Résumé

L'aide aux réseaux dans la prestation de soins communautaires à domicile aux personnes âgées : les différents types d'équipes

**Cheryl A. Cott, Laura–Beth Falter,
Monique Gignac et Elizabeth Badley**

Les changements survenus dans la prestation des soins de santé ont entraîné une modification du lieu où sont offerts ces soins : de l'établissement de santé, il est passé à la communauté. Dans ce contexte, il est devenu nécessaire de réexaminer les modèles actuels en matière de pratiques liées aux soins de santé afin d'en déterminer l'applicabilité et la pertinence en milieu communautaire. L'objectif de cette étude était de déterminer la pertinence des modèles traditionnels fondés sur les équipes multidisciplinaires en examinant les interrelations entre les aînés de la communauté atteints d'arthrite, leur famille ainsi que les fournisseurs de soins de santé et de services communautaires (FSSSC). Des entrevues en profondeur ou des groupes de discussion ont été réalisés avec la clientèle, les membres des familles et les FSSSC. Les participants ont décrit quatre différents types d'interaction dans le réseau d'aide, dont aucun, outre les interactions avec les personnes âgées elles-mêmes, n'est apparu comme le plus courant. Trois types d'équipes sont ressortis : les équipes centrées sur le client, celles centrées sur le gestionnaire de cas, et celles par discipline. On ne trouve dans les résultats aucune mention de l'existence d'équipes interdisciplinaires conjointes structurées, les FSSSC favorisant le modèle par discipline.

Mots clés : équipes multidisciplinaires

Helping Networks in Community Home Care for the Elderly: Types of Team

**Cheryl A. Cott, Laura-Beth Falter,
Monique Gignac, and Elizabeth Badley**

Changes in the delivery of health care have led to a shift in the location of care from the institution to the community. This has resulted in a need to re-examine current models of health-care practice in terms of their applicability and relevance to the community setting. The purpose of this study was to determine the relevance of traditional models of multidisciplinary teams by examining interrelationships amongst community-dwelling seniors with arthritis, their families, and health and community service providers (HCSPs). In-depth interviews or focus groups were conducted with clients, family members, and HCSPs. Participants described 4 different types of interaction within the helping network, with no interaction whatsoever being the most common except for with the seniors themselves. Three types of team emerged: client-centred, case manager-centred, and discipline-specific. No evidence of formal collaborative interdisciplinary teams was found, with HCSPs most valuing the discipline-specific model.

Keywords: Multidisciplinary teams, geriatrics, home care

Introduction

Recent changes in health-care delivery have resulted in a shift in the location of care from hospital and institutional settings to the community, and more specifically the home. This shift signals a need to re-examine institutionally based models of health-care delivery and to develop models and theories that are applicable and relevant to home-based care. Care of older adults is generally modelled on a team approach, one that has been developed in institutional settings (Drinka & Clark, 2000; Qualls & Czir, 1988; Ryan, 1996) and that assumes that seniors have multiple social, psychological, and physical needs that can be met only through the close collaboration of a team of professionals (Clark, 1991, 1995). Few studies have examined issues of teams in the community, where differences in the provision of services may preclude the application of traditional multidisciplinary models (Zimmer, Groth-Juncker, & McCusker, 1985). The home is a unique clinical setting, different from acute-care or institutional environments. The home is more than just a dwelling; it has

myriad meanings with respect to social arrangements, personal identity, security, and privacy (Dyck, 2001; Williams, 2004). Interactions between clients and professionals assume a different dynamic, in that professionals are now practising in the world of the client rather than in the world of the professional (Heckman & Cott, 1997). In this study we examine the relevance of the concept of health-care teams in community settings.

Literature Review

The literature examining community-based care for frail older adults emphasizes the emotional and practical support provided by family, friends, and unregulated health-care workers such as homemakers or personal support workers (Biegel, Sales, & Schulz, 1991; Neysmith & Aronson, 1996). Much of this body of work has social science rather than biomedical roots. As a result, conceptual views of elder care in the community tend to focus on social networks rather than on teams. A social network can be defined as the web of relationships that surround an individual and its characteristics such as the number of network members, the frequency of contact, and the extent to which members are interconnected (Due, Holstein, Lund, Modvig, & Avlund, 1999; Lee, 1985).

The older person with chronic illness may be part of a network of informal (e.g., spouse, children, other family members, friends) and formal care providers (e.g., family physician, nurses, rehabilitation therapists, homemakers, personal support workers) focused on helping them to manage their illness (Chipperfield & Haven, 1991; Noelker & Bass, 1989). The work of managing a chronic illness in the home encompasses more than just housekeeping and personal tasks (Neysmith & Nichols, 1994). It includes symptom management; anticipating and planning for future contingencies; coordinating and supervising the care provided by others; finding, receiving, and passing on information; and coping with disability (Corbin & Strauss, 1988). Decades of research leave no doubt that informal network members, particularly female relatives, perform the bulk of caregiving tasks for community-dwelling seniors (Frederick & Fast, 1999; Hooyman & Gonyea, 1995; Horowitz, 1985; Martin-Matthews & Campbell, 1995; Stoller & Pugliesi, 1991).

