

Culturally Sensitive Collaborative Care Models: Exploration of a Community-Based Health Center

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This qualitative focus group (FG) study describes an interdisciplinary health care team's collaboration while serving an underprivileged patient population. Collaboration was explored with diverse personnel from support staff to upper administration at a nurse-managed community-based health center in the northeastern region of the United States. Biopsychosocial theory and a feminist ecological framework were used to explore how multiple contextual variables of patients and their providers influence the collaborative process of 39 staff. Content analysis revealed facilitators and barriers to collaboration. Providers' perceptions of care revealed a patient-centered approach with serendipitous family and community involvement. Recognized

challenges included the need to improve family and community involvement, develop ongoing cultural sensitivity training for staff at the center, and hire more providers who match the ethnic and racial makeup of the center's clientele.

Keywords: collaborative care, health disparities, cultural sensitivity

Health statistics show that people from racial and ethnic minority groups have poorer health compared with non-Hispanic Whites on indicators ranging from cancer, diabetes, and immunizations (United States Department of Health and Human Services, n.d.) to health care access (Cook, McGuire, & Miranda, 2007; Dominguez, Dunkel-Schetter, Glynn, Hobel, & Sandman, 2008; Whaley, 2001). Vulnerable populations, such as people from ethnic and racial minority groups, women, and those of low socioeconomic status are particularly at risk for mental illness (Kessler et al., 2001; Mauksch et al., 2001) and are less likely to receive adequate treatment (Brown et al., 2008; Chen & Patterson, 2006).

Breland-Noble, Bell, and Nicolas (2006) found that African Americans had more unmet mental health needs than Whites because of relatively few providers of color, little evidence of culturally sensitive treat-

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ments, and provider bias in the delivery of care. African Americans are also more likely to first seek mental health care in their primary health care setting (Oxman, Dietrich, & Schulberg, 2003; Unutzer, Schoenbaum, Druss, & Katon, 2006), suggesting that mental health interventions at the level of primary care is an important objective. Research is needed to proactively explore how collaborative care between medical and mental health providers in primary health care settings can improve underprivileged patient outcomes.

Medical Family Therapy has incorporated these important contextual variables and sociocultural differences into the field and developed models for working with underprivileged patient populations and their families. Willerton, Dankoski, and Martir (2008), for example, proposed a model for addressing health disparities among Latinos by emphasizing a better understanding of the cultural background and salient history of patients and their families. They noted that Latinos are a heterogeneous group, and providers must approach care with cultural sensitivity and not a *one size fits all* recipe. They also recommended colocated services to minimize the cultural stigma associated with seeking mental health services. Previous studies have addressed the need to consider clients and families holistically, incorporating their full sociocultural context to provide culturally sensitive care (Breland-Noble et al., 2006; Chen & Patterson, 2006; Cook et al., 2007; Grames, 2006; Whaley, 2001; Willerton et al., 2008).

Prior studies on collaboration among providers who treat underprivileged patient populations, however, have rarely included the entire health care team from administrative management to support staff (Brucker & Shields, 2003; Fickel, Parker, Yano, & Kirchner, 2007; Gerdes, Yuen, Wood, & Frey, 2001; Miller, Hall, & Hunley, 2004; Westheimer, Steinley-Bumgarner, & Brownson, 2008). It is important to understand and validate the opinions of

all providers in the health care process for a more systemic picture of collaborative care among providers. This focus group (FG) study is unique because it explores collaboration among a transdisciplinary health care team from support staff to upper administration in a nurse-managed community-based health care setting (The Center) that serves families from an underprivileged community. The primary aim of this study was to better understand collaboration among the health care team at the Center, as providers from multiple disciplines work in close proximity to serve the 95% racial/ethnic minority and low-income community members' health care and wellness needs. Relevant research on factors that affect collaboration and health care providers' experiences and attitudes about collaboration will be described in the following section.

FACTORS THAT AFFECT COLLABORATION

Despite the benefits and improved patient outcomes associated with collaborative care, extant research suggests that relatively little collaboration occurs in most health care settings (e.g., Fickel et al., 2007). In their seminal work on medical family therapy, McDaniel, Hepworth, and Doherty (1992) suggested that issues such as hierarchy within the health care system, different treatment and practice philosophies, and different payment structures were ongoing challenges for the field of medical family therapy. In response, medical family therapy scholars have conducted research on the process of collaboration to address these challenges.

