

# **Interprofessional Collaboration**

## **A Summary of Key Reference Documents & Selected Highlights from the Literature**

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In his letter of June 28, 2007, the Minister of Health and Long-Term Care asked the Health Professions Regulatory Advisory Council (HPRAC) to

*recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges beginning with the development of standards of practice and professional practice guidelines where regulated health professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession [and to] take into account, when controlled acts are shared, of public expectations for high quality services no matter which health profession is responsible for delivering care or treatment.*

The context for the Minister's request recognizes the importance of health professions being self-governing but also acknowledges the need for change arising from a number of factors, including:

- Changing expectations (i.e., how Colleges govern in a health care system that is being transformed);
- The need to strengthen the system and reassess the roles of health professionals within that system; and
- The move toward greater integration among health care providers, organizations and sectors.

## Context

Many challenges face the current health care system, including rising costs, changing demographics, health human resources pressures, increased reliance on high technology solutions, the introduction of new professions and the need to modernize the system. Each of these places pressure on the system's ability to balance the requirement for patient safety with the need to ensure access to high quality medical services.

To address these issues, the Government of Ontario has embarked on an ambitious transformation of Ontario's health care system. The changes are designed to help Ontarians stay healthy, to reduce wait times, and to bring about quality improvements in the health care system as a vehicle for improving patient care and ensuring sustainability of the system. Achieving these goals will require the most effective use of all the system's resources –including the utilization of health care providers across the continuum of care.

**The need for interprofessional collaboration is being driven by the same pressures that are driving the transformation agenda:**

- *Changing demographics*
- *Technology driven changes*
- *Recruitment and retention issues*
- *Pressures on access to care*
- *Funding pressures*
- *Efficiency of processes/procedures*
- *Patient safety and effectiveness*
- *Lack of coordination along the continuum*
- *Introduction of new professions*
- *Emerging evidence supporting that interprofessional care = good care*

In 2007, the Ontario Government passed the *Health System Improvements Act*. The Act established a platform to begin modernizing Ontario's health care regulatory system and enable it to respond to some of the systemic challenges noted above. The Act amended the *Regulated Health Professions Act, 1991*, to include new mandates for health regulatory colleges regarding interprofessional collaboration. Under the revised Act, health regulatory Colleges in Ontario are now required:

- To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public;
- To promote inter-professional collaboration with other health profession colleges; and
- To develop, establish and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.

### **Interprofessional Collaboration: An Overview**

There has been a renewed interest in collaborative models of health care delivered by interdisciplinary teams. Interprofessional collaboration is increasingly being viewed as a key strategy for providing the best quality and most effective care to people who require multiple services, or who use both acute and primary health care services [EICPHC, April 2005-B]. Although many patients, caregivers, health professionals, and decision-makers are ready to embrace collaborative health care, current policies and systems issues are acting as barriers hampering the transformation to team-based health care. These barriers include: inconsistent government policies and approaches; limited health human resource planning; regulatory/legislative frameworks that create silos; and models of funding and remuneration that discourage collaboration. [CHSRF, June 2006]

Momentum for enhanced interdisciplinary collaboration requires supportive structures including legislative, regulatory and legal frameworks. While momentum for change seems to be emerging in legislative and regulatory frameworks, some of the literature concludes that overall the current legislative and regulatory frameworks are not conducive to interdisciplinary collaboration [Watson and Wong, 2005]. The growing interest in interprofessional collaboration is also raising issues with respect to the management of professional boundaries and, in particular, the relationship of professional health care providers with one another, as well as those responsible for regulating health professionals.

## Purpose, Approach & Format of the Paper

This paper summarizes some of the recent literature related to interprofessional collaboration. It is not intended to represent an exhaustive review of the literature, rather it focuses on identifying key documents in the literature that will inform discussions about **legislative, regulatory, policy and structural/organizational issues** as they relate to facilitating and supporting Health Regulatory Colleges and their members in advancing interprofessional collaboration.

The literature included in this review comes from diverse sources. The initial focus of the research undertaken for this review related to questions of interprofessional collaboration and regulation, and interprofessional collaboration among Health Regulatory Colleges. The search began with a focus on broad search terms, including: Regulation of Interprofessional Collaboration; Interprofessional Collaboration and Regulation; Interprofessional Collaboration in Ontario; Ontario Regulation of Interprofessional Collaboration; and Interprofessional Practice Models. Specific searches were undertaken to obtain specific articles from government websites, research institutes, health policy think tanks and universities in an attempt to locate studies related to regulation and interprofessional collaboration reported in some of the literature reviewed. Some of these searches were successful, others were not.

The review also included a review of regulatory-related articles on *PubMed*, as well as secondary literature searches in *LegalTrac* and the *Index to Legal Periodicals* (on LexisNexis), both of which provide citations and journal abstracts for law journal articles from Canadian, U.S., British, Commonwealth and some other international sources like EU countries. The search was conducted using various terms for "health care industry" or "health professions" as well as collaboration and regulation. Some advanced search strings included "health with 2 professions", "law or legislation or regulation or policy & collaboration", "interprofessional collaboration and health". These searches were then re-run using a broader search index, *ABI/inform*, which is a business and industry index. This search yielded articles on interprofessional collaboration from Australia and New Zealand. This information was used to inform a jurisdictional review that was undertaken in addition to the preliminary literature review.

Given the variety of issues impacting on the issue of interprofessional collaboration and the different ways in which it is defined and discussed in the literature, the review was undertaken with a view to addressing key questions that will help inform discussions about interprofessional collaboration and the regulatory environment.

For example,

*What is the definition of interprofessional collaboration? What other terminology is used to define the concept? (Interprofessional Collaboration Terminology)*

*What is driving current interest in interprofessional collaboration? (Interprofessional Collaboration & Health Reform)*

*What are the benefits attributed to interprofessional collaboration? Does it improve patient outcomes? (Interprofessional Collaboration & Evidence/Outcomes)*

*What are the regulatory levers and barriers to interprofessional collaboration reform? (Interprofessional Collaboration & Regulation/Regulatory Change)*

Accordingly, the literature reviewed on the issue has been organized as follows:

<p><b>Section 1: Summary of documents reviewed</b></p>	<p>This section summarizes the documents reviewed including the citation and a brief description of the purpose of the report/article. The documents related to the evidence base supporting interprofessional collaboration also include a summary of the key findings arising from these studies.</p>
<p><b>Section 2: Analysis and key findings arising from the literature</b></p>	<p>This section summarizes the key findings arising from the literature and it is organized under the following subheadings.</p> <p><b>Interprofessional collaboration terminology:</b> Clarifies the use of key terms related to interprofessional collaboration including <i>interprofessional care</i>. Also included is a statement to define what is meant by the concept of facilitating and supporting <i>collaboration among health Colleges</i> developed by HPRAC as the basis for stimulating discussion on this issue. They are intended to guide stakeholders in considering frameworks, structures and processes (including legislation and regulations) that may facilitate interprofessional collaboration.</p> <p><b>Interprofessional collaboration and the broader health reform agenda:</b> Summarizes some of the core messages emerging from key federal and provincial/territorial health reform documents that have focused on interprofessional collaboration as a major strategy for health reform in Canada.</p>

Documents include key 'Health Reform' and 'Blueprint' documents that represent the results of work undertaken to address issues related to health human resources (HHR) and/or how interprofessional collaboration is being discussed as part of current health reform agendas (i.e., implementation of primary health care reform; health human resources planning; interprofessional education).

**Interprofessional collaboration and the evidence base:** Provides a synthesis of some of the evidence in the literature about the role, benefits, costs and challenges related to interprofessional collaboration models. For the most part, documents included in this section represent key reference sources that arise from evidence-based research related to questions, such as: What is the rationale for interprofessional collaboration? Is there a clinical rationale for interprofessional collaboration? Does interprofessional collaboration lead to enhanced quality of care for patients? What are the advantages of interprofessional collaboration for providers? Where is interprofessional collaboration working, and why? Some of the documents represent the results of reviews/syntheses that have been undertaken on experiences in implementing interprofessional collaboration.

**Interprofessional collaboration and regulatory change:** Provides an overview of the regulatory issues and challenges associated with the move towards interprofessional collaboration and explores the types of regulatory changes proposed in the literature to improve interprofessional collaboration. The review includes a summary of seminal documents published by the following groups:

- The Conference Board of Canada (2007)
- The Canadian Health Services Research Foundation (2006)
- Government of Canada – EICPHC Initiative (2005-06)
- The Pew Health Professions Commission in the U.S. (1995, 1997)

These documents provide an overview of the regulatory issues and challenges associated with the move toward interprofessional collaboration. Additional documents related to the issue of regulatory reform are also included in this analysis.

## Section 1: Summary of Documents Reviewed

The following is a summary of the documents reviewed as part of this literature review. Appendix 1 includes references to additional documents used in the review of definitions related to interprofessional collaboration.