Most previous research has examined each part of the helping network separately or in dyads, looking at (for example) self-care, family support of the elderly, informal versus formal support, and relationships between seniors and service providers (Eustis & Fischer, 1991; Fischer & Eustis, 1994; McWilliam et al., 1997; Neysmith & Nichols, 1994). Studies have consistently shown that elderly persons turn to formal caregivers as a last resort, when informal networks have been exhausted (Stoller &

Pugliesi, 1991). Upon contact with formal services, the supportive relationship between older individuals and their families expands to include health-care workers who assume part of the work of managing the chronic illness. It is at this point, when health professionals are involved, that the discourse of team appears.

Ovretveit (1993) defines a community multidisciplinary team as "a small group of people, usually from different professions and agencies, who relate to each other to contribute to the common goal of meeting the health and social needs of one client or those of a client population in a community" (p. 55). He identifies three types of team in community settings: the client's team, which consists of a group of people (who may not know each other or may not meet), helping one client at a particular time; a network association team, which is a more stable grouping, often for cross-referencing clients; and a formal team, whose members meet to arrange assessments for a client population and to coordinate their work. Ovretveit does not specify the extent to which this typology of teams applies to community-dwelling seniors with arthritis who receive home care services. A few studies have examined relationships between nurses and homemakers (Ward-Griffin & McKeever, 2000), but many other health professionals, such as social workers, physicians, and therapists, also work in home care. Little is known about how this multitude of providers interact with each other and with clients and families.

A further problem with research in the community has been its emphasis on profoundly disabling conditions, such as Alzheimer disease or stroke, resulting in a body of literature that often overlooks older persons with chronic health problems who are active participants in their own care and who are likely to be in interdependent relationships within their social network. Little attention has been paid to community-dwelling seniors with chronic physical conditions such as arthritis that may require support but still allow them to be actively involved in the management of their illness. Musculoskeletal disorders like arthritis are the leading cause of disability in adults aged 65 and over (Badley, 1995). Given projected future increases in the number of Canadians with arthritis (Badley & Wang, 1998), it is important for us to find ways of enhancing the ability of these seniors to manage their disability in the home.

This study was part of a program of research examining the interrelationships between community-dwelling seniors with arthritis and their informal and formal networks, in order to develop an understanding of community-based teams. Since we were attempting to determine whether the concept of *team* is relevant in the community, we avoided using the word team in recruitment for and information about the study,

instead choosing the term helping networks. Specifically, we were inter-ested in addressing two questions: 1. *What are the patterns of interaction and communication between members of helping networks (e.g., frequency and types of contact)?* 2. *What organizational, structural, and decision-making processes are used among members of helping networks?*

Methods

We used an ethnographically framed social network analysis employing focus groups and semi-structured interviews to examine community-based helping networks from the perspective of three distinct groups: community-dwelling seniors with arthritis receiving health or social services in the community; their family members and/or friends; and health and community service providers (HCSPs) from the Arthritis Society or a Community Care Access Centre (CCAC), including regulated and unregulated health-care workers. An ethnographic approach is appropriate for studying patterns of relationships within a social group. Typically, ethnographic network mapping consists of extensive qualitative interviewing at the community level, combined with observations of people's behaviour (Cresswell, 2003; Field & Morse, 1995). It was beyond the scope of this study to conduct observations of network behaviour, so we took a focused ethnographic approach. Focused ethnography differs from traditional ethnographic approaches in that it usually relies on interviews rather than participant observation (Field & Morse, 1995).

Theoretical Perspective

We used a combination of symbolic interactionist and social network perspectives to frame our conceptualizations of interrelationships within helping networks in the community. Both of these perspectives focus on human relationships. According to symbolic interactionism, the meanings that individuals attach to the people, objects, and events in their lives develop through interaction with others. People act on the basis of their subjective perceptions of the world, which are constantly modified and negotiated through communication with others using language and other symbols (Plummer, 2000; Schwandt, 2001).

A social network approach suggests that social relations define people's roles and positions in a group. People are classified as occupying the same role or position as others in the group on the basis of having similar patterns of relations (White, Boorman, & Brieger, 1976). We define the structure of helping networks as a set of ties or relationships that occur among team members as they go about their day-to-day activities.

Context

In the Canadian province of Ontario, in-home services for seniors with arthritis are provided through CCACs and the Arthritis Society, which has community therapists who provide in-home assessment and treatment. In 1997, after a decade of less radical restructuring under New Democratic Party and Liberal governments, the Conservative government of Ontario introduced the CCAC model of service delivery. This model is based on competition, with both for-profit and not-for-profit agencies bidding for contracts to provide services for one or more of the province's 43 CCACs (Aronsen, 2002; Denton, Zeytinoglu, & Davies, 2002).