Several studies have explored key factors that affect collaboration between multidisciplinary providers. For example, Foster-Fishman, Salem, Allen, and Fahrback (1999) examined ecological factors affecting provider attitudes toward reform in human service delivery. Foster-Fishman et al. (1999) found that staff's perceptions of the commitment of their organizational lead-

ers to service coordination were significantly related to their own attitudes. The most significant factor that shaped provider attitudes toward service coordination was the external environment. Providers could more likely adopt collaborative models when they perceive that their institutional and internal leadership are also committed to this process.

While different external factors can affect collaboration including the location of health services, commitment of leadership, and institutional environment, the experiences, and attitudes of the health care providers themselves influence the quality of collaborative relationships. Gerdes et al. (2001) found that the quality of the relationship between providers, primary care providers' attitudes and characteristics, and the frequency of collaboration are key variables associated with effective collaboration. Greater frequency of collaboration, colocation, family practice specialty, and a commitment to collaborative models were positively associated with collaboration. They also found that active ongoing collaboration was the most useful and collaboration limited to "parallel care is not adequate to manage high severity/low social support patients who are most likely to require seamless and ongoing PCP/MHP collaboration" (Gerders et al., 2001, p. 438).

Todahl, Linville, Smith, Barnes, and Miller (2006) conducted a qualitative study of two physicians, five therapists, one nurse, one office manager, and five patients to examine their experiences with collaborative care. All participants viewed collaboration as a beneficial process and identified the relationships between providers, ease of access to services, and access to a more complete treatment picture as key components. Noteworthy, hierarchy between medical and mental health providers was identified as a challenge. These findings highlight the complexities of the collaborative process.

While prior studies have provided useful information about providers' percep-

tions of the collaborative process, they have several limitations. Few studies have focused on providers who serve patients from underprivileged populations and the studies that have focused on this group have not specifically explored how providing services to them can affect the process of collaboration and care (Grames, 2006; Willerton et al., 2008). Furthermore, most of the previous studies included only part of the health care team. These studies typically focused on the perspectives of the medical providers and to a lesser extent, the mental health care providers. Only one study included a single administrative staff person. Bischof, Lieser, Taratuta, and Fox (2003) critiqued the medical field as privileging positions such as physicians and primary care over other members of the health care team, and the research literature corroborates this critique. Members of the health care team from front desk staff to medical assistants to administration all play important roles in the process of collaborative care, however, their voices have not always been heard or valued. Research is needed that both addresses the impact of serving an underprivileged patient population and gives the entire health care team a voice in the process. Two theoretical frameworks, biopsychosocial theory (Engel, 1977) and feminist ecological theory (Ballou et al., 2002) informed the design of this qualitative FG study, which are briefly described in the next section.

BIOPSYCHOSOCIAL THEORY

Engel's biopsychosocial (BPS) theory (Engel, 1977) informed the design of this study through its focus on the interconnected dimensions of physical and mental health. This theoretical framework suggests that how interdisciplinary health care providers interact and relate to each other is an important and often overlooked part of health care. This FG study also explored the relationships between providers and their attitudes toward the emphasis placed on the inclusion of family and

community in patient care. Campbell (2003) noted there is ample evidence that family and community impact health and health care practices. Not enough studies, however, have clearly documented family based interventions' effectiveness in addressing physical disorders. He suggested a need for more research on family based interventions for adult illness, and recommended that family involvement in health care preventive behaviors is an underdeveloped area of great promise.

FEMINIST ECOLOGICAL THEORY

Although Engel's BPS Theory (Engel, 1977) stresses the importance of including the biological, psychological, and sociological aspects of health, it was less specific on how the sociodemographic or contextual aspects of functioning affect health and development. Ballou et al. (2002) proposed a feminist ecological theory (FET) to more fully address these contextual issues. FET suggests that individuals have core contextual coordinates of race, sex, class, and age that interact profoundly within the individual at every level. FET informed the current study by expanding the emphasis on contextual variables. In a health care setting, the core coordinates of race, sex, class, and age influence not only the patients, but also the providers and how they collaborate with each other. The health care provider is influenced not only by his or her own coordinates, but also of her coworkers and the patients served in the community. The current study explored how providers' core coordinates influence the collaborative process when serving patients from an underprivileged community.

METHOD

Using the methodology described by Krueger (1994), this FG study was designed to explore experiences of collaboration among diverse health care providers while serving underprivileged patients. The study consisted of six FGs that were conducted to explore the following research

questions: (1) What can facilitate and/or impede collaboration? (2) How do provider and patient characteristics affect the collaborative process? (3) What are the providers' perceptions of family and community involvement in health care?

