Processes that influence the evolution of family health teams

Judith Belle Brown MSW PhD   Bridget L. Ryan PhD

Abstract

Objective To identify the processes that influence the evolution of family health teams (FHTs).

Design Qualitative study using grounded theory methodology.

Setting Family health teams in Ontario.

Participants A total of 110 team members from 20 FHT sites in Ontario.

Methods Individual semistructured interviews were conducted and data were analyzed using initial coding, focused coding, and a constant comparison analysis.

Main findings The analysis illuminated the complex and diverse nature of the FHTs' evolutionary trajectories, which were influenced by 7 discrete but interrelated processes: sharing a common philosophy about teamwork; having effective leadership; respecting each other's scopes of practice; sharing the physical environment; including team activities; supporting conflict resolution; and managing change. The status of each site's evolution was categorized as evolving, progressing, or stalled.

Conclusion The concept of evolution by its very definition does not imply stasis, and as the data revealed, change is always on the horizon. This study revealed 7 processes that influenced team evolution, and these processes were observed to be either optimally applied or noticeably limited in their execution, irrespective of team composition or configuration. These processes can be extrapolated to other primary health care teams to facilitate team evolution.

Editor's key points

‣ Family health teams (FHTs) bring an interdisciplinary group of providers together, including family physicians and other primary care professionals, to improve access to and quality of care, achieve interdisciplinary teamwork, promote patient engagement, and support coordination of care. Now that it has been more than a decade since the inception of FHTs in Canada, this study sought to understand what processes influenced the evolution of FHTs.

‣ This study found 7 interrelated processes (eg, sharing a common philosophy about teamwork, having effective leadership) that promoted a team's evolution. If these processes were not part of a team's values or structure (eg, sharing the physical environment, supporting conflict resolution), its evolution was hindered. Failure in implementing these processes determined whether a team was evolving, progressing, or stalled in its evolution.

‣ It is common for teams to experience growing pains. This study's findings highlight actions (eg, holding social events, creating formal case resolution protocols) that might enhance team renewal.

Points de repère du rédacteur

▸ Une équipe de santé familiale (ESF) regroupe des soignants de plusieurs disciplines comprenant des médecins de famille et d'autres professionnels des soins primaires; elle a pour buts de faciliter l'accès aux soins et d'améliorer leur qualité, de mieux travailler en équipe, de promouvoir la participation des patients et de faciliter la coordination des soins. Il y a maintenant plus de 10 ans que les ESF existent au Canada, et cette étude voulait connaître les facteurs qui influent sur leur évolution.

▸ Cette étude a identifié 7 facteurs interreliés qui facilitent l'évolution d'une équipe (par exemple partager la même philosophie concernant le travail en équipe et posséder un bon leadership). L'évolution d'une équipe est ralentie si certains facteurs, comme le fait de partager le même environnement ou de faciliter le règlement des conflits, ne font pas partie des valeurs ou du milieu de travail d'une équipe. Le fait d'adopter ou non de telles mesures déterminera si l'équipe évoluera vers une progression ou vers une stagnation.

▸ Il est fréquent qu'une équipe de santé familiale connaisse de plus en plus de problèmes. Les présentes observations suggèrent l'adoption de certaines mesures susceptibles d'améliorer le renouvellement d'une équipe, par exemple la tenue de rencontres sociales, l'élaboration de protocoles formels pour régler les conflits.

Les facteurs qui influent sur l'évolution des équipes de santé familiale

Judith Belle Brown MSW PhD   Bridget L. Ryan PhD

Résumé

Objectif Déterminer les facteurs qui influent sur l'évolution d'une équipe de santé familiale (ESF).

Type d'étude Étude qualitative utilisant la méthodologie de la théorie ancrée.

Contexte Des équipes de santé familiale de l'Ontario.

Participants Un total de 110 membres de 20 ESF situées en Ontario.

