Interprofessional collaboration in family health teams

An Ontario-based study

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ABSTRACT

OBJECTIVE To examine family health team (FHT) members' perspectives and experiences of interprofessional collaboration and perceived benefits.

DESIGN Qualitative case study using semistructured interviews.

SETTING Fourteen FHTs in urban and rural Ontario.

PARTICIPANTS Purposeful sample of the members of 14 FHTs, including family physicians, nurse practitioners, nurses, dietitians, social workers, pharmacists, and managers.

METHODS A multiple case-study approach involving 14 FHTs was employed. Thirty-two semistructured interviews were conducted and data were analyzed by employing an inductive thematic approach. A member-checking technique was also undertaken to enhance the validity of the findings.

MAIN FINDINGS Five main themes are reported: rethinking traditional roles and scopes of practice, management and leadership, time and space, interprofessional initiatives, and early perceptions of collaborative care.

CONCLUSION This study shows the importance of issues such as roles and scopes of practice, leadership, and space to effective team-based primary care, and provides a framework for understanding different types of interprofessional interventions used to support interprofessional collaboration.

EDITOR'S KEY POINTS

- This study reinforces previous research findings concerned with the challenges of team-based primary health care and also provides insight to the factors that support effective family health team (FHT) development.
- Family health teams are undertaking a range of interprofessional organization, practice, and education initiatives to support interprofessional collaboration; this will enable FHTs to learn from one another.
- The transition to interprofessional collaboration in FHTs is perceived as resulting in positive outcomes, but attention to critical issues such as management, leadership, time, and space is needed to support further development of FHTs.
- Future research is needed to better understand how various types of interprofessional interventions affect outcomes at different levels.

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Collaboration interprofessionnelle dans les équipes de santé familiale

Une étude en Ontario

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RÉSUMÉ

OBJECTIF Étudier l'opinion et les expériences des membres des équipes de santé familiale (ÉSF) relativement à la collaboration interprofessionnelle et à ses avantages.

TYPE D'ÉTUDE Étude de cas qualitative à l'aide d'entrevues semi-structurées.

CONTEXTE Quatorze ÉSF de régions urbaines et rurales de l'Ontario.

PARTICIPANTS On a utilisé un échantillon raisonné de membres des 14 ÉSF, incluant des médecins de famille, des infirmières praticiennes, des infirmiers, des diététistes, des travailleurs sociaux, des pharmaciens et des gérants.

MÉTHODES On a utilisé une approche d'étude de cas multiples portant sur les 14 ÉSF. On a mené 32 entrevues semi-structurées, et les données ont été analysées par une méthode inductive thématique. On a utilisé une technique de vérification par d'autres membres pour augmenter la validité des observations.

PRINCIPALES OBSERVATIONS Cinq thèmes principaux ont été identifiés : remise en question des rôles et des champs de pratique; gestion et leadership; contraintes de temps et d'espace; initiatives interprofessionnelles; et premières impressions des soins en collaboration.

CONCLUSION Cette étude montre que les rôles et champs de pratique, le leadership et l'espace sont des facteurs importantes pour des soins de santé primaires en équipe; elle fournit aussi un cadre pour comprendre les différents types d'interventions interprofessionnelles qui servent de support à la collaboration interprofessionnelle.

POINTS DE REPÈRE DU RÉDACTEUR

- Cette étude corrobore les résultats d'études antérieures portant sur les défis de la dispensation de soins primaires en équipe, tout en fournissant un aperçu des facteurs qui favorisent le développement d'équipes de santé familiale (ÉSF) efficaces.
- Pour promouvoir la collaboration interprofessionnelle, les équipes de santé familiale entreprennent divers changements au niveau de l'organisation, de la pratique et de la formation interprofessionnelles : les ÉSF pourront ainsi profiter de l'expérience des autres.
- On considère que le passage vers une collaboration interprofessionnelle dans les ÉSF donne des résultats favorables, mais pour favoriser le développement ultérieur des ÉSF, on devra tenir compte de certaines questions majeures comme l'administration, le leadership et les contraintes de temps et d'espaces.
- D'autres études seront nécessaires pour mieux comprendre comment les divers types d'interventions interprofessionnelles peuvent influer sur les résultats à différents niveaux.