Participants

Each FG was comprised of between seven to 12 people (Kleiber, 2004). The six interdisciplinary teams at the Center were kept together to facilitate open discussions (Krueger, 1994). Groups included: (1) Nurse Family Partnership, (2) Mixed Group, (3) Primary Care One, (4) Primary Care Two, (5) Dental Group, and (6) Behavioral Health.

Nurse Family Partnership

This group consisted of four women. They provided home based nursing services to first time mothers and included three full time nurses (1 African American and 3 White), and one part-time supervisor (White).

Mixed Group

This group consisted of a mix of disciplines within the center including administration, AmeriCorps volunteers, a physical therapist, a nurse educator, a health educator, a pediatric social worker, and a pediatric and adult behavioral consultant. Because of the small size of some of the disciplines, several of them were combined to create this diverse group of staff members, comprised of 7 females and 2 males who were all White.

Primary Care One

Primary Care One consisted of nurses (White), medical assistants (African American), front desk staff (African American and Hispanic), a social worker (White), and a health education outreach coordinator (White), for a total of seven women.

Primary Care Two

Primary Care Two consisted of nurses (African American and White), medical as-

sistants (African American), and front desk staff (African American and Hispanic), for a total of six women.

Dental Group

This group included 2 males and 5 females. The group consisted of dentists (White male and Asian female), a dental hygienist (White male), dental assistants (African American female), an office manager (African American female), and a front desk staff person (African American female).

Behavioral Health Group

This group consisted of four full-time therapists (3 White female and 1 White male), an associate director (African American female), and one front desk staff person (African American female).

Participants consisted of 39 staff out of a sampling frame of 57 who were employed at the Center in April, 2009. Nearly half of the staff members (43.6%) ranged in age from 46–60 years old, and about a third (30.8%) were between 18 and 30 years old. The sample was comprised primarily of women (87.2% female; 12.8% male); and racial composition was 33.3% African American, 2.6% Asian, 10.3% Hispanic, 46.2% Non-Hispanic White, 2.6% Native American, and 5.1% Other. Most of the upper level and provider positions were held by White females and most of the support staff positions were held by African American or Hispanic females.

Approximately a third (35.9%) of the sample worked within the primary health care discipline, and 17.9% worked in either the behavioral health or the dental disciplines. The rest of the sample was represented by administration, physical therapy, and holistic health education. Regarding education, over half of the sample (51.3%) had graduate degrees, and 23.1% had some college education. Participants work experience in their respective professions varied. Approximately half of the staff (45%) worked 40 hr per week or more, approximately half

(45%) worked between 31 and 40 hr per week, one individual reported working 21–30 hr per week, and two individuals reported working between 10 and 20 hr per week. Considering time spent in their position at the Center, 31% worked there for less than 1 year and 28% had been in their positions for 5 to 6 years. Therefore, more than half of the staff members at the Center were relatively new.

Procedure

After receiving approval of the study from the Institutional Review Board at a northeastern University, multidisciplinary teams of professionals participated in six FGs that were conducted from April, 2009 until September, 2009. Permission was obtained from the Center Director for direct access to the staff and to hold the groups on site in a private conference room. Participants were assigned to each of the six FGs according to their team membership within the center and also according to their staff schedules. All participants completed an informed consent form before participation. The six FG were all presented with the same set of questions (see Appendix). FGs lasted approximately 1 hr and scheduled during lunch breaks to minimize disruption to participants work day.

Each FG was audiotape recorded. The principal facilitator and two trained FG facilitators met several times to review the FG procedure and guide. The principal facilitator (first author) led the discussion, while the assistants (second and third author) took extensive notes during the discussion and monitored the audio recorder. Process notes were also transcribed and included as data.

Analysis

Audio recordings were transcribed verbatim and then checked against the transcriptions for accuracy. Conventional content analysis method was used to evaluate the content and contextual meaning of the text (Hsieh & Shannon, 2005). This ap-

proach is useful when research literature on a phenomenon is limited. Moreover, it enables a systematic review of statements within the transcripts (Miles & Huberman, 1994) with the aim of identifying frequent and notable themes.

Initially, the research team read through the transcripts independently and assigned open codes to the text. Then, the team discussed each code and kept those codes agreed upon by at least two out of the three researchers. During the third stage, codes were collapsed under higher order themes. The themes and codes were then validated by going back to the transcripts and counting the number of staff within each of the six groups who mentioned the code. Only themes that were supported by three out of the six groups were classified as dominant themes and are described in this paper.

