the process of interaction with others .....

Change Orientation: initial interaction - the relationship is initiated as participants intend to engage in some change .....

Change Orientation: ongoing interaction - the relationship continues to exist as participants intend to engage in some change .

Negotiate Multiple Perspectives - process of negotiating a variety of professional perspectives .....

Shared Rules, Norms, and Structure
Rank the following *ten* sub-components (1 = most important 10 = least important):

Communication: Mode - the method used for communication (phone calls, e-mail, letters, face-to-face meetings) between professionals .....

Communication: Frequency: - how often the MFT and HCP communicate regarding patient care .....

Communication: Confidentiality - the role of professionally dictated codes of ethics around confidentiality .....

Communication: Language - professional or technical jargon/language; mutual understanding .....

Communication: Content - norms for communicating about individual patients' care; as well as communication regarding professional relationship dynamics .....

Provision of services - how care and treatment is provided (jointly, separately, combination) .....

Shared support staff - sharing of receptionists, nurses, etc... .....

Record Keeping - sharing/keeping joint records .....

Location of Services - geographic location of providers .....

Explicit/Implicit - extent to which rules and norms are overtly discussed .....

Professional Autonomy
Rank the following *three* sub-components (1 = most important 3 = least important):

Hierarchy: patient focus - professional with most expertise given the situation exerts most influence .....

Hierarchy: relationship focus - professional arrangement; employer/employee, etc... .....

Independent Decision Making - professionals retain their autonomy regarding decisions .....

Stakeholder
Rank the following *four* sub-components (1=- most important 4 = least important):

Relationship: trust - building trust as relationship matures, increased personal communication .....

Relationship: personal communication - discussion turns more often toward what is going on with the providers, indicating a relationship independent of patient care issues .....

Stake - professionals have with an interest in the patient's care ....

Shift in Paradigm - conceptualization of patient wellness/illness (biomedical/psychosocial, biopsychosocial) .....

Domain Orientation
Rank the following *three* sub-components (1 = most important 3 = least important):

Common Purpose - professionals unite around common goal .....

Act or Decide - interaction between participants result in an action or decision .....

Orientation - professionals orient processes, decisions, and actions toward patient care issues .....

Please note below any additional **Collaborative Sub-components** you believe should be added to the inventory. Please include what component you feel it falls under.

_____

_____

_____

_____

Additional General Comments _____

_____

_____

_____

_____

Appendix D: Survey Correspondence - Round 2

- D-1: Round 2: Letter
- D-2: Round 2: Collaboration Inventory:
  - Section 2: Inventory Items
  - Section 3: Rank Order Form

August 25, 2000

Department of Family and Child Ecology
107 Human Ecology
East Lansing, MI 48824

Dear Colleague:

Thank you for completing the **Collaboration Inventory** in Round #1. I really appreciate your assistance with this project, knowing how busy you are. The return rate has been good for Marriage and Family Therapists and should supply valuable information to further our work in collaboration with Health Care professionals. Your final contribution will assist me in the completion of my doctoral program, but more importantly should yield lasting benefits for our profession.

As I mentioned in my first letter, a second round is required by the research technique I am using - the Delphi methodology. Round #2 is an opportunity for panelists to see how other panelists rated the importance of each item and to rank each item again. The overall goal is to determine the consensus or agreement about the survey items.

Please find enclosed a *shorter version* of the original survey; descriptive questions (demographics, did/did not occur) were excluded. The enclosed survey also contains responses from Round #1. Adjacent to each possible check box/rating box is the percent of individuals who responded with that particular rating. This information is made available for you to consider when you are re-rating each item. In order to work within time constraints, please try to return the Collaboration Inventory in the envelope provided by **September 8, 2000.**

Please be assured that confidentiality will be maintained regarding all responses. Research findings will be reported in all write ups as averages and/or achievement of consensus, therefore no specific responses will be known. A list of all panelists will appear in the final study summary, unless you indicated otherwise previously on the Background Information sheet (Round #1). Your privacy will be protected to the maximum extent allowable by law. Please note that you indicate your voluntary agreement to participate by completing and returning this questionnaire. If you have any further questions, please feel free to contact me at 517-699-1069 or Marsha T. Carolan at 517-432-3327. You may also contact David E. Wright at 517-355-2180 for questions about your rights as a human subject of research. Thank you in advance for your support of this study which will promote the advancement of the profession.