Méthodes On a utilisé des entrevues individuelles semi-structurées qui ont été analysées selon le codage initial, un codage sélectif et une méthode de comparaison continue.

Principales observations L'analyse a révélé la nature complexe et variée des modes d'évolution des ESF, qui étaient influencés par 7 processus distincts mais interreliés, c'est-à-dire le fait d'avoir la même philosophie du travail en groupe; de profiter d'un leadership efficace; de respecter les champs de pratique des autres membres; de partager le même environnement physique; d'offrir des activités d'équipe; d'être favorable à la résolution des conflits; et de bien gérer le changement. On a utilisé les termes suivants pour caractériser le stade d'évolution de chacun des sites : en évolution, en progrès ou en stagnation.

Conclusion Par sa définition même, le terme évolution suppose une absence de stagnation, et comme l'ont montré nos données, il y a toujours des changements à l'horizon. Cette étude a révélé que 7 facteurs influent sur l'évolution d'une équipe et que ces facteurs sont soit appliqués de façon suboptimale ou encore utilisés de façon incomplète, et ce, quelle que soit la configuration ou la composition de l'équipe. L'extrapolation des mêmes processus à des équipes de santé primaire pourrait être utile à leur propre évolution.

Across Canada, in response to primary care reform, a variety of primary health care (PHC) models have been developed.[1] One model of primary care is interprofessional family health teams (FHTs), which was initially launched by the Ministry of Health and Long-Term Care in Ontario in 2005. Now numbering almost 200, FHTs provide care for more than 3 million Ontarians, approximately 22% of the provincial population.[2,3] The goals of FHTs are intended to be achieved by bringing together an interdisciplinary team of providers including family physicians and other primary care professionals, most commonly nurses, nurse practitioners, social workers, dietitians, and pharmacists, as well as administrative support staff.[4] These goals include improving access to and quality and comprehensiveness of care; achieving interdisciplinary teamwork; promoting patient engagement; and supporting integration and coordination of care.[4]

Since their implementation, specific attributes of FHTs have been evaluated, such as access to care, integration of care, and coordination of services.[5] However, it is now more than a decade since their inception and we still need an understanding of the evolutionary process of FHTs.

Theories pertaining to the processes by which teams evolve have a long history.[6] Perhaps best known is the seminal work of Tuckman and Jensen, who described the now-classic stages of group development: forming, storming, norming, performing, and adjourning.[7] In recent years, the literature on how interdisciplinary PHC teams develop and function has increased.[8-12] Specific elements contributing to effective team functioning in PHC have included communication, scope of practice, leadership, conflict resolution, and the role of an optimal physical environment[10,11,13-16]; and many of these elements have been examined in the context of FHTs.[17-21] The goal of this study was to identify the processes that influenced the evolution of FHTs.

—— Methods ——

Study design and participants
This study used grounded theory to explore the processes that influenced the evolution of FHTs in Ontario, as this methodology has the potential to reveal social processes.[22]

Twenty FHT practices were recruited to reflect maximum variation in terms of location across the province of Ontario, as well as different health professionals and practice configurations (**Table 1**). The FHTs were recruited by an administrative staff member supported by the Ontario College of Family Physicians. The interview participants (N=110) were recruited from each of the 20 participating practices, reflecting the overall team composition (**Table 1**).

Data collection
We conducted a semistructured interview with each participant. Participants were asked about what made their teams work, how they sustained and built their teams, and how their teams responded to change and new ideas. Interviews were conducted in a private room at the practice. The interviews were 30 to 40 minutes in length and were audiorecorded and transcribed verbatim. Although saturation was achieved by the time of interview completion at the 12th site, we were committed to complete data collection and analysis for all 20 sites to ensure geographic variation.

