

Does functional diversity increase effectiveness of community care teams? The moderating role of shared vision, interaction frequency, and team reflexivity

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Funding information

Dutch Taskforce for Applied Research [Nationaal Regieorgaan Praktijkgericht Onderzoek SIA], Grant/Award Number: Raak Publiek 2014-01-13M

Abstract

As interprofessional collaboration becomes more commonplace in health and social care, both scholars and practitioners are searching for ways to make the most out of functionally diverse teams. Earlier research has shown that the presence of different functional backgrounds may lead teams to perform better, because they have a larger pool of knowledge and experience to draw from. Other studies show, however, that functional diversity increases categorization, reduces team cohesion, and complicates interpersonal communication, thereby reducing performance. It remains unclear under which conditions positive or negative outcomes may occur. The present research tested the influence of functional diversity on team identity, team performance, and client satisfaction, and examined factors which may moderate these relationships. Based on earlier studies in this specific context, we focused on three team processes as possible moderators: shared vision, interaction frequency, and team reflexivity. In a survey among health and social care professionals working in community care teams in the Netherlands ($n = 167$), all three are shown to moderate the relationship between functional diversity and team effectiveness. In the absence of these processes, functional diversity appears to reduce team outcomes, whereas when these processes are present, the relationships are positive. In sum, in order for community care teams to reap the benefits of functional diversity, it is essential that members develop a shared vision, interact frequently, and practice team reflexivity.

KEYWORDS

community care, functional diversity, interprofessional collaboration, shared vision, team identity, team performance, team reflexivity

1 | INTRODUCTION

Interprofessional collaboration has become a high priority for health and social care professionals around the globe (WHO, 2010). For example, in the Netherlands, a shift in government policies has increased the need for locally organized community care teams, in which professionals from different functional backgrounds work together. The aim of such teams is to raise client satisfaction in community care, while simultaneously increasing cost-effectiveness (Rutte & Samsom, 2012; Ten Den, Hofhuis, & De Vries, 2015). Existing research shows that teams in which professionals with different functional backgrounds collaborate, may indeed be more effective than functionally homogenous teams. The presence of different experiences and viewpoints may make the group as a whole more flexible and innovative (De Dreu & West, 2001; Tekleab, Karaca, Quigley, & Tsang, 2016; Van Knippenberg, De Dreu, & Homan, 2004). On the other hand, however, functional diversity may also hinder collaboration, e.g., by increasing the risk of miscommunication and conflict between team members, or by reducing team cohesion (Mitchell, Parker, & Giles, 2011; Pelled, Eisenhardt, & Xin, 1999; Woehr, Arciniega, & Poling, 2013).

A review of the literature on interprofessional collaboration reveals several team processes which may increase effectiveness of functionally diverse care teams (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005; Fay, Borrill, Amir, Haward, & West, 2006; Xyrichis & Lowton, 2008). However, empirical studies that systematically compare how these variables moderate the diversity-effectiveness link, especially within the context of health and social care, remain scarce (Supper et al., 2015). In this paper, we present a quantitative field study which examines the influence of functional diversity on the effectiveness of community care teams, and the moderating role of three team process variables: shared vision, interaction frequency, and team reflexivity.

1.1 | Outcomes of functional diversity in teams

In recent decades, the effects of diversity on team performance have been widely studied, revealing inconsistent results: depending on context and conditions, diversity may display a positive, negative or no relationship to performance (Hofhuis, van der Zee, & Otten, 2015; Van Knippenberg & Schippers, 2007; Williams & O'Reilly, 1998). The most commonly used framework for explaining the ambiguities in research findings is the Categorization-Elaboration Model (CEM; Van Knippenberg et al., 2004). It poses that the advantages and disadvantages of diversity for teams are caused by two independent but interacting paths.

Firstly, the main selling point of diversity is that it may enhance effectiveness of work groups, because the greater pool of available knowledge and experiences facilitates *elaboration of task-relevant information*. Expression of divergent ideas and opinions may force team members to be more alert and critical in their evaluation of problem-solving strategies (Brodbeck & Greitemeyer, 2000; Collins & Geutzkow, 1964). This, in turn, may result in a reduced risk of groupthink, more effective decision-making, and higher team performance

(De Dreu & West, 2001; Hofhuis, Van der Rijt, & Vlug, 2016; Nijstad & De Dreu, 2017; West, 2002).

However, the CEM also poses that the positive effects of diversity on team functioning are moderated by categorization: the tendency of individuals to cognitively organize their social environment into groups (Tajfel & Turner, 1986; Turner, 1985). When individuals identify with a social in-group, this is usually done on the basis of shared characteristics. Individuals who are different are categorized as belonging to an out-group. This categorization helps individuals to predict and give meaning to their social environment. The downside of social categorization is that it leads to the emergence of stereotypes and group representations that tend to favor the in-group over the out-group (Brewer & Brown, 1998; Fiske, 1998). This, in turn, has a negative impact on interpersonal communication between team members (Woehr et al., 2013), reduces job satisfaction and may increase turnover intent (Hofhuis, Van der Zee, & Otten, 2014). As a result, categorization processes and the resulting negative influence on social interactions may reduce team performance (Van Knippenberg et al., 2004).

The above-mentioned effects of diversity on team effectiveness, both positive, through elaboration, as well as negative, through categorization, have been established for different types of diversity, and in different contexts and settings (Guillaume, Dawson, Otaye-Ebede, Woods, & West, 2017; Schippers, West, & Dawson, 2015). In the present study, we focus specifically on functional diversity, which we define as the presence of employees with different functional and/or educational backgrounds within a single work group. The body of research that specifically deals with functional diversity is smaller than that focusing on cultural, ethnic, or gender diversity but those studies that link functional diversity to workgroup performance report similar findings, and confirm the applicability of CEM to this domain (Bell, 2007; Gebert, Boerner, & Kearney, 2006; Tekleab et al., 2016; Van Dijk, Van Engen, & Van Knippenberg, 2012).