Sampling and Recruitment

To be eligible to participate, clients had to be living in the community, aged 55 or older, diagnosed with arthritis, currently receiving formal services in the home from either the Arthritis Society or a CCAC, and able to take part in an interview in English lasting 1 to 2 hours. Family members, friends, or neighbours had to be currently providing practical assistance to an older adult with arthritis currently receiving formal services from either the Arthritis Society or a CCAC in the home and be able to take part in an interview in English lasting 1 to 2 hours. HSCPs had to be currently working with older adults with arthritis who were receiving or who had received formal services in their homes through the Arthritis Society or a CCAC and be able to take part in a focus group or interview in English lasting 1 to 2 hours. We did not attempt to match HCSPs and clients during this phase of data collection, as we were interested in meanings and structures of relationships in general rather than characteristics of specific helping networks, which were addressed in another phase of the research reported elsewhere.

Potential participants were identified through the Arthritis Society (Ontario Division) and four CCACs. The overall sampling strategy was theoretical and purposive, with individuals and/or groups selected on the basis of their ability to contribute to evolving concepts. Initial contact with potential participants was made through our partners, who obtained permission to give names to the project coordinator. The project coordinator then contacted potential participants by phone, screened for eligibility criteria, and scheduled focus groups or individual interviews. Permission from the clients was required before approaching family members. Recruitment of the HCSPs was independent of client recruitment — that is, although we recruited the HCSPs and clients from the same Arthritis Society locations and CCACs, we did not specifically

recruit HCSPs who were working with the clients taking part in the study.

Data Collection

Data collection with HCSPs consisted mainly of focus groups. We sampled HCSPs using break characteristics in which one samples to differentiate one group from another (Knodel, 1993). Service providers who participated in focus groups were homogeneous with respect to professional background and provision of care to community-dwelling seniors with arthritis. In some organizations, such as the Arthritis Society, where occupational therapists and physiotherapists play a similar role in the community, focus groups included members of both professions. Otherwise, separate focus groups were held, based on professional or disciplinary affiliation. Individual interviews were conducted with 10 HCSPs who were unable to attend focus groups due to scheduling difficulties (mainly the physicians) or due to insufficient numbers for a focus group (social worker and pharmacist). Table 1 summarizes the composition of the focus groups and the HCSP interviews according to profession.

We conducted individual interviews with the seniors ($n = 11$) and family members ($n = 2$) to avoid limiting the sample to those who were physically able to attend a focus group. The small number of family members interviewed reflects a methodological challenge in that family members were recruited through the seniors — that is, we asked the

Table 1 *HCPS Focus Groups and Individual Interviews*		
Provider Group	**Focus Groups**	**Interviews**
Arthritis Society physical and occupational therapists	3	
Community physical therapists	2	
Community occupational therapists	2	
Arthritis Society social worker		1
Community social worker	2	
CCAC case managers	3	
Personal support workers	3	
Nurses	2	
Family physicians		8
Pharmacist		1

seniors for their permission to interview family members, and invariably they were reluctant to provide it; as a result, the findings presented below primarily reflect the perspectives of the HCSPs and the seniors.

Procedures

The principal investigator (PI) and two research associates (RAs) conducted the focus groups following guidelines set out by Krueger (1994). The focus groups lasted an average of 80 minutes. During each focus group, one of the RAs kept a speaker log to indicate whether a particular view was expressed by a number of persons or by one person a number of times. Two trained RAs conducted the individual interviews in participants' homes or in another location of the participant's choosing. These interviews lasted approximately 60 minutes.

Interview questions were semi-structured and non-directive, to encourage participants to identify issues that were important to them. Examples of questions for HCSPs include *Who would you have contact with during a typical day?* Probes were used to elicit frequency and types of contact (e.g., *How often do you see X? What do you communicate with X about?*). The sequencing and phrasing of questions varied as the focus group or interview progressed. Prompts were used only to ask for clarification or expansion of points made by participants. As the focus group or interview progressed, the questions became more specific to teams in the community. For example, in the HCSP focus groups a more targeted question was *Would you say that you feel like you are part of a team when looking after a client's health-care needs in the home?* Similarly modified questions were posed to clients and families.

All focus groups and interviews were audiotaped and transcribed verbatim. Transcripts were checked for accuracy by the focus group leader, following which data were entered into NUD*IST Version 6.

Data Analyses

Data analyses took place concurrently with data collection and guided the sampling. We employed an iterative approach using a categorizing and editing process (Crabtree & Miller, 1999). Initially, client, family, and HCSP interviews were analyzed separately. All data sets within a particular category of participant (e.g., client, family member, or HCSP) were read and coded based on concepts, categories, ideas, and issues that emerged from the data. All the core categories were systematically related to others within that particular class of participant. Finally, comparisons were made across categories of participant (e.g., client, family, and HCSPs).