Data analysis
Data collection and analysis occurred simultaneously, following an inductive, iterative process. Data were analyzed using 2 steps specific to grounded theory methodology: initial coding and focused coding as outlined by Charmaz.[22] First, each transcript was independently reviewed and coded by the researchers to determine the key concepts emerging from the data. Second, the researchers then met to examine their independent coding, culminating in a consensus that informed the development of the coding template. The final iteration of the analysis used focused coding to generate summaries for each main theme with exemplar quotations. A constant comparison analysis was conducted to identify processes that influenced the evolution of the FHTs.

Table 1. Participant (N 110) and site (N 20) characteristics	
CHARACTERISTICS	**VALUE**
Participants	
Mean (SD) age, y	41 (11.6)
Mean (SD) time in current position, y	5.5 (6.7)
Sex, n (%)	
• Male	21 (19.1)
• Female	89 (80.9)
Professional affiliation, n (%)*	
• Family physician	28 (25.5)
• Nursing professions	28 (25.5)
• Administrative staff†	25 (22.7)
• Interprofessional providers‡	29 (26.4)
Sites	
Range of time as FHT, y	<1 to 8
Range in no. of team members	9 to 80

FHT family health team.
*Percentages do not add to 100% owing to rounding.
†Examples of administrative staff include executive director and administrative assistant.
‡Examples of interprofessional providers include social worker, dietitian, and pharmacist.

Subsequently, a matrix was developed for each process to help determine the status of each FHT's evolution as an interdisciplinary team; evolution status was categorized as evolving, progressing, or stalled. Data were organized using NVivo 10 software.

The trustworthiness and credibility of the analysis were ensured by the following: audiotaped and verbatim transcripts; independent and team analysis; memo writing; and detailed field notes. In a commitment to reflexivity, we considered how our professional backgrounds, particularly in how the data were coded and interpreted, could influence the findings.[23]

Ethics approval was received from the Health Sciences Research Ethics Board at Western University in London, Ont. Informed consent was received from each participant before the interview began.

—— Findings ——

The analysis illuminated the complex and diverse nature of the FHTs' evolutionary trajectories, which were influenced by 7 discrete but interrelated processes: sharing a common philosophy about teamwork; having effective leadership; respecting each other's scopes of practice; sharing the physical environment; including team activities; supporting conflict resolution; and managing change. These processes were found to be common across all teams, irrespective of team composition, configuration, or size.

The status of each practice's evolution as an interdisciplinary team was categorized as evolving, progressing, or stalled. Teams that were categorized as evolving demonstrated mastery and implementation of all 7 processes. Teams that were categorized as progressing endorsed the 7 processes but were varied in their execution. Teams that were categorized as stalled had substantial difficulties in adopting and implementing any of these 7 influential processes. The following discussion examines each of the 7 processes in more detail with participant quotations (site [S] number, participant [P] number) illustrating how these processes, if applicable to the team's structure, were demonstrated in evolving, progressing, and stalled teams.

Sharing a common philosophy about teamwork. A central value among evolving teams was sharing a common philosophy about teamwork that was both articulated and enacted. This was apparent when team members expressed pride in their team and had common goals. As one participant described, "We're proud to be part of this team. We want to provide excellent service, excellent care, excellent teamwork. We're all on the same page. We all have the same goals." (S5, P27)

For many evolving teams, part of their evolution was moving from an individual to a collective mindset: "People working together rather than sort of in parallel play. They're kind of in the same sandbox now working together, building the same sand castle as opposed to each building their own." (S6, P45)

If a team was perceived to be physician-centric and operating more from a referral model rather than a collaborative model, team evolution did not progress as much as it might. One participant indicated that they were using "a referral model right now, most definitely, so the physician will refer to the dietitian, or refer to … the social worker. It works but we could do it a little better." (S10, P51)

Therefore, an essential component of the evolutionary process was securing physician buy-in as articulated by a physician on an evolved team. "If these teams are going to work … we do need to have physician buy-in." (S12, P66)

Having effective leadership. The style and configuration of leadership varied widely across teams. Nonetheless, leadership was a prominent theme articulated by all the teams with regard to team evolution. Effective leadership was most evident when leaders promoted shared philosophies and common values. For example, "If the leader can establish a great culture and you have that trust and sharing, and a common vision then, then you can overcome anything, right?" (S13, P72)

