Ready, Set … Collaborate? The Evidence Says "Go," So What's Slowing Adoption of Inter-professional Collaboration in Primary Healthcare?

Jennifer Thornhill, Mylène Dault and Dave Clements

A vision of primary healthcare reform only takes shape with images of physicians, nurses, nurse practitioners and other allied health professionals working together as partners to deliver first-line care (Jones and Way 2007). Such inter-professional collaboration leads to care that is better than that offered by doctors alone (Canadian Health Services Research Foundation [CHSRF] 2005, 2007a). It's better because it improves quality and access as well as increases continuity of care for patients, while making more appropriate use of resources (Barrett et al. in press; CHSRF 2005, 2007a; Oandasan et al. 2006; Mable and Marriott 2002).

Still, it's fitting to speak of such collaboration as a vision for primary healthcare as it "remains in its infancy" in Canada (Barrett et al. in press). These words are from a newly launched decision support synthesis by Barrett et al. (in press), *Interprofessional Collaboration and Quality Primary Healthcare*. The synthesis is the result of a partnership between the CHSRF and the Health Council of Canada to gain a better understanding of the evidence on inter-professional collaboration in Canadian primary healthcare and its potential benefits for patients, providers and healthcare at large (Barrett et al. in press). The report bolsters the case for inter-professional collaborative care and delivery in primary healthcare with the best available research evidence. It also provides perspectives from other literature (grey literature and peer-reviewed literature not meeting the study's inclusion criteria) as to what's slowing progress in the advancement of collaborative care on the front lines. Previous foundation-led work provides more in-depth insights into the major issues barring implementation.

What Does the Research Evidence Say?

There's some disagreement in the literature about what inter-professional collaboration means (Oandasan et al. 2006). No matter how you define it, this kind of partnership moves beyond models where physicians are regarded as healthcare's lone rangers (CHSRF 2007a). In collaborative care, health professionals work together, across disciplines and with patients to achieve high-quality care that benefits patients, providers and systems (Barrett et al. in press).

The most significant improvements brought on by inter-professional collaboration are in quality and safety (Barrett et al. in press; Oandasan et al. 2006). In terms of safety, collaboration is well-known to reduce medical errors as teams are less likely to make mistakes than are individuals (CHSRF 2007a; Oandasan et al. 2006). In terms of quality, collaboration leads to more timely referrals among different professionals, increases patient satisfaction and improves patients' access to and self-management of care (Barrett et al. in press). These and other positive outcomes are particularly visible in collaborative mental healthcare and chronic disease management and prevention (Barrett et al. in press) – particularly for patients with asthma or other lung diseases, diabetes, heart disease or depression (CHSRF 2005).

Inter-professional collaboration can also lead to cost benefits (Barrett et al. in press). In some primary healthcare settings, for example, collaborative care has led to decreases in average provider and patient costs for blood pressure control, as well as lower readmission rates and costs for team-managed home-based primary care (Barrett et al. in press). Various other reports – most notably the Health Transition Fund's Synthesis Series on primary healthcare (Mable and Marriott 2002) – have also demonstrated the value of inter-professional collaboration to primary healthcare.

> **"Gettin' good players** is easy. Gettin' 'em to play together is the hard part."

One practical example in the Canadian context is the Saskatchewan Chronic Disease Management Collaborative. This province-wide quality improvement collaborative model

is sponsored by the province's Health Quality Council and brings together a range of healthcare providers to learn about, test and share experiences with improvement ideas in diabetes and coronary artery disease care (CHSRF 2007b). In a truly collaborative fashion, this initiative has a web-based toolkit, which virtually connects professionals to shared patient medical information. The initiative has already brought about improvements to patient care – for example, more patients are receiving their recommended drugs and services (CHSRF 2007b).

So What's Slowing Progress?

