

## Position paper of the European Forum for Primary Care

# Improving interprofessional collaboration in primary care: Position Paper of the European Forum for Primary Care

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### ABSTRACT

Primary care is the central pillar of health care. The increasingly complex health needs of the population and individual patients in a changing society can only be met by promoting interprofessional collaboration (IpC) within primary care teams. The aim of this Position Paper of the European Forum for Primary Care (EFPC) is to analyse how to improve IpC within primary care teams. Clarification of the concept is the first step. Conditions to improve IpC are based on the education of healthcare professionals, adapting human resources, the occu-

pational structure and the skill-mix in primary care. These conditions, dependent on contextual factors, have a major influence on the development of IpC. They can be developed and organised at different levels: national, regional or team level. A framework is also needed to evaluate the level of collaboration within teams. Examples of good practice throughout Europe issued from the EFPC network illustrate this.

**Keywords:** collaboration, IpC, primary health care

### Introduction

Primary health care is the health system's central pillar. It needs to respond to people's needs and expectations. Because these needs are increasingly complex and often cannot be solved by single professionals, there is a need for more and efficient interprofessional collaboration (IpC) within primary care teams or networks. Primary care has to have an optimal skill-mix of various professionals and has to use the added value of collaboration between them. The aim of this Position Paper is to address the issue of IpC within

primary care teams to face current and future health challenges. In this, paper we use the term IpC rather than interdisciplinary collaboration to avoid confusion with collaboration between different medical disciplines only.

The dissemination of best practices in IpC is, from the perspective of the European Forum for Primary Care (EFPC), important to ensure that primary care is able to face the challenges of the future. Each country experiences its own development in terms of IpC and

distribution or delegation of responsibilities within primary care teams and networks. To understand this European variation, and distill from this the key messages for improving IpC and through this the health of the population, a first step is to define common conceptual ground. IpC requires conditions including educational, workforce and skill-mix policies to assure this. These will be illustrated by examples from different European countries.

This Position Paper considers IpC to be a good thing, if and only if it contributes to meeting the expectations and wellbeing of all citizens, and the health performance challenges of society.

## The problem

IpC is particularly important for the management of long-term conditions, often with multimorbidity, and for conditions that involve multiple health problems; but also prevention and health promotion, at the crossroads of health care and social care. Currently, in many situations, patients themselves or their social network have to coordinate care, in the absence of good collaboration between professionals. Where in the past people with multiple problems and a weak social network were often institutionalised, there is now a trend towards living longer in the community. This poses strong demands on key community health services, namely the primary care teams.

Countries with a strong primary care system and established IpC within primary care teams tend to develop more comprehensive models to manage complex care problems, ensure access to services, continuity of care, coordination and integration of services, and better clinical outcomes. There are also many examples of healthcare systems with primary care being composed of scattered, small and autonomous services. Here IpC is much more difficult to realise.

The idea behind good IpC is that it provides added value to the competences, brought in by individual professionals. In terms of professional competence, 'collective competence is more than the sum of the individual competence of the team members and is built on their specific combination' (translated by the MS).<sup>1</sup> The challenge is how to build the 'collective competence' to address the complex healthcare needs of a defined population, or of an individual patient attending a primary care setting. IpC is also needed to build governance that allows each healthcare team professional to 'give one's best' in the interaction with the other members of the team. The problem we address in this Position Paper is how to improve IpC within primary care.