Sincerely,

Laura A. Mohr, M.S.
Doctoral Student
Michigan State University

Marsha Carolan, Ph.D
Dissertation Chairperson
Michigan State University

Collaboration Inventory - Round 2
Section 2: Collaborative Experience

Please consider response rates from panelists in Round 1, re-read each statement and respond regarding your most successful MFT/HCP professional collaborative relationship within the past five calendar years (1995 - 2000) around patient care.

Name: (please include to match with Round 1 answers) _____

Directions:
1. Beneath each check box is the response rate (in percent form) from Round 1. Consider how panelists responded in Round 1.
2. Check the appropriate box to identify the importance of each item to collaboration.

MFT: Marraige and Family Therapist
HCP: Health Care Professional (physician, nurse, physician assistant, etc..)

Communication: Mode

	Very Important	Important	Not Important
HCP sent **letter/e-mail** to MFT regarding patient care issues.	❑	❑	❑
	33.3%	33.3%	33.3%
MFT sent **letter/e-mail** to HCP regarding patient care issues.	❑	❑	❑
	48.4%	35.5%	16.1%
HCP **phoned** MFT regarding patient care issues.	❑	❑	❑
	48.3%	24.1%	27.6%
MFT **phoned** HCP regarding patient care issues.	❑	❑	❑
	50%	19.2%	30.8%
HCP and MFT had an **informal face-to-face** (bump in the hallway) meeting regarding patient care issues.	❑	❑	❑
	69.2%	25.6%	5.1%
HCP and MFT had **formal arranged meeting** regarding patient care issues.	❑	❑	❑
	55.6%	33.3%	11.1%

Relationship: Developmental/Trust

	Very Important	Important	Not Important
Initially, the MFT - HCP providers **shared** personal and professional information	❑	❑	❑
	44.7%	42.1%	13.2%
As the collaboration progressed, the MFT - HCP providers **disclosed more** personal and professional information	❑	❑	❑
	40.0%	42.9%	17.1%
As the collaboration evolved, the MFT - HCP providers **exchanged** personal and professional informatior	❑	❑	❑
	50%	30.6%	19.4%

Stakeholder

	Very Important	Important	Not Important
The **HCP referred** patients to MFT	❑ 57.5%	❑ 37.5%	❑ 5.0%
The **MFT referred** patients to HCP	❑ 54.3%	❑ 37.1%	❑ 8.6%
The **HCP contacted** the MFT regarding the referrals	❑ 53.1%	❑ 40.6%	❑ 6.2%
The **MFT contacted** the HCP regarding the referrals	❑ 64.9%	❑ 32.4%	❑ 2.7%
The **HCP provided care/treatment** for the patients	❑ 58.5%	❑ 41.5%	❑ 0.0%
The **MFT provided care/treatment** for the patients	❑ 66.7%	❑ 33.3%	❑ 0.0%
The **HCP continued care** after referring patient to the MFT	❑ 64.1%	❑ 35.9%	❑ 0.0%
The **MFT continued care** after referring patients to the HCP	❑ 64.7%	❑ 29.4%	❑ 5.9%

Shift in Paradigm

	Very Important	Important	Not Important
The **HCP was initally** concerned with *only the physical* well-being of patients	❑ 34.5%	❑ 41.4%	❑ 24.1%
The **MFT was initally** concerned with *only the psychosocial* well-being of patients	❑ 40.7%	❑ 37.0%	❑ 22.2%
The **HCP was initially** concerned with *both physical and psychosocial* well-being of patients	❑ 80.5%	❑ 19.5%	❑ 0.0%
The **MFT was initally** concerned with *both psychosocial and physical* well-being of patients	❑ 85.0%	❑ 15.0%	❑ 0.0%
With the progression of the collaboration, the HCP was concerned with *only the physical* well-being of the patients	❑ 36.0%	❑ 44.0%	❑ 20.0%
With the progression of the collaboration, the MFT was concerned with *only the psychosocial* well-being of patients	❑ 36%	❑ 40%	❑ 24%