While the evidence and examples for inter-professional collaboration are strong in primary healthcare – particularly in the care of patients with mental illness or chronic disease – this collaboration is moving at a snail's pace when it comes to wide-scale adoption. Over and over, the research evidence is trumped by jurisdictional, regulatory and funding issues, among other things. Scopes-of-practice issues are particularly tricky. The former manager of the New York Yankees, Casey Stengel, once said, "Gettin' good players is easy. Gettin' 'em to play together is the hard part." The same applies in primary healthcare. Providers want to give the utmost in care to their patients, but they still fear that working collaboratively means relinquishing their professional "turf" (Clements et al. 2007).

As of late, liability and malpractice issues have stood out as serious barriers keeping professionals from partnering to deliver care. In particular, professionals worry they will be held responsible for the acts and omissions of their team members. But the Canadian Medical Protective Association (2006) and the Conference Board of Canada (2007) have recently argued that liability is not the obstacle some say it is. Barrett et al. provide an overview of the facts, pointing out that "the same medico-legal liability system that currently protects patient and provider interests can also support collaborative practices" (in press).

Still, plenty of other barriers persist: the self-regulation of health professions continues to be largely resistant to collaborative practice; systems of payment do not reward collaboration (most notably, fee-for-service structures keep physicians from taking the leap); and professional silos persist in inter-professional education (Clements et al. 2007). With no designated responsibility for ensuring collaboration happens, it has become everybody's, but nobody's, problem too (Clements et al. 2007).

But most of these barriers can be tackled with appropriate legislation or positively influenced by the health professions themselves. The real and underlying challenge is a cultural one. Effective collaboration requires a rapprochement from all of the major healthcare professions, something often limited by the fact that each has its own history and traditions. Doctors seem to be singled out most frequently as a roadblock, although criticisms could probably be made of each profession. As Dr. Donald Berwick and colleagues noted in an article on total quality management in the National Health Service back in 1992, "Effective teams in health care will in almost all situations require active participation of doctors and frequently their leadership. Yet many doctors seem uncomfortable with real team activity" (Berwick et al. 1992). Berwick et al. (1992) say doctors "arrive late or not at all to meetings; they dominate when they are present; and they sometimes leap to solutions before the team has done its proper diagnostic work on the process."

What Now?

For patients, primary healthcare is the entryway into the healthcare system. When health professionals from various disciplines collaborate to deliver that care, they create multiple entry points, improving quality and access. To get to this stage, there is a need for greater regulatory and legislative support to foster inter-professional collaboration (Barrett et al. in press). Even before that, there need to be strong leadership, cultural readiness, trust and respect (Clements et al. 2006, 2007). Part of the solution must also involve inter-professional education and training before and after entry to practice and across the continuum of care (Health Canada 2007; Health Council of Canada 2007).

As the evidence surrounding inter-professional collaboration still needs to be shared, CHSRF is hosting a *Researcher on Call*, featuring the latest decision support synthesis (CHSRF, 2008). Researcher on Call is a series of conference calls for healthcare researchers and decision-makers designed to accelerate improvements in healthcare. In 2006, the foundation also released an electronic video documentary on teamwork, produced by journalists and filmmakers Ray Moynihan and Miranda Burne. For more information about CHSRF's work on inter-professional collaboration, visit our website at http://www.chsrf.ca/research_themes/workplace_e.php. HQ

References

Barrett, J., V. Curran, L. Glynn and M. Godwin. In press. *CHSRF Decision Support Synthesis: Interprofessional Collaboration and Quality Primary Healthcare.* Ottawa: Canadian Health Services Research Foundation.

Berwick, D.M., A. Enthoven and J.P. Bunker. 1992. "Quality Management in the NHS: The Doctor's Role-II." *British Medical Journal* 304(6822): 304–308.

Canadian Health Services Research Foundation. 2005. "Interdisciplinary Teams in Primary Healthcare Can Effectively Manage Chronic Illnesses." *Evidence Boost for Quality* <http://www.chsrf.ca/mythbusters/pdf/boost3_e.pdf>. Retrieved January 21, 2008.