Trustworthiness and Credibility

Trustworthiness was enhanced through the use of multiple coders. The first, second, and third authors, who are experienced qualitative researchers, independently identified common codes and then consulted with each other during meetings to discuss the codes and then reanalyzed the data to reach consensus. Participant quotes were also included in the findings section to help clarify and illustrate the dominant codes that emerged (Green & Thorogood, 2004).

Credibility was addressed by presenting the findings and the identified codes several times to the study participants to ensure their agreement. This was done both at the immediate conclusion of each FG session, and again through electronic communications after the final list of codes was compiled. The authors also met with the Center's director (April, 2010) to review the findings and to learn about recent changes at the Center since the study was completed. Participant feedback and member checking was used to increase validity of the study by making sure the researchers

had captured the participants' thoughts and feelings accurately and had not unduly influenced the interpretation of the data (Krueger, 1994). The study findings were triangulated between data collected from the participants and the three coders to increase validity. We compared the transcripts and all process notes to the first author's field journal to look for consensus and to capture an accurate and complete picture of the data (Miles & Huberman, 1994).

To maintain anonymity of the staff who participated in this study, the findings section below provides a minimum amount of identifying information and only describe the dominant themes that emerged in at least three out of the six focus groups. Although there were some differences between the six groups, the focus of this paper is to describe our main findings summarized across the six groups.

Findings

Five dominant themes emerged from the FG data: (1) facilitators of collaboration, (2) barriers to collaboration, (3) provider characteristics and collaboration, (4) patient characteristics and collaboration, and (5) family and community involvement.

Facilitators of Collaboration

Staff identified many ways of communicating as a major facilitator of collaboration at the center. *Communication systems* were identified by five out of the six groups as a facilitator of collaboration. Staff valued multiple ways of connecting with each other about shared patients, including the use of email, telephone calls, and meetings. Staff stressed the value of regular contact between providers both in more formal and informal ways. Although they noted multiple ways that they do communicate, most staff preferred face to face contact.

... good communication lines, we do weekly interbuilding newslet-

ters . . . we have scheduled transdisciplinary meetings and we have a strong management team that really works together to try to bridge the gap between any barriers.

Provider interactions were noted by five out of the six groups as a facilitator of collaboration. Respect between providers and valuing each other's expertise was emphasized in addition to the importance of providers being open and receptive to collaboration.

The respect among those groups and teams is definitely seen, everyone is friendly and open.

Patient factors were noted by five out of the six groups as patient's multiple issues such as underprivileged status, poor previous health care history, and exposure to violence and trauma tended to trigger collaboration.

I feel like collaboration happens . . . when I have a complicated patient particularly if they have lots of needs that affect what I'm doing with them but that required something that I can't provide so they really have a problem that has multidisciplinary needs.

Physical structural/building issues were commented on by all six groups. Being colocated and having easy access to other providers was viewed as an important facilitator of collaboration for both the providers and their underprivileged patients. They noted that colocated services and availability of transportation services were essential to collaboration and culturally sensitive treatment.

. . . what really helps us collaborate is that everything is right here so you know everyone is within a phone call or within two flights of each other.

Shared vision was noted by three out of the six groups. They focused on the value of

having shared goals and working in a team atmosphere. In particular, several staff noted the importance of being guided by upper management's vision.

The director has a vision/need for collaborative health care environment for years . . . Now we have an environment of people who are very open team players . . . people who are very interested in that vision and that common goal.

Barriers to Collaboration

Regarding factors that were considered barriers to provider collaboration, there was a great deal of consensus among the six FGs. Often topics that were considered facilitators were also considered barriers to collaboration.

Patient factors were noted by all six groups as a barrier to collaboration. Staff reported that their patients often had multiple issues such as low socioeconomic status, poor health care history, chaotic lives, and experienced racism, which often interfered with their health care practices. Many staff said that patients can be their own barrier when they do not come to scheduled appointments or follow through with health care recommendations.

Impediments toward reaching the goal of effective collaboration is being able to get in touch with the client again or difficulties keeping in touch and getting information conveyed . . . so it is not what is going on between departments here . . . it's more about how the client's life impacts the result.