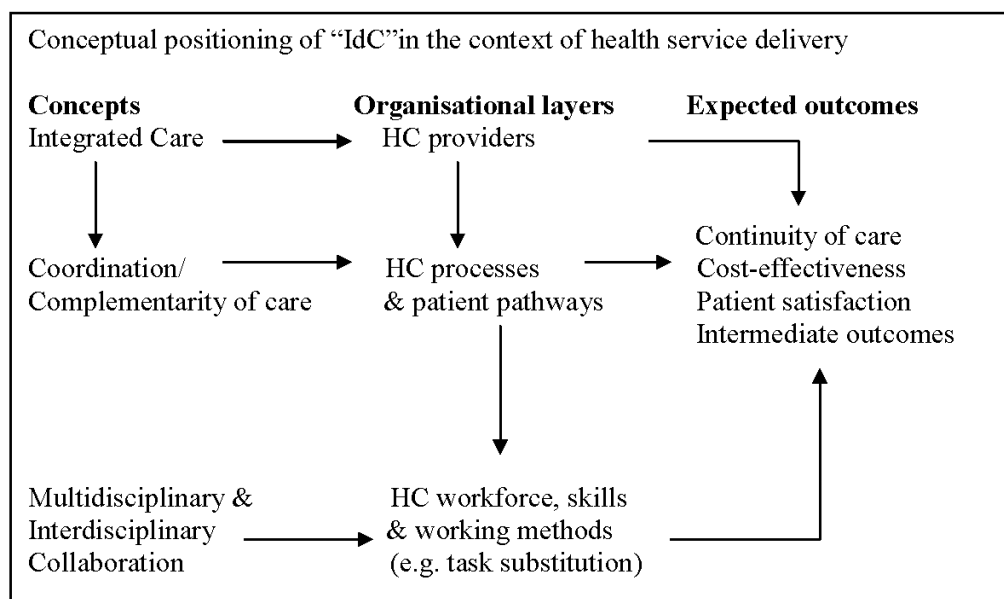
## Conceptual clarification

In order to have a common understanding and explore examples of good practice, it is important to initially explore the concept of IpC and how it applies to primary care teams and networks.

We start by positioning and defining IpC in relation to other important characteristics of health service delivery, such as integrated care, coordination or complementarity of care, multiprofessional care, task substitution and division. These terms are often used interchangeably. However, they do indicate different features of interactivity in health service delivery, although they apply to different organisational layers (e.g. healthcare provider, process of care, professional roles and skills). We do not provide the ultimate definition of IpC, but rather a common understanding of its features and relations with other important aspects of care. Figure 1 shows how we see IpC in relation to these other aspects of care.

Integrated care has long been something of a holy grail for many healthcare systems: 'though it is something everyone agrees is desirable, there is less agreement on how to overcome the very real challenges to implementation' (J Dixon, Director, The Nuffield Trust, personal communication). Integrated care relates to organisational entities because it requires governance frameworks (to link culture and behaviours to mutual accountability), management systems (to deal with risks, performance and incentives), as well as technological capabilities (to ensure support to decisions, comprehensive patient care and continuity of care). Integrated care is of course a very important aspect of primary care and the interfaces among different levels of care. It often appears to be needed to ensure complementarity of care.

Complementarity (or coordination) of care has different meanings (e.g. between treatments, professional roles, level or specialisation of providers, public vs. private actors). In relation to IpC, we focus on complementarity of care processes. This means that services are delivered within primary care teams on the basis of optimal sequential combinations of skills and resources. In this sense, IpC in primary care teams supports complementarity of care, making sure, for example, that patients' problems are managed as much as possible outside hospital settings through organised patient pathways (e.g. disease management, case management). IpC also makes it possible to discuss and determine clinical and functional priorities, taking into account patient perspectives and environmental possibilities, avoiding unnecessary treatments in the context of multimorbidity, and social complexity, emphasising prevention and health promotion.



**Figure 1** Conceptual positioning

Multiprofessional collaboration is different from IpC. Multiprofessional is a ‘non-integrative mixture of professionals in that each profession retains its methodologies and assumptions without change or development from other professionals within the multiprofessional relationship’. Within a multiprofessional relationship cooperation ‘may be mutual and cumulative but not interactive’,<sup>2</sup> while interprofessional blends the practices and assumptions of each profession involved.