Document/Report	Description/ Focus
<p>Baggs JG, Schmitt MH, Mushlin AI, Mitchell PH, Eldredge DH, Oakes D, Hutson AD., (Sept 1999).            “Association between nurse-physician collaboration and patient outcomes in three intensive care units,” <i>Critical Care Medicine</i>, 27:9, 1991-8.</p>	<p>Investigates the association of collaboration between intensive care unit (ICU) physicians and nurses and patient outcome. When patients were ready for transfer from the ICU to an area of less intensive care, questionnaires were used to assess care providers' reports of collaboration in making the transfer decision. After controlling for severity of illness, the association between interprofessional collaboration and patient outcome was assessed.</p> <p><u>Key findings:</u> Medical ICU nurses' reports of collaboration were associated positively with patient outcomes. No other associations between individual reports of collaboration and patient outcome were found. The study offered some support for the importance of physician-nurse collaboration in ICU care delivery.</p>
<p>Baggs JG, Ryan SA, Phelps CE, Richeson JF, Johnson JE.,            The Association between Interdisciplinary Collaboration and Patient Outcomes in Medical Intensive Care, <i>Heart and Lung</i>, Volume 21, Number 1, 18-24, 1992</p>	<p>Examines the relationship between interdisciplinary collaboration and patient outcomes in the medical intensive care unit (MICU) using nurses' and residents' reports of the amount of collaboration involved in making decisions about transferring patients from the MICU to a unit with a less intense level of care.</p> <p><u>Key findings:</u> Nurses' reports of collaboration were significantly and positively associated with patient outcome, controlling for severity of illness. Patient predicted risk of negative outcome decreased from 16%, when the nurse reported no collaboration in decision making, to 5% when the process was fully collaborative. When alternatives were available, collaboration was more strongly associated with patient outcome.</p>
<p>Barr, Hugh and Ross, Fiona.            (January 2007). “Working Together</p>	<p>Examines the global transformation in health care delivery models in response to world wide health human resource (HHR) challenges.</p>

<p>for Health" <i>The Journal of Interprofessional Care</i>, 21: 1, 1-2</p>	<p><u>Key findings:</u> There is a global crisis in HHR, particularly in those countries where trained health care workers are most needed. According to the WHO's 2006 World Health Report, health care workers are experiencing increasing stress and insecurity, exacerbated by population concentrations in urban areas and migration from poor to rich countries. This crisis has the potential to deepen in the coming years as demand for services escalates in countries facing lower fertility and aging populations.</p> <p>The shift from acute tertiary hospital care to patient-centred, home-based and team-driven care requires new skills and collaboration between workers and with patients. A team approach is required to address the needs of individuals with chronic conditions and to address challenges in public health.</p> <p>The report identified the following core competencies required for working with patients with chronic conditions: patient-centered care; partnering; quality improvement; information and communication technology; a public health perspective. Both health care employers and managers must pay attention to building teams if they are to meet the challenges and targets of the future.</p>
<p>Barr, Hugh. (May 2005). Editorial: Canada as a case study. <i>Journal of Interprofessional Care</i>. 19: S1, 5-7.</p>	<p>Provides an overview of a supplementary edition of the <i>Journal of Interprofessional Care</i> focused on publication of a series of papers commissioned by Health Canada as part of its initiative to promote interprofessional education for collaborative patient-centred practice. The papers provide an overview of the state of interprofessional care in Canada and make the case for interprofessional education to advance interprofessional practice.</p> <p><u>Key findings:</u> Collaborative education and collaborative practice are not new ideas in Canada; however, neither has succeeded in creating a system of co-operating independent equals who contribute to a common vision of health. The challenge is to re-visit and re-appraise past experience, re-model existing provision, weaving in new initiatives. Structural changes are needed within university settings to overcome barriers to interprofessional education. The role of academic administrators in initiating and supporting effective interprofessional education and creating an environment in which interprofessional education can be sustained is integral to the</p>

	<p>change process.</p> <p>Post-licensure collaborative interventions can improve patient services and patient care, while comparable evidence about the effectiveness of pre-licensure interprofessional education is lacking. Ways to reduce the risk of failure in interprofessional initiatives include the constructive use of conflict, creating a culture supportive of risk, shared leadership and the use of a variety of models.</p>
<p>Bourgeault, Ivy Lynn and Mulvane, Gillian. (2006). "Collaborative health care teams in Canada and the USA: Confronting the structural embeddedness of medical dominance." <i>Health Sociology Review</i>, Vol 15, Issue 5, Dec 2006, 481-495.</p>	<p>Includes a critical analysis of the factors both promoting and impeding collaborative care models of primary and mental health care in Canada and the USA. The analysis includes a review of documents as well as information arising from interviews undertaken with key stakeholders influential in various collaborative care initiatives. Based on the data, the authors develop a conceptual model of the various levels of influence, focusing in particular on the macro (regulatory/funding) and meso (institutional) factors. The authors' comparative policy and institutional analysis reveals the similarities and differences in the influences of the broader contexts in Canada and the USA, and the different ways that the structural embeddedness of medical dominance impinges upon and reacts to recent policy changes regarding collaborative health care teams.</p>
<p>Buist, Michael D., Moore, Gaye E., Bernard, Stephen E., Waxman, Bruce P., Anderson, Jeremy N., Nguyen, Tuan V., Effects of a medical emergency team on reduction of incidence of and mortality from unexpected cardiac arrests in hospital: Preliminary study, <i>BMJ</i> 2002;324, 387-390.</p>	<p>This study sought to determine whether earlier clinical intervention by a medical emergency team prompted by clinical instability in a patient could reduce the incidence of and mortality from unexpected cardiac arrest in hospital.</p> <p><u>Key findings:</u> In clinically unstable inpatients, early intervention by a medical emergency team significantly reduces the incidence of and mortality from unexpected cardiac arrest in hospital. Results of the study demonstrate that an early intervention following cardiac arrest, based on well defined criteria of clinical instability together with a system of support, ongoing education, and performance feedback to the primary caregivers can significantly reduce the incidence of and mortality from cardiac arrest in hospital.</p>
<p>Canadian Health Services Research Foundation (June 2006). <i>Teamwork</i></p>	<p>The report was commissioned to answer three questions:</p> <ul style="list-style-type: none"> <li>▪ <i>What are the characteristics of an effective team and how do we measure the effectiveness of a team (such</i></li> </ul>

<p><i>in healthcare: promoting effective teamwork in healthcare in Canada. A policy synthesis.</i></p>	<p><i>as increased job satisfaction, shared workload, reduction of stress, etc.)?</i></p> <ul style="list-style-type: none"> <li>▪ <i>What interventions have been successful in implementing and sustaining teamwork in health care? What can we learn from other settings and countries?</i></li> <li>▪ <i>To what extent has teamwork been implemented in health care settings in Canada? What are the barriers to implementation?</i></li> </ul> <p>The report identifies implications for practice, policy and research required to achieve effective 'teamwork' in the health care sector.</p>
<p>Conference Board of Canada (2007). <i>Achieving Public Protection through Collaborative Self-Regulation: Reflections for a New Paradigm.</i></p>	<p>The report examines the legislative and regulatory environment in Canada and whether, and how, it acts as a barrier or facilitator to interdisciplinary collaboration in health care. It includes advice to both regulators and policymakers as to the role that legislation and regulation could play in enhancing collaborative practice and improving health human resource management.</p>
<p>D'Amour, Danelle, Ferrada-Videla, Marcela, Rodriquez, Leticia San Martin, Beaulieu, Marie-Dominique. (May 2005). "The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks." <i>Journal of Interprofessional Care</i>. 19: S1, 116-131.</p>	<p>Identifies conceptual frameworks that could improve understanding of interprofessional relationships by taking into consideration various definitions proposed in the literature, various concepts associated with collaboration, and various theoretical frameworks of collaboration.</p> <p><u>Key findings:</u> Results of the review demonstrated that:</p> <ul style="list-style-type: none"> <li>▪ The concept of collaboration is commonly defined through five underlying concepts: sharing, partnership, power, interdependency and process;</li> <li>▪ The most complete models of collaboration are those based on a strong theoretical background, either in organizational theory or in organizational sociology and on empirical data;</li> <li>▪ There is a significant amount of diversity in the way the various authors conceptualize collaboration and in the factors influencing collaboration;</li> <li>▪ These frameworks do not establish clear links between the elements in the models and the outputs; and</li> <li>▪ The literature does not provide a serious attempt to determine how patients could be integrated into the health care team, despite the fact that patients are recognized as the ultimate justification for providing collaborative care.</li> </ul>

