



# Developing Relational Coordination: A Qualitative Study of Outpatient Mental Health Teams

Elizabeth G. Spitzer<sup>1</sup> · Jenesse Kaitz<sup>2</sup> · Gemmae M. Fix<sup>3</sup> · Kimberly L. L. Harvey<sup>1</sup> · Nicole A. Stadnick<sup>4</sup> · Jennifer L. Sullivan<sup>5</sup> · Alicia K. Williamson<sup>6</sup> · Christopher J. Miller<sup>7</sup>

Accepted: 21 February 2023 / Published online: 9 March 2023

© This is a U.S. Government work and not under copyright protection in the US; foreign copyright protection may apply 2023

## Abstract

Previous studies have shown Relational Coordination improves team functioning in healthcare settings. The aim of this study was to examine the relational factors needed to support team functioning in outpatient mental health care teams with low staffing ratios. We interviewed interdisciplinary mental health teams that had achieved high team functioning despite low staffing ratios in U.S. Department of Veterans Affairs medical centers. We conducted qualitative interviews with 21 interdisciplinary team members across three teams within two medical centers. We used directed content analysis to code the transcripts with a priori codes based on the Relational Coordination dimensions, while also being attentive to emergent themes. We found that all seven dimensions of Relational Coordination were relevant to improved team functioning: frequent communication, timely communication, accurate communication, problem-solving communication, shared goals, shared knowledge, and mutual respect. Participants also described these dimensions as reciprocal processes that influenced each other. In conclusion, relational Coordination dimensions can play pivotal roles in improving team functioning both individually and in combination. Communication dimensions were a catalyst for developing relationship dimensions; once relationships were developed, there was a mutually reinforcing cycle between communication and relationship dimensions. Our results suggest that establishing high-functioning mental health care teams, even in low-staffed settings, requires encouraging frequent communication within teams. Moreover, attention should be given to ensuring appropriate representation of disciplines among leadership and defining roles of team members when teams are formed.

**Keywords** Relational Coordination · Mental health · Outpatient · Team functioning · Teamwork

---

✉ Elizabeth G. Spitzer  
elizabeth.spitzer2@va.gov

<sup>1</sup> VA Boston Healthcare System Center for Healthcare Organization and Implementation Research, Boston, Massachusetts and Department of Psychiatry, Harvard Medical School, Boston, Massachusetts, United States

<sup>2</sup> VA Bedford Center for Healthcare Organization and Implementation Research, Bedford, Massachusetts, United States

<sup>3</sup> VA Bedford Healthcare System Center for Healthcare Organization and Implementation Research and Boston University School of Public Health Boston, Bedford, Massachusetts, United States

<sup>4</sup> Department of Psychiatry, University of California, San Diego; UC San Diego, Altman Clinical and Translational Research, Institute, Dissemination and Implementation Science Center, La Jolla, California; and Child and Adolescent Services Research Center, San Diego, California, United States

<sup>5</sup> A Medical Center, Center of Innovation in Long Term Services and Supports and Brown University School of Public Health, Providence, Providence, Rhode Island, United States

<sup>6</sup> School of Information, University of Michigan, Ann Arbor, USA

<sup>7</sup> VA Boston Healthcare System Center for Healthcare Organization and Implementation Research and Department of Psychiatry, Harvard Medical School, Bedford, Massachusetts, United States

## Introduction

Healthcare is interdisciplinary, requiring professionals from different training backgrounds and specialties to work alongside one another. Ample research has shown that team functioning in integrated healthcare teams affects the quality and safety of patient care and reduces healthcare service fragmentation (Fleury et al., 2020; Manser, 2009; Schmutz & Manser, 2013). Teamwork is an especially important component of mental health services, as many patients present with complex medical and psychosocial needs, which may require providers from psychiatry, psychology, social work, nursing, and pharmacology, among others (Kinnair, Anderson, van Diepen, & Poysey, 2014). Integrated healthcare teams improve job satisfaction among healthcare professionals, which is especially important for mental health providers as they experience elevated rates of burnout and occupational stress (Fleury et al., 2017, 2020; Onyett, 2011). In turn, job satisfaction also contributes to enhanced patient safety and higher quality of health care services (Wallace et al., 2009). Within the Veterans Affairs (VA) healthcare system, outpatient mental health teams are known as Behavioral Health Interdisciplinary Program (BHIP) teams. Prior studies on BHIP teams have shown that committing to this team-based structure has increased staff communication, fostered improved working relationships among staff, and ultimately improved clinical care (Bauer et al., 2019).

Although there is substantial research on the benefits of good team functioning in healthcare settings—including within BHIP teams—there is markedly less research on team functioning in resource-constrained teams specifically, such as teams with low staffing ratios (i.e., the number of available staff relative to the number of patients for which the team is responsible). In hospital settings, higher provider/patient staffing ratios are associated with lower mortality rates and higher patient satisfaction (Assadian et al., 2007). Furthermore, in mental health workers, higher case-loads (or lower provider/patient staffing ratios) have been associated with lower reported performance and lower general well-being (King et al., 2000). Given the resource-constraints and staffing issues often faced by frontline clinical teams—which in many cases have only been exacerbated by the COVID-19 pandemic (U.S. Department of Health and Human Services, 2021; U.S. Department of Veterans Affairs, 2021)—there is an urgent need to better understand how to accomplish effective teamwork in such settings.

Thus, in a previous study, we set out to investigate how low-resourced BHIP teams (i.e. BHIP teams with low staffing ratios) were able to overcome this challenge to develop high team functioning (Miller et al., 2021). Our initial analyses for that study focused on the structural and operational components necessary to promote teamwork in

resource-constrained clinical settings. However, those initial analyses did not fully examine how effective *relationships* between clinical team members were developed and maintained in this context. To further our understanding of how to develop and maintain high-functioning integrated outpatient mental health teams despite low staffing ratios, it is necessary to examine how working relationships are established in these teams. Therefore, the follow-up analyses described in this paper examined the relational factors needed to support team functioning in outpatient mental health care teams with low staffing ratios.

