

May 8, 2007

Ms. Annie Schiefer, Project Manager  
Health Professions Regulatory Advisory Council  
55 St. Clair Avenue West  
Suite 806, Box 18  
Toronto, ON M4V 2Y7

Dear Ms. Schiefer,

The Canadian Medical Association (CMA) appreciates the opportunity to provide comments on the Health Professions Regulatory Advisory Council (HPRAC) consultation on Interprofessional Collaboration (IPC).

Enhancing patient-centred collaboration amongst the health professions is a priority for the CMA. If designed appropriately, collaborative care models have the potential to improve access and enhance the quality and safety of care. In an effort to advance a more patient-centred approach to collaborative care, the CMA has produced the attached policy and associated background paper. This policy outlines 12 factors that we believe are critical to fostering greater collaboration.

We would encourage you to review and utilize this policy as you proceed through your consultation.

We have also had an opportunity to review the Ontario Medical Associations (OMA) detailed analysis of HPRAC's consultation guide and fully support the comments and concerns outlined in their response.

We want to reinforce the notion that collaboration is not contingent upon the expansion of scopes of practice for certain provider groups. Furthermore, it is essential that any new model of care does not create an environment of provider competition or an expectation/requirement for physician substitution.

Clarity of roles, responsibilities, accountabilities and communication is at the heart of any newly established interprofessional collaboration. We don't believe that successful collaborative arrangements can be achieved through regulation or legislation but rather are only sustainable through mutual respect and trust, open communication and the removal of barriers between the provider groups. The CMA's policy provides a road map for this facilitation. In addition, the "Courses of Care" approach as outlined in the OMA submission provides a means to tangibly define the working relationships in the integrated care of a particular patient.

***A healthy population and a vibrant medical profession • Une population en santé... une profession médicale dynamique***

We remain hopeful and confident that enhanced interprofessional collaboration will have a real and positive impact on the care of patients and on the professional lives of providers.

Thank you again for the opportunity to participate in this consultation.

Sincerely,

Todd Watkins, BSc, MD, CCFP  
Director, Office of Professional Services

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## ACHIEVING PATIENT-CENTRED COLLABORATIVE CARE (2008)

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The Canadian Medical Association (CMA) recognizes that collaborative care is a desired and necessary part of health care delivery in Canada and an important element of quality, patient-centred care. The CMA considers patient-centred care to be the cornerstone of good medical practice. This is reflected in the first principle of the CMA Code of Ethics, which states that physicians have a fundamental responsibility to “Consider first the well-being of the patient.” As patient advocates, physicians strive to ensure that their patients receive the best possible care.

The CMA supports greater collaboration among providers in the interest of better patient care. In the context of clinical practice, the CMA defines collaborative care as follows:

*“Collaborative care entails physicians and other providers using complementary skills, knowledge and competencies and working together to provide care to a common group of patients based on trust, respect and an understanding of each others’ skills and knowledge. This involves a mutually agreed upon division of roles and responsibilities that may vary according to the nature of the practice personalities and skill sets of the individuals. The relationship must be beneficial to the patient, and acceptable to the physician and other providers.”*

If designed appropriately, collaborative care models have the potential to:

- improve access to care;
- enhance the quality and safety of care;
- enhance the coordination and efficiency of care;
- enhance provider morale and reduce burnout within health professions.

To realize this full potential, the profession acknowledges and accepts that it has a central role to play in the evolution of a team-based approach to care.

These policy principles have been prepared by the Canadian Medical Association in order to ensure that the evolution of collaborative care in Canada is built around the needs of individual patients and groups of patients. This policy is founded on the CMA’s document, *Putting Patients First: Patient-Centred Collaborative Care – A Discussion Paper*.

### Principles for Collaborative Care

The medical profession supports collaborative care, both in the hospital and in the community, as one of the essential elements of health care delivery in Canada. In the interests of enhancing the evolution of patient-centred collaborative care, the CMA proposes the following “critical success factors” and principles to address meaningfully

the issues and barriers identified by physicians and bring clarity to the discussions.

## 1. PATIENT-CENTRED CARE

First and foremost, medical care delivered by physicians and health care delivered by others should be aligned around the values and needs of patients.

Collaborative care teams should foster and support patients, and their families, as active participants in their health care decision-making. New models should have the potential to empower patients to enhance their role in prevention and self-care.

*Models of collaborative care must be designed to meet the needs of patients.*

*Collaborative models of practice must reduce fragmentation and enhance the quality and safety of care provided to patients.*

*It is the patient who ultimately must make informed choices about the care he or she will receive.*

## 2. RECOGNITION OF THE PATIENT- PHYSICIAN RELATIONSHIP

The mutual respect and trust derived from the patient-physician relationship is the cornerstone of medical care. This trust is founded on the ethical principles that guide the medical profession as defined in the CMA Code of Ethics. The impact of collaborative models of practice on this relationship, and hence the patient's satisfaction and experience with their care, is unknown.

*Models of collaborative care must support the patient-physician relationship.*

*Entry into and exit from a formal collaborative care arrangement must be voluntary for both the patient and the physician.*

*A common Code of Ethics should guide the practice of collaborative care teams.*

*Every resident of Canada has the right to access a personal family physician. †*

## 3. PHYSICIAN AS THE CLINICAL LEADER

Effective teams require effective leadership. A defined clinical leader is required to ensure proper functioning of the team and to facilitate decision-making, especially in complex or emergent situations. In collaborative care the clinical leader is responsible for maximizing the expertise and input of the entire team in order to provide the patient with comprehensive and definitive care.

