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Jennifer E. Lape

Chatham University, jlape@chatham.edu

Brian D. Scaife

West Virginia University, bscaife@hsc.wvu.edu

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Use of the KAWA Model for Teambuilding with Rehabilitative Professionals: An Exploratory Study

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Author Bio(s)

Jennifer E. Lape, OTD, OTR/L is an Assistant Professor of Occupational Therapy at Chatham University in Pittsburgh, Pennsylvania. She is a licensed occupational therapist in the state of Pennsylvania.

Brian D. Scaife, OTD, OTR/L is an Assistant Professor of Occupational Therapy at West Virginia University in Morgantown, West Virginia. He is a licensed occupational therapist in both Pennsylvania and West Virginia.



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Jennifer E. Lape, OTD, OTR/L¹
Brian D. Scaife, OTD, OTR/L²

1. Chatham University
2. West Virginia University

United States

Abstract

Purpose: The KAWA model, a culturally-sensitive model of occupational therapy practice, can enhance patient-provider collaboration, but its use as a tool for teambuilding and collaboration among an interprofessional group has not been studied. Teambuilding has been positively correlated with job satisfaction and quality of client care. The purpose of this exploratory qualitative study was to identify potential uses of the KAWA model and areas for future research related to teambuilding. **Method:** Trainings on the model, including a review of model components, its potential utility with clients, and an interactive activity, were provided to two rehabilitative teams (N=26) within two skilled nursing facilities. **Results:** Focus groups were conducted and analysis of the discussions revealed 4 potential applications of the model: 1) as a teambuilding tool to build team cohesiveness/morale; 2) as a tool to address performance issues with individual team members; 3) as a tool for conflict resolution among multiple team members; and 4) as a means to address workplace challenges external to the team itself. **Conclusions & Recommendations:** Teambuilding in healthcare settings can benefit both clients and rehab professionals, and the KAWA model may be an effective tool for this purpose. Limitations include a modest sample and interpreter bias; however, this study provides a foundation for future research on the KAWA model related to teambuilding and interprofessional collaboration.

INTRODUCTION

Background & Literature Review

The KAWA model is a conceptual model of practice developed by a group of Japanese occupational therapists in order to address client performance from a more culturally sensitive perspective.¹ The model uses a metaphor of nature, specifically that of a river, to focus on the synchronization of the client within his or her contexts or environment. According to the Occupational Therapy Practice Framework, contexts can include both internal and external factors that can support or hinder one's occupational performance.² In addition to the physical and social environment, it is critical to examine the cultural, personal, temporal, and virtual contexts when there is a gap in occupational engagement or satisfaction.²

The use of the KAWA model in treatment often involves guiding the client to draw a river that represents his or her life. Various elements of the river have symbolic meaning. In a most simplistic explanation, a river originates from the mountains, which symbolizes birth or life's beginning, and flows along life's journey, until it empties into the sea, which symbolizes death. The banks of the river represent one's social and physical environments, or contexts and examples might include one's family and friends or the physical environment of one's home or community. Ideally, these external elements would support and guide the client through difficult times just as the banks of the river support its flow. Rocks are placed throughout the river to represent problems, issues, or challenges. The location and size of the rocks can suggest the timing of these events as well as a client's perception of them. Larger rocks are used to indicate issues that cause greater disruption in life, whereas smaller rocks might indicate more routine or daily challenges. Finally, driftwood can be added to the illustration. Driftwood is used to embody one's strengths and weaknesses, such as having good interpersonal skills or a special talent, or being detail-oriented or stubborn. In action, the driftwood (internal strengths or weaknesses) can positively or negatively impact life's flow. The goal is to use the positive aspects of the environment,

social supports, and personal strengths (river banks and driftwood) to bump the rocks (problems or issues) out of the way, allowing the river or life flow to continue unabated.