1.2 | Moderators of the functional diversity-effectiveness link

The apparent paradox in findings suggests that the effects of functional diversity on team outcomes may be contingent on other variables. The CEM (Van Knippenberg et al., 2004) itself mentions several conditions which enable both the categorization as well as the elaboration paths toward diversity outcomes. For the categorization path, the CEM proposes that social categories must be cognitively accessible, and that a threat to the in-group will enhance categorization. Other scholars point out that attitudes toward diversity play a role in in-group bias (Hofhuis, Van der Zee, & Otten, 2016), or the relationship between diversity and team identity (Luijters, Van der Zee, & Otten, 2008; Van Dick, Van Knippenberg, Haegele, Guillaume, & Brodbeck, 2008).

The CEM also mentions moderators of the elaboration path. For example, it states that the process of elaboration is only relevant in teams in which members possess the motivation and ability to discuss task-relevant information. Other scholars have shown that the

positive effect of information elaboration is limited to teams with high task complexity (Van Dijk et al., 2012). Hofhuis, van der Rijt, and Vlug (2016) extend this by showing that positive diversity beliefs may also affect the elaboration path, through enhanced knowledge sharing between team members. For an extensive overview of constructs which have been established to moderate the diversity-effectiveness link, see a recent review by Guillaume and colleagues (2017).

In an earlier meta-analysis on the role of context in diversity research, Joshi and Roh (2009) report that relationships and moderators that are found in one type of setting or team do not automatically translate to another. The specific characteristics of the task, the profession or the industry, have a profound influence on how functional diversity manifests itself, and which moderators apply. The goal of the present paper is to specifically zoom in on health and social care professionals in community care teams, and examine whether, and under which conditions, functional diversity relates to team effectiveness in this specific context. Below we will first outline the setting in which this study took place.

1.3 | Functional diversity in community care teams

Since 2015, the Netherlands' Government has actively encouraged the formation of locally organized care teams, consisting of members of different functional groups in health and social care, such as community nurses, social workers, general health practitioners, physiotherapists, psychologists, job coaches, and youth counselors. The aim of these newly formed teams is to provide a single access point for community members in need, improving the sense of cohesion within the community, as well as increasing effectiveness of the provided care (Rutte & Samsom, 2012). It is important to note that the health and social care professionals generally remain employed by an overarching organization rooted in their functional discipline. For example, each region will have a number of community nursing organizations, who assign their employees to work within one or more of the local community teams. Simultaneously, organizations in other disciplines, such as the regional providers of social work, will also assign their employees to these teams. The size and exact composition of the community care teams are flexible and demand-driven; they depend on the characteristics of the community, such as the percentage of elderly inhabitants, the number of schools within the community, social-economic conditions, etc. The system results in a patchwork of different community care teams around the country, with a myriad of different functional disciplines represented within the team. It is important to note that the daily work of members of these teams is highly complex; they deal with many different clients, with many different and often co-occurring needs, and engage in both social- and healthcare related tasks. Problem-solving and effective interprofessional communication thus are essential skills for working successfully in this dynamic environment (D'Amour et al., 2005).

The concept of information elaboration, as explained above, is also the drive behind these changes in community care practices. The integrative cooperation of different health and/or social care

professionals allows them to blend complementary knowledge, competences, and skills to make best use of available resources (D'Amour et al., 2005; Supper et al., 2015). Earlier studies have provided evidence for the increased effectiveness of interprofessional teams over functionally homogenous teams in this sector. For instance, one study reports that interprofessional cooperation between physicians reduces hospitalization cost and readmission rates (Uddin, Hossain, & Kelaher, 2012), whereas another found support for the hypothesis that interprofessional collaboration increases innovation among health care workers in hospital teams (Fay et al., 2006). A narrower review which focuses specifically on the literature on functional diversity in community care teams, confirms that under the right circumstances, interprofessional collaboration is an efficient and productive way of achieving goals and results (Xyrichis & Lowton, 2008).

The authors of the latter review also report, however, that functional diversity does not *automatically* increase effectiveness of care teams. In fact, in many studies, nonsignificant or even negative effects are reported (D'Amour et al., 2005; Gebert et al., 2006; Kozłowski & Ilgen, 2006; Supper et al., 2015; Xyrichis & Lowton, 2008). These findings may be explained through the categorization path of the CEM (Van Knippenberg et al., 2004). When team members identify strongly with their own profession, feelings of inclusion, and cohesion within the interprofessional team may be reduced, which results in lower team identity (Mitchell et al., 2011). This, in turn, has been associated with lower performance, less job satisfaction and increased turnover (Allen & Meyer, 1990; Hofhuis, Van der Zee, & Otten, 2012; Tekleab et al., 2016). Another possible explanation for these findings is that each profession develops strong theoretical and function-based frameworks that form the professionals' attitudes, norms, and values toward the job. Interprofessional collaboration thus entails working together with colleagues with different value systems and/or work ethics (Brown, 2002; D'Amour et al., 2005). Studies that have inquired into the effects of differences in values or cognitive schemas, termed deep-level diversity, generally report a negative relationship with team cohesion and effectiveness (Bell, 2007; Mello & Rentsch, 2015).

In sum, existing literature shows that the CEM is able to explain the effects of functional diversity on performance in community care teams: both elaboration and categorization processes may occur, depending on the characteristics of the team. In the present study, we investigate possible moderators of these processes, to establish under which conditions these teams may function most effectively. However, before examining possible moderators, it is important to first establish what constitutes team effectiveness in this context.

1.4 | Effectiveness of community care teams

Based on existing literature, the present study employs three distinct outcome measures that have been shown to relate to care teams' ability to reach goals (Cole, Waite, & Nichols, 2004; Supper et al., 2015; Suter, Oelke, Adair, & Armitage, 2009). Firstly, *team identity*, is defined as the degree to which professionals identify with their interprofessional team, and experience a sense of cohesion. Team identity has

been shown to be an important predictor of team effectiveness, and also relates strongly to affective job evaluations, such as job satisfaction, job recognition, and turnover intent (Allen & Meyer, 1990; Mitchell et al., 2011; Tekleab et al., 2016). Within the context of team diversity literature, team identity is most closely associated with the CEM's categorization path, where a strong team identity is indicative of less categorization and higher team cohesion (Hofhuis et al., 2012; Van Dick et al., 2008).

Secondly, *team performance*, is defined as the professionals' perception of how successful the team is in completing their tasks. Perceived performance has been shown to be a strong predictor of actual team performance (Brannick, Salas, & Prince, 1997). In contrast with team identity, which is included to measure an affective outcome, performance is included as a more concrete measure of effectiveness. It is likely to be affected by both the categorization and elaboration paths of the CEM (Van Knippenberg et al., 2004).