It is important to differentiate “clinical leadership” from “team coordination.”

The CMA defines a clinical leader as:

*“The individual who, based on his or her training, competencies and experience, is best able to synthesize and interpret the evidence and data provided by the patient and the team, make a differential diagnosis and deliver comprehensive care for the patient. The clinical leader is ultimately accountable to the patient for making definitive clinical decisions.”*

Whereas, the team coordinator is defined as:

*“The individual, who, based on his or her training, competencies and experience, is best able to coordinate the services provided by the team so that they are integrated to provide the best care for the patient.”*

The concept of “most responsible physician” has been and continues to be used to identify the individual who is ultimately responsible for the care of the patient. The “most responsible physician” is responsible for collecting, synthesizing and integrating the expert opinion of physician and non-physician team members to determine the clinical management of the patient. Similarly, the presence of a defined clinical leader in a collaborative care setting creates clarity for

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† Where the term “family physician” is used, it is also meant to include general practitioners.

patients, their families and the health care team by making lines of communication and responsibility clear, ultimately improving the quality and safety of care.

In the CMA's opinion, the physician is best equipped to provide clinical leadership. This does not necessarily imply that a physician must be the team coordinator. Many teams will exist in which the physician will have a supporting role, including those focused on population health and patient education. We believe the most effective teams are ones in which the leadership roles have been clearly defined and earned. Some physicians may be prepared to play both roles; however, other members of the team may be best suited to serve as team coordinator.

Currently, patients rely on, and expect, physicians to be clinical leaders in the assessment and delivery of the medical care they receive. In a collaborative care environment this expectation of physician leadership will not change. Team members will have specific knowledge and expertise in their respective disciplines. Physicians, by virtue of their broad and diverse knowledge, training and experience, have a unique appreciation of the full spectrum of health and health care delivery in their field of practice and are therefore best qualified to evaluate and synthesize diverse professional perspectives to ensure optimal patient care.

*The physician, by virtue of training, knowledge, background and patient relationship, is best positioned to assume the role of clinical leader in collaborative care teams. There may be some situations in which the physician may delegate clinical leadership to another health care professional. Other health care professionals may be best suited to act as team coordinator.*

#### **4. MUTUAL RESPECT AND TRUST**

Trust between individuals and provider groups evolves as knowledge and understanding of competencies, skills and scopes of practice are gained. Trust is also essential to ensuring that the team functions efficiently and maximizes the contributions of all members.

Funders and providers should recognize the importance of team building in contributing to team effectiveness. Collaborative care funding models should support a more formalized and integrated approach to both change management and team building.

As relationships are strengthened within the team, so too are trust and respect. Physicians and all team members have an opportunity to be positive role models to motivate and inspire their colleagues. All team members ought to make a commitment to respect and trust each other with the knowledge that it will lead to enhanced care for patients and a more productive work environment for all.

*To serve the health care needs of patients, there must be a collaborative and respectful interaction among health care professionals, with recognition and understanding of the contributions of each provider to the team.*

*In order to build trust and respect within the team it is essential that members understand and respect the professional responsibility, knowledge and skills that come with their scope of practice within the context of the team.*

#### **5. CLEAR COMMUNICATION**

In collaborative care environments, it is essential that all members of the team communicate effectively to provide safe and optimal care. Effective communication is essential to ensure safe and coordinated care as the size of the team expands to meet patient needs. It is the responsibility of all team members to ensure that the patient is receiving timely, clear and consistent messaging.

Physicians can take a leadership role in modeling effective communications throughout the team. In particular, there is an opportunity to enhance the consultation and referral process, in order to provide clear and concise instructions to colleagues and optimize care. Sufficient resources, including dedicated time and support, must be available to the team to maximize these communication requirements.

*Effective communication within collaborative care teams is critical for the provision of high quality patient care. Planning, funding and training for collaborative care teams must include measures to support communication within these teams.*

*Mechanisms must be in place within a collaborative team to ensure that both the patients, and their caregiver(s) where appropriate, receive timely information from the most appropriate provider.*

*Effective and efficient communications within the collaborative care team, both with the patient and among team members, should be supported by clear documentation that identifies the author.*

*A common, accessible patient record in collaborative care settings is desirable to ensure appropriate communication between physicians and other health care professionals, to prevent duplication, coordinate care, share information and protect the safety of patients.*

*An integrated electronic health record is highly desirable to facilitate communication and sharing among team members.*

## **6. CLARIFICATION OF ROLES AND SCOPES OF PRACTICE**

In order for the team to function safely and efficiently, it is critically important that the scope of practice, roles and responsibilities of each health care professional on the team be clearly defined and understood. In turn, the patient, as a team member, should also have a clear understanding of the roles and scopes of practice of their providers.

*Collaborative care must first and foremost serve the needs of patients, with the goal of enhancing patient care; collaborative care is not contingent upon altering the scope of practice of any provider group and must not be used as a means to expand the scope of practice and/or independence of a health professional group. Changes in the scope of practice of all provider groups must be done with oversight from the appropriate regulatory authority.*

*Where non-physicians have been provided with an opportunity to undertake activities related to patient care typically unique to the practice of medicine (e.g., ordering tests) they must not do so independently but undertake these activities within the context of the team and in a manner acceptable to the clinical leader.*

*The role and scope of practice of each member of the collaborative care team should be clearly understood and delineated in job descriptions and employment contracts.*

*A formal process for conflict resolution should be in place so that issues can be dealt with in a timely and appropriate manner.*

## **7. CLARIFICATION OF ACCOUNTABILITY AND RESPONSIBILITY**

In the context of providing optimal care, providers must be accountable and responsible for the outcome of their individual practice, while sharing responsibility for the proper functioning of the collaborative care team. This individual responsibility is required so that regardless of the number and diversity of providers involved in the team, patients can be assured that their well-being is protected and that the team is working toward a common goal.