In application of the model, the river is created by the client and is symbolic of his or her life. Through this process, the model provides a platform to explore life's problems, to discuss support systems, and to brainstorm effective methods of problem resolution. The interaction of all elements of the model is viewed collectively to determine levels of intervention. Use of the KAWA model promotes self-discovery and ownership of one's destiny. Studies to-date on the KAWA model have focused largely on its application to recipients of healthcare services, or on therapists' perceptions of use of the model with clients.³⁻⁶ Several theoretical articles on the model have also been published as well as a comprehensive book.⁷⁻¹⁰

The KAWA model has been found to enhance patient-provider collaboration, but literature does not address whether the model could be an effective tool for teambuilding and collaboration among an interprofessional group.³⁻⁶ For the purposes of this study, a team is defined as "a small number of people with complementary skills who are committed to a common purpose, set of performance goals, and approach for which they hold themselves mutually accountable."¹¹ Furthermore, teambuilding is described as a set of strategies used to improve interpersonal relations, achieve goals and tasks, and address problems.¹²

In today's ever-changing healthcare environment, retention of healthcare professionals and teambuilding among interprofessional groups are of paramount importance. Teambuilding has been positively correlated with job satisfaction, and quality of client care.¹³⁻¹⁸ Conversely, a lack of teamwork can lead to decrease morale/job satisfaction, decreased productivity and lost revenue, and decreased client satisfaction and quality of care.^{12,13,19}

Differing roles and responsibilities, educational backgrounds, and the values and beliefs of each professional on the team can impact team cohesion and the ability to work together.^{20,21} Just as a particular religious or ethnic group develops its unique culture, or "set of shared attitudes, values, goals, and practices," so does each profession.²² Effective interprofessional collaboration requires an understanding of the roles of other professionals, good communication, mutual respect, and resolution of conflict or tensions among the team.^{21,23,24} While the benefits of teambuilding and collaborative practice are clear, the best approach or tool for this purpose is not. The purposes of this exploratory study are to 1) Investigate perceptions of groups of rehabilitative professionals on use of the KAWA model, 2) Determine ways in which an interprofessional group could use the KAWA model to promote teambuilding and collaboration and 3) Identify potential areas for future research on the KAWA Model related to interprofessional collaboration and teambuilding.

METHOD

Study design

An exploratory qualitative design was chosen to explore this topic, since exploratory research "tends to tackle new problems on which little or no previous research has been done."²⁵ An exploratory study, as the name implies, aims to explore a topic to generate new insights, ideas, or understanding, but seldom results in definitive conclusions. Instead, these studies, which frequently employ qualitative methods including focus groups or informal discussions with participants, can be helpful in determining the methodology for later, more conclusive studies.²⁶ In contrast, a pilot study is used to develop larger-scale clinical trials, and typically assesses the feasibility of sampling methods, study methodology, and data analyses, as well as estimating resources necessary to successfully conduct future research.²⁷ As discussed previously, research on the KAWA model to date has been limited, and no prior studies have explored use of this model for teambuilding or interprofessional collaboration. The goal of this study was to generate potential uses of the model related to teambuilding and collaboration to provide a foundation for future pilot studies; therefore, an exploratory design, rather than a pilot study, was most appropriate for the aforementioned goals.

Study Participants

Subjects for this study included 26 members of two interprofessional rehabilitative teams (12 subjects from Team A and 14 subjects from Team B) at two different skilled nursing facilities recruited through convenience sampling. All subjects were full time employees with a contract therapy provider in Pennsylvania, United States, at the time when the data were generated. Subjects held one of the following positions on the rehab team: occupational therapist, occupational therapy assistant, physical therapist, physical therapy assistant, speech language pathologist, or rehabilitation aide. Subjects at both facilities participated in separate trainings on the KAWA model, given by both investigators, as part of a staff meeting and regular staff training. The distribution of subjects by team and professional job title is included in Table 1. While the distribution of subjects among disciplines varied, this distribution accurately reflected rehabilitation staffing trends in nursing facilities at the time, with larger numbers of occupational therapy and physical therapy practitioners employed as compared to speech language pathologists and rehabilitation aides. The investigators felt it was important for the trainings to emulate a typical rehabilitation team; thus, these two naturally occurring teams were recruited for participation.

Table 1: Distribution of Subjects by Team & Professional Job Title

Professional Job title	Number of Subjects from Team A	Number of Subjects from Team B	Total by Professional Job Title
Occupational Therapist	1	2	3
Occupational Therapy Assistant	3	3	6
Physical Therapist	1	2	3
Physical Therapy Assistant	3	3	3
Speech Language Pathologist	2	2	4
Rehabilitation Aide	2	2	4
TOTAL Team Members:	12	14	26

Procedures

Two separate trainings on the KAWA model were provided to the rehabilitative teams at two skilled nursing facilities by both investigators. The trainings lasted between 1 and 1.5 hours and occurred as part of a regularly scheduled training during a monthly staff meeting. The trainings were conducted one week apart. During the training, team members were educated on the components of the KAWA model and how the model could be used in practice with clients. All team members were guided to create their own KAWA model, a visual representation/drawing of their lives based upon the metaphor of a river, which highlights their personal and professional histories and goals. Following this activity, the investigators facilitated group discussions focused on perceptions of the model, its utility with clients, and its potential for use as a teambuilding tool. The guiding questions used in both focus groups can be found in Table 2.

