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Promoting high-functioning mental health treatment teams in the context of low staffing ratios

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Background: Many previous studies of health care teamwork have taken place in clinical teams with high staffing ratios (i.e., high ratios of staff to patients).

Purpose: The aim of this study was to identify clinicians' viewpoints of foundational resources necessary to support good team functioning in the context of low staffing ratios.

Methodology: We used administrative data, validated with local mental health chiefs, to identify mental health teams that had achieved high team functioning despite low staffing ratios in U.S. Department of Veterans Affairs medical centers. Guided by a recently developed model of team effectiveness, the Team Effectiveness Pyramid, we conducted qualitative interviews with 21 team members across three teams within two medical centers. Interview questions focused on the resources needed to support good team functioning despite low staffing ratios. We used directed content analysis to analyze results.

Results: We found there were several domains of relevant resources: material, staffing, temporal, organizational, and psychological. These represent an expansion of the domains originally included in the Team Effectiveness Pyramid.

Conclusions: Within the five domains, we identified key tensions to be addressed when forming teams, including the balances between providing care for new versus established patients, emphasizing shared caseloads within the team versus matching patients to clinicians based on individual expertise, and establishing reporting structures by clinical discipline versus team membership.

Practice Implications: Establishing high-functioning health care teams in the context of low staffing ratios requires attention to key resource domains and fundamental trade-offs in how teams are structured.

Key words: Mental health, outpatient, staffing ratios, team functioning, teamwork

Health care is often delivered by interdisciplinary teams of clinicians (Mitchell et al., 2012). Good team functioning has been shown to improve patient care and staff satisfaction (Gittell et al., 2000; Helfrich et al., 2014), and poor team functioning is associated with subpar patient care, communication lapses, and increased costs (Baker, 2001; Olsen et al., 2010). Although health care teams are becoming

increasingly widespread, many teams continue to underperform (Pronovost & Freischlag, 2010).

There is substantial literature on improving health care teamwork, but this research focuses heavily on surgery and acute care settings (e.g., Marlow et al., 2017). Less research has addressed health care teams in nonacute settings (Miller et al., 2018). This represents a pivotal gap, as chronic conditions (e.g., diabetes, depression) are likely to be managed primarily on an outpatient basis and are responsible for an increasing proportion of health care costs (Thorpe & Howard, 2006).

Furthermore, research has frequently focused on high-functioning health care teams as examples of good teamwork (e.g., Nelson et al., 2014). Such teams, however, are typically selected for study without regard to the resources they have available. For example, staffing ratios—the number of available staff relative to the number of patients for which a team is responsible—are one of the strongest predictors of health care quality (Boden et al., 2018). Thus, failure to account for staffing ratios may lead to selection bias: It is possible that having a favorable staffing ratio allows for novel teamwork procedures to be implemented and also contributes to good team functioning. Unfortunately, this study design may encourage researchers to erroneously attribute success to the teamwork procedures themselves. This is problematic because teamwork procedures that appear to work well in settings with high staffing ratios may be less useful—or even detrimental—in

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environments where staff are overwhelmed with large numbers of patients (e.g., long weekly team meetings).

We therefore set out to investigate the resources necessary to support good team functioning in outpatient health care teams with low staffing ratios. We undertook this study in U.S. Department of Veterans Affairs (VA) outpatient general mental health teams. This is an ideal setting for this research, as VA outpatient clinics are increasingly team based (e.g., Bauer, Miller, et al., 2019; Yano et al., 2014), and VA data allow estimation of staffing ratios and team functioning. To our knowledge, this is the first study of teamwork to use staffing ratios to guide selection of high-functioning outpatient mental health teams.