Finally, although the main goal of community care teams is to provide adequate care, client-centered outcome measures are underrepresented in existing studies within such teams (Suter et al., 2009). In the present study, *client satisfaction*, defined as the degree to which professionals feel their interprofessional collaboration enhances the experience of their clients, is included as the third measure of team effectiveness. As an external extension of team performance, this outcomes variable is also likely to be influenced by both categorization and elaboration-related processes.

1.5 | Moderating effects of team processes

As mentioned earlier, the effectiveness of functionally diverse teams may be contingent on many other factors (Guillaume et al., 2017). Several of the moderators mentioned above, such as task complexity, diversity beliefs, and identity threat (Van Dijk et al., 2012; Van Knippenberg & Haslam, 2007; Van Knippenberg et al., 2004), are all applicable to this context. However, a recent review of literature, focusing specifically on care teams, points toward team process variables as the most relevant factors in determining their success (Supper et al., 2015). In the present study, we focus on three which have previously been shown to affect outcomes in teams within similar contexts: shared vision, interaction frequency, and team reflexivity.

Shared Vision is defined as the degree to which team members have a clear picture of, and agree upon, the goals of the team. Within the context of health and social care, Fay and colleagues (2006) argue that having a shared vision provides the "glue" that holds an interprofessional team together. Other studies also confirm that problems that arise from the categorization path of the CEM (Van Knippenberg et al., 2004) may be circumvented by creating a shared mental model of how the team should provide care to their clients (see also Young et al., 2017).

Furthermore, in a team which consists of members with different professions, team goals may be more diffused, due to the different functional frameworks within which the team members operate (Peltokorpi & Yamao, 2017). This could reduce the

opportunities for information elaboration, thus reducing team effectiveness. Establishing a shared vision may be an essential requirement for overcoming these difficulties (DeChurch & Mesmer-Magnus, 2010; Inkpen & Tsang, 2016). Other scholars have also shown that by creating shared mental models of the task, knowledge sharing, and problem-solving are enhanced (Bergman, Rentsch, Small, Davenport, & Bergman, 2012; Rentsch & Klimoski, 2001). Based on these findings, we hypothesize that shared vision will reduce categorization processes, thereby enhancing the relationship between functional diversity and team identification, as well as increasing the likelihood of elaboration of task-relevant information, thereby enhancing the relationship between functional diversity and team performance and client satisfaction.

Hypothesis 1a-c. Shared Vision moderates the relationship between Functional Diversity and (a) Team Identity, (b) Team Performance, and (c) Client Satisfaction, such that the relationship is more positive when Shared Vision is high.

A second important team process variable that was shown to affect functioning of care teams is *Interaction frequency*, defined as the degree to which team members communicate regularly, and feel the obligation to attend meetings (Fay et al., 2006). It is well known that regular interaction increases liking between individuals and enhances team identification (Tropp & Pettigrew, 2005; Tröster, Mehra, & van Knippenberg, 2014). In the present study, we will examine whether interaction frequency may also play a moderating role between functional diversity and team identity, thus impacting the categorization path. Furthermore, frequent interaction has been shown to open up the possibilities of interprofessional teams to make use of their functional diversity to increase innovation (Fay et al., 2006), which suggests it may also act as a moderator on the elaboration path. More evidence for this relationship is provided by Monteiro, Arvidsson, and Birkinshaw (2008) who report that communicating regularly enhances knowledge transfer, and leads to more in-depth problem-solving in teams. So far, it remains unclear whether this construct also acts as a moderator of the relationship between functional diversity and productive team outcomes, but we predict that a similar influence will be observed.

Hypothesis 2a-c. Interaction Frequency moderates the relationship between Functional Diversity and (a) Team Identity, (b) Team Performance, (c) and Client Satisfaction, such that the relationship is more positive when Interaction Frequency is high.

Finally, the present study examines whether the relationship between functional diversity and team effectiveness may also be contingent on *Team Reflexivity*, defined as the ability of a team to critically reflect on their own interactions, and adjust where necessary (West, 1996). Reflexivity has been shown to be useful for team performance in general but even more so in case of interprofessional collaboration (Schippers et al., 2015; Widmer, Schippers, & West, 2009). Literature

on the relationship between team reflexivity and categorization is scarce, but based on the notion that interpersonal contact and discussion of common goals is known to increase cohesion (Fay et al., 2006; Mitchell et al., 2011) we also expect it to moderate the effects of functional diversity on team identity. Furthermore, with regards to the elaboration path, as functional diversity may increase miscommunication and inhibit the flow of interpersonal interaction, reflexivity may be necessary to overcome these difficulties and to establish high performance (Schippers, Edmondson, & West, 2014). By openly discussing and communicating about the way they cooperate, members of community care teams may be able to make the best use of their different functional backgrounds. Within the context of health and social care, team reflexivity has been reported to positively affect innovation and performance (Sheppard, Newstead, Di Caccavo, & Ryan, 2000). We predict it will moderate the relationship between functional diversity and team outcomes in similar fashion.

Hypothesis 3a-c. Interaction Frequency moderates the relationship between Functional Diversity and (a) Team Identity, (b) Team Performance, and (c) Client Satisfaction, such that the relationship is more positive when Team Reflexivity is high.

2 | METHODS

2.1 | Procedure and respondents

Data for this study were gathered using a digital survey among health and social care professionals who were working in community care teams in the Netherlands. As explained above, most of these professionals are employees of discipline-based care organizations, and are posted to different community care teams which also include members of other functional disciplines and organizations.

Respondents were recruited through several channels. Firstly, a number of professionals were contacted through personnel departments of participating care organizations, who agreed to send out invitations to their employees by e-mail. Secondly, the researchers directly contacted health and social care professionals by phone and e-mail. Those that were willing to participate were sent a digital invitation with a link to the survey. Thirdly, this link was also distributed through social media channels and digital newsletters of participating organizations, as well as through informal networking.

At the start of the survey, respondents were asked if they were professionals working in primary health or social care, and within an interprofessional community care team. Those who answered negatively to either of these questions, were excluded from the sample, since they did not belong to the target group. In total, 186 members of the target group returned the questionnaire. Those respondents who did not fully complete the questionnaire were also removed from the dataset. The final sample which was used

to test the hypotheses included 167 respondents (74.3% female; $M_{\text{age}} = 44.3$ years, $SD = 10.8$).