## Conceptual Framework

We used Relational Coordination as a framework for understanding the relational dynamics of interdependent work applied to interprofessional mental health teams in resource-constrained environments (Gittell et al., 2000). Relational Coordination posits that high-functioning (i.e., well-coordinated) teams are established through the interaction of frequent, high-quality communication and relationships with shared goals, shared knowledge and mutual respect (Gittell, 2002a). It specifies seven dimensions of Relational Coordination across the two domains of communication and relationships, which are described in Table 1.

Relational Coordination was developed by expanding on Follett's (1924, 1949) seminal work on coordination. Although coordination has been studied by many theorists (e.g., Argote, 1982; Weaver & Jacobsen, 2018; Young et al., 1998), Relational Coordination is unique in that it focuses on improving task integration through mutually reinforcing process of communication and relationships, specifically in work settings that are highly interdependent, uncertain or time sensitive (Gittell et al., 2000; Gittell, 2002a). This framework is well-suited for the current study as outpatient mental healthcare teams in a resource-constrained environment require a high level of interdependent teamwork between numerous disciplines and often involve time-sensitive and uncertain situations (e.g., suicidal crises). BHIP teams are structured to have a high degree of reciprocal interdependence (Thompson, 1967), which requires high levels of information sharing. Often in BHIP teams, members need to adjust to changes in a patient's care (e.g., medication changes, housing stability, changes in health status), and it is not always clear from the intake which team members will need to be involved in care. For instance, some Veterans may state that they are only interested in medication management and later decide that they would like to engage in psychotherapy. Relational Coordination has previously been used to examine a range of medical care teams (e.g., Gittell et al., 2000; Gittell, Weinberg, Bennett,

**Table 1** Dimensions of Relational Coordination used for A Priori Coding

<b>Communication</b>	
Frequent Communication	Perceptions of how frequently BHIP team members communicate with one another
Timely Communication	Perceptions on if BHIP team members are able to communicate about patient care and BHIP processes in a timely manner or if communication becomes delayed
Accurate Communication	Perceptions of how accurately BHIP team members communicate with one another regarding patients, processes, and team-related duties
Problem-Solving Communication	When a problem occurs with a patient or with a work process, do the people in these groups blame one another or work with one another to solve the problem? Includes mention of blaming, avoidance of blame, how conflict is managed
<b>Relationships</b>	
Shared Goals	Do BHIP team members, especially providers across disciplines, share goals regarding work processes and patients? Are the provider's functional goals a higher priority than the superordinate goals of the work process/team?
Shared Knowledge	Do providers from one specialty/discipline have knowledge about the work done by providers in other specialties/disciplines on their BHIP team regarding work processes and patient care? Do providers understand the tasks of other groups of providers on their team? Do providers know how tasks fit together with the tasks of others on their team? How do differences in training, socialization, expertise among groups of providers impact the shared understanding of the work process?
Mutual Respect	Do providers from each discipline respect the work done by providers (from other disciplines and from within their discipline) with regard to their team/work process/patients? Does occupational identity/pride get in the way of respecting other's roles on the team? Is there respect for the competence of others from other occupational disciplines?

Note. BHIP = Behavioral Health Interdisciplinary Program

& Miller, 2008). It has previously been shown to improve job satisfaction by providing social support and allowing workers to more effectively carry out their job duties, (Gittell, 2008; Gittell, Weinberg, Pfefferle, & Bishop, 2008); however, this is the first study to our knowledge to examine Relational Coordination in an outpatient mental health care setting.

This study uses Relational Coordination as the primary guiding model for our thematic qualitative analysis to examine teams that work well together within resource-constrained environments. Specifically, this paper aims to explore how these communication and relational processes

work and are maintained within the context of low-resourced outpatient mental health teams.

## Methods

We used a qualitative study design to examine the relational aspects of high-functioning clinician teams in the context of low staffing ratios. This paper builds on our work examining resources required to support team functioning in the context of low staffing ratio teams (Miller et al., 2021). This study was approved by the VA Boston Institutional Review Board.

## Study Setting and Population

The study targeted clinicians in VA-based general outpatient mental health teams, known as BHIP teams. As noted above, mental health care teams often report high levels of burnout and occupational stress and require interdisciplinary coordinated care. These teams typically include 5–10 full-time mental health staff (e.g., psychiatrists, psychologists, social workers, nurses, and administrative support), treating about 1,000 Veteran patients per team (U.S. Department of Veterans Affairs, 2019). Clinical services delivered within BHIPs can include individual psychotherapy, group psychotherapy, medication management, peer support, and case management.

## Sampling and Recruitment

**Step 1: Administrative Data Review.** We used a two-step process to identify BHIP teams that achieved high-functioning despite low staffing ratios. First, teams were initially identified through administrative data from FY2017 (the last year with complete data at the time that we began identifying teams) including the VA All Employee Survey (AES), the VA Mental Health Provider Survey (MHPS), VA Corporate Data Warehouse (CDW), the VA Mental Health Management System (MHMS) and further detailed elsewhere (Miller et al., 2021; also see Supplemental File 1). Briefly, high-functioning BHIP teams were defined as those with high levels of self-reported job satisfaction, low burnout, and no plans or intentions to leave their current job (i.e., low turnover plans/intentions). We operationalized BHIP team functioning this way (a) due to established associations between clinician satisfaction, burnout, and turnover with care quality (e.g. Hall, Johnson, Watt, Tsipa, & O'Connor, 2016), and (b) because VA administrative datasets do not include reliable team-level clinical outcomes data to directly estimate team functioning. Teams with low staffing ratios were defined as having a below average ratio

of staff per clinical encounter and mental health patients treated. We calculated this based on the VA Mental Health Workforce Report (MHWR), clinic visit data from the VA Corporate Data Warehouse (CDW), and the MHMS (U.S. Department of Veterans Affairs, 2018; also see Supplemental File 1). These criteria identified 11 VA medical centers as candidates.

**Step 2: Data Validation with Mental Health Chiefs.** Second, we asked mental health chiefs at these medical centers to confirm administrative data and identify one (or more) of their BHIP teams that appeared to be functioning well despite higher-than-average workload. We undertook this step to ensure that our team selection process identified teams that met our inclusion criteria based on administrative data. These data were then validated by the mental health chiefs responsible for the teams in question; our a priori recruitment goal was to interview at least 20 BHIP staff members across 3–4 BHIP teams. Three BHIP teams located at two Veteran Affairs medical centers were included. Once teams were identified, individual clinicians within those teams were recruited via e-mail and telephone.