<p>Deber, Raisa and Baumann, Andrea (2005). "Barriers and Facilitators to Enhancing Interdisciplinary Collaboration in Primary Health Care." <i>The Conference Board of Canada, Commissioned by the EICPHC Initiative.</i></p>	<p>Examines barriers and facilitators to interdisciplinary collaboration. Proposes that the extent to which regulatory issues are barriers to increased collaboration tends to be based in potential legislative and regulatory deficiencies rather than in fundamental conflicts or values or interests.</p>
<p>Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative (EICPHC Initiative)</p>	<p><b>EICPHC Initiative (January 2005).</b> <i>Regulatory Factors Task Group Snapshot.</i>  This document provides a preliminary examination of the implications of regulatory factors on collaboration and teamwork at the front line of primary health care in Canada based on initial findings emerging from the EICPHC initiative. The snapshot defines the issues, discusses their importance, and proposes possible solutions and options.</p> <p><b>EICPHC Initiative (April 2005-A).</b> <i>Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada.</i>  This document articulates the Principles and Framework developed as part of the EICPHC Initiative. The Principles are considered to be the values shared by stakeholders that are critical to establishing collaboration and teamwork to achieve the best health outcomes.</p> <p><b>EICPHC Initiative (April 2005-B).</b> <i>Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada.</i>  This report was commissioned to develop an in-depth understanding of the theory and practice of interdisciplinary collaboration in primary health care in Canada. The report provides an overview of the key issues related to interdisciplinary care, including:</p> <ul style="list-style-type: none"> <li>▪ The Composition of interdisciplinary teams;</li> <li>▪ The Principles and framework for interdisciplinary composition in primary health care;</li> <li>▪ Patient centred-care;</li> <li>▪ Lessons from other jurisdictions;</li> <li>▪ Barriers to interdisciplinary collaboration;</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Patient/client outcomes;</li> <li>▪ Findings of small group consultations with Canadian health providers and patients/clients; and</li> <li>▪ Best and promising examples of practice.</li> </ul> <p><b>EICPHC (May 2005).</b> <i>Enhancing Interdisciplinary Collaboration in Primary Health Care, Barriers and Enabling Factors Task Groups Report.</i></p> <p>The EICPHC Initiative identified the following five key framework elements that were considered to dominate thinking about collaboration in primary health care: Liability/risk management; Funding; Electronic Health Records; Regulatory Factors; and Health Human Resources. The key regulatory issues identified in the EICPHC Initiative’s research and consultations were:</p> <ul style="list-style-type: none"> <li>▪ Need to harmonize scopes of practice;</li> <li>▪ Need to harmonize standards of practice;</li> <li>▪ Need to protect confidentiality/privacy while providing access to information;</li> <li>▪ Need to address the slow pace of legislative change; and</li> <li>▪ Need to examine labour relations and collective agreements to include interdisciplinary collaboration issues.</li> </ul> <p><b>EICPHC Final Report (date unknown).</b> <i>Interdisciplinary Primary Health Care: Finding the Answers – A Case Study Report.</i> Ottawa.</p> <p>The final report of the <i>Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative</i> focuses on how to create the conditions for health care providers to work together in the most effective and efficient way so they produce the best health outcomes for their patients and clients. The report explores the reality of interdisciplinary collaboration in Canada through an examination of health care organizations representing a mix of urban and rural, small and large, old and new interdisciplinary organizations.</p>
Hall, Pippa, Weaver, Lynda; Gravelle, Debbie; Thibault, Hélène. (Jan 2007). Developing collaborative person-centred	Reviews the experience of a palliative care team that piloted a different approach to patient and family care when faced with a reduction in medical staff. <u>Key findings:</u> Preliminary findings showed that the pilot project team perceived some specific benefits in continuity of care and interprofessional collaboration, while the presence of the

<p>practice: A pilot project on a palliative care unit." <i>Journal of Interprofessional Care</i>. 21:1, 69-81.</p>	<p>physician was reduced to an average of 3.82 hours on the pilot wing, compared with 8 hours on the non-pilot wings. The study suggests that a person-centred model, when focused on the physician-nurse dyad, may offer improved efficiency, job satisfaction and continuity of care on a palliative care unit. Incorporating all team members and developing strategies to successfully expand the model across the whole unit are the next challenges. Further research into the impact of these changes on the health care professionals, management and patients and families is essential.</p>
<p>Hall, Pippa. (2005). "Interprofessional teamwork: Professional cultures as barriers." <i>The Journal of Interprofessional Care</i>. 19:S1, 188-196.</p>	<p>Reports on the effect of professional culture on effective interprofessional teamwork.</p> <p><u>Key findings:</u> Each health care profession has a different culture which includes values, beliefs, attitudes, customs and behaviours. Professional cultures have evolved as individual professions developed, reflecting historic factors, as well as social class and gender issues. Educational experiences and the socialization process that occur during the training of each health professional reinforce the common values, problem-solving approaches and language/jargon of each profession. Increasing specialization has led to even further immersion of the learners into the knowledge and culture of their own professional group. These professional cultures contribute to the challenges of effective interprofessional teamwork. Insight into the educational, systemic and personal factors which contribute to the culture of the professions can help guide the development of innovative educational methodologies to improve interprofessional collaborative practice.</p>
<p>Headrick, Linda A Wilcock, Peter M and Batalden, Paul B. (1998) "Continuing medical education: Interprofessional working and continuing medical education," <i>BMJ</i>. March 7, 316(7133): 771-774.</p>	<p>Explores the increased focus on the results of professional practice related to health outcomes of individuals and populations and the associated tensions related to: the need for improved working and collaboration among different health professionals, and the demand for a broader vision of continuing medical education (CME).</p> <p><u>Key findings:</u> Greater focus on results of professional practice creates a need for improved collaboration by medical professionals and a broader vision of CME. Effective interprofessional working relationships ranges from loosely coordinated collaboration to closely organised teamwork. Across this range, certain elements increase the likelihood of success:</p> <ul style="list-style-type: none"> <li>▪ Shared goals around patients' needs, and an approach focused on processes that serve that need, can help transcend traditional barriers;</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Effective adult learning occurs when the topic is important to the learner and when learning combines reflection with concrete experience;</li> <li>▪ Improved health outcomes usually lie outside the scope or control of any single practitioner. Real improvements are likely to occur if the range of professionals responsible for providing a particular service are brought together to share their different knowledge and experiences, agree what improvements they would like to see, test these in practice, and jointly learn from their results. As they build their knowledge about how things currently work, such groups are likely to discover that their difficulties are more often derived from the processes they use than from each other;</li> <li>▪ An incentive for greater teamwork is created by focusing on the areas where changes are likely to result in measurable improvements for the patients they serve together, rather than concentrating on what seem to be irreconcilable professional differences; and</li> <li>▪ Dedication to interprofessional approaches to care require a different investment of resources: teachers who can coach rather than lecture; professional time away as a work group rather than as individuals; opportunities to study current processes, design and test changes, and analyse the results; and the support of interprofessional education from the senior leadership of each of the professions involved, perhaps in exchange for time now spent in uniprofessional learning.</li> </ul>
<p>Health Canada. (February 20, 2004). <i>Interdisciplinary education for collaborative patient-centered practice</i>. Research and findings report. Project Leader: Ivy Oandasan, MD, CCFP, MHSc - Assistant Professor and Research Scholar at the Department of Family &amp; Community Medicine, University of Toronto and Toronto Western Hospital, University Health Network.</p>	<p>The 2003 First Ministers' Health Accord identified that changing the way health professionals are educated is a key component of health system renewal. This change was mobilized through the development and implementation of an initiative on interdisciplinary education for collaborative patient-centred practice (IECPCP). A team of health researchers with expertise and experience in the field of interdisciplinary education and collaborative practice was assigned the task of examining this issue. This report provides the findings arising from the research team (led by Ivy Oandasan) that explored both successful and unsuccessful interdisciplinary education and collaborative practice initiatives within health care practice settings and academic institutions. The findings from a literature review and environmental scan conducted for this report provided the necessary information to develop a framework to define the essential features and determinants for IECPCP. The report covers:</p>

	<ul style="list-style-type: none"> <li>▪ Current trends of interdisciplinary education for collaborative patient-centred practice in Canada and abroad and what are best practices for patient outcomes;</li> <li>▪ A review of existing studies on the effects of interdisciplinary education and collaborative practice for quality of care and patient outcomes;</li> <li>▪ Key features in the relationship between, and elements for, successful interdisciplinary education and collaborative practice models;</li> <li>▪ The barriers to implementing interdisciplinary education and collaborative practice and descriptions of change management strategies to overcome these barriers;</li> <li>▪ The enablers that influence interdisciplinary education and collaborative practice;</li> <li>▪ Current policies, programs and strategies in health and education that support IECPCP;</li> <li>▪ Recommendations on how to advance IECPC in Canada including research priorities;</li> <li>▪ A conceptual framework to consider the essential elements and determinants for IECPCP based on available evidence and theoretical considerations.</li> </ul>
<p>Herbert, Carol P. (May 2005). Editorial: “Changing the culture: Interprofessional education for collaborative patient-centric practice in Canada.” <i>Journal of Interprofessional Care</i>. 19: S1, 1-4.</p>	<p>An editorial on the importance of changing the way that health care providers are educated as the means to achieving health system change.</p> <p><u>Key Findings:</u> Changing the way that health care providers are educated is the key to achieving health system change. Citing both the Romanow Commission’s report on the <i>Future of Health Care in Canada</i> (2002) and the 2003 <i>Federal Budget</i>, the author states that the importance of education is to enhance interprofessional patient-centred care. However, despite numerous attempts over 40 years, Canada has not been successful in shifting a culture of health care silos to a system culture of cooperating equality where individuals contribute to a common vision of health. The intent of the current thrust of interprofessional education is to change this culture.</p>
<p>Hudson, Bob. (Jan 2007), “Pessimism and optimism in inter-professional working: The Sedgefield Integrated Team” <i>The Journal of Interprofessional Care</i>. 21:1, 3-15.</p>	<p>Develops two models (i.e., the optimistic and pessimistic models) to understand the factors that may underpin different rates of interprofessional achievement.</p> <p><u>Key Findings:</u> Key features of the Pessimistic Model of Interprofessional Working that may inhibit effective collaboration: distinctiveness of trait; distinctiveness of knowledge; distinctiveness of status; distinctiveness of power; distinctiveness of accountability; distinctiveness of culture. Key features of the Optimistic Model of Interprofessional Working that may promote effective</p>