A focus group was the most appropriate method for data collection because the investigators wanted to solicit perceptions and brainstorm new ideas regarding the KAWA model.²⁸ The group format also promotes richer content because participants can share their own ideas as well as reflect on the ideas shared by others.²⁹ The guiding questions for the focus group were developed to promote optimal participation from the subjects and followed the progression of engagement, exploration, and exit questions.²⁹ Initially, engagement questions, or introductory questions, were designed to facilitate comfort with participation and sharing in the group. Then, exploration questions were used to elicit responses directly related to the study objectives, and finally, an exit question was provided to ensure participants had the opportunity to share any remaining thoughts or ideas.³⁰

Table 2: Guiding Questions for Focus Group Discussions

Type of Question	Question
Engagement	Was the KAWA model easy to understand?
Engagement	Did you enjoy constructing your own KAWA model?
Engagement	Would you like to share anything from your model with the group?
Exploration	How did you feel about your KAWA model? Did the activity provide any insights?
Exploration	How might this process/model be useful with a client?
Exploration	How might this process/model be useful to us as a professional team?
Exit	Is there anything else you would like to share regarding the KAWA model today?

In their role as rehabilitation team managers, the investigators took minutes during each training and subsequent focus group discussion. Separate minutes were maintained for each training/discussion and included perceptions, comments, and suggestions generated by all members of each group, with no identification of individual team members. The same process for notetaking was used in each focus group, with the investigator assigned to that task recording the date of the group, the start and end time for the group, as well as the number and distribution of rehabilitation professionals by job title present. Each question from Table 2 was prepopulated into an electronic file, with adequate space to record keywords or phrases expressed by the participants, important concepts or ideas shared, and non-verbal cues such as head nodding/shaking, eye rolling, or laughter during the discussion.

The first investigator conducted the training and group discussion with Team A, while the second investigator transcribed minutes during this time. For the Team B training, the investigators switched roles, with the second investigator conducting the training and group discussion, and the first investigator recording minutes. While audio recording focus groups can improve rigor in qualitative research, the investigators made the conscious decision not to do so, since this would have deviated significantly from the established norms during typical staff meetings and trainings at both facilities. Trainings and group discussions on a variety of

topics occurred regularly and the investigators felt a change in procedures, or having someone other than the rehabilitation team managers conduct the training/discussion, could hinder the participants' willingness to freely share and discuss uses of the KAWA model. To further clarify, the first investigator served as the rehabilitation team manager for Team A, while the second investigator served as the manager for Team B; in these roles, each investigator conducted the training for his or her own team, as was typical practice at the time, with the opposing investigator recording minutes in an effort to decrease the team manager's bias. The study was approved by the institutional review board at Chatham University.

Data Analysis

Data were analyzed inductively through constant comparative analysis.^{31,32} Open coding was used to compare notes from each training and focus group discussion and to develop and appropriately label provisional categories; the categories were not predefined, but rather they were derived from the notes through inductive reasoning. To develop the coding (category) scheme, each investigator individually coded data from the Team A training by placing similar data together within its identified category and creating a new category when data represented a dissimilar topic or idea. Both investigators used memos during this process to further describe categories and concepts. Following this individual coding, the investigators met to discuss the provisional categories and their related properties. Only minor discrepancies in theme identification were noted and were primarily related to the labeling of the categories or their relationship to one another. After further discussion and review of the data and memos, consensus was reached regarding the final coding scheme. The same process was repeated with the data resulting from the Team B training. Finally, emergent themes from both trainings were compared, contrasted, and refined collaboratively by the investigators with the aim of reconstructing the perspectives of the study participants. By simultaneously coding and comparing the data, categories were identified, refined, and integrated, resulting in five broad themes related to application of the KAWA model. Trustworthiness was improved by use of multiple coders in the data analysis, and triangulation was achieved via use of two distinct focus groups with independent data analysis of content from each group.³³ Member checking was accomplished by sharing the resultant themes with two randomly selected team members from each training (four members total) for feedback.³² All four members agreed that the themes accurately represented the information conveyed in the focus group discussions.