Conceptual Framework

There is a vast literature on teamwork more broadly (e.g., Hackman, 1990), and substantial literature on health care teamwork specifically (e.g., Driskell et al., 2018; Marlow et al., 2017). The underlying conceptual model for our qualitative interviews and analysis was the set of foundational resources from the Team Effectiveness Pyramid based on a systematic literature review (Miller et al., 2018; Figure 1). These resources include a supportive organizational context (Lemieux-Charles & McGuire, 2006), tangible resources such as staffing (Helfrich et al., 2014; Nelson et al., 2014) and space (Oandasan et al., 2009), and psychological resources such as psychological safety (Edmondson, 1999) and mutual respect (Gittell et al., 2000). Without at least some resources in each of these domains, health care teams are unlikely to achieve high performance; in this regard, the Team Effectiveness Pyramid is similar to other pyramid models, such as Maslow's (1943) hierarchy of needs. Specifically, in

the absence of at least a modicum of tangible resources (e.g., staffing, space), clinicians are unlikely to have the capacity to effectively treat their patients or collaborate with colleagues. Similarly, without at least baseline levels of mutual trust and psychological safety (i.e., the ability to bring up problems within the team without fear of reprisal), frontline clinicians are unlikely to coordinate care with other team members.

We also included items related to provider workload and time available for clinical tasks: Although not reflected explicitly in the Team Effectiveness Pyramid, these constructs are highly correlated with team functioning (Boden et al., 2018). Each domain was represented in our semistructured interview guide, alongside more general questions regarding effective teamwork in these settings (see Supplemental Digital Content 1, <http://links.lww.com/HCMR/A83>).

Method

All study procedures were approved by the VA Boston Institutional Review Board. Interviews were conducted from August to October 2018. Briefly, we used quantitative data to identify outpatient general mental health teams that had achieved high team functioning despite low staffing ratios. We then conducted qualitative interviews with members of a subset of those teams and used directed content analysis (Zhang & Wildemuth, 2009) to develop a more nuanced understanding of the foundational resources needed to support good team functioning in the context of low staffing ratios. This therefore qualifies as a sequential explanatory mixed-methods design (with quantitative data used to inform sampling for qualitative data collection; Ivankova et al., 2006; Palinkas et al., 2011).