The sample consisted of professionals with many different functional backgrounds, including, but not limited to, community nurses, social workers, general health practitioners, physiotherapists, psychologists, job coaches, youth counselors, financial advisors, and law enforcement professionals.

2.2 | Measures

The survey was written in Dutch, the main working language of the respondents. Formulations and sample items as provided below were translated by the authors. Unless stated otherwise, all items were measured on a 1–5 Likert scale, ranging from 1 (totally disagree) to 5 (totally agree).

The first section of the survey asked respondents to indicate their own profession, from a list of 28 options. Next, they were asked to select, from the same list, which other professions were also represented in their team. The total number of professions per team were used as a raw indicator of functional diversity. Measuring diversity in this way is in line with Harrison and Klein's (2007) concept of maximum variety, in which the degree of diversity is highest when all members of the team are of a different professional group. This fits well with the context of interprofessional community care teams, because there are many professional categories, and no clear distinction between majority or minority groups. The main criticism of this type of diversity measure is its dependence on team size. To circumvent this, we divided the number of different professions by the total number of professionals in the team (Mean team size = 11.6; Min = 4; Max = 45; $SD = 7.1$). This provided us with a relative measure of functional diversity per team ($M = 6.4$; Min = 2.0; Max = 21.0; $SD = 3.4$), which was used as a manifest variable in our analyses. Again, this applies well to the dynamic context of community care teams, which potentially involves members with many different professions collaborating together, but where team size and composition are highly dependent on context and availability of professionals.

It is important to note that, due to the nature of the recruitment process, our respondents were working in many different community care teams around the Netherlands. Only in a few occasions did more than one member of the same team complete our questionnaire. As such, the descriptions of team composition given above are based on the response of individual team members only, not by aggregating data from several team members.

The survey included three outcome variables. *Team identity* was measured using four previously validated items (Allen & Meyer, 1990), including "The team I work for means a lot to me" ($\alpha = 0.83$). *Team performance* was also measured using four previously validated items (Bolino & Turnley, 2003), including "This teams fulfills its duties and responsibilities effectively" ($\alpha = 0.79$). *Client satisfaction* was measured using three original items constructed by the authors, specifically intended to measure the perceived added value of the team collaboration to client well-being as reported by the professionals themselves. The items were "Our way of collaborating has added

value for the client,” “The existence of this team is good for the clients in our community,” and “Clients are satisfied about the way this team performs its work” ($\alpha = 0.80$).

Three moderators were included. *Shared Vision* was measured using three items adapted from the Team Climate Inventory (TCI; Anderson & West, 1998), including “All of the members of this team agree on the team’s goals” ($\alpha = 0.82$). *Interaction frequency* was measured using three items from the TCI (Anderson & West, 1998) including “The members of this team keep in regular contact with each other” ($\alpha = 0.72$). *Reflexivity* was measured using three items from the original team reflexivity scale by West (1996), including “Within this team we regularly evaluate the way we work together” ($\alpha = 0.78$).

Finally, to control for the effects of team tenure, we asked respondents to indicate how long their team had been working together. The mean team tenure was 32.2 months (Min = 0.5; Max = 120; SD = 32.6).

2.3 | Measurement model

We conducted a confirmatory factor analysis to test the discriminant validity of the scales for team identity, team performance, client satisfaction, shared vision, interaction frequency, and team reflexivity, using structural equation modeling (AMOS 22; Arbuckle, 2013). First, a model was constructed in which all manifest variables predict a single latent factor. This model was unidentified. Next, a 6-factor model was constructed using the individual items as observed variables, predicting the six intended constructs as latent variables. This model produced a satisfactory fit with the data ($\chi^2(155) = 283.354$; CFI = 0.936; TLI = 0.931; RMSEA = 0.071). Based on these findings, all six constructs can be included in our model as intended. Table 1 displays the descriptive statistics and correlations of all variables used in the study.

2.4 | Assumptions

Our analyses were at risk of being affected by multicollinearity, as evidenced by significant correlations between some of the predictor variables (see Table 1). Multicollinearity inflates the standard errors of regression estimates, thus leading to unreliable estimates of regression coefficients (Grewal, Cote, & Baumgartner, 2004). To test for the degree of multicollinearity between predictors, it

is recommended to calculate the Variance Inflation Factor (VIF), by conducting single regression analyses between the predictor variables, and calculating the VIF from the resulting R^2 values. A VIF > 3.0 is generally considered problematic (Dormann et al., 2013). In the present study, the VIF’s between the four independent variables remain well below this threshold, the highest being found between *Interaction Frequency* and *Team Reflexivity* ($R^2 = 0.12$; VIF = 1.14).

Furthermore, using AMOS 22.0 (Arbuckle, 2013), we tested for normality (multivariate kurtosis = 2.872; Mardia’s index = 1.632), which was within the boundaries for a multivariate analysis with our sample size (Byrne, 2013).

2.5 | Common method variance

Because the present study makes use of self-reported data from a single source, our results may be at risk of being influenced by common method bias (Podsakoff, MacKenzie, & Podsakoff, 2012). It has been argued that common method bias is less of a concern when conducting moderation analyses, and may in fact lead to an underestimation of the strength of interactions (McClelland & Judd, 1993). However, it is still considered good practice to test for its possible influence. In a comparison of three possible methods, Richardson, Simmering, and Sturman (2009) recommend using the CFA latent marker technique as the most robust method for testing for common method variance. In line with their procedure, the measurement model was extended with a theoretically unrelated marker, with paths to each of its own indicators as well as with paths to the indicators of all other latent variables in the model. Next, we examined the change in model fit of the model in which the marker’s item loadings are freely estimated, versus one in which they are constrained. The change in model fit was not significant ($\Delta\chi^2 = 16.591$; $p = 0.06$), which implies that our findings are unlikely to be influenced by common method variance.