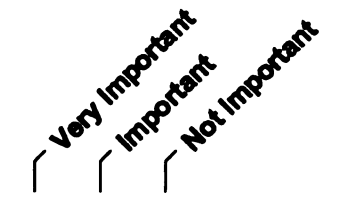
Part Two:

Directions:
1. Beneath each check box is the response rate (in percent form) from Round 1. Consider how panelists responded in Round 1.
2. Check the appropriate box to identify the importance of each item is to collaboration.

Shared Rules, Norms, and Structure

	Very Important	Important	Not Important
How important was **the frequency of communication** to the collaboration?	❑	❑	❑
	42.9%	47.9%	9.5%
How important was **confidentiality** to the collaboration?	❑	❑	❑
	31.0%	45.2%	23.8%
How important was **language** to the collaboration?	❑	❑	❑
	61.9%	31.0%	7.1%
How important was the **content of communication (patient care/professional relationship)** to the collaboration?	❑	❑	❑
	41.5%	51.2%	7.3%
How important was **the provision of services (care and treatment)** to the collaboration?	❑	❑	❑
	41.5%	58.5%	0%
How important was **sharing support staff** to the collaboration?	❑	❑	❑
	22.5%	37.5%	40%
How important was **shared record keeping** to the collaboration?	❑	❑	❑
	45.2%	26.2%	28.6%
How important was the **location of services (geographic)** to the collaboration?	❑	❑	❑
	54.8%	28.6%	16.7%
How important were **explicit rules and norms** to the collaboration?	❑	❑	❑
	11.9%	54.8%	33.3%

Interactive Process



How important was **valuing interpersonal processes** to the collaboration? .....

❑ ❑ ❑

66.7% 33.3% 0%

How important was **a change orientation (intent to change) during the initial interaction** to the collaboration?

❑ ❑ ❑

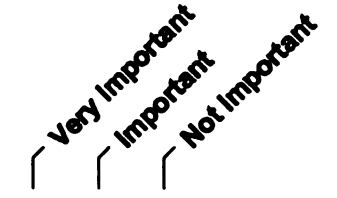
34.1% 53.7% 12.2%

How important was **a change orientation (intent to change) during the ongoing interaction** to the collaboration? .....

❑ ❑ ❑

40% 55% 5%

Professional Autonomy



How important was **negotiating multiple professional perspectives** to the collaboration? .....

❑ ❑ ❑

43.9% 46.3% 9.8%

How important was **the professional hierarchy** to the collaboration? .....

❑ ❑ ❑

47.6% 45.2% 7.1%

How important was **hierarchy of professional expertise in relation to patient care issues** to the collaboration? .....

❑ ❑ ❑

45.2% 40.5% 14.3%

How important was the **MFT's independent decision making** to the collaboration? .....

❑ ❑ ❑

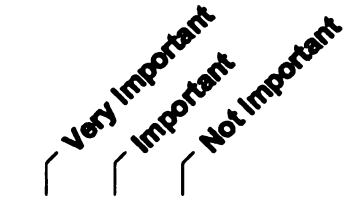
37.5% 55% 7.5%

How important was the **HCP's independent decision making** to the collaboration? .....