In collaborative care teams, a physician should be identified as the person most responsible for the clinical care of individual patients, and as such must be accountable for the care rendered to patients. This is consistent with the commitment made by the physician in the doctor-patient relationship, mirrors the clinical training of the physician relative to other providers, is reflective of the current state of tort law as it applies to medical practice, and is compatible with the structure of care delivery in hospitals and in the community. Clearly, this type of arrangement does not eliminate the necessity for all providers to be accountable for the care that they provide.

*It is essential that all providers be responsible and accountable for the care that they provide and for the well-being of the patient.*

*As clinical leader, the physician should be responsible for the clinical oversight of an individual patient's care.*

## **8. LIABILITY PROTECTION FOR ALL MEMBERS OF THE TEAM**

As discussed earlier in this paper, the resolution of the multiplicity of liability issues that result from care delivered by teams requires clearly defined roles and responsibilities in the team setting and the absolute requirement for appropriate and sufficient liability coverage for each health professional. The August 2006 statement of the Canadian Medical Protective Association, *Collaborative Care: A medical liability perspective*, identifies issues of concern to physicians and proposes solutions to reduce those risks.

*All members of a collaborative care team must have adequate professional liability protection and/or insurance coverage to accommodate their scope of practice and their respective roles and responsibilities within the collaborative care team.*

*Physicians, in their role as clinical leaders of collaborative care teams, must be satisfied with the ongoing existence of appropriate liability protection as a condition of employment of, or affiliation with, other members on collaborative care teams.*

*Formalized procedures should be established to ensure evidence of this liability protection.*

## **9. SUFFICIENT HUMAN RESOURCES AND INFRASTRUCTURE**

Collaborative models of health care delivery hold the promise of enhancing access to care for patients at a time of serious health human resource shortages. However, effective patient-centred collaborative care depends on an adequate supply of physicians, nurses and other providers. Governments and decision-makers must continue to enhance their efforts to increase the number of physicians and nurses available to provide health care services.

Collaborative care should not be seen as an opportunity for governments to substitute one care provider for another simply because one is more plentiful or less costly than the other.

In addition, governments must understand that co-location of individuals in a team is not a requirement for all collaborative care. Where team co-location does not exist, appropriate resources must be dedicated to ensure communication can be timely, effective and appropriate between providers.

*Governments, at all levels, must address the serious shortage of physicians to ensure quality patient care for Canadians.*

*The effective functioning of a collaborative care team depends on the contribution of a physician.*

*Governments must enhance access to medical care by increasing the number of physicians and providers, and not by encouraging or empowering physician substitution.*

## **10. SUFFICIENT FUNDING & PAYMENT ARRANGEMENTS**

Funding must be present to support all aspects of the development of collaborative care teams. At the practice level, remuneration methods for physicians, irrespective of their specialty, must be available to facilitate collaborative care arrangements and environments in which physicians practice. All care delivery models, including collaborative care teams, must have access to adequate and appropriate resources. This includes, but should not be limited to, funding for health human resources, administration/management infrastructure, liability protection, clinical and team/administrative training, team building, and information technology.

Remuneration models should be established in a manner that encourages providers to participate effectively in the delivery of care and team effectiveness.

Reimbursement models must be configured to remunerate the communicator, coordinator, manager, and other roles and responsibilities of providers necessary for the success of collaborative care practice.

*The ability of a physician to work in a collaborative care team must not be based on the physician's choice of remuneration. Similarly, patients should not be denied access to the benefits of collaborative practice as a result of the physician's choice of payment model.*

*Collaborative care relationships between physicians and other health care providers should continue to be encouraged and enhanced through appropriate resource allocation at all levels of the health care system.*

*Physicians should be appropriately compensated for all aspects of their clinical care and leadership activities in collaborative care teams.*

*Physicians should not be expected to incur the cost of adopting and maintaining health information technology capabilities that facilitate their ability to participate in collaborative practice teams. Governments must fund and support in an ongoing manner, both financially and technically, the development and integration of electronic health records.*

## **11. SUPPORTIVE EDUCATION SYSTEM**

Canada is renowned for a quality medical education system and for the early efforts to enhance interprofessional training. The success of collaborative care requires a commitment towards interprofessional education and is contingent upon the positive attitudes and support of educators. To facilitate a sustainable shift toward collaborative practice, these efforts must be continued and enhanced in a meaningful way. However, governments and educators must ensure that the availability and quality of medical education is not compromised for medical trainees.

*Interprofessional education, at the undergraduate, postgraduate and continuing education levels, is necessary to facilitate a*

*greater understanding of the potential roles, responsibilities and capabilities of health professions, with the overall goal of building better health care teams founded on mutual respect and trust.*

*Governments must understand the importance of interprofessional education and fund educational institutions appropriately to meet these new training needs.*

*Educational opportunities must exist at all levels of training to acquire both clinical knowledge and team effectiveness/leadership training.*

*Interprofessional education opportunities must not come at the expense of core medical training. High quality medical education must be available to all medical trainees as a first priority.*

## **12. RESEARCH AND EVALUATION**

More research and evaluations are necessary to demonstrate the benefits of collaborative care, to foster greater adoption by providers and to attract the necessary investment by governments. Quality management systems must be built into the team to ensure efficiencies can be recorded. Measures of the quality of care, cost effectiveness and patient and provider satisfaction should be evaluated.