## Data Collection

Qualitative interviews were conducted over the telephone with BHIP team staff between August and October 2018 by a psychologist with qualitative research experience with no pre-existing connections to the participants. Federal regulations did not allow us to pay participants for their time, and so we took several steps to limit participant burden including: scheduling interviews around participants' schedules; streamlining our interview guide to be as efficient as possible (interviews took 20–40 min to complete); and limiting the number of outreach emails sent to each potential participant. The interview guide was based on the Team Effectiveness Pyramid framework, which was developed in the context of a systematic review of team functioning in outpatient healthcare teams (Miller et al., 2018). We chose the Team Effectiveness Pyramid to inform our interview guide based on its breadth: it includes questions about teamwork and team structure, and includes some dimensions from Relational Coordination (e.g., team communication, shared knowledge, shared goals, mutual respect), as well as domains from other frameworks (e.g., psychological safety [Edmondson, 1999]) and questions about tangible resources (e.g., physical workspace). All seven dimensions of Relational Coordination were presented in the interview guide except accurate communication, as measuring accuracy of communication does not lend itself to qualitative methods of measurement. Interviews were audio-recorded and professionally transcribed verbatim.

## Qualitative Analysis

The current manuscript presents results from a novel analysis of qualitative interview data (Miller et al., 2021). In Miller et al., 2021, authors examined the foundational resources that were necessary to build effective teams in the context of low staffing ratios. Following this analysis, we had remaining questions about how interpersonal and relational dynamics impacted team functioning in the same environments (e.g., teams with low staffing ratios). Thus, the analyses for the current manuscript focused on the Relational Coordination dimensions (Gittell et al., 2000) to determine how these dimensions were developed and maintained despite their low staffing ratios, rather than the structural- and resource-related codes that are described in our original paper (Miller et al., 2021). Specifically, for the current analyses, a team of two primary analysts and two additional analysts used the eight-step directed content analysis method outlined by Zhang and Wildemuth (2009) to code the transcripts. A priori codes were based on the Relational Coordination dimensions and the proposed interplay between dimensions laid out in the Relational Coordination framework, which were used to inform the codebook (Gittell et al., 2000). The two primary analysts first read through the transcripts to familiarize ourselves with the data. We then jointly coded three interviews to inform definition clarity and coding consistency. After establishing coding consistency, we divided the remaining transcripts, designating one person as the primary coder for each transcript, while the other served as a reviewer, and then discussing for consensus and consistency. All questions and discrepancies were brought to the full coding team during bi-weekly meetings. Discrepancies were resolved through discussion to reach 100% consensus. The primary coders met upon completion of coding for each BHIP team to review themes and summaries across all interviews for each team. The coding was summarized by participant, team, and Relational Coordination dimensions. Then, the larger team met to discuss themes, including patterns and relationships between codes, with the overarching goal of identifying commonalities across teams rather than comparing or contrasting the teams to one another. At the end of coding the last transcripts, the two primary analyst re-reviewed the first transcripts to ensure consistency across the data. This method was used to ensure we were coding to consensus (Morse, 2015; Zhang & Wildemuth, 2009). Findings were developed iteratively through team discussion and consensus. All coding was completed using Microsoft Office Suite (Meyer & Avery, 2009).

## Results

We interviewed 21 BHIP team members from three BHIP teams located at two Veteran Affairs medical centers (from among 65 total BHIP team members; 32% response rate). In fewer than ten cases, non-participants actively declined to participate; for the remaining non-participants, we sent initial recruitment emails but ceased recruitment efforts once we had met our *a priori* enrollment goal. Participants were 86% female. The median number of years on the BHIP team was three years. Participants included: eight psychologists, five nurses, four psychiatrists, two social workers, one physician assistant, and one pharmacist. Findings were organized by the seven dimensions of Relational Coordination, divided into two broad domains: communication (four dimensions; Table 1) and relationships (three dimensions; Table 1). We provide definitions used for this study based on definitions provided by Gittel et al. (2000). Themes also emerged related to the interconnectedness and developmental process of these domains, such that gains in one domain frequently led to gains in other domains.

### Communication

Based on our guiding framework, Relational Coordination, we focused on four forms of communication: frequent, timely, accurate, and problem-solving communication.

#### Frequent and Timely Communication

For our analyses, we defined *frequent communication* as the perception of how often BHIP team members communicated with one another, including scheduled, repeated interactions, as well as impromptu communication. *Timely communication* was defined as communication occurring in a reasonable amount of time for patient care (e.g., not delayed). We noted that frequent and timely communication were often discussed in tandem, and so we report them here in aggregate.

Broadly, all teams reported having both frequent and timely communication. Specifically, participants reported having brief, informal huddles either once or twice daily, and meeting formally as a team for longer periods (typically at least 30–60 min) on a weekly basis. Moreover, each team noted numerous additional forms of communication, including instant messaging, email, adding providers as cosigners on electronic medical record notes, and face-to-face interactions (e.g., open door policy, office “swing-bys,” stopping each other in the hallway). Team members stressed the importance of finding the right modality and balance of communication for their team. For instance, one team found instant messaging to be the most efficient way to stay up to

date on patients, while another team found instant messaging to be intrusive. Teams discussed and determined which communication modalities worked best for their team during their team huddles time. All teams reported that having dedicated time (i.e., blocked time on their schedules) for huddles greatly increased attendance and participation. Furthermore, participants found these aspects of communication to be positive components of the BHIP team structure. Teams emphasized the importance of timely and regular communication for building familiarity and shared knowledge among providers. A physician assistant (Team 3) shared their view on the importance of frequent and timely communication:

Well, the ability to communicate and to catch a quick word with somebody. I can't put enough value on that. Even if it's just a few minutes where -- where you can come ask people their opinion or...talk about a particular patient.

Similarly, one nurse (Team 2) highlighted the importance of having a brief, scheduled meeting every day:

The basic thing is that the meeting every day, meeting for the five to ten minutes that we meet, has created like more cordial relationship with the BHIP members. It's something that you cannot overlook -- even if it's five minutes... make it very brief so that it doesn't like consume you every day of seeing the patients.