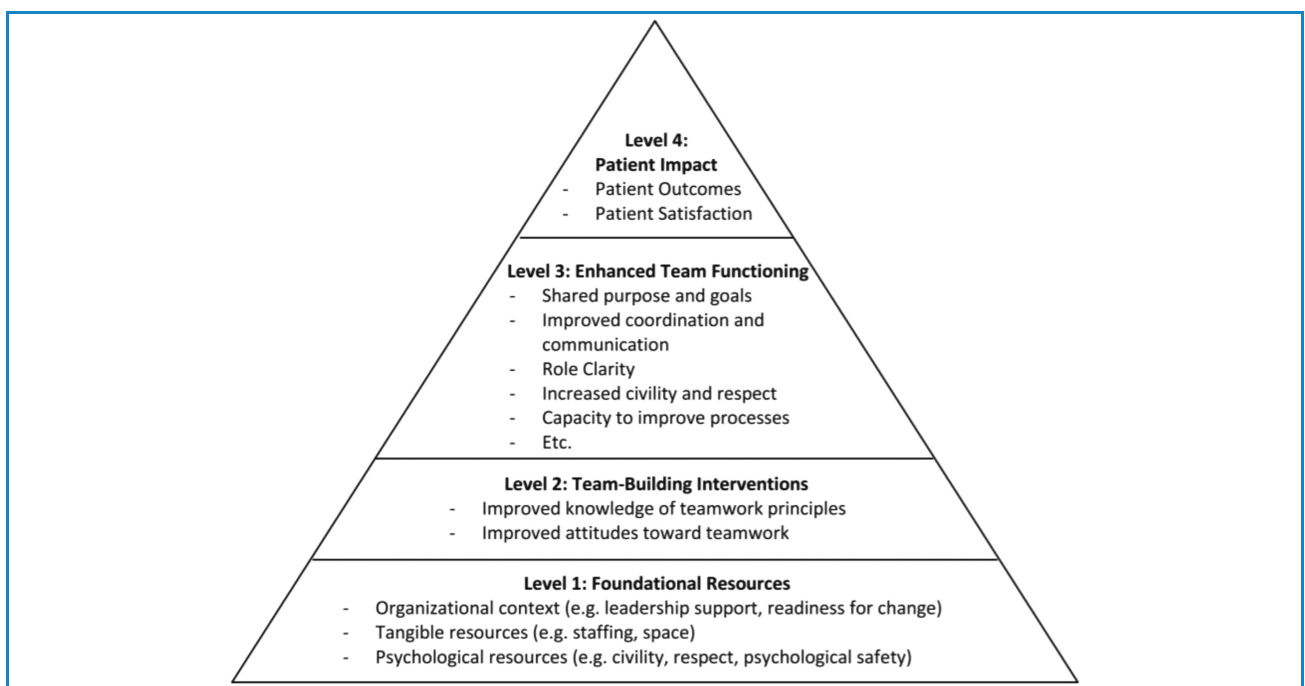


Figure 1. The Team Effectiveness Pyramid. This is copied with permission from Miller et al. (2018, p. 2) under the terms of the Creative Commons Attribution 4.0 International License (<https://creativecommons.org/licenses/by/4.0/>).

Study Setting and Population

The target population for this study was clinicians in VA-based general outpatient mental health teams, known as Behavioral Health Interdisciplinary Program (BHIP) teams. 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. VA's Office of Mental Health and Suicide Prevention mandated that each of the approximately 170 VA medical centers across the United States establish one BHIP team in 2013 (Bauer, Weaver, et al., 2019). Although some medical centers retain only one BHIP team, others have established multiple such teams, meaning that thousands of VA mental health staff currently provide care as part of one or more BHIP teams.

Sampling Plan and Recruitment

As described briefly above, we used a multistep process to identify BHIP teams from which to draw our study sample. Additional detail on the data sources listed in this section can be found in the Quantitative Data Sources section below.

Step 1: Identify high-functioning BHIP teams. We defined high-functioning BHIP teams as those whose members had high levels of self-reported job satisfaction, low burnout, and the absence of plans or intentions to leave their current job (i.e., low turnover plans/intentions). We chose to operationalize BHIP team functioning this way (a) because of established associations between clinician satisfaction, burnout, and turnover with overall health care quality (e.g., Hall et al., 2016) and (b) because VA administrative data sets do not include reliable team-level clinical outcomes data that could otherwise have been used to assess team functioning more directly. We combined data from several dashboards and provider surveys, including the VA All Employee Survey (AES), the VA Mental Health Provider Survey (MHPS), and the VA Mental Health Management System (MHMS), to estimate an overall team functioning score for candidate BHIP teams. The online digital supplement contains additional information on our specific process for aggregating these data.

Step 2: Identify BHIP teams with low staffing ratios.

We used several VA data sources to identify BHIP teams with low staffing ratios, operationalized as staff per clinical encounter and staff per mental health patient treated. We calculated the ratio from VA's mental health workforce report, outpatient mental health clinic visit data from the VA Corporate Data Warehouse (CDW), and the MHMS (U.S. Department of Veterans Affairs, 2018a). Taken together, these variables allowed us to estimate an overall staff ratio score for candidate BHIP teams (see Supplemental Digital Content 1, <http://links.lww.com/HCMR/A83>).

Step 3: Use performance and staffing ratio estimates to identify VA medical centers. We used the team performance and staffing ratio calculations above to identify candidate VA medical centers. Eleven VA medical centers potentially met our inclusion criteria, appearing to have one or more BHIP teams with high team functioning despite low staffing ratios.

Step 4: Validate data collection and identify candidate BHIP teams. To corroborate the administrative data described above, we contacted the mental health chief at each of the 11 identified medical centers. After briefly describing the study, we asked these leaders if they could identify one (or more) of their BHIP teams that appeared to be functioning well despite higher-than-average workload. Once teams were identified, we moved forward with recruitment of individuals within those teams via e-mail and telephone. Our sampling goal was to interview at least 20 team members across a minimum of three BHIP teams that had demonstrated high team functioning despite low staffing ratios.

Quantitative Data Sources

VA AES. The AES is administered annually to all VA employees, with an annual response rate of about 60% (Ogrysko, 2018). It is meant to help guide improvement efforts within VA. Individual AES subscales typically demonstrate strong validity and reliability (e.g., Cronbach's alpha of above .85; Osatuke et al., 2012).

VA CDW. The CDW is derived from the computerized patient record system, VA's integrated medical record. It contains data for each patient visit to all VA medical centers across the country, with flags to identify visits to specific clinics. For this study, we used CDW counts of general outpatient mental health visits by BHIP clinicians.