Leaders on both progressing and evolving teams were inspirational and respected for their direction: "I appreciate their vision …. They're very encouraging and inspiring to work with." (S4, P24)

However, leadership style could also considerably influence a team's stalled evolution. An autocratic stance left some team members feeling powerless to move forward as an interdisciplinary team: "When we started [the leader] very much told us that this is not a democracy, 'I'm in charge and there is no conflict resolution …. You take it the way it is or if you don't like it, you go.'" (S19, P102)

When leadership was absent, team members felt untethered and uncertain: "I think a gray area for people is the [lack of] leadership with regards to not knowing where to go." (S6, P33) Hence, some teams faltered in their progression or at worst stalled.

Respecting each other's scopes of practice. Sharing a common philosophy about teamwork, having effective leadership, and understanding and respecting each team member's scopes of practice were inextricably linked. Highly conducive to promoting an evolving team was understanding and respecting each team member's scope of practice. As one participant indicated, "The things that make it work are mutual respect and mutual understanding of one another's scope of practice, then trying to do what's best for patients." (S3, P17)

For some professionals, gaining respect for their scope of practice was particularly challenging, in part based on historical tensions, such as the relationship between nurse practitioners and family physicians.

If unresolved, team evolution could stall: "There was a bit of animosity between physicians and nurse practitioners. A bit of a turf war almost." (S10, P55)

However, when the family physicians understood and respected nurse practitioners' scopes of practice, team evolution progressed. One nurse practitioner explained: "I think [why a team works] is largely a function of everybody knows what everybody's role is …. The docs know what my capabilities are." (S7, P36)

Sharing the physical environment.   Team location varied across the 20 teams, with some teams being co-located while others were not. Evolving teams endorsed how co-location facilitated communication: "Having everyone altogether … it's really nice because you can get that face-to-face." (S13, P74)

Conversely, lack of co-location impeded team evolution and could result in the team becoming stalled. One participant explained the following when referring to the team members at a different site: "We just don't know them as well. Because we don't really see them that often so the communication is limited." (S1, P5)

Including team activities.   Both formal and informal activities facilitated team evolution. Evolving teams made administrative team meetings a priority: "We do have weekly meetings … that's a very effective strategy. It does take 2 hours of time once a week, which is sometimes tricky. But they've made it a very big priority to do this." (S12, P64)

A lack of formal meetings was most often observed in teams that were stalled in their evolution. For example, "I would say formally there probably aren't enough meetings. I think our last formal meeting was at least a year ago." (S8, P41)

When participants were asked about what sustains their team, evolving team members identified a variety of informal social activities, such as birthday celebrations and seasonal parties. When those who were part of progressing and stalled teams attempted to generate informal team-building activities, the results were disappointing. One team indicated they were "trying to do a few things. Unfortunately the barbecue last year was poorly attended." (S19, P102)

Supporting conflict resolution.   Participants in all teams reported experiencing conflict and acknowledged the importance of addressing conflict. As one participant described, "We've had a lot of conflict between people, whether it's personality issues or it's just been hard figuring out how to get going without having the conflict." (S7, P38)

However, what distinguished each team's position in the evolutionary process was how it resolved conflict. Several progressing and evolving teams had formal conflict resolution protocols, some of which translated into policy: "We've had a lot of conflict between people ….