	<p>collaboration: commonality of values; commonality of accountability; commonality of learning; commonality of location; commonality of culture; commonality of case. A case study of the Sedgefield Integrated Team in County Durham, UK is used to test aspects of the models. Findings arising from the case study were:</p> <ul style="list-style-type: none"> <li>▪ The promotion of professional values of service to users can form the basis of interprofessional partnership.</li> <li>▪ Socialization to an immediate work group can override professional or hierarchical differences among staff. Factors that help to explain this finding, include: Selection of team membership; Parity of self-esteem; Reorientation of professional affinities; Co-location.</li> <li>▪ Effectiveness of interprofessional working can lead to more effective service delivery and better user outcomes. Good outcomes depend on effective processes for their achievements, including: speed; flexibility; creativity.</li> </ul> <p>Conclusion: The barriers related to pessimism have been overstated. The scope for professional integration is greater than tends to be assumed. Given the right degree of inter-organizational commitment, preparation, planning and sustained fashioning, it is feasible to transcend traditional professional boundaries. There is good evidence that a well-prepared, co-located team can use commonality of cases to establish a culture within which learning can flourish and accountability focused on the needs of consumers rather than professional domains.</p>
<p>Kornelsen J, Dahinten VS, Carty E. (2003 – Mar-Apr) “On the road to collaboration: nurses and newly regulated midwives in British Columbia, Canada.” <i>J Midwifery Womens Health</i>. 48:2, 126-32.</p>	<p>Describes results of a survey conducted shortly after the introduction of midwives as a regulated and publicly funded provider within the British Columbia health care system. The survey asked hospital-based perinatal nurses about their knowledge and attitudes of midwifery and their experiences with midwives.</p> <p><u>Key Findings:</u> Results suggest that nurses, for the most part, had a negative view of midwives and their practice and that inattention to the necessary conditions for interprofessional collaboration and positive interprofessional relationships have resulted in a parallel practice between the professions instead of interdisciplinary practice.</p>
<p>Lahey W, Currie R. (2005). “Regulatory and medico-legal</p>	<p>Examines the regulatory and medico-legal barriers that might prevent or inhibit health care professionals from working together on an interprofessional basis, and to forecast the kinds of</p>

<p>barriers to interprofessional practice." <i>Journal of Interprofessional Care</i>. Volume 19, Issue S1, May 2005, 197 – 223.</p>	<p>changes within legal systems which will be necessary to accommodate the change.</p> <p>The authors conclude that law reform should focus on two objectives: reducing the restrictiveness of individual scopes of practice and the regulatory framework within which specific scopes of practice operate; and transforming the regulatory culture comparable to the change in practice culture that is needed to make interprofessional practice possible. The authors argue for the role of law, particularly in the articulation of accountabilities and in the development, implementation and functioning of regulatory institutions, as one of the determinants of the shift to a culture of interprofessional regulation.</p>
<p>Lindeke, Linda L., and Sieckert, Ann M. (2005) "Nurse-Physician Workplace Collaboration," <i>The Online Journal of Issues in Nursing</i>, 10:1, January 31.</p>	<p>Describes strategies to facilitate effective nurse-physician collaboration. Reviews the nature and the benefits of collaborative communication, followed by a discussion of self-development, team-development, and communication-development strategies that enhance nurse-physician collaboration.</p> <p><u>Key Findings:</u>  Collaboration is vital not only for the benefit of patients, but also for the satisfaction of health care providers. Collaboration between physicians and nurses is rewarding when responsibility for patient well-being is shared. Professionalism is strengthened when all members take credit for group successes. Appreciation of the unique knowledge of contributing disciplines and a clear understanding of the unique contributions of nursing to care can demonstrate that nurses play an important role in achieving the positive patient outcomes that occur only through collaborative efforts. Health care teams must work together by fostering self-awareness and preventing burnout.</p>

<p>Morey, John C., Simon, Robert., Jay, Gregory D., Wears, Robert L., Salisbury, Mary., Dukes, Kimberly A, and Berns, Scott D. (2002)  “Error Reduction and Performance Improvement in the Emergency Department through Formal Teamwork Training: Evaluation Results of the MedTeams Project,” <i>Health Services Research</i> 37:6, 1553–1581.</p>	<p>Describes the results of a study to evaluate the effectiveness of training and institutionalizing teamwork behaviours, drawn from aviation crew resource management (CRM) programs, on emergency department (ED) staff organized into caregiver teams.</p> <p><u>Key Findings:</u> A statistically significant improvement in quality of team behaviours was shown between the experimental and control groups following training. Subjective workload was not affected by the intervention. The clinical error rate significantly decreased from 30.9 percent to 4.4 percent in the experimental group. In the experimental group, the ED staffs' attitudes toward teamwork increased and staff assessments of institutional support showed a significant increase. The study’s findings point to the effectiveness of formal teamwork training for improving team behaviours, reducing errors, and improving staff attitudes among staff in Emergency Team Coordination Course trained hospitals.</p>
<p>Pew Health Professions Commission. (1995). <i>Reforming Health Care Work Force Regulation: Policy Considerations for the 21<sup>st</sup> Century</i>, Report of the Task Force on Health Care Work Force Regulation, December 1995.</p>	<p>The Pew Health Professions Commission assembled a Taskforce on Health Care Workforce Regulation in 1994 to identify and explore how regulation protects the public’s health and to propose new approaches to health care workforce regulation to better serve the public’s interest.</p> <p><u>Key Findings:</u> The report identifies the following health regulatory challenges that must be faced by all interested stakeholders.</p> <ul style="list-style-type: none"> <li>▪ The lack of uniformity in language, laws, and regulations between the states limits effective professional practice and mobility, confuses the public, and presents barriers to integrated delivery systems and the use of telemedicine and other emerging health technologies. These difficulties transcend state boundaries and call for standardization across the individual states.</li> <li>▪ Current statutes grant broad, near-exclusive scopes of practice to a few professions and “carved-out” scopes for the remaining professions. These laws erect unreasonable barriers to high-quality and affordable care. The need for accessible health care calls for flexible scopes of practice that recognize the demonstrated competence of various practitioners to provide the same health services.</li> </ul>

The 10 Recommendations emerging from the work of the Taskforce were:

- States should use standardized and understandable language for health professions regulation and its functions to clearly describe them for consumers, provider organizations, businesses, and the professions.
- States should standardize entry-to-practice requirements and limit them to competence assessments for health professions to facilitate the physical and professional mobility of the health professions.
- States should base practice acts on demonstrated initial and continuing competence. This process must allow and expect different professions to share overlapping scopes of practice. States should explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills.
- States should redesign health professional boards and their functions to reflect the interdisciplinary and public accountability demands of the changing health care delivery system.
- Boards should educate consumers to assist them in obtaining the information necessary to make decisions about practitioners and to improve the board's public accountability.
- Boards should cooperate with other public and private organizations in collecting data on regulated health professions to support effective workforce planning.
- States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals.
- States should maintain a fair, cost-effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health.
- States should develop evaluation tools that assess the objectives, successes and shortcomings of their regulatory systems and bodies to best protect and promote the public's health.
- States should understand the links, overlaps and conflicts between their health care workforce regulatory systems and other systems which affect the education, regulation and practice of health care practitioners and work to develop partnerships to streamline regulatory structures and processes.

<p>Risser DT, Rice MM, Salisbury ML, Simon R, Jay GD, Berns SD., The potential for improved teamwork to reduce medical errors in the emergency department: The MedTeams Research Consortium, <i>Annals of Emergency Medicine</i>, Volume 34, Number 3, September 1999, 373-383.</p>	<p>Describes the experience of emergency department care work teams designed to improve team communication and coordination and reduce error.</p> <p><u>Key Findings:</u> The core of this teamwork system is the teaching of teamwork behaviours and skills, development of teamwork habits, and creation of small work teams, all of which are key teamwork concepts largely drawn from successful aviation programs. Arguments for enculturating teamwork into Emergency Department practice are drawn from a retrospective study of 54 incidents of Emergency Department malpractice in 8 hospitals between 1985 and 1996. These were reviewed and judged preventable by better teamwork. An average of 8.8 teamwork failures occurred per case. More than half of the deaths and permanent disabilities that occurred were judged avoidable. Better teamwork could save nearly \$3.50 per ED patient visit. Caregivers must improve teamwork skills to reduce errors, improve care quality, and reduce litigation risks.</p>
<p>Roberts, P, Priest, H. (Oct. 1997). "Achieving interprofessional working in mental health." <i>Nursing Standard</i> 1;12 (2), 39-41.</p>	<p>Describes how IP education, in conjunction with service initiatives, can enhance the development of collaborative practice based on users' and carers' needs.</p> <p><u>Key Findings:</u> Interprofessional collaboration in health care has been high on the political agenda in recent years. However, despite several government reports, progress has been relatively slow. Several structural and organizational challenges need to be addressed, in addition to the development of valid research in this field, to accelerate the pace of change.</p>
<p>Thistlewaite, Jill (2007) "A Commentary from the Editorial Team in response to: The promise of 21st century professionalism: Regulatory reform and integrated care." <i>Journal of Interprofessional Care</i>, Volume 21, Issue 3 June 2007, 233 - 239</p>	<p>This editorial is a commentary from the Journal of Interprofessional Care's editorial team in response to the editorial by Celia Davis. The editorial raises questions about the regulation of health professions in the United Kingdom, particularly its effect on interprofessional collaboration and patient care. The continuing debate about the nature of self-regulation, and in particular its effects on interprofessional practice, is important.</p>
<p>Watson, Diane and Wong, Sabrina (2005). <i>Canadian Policy Context:</i></p>	<p>Identifies the elements of the policy context that are likely to facilitate, support or affect the nature of interdisciplinary teams in primary health teams in Canada, and the extent to which these</p>