#### Problem-Solving Communication

*Problem-solving communication* included descriptions of how problems were solved when they arose with patient care or with a work process within the BHIP team. Any references to conflict, blame, avoidance of conflict, and avoidance of blame were also captured in this theme. Participants' responses varied considerably when discussing problem-solving communication. Participants that noted good problem-solving communication shared that their teams used time in huddles and team meetings to openly discuss disagreements or processes that were not working well. Specifically, participants cited using problem-solving communication to improve triage processes, discuss concerns with roles and working outside of scope of practice, as well as to discuss how to lessen burden on providers with largest caseloads. For instance, one nurse (Team 2) shared:

We had conflicts initially because I remember group formation and there was a time initially we could have a lot of squabbles, conflicts, of who is supposed to

do this and who is not supposed to do this. But the basic thing is that we brought it out into the open, and discussed it, and then we were able to resolve those issues.

In addition, some participants shared that having one-on-one conversations about disagreements helped resolve issues before they became larger team issues. Others noted the importance of in person meetings to discuss disagreements to lessen the likelihood of misread tone in emails or other electronic messages. Participants that were dissatisfied with problem-solving communication on their team shared that it felt like team members were uncomfortable having difficult conversations which impeded conflict resolution or noted that leadership could do a better job of modeling having difficult conversations. One psychologist (Team 2) described their frustration with problem-solving communication on their team:

I often wish that people felt more comfortable... confronting in a professional way, or looking into something that seems like a conflict or a problem or whatever... It seems like our clinic has, particularly leadership, honestly, like has kind of a chronic problem of that...struggling to have difficult conversations.

### Accurate Communication

*Accurate communication* referred to perception of how precise and pertinent information shared about patients and processes are within the BHIP team. The Relational Coordination concept of accuracy was infrequently raised by participants. As an example of communication accuracy within teams, providers from two teams stated that having a structure and agenda for meetings lead to better quality and accuracy of communication. In addition, providers shared that team meetings allowed providers to share information about patients that might not be readily available in charts thus ensuring that providers have the most accurate clinical picture of their patients. One nurse (Team 1) stated:

We all go in, we all sit around the table and we'll look like at today's list of patients and if there's anything particular about somebody, we'll, you know, we'll talk about that...it's interesting to see the different points of view...Like one person may say something to the psychologist that they didn't say to anybody else. And we can, you know, better treat the patient knowing all the different, you know, little things going on with them.

### Relationships

Based on the Relational Coordination framework, we focused on three components of relationships: shared goals, shared knowledge, and mutual respect.

### Shared Goals

*Shared goals* refers to BHIP team members reporting similar goals to one another for their patient care and work processes, and sensing that others on the team share these goals. Across all teams, participants expressed a strong shared goal of providing the best care to their Veteran patients. Participants discussed the Veterans being “top priority” (social worker; Team 1) and all team members being concerned “about the patients and the recovery” (psychologist; Team 2). Not only did teams share this goal, but they also noted that the BHIP team configuration aided them in working toward this goal. One psychologist (Team 2) shared: “Well, the biggest benefits of the BHIP. Well, I think it serves the Veteran the most...like now in this current model it helps all disciplines to get together to see who can help the most.”

This common purpose and structure of the BHIP team increased collaboration within teams and across disciplines. For instance, participants discussed how their team worked collaboratively and made efforts to divide labor in a fair way, especially while understaffed. Teams found ways to balance differing levels of demands across disciplines (e.g., having disciplines with more available time call patients to reduce no-shows) to help with the common goal of providing the best possible service for the patient. Furthermore, participants shared that team members were often willing to cover for each other within their scope of practice when emergencies arose and that “everyone jumps in to help out” (nurse, Team 2). A psychologist (Team 2) shared how being understaffed with a strong sense of shared purpose created a “battlefront mentality” where team members “jump in where we can” to complete the tasks at hand. Many directly discussed how helping each other served the team and ultimately provided better patient care. Having a common purpose and ethos to help one another appeared to help increase provider satisfaction despite high caseloads. One nurse (Team 2) shared:

I like the camaraderie that you have with the BHIP. You get to listen to all the disciplines on a daily basis. When we discuss the patient, we discuss it all together at one time and how each discipline can help the patient in whatever instance they need.

Similarly, a psychologist (Team 2) shared how communication was crucial in maintaining shared goals:

I think for the most part we try to maintain our -- you know, maintain the same goals. I think we have good discussions about what it is we're going to provide this Veteran and what they need and how we're going to communicate that to them. I think that we do great with that.

### Shared Knowledge

*Shared knowledge* refers to how well providers from one discipline understand the competencies, scope of practice, and strengths of providers from other disciplines within their BHIP team. It also included information related to how tasks from different providers fit together for the overall good of the patient or team. In addition, shared knowledge refers to how differences in training, socialization, and expertise among disciplines impacts providers shared understanding of their work process. Overall, teams reported having an understanding of different disciplines' scope of practice and roles within the team. Robust knowledge of other team members' skills and roles was seen as an important contributor to efficient triage and referral processes. One nurse (Team 2) described how learning the unique roles and skill sets of each discipline helped streamline referrals so that they went to the appropriate provider:

When we first met together as a team, ...none of us knew each other. We only knew what our job description was...but the more we met together and the more we discussed what we could and could not do, the more we were able to focus on what specific questions to ask concerning a patient. If a patient was homeless or didn't have food to eat or something, instead of asking the doctor [psychiatrist], which we know they're not going to be able to do much then we would know we would probably have to ask the social worker.

Team members also shared how they explicitly worked toward role clarity on their teams by dedicating time to reviewing roles and specialties during team huddles. This dedicated time was described as happening at two key time points: when BHIP teams were first rolled out and when new members (including trainees) joined the team. In addition, many participants across teams emphasized the value of gaining more understanding of the resources and information from other disciplines on their team could provide to their patients. A psychologist (Team 2) described how shared knowledge and mutual respect for other providers aided in patient care:

I have found it really rewarding to be able to have someone of another discipline to be able to flesh things out with ... if a patient is reporting a particular medication reaction then I know that I either have a pharmacist or a psychiatrist or even a nurse practitioner to talk to about those things... I do think other providers really appreciate what we have to offer as clinicians -- to be able to talk about specific types of therapy or if there are times when a person needs therapy but they're not ready and they don't want therapy.