Provider interactions were noted by five out of the six groups as a barrier to collaboration. Participants spoke about some ownership of patients and an unwillingness to learn from others. Some staff described a lack of follow through between providers and not always communicating regularly about problems as salient collaborative issues that needed to be resolved at the Center. In particular, numerous staff

noted some tension between the primary care and behavioral health care departments. They mentioned behavioral health's view that primary care did not seem to value their interdepartmental meetings and primary care's perception of a condescending attitude from the behavioral health department.

I think there is some ownership of patients that impedes collaboration . . . this is the exception . . . but there are staff members that feel like they can't learn from other staff members or feel that they really know all there is to know about a patient . . . and that's where collaboration immediately dies.

Busy or the volume of work as a barrier to collaboration was noted by five out of the six groups. While all groups noted a strong desire to collaborate with each other, the volume of patients and amount of paperwork to complete often got in the way of face to face meetings about shared cases. Many staff talked about finding it difficult to accomplish their daily tasks, let alone connect with other providers. Even when they were able to connect, the limited amount of time they had made it difficult to talk about everything that needed to be addressed.

. . . the volume that we see, the amount of work that we do sometimes means we just need to keep going and don't have the time to step back, which is what it kind of takes to bring the other folks in to collaborate.

Physical structural/building issues were noted as a barrier to collaboration by five out of the six groups as having providers on different floors often made it difficult to interact. Staff noted missing out on more informal face to face contact in the halls to discuss shared cases. Groups located in the basement like dental tended to feel isolated, likewise groups such as the nurse family partnership who spent relatively less time working in the building felt they

had difficulty connecting with other providers.

You need to walk around easier, you need to see people's faces, they need to see you . . . that's going to create collaboration and break down those silos . . .

Provider Characteristics and Collaboration

Patient treatment was emphasized by all six groups as an important part of who they were as providers. They emphasized respecting the patient and not questioning or judging a patient's provider choices. Specifically, they believed in advocating for their patients and were concerned with providing them with the best health care possible. They recognized that their patients often approached health care with anxiety and mistrust; therefore, comforting and connecting with their patients was an essential part of the collaborative process. In addition, staff reported that their patients perceived how the providers respected them, which facilitates the collaborative process.

At the end of the day our main goal is to get patients what they need and it doesn't matter if it comes from me or our co-ops . . . you know at the end of the day that patient gets what they need and they leave here satisfied.

Demographics of the providers were noted by three out of the six groups. Most staff stated that their own sociodemographic characteristics do not affect their interactions with patients at the Center. A few participants stated that trust issues associated with providers' race, sex, or education sometimes emerged, which they had to overcome.

"Personally, I haven't had any problems with racial factors even though we see a lot of minorities. . . I've never really run into any kind of interaction.

I was a White woman with a PhD coming into an all Black public housing neighborhood and there was a huge barrier . . . they weren't going to trust me and I had to build that trust.

Provider overload was noted by three out of the six groups as a provider characteristic that negatively affected their collaboration. The high patient volume, work overload, and the ongoing development of new programs often left providers feeling overloaded. Many staff noted a need to focus on self-care to be available for collaboration and meet the needs of their patients.

"We don't take the time for us . . . we worked on caring for ourselves and taking a moment for us because if we don't take care of ourselves we can't take care of our patients, which is what we tell our patients and their caregivers all the time . . . we are working on practicing what we preach to our patients.

Provider roles were noted by three out of the six groups. Their roles and duties affect collaboration; for example, front desk staff may hear patient information that other providers may not hear, and they play a crucial role disseminating this information to providers.

I would not have known about my one client ending up in the hospital if it had not been for our transportation person letting me know.

Additionally, management level providers through their involvement in upper level meetings may have more ease with collaboration because they see each other more regularly.

Patients' Characteristics and Collaboration

When asked directly about how patients' demographic characteristics affect providers' collaborative process, staff from four out of six groups stated that it did not

or should not affect the process. Other staff, however, recognized the multiple issues that their underprivileged patients face. However, most staff asserted that they were not biased in their care and provided equal care regardless of patient characteristics such as race, ethnicity, class, and sex, suggesting that every patient at the Center is treated the same way.

We treat all patients with respect regardless of their backgrounds . . . we listen to the patient and do not judge them.

Cultural factors were noted by four out of the six groups, as staff discussed some barriers to treatment because of cultural differences between providers and patients, stigmatization, and an understandable mistrust of some services such as behavioral health.

I think patients don't trust me immediately . . . especially when I'm working with African American or Latino men . . . who would feel more comfortable with someone who's male or who's African American/Latino . . . I never try to make assumptions about people . . . I'm constantly learning not just from staff but from patients as well.