2.6 | Team-level variance

Although the present study examines team-level constructs, our analyses were limited by the way in which the data are structured. Because of the nature of the recruitment, our respondents were not organized in a small number of groups. In fact, our respondents were members of almost as many different community care teams; only in a

TABLE 1 Descriptive statistics and correlations

Variables	α	M	S.D.	(2)	(3)	(4)	(5)	(6)	(7)
1. Functional Diversity		0.63	0.35	0.02	0.17*	0.08	0.04	-0.06	-0.05
2. Team Identity	0.83	3.89	0.52	-	0.43***	0.49***	0.40***	0.44***	0.50***
3. Team Performance	0.79	3.52	0.68		-	0.71***	0.57***	0.28***	0.43***
4. Client Satisfaction	0.80	3.88	0.60			-	0.51***	0.38***	0.47***
5. Shared Vision	0.82	3.50	0.76				-	0.29***	0.31***
6. Interaction Frequency	0.72	3.74	0.62					-	0.48***
7. Team Reflexivity	0.78	3.82	0.61						-

Note. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$; $n = 167$.

few cases did more than one member of the same team complete the survey. Nevertheless, we tested for the presence of team-level variance, using Hierarchical Linear Modeling (Raudenbush, Bryk, Cheong, Congdon, & Du Toit, 2011), but it was found to be insignificant ($u_0 = 0.12$; ICC = 0.026). Therefore, our analyses do not benefit from multilevel modeling. As a result, the present study infers information on team-level constructs through individual-level measurements. The disadvantage of this, is that we cannot account for possible team-level effects on individual perception of our moderators or outcome variables. The advantage, on the other hand, is that there is no nested structure in the data, which negates the need to control for this.

3 | RESULTS

The hypothesized moderating influence of shared vision, interaction frequency, and team reflexivity on the relationship between functional diversity and team effectiveness was tested through moderated structural equation modeling (MSEM), using latent interaction effects (Klein & Moosbrugger, 2000). In this case, MSEM is preferred over regular regression analyses, because the latter method does not take into account how manifest indicators predict latent constructs (Cortina, Chen, & Dunlap, 2001; Dawson, 2014). Ideally, all three moderators and outcome variables would be entered in a single structural model. However, fitting a model of the resulting complexity would require statistical power which exceeds that provided by the sample size of this study. Therefore, three separate models were constructed, one for each outcome variable. Each model includes seven predictors: the main effect of functional diversity, main effects of the three moderators, and interaction effects between functional diversity and each of the moderators. Age and gender of

the respondents, as well as team tenure, were included as control variables in all the analyses presented below.

3.1 | Team identity

Figure 1 presents the hypothesized model of the relationship between functional diversity and team identity, and its moderators. No main effect of functional diversity is found. Shared vision ($b^* = 0.24$; $p < 0.001$), interaction frequency ($b^* = 0.20$; $p = 0.011$), and team reflexivity ($b^* = 0.31$; $p < 0.001$) all display a positive main effect on team identity. The interaction effects of functional diversity with shared vision ($b^* = 0.18$; $p = 0.018$) and team reflexivity ($b^* = 0.15$; $p = 0.018$) are also found to be significant, meaning they moderate its relationship with team identity.

As shown in Figure 2, when shared vision is low (-1 SD), functional diversity has a negative effect on team identity ($b^* = -0.23$; $p = 0.002$), whereas when shared vision is high ($+1$ SD), the effect is positive ($b^* = 0.13$; $p = 0.021$). This confirms Hypothesis 1a. For interaction frequency, the moderation effect is not found to be significant, leading to rejection of Hypothesis 2a. For team reflexivity, the interaction effect is quite pronounced. As shown in Figure 3, when reflexivity is low (-1 SD), functional diversity has a negative effect on team identity ($b^* = -0.29$; $p < 0.001$), whereas when reflexivity is high ($+1$ SD), the effect is positive ($b^* = 0.16$; $p = 0.010$). This confirms Hypothesis 3a.

3.2 | Team performance

Figure 4 presents the model of the relationship between functional diversity and team performance, including the three moderators. Again, no main effect of functional diversity is found. Shared vision

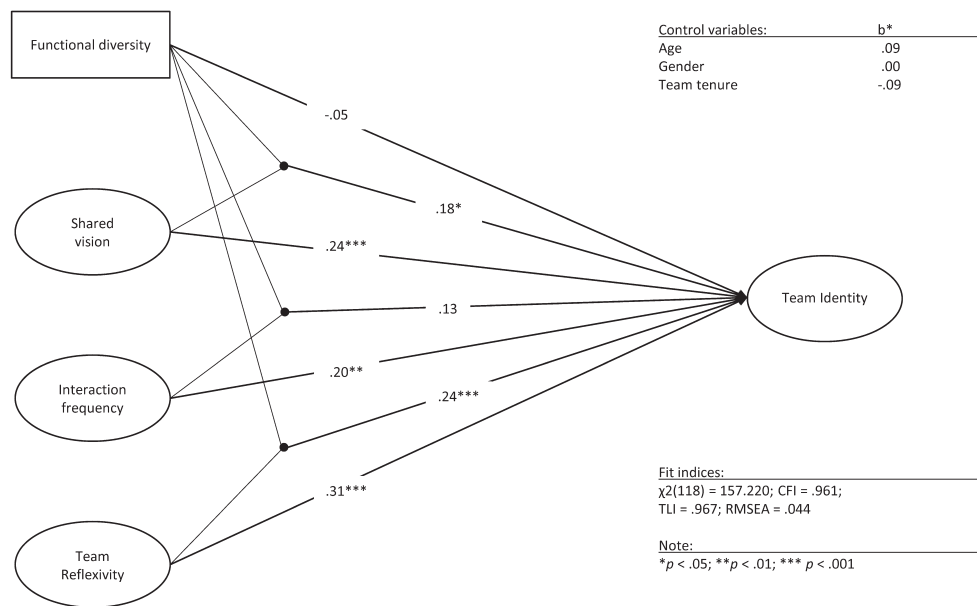


FIGURE 1 Structural equation model of the influence of functional diversity, shared vision, interaction frequency, team reflexivity, and their interactions on team identity

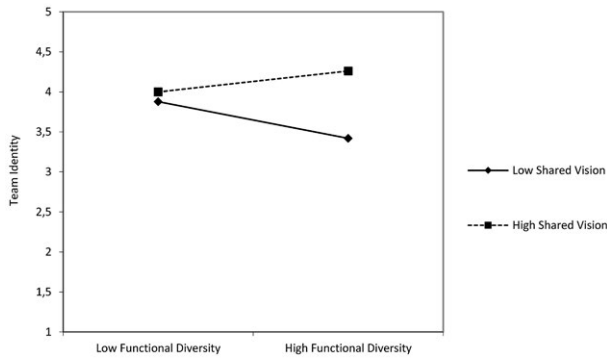


FIGURE 2 Simple slopes of the interaction effect of functional diversity with shared vision on team identity