Conversely, deficits in role clarity sometimes led to more challenges with triaging patient care when clinicians relied on stereotypical provider groupings, as opposed to the personalized approach from other teams. For example, when team members were divided into groups such as "prescribers" or "therapists" instead of specific disciplines or individual providers with unique skills sets and strengths. A psychologist (Team 2) shared:

I think we get a little lumped as the therapist rather than the psychologist and the social [worker]...there's sometimes an assumption that we all do exactly the same thing exactly the same way at the same level of performance in the same way that I think the medical staff has a little bit of that the same with the providers, they're called. But the nurses, so RN, LVN, PharmDs, PAs, psychiatrists, NPs. And they're all lumped and I think sometimes that doesn't work well.

### Mutual Respect

*Mutual respect* refers to each BHIP member respecting the work done by other team members, especially those from other disciplines. There were examples of both mutual respect and lack of respect. Lack of respect usually highlighted how occupation identity and pride caused team divisions, while examples of mutual respect included references to respect for other disciplines competences, strengths, and unique perspectives. Similar to shared knowledge, participants described mutual respect as recognizing the unique contributions of each team member. One team found that having rotating leadership fostered mutual respect, as no one discipline was viewed as superior or in charge.

Participants noted that they valued one another's roles and disciplines and also felt that they were valued and respected on the team. They also shared how an environment of mutual respect contributed to their overall job satisfaction, as one psychologist (Team 3) stated:

I would say as a psychologist, I've had different experiences of how different disciplines kind of react to us, both being positive and negative. And I would say that out of any environment I've worked in, this is one environment where I feel the most kind of respected. And also I really feel like I'm helping to contribute in a sense where I really am helping to kind of make a difference within the team.

### Interconnectedness Between Factors

Relational Coordination dimensions did not occur in isolation; nearly all of the Relational Coordination dimensions were notably related and interconnected to one another and BHIP team members' narratives frequently raised the dimensions together. Participant narratives showed how the different dimensions interacted to further fuel collaboration within the team. This often manifested as a positive feedback loop, with participants noting that improvements in one area could foster improvements in other areas. We found areas of interconnectedness among the communication dimensions, relationship dimensions, and across communication and relationships.

First, communication dimensions often interacted with each other to facilitate more robust communication overall. For example, respondents noted that structured, frequent communication helped them adopt a problem-solving approach to addressing team challenges. In Relational Coordination terms, frequent and timely communication was instrumental to achieving problem-solving communication. Teams used their regular team meetings for quality improvement—specifically, brainstorming how to best support one another, improve team processes, and resolve issues as they arose.

Similarly, relationship dimensions also interacted with one another. For example, shared knowledge, which was built through frequent communication, helped improve mutual respect amongst team members. Specifically, providers found that having a forum, such as daily huddles, to discuss problems and difficult cases improved their shared knowledge of provider roles and specialties, which further enhanced their mutual respect. One psychologist (Team 2) shared:

The most important contributors [to satisfaction on BHIP team]-- I would say would be equal participation. Maybe respect for each other's skill set within, you know, amongst the disciplines... that was really important...that providers and the social workers do tend to respect our input as psychologists, we respect their input as social workers and med[ication]

providers. So I think that there's a mutual respect that we have.

Furthermore, across teams, participants noted that improving communication led to better relationships and vice versa. Even on the teams where there were existing interpersonal relationships, the structure of the BHIP improved their sense of shared goals and shared knowledge through more frequent communication and problem-solving communication. One social worker (Team 2) explained:

Well I think when the BHIP model first rolled out that was a bit, a lot of confusion about what is the role of the providers and so I keep saying this but again we had a lot of meetings about that kind of defining the role, it took us a while and I think what we kind of went with was we let each BHIP kind of define the role of their members of the team because we realized that some people have more strengths in some areas than others. Moreover, for teams without pre-existing relationships, frequent communication helped foster mutual respect and a sense of camaraderie in shared goals. The BHIP structure providing scheduled time for frequent communication was a key component of building the team identity: "And so then the next thing you know, yeah, you're having like two conversations a day with your whole team and then, yeah, I think that helps to forge a team identity" (psychologist, Team 2).

### Discussion

This study examined how Relational Coordination fosters effective team functioning in the context of VA outpatient mental health teams with low staffing ratios. Our findings elucidate the key ingredients for developing and maintaining good team functioning through components of Relational Coordination in the context of low resources. Consistent with the Relational Coordination framework (Gittell et al., 2000), our primary overarching finding was that these domains were described by participants as reciprocal processes that influenced each other. From participant reflections on team formation, communication dimensions emerged as a catalyst for developing relationship dimensions. Once relationships were developed, we noted a mutually reinforcing cycle between the communication and relationship domains. Specifically, our results noted how frequent and timely communication allowed teams to work toward improved problem-solving. In addition, frequent and timely communication led to increased shared knowledge, which in turn improved mutual respect amongst team



members. Similarly, shared knowledge, mutual respect, and shared goals also improved the quality of communication, thus highlighting the reciprocal nature of the Relational Coordination domains.

This type of reciprocal reinforcement was evidenced in several ways. First, communication was seen as a catalyst for developing relationships among team members and building strong team cohesion. Consistent with prior findings and theory, frequent communication played a central role in developing all Relational Coordination dimensions (Gittell, 2011; Rundall, Wu, Lewis, Schoenherr, & Shortell, 2016). Specifically, in this study, across all teams, having reserved time in team members' schedules for brief, daily meetings in addition to longer weekly meetings provided the context for all other aspects of Relational Coordination to develop. Prior research has shown that regular meetings between interdisciplinary team members in healthcare can improve performance on interdependent work processes and increase levels of Relational Coordination (Gittell, 2002; Hartgerink et al., 2014). Similarly, team members in the current study expressed that having frequent and regular contact that was built into and protected in providers' daily schedules was crucial to developing team identity, building trust, highlighting shared goals, encouraging problem solving, and providing timely and coordinated care. It was vital to have this protected time, as these teams with high caseloads may otherwise quickly fill their schedules. Providers shared that the BHIP teams that huddled daily performed better. There was also a compounding effect for frequent communication in that daily communication built trust between providers over time. Participants shared that through daily communication with their team they were able to learn each other's personalities, work styles, roles, skill sets, strengths, and in turn, function more efficiently and synchronized as a team. Although past studies suggest that having structured meetings or structured agendas for daily huddles were advantageous (e.g., Crompton et al., 2015), participants in the current study shared that having flexibility in meeting structure (e.g., discussing most pressing cases, allowing for conversations on work processes, conflict resolution and even personal connection) was an important aspect of the developing relationships. More research is needed to fully understand in what context structured versus more unstructured/flexible meetings are most useful; however, this study provides some guidance that flexible meeting structure fosters interpersonal connections and improves team morale.