VA MHPS. The MHPS is a web-based survey administered annually to all 25,000+ full-time VA mental health providers and is maintained by the Veterans Health Administration Support Service Center (U.S. Department of Veterans Affairs, 2018a, 2018b). Its response rate is about 35% (i.e., over 8,000 respondents annually; U.S. Department of Veterans Affairs, 2018b), and it informs VA's strategic improvement efforts (Lemke et al., 2017).

VA MHMS. The MHMS provides data regarding resource allocation, productivity, and staffing at VA medical centers (Schmidt et al., 2017). It is derived from VA mental health clinical data and maintained by the Program Evaluation and Resource Center within the Office of Mental Health and Suicide Prevention.

Mental health workforce report. The mental health workforce report provides counts of outpatient mental health clinical staff at each VA medical center, accounting for the percentage of their time dedicated to clinical duties. It is maintained within the VA network by the VA Office of Productivity, Efficiency, and Staffing.

Qualitative Interviews and Data Collection

Interview guide questions focused on the foundational resources necessary to support effective BHIP teams in the eyes of the participants, consistent with our conceptual framework (i.e., the first level of the Team Effectiveness Pyramid; Figure 1). Additional questions focused on core teamwork concepts such as role clarity, communication, and shared team goals, as well as broader questions about how BHIP teams at participating sites were structured (e.g., team size, frequency of clinical meetings). See the supplemental digital files for example questions. Interviews were conducted over the telephone by the lead author, a psychologist with qualitative research experience. Each interview took 20–40 minutes to complete and was audio-recorded and professionally transcribed verbatim.

Qualitative Analysis

A team of two analysts (C. J. M., J. L. S.) used directed content analysis (Zhang & Wildemuth, 2009) guided by the a priori domains described above. First, we read through several transcripts to obtain initial impressions of the data. We then developed an initial set of coding definitions based on the domains in the interview guide—including perceptions of foundational resources and teamwork processes—as well as themes that emerged from the interview data (see Supplemental Digital Content 1, <http://links.lww.com/HCMR/A83>). The two analysts met to review the definitions and coded three interviews together to inform definition clarity and coding consistency. Upon resolving coding differences and updating the codebook, the two analysts coded the remaining transcripts in NVivo 11 (QIP Ltd., 2017) and met to come to consensus and ensure reliability of coding. Once coding was complete, the analysts created within-site summaries consolidating data for each BHIP team. Once we summarized data across all participants for each site, we compared data across the three teams to assess similarities and differences for each coding domain. Throughout data analysis and interpretation, we discussed our own potential biases and relationship with the data to minimize the influence of our perspectives on the results.

Results

Study Sample

Our recruitment procedures identified three BHIP teams at two medical centers that had achieved high team functioning despite low staffing ratios. The three identified BHIP teams comprised 65 total staff. E-mail outreach resulted in 21 participants (32% response rate). The participant sample was 14% male; the median number of years on the BHIP team among respondents was 3 years, and the median number of years at the VA was 9 years.

Qualitative Results: Views on Foundational Team Resources

Based on our guiding conceptual framework, we focused on three types of foundational resources: organizational, tangible, and psychological (Figure 1). We were also attentive to themes of provider workload and time available for clinical tasks (Boden et al., 2018). In reviewing the interview transcripts, we were struck by the distinct ways that interview

respondents discussed staffing versus physical space, resulting in disaggregating these two concepts from the more generic “tangible resources” domain. We also noted that interview respondents spoke similarly about physical space and material equipment, leading us to consolidate these subdomains into a broader domain of material resources. Thus, we organize our findings by the resulting five domains of foundational resources: material, staffing, temporal, organizational, and psychological. Based on our results, Table 1 contains key questions that administrators and clinician leaders may find useful for addressing these domains, details of which can be found below.