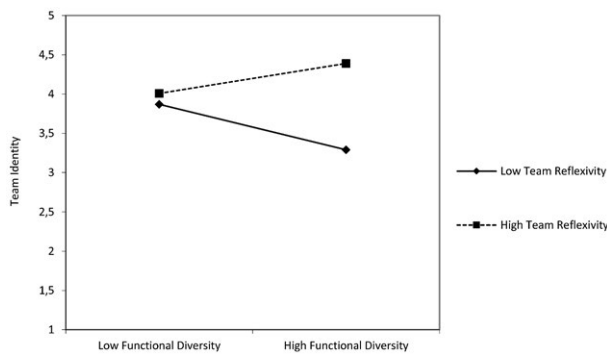


FIGURE 3 Simple slopes of the interaction effect of functional diversity with team reflexivity on team identity [Correction added on 24 August 2018, after first online publication: Figure 3 has been corrected.]

($b^* = 0.46; p < 0.001$) and team reflexivity ($b^* = 0.21; p = 0.005$) display a positive main effect on team performance, interaction frequency does not.

Shared vision does not display a significant interaction, so Hypothesis 1b is rejected. The moderating effect of Interaction frequency is significant ($b^* = 0.26; p < 0.001$). As shown in Figure 5, when interaction frequency is low ($-1 SD$), functional diversity has no significant effect on team performance, whereas when interaction frequency is high ($+1 SD$), the effect is strongly positive ($b^* = 0.41; p < 0.001$). This confirms Hypothesis 2b. Finally, there is no evidence for a moderating effect of team reflexivity, thus rejecting Hypothesis 3b.

Finally, for team performance, a small positive relationship is also found with team tenure ($b^* = 0.13; p = 0.043$), meaning that performance is higher in teams that have been working together longer.

3.3 | Client satisfaction

Figure 6 presents the model of the relationship between functional diversity and client satisfaction, including the three moderators. Again, no main effect of functional diversity is found. Shared vision ($b^* = 0.26; p < 0.001$) and interaction frequency ($b^* = 0.23; p = 0.003$) display a positive main effect, team reflexivity does not.

The interaction effects of functional diversity with shared vision ($b^* = 0.24; p = 0.002$), interaction frequency ($b^* = 0.37; p < 0.001$), and team reflexivity ($b^* = 0.25; p = 0.001$) are all found to be significant, meaning they moderate its relationship with client satisfaction. As shown in Figure 7, when shared vision is low ($-1 SD$), functional diversity has a negative effect on client satisfaction

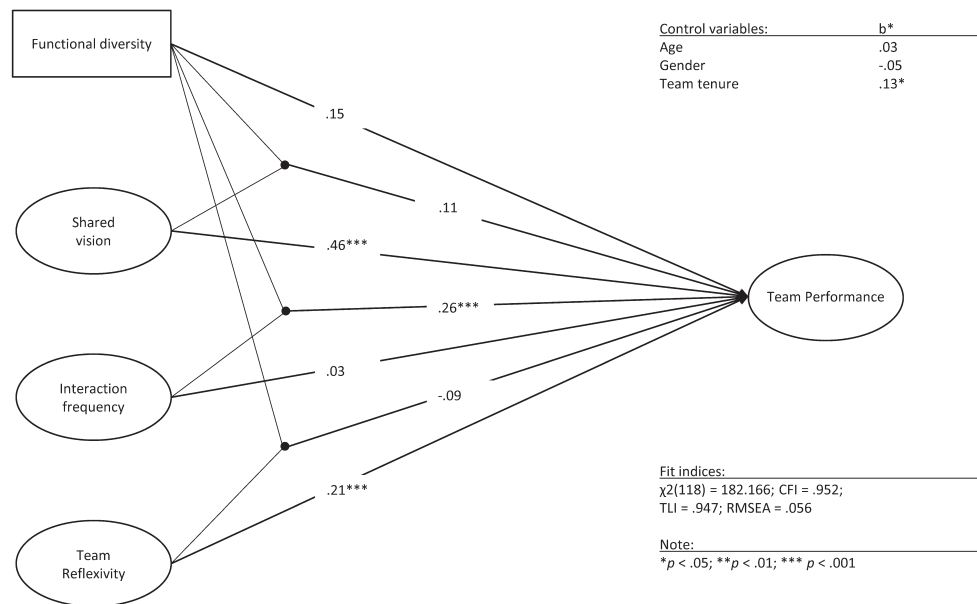


FIGURE 4 Structural model of the influence of functional diversity, shared vision, interaction frequency, team reflexivity, and their interactions on team performance

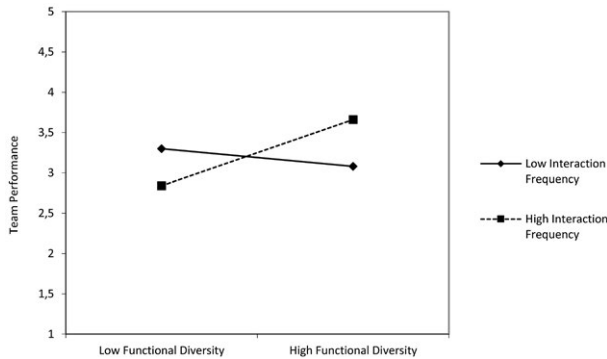


FIGURE 5 Simple slopes of the interaction effect of functional diversity with interaction frequency on team performance [Correction added on 24 August 2018, after first online publication: Figure 5 has been corrected.]

($b^* = -0.15$; $p = 0.017$), whereas when shared vision is high (+1 SD), the effect is positive ($b^* = 0.33$; $p < 0.001$). This confirms Hypothesis 1c.

As shown in Figure 8, interaction frequency has an even stronger moderating effect. When interaction frequency is low (-1 SD), functional diversity has a negative effect on client satisfaction ($b^* = -0.28$; $p < 0.001$), whereas when interaction frequency is high (+1 SD), the effect is positive ($b^* = 0.49$; $p < 0.001$). This confirms Hypothesis 2c.