*Research into the effectiveness of collaborative care models on health outcomes, patient and provider satisfaction and health care cost effectiveness should be ongoing, transparent and supported by governments.*

*Quality assessment measures must be incorporated into the ongoing work of collaborative care teams.*

**PUTTING *PATIENTS FIRST*<sup>®</sup>:**  
**PATIENT-CENTRED COLLABORATIVE CARE**  
**A DISCUSSION PAPER**  
**JULY 2007**



## Preamble

This discussion paper responds to a request from the Canadian Medical Association (CMA) Board of Directors to better define and clarify the roles and responsibilities of physicians practising in collaborative care environments and to develop principles that could guide the future evolution of patient-centred collaborative care in Canada.

This paper was developed by a CMA Working Group comprised of members drawn from various sectors of the medical profession (see Appendix A) and does not represent CMA policy. It will be presented to General Council in August 2007 as a working draft intended to inform the development of future policy. Ultimately, the Board hopes that future policy and an associated advocacy strategy will influence the evolution of collaborative care in Canada, enhance cooperation among health care professionals and promote quality health care for Canadians in all care settings.

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## Introduction

The Canadian Medical Association (CMA) recognizes that collaborative care practice is a desired and necessary part of health care delivery in Canada and an important element of quality, patient-centred care. Physicians have always practised in an environment that requires collaboration and sharing of responsibilities for care with others. Whether their practice is hospital or community-based, in an urban or rural practice setting, as a family physician or other specialist; all physicians seek out, and rely upon collaborative interaction with many other health care professionals. They do this to ensure that their patients receive effective and seamless care.

The evolution of collaborative care in Canada must be built around the needs of individual patients and groups of patients. The CMA considers patient-centred care to be the cornerstone of good medical practice. This is reflected in the first principle of the CMA Code of Ethics, which states that physicians have a fundamental responsibility to “Consider first the well-being of the patient.” As patient advocates, physicians strive to ensure that their patients receive the best possible care.

At the heart of patient-centred care lies the patient-physician relationship, the importance of which cannot be overstated. Built on the values of trust, empathy, respect and honesty, it is the foundation on which our therapeutic alliance exists.

The CMA perspective on patient-centred care is consistent with the Institute for Healthcare Improvement definition:

*“Care that is truly patient-centred considers patients’ cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes patients and their loved ones an integral part of the care team who collaborate with health care professionals in making clinical decisions.*

*Patient-centred care puts responsibility for important aspects of self-care and monitoring in patients’ hands – along with the tools and support they need to carry out that responsibility.*

*Patient-centred care ensures that transitions between providers, departments, and health care settings are respectful, coordinated, and efficient.”<sup>1</sup>*

The CMA believes that the patient must remain the focal point in any discussions surrounding collaborative care. Collaborative care is a means to an end, and as the Canadian population continues to age and care becomes more complex, technology continues to evolve and the education and training of health care providers progresses, the roles, responsibilities and relationships of physicians and all other health care professionals will need to adapt to these realities.

## Background

Beginning in the 1990s, a number of federal initiatives and projects have focused on creating and enhancing collaborative care team arrangements. At the federal level, the majority of such initiatives have been sponsored by the 1997 Health Transition Fund or the 2000 Primary Health Care Transition Fund (PHCTF). One of the PHCTF funding envelopes was specifically targeted at development of a national strategy on collaborative care, and five national initiatives were approved, with goals of:

- providing evidence of what works and what does not work regarding the implementation of collaborative, interprofessional primary health care;

- creating resources and tools to assist various health care professionals to work in a more collaborative environment; and
- obtaining support and agreement among various professionals about their roles and responsibilities in collaborative settings.

By 2004, the First Ministers' Health Accord identified that changing the way health professionals are educated is a key component of health system renewal. As a result the Interprofessional Education for Collaborative Patient Care Practice initiative was established with the following objectives:

- to promote and demonstrate the benefits of interprofessional education for collaborative patient-centred practice;
- to increase the number of educators prepared to teach from an interprofessional, collaborative, patient-centred perspective;
- to increase the number of health professionals trained for patient-centred collaborative practice before, and after, entry to practice;
- to stimulate networking and sharing of best educational approaches for collaborative patient-centred practice; and
- facilitate interprofessional collaborative care in both the education and practice settings.<sup>2</sup>

The final report of Task Force Two, an initiative of the Canadian Medical Forum that was co-chaired by the College of Family Physicians of Canada (CFPC), Royal College of Physicians and Surgeons of Canada (RCPSC) and CMA, identified a need to enhance interprofessionalism. It suggested three core strategies:

1. Create a culture for interprofessional collaboration.
2. Establish sustainable funding/remuneration models that support collaborative practice.
3. Provide a regular evaluation of the impact of interprofessional collaborative practice on patient/client, system and provider outcomes, and apply the findings to the planning process.<sup>3</sup>

Most recently, 10 health professional organizations, including CMA and CFPC, ratified the principles and framework for interdisciplinary collaboration in primary care developed through the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) project. The document articulates six principles for primary care:

1. patient/client engagement;
2. population health approach;
3. best possible care and services;
4. access;
5. trust and respect; and
6. effective communication.