In summary, we see IpC as an integrative cooperation of different health professionals, blending complementary competence and skills, to the benefit of the patient, making possible the best use of resources in a primary care setting.

## Conditions for IpC in primary care

IpC is greatly facilitated when professionals work together in the same local primary care organisation or have continuous relationships. This does not necessarily imply ‘being under the same roof’. Modern network solutions increasingly substitute for ‘bricks and mortar’ organisations. However, the situation of single professionals – such as general practitioners (GPs) or nurses – working in solo models, makes IpC a challenge. Therefore, IpC is enhanced by the development of primary care organisations, be they physical and located or virtual and network.<sup>3,4</sup> Apart from

these organisational conditions, we want to discuss some other features, drivers and barriers to IpC that are related to the education of professionals, the human resources and occupational structure of health care, and issues of skill-mix at different levels.

## Professional education

‘Professionals are falling short on appropriate competencies for effective team work’ is the conclusion of *The Lancet* Commission on health professionals’ education.<sup>5</sup> In almost all countries the education of health professionals has failed to solve the dysfunctions and inequities in health systems due to, among other things, curricular rigidities and professional silos. By interprofessional education we do not mean shared learning of various professionals on a common topic, but learning ‘from and about each other’ in order to improve collaboration.<sup>6</sup> Of course, shared learning on common topics can be a first step to real integrated team-based education that promotes collaboration. The challenge is how to educate professionals to collaborate, as the different professions usually have their own faculties or schools.

An example of an innovative educational approach outside Europe can be traced from Ontario in Canada, where the five university chairs of family medicine and the ten university deans and directors of nursing identified a vision for collaboration of physicians, nurses and nurse practitioners in the delivery of care and the resulting requirements for their education.

Central to the realisation of this view of primary care were ‘collaborative interdisciplinary teams’, consisting of family physicians (and/or paediatricians), nurses and nurse practitioners, with other providers, such as social workers, involved according to the needs of the local population.<sup>7</sup> Team-based learning has been proposed more recently in health professional undergraduate education as a tool to prepare students for effective, collaborative group work.<sup>5</sup> It involves the education of students of two or more professions learning together, by interacting on a common educational agenda. However, interprofessional education is difficult to implement due to barriers such as large numbers of students, limited facilities and rigid accreditation standards that restrict collaboration. Other mechanisms to promote team learning are shared seminars, joint course work, joint professional volunteering and interprofessional living–learning accommodation.<sup>5</sup> Furthermore, interprofessional education should be part of life-long learning and become part of the continuous development of all health professionals.<sup>5</sup>

IpC requires therefore interprofessional education, starting in existing primary care centres where collaboration is already real and which can act as teaching centres; so that students can be exposed to IpC in clinical settings and start to internalise its features and benefits from the very beginning of their professional career.

## Human resources and occupational structure

Because primary care services are labour-intensive services, IpC has to deal with workforce issues very closely. There are growing concerns throughout the European Union (EU) about health workforce numbers, including the right skills at the right location.<sup>8</sup>

Human resource policies should aim at better use of the available health workforce and improve retention (particularly through better workforce organisation and management policies, in particular in remote rural areas or deprived areas), and enhance integration in the health workforce (e.g. by attracting back those who have left the health workforce and by improving the procedures for recognising, and if necessary, supplementing foreign qualifications of immigrant health professionals). Different countries are likely to choose a different mix of policies, depending on the flexibility of their health labour markets, institutional constraints and cost.