❑ ❑ ❑

41.5% 53.7% 4.9%

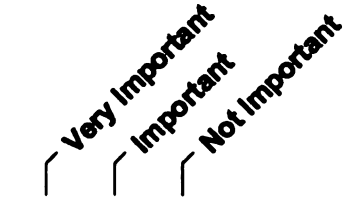
Stakeholder



How important was **personal communication between MFT and HCP** to the collaboration? . . . . . ❑ ❑ ❑

12.5% 62.5% 25%

Domain Orientation



How important was **the MFT stating explicitly any decisions and/or plans of action regarding patient care** to the collaboration? . . . . . ❑ ❑ ❑

55% 40% 5%

How important was **the HCP stating explicitly any decisions and/or plans of action regarding patient care** to the collaboration? . . . . . ❑ ❑ ❑

46.2% 51.3% 2.6%

How important was **a common purpose between MFT and HCP professionals** to the collaboration? . . . . . ❑ ❑ ❑

58.5% 36.6% 4.9%

How important was an **orientation focused on overall patient care and health promotion** to the collaboration? . ❑ ❑ ❑

52.4% 45.2% 2.4%

Collaboration Inventory - Round 2
Section 3: Rank Order of Components

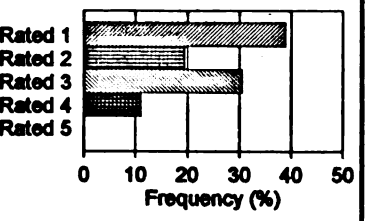
For ease of understanding, bar graphs (in the right column) have been provided which represents the frequency of response rates (in percentage form) from Round 1. **Consider how panelists have responded and re-rank as appropriate.**

Directions:
Please rank order the items in each section box in relationship to the importance to achieving a successful collaborative relationship. There should only be <u>one</u> number in each number box. Place your ranking in the box to the right: 1= most important 5=least important.

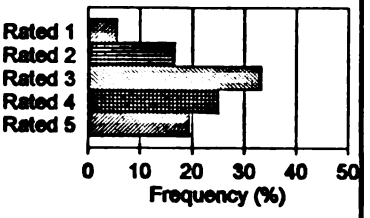
<u>Collaborative Components:</u>

Select 1, 2, 3, 4, or 5

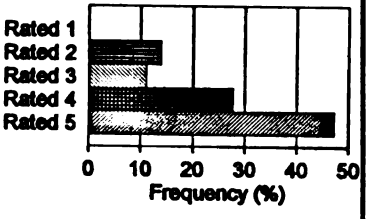
Interactive Process: the skills and knowledge related to the *process of interacting* between professionals. .....



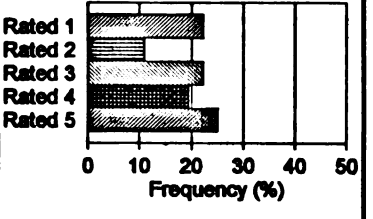
Shared Rules, Norms, and Structure: the extent to which individuals understand *cultural rules and norms and the structure* of the professionals involved. .....



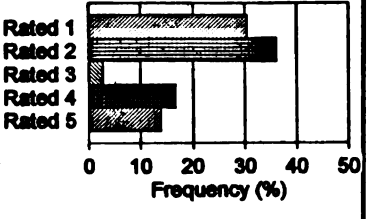
Professional Autonomy: the skills and knowledge related to each individual *maintaining professional autonomy* within the relationship. .....



Stakeholder: the extent to which an individual, or individuals, have *a stake, or investment* in patient care issues. .....



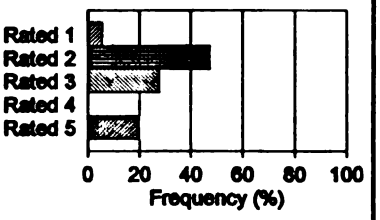
Domain Orientation: actions and decisions between individuals are *oriented toward* patient health care. .....



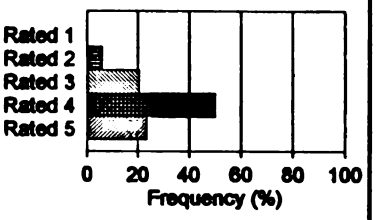
Interactive Process:
The skills and knowledge related to the *process of interacting* between professionals.

Select 1, 2, 3, or 4

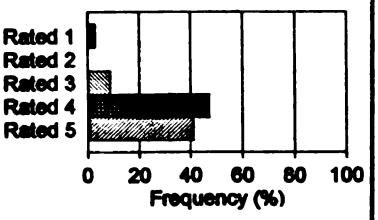
Value Interpersonal Processes - professionals place value on the process of interaction with others .....