While endorsing this document, the CMA Board of Directors noted that many important issues remained unresolved and proposed that the medical profession take a greater leadership role in the evolution of collaborative care in Canada.

In March 2007, the Canadian Health Services Research Foundation published a policy synthesis with recommendations on teamwork. Its report spelled out the research evidence and system factors that affect teamwork, together with priorities and implications for government and decision-makers, educators and professions to create more effective teams. It concluded that “a health care system that supports effective teamwork can improve the quality of patient care, enhance patient safety, and reduce workload issues that cause burnout among health care professionals.”<sup>4</sup>

Despite all the research, planning and activity targeted at enhancing collaborative care in Canada, challenges and barriers still exist. In 1998, researchers Headrick, Wilcock & Batalden identified some impediments to effective collaborative care teams. Many of these remain:

- Differences in history and culture, coupled with historical interprofessional and intraprofessional rivalries, complicate the establishment of effective collaborative care teams.
- Communication between team members is difficult as various professions use different language and jargon.
- Differences in schedules and professional routines may affect a team's ability to meet to discuss patient care issues.

Additional impediments include varying levels of preparation, qualifications and status among the professions, as well as varying requirements, regulations and norms of professional practice and education.

## View from the profession

The CMA supports greater collaboration among providers in the interest of better patient care. In the context of clinical practice, the CMA defines collaborative care as follows:

*“Collaborative care entails physicians and other providers using complementary skills, knowledge and competencies and working together to provide care to a common group of patients based on trust, respect and an understanding of each others’ skills and knowledge. This involves a mutually agreed upon division of roles and responsibilities that may vary according to the nature of the practice personalities and skill sets of the individuals. The relationship must be beneficial to the patient, the physician and other providers. \*”*

Physicians recognize the value of collaborative care. CMA's recent online Specialty Care Consultation involving family physicians and other specialists revealed that 80% of the 4127 respondents indicated support for pursuing alternative models of care delivery, with 93% of respondents supporting collaborative models throughout the system. However, they also identified a number of barriers to the successful implementation of collaborative care, including:

- ineffective supports including information technology;
- unresolved remuneration and pay issues;
- lack of adequate program funding;
- lack of time for proper implementation;
- accountability for patient care is ambiguous;
- unresolved medical liability issues; and
- resistance to change for professions, institutions, politicians and governments.

The CFPC acknowledges the importance of collaboration and notes that family physicians see themselves as part of a community network of health care providers, as important members of collaborative care teams and as clinical leaders on these teams. Similarly, the RCPSC identifies “collaborator” as one of the seven key roles for physicians. The two associated competencies of collaboration include consulting effectively with other physicians and health care professionals, and contributing effectively to other interdisciplinary team activities.<sup>5</sup> Most recently, the CFPC and the RCPSC issued a paper with recommendations to promote increased intraprofessional collaboration among family physicians and other medical specialists.

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\* Adapted from the Ontario Medical Association definition of collaborative care, 2007.

Examples of successful collaborative practice arrangements abound in areas such as rehabilitative medicine, mental health, palliative care, geriatric care, chronic disease management and community-based primary care/family medicine clinics. In fact, one could say that there isn't an intensive care unit in Canada in which the providers do not function in a collaborative manner. Such collaboration is critical for the delivery of high quality care to patients with complex problems.

While the underlying concepts and guiding principles of collaborative care are eminently supportable, the "politics" of collaborative care has not been. Too often, governments, other providers and health system managers have used "collaborative care" as a vehicle to achieve objectives and address agendas that are not focused on patient care. These include:

- constraining health care costs;
- controlling the medical profession;
- diminishing physician influence;
- advancing individual personal and/or professional self-interests such as expanding scope of practice, or constraining competition by others;
- altering physician payment mechanisms; and
- reconfiguring models for health care delivery.

In addition, collaborative care models have often been developed and implemented hastily in a random and ad hoc manner, and without any meaningful involvement of physicians. They have therefore often been perceived as things done "to" physicians, not "with" them, and have therefore been met with skepticism and resistance.

Competitive, rather than collaborative, models of practice threaten to cause fragmentation and confusion that could adversely affect the quality and safety of care provided to patients. Physicians are very concerned about the unintended consequences of an ever expanding "team" of providers who have enhanced roles and responsibilities. The focus of our efforts to enhance collaborative care must be on the quality and safety of care provided to Canadians.

## Principles for Collaborative Care

The medical profession has a responsibility to help lead the evolution of collaborative care in order to meet the current and future health care needs of Canadians.

If designed appropriately, collaborative care models have the potential to:

- improve access to care;
- enhance the quality and safety of care;
- enhance the coordination and efficiency of care; and
- enhance provider morale and reduce burnout within health professions.

To realize this full potential the profession acknowledges and accepts that it has a central role to play in the evolution of a team-based approach to care. Specifically, as members of collaborative care teams, all physicians have a responsibility to:

- collaborate with team members;
- maintain a patient-centred focus of care;
- understand and respect the roles and skills of providers within the team;
- listen to and value the input of team members in the care of a patient;
- communicate effectively with all members of the team;

- enhance intraprofessional collaboration within medicine and interprofessional collaboration with other providers;
- provide leadership in the evolution of collaborative care at all levels;
- encourage and foster personal growth of team members; and
- champion ethical practice and work with the other health professions to develop a common code of ethics to be used by collaborative care teams.