Second, having reserved time for team communication also provided a designated time and space for problem-solving communication. Participants shared how they used the team meetings to improve triage processes, discuss concerns with roles and working outside of scope of practice, as well as to discuss how to lessen burden on providers with

largest caseloads. These open discussions provided a time to establish role clarity and to review roles when new members joined the team. Participants highlighted the importance of open discussions in face-to-face settings when discussing disagreements or providing critical feedback to reduce the possibility of misread tone that can occur by email or messaging. Team members shared that it was difficult to have these disagreements in the beginning of team formation but with time became easier to navigate. Though the majority of team members shared that their team had made considerable improvements or had successful problem-solving communication, there were notably some team members shared that they were frustrated with the lack of open communication for difficult or confrontational discussions. These differing perspectives highlight that there is still room for improvement within problem-solving communication. One individual shared their belief of the need for leadership to model better dialogue for difficult conversations. Problem-solving methods involved using trial-and-error, feedback with one another, and ongoing conversations to find amenable solutions. Having regular, scheduled meetings allowed teams to continually work on problems together and check-in with one another regarding success of trialed solutions. This is consistent with prior findings that suggest that when teams engage in timely problem-solving communication it is easier to implement the identified opportunities for improvement (Bolton et al., 2021). Importantly, it was noted that to get team members to attend meetings regularly, one team had to use creative problem solving through focus groups and brainstorming to find meeting times and formats that best suited team member's needs. Thus, problem-solving communication impacted frequent communication, which further allowed for additional problem-solving. This cycle is important to note, as it could lead to negative feedback loops. For instance, without regularly attended meetings, team members may try to problem solve meeting times over email, have miscommunication due to tone or writing styles, that increase tensions and decrease cooperation. Thus, it is important to encourage face-to-face communication for problem solving, have leadership modeling open communication, and persist through discomfort with differing perspectives.

Furthermore, this study illustrated how Relational Coordination enhanced and highlighted many intended benefits of interdisciplinary teams. Notably, participant responses pointed to how Relational Coordination positively impacted job satisfaction. Providers shared that they felt like they were not alone in providing patient care. Some participants shared how frequent communication, shared knowledge, and mutual respect allowed them to receive support both emotionally and in decision making when faced with difficult patient decisions (e.g., with patients at high risk for

suicide). This finding is consistent with literature suggesting that dimensions of Relational Coordination increased shared accountability and support among team members across numerous business sectors and settings (Bolton et al., 2021). Feeling supported is essential in mental health teams because the work can often be challenging (Fleury et al., 2020). Moreover, participants noted that having mutual respect and shared goals of prioritizing patient care enabled team members to cover for one another within their scope of practice, which in turn, improved provider job satisfaction. This shared responsibility is especially important in teams with low staffing ratios, as they have high caseloads and one team member being out for planned or unexpected leave may have a huge impact on the team. These results support the concept of “relational job design,” or creating clear roles with flexible boundaries with expectations of cross-role coordination (Bolton et al., 2021, p.298). This concept discusses how both clear roles and fluidity across role boundaries are both aspects of relational job design and positively related to Relational Coordination (Gittell, 2000). In the current study, participants remarked on how clarifying roles and having this fluidity were both important aspects of team functioning. In our results, participants noted that as the relationships between team members improved, participants reported reduced stress and increased enjoyment at work. This finding is in line with other studies that have shown Relational Coordination impacts job satisfaction (Havens et al., 2018).

Additionally, participants perceived improvements in patient care through increased knowledge of their patients. Through frequent and timely communication with multiple providers on the team, participants gained a more accurate and well-rounded understanding of the patient and their presenting concerns from multiple perspectives. Furthermore, the development of shared knowledge of team members’ strengths and discipline-relevant skill sets improved triage processes and treatment planning. Teams also used problem-solving to continuously provide feedback to one another about referrals and to connect patients more efficiently to the appropriate provider on the team. Although this study did not directly measure patient outcomes, prior literature shows that Relational Coordination is significantly related to improved patient outcomes and quality of care (e.g., Havens, Vasey, Gittell, & Lin, 2010). Future studies should examine how dimensions of Relational Coordination affect patient outcomes, patient satisfaction, and service efficiency in other mental health teams.

### Limitations and Future Directions

This study is novel in that it examines the relational factors needed to support effective team functioning in outpatient

mental health care teams with low staffing ratios; however, some limitations are noted. We were unable to obtain clinical outcome data to examine effects of Relational Coordination on patient care, as noted by Miller et al. 2021. In the current study, however, participants spontaneously noted the value of team based care on their perceptions of improvements in patient care. In addition, accurate communication was not directly inquired about during the interviews and was the least mentioned dimension of Relational Coordination. It is possible that inquiring about accurate communication directly, or including more detailed probes in our semi-structured interview guide related to the other dimensions of Relational Coordination, would have uncovered more nuanced findings. It was also difficult to fully assess in qualitative interviews since accuracy is based on perception and not an external measure. Future studies should include mixed methods (i.e. methods that triangulate both quantitative and qualitative data sources) to better assess accurate communication and how it impacts provider satisfaction and team functioning. In addition, this study only examined the common factors across high-functioning teams in low-resourced settings. We were only able to interview about a third of the team members, and had only limited demographic data on participants themselves; thus, there may be additional team dynamics unaccounted for in our analysis. Moreover, teams varied in size, as did the number of team members that participated in interviews. In addition, we do not have data to compare those that participated in interviews from those that did not and thus cannot speak to sample representativeness. Due to limited data from each team, we did not have information on unique constraints faced by each team to comment on the interaction of Relational Coordination with specific constraints. Future studies should examine differences in aspects of Relational Coordination between high- and low-functioning teams, as well as how specific resources constraints may differentially affect teams. Lastly, future studies should inquire how telework impacts daily meetings and problem-solving communication, as participants highlighted the importance of face-to-face meetings.