We've tried to figure out what works for us. So we've actually had to put in a few different policies." (S7, P38)

Therefore, conflict resolution protocols were identified as important in facilitating team evolution: "It goes back to same-old basic collaboration characteristic or strategies around trusting people, talking to people, confronting issues with conflict." (S16, P87)

Some progressing teams had only informal conflict resolution strategies. One approach was to support team members in assuming personal responsibility for resolving conflict: "If they come and say we've got a problem, we try to empower them and say, 'You have to work it out and you've got to find the answer to this.'" (S1, P2)

A characteristic of stalled teams was having members who felt disempowered or who described issues of conflict in the following manner: "The barriers come when somebody can't see your point of view, or says they see it, but nothing changes." (S3, P16)

Managing change.   Participants from all the teams explained how change had been an inherent part of the evolutionary process: "Change has been so normal here that people are just sort of used to it …. There's just always changes." (S1, P3)

In evolving teams, change was both accepted and welcomed: "I think they [team members] embrace it because if they didn't embrace it they wouldn't be here. This is a wonderful place for people who like change." (S15, P83)

Members in progressing teams explained the challenges in managing change: "I think change is hard for everyone …. People are always scared of change." (S11, P58)

However, if the amount of change became overwhelming, some teams began to stall in their evolution:

> It's just been exhausting and people are a bit staggered yet continue to function …. So I think how we've managed to soldier on is just focusing on our strengths, not taking on more and just getting through. (S11, P57)

When leadership failed to encourage change, team evolution stalled: "I think from a leadership point of view, the team finds it frustrating … that the physician lead in particular feels certain changes … we don't need those here." (S19, P100)

— Discussion —

This study has advanced our understanding of how FHTs evolve by providing empirical evidence supporting 7 processes that specifically influence the evolutionary trajectory of PHC teams. In addition, 3 stages of team evolution have been proposed: evolving, progressing, and stalled. The concept of evolution by its very definition implies a lack of stasis—change is always on the horizon, as the data revealed. A key issue is how FHTs

can successfully negotiate this change to reach a higher level of team functioning.

The stages of team evolution presented in this article do have parallels with the stages of Tuckman and Jensen's model of group development: forming, storming, norming, performing, and adjourning.[7] Evolving teams would be those characterized in this model as at the performing stage. At the opposite end, stalled teams had not moved beyond the forming and storming stages. Teams that were progressing in their evolution could experience an oscillation between the stages of norming and performing. The teams in this study might not fit the classic description of *norming* because they are not expected to reach homeostasis. Teams will always be required to adapt to change, for example when new clinical practice guidelines are introduced, financial structures are altered, or transitions in staff composition occur. Furthermore, it would not be expected that a PHC team would in fact *adjourn*, described by Tuckman and Jensen as the final stage of team development.[7]

While PHC team evolution has been a subject of interest for almost 2 decades,[8,9,11] our study has identified 7 specific processes that contribute to team evolution: sharing a common philosophy about teamwork; having effective leadership; respecting each other's scopes of practice; sharing the physical environment; including team activities; supporting conflict resolution; and managing change. As we note below, there is literature describing the influence of these 7 processes on team effectiveness; however, our findings extend to how these processes influence team evolution. The teams we identified as evolving were those enacting all these processes, while teams who were stalled demonstrated very few of them. Teams that were progressing endorsed all 7 processes and movement toward achieving all.

A common philosophy of teamwork was foundational to the evolutionary process experienced by teams. Having a common philosophy has been articulated as sharing a similar vision for the team and having common goals regarding teamwork.[24] Leadership was fundamental in the evolutionary process in supporting the values and beliefs of teamwork. Other studies have also highlighted the pivotal role of leadership in PHC teams.[15,16,18,24,25] Strong leadership was also essential in promoting the adoption of other team members' full scope of practice, which was an important feature of evolving teams; it can be challenging for team members to understand others' scopes of practice, recognize how their competencies can be used, and learn to trust each other's skills.[26]

Sharing the physical environment, which was defined as the opportunity for co-location and allocation of space that facilitated team interaction, contributed to team evolution. The role of the optimal physical environment is receiving growing attention in the area of PHC teams.[16,17] Opportunities for formal and informal team activities were valued as encouraging evolution

as an interdisciplinary team. The importance of sustaining activities (eg, team meetings, social events) has been cited previously but not directly related to team evolution.[27,28] With the substantial changes experienced by FHTs over their short history, supporting conflict resolution strategies and adapting to change were influential in a team's ability to successfully evolve. Adapting to change and creating conflict resolution strategies have been described as important for effective teamwork.[14,18,25]

Limitations and future research

The data were collected at one point in the teams' history and therefore we were unable to fully observe each team's process of evolution. Further, given the scope of the mixed-methods study, we were unable to interview participants more than once to expand the theoretical sample. While the data in this study were collected in only 1 province, there was wide geographic variation across the province.