The PI and a trained RA developed the initial coding schemes for each category of participant using the following approach: first, each

open-coded two or three transcripts independently; next, they met to compare and contrast codes emerging from the data, to ensure consistency; and finally, once satisfied that they were coding consistently, each coded approximately half of the remaining transcripts. Consistent with the social network approach and previous research on multidisciplinary teamwork, we were interested in identifying the nature of the ties between network members, the presence of subgroups or subunits within the network (characterized by greater interconnectedness between subgroup members), and the presence of key linking or bridging positions (people who connect subgroups).

Findings

The clients ranged in age from 69 to 88 years. Eight of the clients lived alone and three lived with a spouse. All but one reported having adult children who provided some assistance with transportation, household maintenance, and occasionally meals. All were currently receiving home-making services from CCACs and had a family physician who saw them regularly. Most had received nursing and rehabilitation services at some point.

Patterns of Interaction and Communication between Network Members

Four types of interaction between participants emerged from the data: *direct personal, direct impersonal, indirect impersonal,* and *none at all.*

Direct personal interaction included face-to-face or voice-to-voice communication such as planned meetings, case conferences, chance meetings, and phone calls. The senior was the only person with direct personal interaction with everyone else in the network. The seniors reported seeing or talking with friends and family members more often than with HCSPs. One said, "My daughter comes nearly every day, and I have friends in the building." They reported having fairly frequent, regular contact with personal support workers/homemakers and less frequent contact with case managers and other professionals such as nurses, therapists, and physicians, although they were not always able to identify the profession of the HCSPs with whom they had contact (other than in the case of physicians). One client said, "I think she was a nurse."

Case managers were the only HCSPs to report having direct personal contact with other members of the helping network. Direct personal interaction for the other HCSPs, when it did occur, was usually by phone. Face-to-face interaction between HCSPs was rare, and usually involved a chance encounter. A physical therapist said:

> We used to run into team members more often, and as money has gotten tighter — I mean, I have seen…one [name of agency] nurse about once

in a year…but if you do run into them it's a real delight, because you do a quick little conference and solve problems that have been bugging you for ages, and you get them done a lot quicker, and [it's] a real pity…we do miss running into them.

The organization of home care services discourages this type of encounter. HCSPs explained that they avoided scheduling clients at the same time as other providers so as not to encroach on their time, as this was seen as "double-billing."

Direct impersonal interaction was more common among HCSPs than direct personal interaction. It involved communication such as e-mail, voicemail, fax, notes, flow sheets, "communication books," formal reports, and letters. Although it was usually informal — for example, a note stuck on the fridge — occasionally there was a formal system in place:

In [name of city] there's a folder…it's the red folder that's usually kept on top of the fridge, and there's supposed to be a communication folder for everybody, and I've certainly seen it where the family member has written the most. It's often a caregiver who's out during the day and then comes back and has left messages, or she's out some of the day and has left messages for various members of the team, asks questions… The people who tend to write most are the personal care workers.

Once again, the organization of services precluded the effectiveness of even this simple mechanism, as HCSPs are not supposed to read the communication books of other agencies. This regulation reflects the managed competition approach to home care. The participants gave numerous examples of how the transition to managed competition affected their interactions with clients and other HCPSs. For example, it is possible for HCSPs from different agencies to be providing services to the same client, leading to a situation of multiple communication books in the home, with HCSPs reading only the one belonging to their particular agency. In focus groups where this issue arose, participants' typical response to the question "So how many communication books might there be on top of the fridge?" was "Oh, two or three."

Some HCPSs felt that under the managed competition system other health-care workers were increasingly infringing on their practice domain. Physical and occupational therapists explained that usually only one type of therapist is sent to see a particular client, and is expected to play a dual role — that of both physical and occupational therapist. Similarly, social workers reported that nurses are now expected to perform traditional social work tasks. The clients were also aware of these issues: "It's bad to be having all this controversy over who's going to look

after you and…when they are going to come and how long they can [stay]."

Indirect impersonal interaction involved the use of an intermediary. The personal support workers indicated that they had very little direct contact with other HCSPs. Aside from chance encounters, their communication with other HCSPs occurred through their supervisors. Other HCSPs confirmed that their contact with personal support workers took place through a supervisor or coordinator at the worker's agency:

> Interviewer: *Would you have any direct contact with the homemaker, or is it through* —
> Case Manager (CM): — *through the coordinator. We don't usually talk to the homemaker on the phone. Sometimes when we go to the home we see the personal support worker coming in to service and we'll meet them that way, but generally any issue is passed through the coordinator of the homemaking agency.*

Some HCSPs, particularly physicians, reported that they learned from the client about care provided by another HCSP. One family physician said:

> *I've made a referral for physiotherapy and I'll only hear from the patient that, yes, the physiotherapist is coming in 2 weeks, and they may only come for two sessions and then they won't be coming again, or the physiotherapist has discontinued their services. I'll usually hear it from the patient long before I get the note telling me that's happened.*

No interaction. The HCSPs indicated that the most common form of interaction they had with each other was none whatsoever: "We don't have contact with each other. We're basically on our own." They avoided each other so as not to encroach on each other's time with the client. When the HCSPs were asked if the notion of team was relevant to them, considering their isolation and lack of contact with other HCSPs, the response in all the focus groups was resoundingly affirmative. However, as described below, the nature and composition of teams in the community are very different to the traditional notions of health-care teams in institutional settings.