Material resources. We define foundational *material resources* as the physical components (space and equipment) required for team members to conduct their clinical work and coordinate care with one another. In terms of physical space, some respondents reported appreciating having team members colocated (i.e., with offices located close to one another). However, this type of arrangement was not universal among the teams we interviewed: Some respondents noted that their teams were distributed across multiple floors, which could exacerbate interdisciplinary conflict. For example, one respondent noted that a split between “the therapeutic disciplines” (e.g., psychology, social work) and “the prescribing disciplines” (e.g., psychiatry, advanced practice nursing) across floors. This respondent, a psychologist, went on to describe these two broad categories of clinicians as “sects,” while noting that the split between floors contributed to an unhealthy perception of homogeneity within each group:

Well, I think that there's sometimes an assumption that we [e.g., psychologists, social workers, and other therapists] all do exactly the same thing exactly the same way at the same level of performance. In the same way, I think the providers [i.e., psychiatrists, nurse practitioners, and other prescribing clinicians] are all lumped and I think sometimes that doesn't work well.

Even if team members were located on the same floor, heavy foot traffic on their hallway could make it difficult to connect with their colleagues. Other participants noted the importance of standard equipment, such as computers and printers. Respondents from one participating team noted that they were without a functioning shared printer for over a year, making routine tasks (e.g., printing patient handouts) difficult.

Staffing resources. We define foundational *staffing resources* as having the personnel needed to accomplish the team's work (e.g., psychiatry or specialized nursing staff for medication management). Our respondents noted several structures and processes for managing the staffing and workload challenges common to their settings. For example, two participating teams had each recently consolidated into their current form from smaller teams. This consolidation resulted in each discipline being represented at least twice (e.g., two psychologists, two social workers). This had two concrete benefits: first, if one team member had to miss a team meeting

TABLE 1: Key questions for building teams in the context of low staffing ratios

Resource and subdomains	Key questions
Material	
Space	<ul style="list-style-type: none"> - Do providers have colocated space? If not, what synchronous communication mechanisms are needed? - Does the team have meeting space? If not, what virtual options exist?
Equipment	<ul style="list-style-type: none"> - Does the team have the equipment it needs to conduct its work?
Staffing	
Skills coverage	<ul style="list-style-type: none"> - Does the team have the work roles needed to conduct its work? If not, what patients or care needs can be sent to other staff?
Role clarity	<ul style="list-style-type: none"> - Do team members know one another's roles? Do they know how each team member contributes to the team's success?
Team size	<ul style="list-style-type: none"> - Is the team small enough to develop internal working relationships? - Is the team large enough to have disciplinary representation at each team meeting and a succession plan if staff leave the team?
Temporal	
Clinical	<ul style="list-style-type: none"> - Do team members have sufficient time for new patient intakes, returning patients, and walk-in appointments? If not, which should be prioritized?
Meetings and huddles	<ul style="list-style-type: none"> - Does the team have sufficient time carved out for team meetings and huddles? If not, how can meetings be streamlined?
Administrative	<ul style="list-style-type: none"> - Do team members have time to conduct administrative tasks like trainings and documentation? If not, how can administrative burden be reduced?
Organizational	
Leadership	<ul style="list-style-type: none"> - Do team members receive consistent input from leadership (including matrix leadership if applicable) regarding the team? If not, to what extent can leadership input be made more consistent?
Shared purpose and goals	<ul style="list-style-type: none"> - What are the highest clinical priorities for the team (e.g., providing evidence-based practices, focusing on high-risk patients, meeting productivity metrics, ensuring access to walk-in services)? If there is disagreement, how can shared goals be established more firmly? - To what extent do team members share caseloads? If caseloads are not shared, how can team members with little overlap in their caseloads best contribute to the team?
Psychological	
Mutual trust and respect	<ul style="list-style-type: none"> - Do team members trust and respect one another and the roles that can be played by other team members? If not, can the sources of mistrust or disrespect be addressed?
Conflict management	<ul style="list-style-type: none"> - Does the team have the means to discuss and address conflict openly and empathically? If not, is leadership intervention required?
Psychological safety	<ul style="list-style-type: none"> - Is the team a safe environment to bring up clinical problems or safety issues? If not, how can a more open culture be established?

unexpectedly, that discipline would still be represented, and the absent team member could be brought up to speed afterward; and second, if one team member left the team, there was a member of that discipline to train his or her replacement. As one respondent summarized:

It wasn't functioning well, so what happened was we sat down and talked about it and then there was a collapse of the BHIP and that brought it down to four [total teams instead of eight], where most of the times you

have two psychiatrists or nurse practitioners or physician's assistants on a particular team. So, 90% of the time or more, you will have enough people...and any person who cannot make it for very good reason, [their corresponding team member can] send the information on what they wanted to discuss.