### Practice Implications

In this study, we identified specific relational domains that may improve how healthcare teams work together, despite working in an environment with low staffing ratios. The COVID-19 pandemic has further exacerbated the staffing and resource constraints that exist in our medical systems (U.S. Department of Health and Human Services, 2021). Our findings highlight the interrelated nature of relational dimensions. In particular, our results suggest the importance of encouraging frequent communication within teams

**Table 2** Summary of Practice Implications Rooted in Relational Coordination Dimensions

Dimension	Practice Implication
Frequent Communication	Reserve dedicated time for team communication in both brief, daily (e.g., 5–10 min) and weekly meetings (usually 1 h) to build familiarity, increase shared knowledge, and develop mutual respect
Problem-Solving Communication	Use team meetings to problem solve around team preferences and streamline processes including triage procedures
Shared Goals and Shared Knowledge	Highlighted shared goals between providers and discuss team members' skill sets, clinical preferences, and discipline-specific knowledge areas to improve patient triage and referral processes
Shared Knowledge	Define roles when teams are formed and reevaluate these roles when new members join to assist in building and reinforcing shared knowledge on the team
Mutual Respect	Ensure broad representation of disciplines among leadership, having an egalitarian team without a defined leader, or rotate team leadership by discipline to aid in the development of mutual respect and equality

as a catalyst and sustainer of other Relational Coordination dimensions. Therefore, we offer several recommendations for mental health teams building coordinated teams (Table 2): First, reserve dedicated time for team communication in both brief, daily (e.g., 5–10 min) and weekly meetings (usually 1 h) to build familiarity, increase shared knowledge, and develop mutual respect. Second, highlight shared goals between providers and discuss team members' skill sets, clinical preferences, and discipline-specific knowledge areas to improve patient triage and referral processes. Third, ensure broad representation of disciplines among leadership, with approaches such as having an egalitarian team without a defined leader or rotating team leadership by discipline to aid in the development of mutual respect and equality. Fourth, define roles when teams are formed and reevaluate these roles when new members join to assist in building and reinforcing shared knowledge on the team. Finally, use team meetings to problem solve around team preferences and streamline processes including triage procedures.

This study used the Relational Coordination framework to understand provider perspectives on team functioning. Our findings highlight the aspects of communication and relationships that aided in team cohesion, streamlined work processes, and boosted team member satisfaction. Relational Coordination is needed most in situations with high interdependence, uncertainty, and time-constraints (Gittell, 2000), which describes most mental healthcare settings, but even more so, settings with resource-constrained teams. This study shows how teams, despite having low

staff for their patient demand, are able to maintain high job satisfaction and low turnover through Relational Coordination. This study not only confirmed that regular interdisciplinary meetings were imperative to team success, but it also highlighted new findings to the literature, such as the importance of equal representation among disciplines in leadership roles, regularly reviewing team roles, and the need for open, face-to-face discussion for problem-solving. Time is often cited as a barrier to team coordination (Tschudy et al., 2016); however, in strained conditions where providers likely had very limited time, they were able to prioritize all aspects of Relational Coordination and found value in doing so. It is possible that the fact that they are resourced constrained teams meant that they have to rely on the team even more so to efficiently care for their patients. Further work should investigate if resourced constrained teams are actually more likely to have high Relational Coordination due to their setting constraints. Overall, this study provided important insights into the development of high-functioning and satisfied teams in the context of a common problem of healthcare teams, especially mental health teams- low staffing ratios. We hope that these insights will help other teams improve their relationships, coordination, and patient care.

**Supplementary Information** The online version contains supplementary material available at <https://doi.org/10.1007/s10488-023-01261-2>.

**Funding** Funding for this study was provided by the U.S. Department of Veterans Affairs Health Services Research and Development Service (VA HSR&D Grant PPO 16-329 [PI: Miller]).

## Declarations

**Conflict of Interest** The authors declare no conflicts of interest.

## References

- Argote, L. (1982). Input uncertainty and organizational coordination in hospital emergency units. *Administrative Science Quarterly*, 27(3), 420–434.
- Assadian, O., Toma, C. D., & Rowley, S. D. (2007). Implications of staffing ratios and workload limitations on healthcare-associated infections and the quality of patient care. *Critical Care Medicine*, 35(1), 296–298.
- Bauer, M. S., Miller, C. J., Kim, B., Lew, R., Stolzmann, K., Sullivan, J., Riendeau, R., Pitcock, J., Williamson, A., Connolly, S., Elwy, A. R., & Weaver, K. (2019). Effectiveness of implementing a collaborative chronic care model for clinician teams on patient outcomes and health status in mental health: A randomized clinical trial. *JAMA Network Open*, 2(3), e190230.
- Bolton, R., Logan, C., & Gittell, J. H. (2021). Revisiting relational coordination: a systematic review. *The Journal of Applied Behavioral Science*, 57(3), 290–322.
- Crompton, D., Hsu, C., Coleman, K., Fishman, P. A., Liss, D. T., Ehrlich, K., Reid, R. J., et al. (2015). Barriers and facilitators to team-based