IpC in primary care is an important feature to respond to workforce challenges, as it might foster a potential contribution to the efficient use of the health workforce, for example, by leveraging on the mix of staff in the workforce or the demarcation of roles and

activities among different categories of staff (and not just necessarily physicians and nurses). However, the relationships between different professionals in the health workforce are characterised by differences in social and professional status, clinical autonomy, and economic and political power. These differences exist, for example, between physicians and nurses. They vary strongly across European healthcare systems, making it easier to realise IpC in healthcare systems with less distance in occupational position between primary care professionals. Changes in the balance of power among different professions are important for IpC and new professional roles have to be mutually recognised. In some countries, for example, advanced nursing is becoming first-contact care (challenging the prescribing monopoly of doctors), but also the pivotal role of modern disease management programmes changes the position of nurses.<sup>9</sup> Such innovations are likely to produce tensions over established roles, challenging previous professional identities and educational paths. In the European context, collaboration between healthcare providers is a challenge not only when they come from different professional cultures, but also when they come from different countries with their own culture as a result of the migration of healthcare professionals.

## Skill-mix

The available skill-mix in primary care is an important condition for the benefits of IpC to be realised. Skill-mix developments include enhancement of skills among a particular group of staff, substitution between different groups, delegation up and down a disciplinary ladder, and innovation in roles. Such changes may be driven by different dynamics including service innovation, shortages of particular categories of worker (especially in deprived areas of cities or rural areas), quality improvement and a desire to improve the cost-effectiveness of service delivery.<sup>10</sup> Guidelines should take into account the role of various professionals concerned with a specific problem. Skill-mix should reflect the needs of the local population.

## Contextual factors for improving collaboration in primary care

The contextual factors that enhance or impinge the mentioned conditions: education, improving the use of human resources and skill-mix initiatives can be divided into three levels: the macro-, meso- and micro-levels as are shown in Table 1. Table 1 was developed by the WHO Health Evidence Network (HEN) to describe contextual factors that affect skill-mix initiat-

**Table 1** Contextual factors that have an impact on IpC

Levels and factors	Issues and requirements
<b>Macro</b>	
<b>Economic factors</b>	
Funding	Stability and level of funding for primary care
Remuneration	How providers are paid within and across professions
Insurance coverage	Needed especially for the expanded role or new role of providers
<b>Regulatory and legal factors</b>	
Scopes of practices	Population-based approach and overlapping practice populations allow cooperation of professionals with different training
Registration requirements	Differences in education levels required for professional registration must allow IpC
Provider accountability	Comfort with delegating authority to most responsible provider. Compatibility of providers insurance across professions. Clear structure of legal responsibilities
<b>Education</b>	
	Opportunities for interprofessional education and team learning
<b>Meso</b>	
Population health needs	Demographic cultural and health needs of the community
Provider supply	Availability of providers from different professions who can address population needs with different skill mixes
Existing local health system	Recognition that IpC is necessary to meet increasingly complex care needs
Interprofessional guidelines	Development of guidelines that acknowledge the different professionals involved and structures their collaboration
Stakeholder support	Support by professional associations for IpC
Legal aspects, patient safety	Responsibility and liability for diagnosis, prescriptions, and treatments (taking into account patient's safety)
<b>Micro</b>	
Uncertainty/insecurity	Degree of uncertainty or insecurity about own role and competencies among affected professionals, and any previous experience with IpC
Professional cultures and practice styles	Degree to which differences in professional cultures and practice styles are recognised and adjustments made to respect differing needs and expectations of patients
Communication	Formal and informal methods of communication among professionals
Working relationships	Pre-existing and evolving relationships among professionals

Adapted from WHO HEN Policy Brief 'How can optimal skill mix be effectively implemented and why?'.<sup>11</sup>

ives. For this Position Paper we adapted it to contextual factors that might affect IpC.

## Levels of IpC

A useful example of a framework for understanding collaboration has been developed by D'Amour *et al*<sup>12</sup> on the basis of research on IpC in a primary care setting. The framework is based on the premise that professionals want to work together to provide better care. However, at the same time, they have their own interests and want to retain a degree of autonomy and independence. The framework suggests that collaboration can be analysed in terms of four dimensions and ten associated indicators. As shown in Figure 2, two of the dimensions involve relationships between individuals (shared goals and visions, internalisation) and two involve organisational settings (formalisation and governance which influences collective action).