Temporal resources. We define foundational temporal resources as having sufficient time to conduct the team's work (including direct delivery of clinical services, documentation,

administrative tasks, and coordination among team members). Participants within all three teams noted the importance of having time carved out in their schedules for team activities (e.g., meetings, huddles), even though this can be difficult in the context of high caseloads—and especially difficult when BHIP team members have collateral duties outside their BHIP teams. Among our respondent teams, there was variation in how this was achieved. For example, one team blocked clinicians' schedules for 2-hour-long blocks each day (from 10–11 a.m. to 2–3 p.m.). This time allowed for brief team check-ins at 10 a.m. and 2 p.m., with prescribing clinicians typically attending both check-ins and psychologists typically attending one (and conducting therapy groups during the other). Crucially, this structure also accommodated other important clinical and administrative tasks during those hours, such as assigning time to see walk-in patients with issues that required same-day access but not a trip to the emergency room, conducting clinical supervision of trainees, writing clinical notes, and engaging in coordination or care management activities with other clinicians.

Organizational resources. We define foundational *organizational resources* as higher level support for the team's work within the organization, including strategic guidance from leadership. For example, participants described several leadership qualities as particularly important in their work environments. First, respondents across multiple sites noted the importance of leadership flexibility. One respondent noted this was particularly important in the context of a large bureaucracy like VA:

And [within] VA as a large organization, I feel like I don't have a lot of control. But within [my BHIP team] I feel like our directors are very responsive and I know they do whatever they can to try to grant us some flexibility in a system that isn't necessarily flexible.

Other respondents expressed appreciation for leaders who were approachable, responsive, and knowledgeable of the challenges faced by frontline staff “in the trenches” delivering direct patient care.

Concurrently, interview respondents noted three aspects of their organizational structures that could complicate efforts to achieve high team functioning. In each case, these structural components appeared to make it especially difficult to align team members' efforts toward shared team purpose and goals. First, all three of our participating teams featured a matrix reporting structure in which clinicians reported to both their BHIP team leader (e.g., for clinical issues) and to their discipline chief (e.g., for professional or administrative issues). One respondent noted that maintaining good team functioning within this structure relied heavily on within-team trust and cooperation: “The team's able to get along well despite the fact that everyone's answering to different people.” Respondents from a different team noted that some of the reporting lines within their matrix structure converged at the Chief of Psychiatry, who oversaw the psychiatrists, nurses, and BHIP team leaders. Typically, medical support staff reported

through separate channels, meaning that it could be difficult to fully engage them as team members in their own right despite their importance to the team's functioning. Within this matrix structure, there was variety in how participating BHIP teams approached leadership of day-to-day activities. For example, one team featured a single team lead (a psychiatrist), a second team was co-led by a psychiatrist and nurse, and a third team had an overall administrative lead but rotated management of team meetings among all team members.

A lack of overlap among team caseloads emerged as a second potential organizational challenge to establishing shared purpose and goals within our respondent teams. Specifically, clinicians whose caseloads featured little overlap with their fellow team members could find themselves torn between focusing on team-wide challenges and focusing on their personal panel of patients. For example, psychologists on one BHIP team were assigned patients based on clinical expertise rather than team membership, meaning that they shared a significant number of patients with clinicians on other teams instead. One psychologist elucidated the costs and benefits of that approach:

As psychologists we have one foot in the BHIP, meaning that we...have a whole set of our therapy patients that are not on our BHIP. So we have to collaborate with the other BHIPs, which is totally fine; it just leads to a little bit more separation of our work, and often with our higher risk therapy patients we don't have the built in team that we're seeing every day so we have to reach out and consult and collaborate outside of the BHIP. The pros of that are that we are able to see more therapy patients based upon our specialties and our preferences.

This psychologist went on to state that the ability to take on patients based on preferences rather than simply team assignment led to improved morale among psychologists.