Canadian Health Services Research Foundation. 2007a. "Myth: We Can Improve Quality One Doctor at a Time." *Mythbuster* <http://www.chsrf.ca/mythbusters/pdf/myth25_e.pdf>. Retrieved January 21, 2008.

Canadian Health Services Research Foundation. 2007b. "Turning the Tide on Chronic Disease: How a Province Is Using Evidence to Build Quality Improvement Capacity." P*romising Practices in Research Use*

<http://www.chsrf.ca/promising/pdf/ppractices_13_e.pdf>. Retrieved January 21, 2008.

Canadian Health Services Research Foundation. 2008. *Researcher on Call* <http://www.chsrf.ca/research/researcher_on_call_e.php>. Retrieved January 21, 2008.

Canadian Medical Protective Association. 2006. *Collaborative Care: A Medical Liability Perspective.* Ottawa: Author. <http://www.cmpa-acpm.ca/cmpapd03/pub_index.cfm?LANG=E&URL=cmpa_docs/english/resource_files/admin_docs/common/com_collaborative_care-e.html>. Retrieved January 21, 2008.

Clements, D. and J. Helmer. 2006. "Teamwork in Healthcare: Pulling It All Together." *Healthcare Quarterly* 9(4): 16–7.

Clements, D., M. Dault and A. Priest. 2007. "Effective Teamwork in Healthcare." *Healthcare Papers* 7(Special issue): 26–34.

Conference Board of Canada. 2007. *Liability Risks in Interdisciplinary Care: Thinking Outside the Box*. Ottawa: Author. <http://sso.conferenceboard.ca/e-Library/LayoutAbstract.asp?DID=1979>. Retrieved January 21, 2008.

Health Canada. 2007. *Pan-Canadian Health Human Resource Strategy 2006/07 Report.* Ottawa: Author. <http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr/2007-ar-ra/2006-07-pan_report_e.pdf Retrieved January 21, 2008.

Health Council of Canada. 2007. *Health Care Renewal in Canada: Measuring Up?* Ottawa: Author. <http://www.healthcouncilcanada.ca/docs/rpts/2007/HCC_MeasuringUp_2007ENG.pdf>. Retrieved January 21, 2008.

Jones, L. and D. Way. 2007. "Healthy Workplaces and Effective Teamwork: Viewed through the Lens of Primary Healthcare Renewal." *Healthcare Papers* 7(Special issue): 92–7.

Mable, A.L. and J. Marriott. 2002. *Sharing the Learning: Health Transition Fund. Synthesis Series: Primary Health Care.* Ottawa: Health Canada.

Moynihan, R. and M. Burne. 2006. *A Film about the Benefits of Teamwork in Healthcare.* Ottawa: Canadian Health Services Research Foundation. <http://www.chsrf.ca/research_themes/workplace_e.php>. Retrieved January 21, 2008.