Cet article a fait l'objet d'une révision par des pairs.
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This past decade has been important for primary health care reform in Canada, beginning with government reports documenting the challenges of fragmented health care[1] to the creation of policies and the allocation of funding to implement interprofessional team-based care.[2] Newly emerging primary health care teams are envisioned as providing "the most appropriate care, by the most appropriate providers in the most appropriate settings."[3]

Research findings illustrate the process of the transition to health care teams and the benefits of this interprofessional approach. Much of the research has focused on factors contributing to effective interprofessional collaboration, such as understanding of one another's roles and knowledge, communication, trust and respect, shared goals, the need for training, and supportive clinical and administrative systems, as well as challenges to collaboration such as power differentials, different approaches to patient care, and funding models.[4-13] Health providers have reported beneficial changes in attitudes and knowledge from working with other professionals, positive outcomes for student training, and improvements in quality of care.[14-17]

While evidence for interprofessional collaboration in primary care is emerging in Canada and internationally, further knowledge about progress and benefits is needed given the considerable changes involved and the importance of examining the effect on professional practice, quality of care, and health outcomes.[2,18] This paper reports on a qualitative study undertaken to examine interprofessional collaboration in family health teams (FHTs) in Ontario. This study, part of a larger project on interprofessional clinical protocol development and implementation in FHTs, examines perspectives of primary health care providers engaged in the early stages of team-based care.[19] The study adds to the developing literature that is focused on factors affecting interprofessional collaboration in primary care and begins to document the interventions being undertaken within FHTs to support teamwork and the delivery of collaborative care.

METHODS

An exploratory case-study approach was employed for this study.[20] The objectives of the study were to examine FHT members' experiences of interprofessional collaboration and its perceived benefits. Ethical approval was obtained from the University of Toronto Research Ethics Board.

Data collection and analysis

The sample consisted of representatives from 12 FHTs and 2 team-based primary care practices. The 2 team-based primary care practices are not FHTs but have a similar focus on team care; given their similar objective of team care, the term *FHT* is used in the paper to include all of the participating primary care practices. A purposeful sample[20] was taken to ensure representation from the professional groups and the different FHTs, which were located in urban and rural Ontario. In total, 32 interviews were conducted in 2 phases over a period of 8 months with the following: family physicians (n = 12); nurse practitioners and nurses (n = 6); pharmacists (n = 5); and other FHT members, including managers, social workers, and dietitians (n = 9). Most of the interviews (n = 25) were with female participants, which is not surprising given the large number of female nonphysician FHT members. Of the family physician interviews, however, half were conducted with female physicians and half were with male physicians. About half of the interviews involved FHT members who were relatively new to their FHTs, having been hired approximately within the previous year.

The interviews were conducted using a semistructured interview guide and occurred by telephone or in person. The interviews explored participants' perceptions and experiences of interprofessional collaboration. Interviews lasted for approximately 30 to 45 minutes and were recorded and transcribed verbatim before analysis. The investigators involved in data collection and analysis (J.G. and S.R.) are not health professionals or FHT members.

Data were analyzed by employing an inductive thematic approach from which major and minor themes were generated.[20] A member-checking technique was also completed, whereby a summary of the findings was sent to the participants for their feedback.[21] Participants were asked to comment upon its accuracy and provide any update on their perceptions or experiences of the project. Twelve people provided feedback and indicated that this summary provided an accurate account of the findings; 3 of these people provided minor revisions.

FINDINGS

The findings reflect the key issues from the analysis and are reported in 5 main sections: rethinking traditional roles and scopes of practice, management and leadership, time and space, interprofessional initiatives, and early perceptions of collaborative care.