A third organizational challenge related to establishing shared purpose and goals was that of deciding how to maximize booked appointments while also leaving time for walk-in hours or other emergent patient needs. One respondent described this as the “core” problem facing BHIPs:

The core problem it seems like with the BHIP model is that there are two aims that are at cross purposes, one being 100% open access any time, and then the other one being productivity...but how can you be utilizing 100% of your clinical time and then also be available for anybody that walks in?

Psychological resources. We define foundational *psychological resources* as the emotional and social components that can allow team members to interact productively. First, our participants noted the importance of mutual trust and respect among team members. The development of this trust and respect was attributed to several sources in our sample, including compatible team member personalities, time spent working

together, and perceptions that other team members had a strong work ethic. Others noted that establishing this type of trust and respect also required appreciation for the skills and training that each team member brought to the table (i.e., “each other’s skillset”). In contrast, trust and respect could break down if team members instead saw others’ approaches to clinical care as inappropriate. For example, one respondent described interdisciplinary tensions arising from differing viewpoints between psychologists and social workers. In this case, a clinical approach viewed as helpful by social workers was viewed as inappropriate by a psychologist:

You’re a social worker so you need to do this. I’m a psychologist, I’ve been trained a certain way and I’m not reaching out to this Veteran because I obey boundaries...So I think sometimes you need to put your training aside if [the clinical approach in question is] still appropriately clinically.

Second, psychological safety, or the ability to bring up mistakes or clinical problems without fear of retribution (Edmondson, 1999), was also highly prized among our respondents. In most cases, this was mentioned specifically in the context of discussing clinical cases (i.e., respondents noted the importance of developing a nonthreatening team meeting environment in which all team members are encouraged to provide clinical input). Along a similar vein, respondents noted that team conflict management skills were in turn required to support psychological safety.

Discussion

Key Findings in Context

We conducted in-depth qualitative interviews with 21 clinicians from three VA-based outpatient mental health teams (BHIPs) at two VA medical centers to determine the structures and processes that allowed them to achieve good team functioning despite low staffing ratios. To our knowledge, this is the first mixed-methods study to explicitly account for staffing ratios in identifying high-functioning mental health teams, potentially enhancing generalizability to other resource-constrained outpatient health care teams. Based on our results, Table 1 summarizes key findings in five resource domains, which represent an expansion of the three domains originally included in the first level of our conceptual framework, the Team Effectiveness Pyramid (Figure 1; Miller et al., 2018): material, staffing, temporal, organizational, and psychological.

Regarding material resources, respondents noted that having teams distributed across multiple floors or wings could make it difficult to establish effective teamwork, especially if clinicians were grouped by disciplines rather than team membership. This is consistent with models of team-based care in other outpatient health care settings (Pomerantz & Sayers, 2010). We note that our interviews took place well before the COVID-19 pandemic; it is likely that the transition of many outpatient mental health teams to distributed work environments and virtual modalities will result in decreased emphasis on shared space and in-person meetings, accompanied by increased reliance on technology to enhance remote

teamwork. Thus, telehealth equipment and bandwidth capacity may represent crucial material resources moving forward.

Regarding staffing resources, some interview respondents noted the value of consolidating small teams into larger ones to allow redundancy in disciplinary representation (e.g., at least two psychologists per team). Such structure provided some buffer against staff transitions, which are all too common in mental health treatment settings (Baker, 2001). Redundancy in team membership, however, may come with associated costs as larger teams may be more unwieldy or prone to conflict (Mueller, 2006). Thus, teams must be small enough to work well together, but large enough to include the necessary expertise. Facilitated connections outside the team (e.g., Wagner et al., 1996) can help ensure that smaller, more nimble teams have access to the skills and resources needed to function well. Regarding temporal resources, interview respondents noted that carving out time for team meetings was difficult given their caseloads. Leadership support for team time, combined with flexibility (i.e., the ability to meet for less than the full meeting time, allowing time for writing notes or other administrative tasks), was highly valued.