I think coming in as a licensed social worker definitely freaks this community out cause they think I'm going to take their kids and I'm going to call the department of human services and I'm just here to point the finger at everything they're doing wrong, so there's that assumption.

Staff noted that there were cultural differences between some patients and providers in terms of race and socioeconomic status that could lead to mistrust if left unaddressed.

Their *underprivileged* status was noted by five out of the six groups regarding patient characteristics and how they affect staff collaboration. Most staff noted that

they serve a homogenous underprivileged patient population at the Center that contributes to a shared understanding of patient issues. Patients were seen as sharing common experiences of exposure to trauma and violence, with many of them having chronic and complicated health conditions. Understanding and being compassionate about those shared conditions often aided providers in planning for the best care and services for their patients.

Having a homogenized group of patients makes it easier because there are some commonalities and some common needs, and common things that we are collaborating on.

I try never to make assumptions about people and I'm constantly learning not just from staff but from patients as well.

We're here to take care of people who are underserved, they're not under competent . . . they're very, very resilient.

Staff reported seeing their patients as resourceful and resilient, rather than focusing on their underprivileged status.

Family and Community Involvement

When staff was asked about partnering with the family and community of their patients, all six focus groups noted that their work is primarily focused on the patient. Inclusion of family or community support is occurring only sporadically. Although this trend was pervasive, several of the pediatric providers noted that partnering with the family was an integral part of their process.

Patient centered emerged as a theme in three out of the six groups as they discussed the emphasis on the one to one relationship between providers and patients. Only serendipitous family and community involvement was occurring and usually initiated by the patient.

. . . that relationship that allows behavior change to occur . . . has to be a trusting relationship and it is best done one to one . . . the more people they involve the more diluted that primary relationship gets.

. . . I think we lose our community perspective of what we have to do out there because we're so focused on kind of intense care of the few that we forget about sometimes the many . . . There's realities to that, you know it's reimbursement and productivity and things that have to be done and having the finances to do it.

Referrals emerged as a theme in three out of the six groups when staff were asked about partnering with the community. Most providers noted little active inclusion of the broader community in treatment other than receiving community referrals. One participant noted that their intense focus on patient care was moving them away from their original community focus.

I can see at least two new patients a day . . . mostly referred from family members or word of mouth so they feel comfortable here.

Family as a tool was noted by four out of the six groups as family members were included in care to explain and reinforce health care recommendations and translating for non-English speaking patients at the Center.

I have a patient who is very noncompliant. She has a cousin who takes her to appointments here . . . if she resists suggestions . . . her cousin is very adamant about reinforcing what to do for her health care.

DISCUSSION

Findings from this FG study revealed facilitators (communication systems, provider interactions, patient factors, structural/building issues, shared vision) and

barriers (patient factors, provider interactions, volume of work, structural/building issues) to collaboration. Provider demographics, provider overload, provider roles, and patient demographic characteristics (e.g., cultural factors, underprivileged) were factors that affected the collaboration of participants in this study. Additionally, providers' perceptions of care revealed a patient-centered approach with serendipitous family and community involvement.

Based on the results of this study, the Center is currently functioning between levels three and four of collaboration (Doherty, 1995) as on-site collaboration is often occurring and mental health professionals and health care professionals tend to have separate record systems, with the exception of a few behavioral health care providers imbedded within primary care who do share a medical record with the primary care providers. Staff does report engaging in regular communication about shared cases, primarily through phone calls and emails and often have face to face meetings. Some nonmedical staff at the Center also shared that the medical staff tend to have more power and influence over case decisions than the other providers that has caused some tension among providers.

Overall this Center demonstrated a strong working model of collaborative health care for its underprivileged patient population. The Center has received national recognition from numerous organizations for its care delivery system including Robert Wood Johnson Foundation for Innovative Care Models, Agency for Health care Research and Quality Innovations Exchange, and the Academy of Nursing *Raise the Voice* campaign, a partnership with the Robert Wood Johnson Foundation. Noteworthy, most participants have only been working at the center for a few years and still have a shared mission, belief in collaboration, and motivation to work as a collaborative team. During the FG discussions, it was apparent that many staff members

were open about conflicts and motivated to find resolutions so they can best meet the needs of their patients.