Future research could use ethnographic methodology allowing for a more intense and prolonged engagement. This would allow direct observation of teamwork in order to examine specific processes and activities rather than relying solely on data from individual interviews. One could speculate that the highest form of evolution is when the 7 processes are no longer discrete but interwoven; perhaps future research should explore this.

Conclusion

This study has illuminated the salience of the 7 processes influencing team evolution. These processes were observed to be either optimally applied or noticeably limited in their execution, irrespective of team composition, configuration, or size. We believe these processes can be extrapolated to other PHC teams to facilitate their evolution. The identification and elucidation of these 7 processes offer both novice and maturing teams concrete tasks and functions to facilitate their evolution. Similarly, the data revealed how failure in implementing these processes can impede progress or stall a team's evolution. This information provides practical solutions that address the growing pains some teams might experience and suggestions for enhancing team renewal. ✿

Dr Brown is Professor and Chair of the MClSc and PhD programs in the Centre for Studies in Family Medicine in the Department of Family Medicine at the Schulich School of Medicine and Dentistry at Western University in London, Ont, and Professor at the School of Social Work at King's University College in London. **Dr Ryan** is Assistant Professor in the Centre for Studies in Family Medicine in the Department of Family Medicine and the Department of Epidemiology and Biostatistics at the Schulich School of Medicine and Dentistry at Western University.

Contributors
Drs Brown and Ryan contributed to the concept and design of the study; data gathering, analysis, and interpretation; and preparing the manuscript for submission. Both

authors meet the 3 authorship criteria of the International Committee of Medical Journal Editors.