<p><i>Interdisciplinary Collaboration in Primary Health Care.</i> The Conference Board of Canada, Commissioned by the Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative. Ottawa.</p>	<p>elements are used. The report begins with an overview of the historic circumstances and current contexts, as the basis for identifying barriers to interdisciplinary collaboration and opportunities to make progress. Next, it reviews predominant and emerging models for organizing primary health care, before assessing how change is taking place in Canada. The conclusion assesses the extent to which Canada will be able to make the transition to more interdisciplinary collaborative care.</p>
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## Section 2: Analysis and Key Findings Arising from the Literature

### *Interprofessional Care Terminology - Findings*

- There is wide variation in the use of terminology that has been used to describe interprofessional collaboration. The range of terminology used included the following terms: *team; teamwork; collaborative care; collaborative practice; multidisciplinary care; interdisciplinary care; interprofessional care; interprofessional collaborative care.*
- A review of the literature reveals that interprofessional collaboration – as it relates to interprofessional practice – has been defined based on a number of common underlying concepts, including: partnership; interdependency of several health professions; different professions coming together to work and learn with, from and about each other; shared responsibility and accountability; and collective action/active cooperation (vs. competition) toward a common goal.
- Specific definitions related to interprofessional collaboration in the context of regulatory reform were not found in the literature.
- To guide discussions concerning collaboration among health Colleges in Ontario and to focus its response to the Minister’s Referral, HPRAC has developed the following statement as a way to define what is meant by the concept of facilitating and supporting collaboration among health Colleges:

Health regulatory colleges and their members working collaboratively (rather than competitively) and learning from and about each other through a process of mutual respect and shared knowledge for a common purpose:

HPRAC has identified the following elements to further elaborate on the common purpose:

- Facilitating better outcomes for patients;
- Protecting the public interest;
- Regulating the professions in a manner that maximizes collective resources effectively and efficiently while protecting the public interest;
- Optimizing the skills and competencies of diverse health care professionals to enhance access to high quality services; and
- Ensuring access to high quality services no matter which profession is responsible for delivering care or treatment.

[Source: HPRAC, 2007]

- There are many definitions and meanings of “interprofessional care” found in the literature. For purposes of clarity and discussion, HPRAC has adopted the following definition of interprofessional care:

**INTERPROFESSIONAL CARE:** The provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.

[Source: *Interprofessional Care Steering Committee, HealthForceOntario, July 2007, p. 44*]

### ***Interprofessional Care & the Broader Health Reform Agenda - Findings***

- *Teamwork and collaboration in health care has emerged as a central issue for Canadians and their decision-makers, with many reports calling for improved collaboration as a key strategy in health care renewal* (CHSRF, June 2006). Interest in interprofessional collaboration as a key strategy for advancing health system reform has been explicitly mentioned as a key goal in a number of major reports on health reform released by the federal and provincial governments over the past decade (see Figure 1). Within these documents, the theme of interprofessional collaboration has emerged in a number of contexts that have included recommendations related to the need for a focus on interprofessional collaboration as it relates to reforms at the education, research, practice and regulatory levels.
- *In 2002, two key reports on health system reform – the Commission on the Future of Health Care in Canada (the Romanow report, 2002), and The Health of Canadians – The Federal Role (the Kirby report, 2002) – focused attention on the need to increase emphasis on interprofessional education and collaborative practice.* The Kirby report tabled the following recommendation related directly to the issue of scope of practice rules and regulations governing the health professions: *[That] an independent review of scope of practice rules and other regulations affecting what individual health professionals can and cannot do be undertaken for the purpose of developing proposals that would enable the skills and competencies of diverse health care professionals to be utilized to the fullest and enable health care services to be delivered by the most appropriately qualified professionals.*

**Figure 1: Selected federal and provincial health reform documents highlighting interprofessional care/collaboration as a key health reform strategy**

1997	National Forum on Health. (1997). <i>Canada Health Action: Building on the Legacy</i> (Vol. 1). (1997). The Final Report of the National Forum on Health. Ottawa: Health Canada. Ottawa. <a href="http://www.hc-sc.gc.ca/hcs-sss/com/fed/nfh-fns_e.html">http://www.hc-sc.gc.ca/hcs-sss/com/fed/nfh-fns_e.html</a>
2002	Commission on the Future of Health Care in Canada (Roy Romanow, Chair). (2002). <i>Building on Values: The future of health care in Canada</i> (Final Report). "Primary Health Care and Prevention" (Chapter 5: 115-135). <a href="http://www.healthcarecommission.ca">www.healthcarecommission.ca</a>  Standing Committee on Social Affairs, Science and Technology. (Michael Kirby, Chair) (2001). <i>The Health of Canadians: the Federal Role</i> . <a href="http://www.parl.gc.ca/common/Committee_SenRep.asp?Language=E&amp;Parl=37&amp;Ses=2&amp;comm_id=47">http://www.parl.gc.ca/common/Committee_SenRep.asp?Language=E&amp;Parl=37&amp;Ses=2&amp;comm_id=47</a>
2003	2003 First Ministers' Accord on Health Renewal <a href="http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index_e.html">http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index_e.html</a>
2004	Interdisciplinary Education for Collaborative, Patient-Centred Practice, Health Canada <a href="http://www.ferasi.umontreal.ca/eng/07_info/IECPCP_Final_Report.pdf">http://www.ferasi.umontreal.ca/eng/07_info/IECPCP_Final_Report.pdf</a>
2005	Health Council of Canada (2005). <i>Health Care Renewal in Canada: Accelerating Change</i> . <a href="http://www.healthcouncilcanada.ca/docs/rpts/2005/Accelerating_Change_HCC_2005.pdf">http://www.healthcouncilcanada.ca/docs/rpts/2005/Accelerating_Change_HCC_2005.pdf</a>
2005	Enhancing Interdisciplinary Collaboration in Primary Health Care (EICPHC) Initiative <a href="http://www.eicp.ca/en/">http://www.eicp.ca/en/</a>
2006	Canadian Health Services Research Foundation (2006). <i>Teamwork in Healthcare: Promoting Effective Teamwork in Canada</i> <a href="http://www.chsrf.ca/research_themes/pdf/teamwork-synthesis-report_e.pdf">http://www.chsrf.ca/research_themes/pdf/teamwork-synthesis-report_e.pdf</a>
2006	Government of Ontario. (June 2006). <i>Proceedings Report for the Summit on Advancing Interprofessional Education and Practice</i> . <a href="http://www.healthforceontario.ca/WhatIsHFO/IPCProject/ProjectResources.aspx">http://www.healthforceontario.ca/WhatIsHFO/IPCProject/ProjectResources.aspx</a>
2007	HealthForceOntario. (July 2007). <i>Interprofessional Care: A Blueprint for Action in Ontario</i> , Interprofessional Care Steering Committee, Government of Ontario <a href="http://www.healthforceontario.ca/WhatIsHFO/IPCProject/ProjectResources.aspx">http://www.healthforceontario.ca/WhatIsHFO/IPCProject/ProjectResources.aspx</a>

- *The 2003 First Ministers' Accord on Health Care Renewal highlighted the issue of appropriate planning and management of health human resources as a key to ensuring Canadians have access to the health providers when needed. In this context, collaborative patient-centred practice in interprofessional teams was one of the strategies identified as essential for health care delivery and health professional education now and in the future.*
- *Although all provincial governments have included interdisciplinary collaboration as one of their goals and objectives, without a clear vision of this concept, national policy recommendations (and champions), synchronizing the health policy, regulatory and legal frameworks that are necessary to ensure its success, are difficult. [Watson, Wong, 2005]*
- *Through its HealthForceOntario Strategy, the Ontario Government has made interprofessional care a key component of its health renewal strategy. In June 2006, the Ontario Government convened a two-day Summit on Advancing Interprofessional Education and*

*Practice to seek input and guidance from participants in developing and implementing methods to remove the barriers that prevent effective use of health human resources and interprofessional care.* In a follow-up to the Summit, the Government established a Steering Committee to develop a blueprint to advance interprofessional care in Ontario. The Blueprint's recommendations (see Figure 1) focused on creating a systemic approach to interprofessional care including a focus on partnership, integration, shared responsibility, communication, foundation-building and supporting change.

### ***Interprofessional Care and the Evidence-Base - Findings***

- *There is a large (and growing) body of research related to the concept of interprofessional care and its value.* Much of this literature describes past and current experiences related to interprofessional care models, and comments on the successes and barriers related to these practices. Recent literature, in particular, has started to look more closely at some of the current policy and system issues that have facilitated and/or acted as barriers to collaborative-based health care.
- *Little research has been focused on the broader/macro factors that influence the success in implementing collaborative care models, particularly outside of institutional settings.* [Bourgeault & Mulvane, 2006]
- *Each organization practices interdisciplinary care in its own unique way. There is no single right way to practice interdisciplinary collaboration and no step-by-step process for how best to practice interdisciplinary care.* The structure and composition of the teams that were studied differed, depending on the needs of the population, the choices of the professionals involved, and the availability of regional support teams. [EICPHC, Final Report]
- *Although there is a general sense that teamwork produces better patient outcomes, there are difficulties in demonstrating the relationship through research.* There is, however, some evidence in the literature that support the value of interprofessional collaboration care models and their effectiveness in improving patient outcomes, increasing patient and provider satisfaction, and decreasing health care costs when employed in a variety of practice settings. [CHSRF, 2006]