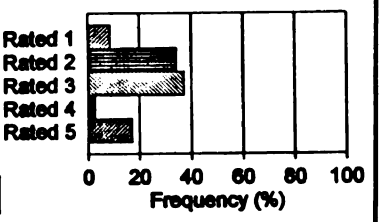
Change Orientation: initial interaction - the relationship is initiated as participants intend to engage in some change .....



Change Orientation: ongoing interaction - the relationship continues to exist as participants intend to engage in some change .....



Negotiate Multiple Perspectives - process of negotiating a variety of professional perspectives .....

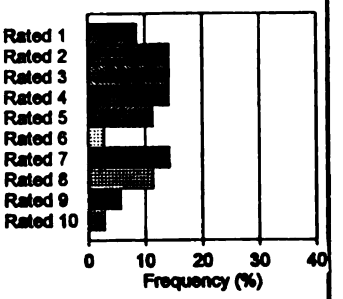


Shared Rules, Norms, and Structure

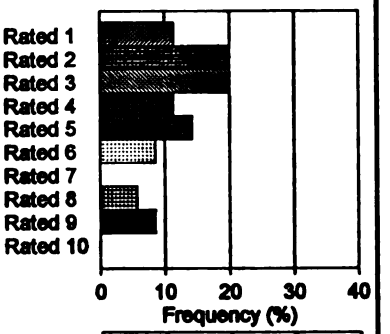
The extent to which individuals understand *cultural rules and norms and the structure* of the professionals involved.

Select 1, 2, 3, 4, 5, 6, 7, 8, 9, or 10

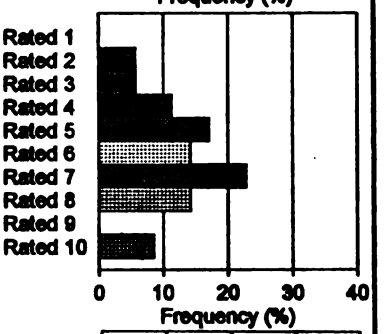
Communication: Mode - the method used for communication (phone calls, e-mail, letters, face-to-face meetings) between professionals .....



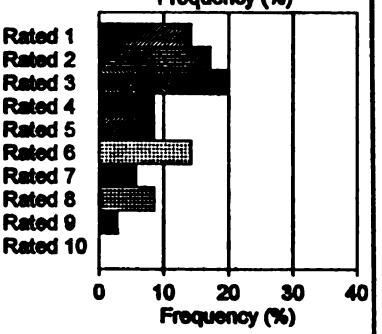
Communication: Frequency: - how often the MFT and HCP communicate regarding patient care .....



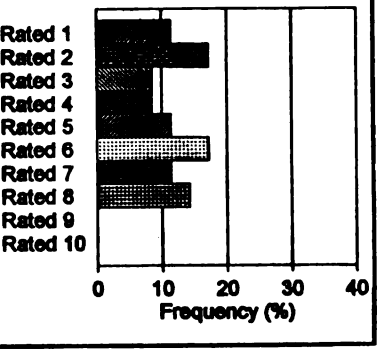
Communication: Confidentiality - the role of professionally dictated codes of ethics around confidentiality .....



Communication: Language - professional or technical jargon/language; mutual understanding

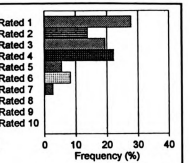


Communication: Content - norms for communicating about individual patients' care; as well as communication regarding professional relationship dynamics .....

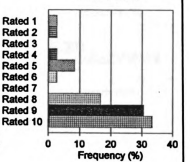


Continued on next page...

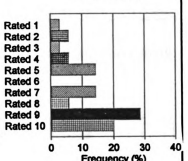
Provision of services - how care and treatment is provided (jointly, separately, combination) .....



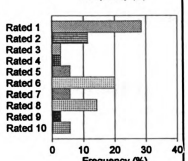
Shared support staff - sharing of receptionists, nurses, etc.... .....