In particular the Center is addressing many of the barriers to health care that underprivileged patient populations tend to experience such as providing transportation, access to diverse disciplines, and availability of health insurance. A dominant theme that emerged from the research was the investment in collaboration shared by the various participants. Staff members were very excited about their work environment and many of them lauded that this was the best work environment that they had ever experienced. This shared vision and commitment to collaboration seemed to guide the decisions at the Center and were driven by a strong management team that fostered this vision and sought out providers equally motivated to practice this model of care.

Another key aspect of their collaborative model was the personal connection developed with their patients. Participants frequently noted their desire to provide the best health care possible to their patients and to advocate for them in terms of referring them to other services and finding insurance and low cost medication options. These efforts seemed effective as the participants described a great deal of word of mouth referrals in the community, suggesting that the community values their efforts and model of care.

A noteworthy strength of the Center was the ability of most staff members to openly discuss their concerns and challenges during the FG discussions. While challenges such as hierarchy seem to exist both within and between disciplines, the participants did not shy away from discussing these topics, and described both their frustrations, and the steps they were currently taking to address and resolve them. Likewise, participants discussed how their heavy work volume contributed to a sense of overload and difficulty in collaborating more actively with other providers. Ten-

sion also exists between the continued drive for new and innovative programs and the desire to work on maintaining their current level of care; however, engaging in an open dialogue seems to foster the type of atmosphere where tensions can be addressed and resolved.

While the transdisciplinary model currently practiced at this Center represents an excellent health care model for serving underprivileged populations, there are several challenges that this particular Center still needs to overcome. First of these is a more active inclusion of family and community in the health care process. Health issues in one family member significantly impact other relationships such as with spouses (Benazon & Coyne, 2000), and with the entire family (Campbell, 2003). In addition, family involvement in illness management tends to have a more positive impact on health outcomes (Clabby & Howarth, 2007; McDaniel & LeRoux, 2007). Despite these strong research findings that support family and community involvement in medical care, the FG participants from the Center reported little direct family or community involvement in their health care practices.

Staff, however, reported positive feedback from the patients and community on the quality of care they received at the Center and emphasized fostering a close personal connection with their patients. The Center seems to excel at forming these bonds with the community they serve. Inclusion of a more relational and systemic family and community focus may further enrich these bonds. A number of participants expressed the need for an explicit goal that promotes future inclusion of these relationships that could greatly improve health outcomes and foster improved support systems for patients. It was noted that the Center was originally developed as a partnership with the community and that the current intense patient focus has shifted this emphasis. Reincorporation of this emphasis could enrich the current fo-

cus on intense patient care by broadening the holistic picture of patients and fostering the development of supportive family relationships.

A second challenge is continued work with staff on cultural awareness, in particular the need for center-wide cultural sensitivity training. The participants all stated that they serve an underprivileged patient population and noted the many challenges that their patients faced. They also stressed the importance of treating all of their patients with respect regardless of their backgrounds. These values represent a strong foundation for the development of culturally sensitive practice; however, current health care models for serving ethnic and racial minority populations suggest that it is also important to actively and explicitly discuss issues such as race, sex, and culture (Kagawa-Singer, Dadia, Yu, & Surbone, 2010; Whaley, 2001; Willerton et al., 2008). Not only is it important for staff to openly discuss these issues with their patients, they should also be able to explicitly discuss these issues with each other and not make assumptions about what their patients and/or fellow workers are thinking or feeling. Therefore, increased emphasis on this aspect of the patient-provider relationship may improve the already strong relationships the Center has forged with their patient community.

In addition to addressing the patient-provider relationship, the Center could benefit from more ethnic and racial diversity in their staff. While over half of the study participants were racial or ethnic minorities, approximately 75% of them were in support staff positions. The majority of department leaders and management positions were held by White staff members. According to Breland-Noble et al. (2006) the lack of providers of color can be a barrier to service for racial and ethnic minorities. Therefore, the Center may better serve their 95% ethnic and racial minority patients with a more racially and ethni-

cally diverse provider base, particularly in professional and leadership positions.

To fully expand the cultural sensitivity and awareness at the Center, the staff members could first focus on their own power and privilege and self awareness. As feminist ecological theory suggests (Ballou et al., 2002) attending to issues of power and privilege are essential in understanding how people and systems interact. As previously noted, ethnic and racial minority support staff seemed to be silenced in the process; despite the majority of participants reporting that their own personal characteristics had little or no impact on their collaboration. Their silence seems to imply that providers with less power and privilege may not feel valued or heard at the Center. The results of this study suggest that issues of power and privilege could be silencing ethnic and racial minority staff members in the front line staff position.