Rethinking traditional roles and scopes of practice

As noted above, the FHT approach involves considerable changes in the provision of care. Family physicians (sometimes together with nurses) were previously the main providers of care within primary care practices; however, now, in the new FHT model, a broader group of professionals are working with them. This transition

involved uncertainty and substantial changes in terms of roles and responsibilities for each team member. As many participants noted, to work in a FHT one needed to adopt a new way of working.

A range of family physician attitudes toward team-based care were offered. Some participants believed that certain family physicians would have greater difficulty with the concepts of teamwork and collaboration, compared with others, who had "more awareness and appreciation and value of what the other disciplines can provide [to patient care]." (SW24)*

Some participants, such as pharmacists and nurse practitioners, described the challenges of defining their roles within the FHT and educating their colleagues about their expertise and what they could contribute to the team and patient care. While many had experience working in their professions before joining FHTs, there was much uncertainty about how this professional expertise would be applied within the FHT context:

> I'm a pharmacist so I know how to be a pharmacist. I don't know how to be a pharmacist in a FHT because nobody knows about that yet. I walked in and I did pharmacy things, but I didn't know what that meant in relation to what the nurse does or what the dietitian does. (P32)

A few participants discussed the role of nurse practitioners and the need for further clarification about their expertise and responsibilities. A small number of participants held unique professional positions (eg, case managers, patient educator, and healthy child coordinator), which were developed to ensure that FHTs were comprehensive and organized to meet patients' needs. These roles were being filled by people from various professions; the challenge, however, was in defining and shaping these innovative roles.

While some participants noted their practices were multiprofessional before forming FHTs, in that different health care professionals worked within the practice, they reported limitations in the extent of their communication and collaboration. The formal designation of an FHT and the hiring of additional health professionals meant that FHT members had a responsibility to explicitly reflect upon and address how to work as a team.

A range of perspectives regarding team-based care were also held. Some discussed the concepts of shared responsibility and accountability. For example, in one FHT, the importance of changing notions of who is the primary contact person was stressed:

> [Physicians need to] relinquish in concrete identifiable ways power over all aspects of their work, including who controls patient load, contact with patients, and decision making about patients. (FP15)

Others described how family physicians were learning to integrate various health professionals into what had previously been their practices.

A few participants discussed the implications of their newly formed FHTs on medical residents and students. It was noted that there was a need to modify training within the context of interprofessional care to include a focus on developing trainees' understanding of teamwork. The importance of faculty development for all health professionals whose roles included teaching medical residents and students was also noted.

Management and leadership

Numerous participants discussed the essential role of a manager or executive director responsible for the overall management and team development of FHTs. It was reported that this individual should be innovative and creative, as well as possess project development and management skills:

> [The executive director] has a very clear vision as to where she sees our family health team going and how can we get that in action. So I think her communication skills are great. And really, having discussions with all of us versus just the doctors, just the allied health, or just the front staff, that really, really helps get everyone on the same page. (D31)

In cases where FHTs did not have an individual in such a role or the individual in that role was perceived as not performing optimally, participants lamented a lack of team development.

Family physician leadership was identified as another critical factor that could affect FHT development. Positive physician role modeling was also regarded as key to encouraging change.

Time and space

Many FHTs included large numbers of team members, who were frequently located at more than 1 site or on different floors within a building. This geographic separation resulted in a lack of shared time and space, which was believed to impede FHT development:

> I think the biggest challenge for us currently is space, because our offices weren't designed to incorporate interprofessional staff and interprofessional care. So that's one of the biggest issues. (FP21)

Participants thought team spaces needed to be structured to optimize opportunities for communication and

*Interviewee pseudonyms indicate the following: dietitian (D), family physician (FP), manager (M), nurse practitioner (NP), pharmacist (P), and social worker (SW), as well as an interview number.