RESULTS

Five themes emerged from analysis of the focus group data related to the research objectives. Emergent themes include:

1. Positive perceptions of the KAWA model by team members
2. Use of the KAWA model as a teambuilding tool
3. Use of the KAWA model to address performance issues
4. Use of the KAWA model for conflict resolution
5. Use of the KAWA model to address workplace challenges

Theme 1: Positive Perceptions of the KAWA Model by Team Members

The participants reported that during the sessions, they felt more comfortable sharing personal information with their co-workers. Several stated that they had a better understanding of their co-workers' goals, cultures, and past, and were more sympathetic to their personal issues. They described the session as a "non-threatening environment," and communicated that they felt a similar session would be beneficial for other departments in facility. For example, one participant disclosed that her spouse had recently lost his job and they were having difficulty paying bills. Another member of the group then offered information about a local company hiring per diem therapists. The members of the group appeared to have an increased understanding of each other's personal barriers and how they relate to the team performance, and embraced the process of supporting others.

In addition, many of the participants remarked that the use of the KAWA model with clients in the facility would be beneficial in planning treatment interventions. In both sessions, participants expressed an interest in learning more about the model to enable use with clients. They felt that by engaging their clients in a similar session, the clients would be more willing to discuss barriers to returning home and see more positive aspects of their current situations.

Theme 2: Use of the KAWA Model as a Teambuilding Tool

Both teams proposed the KAWA model as an effective tool to support staff teambuilding and collaboration and to decrease team member stress and burnout. Ideas generated focused on using the model collectively during staff in-service's to promote teamwork, and employee satisfaction and retention. One example of a teambuilding activity could include employing a large marker board or flip chart to create a departmental "river." All team members could contribute by suggesting supports and barriers to performance and problem solving solutions. Similar to the use of a SWOT analysis where teams brainstorm strengths, weakness, opportunities, and threats of organizational success, the KAWA model could allow members to collaborate positively. This could be especially helpful in departments where the staff come from diverse cultural, socioeconomic, and educational backgrounds. After the initial

activity, the model could be hung in an office or other central location, and used as a visual reminder of department goals and progress and the ongoing need for collaboration and teamwork to improve department success. This would also enable other departments and new staff members to visualize the department's goals.

Another alternative elicited during the group discussions involved members creating individualized KAWA models and sharing meaningful features with fellow team members. This could allow an increased understanding of each other's roles and personal and professional challenges. This approach might be especially useful in teams where increased dissension or decreased morale is noted.

Theme 3: Use of the KAWA Model to Address Performance Issues

Several ideas suggested by the teams centered around using the model with individual team members to address performance issues. The issue of poor staff performance is often a difficult one for managers or administrators to address, and most team members would agree that it is usually just as difficult to be on the receiving end of that type of message. For this reason, the KAWA model could be effective in allowing both the manager and rehab team member to come together to work through performance problems. Together, they could create a "river" model of the team member's work history and performance with the company. Employing this model could enable the manager to adequately recognize the team member's strengths, as well as additional supports that the manager, coworkers, or company may be able to provide to strengthen performance.

In this scenario, the team member is allowed time for self-reflection while issues are discussed in a non-threatening manner. With this approach, problem resolution is collaborative and takes the sole burden off of the team member. Furthermore, team members may be more willing to modify behaviors and actions if they feel the manager is supportive and invested in their success. During the focus group discussion, several team members also felt this could be an effective and positive approach to use with students completing residency or fieldwork rotations at the facilities.

Theme 4: Use of the KAWA Model for Conflict Resolution

Conflict resolution emerged as a potential use of the KAWA model during both focus group discussions. Team members suggested that a small group, perhaps including only two to four members, could each draw their own KAWA model to identify individual strengths, supports, and barriers in a non-threatening manner. Then a group discussion could follow, with individual team members sharing their own strengths, supports, and barriers, and noting the similarities and differences among the team. For this purpose, the group discussion would focus on the strengths of individual team members and how they could complement each other to decrease barriers and conflict, and to establish a positive and supportive working environment.

Theme 5: Use of the KAWA Model to Address Workplace Challenges

Finally, multiple team members recommended that the KAWA model be employed to promote accomplishment of work tasks when challenges arise. These professional challenges, which could occur internally or externally to the department, were defined as occurrences beyond the control of the department or team that may impede team success or client outcomes. Some example of internal challenges could include staff turnover, short staffing, lack of needed equipment, or budgetary concerns. Examples of external challenges might be regulatory changes, lack of reimbursement, or insurance denials.