Finally, as shown in Figure 9, the interaction between functional diversity and team reflexivity displays a similar direction. When reflexivity is low (-1 SD), functional diversity is negatively related to client satisfaction ($b^* = -0.16$; $p = 0.009$), whereas when reflexivity is high (+1 SD), a positive relationship is found ($b^* = -0.29$; $p < 0.001$). This confirms Hypothesis 3c.

In sum, our findings confirm that shared vision moderates the effects of functional diversity on team identity and client satisfaction.

Interaction frequency moderates the effects of functional diversity on team performance and client satisfaction. Team reflexivity moderates its relationship with team identity and client satisfaction. All moderation effects show a similar direction: in the absence of these team processes, functional diversity displays negative or no effects on team outcomes, but when these processes are present, the effects are positive.

4 | DISCUSSION AND CONCLUSION

As interprofessional collaboration becomes more commonplace in health and social care, both scholars and practitioners are searching for ways to make the most out of functionally diverse teams. Earlier research has shown that the presence of different functional backgrounds may lead teams to perform better (Mitchell, Parker, Giles, & White, 2010; Van Knippenberg et al., 2004), but the question remained under which conditions this may occur. The present research tested the influence of functional diversity on team identity, team performance, and client satisfaction within community care teams in the Netherlands, and examined factors which may moderate these effects. In line with existing literature, we specifically focused on three variables related to team processes: shared vision, interaction frequency, and reflexivity (Fay et al., 2006; Supper et al., 2015; Xyrichis & Lowton, 2008).

4.1 | Overview of findings

The first research question of the present study was whether or not functional diversity increases effectiveness of community care teams. Based on our results, we can state that that this is indeed the case, but only under the right conditions. Across the sample as a whole, the relative number of different professions does not directly relate to team effectiveness. These findings are

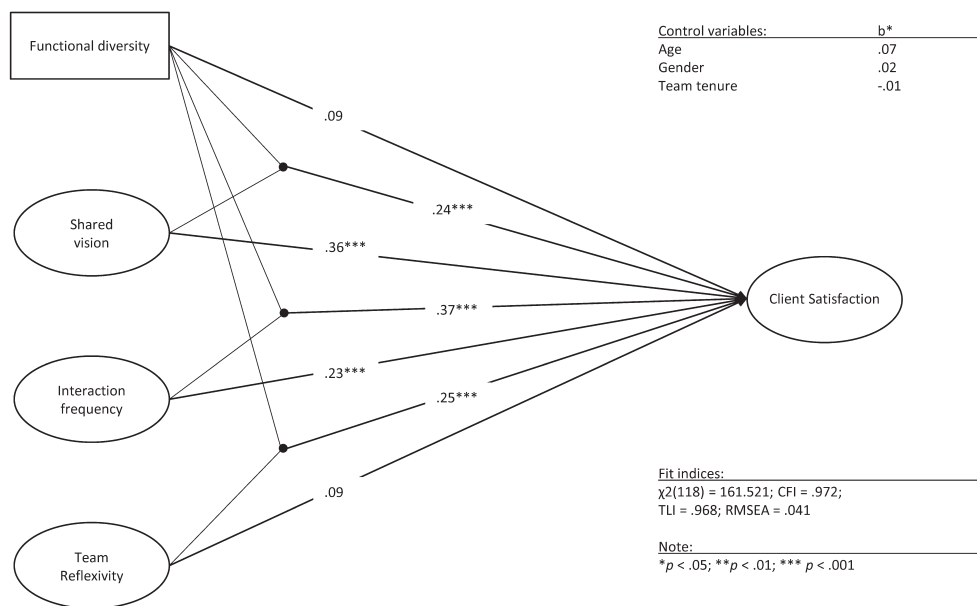


FIGURE 6 Structural model of the influence of functional diversity, shared vision, interaction frequency, team reflexivity, and their interactions on client satisfaction

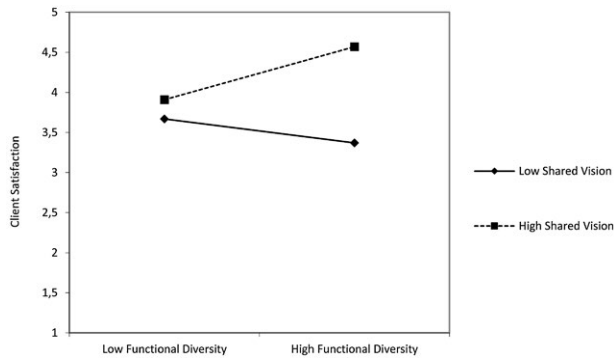


FIGURE 7 Simple slopes of the interaction effect of functional diversity with shared vision on client satisfaction

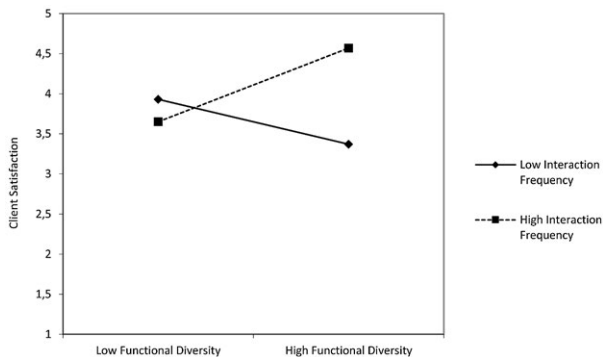


FIGURE 8 Simple slopes of the interaction effect of functional diversity with interaction frequency on client satisfaction

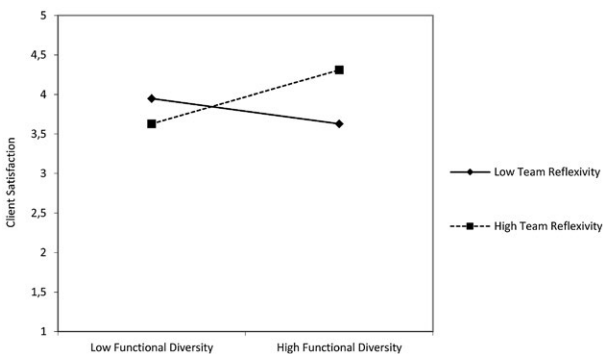


FIGURE 9 Simple slopes of the interaction effect of functional diversity with team reflexivity on client satisfaction

in line with earlier studies showing that the positive and negative effects of diversity may cancel each other out, thereby not resulting in a net effect on outcomes (Hofhuis, Van der Rijt et al., 2016; Kearney & Gebert, 2009; Van Knippenberg & Schippers, 2007). However, the added value of the present study is that possible moderators of these relationships were also examined, to test whether the effects of functional diversity may be contingent on team processes.