informal meetings and to discourage working in silos. In addition, it was generally agreed that FHT development required time for ongoing discussion and negotiation of roles and scopes of practice:

> You have to have meetings to find a way to handle the uncertainty and ambiguity [when developing a FHT] .... You're going to have to sit down and talk to each other about the ambiguity and uncertainty of the work they do. Yeah, it's a big change. (FP17)

Interprofessional initiatives

Participants reported on a range of activities and initiatives that FHTs were implementing to foster a team approach to care. Given that FHTs were at the early stages of development during this study, it was noted that a number of organizational activities were occurring, such as creation of team policies and the hiring of FHT members. The challenge of defining job descriptions and recruiting qualified individuals who could work collaboratively was reported:

> We need to be flexible, both the new team members and the more established team members .... I think people are quite prepared to be flexible, but it's a little bit of putting up with the uncertainty. So if you can imagine yourself as a person coming to a role that's never existed in a team, that you're being asked, as a newcomer joining a new team, to help define. (M3)

A range of other organizational initiatives (eg, creating interprofessional committees or working groups, organizing team retreats) to enable interprofessional dialogue was also reported. The key aim of these organizational activities was to create systems to support the goal of the most effective provider providing the necessary care:

> The [key to] access and efficiency is making sure that people are getting to the right profession; for example, if somebody is coming in for their second hep B shot, they don't need to see a physician. They could see a nurse. That opens up a 15-minute slot for the physician to use. (P32)

Other activities that were identified aimed to facilitate the actual process of collaboration in practice. Many participants discussed challenges with inappropriate referrals and scheduling difficulties. As a result a number of FHTs had developed approaches to improve this process, such as a checklist to use during annual health examinations, which would indicate whether a referral to the pharmacist was required. A few participants noted that their FHTs had begun regular activities such as interprofessional case conferences or case management rounds, in which members of the team met to discuss and develop interprofessional care plans for specific patients.

The electronic medical record (EMR) was a further tool being used within some practices to facilitate collaboration. A number of successes were reported; for example, in one FHT the EMR was used by the physicians, nurse, and dietitian to enter and share patient information, thus avoiding duplication of effort in the interprofessional diabetes program. While challenges with EMRs were encountered, their potential to facilitate communication was recognized.

Because FHTs were at an early stage of development, organizational and practice issues were a priority. As a result, there had not been as much opportunity to focus on interprofessional education activities, but their importance was recognized. Some FHTs had organized retreats in which team members learned about one another's approaches to care, communication processes, and decision-making styles. Other examples include an interprofessional journal club and education rounds.

Early perceptions of collaborative care

Most participants reported their FHTs were "going in the right direction" (SW14) and had already achieved gains in collaborative care. Some particularly valued the interprofessional interactions that were occurring, such as an increasing focus on collaborative patient-centred care:

> It's great to be able to do the teaching for somebody (a patient) who has a high cholesterol level and has hypertension and talk to them about the changes that they need to make and how it will affect their long-term health from a medical point of view, but then it's great ... to just be able to refer them to a dietitian and know that they're getting the best. (NP11)

Participants also thought the FHT transition was an adjustment for patients, who were accustomed to seeing their physicians, and in some cases nurses, for their primary care visits. A few participants discussed the need for patient education to explain this new model of care:

> You would explain to them [patients] that their primary care person was going to be the nurse practitioner and that there was a physician partner that they were attached to but their primary person wasn't going to be a physician .... [M]ost people were receptive to having a nurse practitioner. (M3)

Participants recognized the value of patients consulting with health professionals with the greatest expertise for particular problems. This shared care approach enabled physicians to have more time to see other patients. In addition, participants thought that patients

who were attending interprofessional clinics or were being referred appropriately to other professions were benefiting from, and appreciative of, the enhanced primary care that was provided.