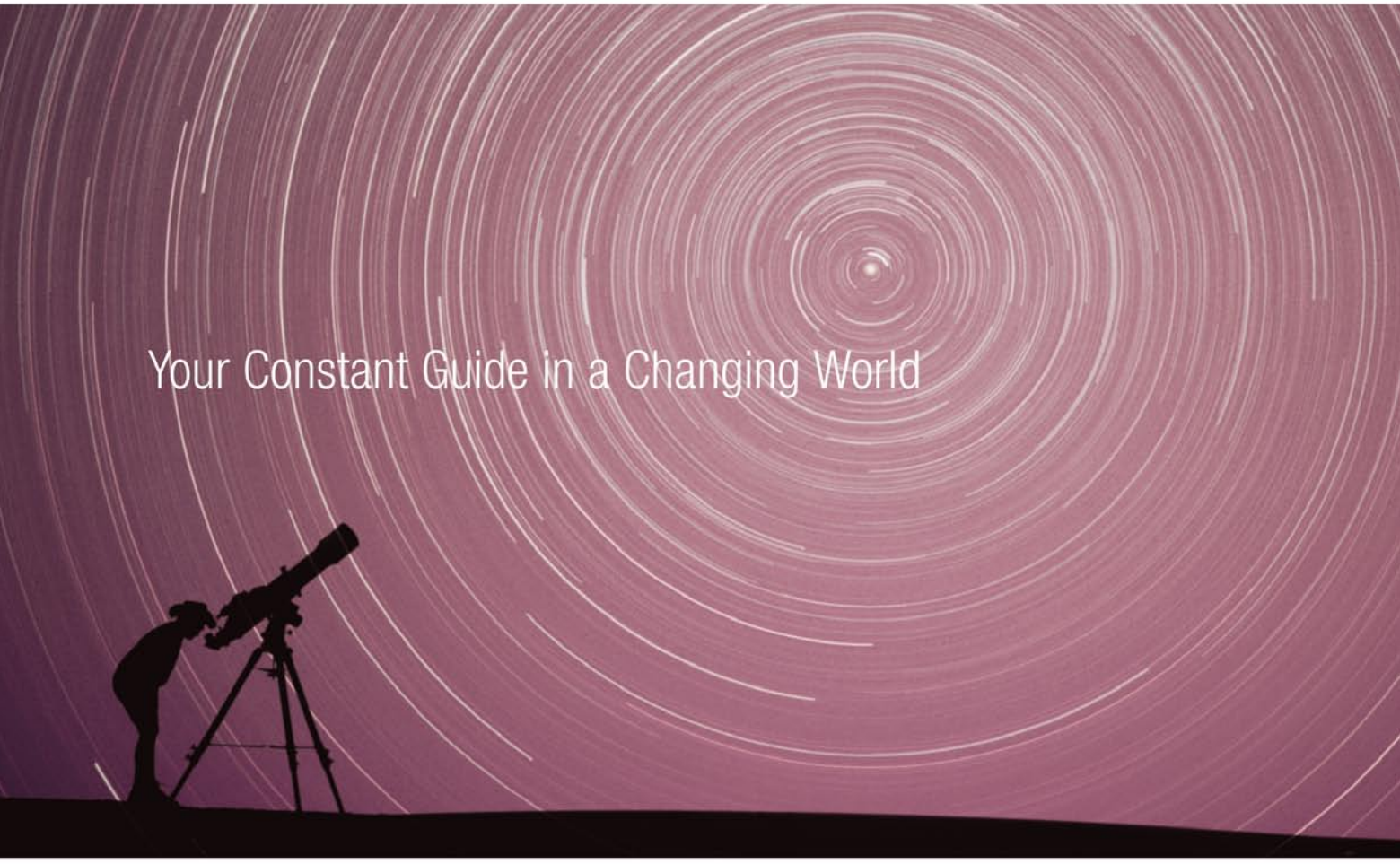
Oandasan, I., G.R., Baker, K. Barker, C. Bosco, D. D'Amour, L. Jones, S. Kimpton, L. Lemieux-Charles, L. Nasmith, L. San Martin Rodriguez, J. Tepper and D. Way. 2006. *Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada*. Ottawa: Canadian Health Services Research Foundation.

About the Authors

Jennifer Thornhill is the senior advisor, knowledge summaries, within CHSRF's Knowledge Exchange Branch.

Mylène Dault is the director, organizational learning, within CHSRF's Knowledge Exchange Branch.

Dave Clements CHSRF's vice-president of Knowledge Exchange.



Look to 3M to Keep Your Health Care Organization on Course

In today's environment of changing compliance regulations and evolving industry standards, it's easy to lose your bearings. Fortunately, nobody knows the territory like 3M Health Information Systems. For more than 15 years, Canadian health care organizations have utilized 3M and SoftMed products to:

- ★ Dramatically increase productivity, virtually eliminating scanning backlog
- ★ Significantly reduce transcription costs and turnaround time
- ★ Reduce redundant data collection and enhance data integrity

No matter how the health care world changes, with 3M Health Information System's recent merger with SoftMed, you can count on the experts at 3M to help you prepare, adapt and thrive.

www.3M.com/ca/HIS

3M SoftMed

Two Industry Experts Have Converged