Open discussions about providers' race and how that affects their interdisciplinary collaboration were not fully addressed during the six FG discussions. This could have been because of the current staff configuration at the Center with upper administration comprised of Whites and most support staff comprised of women racial minorities. Just as it is important to openly discuss these sociocultural issues with patients at the Center, staff from all levels could benefit from more open discussions about why the divisions of labor by race are so sharp at the Center. Therefore, it is recommended that all staff members become more aware of how these factors affect their work and interactions with each other *and* with their patients. Providing culturally sensitive care to their underprivileged patients requires that the providers first examine their own power and privilege (Kagawa-Singer et al., 2010). This process should occur at all levels, from upper management to support staff.

Since the conclusion of data collection, the Center has been taking active steps in

addressing many of these problematic areas. Land adjacent to the Center has been secured that will allow the Center to expand its current services and address many of the issues around space and provider proximity. In addition, the Center is currently developing and implementing a Patient Wellness Tracker where Center providers have open access to shared patient data across disciplines. While this is not a fully shared integrated medical record, it increases the amount of shared information available to providers and may facilitate a higher level of collaboration. They have also incorporated greater coprovision of care in their diabetes program and plan to expand this model to their asthma treatment program. In addition, the Center has expanded its community partnership and has increased its systemic focus by incorporating a part-time couple and family therapy therapist currently working on trauma. In terms of addressing the level of racial and ethnic diversity in the staff, the Director has expressed an explicit desire to hire racial and ethnic minority health care providers, and has already hired a fifth nurse practitioner who is a Spanish speaking minority (P. Gerrity, personal communication). Incorporating ongoing Center-wide cultural sensitivity training is also under development.

A primary aim of this study was to better understand the collaboration among the health care team. It is hoped that this study will facilitate the Center's understanding of how issues of power, privilege, and systemic relationships can be punctuated in their work. The findings from this study and research recommendations can further facilitate this process and increase the Center's ability to serve their underprivileged patients with cultural sensitivity. In conclusion, the Center is developing a comprehensive model for collaborative health care that can act as a model for other centers looking to develop a collaborative process and best serve underprivileged patient populations.

Limitations

This FG group study has a number of limitations that may have affected the findings. The study was limited by a number of unanticipated procedural issues. First, because of time constraints during the six FGs not all of the questions were fully addressed in every FG, which may have contributed to differences in responses between the six groups. Second, several of the groups arrived substantially late to the FGs, which may have been a feasibility issue or may have indicated their level of investment in the process. Third, we were unable to follow up with staff. Center staff members have full caseloads and were unable to reschedule to address all FG questions fully. Additionally, discussions about race may not have been fostered by the membership in the six FGs as staff from similar positions were not grouped together that may have contributed in particular to support staff participating less actively in the FG discussions. Additionally, the research was conducted in collaboration with the upper level administrators who were White females that also may have affected how comfortable staff from racial and ethnic minority cultures felt about discussing racial issues at the Center.

Future Research

While the findings from this study provided valuable insights about the collaborative process at this specific site and about collaborative care in general, many more research questions have yet to be answered. One aim of this study was to explore how collaboration works when serving an underprivileged population. Future research could enrich these findings by comparing the perspectives about collaboration at this site to other sites serving similarly diverse patient populations. This type of future research could help to further elucidate how collaboration and treatment outcomes differ depending on

changes in the provider and patient populations.

Additionally, while this research study was designed to examine the perspective of the health care providers, it is also important to explore patients' and families' perspectives to enrich our understanding of collaborative care and to address health disparities from a more systemic perspective. Just as this study was designed to bring to the fore the voices of all health care providers, future research needs to validate the patients' and family members' perspectives, particularly those from underprivileged communities. Finally, further research designed to attend to the voices of support staff is essential if we are to be truly inclusive in our understanding of the meaning of collaboration.

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Appendix Focus Group Guide

- I. Opening Question: Please introduce yourself and tell us about your role in the center.
- II. Introductory Question: How does your role at the center impact your experience with collaboration?
- III. Transition Questions: When does collaboration occur? With what type of patient is collaboration most likely to occur? Are family and/or community involved in the collaboration?
- IV. Key Questions: Is collaboration effective? What facilitates collaboration? What impedes collaboration? How do your personal characteristics (professional identity, race, sex, SES) affect the process? How do the characteristics of your patients affect the process?
- V. Ending Question: Does this summary capture your thoughts on collaboration, and is there anything else that you would like to say on the subject?

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