DISCUSSION

This study contributes to the developing literature on interprofessional collaboration in primary care by providing insight into the emerging collaborative experiences of FHT members. Owing to FHTs being a new model of primary care, participants focused on the importance of defining and understanding changing roles and scopes of practice. This finding supports other studies in this area.[9,13,14] While all FHT members need to be engaged in discussions regarding shifting roles and scopes of practice, it has been noted that this is particularly essential for family physicians, whose identity can be perceived as undergoing a considerable transition at this stage of primary care reform.[22]

The critical role of physician leadership in supporting change to collaborative care has similarly been documented elsewhere[23] and was confirmed by our findings. This study also highlights the essential role of the FHT manager, whose expertise appears to be critical in supporting and sustaining an interprofessional FHT. This finding should not be surprising, as it is not feasible to expect physicians or other health professionals to perform this vital organizational role in addition to their clinical responsibilities.

The physical layout of the FHT's central practice space is another important factor that can promote or inhibit interprofessional collaboration. As a number of FHTs within this study were based in multiple practice sites, their ability to work effectively as interprofessional teams was challenged. Therefore, it is important to consider how space can be used to support interprofessional collaboration.[14,15]

This study also documents the different strategies and initiatives being used by the FHTs to support interprofessional care. These can be categorized into 3 main types of interprofessional interventions: organizational, practice-based, and educational. This classification is taken from an interprofessional framework that was developed based on a scoping review of the literature and consultations with health care and education decision makers. The framework provides a "road map" for the interprofessional field, including delineation of these 3 types of interprofessional interventions and their defining elements.[24,25] Classifying the interprofessional interventions in these categories enables FHT leaders to understand the different types of interventions and how each plays an important role in supporting interprofessional care. As noted above, many of the interprofessional interventions undertaken in the FHTs at the time of the study were aimed at fostering change at the organizational level, some also aimed at making change at the practice level, and a few aimed at the education level. The emphasis on interventions will change over time as the FHTs develop their foundations and determine priorities for clinical program development and focus.

While challenges were described, in general participants reported that FHTs were progressing toward an interprofessional approach to delivering care. Indeed, most perceived that this approach was making positive changes in patient care. Such perceptions are important, as they can have implications for satisfaction of the team as well as its morale. Such perceptions, however, require further evaluation to understand their relationship to the realities of accessibility of care and improvement in patient health outcomes.

Limitations

While this study had representation from a range of FHT members and yielded a number of rich insights, it is small in nature. As a result, care is needed when applying its findings in other primary care settings. Nevertheless, as noted above, other studies on interprofessional collaboration in primary care settings have identified similar themes, which reinforces the significance of these findings. As qualitative research usually involves small sample sizes, such similar findings can demonstrate their generalizability.

Conclusion

Primary care is the focus of many decision makers in Canada and internationally.[26-28] While various terms are being used to describe primary care models,[27] there is a common focus on the importance of comprehensive and coordinated primary care and on collaboration between health care professionals now integrated within the primary care setting. This study further reinforces the importance of issues such as roles and scopes of practice, leadership, and space to effective team-based primary care. The study also provides insight into the various types of interprofessional interventions being used to support interprofessional collaboration in FHTs, which are based upon a recently developed interprofessional framework. This framework can be used in future primary care research to allow for more direct comparison of research findings and ultimately to help better understand how interprofessional interventions affect outcomes at different levels.

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Contributors

Ms Goldman contributed to the study design, data collection, and analysis, as well as drafting and revising the manuscript. **Dr Meuser** contributed to the study conception and design and revising the manuscript. **Ms Rogers** managed the larger project on interprofessional clinical protocol development and implementation in family health teams and contributed to revising the manuscript. **Ms Lawrie** managed the larger project on interprofessional clinical protocol development and implementation in family health teams and contributed to the study conception and design, as well as revising the manuscript. **Dr Reeves** contributed to the study conception and design, data analysis, and drafting and revising the manuscript. All authors approved the final version of the manuscript for submission.

Competing interests

None declared

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