In these settings, no one person is responsible for the success of the team or possesses the skills and knowledge needed to provide all care that may be required by an individual patient. In these settings, individual team members share a common goal of caring for the patient. An analysis of successful teams will often reveal a common set of traits that facilitate that success. Within these teams, individuals:

- have clear roles and responsibilities;
- understand the scope of practice and competencies of all members of the team;
- understand the leadership and decision-making roles within the team;
- have earned mutual respect and trust among its members; and
- have established clear processes of communication.

The medical profession supports collaborative care, both in the hospital and in the community, as one of the possible essential elements of health care delivery in Canada. In the interests of enhancing the evolution of patient-centred collaborative care, the CMA proposes the following “critical success factors” and principles to meaningfully address the issues and barriers identified by physicians and bring clarity to the discussions.

## **1. PATIENT-CENTRED CARE**

First and foremost, medical care delivered by physicians and health care delivered by others should be aligned around the values and needs of patients. Addressing the health care needs of Canadians in the most comprehensive, effective and efficient way must be the driving force for collaborative care.

Collaborative care teams should foster and support patients, and their families, as active participants in their health care decision- making. New models should have the potential to empower patients to enhance their role in prevention and self-care.

Patients and their families must be provided with access to information and opportunities to ask questions regarding the collaborative care team. They must also be included in discussions regarding their role as a team member – both in terms of making informed decisions about their care and the important role they plan in improving their personal conditions.

***Models of collaborative care must be designed to meet the needs of patients.***

***Collaborative models of practice must reduce fragmentation and enhance the quality and safety of care provided to patients.***

***It is the patient who ultimately must make informed choices about the care he or she will receive.***

## 2. RECOGNITION OF THE PATIENT–PHYSICIAN RELATIONSHIP

The mutual respect and trust derived from the patient-physician relationship is the cornerstone of medical care. This trust is founded on the ethical principles that guide the medical profession as defined in the CMA Code of Ethics. The impact of collaborative models of practice on this relationship, and hence the patient’s satisfaction and experience with their care, is unknown.

*Models of collaborative care must support the patient-physician relationship.*

*Entry into and exit from a collaborative care arrangement must be voluntary for both the patient and the physician.*

*A common Code of Ethics should guide the practice of collaborative care teams.*

*Every resident of Canada has the right to access a personal family physician. †*

## 3. PHYSICIAN AS THE CLINICAL LEADER

Effective teams require effective leadership. A defined clinical leader is required to ensure proper functioning of the team and to facilitate decision-making, especially in complex or emergent situations. In collaborative care the clinical leader is responsible for maximizing the expertise and input of the entire team in order to provide the patient with comprehensive and definitive care.

It is important to differentiate “clinical leadership” from “team coordination.”

The CMA defines a clinical leader as:

*“The individual who, based on his or her training, competencies and experience, is best able to synthesize and interpret the evidence and data provided by the patient and the team, make a differential diagnosis and deliver comprehensive care for the patient. The clinical leader is ultimately accountable to the patient for making definitive clinical decisions.”*

Whereas, the team coordinator is defined as:

*“The individual, who, based on his or her training, competencies and experience, is best able to coordinate the services provided by the team so that they are integrated to provide the best care for the patient.”*

The concept of “most responsible physician” has been and continues to be used to identify the individual who is ultimately responsible for the care of the patient. The “most responsible physician” is responsible for collecting, synthesizing and integrating the expert opinion of physician and non physician team members to determine the clinical management of the patient. Similarly, the presence of a defined clinical leader in a collaborative care setting creates clarity for patients, their families and the health care team by making lines of communication and responsibility clear, ultimately improving the quality and safety of care.

In the CMA’s opinion, the physician is best equipped to provide clinical leadership. This does not necessarily imply that physicians must be the team coordinator. Many teams will exist in which the physician will have a supporting role, including those focused on population health and patient education. We believe the most effective teams are ones in which the leadership roles have been

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† Where the term “family physician” is used, it is also meant to include general practitioners.

clearly defined and earned. Some physicians may be prepared to play both roles; however, other members of the team may be best suited to serve as team coordinator.

Currently, patients rely on, and expect, physicians to be clinical leaders in the assessment and delivery of the medical care they receive. In a collaborative care environment this expectation of physician leadership will not change. Team members will have specific knowledge and expertise in their respective disciplines. Physicians, by virtue of their broad and diverse knowledge, training and experience, have a unique appreciation of the full spectrum of health and health care delivery in their field of practice and are therefore best qualified to evaluate and synthesize diverse professional perspectives to ensure optimal patient care.

Both the RCPC and CFPC identify the roles of medical expert and skilled clinician as central to the competencies physicians are expected to acquire. Achieving optimal outcomes from health care requires a contribution from all members of the team. Difficult decisions abound, and ultimately patients require definitive care that is best directed by physicians based on the extent of their training, clinical experience and legislated scope of practice.

***The physician, by virtue of training, knowledge, background and patient relationship, is best positioned to assume the role of clinical leader in collaborative care teams. There may be some situations in which the physician may delegate clinical leadership to another health care professional. Other health care professionals may be best suited to act as team coordinator.***

#### **4. MUTUAL RESPECT AND TRUST**

In collaborative team settings, efficient and effective health care requires the active involvement and participation of all members of the team. Mutual respect is critical to the success of functional teams and is derived from the knowledge of, and appreciation for, the contributions made by other team members.