- *Finding data on the outcomes of patients/clients served by interdisciplinary teams is a challenge, given that outcome measurement research has been limited by the lack of a clear definition of interdisciplinary collaboration, making it difficult to measure the effectiveness of teams or the impact of their work on clients.* However, recent reviews of international literature on the effectiveness of interdisciplinary collaboration in primary health highlighted increased user satisfaction. Positive outcomes for quality of life, quality of care and health have also been shown in a significant number of studies. [EICPHC Initiative (April 2005-B)]
- *Significant research was undertaken to inform the work related to the federal EICPHC Initiative. This research confirmed that evaluation of interprofessional collaboration models of care is lacking, due to the speed of developments, the newness of the approach and the difficulty in defining the start and end dates of interdisciplinary collaboration projects.* These factors have limited the number of studies that have been published on the outcomes of interdisciplinary collaborative care. Nevertheless, based on existing assessments, clients/patients of interdisciplinary collaborative care show significant satisfaction with the results of this type of care. Studies in various countries show positive results in quality of life and care with a range of patient/client types, including veterans with complex care needs, children with special needs, geriatric patients and users of mental health services, as well as people in the general patient population. Barriers to effective teamwork include: legislative and funding issues; inability to integrate professionals from other disciplines into a team; lack of clarity about what an interdisciplinary team looks like and how they function; and lack of clear definitions of terms (i.e., interdisciplinary collaboration or teams). [EICPHC Initiative, 2005]
- *The available literature to support the value of interprofessional education is thin. This is especially the case for published reports of pre-licensure interprofessional education.* What is needed is educational research to assist in defining evidence-based best-practices for interprofessional education. Without evidence of effectiveness and definitions of best practices, it is unlikely that professional schools will alter curricula to incorporate interprofessional education in a meaningful way. A body of knowledge that defines the dos, frequency and nature of interprofessional experience must be created to ensure that health care professionals have the requisite knowledge, attitudes and skills to engage in collaborative practice. [Herbert, 2005]

- *Key enablers and barriers to interprofessional collaboration education/practice include: a lack of consensus about terminology, the need for interprofessional collaboration initiatives to have champions and external support, sensitivity to the effects of professions' cultures and the logistics of implementation* [Barr, 2005]. Other barriers include structural issues such as reimbursement, licensing, and competition between professionals, as well as conceptual problems, such as a lack of mutual role understanding and lack of experience or training in interdisciplinary collaboration among providers. [CHSRF, 2006]

Transformation to 'teamwork' in Canada has been slow; professionals continue to protect their "turf" or limit their scopes of practice to respond to their own needs/interests rather than the interests of the population. In particular, self-regulation of professionals and current malpractice laws place enormous constraints on teamwork. Existing funding and remuneration models do not support teams, and the educational system has been slow to adopt new approaches for professional training. [CHSRF, 2006]

### ***Interprofessional Collaboration and Regulatory Change – Findings***

- *In recent years, a growing body of literature has emerged related to the issue of interprofessional collaboration, pointing to the need for a focus on changes at the strategic level, including the importance of creating a regulatory climate that will support increased interprofessional collaboration.* Articles and reports that have been published identify the need for mechanisms that will enable regulators of various health professions to work together to build effective interprofessional collaborative arrangements within and across the health care continuum. Mechanisms to be addressed include:
  - A review of **organizational** factors affecting collaboration/teamwork;
  - Assessment of current **policy, legislation and regulation** as they relate to collaboration/ teamwork; and
  - Changes in the policies and practices of Health Regulatory Colleges aimed at encouraging collaborative/interdisciplinary approaches.
- Specific recommendations and implications related to regulatory reform have been considered in a number of key documents that have been produced by the following organizations in recent years:

<b>Canadian Health Services Research Foundation</b>	<b>Canadian Health Services Research Foundation (June 2006).</b> <i>Teamwork in healthcare: promoting effective teamwork in healthcare in Canada. A policy synthesis.</i>
<b>Conference Board of Canada</b>	<b>Conference Board of Canada (2007).</b> <i>Achieving Public Protection through Collaborative Self-Regulation: Reflections for a New Paradigm.</i>

<p><b>Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative (EICPHC Initiative)</b></p>	<p><b>EICPHC Initiative (January 2005).</b> <i>Regulatory Factors Task Group Snapshot.</i></p> <p><b>EICPHC Initiative (April 2005-A).</b> <i>Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada.</i></p> <p><b>EICPHC Initiative (April 2005-B).</b> <i>Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada.</i></p> <p><b>EICPHC (May 2005).</b> <i>Enhancing Interdisciplinary Collaboration in Primary Health Care, Barriers and Enabling Factors Task Groups Report.</i></p> <p><b>EICPHC Final Report (date unknown).</b> <i>Interdisciplinary Primary Health Care: Finding the Answers – A Case Study Report.</i> Ottawa. [The final report]</p>
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Key findings and recommendations arising from these documents and other literature reviewed on the issue of interprofessional collaboration and regulatory change is summarized below under the following sub-headings: Legislative Reform; Regulatory Reform; Policy Reform; Structural/Organizational Reform (including reforms by Regulatory Colleges).

### **LEGISLATIVE REFORM**

- *Each jurisdiction defines its own scope of practice, standards of education, core competencies, ethical frameworks and systems of accountability.* The historic absence of a national framework to guide provincial action has resulted in inconsistency among regions, which has created confusion among different health professionals, students and the public. Many self-regulated health care professionals have argued that current structures for professional self-regulation, including the legislative ability to prescribe scopes of practice, often serve as a barrier to integrated health care systems and to interdisciplinary practice. [Watson & Wong, 2005]
- *The fact that the legislation and regulation of health care in Canada is predominantly a provincial matter, and the corresponding absence of a national framework to guide provincial action, has resulted in variability of regulations and legislation across provinces.* Jurisdictions differ in both the regulatory powers delegated to each profession and in the legislative structures of their regulatory systems. Alberta, British Columbia, Ontario and Quebec have a unique law for each profession, supplemented by a secondary level of law, while the remaining provinces and territories have legislative frameworks limited to various statutes that have been incrementally passed for each health profession. They may also be supplemented by regulations, bylaws and codes of practice. [Watson & Wong, 2005]

The most problematic model or framework is that which regulates health care providers by exclusive scopes of practice. This effectively eliminates the possibility of the sharing of tasks necessary for functional collaborative care. The kind of model adopted in such provinces as Ontario, British Columbia and Alberta, where regulation takes the form of 'controlled acts' which could be shared is more amenable to teamwork. [Bourgeault & Mulvane, 2006]

- ***At the system level, legislative and regulatory reforms need to keep up with changes and trends in the practice environment.*** An examination of legislative and regulatory factors reveals that existing legislative and regulatory frameworks in Canada are inconsistent in the way they define scope of practice among the health professions. Barriers that prevent practitioners from functioning to their full scope of practice mean that health human resources are not being fully utilized. [CHSRF, Policy Synthesis, 2006]
- ***Overall, legislative and regulatory action is required for a shift toward interdisciplinary collaboration to take place.*** Among other things, any revised legislation must: recognize the validity of collective practice; clearly set out scopes of practice for each health profession; define the roles, responsibilities and relationships through an express agreement among members of a collaborative practice. [EICPHC initiative, May 2005]
- ***Legislatures and regulators have not traditionally made collaborative care one of their main objectives.*** Current legislation and regulation do not prohibit collaborative practice, nor do they encourage, require, facilitate or enable it. Legislation and regulations should be updated and amended to expressly support collaboration. In Canada, there is inconsistency and a lack of clarity in legislation and regulation with respect to collaboration. When these flaws exist, regulators and health care professionals err on the side of caution. Therefore, legislators and regulators must be clear and consistent in emphasizing the importance of collaboration. [Conference Board of Canada, 2007]
- ***Current legislation runs counter to the concept of interdisciplinary collaboration since it encourages professionals to work in silos, with few links among them.*** Scope of practice regulations and legislation governing professional responsibilities often inhibit delegation/sharing of duties from one category of provider to another despite good evidence that at least as high a standard of care can be provided cost effectively. Furthermore, descriptions of scopes of practice need to be revised to allow for the effective delegation/sharing of health care provisions. [EICPHC, January 2005]
- ***Agreements are needed on scopes of practice for each profession, as well as a framework for guidelines for collaborative practice.*** [EICPHC, May 2005]

In the Canadian context 'the legal and regulatory framework', particularly as it governs the responsibilities held by each of the professions, represents more of a hindrance to getting professionals to collaborate than the source of leverage it should be.  
Bourgeault & Mulvane, 2006

Law Reform efforts should concentrate on two objectives: The first is reducing the restrictiveness of individual scopes of practice and the regulatory framework within which specific scopes of practice operate. The second is the need for transformation in a regulatory culture comparable to the change in practice culture that is needed to make interprofessional practice possible...We argue for the role of law, particularly in the articulation of accountabilities and in the development, implementation and functioning of regulatory institutions, as one of the determinants of the shift to a culture of interprofessional regulation.  
[Lahey & Currie, 2005]

## REGULATORY REFORM

- *Differing extents of professional authority are based on legislative and regulatory structures imposed by government.* In Canada, there are several self-regulatory models extended to various professions, including:

- State-enforced monopoly;
- State-enforced monopoly over controlled acts only;
- State-enforced monopoly over controlled acts, but with the ability to delegate these acts to others;
- State-enforced protection of title, but not of activities; and
- No state-enforced protection.