Organization, Structure, and Decision-Making among Network Members

Unlike institutional settings, where teams are generally identified through their physical proximity — for example, professionals who work with patients in a particular ward or program — community home care teams function ad hoc, according to the needs of each client. Each elderly client has a different team or group of service providers, and each service provider belongs to many different teams. In addition, over time an indi-

vidual's needs change, further affecting the composition of the home care team. Based on the patterns of interaction found in the helping networks, we identified three categories of team (each with a different hub or a key linking person): *client-centred, case manager-centred,* and *discipline-specific.*

Client–centred team. The first category of team is centred around the client. The client is the hub or the link between all other team or network members, including family and friends:

> CM1: *When you're looking at a client-centred team you're looking at anyone that's providing care to that client, so whether it's physicians, pharmacists…physio, OT, homemaker, social worker, nutritionist, whoever happens to be…actually imparting some kind of care to that client or direction, they all become part of the team.*
> CM2: *Plus the client in the middle.*
> CM1: *The client is very much in the middle.*
> CM2: *Or leading.* [laughter]

These case manager comments reflect the commonly held opinion that the person with arthritis is the core of the client–centred team not only because the purpose of the team is to meet the client's needs, but also because the client is considered the primary decision–maker. The client decides what type of services he or she will accept and can, for the most part, dictate if and when providers can even enter the home. HCSPs frequently alluded to a shift in power to the client when care is delivered in the home. A physical therapist explained:

> *There's also a difference in that in hospital a patient is on your turf…[but] when you go into their home you're like a guest in their home even though you're the professional.*

However, the clients did not see themselves as part of a team, let alone as "in charge." None used the word team during the interviews, and none expressed the view that they were part of a team when asked directly. Although a few clients said they felt they were in control of their own care, most, when asked directly, stated that it was their physician who made the decisions about their care. When asked who made the decisions regarding their arthritis management, one client answered, "I guess the doctor."

Case manager–centred team. This category of team was focused on decision–making about the sorts of services that can be provided given the economic realities of delivering care in the community. It comprised the HCSPs and did not include family and friends. Participants identified the case manager as the central communicator among HCSPs. Case managers were the only network members, aside from the clients themselves, who reported frequent direct personal or direct impersonal

contact with all of the other members. The case manager-centred team was hierarchical, with decision-making revolving around financial concerns rather than patient-care concerns. An occupational therapist explained:

> With regard to the client and the leader of the team, I think that there's a dichotomy of practice, for me anyway, because we're taught very clearly that it's client-centred — the client is the leader of the team — but practicalities and the realities of the situation are economic…it's economic driven, or… there's some sort of outside force that's really dictating who is in fact the leader of the team and who is calling the shots.

Authority clearly rested with the case managers, mainly because of their role in managing scarce financial and human resources:

> Focus group leader: *And who ultimately would make the decisions in that team?*
> OT: *[The] case manager.*
> Focus group leader: *Why is that?*
> OT: *They control the dollars and cents.*

The clients were also cognizant of the role of the case manager in controlling resources. One senior said that the case manager "tells you if you can have a therapist, or a VON [home care nurse], or a homemaker or so forth." However, they also were aware of the scarcity of resources and limited their requests accordingly. Another client explained that the case manager

> is really limited because they've cut her down so much…. I could use a therapist right now, with my back and everything, but I haven't talked to [case manager] about it because I know it's hard for her to have people come in… The government [doesn't] want us.

Discipline-specific HCSP team. This category refers to workers with the same professional or disciplinary affiliation employed by the same organization. In contrast to client-centred teams, these teams were described by most HCSPs as highly valued and as central to home care. Members of discipline-specific teams interacted on a fairly regular basis, both formally during staff meetings or educational sessions and informally during social events. Such direct personal, face-to-face interactions allowed them to discuss common issues, thus fostering professional development, and to problem-solve on specific cases. In addition, direct personal contact among members of the discipline-specific team provided much needed social support and helped to alleviate feelings of isolation. An Arthritis Society therapist said:

I think in terms of team. When our group refers to team, we're talking about almost, like, our emotional team, not a client treatment team… I think when we talk about team it's kind of the emotional resource for us, not necessarily for the client.

Participants expressed regret that, due to recent changes in community care, routine interaction with other HCSPs was less frequent. For example, under the CCAC structure, many health-care providers no longer have a designated office where they can routinely interact with co-workers.