Trust between individuals and provider groups evolves as knowledge and understanding of competencies, skills and scopes of practice are gained. Trust is also essential to ensuring that the team functions efficiently and maximizes the contributions of all members.

Funders and providers should recognize the importance of team building in contributing to team effectiveness. Collaborative care funding models should support a more formalized and integrated approach to both change management and team building.

As relationships are strengthened within the team, so too are trust and respect. Physicians and all team members have an opportunity to be positive role models to motivate and inspire their colleagues. All team members ought to make a commitment to respect and trust each other with the knowledge that it will lead to enhanced care for patients and a more productive work environment for all.

***To serve the health care needs of patients, there must be a collaborative and respectful interaction among health care professionals, with recognition and understanding of the contributions of each provider to the team.***

***In order to build trust and respect within the team it is essential that members understand and respect the professional responsibility, knowledge and skills that come with their scope of practice within the context of the team.***

## 5. CLEAR COMMUNICATION

In collaborative care environments, it is essential that all members of the team communicate effectively to provide safe and optimal care. Effective communication is essential to ensure safe and coordinated care as the size of the team expands to meet patient needs. It is the responsibility of all team members to ensure that the patient is receiving timely, clear and consistent messaging.

Physicians can take a leadership role in modeling effective communications throughout the team. In particular, there is an opportunity to enhance the consultation and referral process, in order to provide clear and concise instructions to colleagues and optimize care. Sufficient resources, including dedicated time and support, must be available to the team to maximize these communication requirements.

***Effective communication within collaborative care teams is critical for the provision of high quality patient care. Planning, funding and training for collaborative care teams must include measures to support communication within these teams.***

***Mechanisms must be in place within a collaborative team to ensure that both the patients, and their caregiver(s) where appropriate, receive timely information from the most appropriate provider.***

***Effective and efficient communications within the collaborative care team, both with the patient and among team members, should be supported by clear documentation that identifies the author.***

***A common, accessible patient record in collaborative care settings is desirable to ensure appropriate communication between physicians and other health care professionals, to prevent duplication, coordinate care, share information and protect the safety of patients.***

***An integrated electronic health record is highly desirable to facilitate communication and sharing among team members.***

## 6. CLARIFICATION OF ROLES AND SCOPES OF PRACTICE

In order for the team to function safely and efficiently, it is critically important that the scope of practice, roles and responsibilities of each health care professional on the team be clearly defined and understood. In turn, the patient, as a team member, should also have a clear understanding of the roles and scopes of practice of their providers.

***Collaborative care must first and foremost serve the needs of patients, with the goal of enhancing patient care; collaborative care is not contingent upon altering the scope of practice of any provider group and must not be used as a means to expand the scope of practice and/or independence of a health professional group.***

***Changes in the scope of practice of all provider groups must be done with oversight from the appropriate regulatory authority.***

***Where non-physicians have been provided with an opportunity to undertake activities related to patient care typically unique to the practice of medicine (e.g. ordering tests), they must not do so independently but undertake these activities within the context of the team and in a manner acceptable to the clinical leader.***

*The role and scope of practice of each member of the collaborative care team should be clearly understood and delineated in job descriptions and employment contracts.*

*A formal process for conflict resolution should be in place so that issues can be dealt with in a timely and appropriate manner.*

## **7. CLARIFICATION OF ACCOUNTABILITY AND RESPONSIBILITY**

In the context of providing optimal care, providers must be accountable and responsible for the outcome of their individual practice, while sharing responsibility for the proper functioning of the collaborative care team. This individual responsibility is required so that regardless of the number and diversity of providers involved in the team, patients can be assured that their well-being is protected and that the team is working toward a common goal.

In collaborative care teams, a physician should be identified as the person most responsible for the clinical care of individual patients, and as such must be accountable for the care rendered to patients. This is consistent with the commitment made by the physician in the doctor-patient relationship, mirrors the clinical training of the physician relative to other providers, is reflective of the current state of tort law as it applies to medical practice, and is compatible with the structure of care delivery in hospitals and in the community. Clearly, this type of arrangement does not eliminate the necessity for all providers to be accountable for the care that they provide.

*It is essential that all providers be responsible and accountable for the care that they provide and for the well-being of the patient.*

*As clinical leader, the physician should be responsible for the clinical oversight of an individual patient's care.*

## **8. LIABILITY PROTECTION FOR ALL MEMBERS OF THE TEAM**

As discussed earlier in this paper, the resolution of the multiplicity of liability issues that result from care delivered by teams requires clearly defined roles and responsibilities in the team setting and the absolute requirement for appropriate and sufficient liability coverage for each health professional. The August 2006 statement of the Canadian Medical Protective Association, *Collaborative Care: A medical liability perspective*, identifies issues of concern to physicians and proposes solutions to reduce those risks.

*All members of a collaborative care team must have adequate professional liability protection and/or insurance coverage to accommodate their scope of practice and their respective roles and responsibilities within the collaborative care team.*

*Physicians, in their role as clinical leaders of collaborative care teams, must be satisfied with the ongoing existence of appropriate liability protection as a condition of employment of, or affiliation with, other members on collaborative care teams.*

*Formalized procedures should be established to ensure evidence of this liability protection.*

## 9. SUFFICIENT HUMAN RESOURCES AND INFRASTRUCTURE

Collaborative models of health care delivery hold the promise of enhancing access to care for patients at a time of serious health human resource shortages. However, effective patient-centred collaborative care depends on an adequate supply of physicians, nurses and other providers. Governments and decision-makers must continue to enhance their efforts to increase the number of physicians and nurses available to provide health care services.