The general trend in Canada appears to be toward State-enforced monopoly over controlled acts, but with the ability to delegate these acts to others. Ontario's approach has been to allow overlapping scopes of practice; various professions have been allowed to perform the same controlled acts. [Deber & Baumann, 2005]

- *Professional self-regulation has created additional boundaries among professions that have been reinforced by collective agreements negotiated between governments and individual professional bodies.* To remove these boundaries, individual and team competencies and the skill sets that health professionals require to work effectively as a team must be considered. [CHSRF, Policy Synthesis, 2006]

- *The key regulatory issues related to interdisciplinary collaboration identified through the EICPHC review include:*

- *Scope of Practice:* Inconsistencies in defined scopes of practice exist across jurisdictions. Flexibility is required in defining scopes of practice to promote innovations in primary health care.
- *Standards of Practice:* Currently, regulatory colleges protect the public in silos. Consistency in standards of practice across jurisdictions and between professions will require improved collaboration and evidence to support interdisciplinary collaboration in Primary Health Care.
- *Confidentiality/Privacy and Access to Information:* Interdisciplinary collaboration requires effective and open communication to promote quality patient care and reduce duplication of patient information and testing. Patient concerns for confidentiality and access to health care information must be considered and resolved.

The move towards more extensive use of collaborative health care teams raises a host of issues related to the management of professional boundaries. There are important institutional, regulatory and economic factors that both foster and hinder the success of collaborative health care teams... Little research has been focused on the broader/macro factors that influence the success in implementing collaborative care models, particularly outside of institutional settings.

[Bourgeault & Mulvane, 2006]

- ***Slow pace of changing legislation:*** Public and stakeholders' input and detailed analysis are required before legislation can be developed and approved. Developing and amending existing legislation is a slow process that will bring about long-term sustainable change. Flexible alternatives to legislation may need to be considered to enhance collaboration of health care professionals, while continuing to promote such safeguards as transparency and accountability.
  - ***Labour relations and collective agreements:*** The use of collective agreements and other labour relations strategies needs to be considered when developing ways to promote interdisciplinary collaboration. [EICPHC, January 2005]
- Regulators tend to place professional interests in control of the scope of occupations' "turf" ahead of their obligation to serve the broader public interest.

[EICPHC, January 2005]
- ***The top five challenges/opportunities facing interprofessional collaboration from a regulatory perspective are:***
    - Establish a regulatory framework for interdisciplinary collaboration specifically, outlining who does what, especially between provincial/territorial governments and professional regulatory bodies;
    - Clarify scopes of practice where there are inconsistencies in defined scopes of practice that exist among jurisdictions;
    - Define competencies, including those that are shared versus ones that are specific to a certain profession. There may be overlapping competencies;
    - Define federal/provincial/territorial jurisdiction where provincial/territorial autonomy is recognized in a regulatory framework; and
    - Provide education for the public, regulators and providers among professions. [EICPHC, May 2005]
  - ***Regulatory frameworks in many provinces have adapted to changing circumstances by adding categories (e.g., Ontario's approach to delegated medical acts). Legislation may be a barrier because change is slow, but it does not appear to be a major or insurmountable one.*** Thus, although many cite regulatory issues as a potential barrier to collaboration, they appear to be manageable, since they do not represent a clash of values. Regulation and legislation are often slow to change, but that does not mean that change is impossible. [Deber & Baumann, 2005]
- There is considerable dispute within the policy community as to when and which regulatory barriers to competition are appropriate. At one extreme, it is vital that only qualified individuals be allowed to give complex care and perform potentially dangerous procedures. At the other extreme, regulation may be seen as a form of 'turf protection' focused more on increasing professional incomes, without necessarily improving patient outcomes.

Source: Deber & Baumann, 2005

## **POLICY REFORM**

- *The creation, implementation, and maintenance of collaborative care teams require a significant long-term commitment.* Effective teamwork/ interprofessional collaboration is achieved when all levels within the health care system can work together. Other sectors (such as the courts, the professional regulatory bodies, education institutions, accreditation organizations, patients/clients and providers) must be ready to review current practices and embark on new initiatives to improve the working environment. [CHSRF, 2006]
- *Policy makers must give the organizational level the autonomy to resolve barriers impeding the systemization of collaborative practices.* This autonomy could be in the form of increased budget allocations, decentralization of services, increased human resource management, incentives, or competency development, etc. Simultaneously, the system level should ensure that best practices (examples of positive change and increased scopes of practice) are communicated nationally. [CHSRF, Policy Synthesis, 2006]
- *Self-regulation of professionals and current malpractice laws place enormous constraints on teamwork/interprofessional collaboration.* Existing funding and remuneration models do not support teams, and the educational system has been slow to adopt new approaches for professional training. [CHSRF, 2006]

## **STRUCTURAL/ORGANIZATIONAL REFORM**

- *The practice level needs to change its prevailing mindset about how health care professionals can work together given the entrenched attitudes about scopes of practice and the resistance to change.* Providers need to address “turf” issues and adopt common goals; break down traditional hierarchical power structures; and educate patients about how each team member will contribute to their care. [CHSRF, Policy Synthesis, 2006]
- *Solutions to addressing barriers confronting interprofessional collaboration include:*
  - Leadership from national and provincial associations and all levels of government;
  - An effective administrative structure that supports collaboration;
  - Increased use of technology;

Regulators can act now, wait for a demographically-driven sustainability challenge to hit the health care system or address a potential crisis of regulation, which could arise from a lack of focus in the areas of recertification, regulatory accreditation or standards.

Source: Conference Board of Canada, 2007

- Shared physical space to encourage collaboration;
  - Regulatory and liability provisions for new scopes of practice;
  - Identification of optimal conditions for collaboration; and
  - Projects that are evaluated as demonstrating effectiveness [EICPHC, April 2005-B]
- *Regulators have an important role to play in supporting collaborative practice through the development of partnerships between themselves and educators, government and the public.* Encouraging regulators to work together in the areas of quality assurance, complaints and discipline would signal the importance of collaboration to health professionals. [Conference Board of Canada, 2007]
  - *Joint statements on liability protections should be issued by regulators.* [EICPHC, May 2005]
  - *Jurisdictions differ in the regulatory powers delegated to each profession and legislation for licensure prohibits all who are not licensed from providing services that fall outside their scope of practice.* A possible solution to this is the widespread adoption of the controlled acts model to increase flexibility in regulatory framework or widespread adoption of certification, supplemented by a “harm clause” which prohibits all treatment and advising by unregulated persons when it is reasonably foreseeable that serious physical harm could result. Overall, if interdisciplinary collaboration is to become institutionalized and sustainable, legislative flexibility needs to be enhanced as it relates to health professions. This could ensure that regulatory matters are subject to the appropriate safeguards of transparency and accountability. [EICPHC, January 2005]
  - *Health professions do not have a good understanding of one another's scopes of practice and competencies.* Competencies that are required in an interdisciplinary team need to be defined. A focus on competencies allows for discussions about (national) standards. Policies and principles can then be examined. In addition, health care providers and the public need to understand each provider’s role and scope. Guidelines for teams to do this need to be created, at minimum, at the provincial/territorial level. There is also a need to document scopes of practice (who is responsible for what) and responsibilities (team vs. individual). Leadership in this area should be provided by Health Colleges of all professions. [EICPHC, May 2005]

## **Concluding Remarks**

Advancing interprofessional collaboration is impacted by the many barriers surrounding its implementation. Barriers to collaborative practice include: jurisdictional issues, flawed regulatory and funding mechanisms, a lack of policy development and medical-legal issues that prevent practitioners from collaborating. In addition, the lack of clarity in defining each team member's scope of practice poses a significant challenge in implementing interprofessional collaboration reforms. The situation is further aggravated by a shortage of health care providers and an absence of ongoing, adequate funding to support collaborative activities. There is a critical need for decision makers to act as leaders in breaking down these barriers and developing the infrastructure required to support interprofessional collaboration at the practice, educational, organizational, regulatory and system levels. The challenge confronting these leaders will be to develop mechanisms that will respond to the barriers, advocate for harmonization of existing legislative and regulatory frameworks, and facilitate the evolution of scopes of practice in response to changing needs and trends in the health care system.

## Appendix 1: Summary of Terminology in the Literature

Team/Teamwork	
CHSRF. (June 2006). Policy synthesis – “ <i>Teamwork in healthcare: promoting effective teamwork in healthcare in Canada</i> ”, page 3.	<p><b>TEAM:</b> A collection of individuals who are <u>interdependent</u> in their tasks, who share responsibility for outcomes, <i>who see themselves and who are seen by others</i> as an intact social entity embedded in one or more larger social systems and who manage their relationships across organizational borders.</p> <p><b>TEAMWORK:</b> The interaction or relationship of two or more health professionals who work independently to provide care for patients. Teamwork means members of the team:</p> <ul style="list-style-type: none"> <li>- Are mutually dependent</li> <li>- See themselves as working collaboratively for patient centred care</li> <li>- Benefit from working collaboratively to provide patient care</li> <li>- Share information which may lead to shared decision making, and</li> <li>- Know when teamwork should be used to optimize patient centred care.</li> </ul>
Cohen SG., and Bailey DR., (1997). What makes team work. Group effectiveness research from the shop floor to the executive suite. <i>J Management</i> . 23(4): 238-90.	<p><b>TEAM</b> is a collection of individuals who work interdependently, share responsibility for outcomes, and see themselves and are seen by others as an intact social entity embedded in one or more larger social systems (for example, business unit or corporation) and who manage their relationship across organizational boundaries.</p> <p><i>Cited in Interprofessional Care: A Blueprint for Action in Ontario, Interprofessional Care Steering Committee, HealthForceOntario, July 2007, page 44</i></p>
Drinka, T. and Clark, P. (2000). Health care teamwork: Interdisciplinary practice and teaching. Westport, CT: Auburn House.	<p><b>INTERDISCIPLINARY TEAM:</b> “A group of individuals with diverse training/backgrounds who work together as an identified unit or system. Team members consistently collaborate to solve patient problems that are too complex to be solved by one discipline or many disciplines in sequence. In order to provide care as efficiently as possible, an interdisciplinary team creates “formal” and “informal” structures that encourage collaborative problem solving. Team members determine the team’s mission and common goals; work interdependently to define and treat patient problems; and learn to accept and capitalize on disciplinary differences, differential power and overlapping roles. To accomplish these they share leadership that is appropriate to the presenting problems and promote the use of differences for confrontations and collaboration.”</p>
Interprofessional Collaboration/Collaborative Practice	
2003 First Ministers’ Accord on Health Care Renewal.	<p><b>COLLABORATIVE PATIENT-CENTRED PRACTICE</b> promotes the active participation of each discipline in patient care. It enhances patient- and family-centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision-making within and across disciplines and fosters respect for disciplinary contributions of all professionals.</p> <p><i>Cited by Interprofessional Care Steering Committee, HealthForceOntario, July 2007, page 44</i></p>