Discussion

Three categories of home care teams emerged in this study: client-centred, case manager-centred, and discipline-specific. Of these, the case manager-centred team most closely resembles the empirically supported hospital-based multidisciplinary team in that it is hierarchical, with a group of professionals and unregulated staff members reporting to a team leader. In the case of the manager-centred team, as with the hospital-based multidisciplinary team, unregulated staff members in the community are excluded from decision-making and goal-setting (Cott, 1997, 1998) and are discouraged from interacting directly with other HCSPs. Unlike the hospital-based multidisciplinary model, however, team composition differs for each client, and HCSPs in the community are members of multiple teams.

Returning to the types of community teams described by Ovretveit (1993), the case manager-centred and client-centred teams fall into the category of client teams: Members of the network may share the goal of assisting the client but have little if any interaction with each other. Overall, we found little indication of formal teams or of functional collaborative teamwork.

According to social network theory, the relationships that develop within teams are based on various types of proximity: physical, professional, task, social, and formal or organization-created. In other words, individuals who work in close physical proximity, in the same formal organizational unit, doing similar tasks, with people who share similar professional backgrounds and social contacts, are more apt to function collaboratively (Cott, 1997, 1998; Farris, 1981). Given that HCSPs do not work in close physical proximity in the community, are actually discouraged from interacting with each other, and belong to multiple teams, it is hardly surprising that we found little evidence of collaborative teams.

This study reveals the emergence of a new team leader in the health-care field: the case manager with a background in nursing or social work. Case managers have the authority to make decisions regarding services

to be provided in the community. According to the HCSPs who partici-pated in the study, including physicians and clients, case managers have the final say in treatment decisions, mainly because they control the purse strings.

Unlike the case manager-centred team, the discipline-specific team is non-hierarchical. It most often includes colleagues from the same disci-pline employed by the same organization. HCSPs identified most strongly with their discipline-specific team because it was a source of emotional support and job satisfaction. With advances in communication technologies, it is likely that in the future many home care workers will not be based at a central location and will have even less contact with their peers. In their study with home care workers in Ontario, Denton, Zeytinoglu, Davies, and Lian (2002) found that those who felt supported by their peers were more likely to be satisfied with their jobs and less likely to experience work-related stress. Home care organizations need to encourage interaction among colleagues through activities such as team meetings, professional training sessions, and planned social events, in order to enhance quality of work life and staff retention.

The HCPSs in the present study felt that clients had greater control over treatment decisions in the community because the health-care encounter took place in their home. For the HCPSs, the shift in power from the professional to the patient was a defining characteristic of the client-centred home care team. However, the clients who participated in the study did not echo this belief. Other researchers have also found that even though clients may have more control in the home setting their power is still limited vis-à-vis the health professionals (Oudshoorn, Ward-Griffin, & McWilliam, 2007). It was beyond the scope of the present study to determine absolute power relations, but the HCPSs' perception of increased client control has implications for the way in which they approach their practice: They may have to modify their approach to ensure that they develop trusting, effective relationships with clients (Heckman & Cott, 2005).

Our findings highlight the impact of the health-care system on team structure. The managed competition approach to care appears to be actually hampering the development of effective teams in the community. The loss of job security and competition among HSCPs, combined with severely limited communication, has exacerbated role-boundary tensions and created a work environment that discourages collaboration. Other researchers have also found that changes in service delivery have impli-cations for the ability of home care workers to provide high-quality personalized care (Aronsen, 2006; Aronson & Neysmith, 1996; Denton, Zeytinoglu, & Davies, 2002). No doubt lessons could be learned from jurisdictions with a different approach to home care delivery. As health

care increasingly shifts from institutions to the community, it will be crucial for decision-makers and researchers to examine whether models of service delivery based on cost–effectiveness are not counterproductive in terms of quality and long-term effectiveness.

Overall, this study reveals a lack of collaboration, a hallmark of effective teamwork, in the community. Participants, particularly HCSPs, believed the word team applied mostly to discipline-specific teams and felt most emotionally engaged with these teams. These teams, although an important source of support for health–care workers, were self-isolating. The lack of opportunity for interdisciplinary exchange, with powerful socialization into the discipline-specific view of the world, can be a barrier to the development of effective interprofessional teamwork. The two other types of team are also problematic. For example, the client-centred team is plagued by a lack of communication among members and inconsistency of membership. The case manager–centred team is rigidly hierarchical, with decision-making revolving around financial rather than patient-care concerns. This lack of collaboration in community care for the elderly with arthritis raises concerns about the quality of care available to this population, as collaborative goal-setting and decision-making are considered essential for the management of chronic conditions (Hall & Weaver, 2001).

Our inability to recruit a sufficient number of family members to include their perspectives in this phase of the research was disappointing. Ironically, our decision to focus on those seniors with arthritis who are likely to be capable of taking part in the management of their condition probably precluded our ability to recruit family members. This in itself may be an indication of the role of family when older adults are able to be active participants in their own care. Community-based teams may differ for groups of patients with conditions other than arthritis or for patients in other age groups. Future studies could examine community-based teamwork for clients of other ages and with other diagnoses.