Correspondence
Dr Judith Belle Brown; e-mail **jbbrown@uwo.ca**

References

1. Hutchison B, Levesque JF, Strumpf E, Coyle N. Primary health care in Canada: systems in motion. *Milbank Q* 2011;89(2):256-88.
2. Hutchison B, Glazier R. Ontario's primary care reforms have transformed the local care landscape, but a plan is needed for ongoing improvement. *Health Aff* (Millwood) 2013;32(4):695-703.
3. Ontario Ministry of Health and Long-Term Care [website]. *Family health teams*. Toronto, ON: Ontario Ministry of Health and Long-Term Care; 2016. Available from: **www.health.gov.on.ca/en/pro/programs/fht/**. Accessed 2018 May 7.
4. Association of Family Health Teams of Ontario [website]. *Value of primary care teams*. Toronto, ON: Association of Family Health Teams of Ontario; 2018. Available from: **www.afhto.ca/teams/value-of-primary-care-teams/**. Accessed 2018 May 22.
5. Ashcroft R. Inadequate performance measures affecting practices, organizations and outcomes of Ontario's family health teams. *Healthc Policy* 2014;10(1):86-96.
6. Tuckman BW. Developmental sequence in small groups. *Psychol Bull* 1965;63:384-99.
7. Tuckman BW, Jensen MA. Stages of small-group development revisited. *Group Organ Stud* 1977;2(4):419-27.
8. Payne M. *Teamwork in multiprofessional care.* Chicago, IL: Lyceum Books Inc; 2000.
9. Drinka TJK, Clark PG. *Health care teamwork: interdisciplinary practice and teaching*. Westport, CT: Greenwood Publishing Group; 2000.
10. Craigie FC Jr, Hobbs RF 3rd. Exploring the organizational culture of exemplary community health center practices. *Fam Med* 2004;36(10):733-8.
11. Grumbach K, Bodenheimer T. Can health care teams improve primary care practice? *JAMA* 2004;291(10):1246-51.
12. Lemieux-Charles L, McGuire WL. What do we know about health care team effectiveness? A review of the literature. *Med Care Res Rev* 2006;63(3):263-300.
13. Brown JB, Lewis L, Ellis K, Stewart M, Freeman TR, Kasperski MJ. Mechanisms for communicating on primary health care teams. *Can Fam Physician* 2009;55:1216-22.
14. Brown J, Lewis L, Ellis K, Stewart M, Freeman TR, Kasperski MJ. Conflict on interprofessional primary health care teams—can it be resolved? *J Interprof Care* 2011;25(1):4-10. Epub 2010 Aug 26.
15. Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. The 10 building blocks of high-performing primary care. *Ann Fam Med* 2014;12(2):166-71.
16. Harris MF, Advocat J, Crabtree BF, Levesque JF, Miller WL, Gunn JM, et al. Interprofessional teamwork innovations for primary health care practices and practitioners: evidence from a comparison of reform in three countries. *J Multidiscip Healthc* 2016;9:35-46.
17. Oandasan IF, Conn LG, Lingard L, Karim A, Jakubovicz D, Whitehad C, et al. The impact of space and time on interprofessional teamwork in Canadian primary health care settings: implications for health care reform. *Prim Health Care Res Dev* 2009;10(2):151-62.
18. Goldman J, Meuser J, Roger J, Lawrie L, Reeves S. Interprofessional collaboration in family health teams. An Ontario-based study. *Can Fam Physician* 2010;56:e368-74. Available from: **www.cfp.ca/content/cfp/56/10/e368.full.pdf**. Accessed 2018 May 7.
19. Gotlib Conn L, Oandasan IF, Creede C, Jakubovicz D, Wilson L. Creating sustainable change in the interprofessional academic primary care setting: an appreciative inquiry approach. *J Res Interprof Pract Educ* 2010;1(3):284-300.
20. Howard M, Brazil K, Akhtar-Danesh N, Agarwal G. Self-reported teamwork in family health team practices in Ontario. Organizational and cultural predictors of team climate. *Can Fam Physician* 2011;57:e185-91. Available from: **www.cfp.ca/content/cfp/57/5/e185.full.pdf**. Accessed 2018 May 7.
21. Brown JB, Ryan BL, Thorpe C, Markle EK, Hutchison B, Glazier RH. Measuring teamwork in primary care: triangulation of qualitative and quantitative. *Fam Syst Health* 2015;33(3):193-202. Epub 2015 Mar 2.
22. Charmaz K. *Constructing grounded theory. A practical guide through qualitative analysis.* Thousand Oaks, CA: Sage; 2014.
23. Malterud K. Qualitative research: standards, challenges, and guidelines. *Lancet* 2001;358(9280):483-8.
24. Harris SB, Green ME, Brown JB, Roberts S, Russell G, Fournie M, et al. Impact of a quality improvement program on primary healthcare in Canada: a mixed-method evaluation. *Health Policy* 2015;119(4):405-16. Epub 2014 Nov 5.
25. Gocan S, Laplante M, Woodend K. Interprofessional collaboration in Ontario's family health teams: a review of the literature. *J Res Interprof Pract Educ* 2014;3(3):1-19.
26. Kotecha J, Brown JB, Han H, Harris SB, Green M, Russell G, et al. Influence of a quality improvement learning collaborative program on team functioning in primary healthcare. *Fam Syst Health* 2015;33(3):222-30. Epub 2015 Mar 23.
27. Freeth F. Sustaining interprofessional collaboration. *J Interprof Care* 2001;15(1):37-46.
28. Brown JB, Lewis L, Ellis K, Beckhoff C, Stewart M, Freeman TR, et al. Sustaining primary health care teams: what is needed? *J Interprof Care* 2010;24(4):463-5.