- care in the context of primary care transformation. *The Journal of ambulatory care management*, 38(2), 125–133.
- Edmondson, A. (1999). Psychological safety and learning behavior in work teams. *Administrative Science Quarterly*, 44(2), 350–383.
- Fleury, M. J., Grenier, G., & Bamvita, J. M. (2017). Job satisfaction among mental healthcare professionals: the respective contributions of professional characteristics, team attributes, team processes, and team emergent states. *SAGE Open Medicine*, 5, 1–12.
- Fleury, M. J., Grenier, G., & Bamvita, J. M. (2020). Relationships among structures, team processes, and outcomes for service users in Quebec mental health service networks. *International Journal of Integrated Care*, 20(2), 12, 1–19.
- Follett, M. P. (1924). *Creative experience*. Green: Longmans.
- Follett, M. P. (1949). Coordination. In L. Urwick (Ed.), *Freedom & co-ordination: lectures in business organisation by Mary Parker Follett* (pp. 61–76). Routledge.
- for relational coordination among teams delivering care to older patients. *Journal of Advanced Nursing*, 70(4), 791–799.
- Gittell, J. H. (2000). Organizing work to support relational coordination. *International Journal of Human Resource Management*, 11(3), 517–539.
- Gittell, J. H. (2002a). Coordinating mechanisms in care provider groups: relational coordination as a mediator and input uncertainty as a moderator of performance effects. *Management Science*, 48(11), 1408–1426.
- Gittell, J. H. (2002b). Relationships between service providers and their impact on customers. *Journal of Service Research*, 4(4), 299–310.
- Gittell, J. H. (2008). Relationships and resilience: Care provider responses to pressures from managed care. *The Journal of Applied Behavioral Science*, 44(1), 25–47.
- Gittell, J. H. (2011). *Relational coordination: guidelines for theory, measurement and analysis* Waltham (p. 1). MA: Brandeis University.
- Gittell, J. H., Fairfield, K. M., Bierbaum, B., Head, W., Jackson, R., Kelly, M., & Zuckerman, J. (2000). Impact of relational coordination on quality of care, postoperative pain and functioning, and length of stay: a nine-hospital study of surgical patients. *Medical Care*, 38(8), 807–819.
- Gittell, J. H., Weinberg, D., Bennett, A., & Miller, J. A. (2008). Is the doctor in? A relational approach to job design and the coordination of work. *Human Resource Management*, 47(4), 729–755.
- Gittell, J. H., Weinberg, D. B., Pfefferle, S., & Bishop, C. (2008). Impact of relational coordination on job satisfaction and quality outcomes: a study of nursing homes. *Human Resource Management Journal*, 18(2), 154–170.
- Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff wellbeing, burnout, and patient safety: a systematic review. *PloS one*, 11(7), e0159015.
- Hartgerink, J. M., Cramm, J. M., Bakker, T. J. E. M., Van Eijnden, A. M., Mackenbach, J. P., & Nieboer, A. P. (2014). The importance of multidisciplinary teamwork and team climate
- Havens, D. S., Gittell, J. H., & Vasey, J. (2018). Impact of relational coordination on nurse job satisfaction, work engagement and burnout: achieving the quadruple aim. *JONA: The Journal of Nursing Administration*, 48(3), 132–140.
- Havens, D. S., Vasey, J., Gittell, J. H., & Lin, W. T. (2010). Relational coordination among nurses and other providers: impact on the quality of patient care. *Journal of Nursing Management*, 18(8), 926–937.
- Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery. <https://oig.hhs.gov/oci/reports/OEI-09-21-00140.pdf>
- King, R., Le Bas, J., & Spooner, D. (2000). The impact of caseload on the personal efficacy of mental health case managers. *Psychiatric Services*, 51(3), 364–368.
- Kinnair, D., Anderson, E., van Diepen, H., & Poyser, C. (2014). Interprofessional education in mental health services: learning together for better team working. *Advances in Psychiatric Treatment*, 20(1), 61–68.
- Manser, T. (2009). Teamwork and patient safety in dynamic domains of healthcare: a review of the literature. *Acta Anaesthesiologica Scandinavica*, 53(2), 143–151.
- Meyer, D. Z., & Avery, L. M. (2009). Excel as a qualitative data analysis tool. *Field methods*, 21(1), 91–112.
- Miller, C. J., Kim, B., Silverman, A., & Bauer, M. S. (2018). A systematic review of team-building interventions in non-acute healthcare settings. *BMC Health Services Research*, 18, 146.
- Miller, C. J., Sullivan, J. L., Harvey, K. L., Williamson, A. K., & Stadnick, N. A. (2021). Promoting high-functioning mental health treatment teams in the context of low staffing ratios. *Health Care Management Review*.
- Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, 25(9), 1212–1222.
- Onyett, S. (2011). Revisiting job satisfaction and burnout in community mental health teams. *Journal of Mental Health*, 20(2), 198–209.
- Rundall, T. G., Wu, F. M., Lewis, V. A., Schoenherr, K. E., & Shortell, S. M. (2016). Contributions of relational coordination to care management in ACOs: views of managerial and clinical leaders. *Health Care Management Review*, 41(2), 88.
- Schmutz, J., & Manser, T. (2013). Do team processes really have an effect on clinical performance? A systematic literature review. *British Journal of Anaesthesia*, 110(4), 529–544.
- Thompson, J. D. (1967). *Organizations in action; social science bases of administrative theory*. New York: McGraw Hill.
- Tschudy, M. M., Raphael, J. L., Nehal, U. S., O'Connor, K. G., Kowalkowski, M., & Stille, C. J. (2016). Barriers to care coordination and medical home implementation. *Pediatrics*, 138(3).
- U.S. Department of Health (2021). and Human Services, Office of the Inspector General
- US Department of Veterans Affairs (2018). Mental Health Management System.
- U.S. Department of Veterans Affairs (2019). BHIP panel management tool. U.S. Department of Veterans Affairs, Office of the Inspector General, OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, Fiscal Year 2021, 6.
- Wallace, J. E., Lemaire, J. B., & Ghali, W. A. (2009). Physician wellness: a missing quality indicator. *The Lancet*, 374(9702), 1714–1721.
- Weaver, S. J., & Jacobsen, P. B. (2018). Cancer care coordination: Opportunities for healthcare delivery research. *Translational Behavioral Medicine*, 8(3), 503–508.
- Young, G., Charns, M., Daley, J., Forbes, M. G., Henderson, W., & Khuri, S. F. (1998). Patterns of coordination and clinical outcomes: study of surgical services. *Health Services Research*, 33(5), 1211–1236.
- Zhang, Y., & Wildemuth, B. M. (2009). Qualitative analysis of content. In B. M. Wildemuth (Ed.), *Applications of social research methods to questions in information and library science* (pp. 1–12). Libraries Unlimited.

**Publisher's Note** Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Springer Nature or its licensor (e.g. a society or other partner) holds exclusive rights to this article under a publishing agreement with the author(s) or other rightsholder(s); author self-archiving of the accepted manuscript version of this article is solely governed by the terms of such publishing agreement and applicable law.