As shown in Figure 2, the four dimensions are interrelated and influence each other. The relational dimensions are in the words of D'Amour *et al*:

- 'Shared Goals and Vision, which refers to the existence of common goals and their appropriation by the team, the recognition of divergent motives and multiple allegiances, and the diversity of definitions and expectations regarding collaboration.
- Internalisation, which refers to an awareness by professionals of their interdependencies and of the importance of managing them, and which translates into a sense of belonging, knowledge of each other's values and profession, and mutual trust.
- Formalisation (structuring clinical care), defined as "the extent to which documented procedures that communicate desired outputs and behaviors

exist and are being used". Formalisation clarifies expectations and responsibilities.

- Governance, that is, the leadership functions that support collaboration. Governance gives direction to and supports professionals as they implement innovations related to interprofessional and inter-organisational collaborative practices'.

These dimensions are subject to the influence of external conditions, such as those mentioned in the previous section. D'Amour *et al*'s framework<sup>12</sup> recognises the complexity of IpC and suggests a diagnostic of collaboration based on 10 different indicators, revealing three possible stages of collaboration: active, developing and potential or latent collaboration (which is in fact no collaboration at this stage). The indicators reported in the next table can be used to ascertain the level of collaboration and link it to clinical outcomes and to orient interventions to improve IpC.

## IpC at work: examples from around Europe

In different countries in Europe conditions for IpC have changed and new practices have developed. We start with illustrating some of these conditions at the three different levels (macro, meso and micro) and then proceed to some lessons from examples of new practices (described on the website of the EFPC).

An example of changing conditions at the macro level is provided by new legislation in France, introduced in 2009.<sup>13</sup> This law defines clear levels of care, task division between doctors and other health professionals, coordination and cooperation between healthcare professionals. It also creates a governance

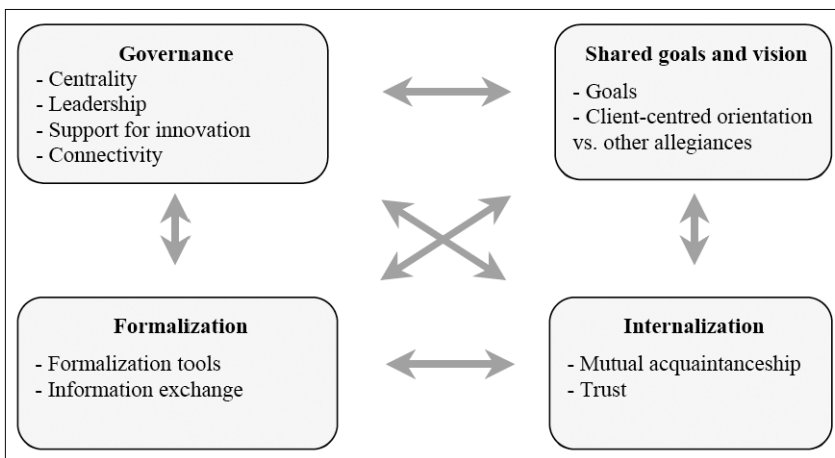


Figure 2 Collaboration dimensions and indicators<sup>13</sup>

**Table 2** Indicators of collaboration<sup>12</sup>

Indicators	Active collaboration (level 3)	Developing collaboration (level 2)	Potential or latent collaboration (level 1)
Goals	Consensual, comprehensive goals	Some shared ad hoc goals	Conflicting goals or absence of shared goals
Client-centred orientation vs. other allegiances	Client-centred orientation	Professional or organisational interests drive orientations	Tendency to let private interests drive orientations
Mutual acquaintanceship	Frequent opportunities to meet, regular joint activities	Few opportunities to meet, few joint activities	No opportunities to meet, no joint activities
Trust	Grounded trust	Trust is conditional, is taking shape	Lack of trust
Centrality	Strong and active central body that fosters consensus	Central body with an ill-defined role, ambiguous political and strategic role	Absence of a central body, quasi-absence of a political role
Leadership	Shared, consensual leadership	Unfocused, fragmented leadership that has little impact	Non-consensual, monopolistic leadership
Support for innovation	Expertise that fosters introduction of collaboration and innovation	Sporadic, fragmented expertise	Little or no expertise available to support collaboration and innovation
Connectivity	Many venues for discussion and participation	Ad hoc discussion venues related to specific issues	Quasi-absence of discussion venues
Formalisation tools	Consensual agreements, jointly defined rules	Non-consensual agreements, do not reflect practices or are in the process of being negotiated or constructed	No agreement or agreement not respected, a source of conflict