Collaborative care should not be seen as an opportunity for governments to substitute one care provider for another simply because one is more plentiful or less costly than the other.

In addition, governments must understand that co-location of individuals in a team is not a requirement for all collaborative care. Where team co-location does not exist, appropriate resources must be dedicated to ensure communication can be timely, effective and appropriate between providers.

***Governments, at all levels, must address the serious shortage of physicians to ensure quality patient care for Canadians.***

***The effective functioning of a collaborative care team depends on the contribution of a physician.***

***Governments must enhance access to medical care by increasing the number of physicians and providers, and not by encouraging or empowering physician substitution.***

## 10. SUFFICIENT FUNDING & PAYMENT ARRANGEMENTS

Funding must be present to support all aspects of the development of collaborative care teams. At the practice level, remuneration methods for physicians, irrespective of their specialty, must be available to facilitate collaborative care arrangements and environments in which physicians practise. All care delivery models, including collaborative care teams, must have access to adequate and appropriate resources. This includes, but should not be limited to, funding for health human resources, administration/management infrastructure, liability protection, clinical and team/administrative training, team building, and information technology.

Remuneration models should be established in a manner that encourages providers to participate effectively in the delivery of care and team effectiveness.

Reimbursement models must be configured to remunerate the communicator, coordinator, manager, and other roles and responsibilities of providers necessary for the success of collaborative care practice.

***The ability of a physician to work in a collaborative care team must not be based on the physician's choice of remuneration. Similarly, patients should not be denied access to the benefits of collaborative practice as a result of the physician's choice of payment model.***

***Collaborative care relationships between physicians and other health care providers should continue to be encouraged and enhanced through appropriate resource allocation at all levels of the health care system.***

***Physicians should be appropriately compensated for all aspects of their clinical care and leadership activities in collaborative care teams.***

*Physicians should not be expected to incur the cost of adopting and maintaining health information technology capabilities that facilitate their ability to participate in collaborative practice teams. Governments must fund and support in an ongoing manner, both financially and technically, the development and integration of electronic health records.*

## 11. SUPPORTIVE EDUCATION SYSTEM

Canada is renowned for a quality medical education system and for the early efforts to enhance interprofessional training. The success of collaborative care requires a commitment towards interprofessional education and is contingent upon the positive attitudes and support of educators. To facilitate a sustainable shift toward collaborative practice, these efforts must be continued and enhanced in a meaningful way. However, governments and educators must ensure that the availability and quality of medical education is not compromised for medical trainees.

*Interprofessional education, at the undergraduate, postgraduate and continuing education levels, is necessary to facilitate a greater understanding of the potential roles, responsibilities and capabilities of health professions, with the overall goal of building better health care teams founded on mutual respect and trust.*

*Governments must understand the importance of interprofessional education and fund educational institutions appropriately to meet these new training needs.*

*Educational opportunities must exist at all levels of training to acquire both clinical knowledge and team effectiveness/leadership training.*

*Interprofessional education opportunities must not come at the expense of core medical training. High quality medical education must be available to all medical trainees as a first priority.*

## 12. RESEARCH AND EVALUATION

More research and evaluations are necessary to demonstrate the benefits of collaborative care, to foster greater adoption by providers and to attract the necessary investment by governments. Quality management systems must be built into the team to ensure efficiencies can be recorded. Measures of the quality of care, cost effectiveness and patient and provider satisfaction should be evaluated.

*Research into the effectiveness of collaborative care models on health outcomes, patient and provider satisfaction and health care cost effectiveness should be ongoing, transparent and supported by governments.*

*Quality assessment measures must be incorporated into the ongoing work of collaborative care teams.*

## Conclusion

Physicians view the patient-physician relationship as central to ensuring the best care for their patients. They also believe that collaborating with other physicians and health providers will help to provide enhanced service delivery, coordination, and improved patient outcomes. Such collaboration, however, must be done in an inclusive manner that respects the skills, competencies and knowledge that each member brings to the team. The principles articulated in this document, built upon the fundamental concept of patient-centred care, are intended to guide health professionals and decision-makers toward realizing the full potential of collaborative care.

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<sup>1</sup> Institute for Healthcare Improvement. *Patient-Centered Care: General*. Retrieved June 27, 2007 from <http://www.ihl.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/>.

<sup>2</sup> Health Canada. *Interprofessional Education for Collaborative Patient Care Practice*. Retrieved June 27, 2007 from [http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/index_e.html)

<sup>3</sup> Task Force Two: A Physician Human Resources Strategy for Canada. Final Report. [www.physicianhr.ca/reports/default-e.php](http://www.physicianhr.ca/reports/default-e.php). Retrieved March 18, 2007.

<sup>4</sup> Canadian Health Services Research Foundation *Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada – Policy Synthesis and Recommendations*. Retrieved May 4, 2007 from [https://www.chsrf.ca/research\\_themes/pdf/teamwork-synthesis-report\\_e.pdf](https://www.chsrf.ca/research_themes/pdf/teamwork-synthesis-report_e.pdf).

<sup>5</sup> Royal College of Physicians and Surgeons of Canada. CanMeds Framework. 2005.

## Appendix A

The creation of this paper was led by the CMA's working group on collaborative care. The CMA would like to thank the following individuals for their contributions:

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Participation in the working group does not necessarily imply endorsement of the paper by an individual's respective organization.