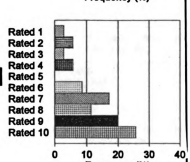
Record Keeping - sharing/keeping joint records .....



Location of Services - geographic location of providers .....



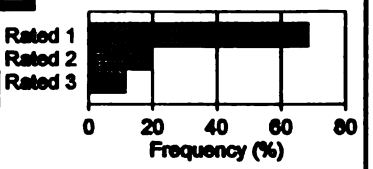
Explicit/Implicit - extent to which rules and norms are overtly discussed .....



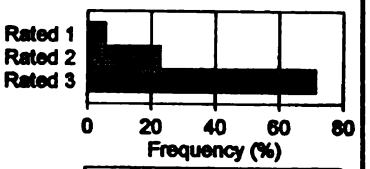
Professional Autonomy:
The skills and knowledge related to each individual *maintaining professional autonomy* within the relationship.

Select 1, 2, or 3

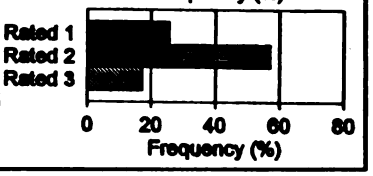
Hierarchy: patient focus - professional with most expertise given the situation exerts most influence .....



Hierarchy: relationship focus - professional arrangement; employer/employee, etc.... .....



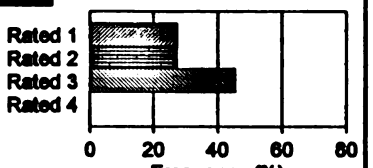
Independent Decision Making - professionals retain their autonomy regarding decisions .....



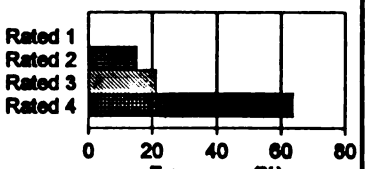
Stakeholder
The extent to which an individual, or individuals, *have a stake or investment in* patient care issues.

Select 1, 2, 3, or 4

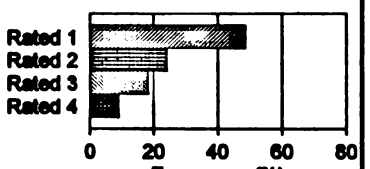
Relationship: trust - building trust as relationship matures, increased personal communication .....



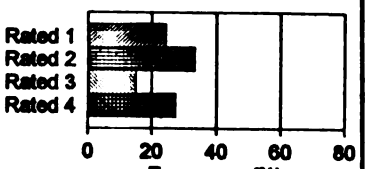
Relationship: personal communication - discussion turns more often toward what is going on with the providers, indicating a relationship independent of patient care issues .....



Stake - professionals have with an interest in the patient's care .....



Shift in Paradigm - conceptualization of patient wellness/illness (biomedical/psychosocial, biopsychosocial) .....

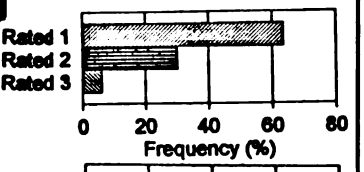


Domain Orientation

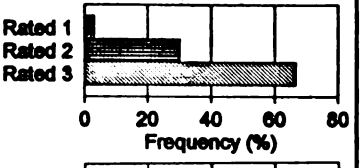
Actions and decisions between individuals are *oriented toward* patient health care.

Select 1, 2, or 3

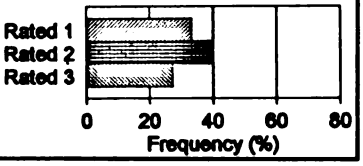
Common Purpose - professionals unite around common goal .....



Act or Decide - interaction between participants result in an action or decision .....



Orientation - professionals orient processes, decisions, and actions toward patient care issues .....



Please include additional general comments you would like to make. _____

Return in the enclosed stamped envelope no later than September 8, 2000, if possible.

THANK YOU!!

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