<p>Canadian Health Services Research Foundation. June 2006. Policy synthesis – “Teamwork in healthcare: promoting effective teamwork in healthcare in Canada”, 3-4.</p>	<p><b>COLLABORATIVE PRACTICE:</b> Health professionals who practice using a process of interprofessional communication and decision-making that promotes collaboration based on shared knowledge and a range of professional skills to influence patient care.</p> <p>When health care includes CONSULTATION OR REFERRAL to another professional the practice shifts to INTERDEPENDENT and INTER-PROFESSIONAL practices.</p> <p>COLLABORATION among health professionals is dynamic and occurs within a spectrum from:</p> <ul style="list-style-type: none"> <li>- <u>Independent parallel practice</u> with autonomous health professionals working side by side, to</li> <li>- <u>Consultation and referral</u> where health professionals exchange information, to</li> <li>- <u>Interdependent co-provision of care</u> with interdependent decision-making.</li> </ul>
<p>D’Amour et al. The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks, <i>The Journal of Interprofessional Care</i>, Volume 19, Issue S1 May 2005, 116-17.</p>	<p><b>COLLABORATION</b> conveys the idea of <u>sharing and implies collective action oriented toward a common goal</u>, in a spirit of <u>harmony and trust</u>.</p> <p>Each discipline develops strong theoretical and discipline-based frameworks that give access to professional jurisdictions that are often rigidly circumscribed. This constitutes the essence of the professional system. Collaboration requires making changes to this paradigm and implementing a logic of collaboration rather than a logic of competition.</p>
<p>D’Amour, Danielle and Oandasan, Ivy., <b>Interprofessionalism as the field of interprofessional practice and interprofessional education: An emerging concept</b>, <i>The Journal of Interprofessional Care</i>, Volume 19, Issue S1, May 2005, 9.</p>	<p>In the health domain, interprofessionalism is a response to the realities of fragmented health care practices. Professionals come from different disciplines and from different health care organizations, each carrying different conceptualizations of the client, the clients’ needs, and the type of response needed to address the clients’ numerous and complex health care situations.</p> <p><b>Interprofessionalism</b> is defined as the development of a <u>cohesive practice between professionals from different disciplines</u>. It is the process by which professionals reflect on and develop ways of practicing that <u>provides an integrated and cohesive answer to the needs of the client/family/population</u>.</p> <p><b>Interprofessionalism</b> comes from the preoccupation of professionals to reconcile their differences and their sometimes opposing views and it involves continuous interaction and knowledge sharing between professionals organized to solve or explore a variety of education and care issues all while seeking to optimize the patient’s participation.</p>
<p>Health Canada. <b>Interprofessional Education for Collaborative Patient-Centred Practice: A Health Canada Initiative</b>  <a href="http://www.med.mun.ca/cchpe/pubs/IECPCP_Pamphlet.pdf">http://www.med.mun.ca/cchpe/pubs/IECPCP_Pamphlet.pdf</a></p>	<p><b>INTERPROFESSIONAL COLLABORATIVE PATIENT-CENTRED PRACTICE</b> is designed to promote the <u>active co-operation of several health care disciplines and professions</u> in providing care. It enhances patient, family and community-centered goals and values, provides mechanisms for continuous communication and <u>fosters respect for the contribution of all providers</u>. There is growing consensus that interprofessional collaborative patient-centred practice will contribute to: improved patient care; access to the appropriate provider at the appropriate time; improved recruitment and retention of health care providers; improved satisfaction among patients and health care providers; and decreased waiting times.</p>

	<p><b>Interprofessional education</b> has been described as learning together to promote collaborative care. It involves collaboration among several professions in the learning process, either in the education or health care sectors in order to:</p> <ul style="list-style-type: none"> <li>▪ socialize health care providers in working together, in shared problem-solving and decision-making;</li> <li>▪ develop mutual understanding and respect for the contributions of various health providers; and</li> <li>▪ instill the requisite competencies for collaborative practice.</li> </ul> <p>There is growing consensus that <b>interprofessional collaborative patient-centred practice</b> will contribute to:</p> <ul style="list-style-type: none"> <li>▪ improved patient care;</li> <li>▪ access to the appropriate provider at the appropriate time;</li> <li>▪ improved recruitment and retention of health care providers;</li> <li>▪ improved satisfaction among patients and health care providers; and</li> <li>▪ decreased waiting times.</li> </ul>
<p><b>Herbert., Carol P., Changing the Culture: Interprofessional education for collaborative patient-centred practice in Canada, <i>The Journal of Interprofessional Care</i>, Volume 19, Issue S1, May 2005, 2.</b></p>	<p><b>COLLABORATIVE PATIENT-CENTRED PRACTICE</b> is a practice orientation, a way of health care professionals working together and with their patients. It involves continuous interaction of two or more professionals or disciplines, organized into a common effort, to solve or explore common issues with the best possible participation of the patient. Collaborative patient-centred practice is designed to promote the active participation of each discipline in patient care. It enhances patient- and family-centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision-making within and across disciplines, and fosters respect for disciplinary contributions of all professionals.</p>
<p><b>The McGill Educational Initiative on Interprofessional Collaboration.</b> <a href="http://www.interprofessionalcare.mcgill.ca/default.htm">http://www.interprofessionalcare.mcgill.ca/default.htm</a></p>	<p><b>INTERPROFESSIONAL PRACTICE [AND EDUCATION]</b> describes the active participation of <u>different professionals learning with, from and about each other</u>. By embracing <u>cooperation rather than competition</u> between the various allied health professions through a process of mutual respect as well as shared knowledge and decision-making, health care professionals are able to make positive change.</p>
<p><b>HealthForceOntario. (July 2007). Interprofessional Care: A Blueprint for Action in Ontario. Submitted by the Interprofessional Care Steering Committee, 44.</b></p>	<p><b>INTERPROFESSIONAL CARE</b> is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.</p>

<p>Rodriguez et al., <b>The determinants of successful collaboration: A review of theoretical and empirical studies</b>, <i>The Journal of Interprofessional Care</i>, Volume 19, Issue S1 May 2005, 133.</p>	<p><b>COLLABORATION</b> in health care teams is the process by which <u>interdependent professionals</u> are structuring a <u>collective action towards patients' care needs</u>. This collaborative process is built on a voluntary basis and necessarily implies <u>negotiation</u>. It requires that the <u>parties forego a competitive approach and adopt one based on collaboration</u>, both between professionals and between health care institutions.</p>
<p>University of Toronto et al., <b>Interdisciplinary Education for Collaborative Patient-Centred Practice</b> (Ottawa: Health Canada, 2004).</p>	<p>The terms multidisciplinary, interdisciplinarity, transdisciplinarity convey different degrees of collaboration within a team. At one end of the spectrum (multidisciplinary teams), professionals intervene on an autonomous, or parallel, basis. At the other end of the spectrum (transdisciplinarity), professionals have a narrower margin of autonomy, the team as a whole is more autonomous and its members are better integrated.</p> <p><b>Multidisciplinary</b> refers to situations where several participants representing several disciplines work on the same project on a limited and transient basis. While they may not necessarily meet, the members of a multidisciplinary team work in a co-ordinated fashion.</p> <p><b>Interdisciplinarity</b> implies a deeper degree of collaboration among team members. It implies an integration of the knowledge and expertise of several disciplines to develop solutions to complex problems in a flexible and open-minded way. This type of team is characterized by ownership of common goals and a shared decision-making process. Members of interdisciplinary teams must open territorial boundaries to provide more flexibility in professional responsibilities in order to meet clients' needs.</p> <p><b>Transdisciplinarity</b> refers to professional practice that seeks consensus. It is more open and sometimes results in vanishing professional boundaries. Transdisciplinarity is characterized by a deliberate exchange of information, knowledge, skills and expertise that transcend traditional discipline boundaries.</p> <p><i>Cited in Enhancing Interdisciplinary Collaboration in Primary Health Care in Canada, The Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative, April 2005, page 3.</i></p>
<p>Way, Jones and Busing N., <b>Implementation Strategies: Collaboration in Primary Care – Family Doctors &amp; Nurse Practitioners Delivering Shared Care</b>. Toronto, ON, Ontario College of Family Physicians, 2000.</p>	<p><b>COLLABORATIVE PRACTICE:</b> An <u>interprofessional process of communication and decision-making</u> that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided.</p> <p><i>Cited by Interprofessional Care Steering Committee, HealthForceOntario, July 2007, page 44.</i></p>