When examining the effects of functional diversity on team identity, we find that respondents who work in a more diverse team

also report higher team identity, but only when they also score high on shared vision and team reflexivity. When there is no shared vision, or when a team does not reflect regularly on their functioning, functional diversity leads to lower team identification. The notion that regular contact and positive team processes will enhance identification is well known (Mitchell et al., 2011), but this study is one of the first to confirm that it will moderate the relationship with functional diversity.

For team performance, our study reveals similar effects. No overall relationship is found between functional diversity and team performance, but moderation analyses reveal that the benefits of diversity for productivity only come to the fore when team members interact frequently. Conversely, when there is less interaction, functional diversity appears to inhibit team performance. That notion that interpersonal contact and communication are essential in creating the conditions for information elaboration is in line with existing research (Hofhuis, van der Rijt, et al., 2016). Contrary to expectations, shared vision and team reflexivity do not moderate the diversity–performance link. Both these team processes do, however, display strong main effects on performance, which implies they are essential in increasing performance of any team, regardless of the degree of functional diversity.

Finally, for client satisfaction we again find no overall effects of functional diversity, but further examination reveals that here too, it strongly depends on team processes. Shared vision and interaction frequency display strong main effects on this outcome variable. More importantly, all three outcomes display moderating effects in the same direction as the ones explained above. Again, this confirms our prediction that team processes are essential for establishing positive outcomes in functionally diverse community care teams. Client satisfaction, although one of the most important outcomes of teams in this context, is often underrepresented as an outcome variable in scientific study. We have shown that even through an indirect subjective approach, it is possible to establish a measure of client satisfaction which displays relationships with team outcomes and team process variables, and explains extra variance over more common measures of team performance. We highly recommend the use of such outcome measures in future studies on effectiveness of care teams.

In sum, the present study adds to existing literature by systematically comparing the moderating effects of three team process variables on the relationship between functional diversity and team outcomes, including both internal (team identity, performance) and external (client satisfaction) constructs. As community care teams become more functionally diverse, having a shared vision, interacting frequently, and reflecting on collaboration will greatly enhance outcomes.

4.2 | Limitations and future research

As with all research, the present study has some limitations. The most important limitation is the fact it was unable to take into account team-level variance. As such, most of the constructs mentioned in this paper should be interpreted as perceptions of individuals on

the functioning of their team as a whole. Replication of our findings using team-level measurements, thereby taking into account the hierarchical nature of such data, would be necessary to better understand the relationships which are reported above.

Secondly, this study relies on self-reported data. Therefore, as with all quantitative surveys, social desirability may be a concern. Special care was taken to guarantee anonymity of respondents, which may have minimized this problem, but replication of our findings using a different method would help confirm the reported relationships. For example, examining the influence of actual levels of interaction frequency, reflexivity, etc. using direct observations would be a logical next step in this line of research.

Another limitation is that the results presented in this paper are based on cross-sectional data, which means we cannot directly test for causal effects. Our conceptual model assumes an influence of functional diversity on team outcomes, since a reverse relationship seems illogical. However, the reported relationships between team processes and outcomes are likely to be reciprocal to a certain degree. Future studies could use longitudinal and/or experimental designs to assess the causal nature of the relationships, e.g., by evaluating the effects of team interventions on outcomes.

The present study has established quantitative evidence of the importance of team processes for the functioning of interprofessional community care teams. Further teasing out the nuances of how these factors affect team performance is essential to gain deeper understanding of the benefits and threats of functional diversity. For example, studies which evaluate the effectiveness of team interventions may shed new light on how shared vision or reflexivity can be enhanced in interprofessional community care teams, and how such teams can be equipped to meet their goals and objectives.

4.3 | Practical implications

Based on the results of the study presented in this paper, we would recommend community care teams to specifically spend time on enhancing team processes. The authors recognize that most professionals in this specific target population are under considerable stress, and their motivation to spend extra time on team-building and reflexivity is generally low (ten Den et al., 2015). However, considering the results presented above, it appears to be worthwhile to invest time and effort in establishing a shared vision, enhancing interaction between team members, and to schedule regular times for reflexivity (Gurtner, Tschan, Semmer, & Nägele, 2007). Many training programs exist that have been shown to enhance these team processes (Delise, Gorman, Brooks, Rentsch, & Steele-Johnson, 2010), many of which are specifically aimed at care practitioners (e.g., McLoughlin, Patel, O'Callaghan, & Reeves, 2018; Smits, Hofhuis, Rijdsdijk, Mensen, & De Vries, 2016; Zwarenstein, Goldman, & Reeves, 2009). Although some energy needs to be spent to implement them, our results confirm that the net gain in terms of team effectiveness is great enough to warrant these

efforts. We highly encourage health care organizations and team managers to invest in such programs.

4.4 | Conclusions

The findings presented in this paper shed new light on factors which may enable community care teams to unlock the benefits of functional diversity. By ensuring that professionals communicate regularly, spend time on defining a common goal for the team, and subsequently reflect on their collaboration, functional diversity may no longer lead to lower team effectiveness. In fact, when these conditions are met, functional diversity enhances team identification, performance, and client satisfaction. Paying close attention to the way professionals interact with each other in interprofessional community care teams and promoting team building activities may help these teams take the most advantage of their different backgrounds and provide better care.

ACKNOWLEDGMENTS

This study was made possible through funding by the Dutch Taskforce for Applied Research [Nationaal Regieorgaan Praktijkgericht Onderzoek SIA], on the project 'Professioneel Samenwerken in de Wijk' (Raak Publiek 2014-01-13M), which was awarded to Windesheim University of Applied Sciences, Research Group Innovating with Older Adults, and Research Group Social Innovation.

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How to cite this article: Hofhuis J, Mensen M, ten Den LM, et al. Does functional diversity increase effectiveness of community care teams? The moderating role of shared vision, interaction frequency, and team reflexivity. *J Appl Soc Psychol*. 2018;00:1–14. <https://doi.org/10.1111/jasp.12533>