structure with a new regional body: Agence Régionale de Santé (ARS: regional health agency). This agency merged seven structures and introduced a multi-professional representation. Regional policy is based on the work of a 'regional health conference', gathering stakeholders, professionals from different backgrounds in the health and social field, and patients. It also marks a shift from a hospital-centred body to a body acting at all levels of care, and from an exclusively national-based health policy to a more regional-based health policy. Territory-based PC settings or organisational models including IpC are described.<sup>14</sup> New payment methods, more adapted to IpC, can be explored and implemented, instead of the old and exclusive fee-for-service payment for most of the healthcare professionals. Education to stimulate IpC

is included. This legal framework thus provides an administrative and legislative basis to stimulate and implement cooperation among professionals at the policy level and at the local healthcare practice level.

Another example of implementing the macro conditions for IpC is in the field of competence-oriented education for nurses in Spain. In the new nursing syllabus in Spain<sup>15</sup> a generic or transversal competency for undergraduate students is the 'capacity to work in a multidisciplinary team'. In the University of Alicante, the nursing syllabus includes two competencies: 'To understand the attitudes, activities and function that the professional has to develop in a Primary Healthcare Team' and 'To have a collaborative attitude with the different members of the team'.<sup>16</sup>

In general the trend towards more competence-oriented education provides opportunities to bring IpC skills into the curriculum.<sup>6</sup>

At the meso level, IpC can be facilitated by guidelines for cooperation in local primary care settings. An example is the Primary Care Collaboration Agreement (Landelijke Eerstelijns Samenwerkings Afspraak; LESA) in the Netherlands. The LESA is a collaborative document that serves as the basis for the realisation of working arrangements in the region between GPs and other professionals in primary care. These agreements link as much as possible to existing guidelines of the professional groups involved. A LESA provides indications for referral, information exchange, shared concerns and suggestions for further exploration within the local context. The recommendations and concerns from the LESA can be adapted to the local situation and needs. In this way, they contribute to a recognisable, unambiguous policy and continuity of care. A LESA is developed by a working group of expert representatives from the different primary care professions. To ensure broad support, members of involved associations are given the possibility to provide their comments. Involved associations will also provide their official approval. Each LESA is published in the journals of the primary care professional groups and on the websites of the Dutch College of GPs and the other associations.<sup>17</sup>

At the micro level, mutual trust and an open attitude of respect for each profession's specific approach and competencies are important conditions for IpC. An example of a tool to facilitate organisational development in multiprofessional teams, specifically PC teams, using team-based formative assessment and benchmarking, is the 'Maturity Matrix'. It covers seven organisational dimensions and is used to facilitate communication and determine common practice development objectives in order to improve quality at the practice level.<sup>18</sup>

## Examples of good practice around Europe

In order to assess the importance of IpC it is relevant to show what primary care teams based on IpC look like around Europe and what they could mean to patients, professionals and tax or third-party payers. We therefore give a few examples from around Europe to show how good practice can be developed and pitfalls avoided. The full descriptions and narratives of these good practices are given in the Appendix to this Position Paper on the EFPC website. We present here a brief summary of their main characteristics,

analysing the context, the conditions that fostered IpC, and the practical actions implying IpC.