To address these challenges, the team could collaboratively create a departmental river to identify department supports and strengths that could be used to positively impact identified barriers. Often these barriers produce a negative environment and can influence team morale, so applying the KAWA model might help frame these unavoidable professional challenges in a new light.

DISCUSSION

The intent of this study was to investigate perceptions of rehabilitative professionals on the usefulness of the KAWA model and to generate potential applications of the model related to teambuilding and collaboration to serve as a foundation for further model development. The rehabilitative professionals in this study overwhelmingly viewed the model in a positive light, stating they felt the model was easy to understand, helped them to focus on their positive attributes, and made them feel comfortable sharing personal information that they may not have shared in another context. Both teams of professionals were fairly cohesive and had worked together for a minimum of 2 years prior to participation in the study, yet multiple team members shared personal concerns and challenges during the activity that they had never shared before. Some of these comments were echoed in a prior study by Paxon et al, in which occupational therapists reported ease in using the model, and a richer, more open dialogue with clients.⁶ Similar to prior research, the majority of rehabilitative professionals in this study also saw value in using the model with clients within the skilled nursing facility.^{3,4,5,6}

In regard to the utility of the model related to teambuilding and collaboration, this study is the first to specifically explore this topic. In a prior study, occupational therapists applied the model to clients in a mental health unit and shared their assessments with members of the interdisciplinary team for feedback, but they did not formally assess the team's ability to collaborate related to the KAWA model.⁵ In the current study, the focus group discussions generated four potential uses of the model including using the model as a teambuilding tool, as a tool to address performance issues, as an approach to conflict resolution, and as a way to navigate workplace challenges.

Both teams felt the KAWA model inherently provided a common way of viewing a situation, person, group, or task, making it a well-suited tool for teambuilding and collaborative practice. Communication is cited throughout the literature as a key determinant of successful collaboration among professionals.^{20,21,23,24} Also, recall that a traditional teambuilding activity is designed to promote improved interpersonal relations, achievement of goals, and problem solving.¹² Not only did both groups of rehabilitative professionals feel the KAWA model would be effective for these three objectives, their participation in the training and focus group discussions was observed to positively impact the work culture and team morale well beyond the training. Both authors served as rehabilitation program managers and witnessed improved interpersonal relations among staff, richer collaboration during client care, and increased positivity related to challenges within the workplace or with clients. While the purpose of this study was to generate ideas related to application of the KAWA model for teambuilding and collaboration, positive changes in the behaviors and attitudes of study participants were an unexpected benefit which further supports use of the model for this purpose. Despite the differing backgrounds, personal circumstances, education, values, and beliefs of each team member, the KAWA model offered a common mode of communication which positively impacted the work culture.

Limitations

Several limitations should be acknowledged including use of a small convenience sample, investigator bias, and data collection methods. While the sample of 26 rehabilitative professionals drawn from two facilities and employed by the same contract company was appropriate for an exploratory study, the ability to generalize findings to other settings and locations is limited. Investigator bias is also a concern since both investigators served as rehabilitation team managers at the facilities where the study was conducted. Both had existing relationships with the study participants which could have impacted results, though in each training, the investigator who was not the team's manager was responsible for recording notes to minimize this impact. The lack of audio recording of the focus groups diminishes the rigor of the data collection methods; however, use of member checking helped to ensure resultant themes accurately reflected the sentiments of study participants and not those of the investigators. Finally, as is characteristic of exploratory studies, definitive conclusions cannot be drawn, but new insights are offered and the need for further research on the topic is evident.

CONCLUSION & FUTURE DIRECTIONS

Work "culture" can support or hinder teamwork and collaboration among professionals, which can ultimately impact quality of client care and job satisfaction. Regardless of differing roles, education, and values, rehabilitative professionals need to merge their individual cultures for positive work and life experiences. Occupational therapists have used the KAWA model to recognize and respond to cultural differences among clients, and this study suggests that the KAWA model may be an effective tool for teambuilding among professionals, as it provides a common way of viewing conflict, performance issues, and professional challenges. It is hoped that this study will motivate others to conduct further research applying the KAWA model for teambuilding and interprofessional collaboration. Suggestions for future research include studies that engage larger more diverse samples, those that incorporate other valued members of interprofessional teams beyond rehabilitative professionals, and studies that specifically explore one of the resultant themes described here.

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