We particularly note three dialectics within the realm of foundational organizational resources, all of which are related to the pivotal step of establishing shared goals for the team (Gittell et al., 2000). First, interview respondents noted a tension between prioritizing new versus established patients. That is, to what extent should the team prioritize getting new patients “in the door” versus scheduling ongoing sessions for patients already engaged in care with the team? This decision can have profound implications for the team’s scheduling practices. For example, prioritizing access for new patients may involve incorporation of “advanced access” appointment slots for intakes (Rose et al., 2011). Second, to what extent should the team prioritize shared caseloads within the team versus matching patients to clinicians based on individual expertise? Having shared caseloads within the team reduced the extent to which team members had to coordinate with clinicians from other outpatient mental health teams. But prioritizing the individual match between clinician and patient (regardless of team membership) could potentially improve clinician morale and patient satisfaction. Third, interview respondents noted that tensions could arise in the context of matrix reporting structures (Westphal, 2005) featuring staff reporting both to a team leader and a discipline chief (e.g., Chief of Psychiatry). This could be particularly difficult if the discipline chief was seen as not valuing the delivery of team-based mental health care. Our interview results suggest that establishing high-functioning outpatient mental health teams in the context of low staffing ratios may require attending to these tensions in priorities explicitly.

Regarding psychological resources, interview respondents echoed findings from other studies regarding the importance of mutual trust and respect (Gittell et al., 2000) as well as psychological safety (Edmondson, 1999). These factors were described not just as preconditions for effective teamwork, but rather as things that required sustained commitment and—when disagreements arose—robust conflict management skills. Establishing these preconditions when team interactions are

primarily virtual (Traylor et al., 2021) is likely to be challenging, but no less crucial.

Limitations

First, we could not obtain team-level clinical outcomes for defining high-functioning teams, such that we defined high team functioning in terms of staff satisfaction, low burnout, and low turnover intentions. However, these variables have been strongly associated with team-level outcomes previously (Hall et al., 2016). Second, our team selection relied in part upon administrative data that (a) were analyzed at the clinic level rather than the team level and (b) have not been validated against clinical outcomes (e.g., Boden et al., 2018). To counteract this, we validated our team selection through conversations with mental health chiefs at the identified clinics, although a more robust team selection method may have identified different teams to recruit. Third, our qualitative results are based on relatively brief interviews with a modest number of BHIP teams at two VA medical centers, and we did not include a comparison group of teams with low team functioning. Results may therefore not generalize to mental health teams in other settings, although many of our findings are consistent with past research on health care team functioning (e.g., Mitchell et al., 2012).

Practice Implications

In this study, we identified several salient resource domains (material, staffing, temporal, organizational, and psychological) for achieving high team functioning in outpatient mental health clinics with low staffing ratios. We undertook this study because much of what we know about health care teamwork is derived from teams whose success may be attributable in part to abundant staffing. Future research is needed to test the applicability of our results to other teams with high case-loads who may be most in need of assistance. Ideally, such studies will obtain perspectives from numerous stakeholders (e.g., clinicians, support staff, and administrators) across a variety of clinical settings. Such research will also ideally collect patient-level outcome data and include “control” teams (e.g., teams with low team functioning) to minimize threats to internal and external validity.

We also identified important tensions for building teams in these environments. These include prioritizing new versus established patients, prioritizing shared caseloads versus matching patients to providers based on clinical expertise, and prioritizing team goals versus discipline-specific goals in the context of matrix reporting structures. These issues are relevant to establishing shared team goals (Gittell et al., 2000): In the context of low staffing ratios, discrepancies in these domains may be particularly damaging to health care teams as team members end up working at cross-purposes rather than in concert.

Moving forward, it is likely that several interrelated factors will increase the importance of teamwork in the context of low staffing ratios. First, projections suggest that many settings will face ever more pressing staffing shortages (Cohen, 2009). Second, there is a relative paucity of research on developing health care teams in nonacute settings (Miller et al., 2018). Third, chronic conditions, for which the bulk of treatment

may be delivered on an outpatient basis, are responsible for an increasing share of health care costs (Thorpe & Howard, 2006). Fourth, the transition of many teams to distributed or virtual formats may continue beyond the current COVID-19 pandemic; the implications of this transition for health care teamwork are still emerging. Thus, there is an urgent need for further research on how to develop and maintain outpatient health care teams that can thrive despite low staffing ratios.

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