Despite these limitations, the present study extends our understanding of community-based teams. By examining the meaning of *team* from many perspectives, including those of clients and both regulated and unregulated health–care workers, the study uncovers three types of team that, although bearing some resemblance to institutionally based teams, are unique to the home care setting. The structure of teams and their function in the community will become more critical in the future, as demographic trends in fertility, migration, and marriage limit the availability of informal caregivers and an increasing number of seniors come to rely on health and support services provided in the home (Neysmith & Aronson, 1996).

References

Aronsen, J. (2002). Frail and disabled users of home care: Confident consumers or disentitled citizens? *Canadian Journal on Aging, 21,* 11–25.

Aronsen, J. (2006). Silenced complaints, suppressed expectations: The cumulative effects of home care rationing. *International Journal of Health Services, 36,* 535–556.

Aronsen, J., & Neysmith, S. M. (1996). The work of visiting homemakers in the context of cost cutting in long-term care. *Canadian Journal of Public Health, 87,* 422–425.

Badley, E. M. (1995). The impact of disabling arthritis. *Arthritis Care and Research, 8,* 221–228.

Badley, E. M., & Wang, P. P. (1998). Arthritis and the aging population: Projections of arthritis prevalence in Canada 1991–2031. *Journal of Rheumatology, 25,* 138–144.

Biegel, D. E., Sales, E., & Schulz, R. (1991). *Family caregiving in chronic illness.* Newbury Park, CA: Sage.

Chipperfield, J. G., & Haven, B. (1991). The transition from informal to formal sources of support with tasks of daily living. *Canadian Journal of Community Mental Health, 10,* 133–149.

Clark, P. G. (1991). A typology of interdisciplinary education in gerontology and geriatrics: Are we really doing what we say we are? *Journal of Interprofessional Care, 7,* 217–227.

Clark, P. G. (1995). Quality of life, values, and teamwork in geriatric care: Do we communicate what we mean? *Gerontologist, 35,* 402–411.

Clark, P. G., Spence, D. L., & Sheehan, J. L. (1996). A service/learning model for interdisciplinary teamwork in health and aging. *Gerontology and Geriatrics Education, 6,* 3–16.

Corbin, J., & Strauss, A. (1988). *Unending work and care: Managing chronic illness at home.* San Francisco: Jossey-Bass.

Cott, C. (1997). We decide, you carry it out: A social network analysis of multi-disciplinary long-term care teams. *Social Science and Medicine, 45,* 1411–1421.

Cott, C. (1998). Structure and meaning in multidisciplinary teamwork *Sociology of Health and Illness, 20,* 848–873.

Crabtree, B. F., & Miller, W. L. (1999). *Doing qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Cresswell, J. W. (2003). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage.

Denton, M. A., Zeytinoglu, I. U., & Davies, S. (2002). Working in clients' homes: The impact on the mental health and well-being of visiting home care workers. *Home Health Care Services Quarterly, 21,* 1–27.

Denton, M., Zeytinoglu, I. U., Davies, S., & Lian, J. (2002). Job stress and job dissatisfaction of home care workers in the context of health care restructuring. *International Journal of Health Services, 32,* 327–357.

Drinka, T. J. K., & Clark, P. G. (2000). *Health care teamwork: Interdisciplinary practice and teaching.* Westport, CT: Auburn House.

Due, P., Holstein, B., Lund, R., Modvig, J., & Avlund, K. (1999). Social relations: Network, support and relational strain. *Social Science and Medicine, 48,* 661–673.

Dyck, I. (2001). Centring the home in research. *Canadian Journal of Nursing Research, 33*(2), 83–86.

Eustis, N. N., & Fischer, L. R. (1991). Relationships between home care clients and their workers: Implications for quality of care. *Gerontologist, 31,* 447–456.

Farris, G. F. (1981). Groups and the informal organization. In R. Payne & C. Cooper (Eds.), *Groups at work* (pp. 95–117). New York: John Wiley.

Field, P. A., & Morse, J. M. (1985). *Nursing research: The application of qualitative approaches.* Rockville, MD: Aspen Systems.

Field, P., & Morse, J. (1995). *Qualitative research methods for health professionals* (2nd ed.). Thousand Oaks, CA: Sage.

Fischer, L., & Eustis, N. (1994). Care at home: Family caregivers and home care workers. In E. Kahano, D. E. Biegel, & J. Wykle (Eds.), *Family caregiving across the lifespan* (pp. 287–311). London: Sage.

Frederick, J. A., & Fast, J. E. (1999). Eldercare in Canada: Who does how much? *Canadian Social Trends* (Autumn). Catalogue #11-008. Ottawa: Statistics Canada.

Hall, P., & Weaver, L. (2001). Interdisciplinary education and teamwork: A long and winding road. *Medical Education, 35,* 867–875.