### CASAP in Barcelona, Catalonia

The context is a large primary care health centre with healthcare professionals of various professions and skills. Among the conditions to develop IpC, the payment system was adapted, and strong leadership and flexibility in working hours were provided. The main practical actions were the development of common projects and common guidelines for specific conditions, for specific types of health needs or groups of patients, Web pages with access to all providers in the centre were created with registration and analysis of critical incidents.

### IJburg in Amsterdam, The Netherlands

The context is a network of healthcare centres and social services in a new urban district coordinated to provide services and information. Conditions were established by health insurers for access to current service delivery without financial or professional obstacles and special living conditions for particular subgroups of inhabitants (clustered homes, assisted living). The main practical actions were enabling patients to make informed choices, providing guidance for patients with specific needs (e.g. mental disorders and poor social environment), and organising an office of volunteer caregivers. Multiprofessional meetings on complex cases took place through the coordination of a 'case manager'.

### Community health centre, Botermarkt in Gent, Belgium

The context is a healthcare centre well integrated within the community of a deprived area. The team is composed of large number and variety of professionals including social workers and street workers. The healthcare centre is involved in community life and good communication exists with community organisations (schools, homes for the elderly, etc.). In terms of action, a successful plan has been undertaken to address the problem of overweight youngsters. Activities to enhance physical exercise in the whole population based on good IpC and the collaboration of the community were the main successes of the project.



## Primary healthcare centre, Jesenice, Slovenia

The context is the integration of standardised cardiovascular prevention programmes in organised primary care centres. Among the reasons for the success of this specific programme, were a large multi-disciplinary team with an adapted skill-mix at practice level, coordination at the regional level and a special focus of primary care teams on cardiovascular health conditions. Actions were taken on risk factors, through cessation of smoking, diet adaptations for weight loss and an emphasis on physical activity.

## Primary healthcare centre, Västra Götaland, Sweden

The context of this programme is a group of large primary healthcare centres in a region of Sweden. The integration of a dietician into the group in connection with all other primary care team professionals and the community allowed implementation of the programme 'Health Equilibrium Initiative'. The main action undertaken was the production of educational material on diet and physical activity in 13 languages disseminated in multiple settings and community facilities (schools, day-care, sport associations) and to local stakeholders.

## Conclusion

IpC is important for tackling the complex health needs of populations and patients. IpC facilitates addressing long-term health conditions, multimorbidity and inequity in health care. IpC may also lead to improved job satisfaction among healthcare professionals. It might be a solution (at least partial) to the diminishing workforce in health care and to the consequences of societal change. IpC is necessary to move from a disease-oriented to a goal-oriented way of dealing with health problems.<sup>19</sup>

The development of IpC in primary care is at stake in all European countries. However, there are large disparities in terms of conditions and contextual factors, such as organisation and geographical localisation, within and among countries. It seems better developed in countries with a tradition of strong primary-care-oriented healthcare systems. An additional challenge to IpC is the migration of healthcare professionals, which requires adaptation of competences of healthcare providers to population needs in the countries of destination, and leads to a brain drain of providers.

Further research is needed to analyse the influence of funding and new payment methods on cooperation between primary care providers, workforce management and the effect of migration of healthcare professionals, and the internal organisation of primary care settings.<sup>20</sup>

Although it seems self-evident that IpC leads to better health outcomes, we did not come across strong studies that showed this.

The key messages of this Position Paper are:

- IpC in primary care is important to face the challenges of increasingly complex health needs in primary care.
- IpC does not develop by itself. Adapted legislation, based on political choice, and contextual factors might strongly influence its development.
- IpC in primary care might help to face the future workforce challenges.
- Existing primary care centres with good IpC should be enabled to act as teaching centres.
- Primary care teams can diagnose their level of IpC by using the indicators such as those developed by D'Amour *et al*<sup>12</sup> or by applying the 'Maturity Matrix'.

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#### CONFLICTS OF INTEREST

None.

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