Heckman, K., & Cott, C. A. (2005). Home-based physiotherapy for the elderly: A different world. *Physiotherapy Canada, 57,* 274–283.

Hooyman, N. R., & Gonyea, J. G. (1999). A feminist model of family care: Practice and policy directions. *Journal of Women and Aging, 11,* 149–169.

Horowitz, A. (1985). Family caregiving to the frail elderly. In M.P. Lawton & G. Maddox (Eds.), *Annual review of gerontology and geriatrics* (pp. 194–246). New York: Springer.

Knodel, J. (1993). The design and analysis of focus group studies: A practical approach. In D. L. Morgan (Ed.), *Successful focus groups: Advancing the state of the art* (pp. 35–50). Newbury Park, CA: Sage.

Krueger, R. A (1994). *Focus groups: A practical guide for applied research* (2nd ed.). Thousand Oaks, CA: Sage.

Lee, G. (1985). Theoretical perspectives on social networks. In W. J. Sauer & R. T. Coward (Eds.), *Social support networks and the care of the elderly: Theory, research and practice* (pp. 21–37). New York: Springer.

Martin-Matthews, A., & Campbell, L. D. (1995). Gender roles, employment and informal care. In S. Arber & J. Ginn (Eds.), *Connecting gender and ageing: Sociological approaches to gender relations in later life* (pp. 129–143). London: Open University Press.

McWilliam, C. L., Stewart, M., Brown, J. B., McNair, S., Desai, K., Patterson, M. L., et al. (1997). Creating empowering meaning: An interactive process of promoting health with chronically ill older Canadians. *Health Promotion International, 12,* 111–123.

Neysmith, S. M., & Aronson, J. (1996). Home care workers discuss their work: The skills required to "use your common sense." *Journal of Aging Studies, 10,* 1–14.

Neysmith, S. M., & Nichols, B. (1994). Working conditions in home care: Comparing three groups of workers. *Canadian Journal on Aging, 13,* 169–186.

Noelker, L. S., & Bass, D. M. (1989). Home care for elderly persons: Linkages between formal and informal caregivers. *Journal of Gerontology: Social Sciences, 44,* S63–S70.

Oudshoorn, A., Ward-Griffin, C., & McWilliam, C. (2007). Client-nurse relationships in home-based palliative care: A critical analysis of power relations. *Journal of Clinical Nursing, 16,* 1435–1443.

Ovretveit, J. (1993). *Coordinating community care: Multidisciplinary teams and care management.* Philadelphia: Open University Press.

Plummer, K. (2000). Symbolic interactionisms in the twentieth century. In B. S. Turner (Ed.), *The Blackwell companion to social theory* (pp. 193–222). Oxford: Basil Blackwell.

Qualls, S. H., & Czir, R. (1988). Geriatric health teams: Classifying models of professional and team functioning. *Gerontologist, 28,* 372–376.

Ryan, D. P. (1996). A history of teamwork in mental health and its implications for teamwork training and education in gerontology. *Educational Gerontology, 22,* 411–431.

Schwandt, T. A. (2001). *Dictionary of qualitative inquiry* (2nd ed.). Thousand Oaks, CA: Sage.

Stoller, E., & Pugliesi, K. (1991). Size and effectiveness of informal helping networks: A panel study of older people in the community. *Journal of Health and Social Behaviour, 32,* 180–191.

Ward-Griffin, C., & McKeever, P. (2000). Relationships between nurses and family caregivers: Partners in care? *Advances in Nursing Science, 22,* 89–103.

White, H. C., Boorman, S. A., & Brieger, R. L. (1976). Social structure from multiple networks. I: Blockmodels of roles and positions. *American Journal of Sociology, 81,* 730–780.

Williams, A. M. (2004). Shaping the practice of home care: Critical case studies of the significance of the meaning of home. *International Journal of Palliative Nursing, 10,* 333–342.

Zimmer, J. G., Groth-Juncker, A., & McCusker, J. (1985). A randomized controlled study of a home health care team. *American Journal of Public Health, 75,* 134–141.

Authors' Note

Comments or queries may be directed to Cheryl A. Cott, Department of Physical Therapy, University of Toronto, 160 − 500 University Avenue, Toronto, Ontario M5G 1V7 Canada. E-mail: cheryl.cott@utoronto.ca.

Cheryl A. Cott, PhD, is Associate Professor, Department of Physical Therapy, Faculty of Medicine, University of Toronto, and Deputy Director, Arthritis Community Research and Evaluation Unit, Toronto Western Research Institute, University Health Network, Toronto, Ontario, Canada. Laura-Beth Falter, MSc, is Instructor and Faculty Head, PTA Program, triOS College, London (Ontario) Campus. Monique Gignac, PhD, is Senior Scientist, Arthritis Community Research and Evaluation Unit. Elizabeth Badley, PhD, is Professor, Department of Public Health Sciences, Faculty of Medicine, University of Toronto, and Director, Arthritis Community Research and Evaluation Unit.