

Collaborative CARE: *a necessary evolution*

No doubt about it, collaboration has become a fact of life for many physicians.

Marla Fletcher



Dr. Louise Cloutier, a family physician in Dartmouth, Nova Scotia, explains that in today's complex health care environment there's a sense that "I can't do it all, because I don't know everything." Cloutier is convinced her patients receive the best possible care because she is part of a group of 20 physicians who work together in a clinic offering 24/7 coverage.

Physicians across Canada seem to agree that more collaborative arrangements are often required to help them provide better access to a broader range of services and higher quality of care. According to the 2007 National Physician Survey (NPS), 78% of all physicians collaborate

with family physicians and the majority collaborate with other health care providers. Nearly half — some 46% — of all physicians surveyed said they work in group medical practices, while 24% work in interprofessional practice settings with other health care providers.

Among those who collaborate, 93% believe this working relationship improves the care their patients receive and 92% feel it enhances the care they deliver. And take a look at this gratifying statistic: more than 76% of all family physicians and general practitioners (FP/GPs) are at least somewhat satisfied with the quality of consultations they receive from other specialists in terms of utility and reliability.

Just 27% of physicians were in solo practice in 2007, compared with 32% at the time of the 2004 NPS.

Key collaborative partners

You'd need a playbook to keep track of all the partners with whom a physician can collaborate these days. FP/GPs say they often consult or work with other family physicians, gynecologists, internists, obstetricians, pediatricians, psychiatrists and surgeons.

In terms of potential collaborators with different skill sets, the list includes dietitians/nutritionists, nurses, occupational therapists, pharmacists, physiotherapists, psychologists and social workers.

Mark Holteron

POUR les médecins, la collaboration entre eux et avec les autres prestataires de soins de santé a toujours été la norme, particulièrement en établissement. Les données tirées du SNM 2007 indiquent toutefois que les modèles de soins en collaboration se répandent de plus en plus en contextes de soins primaires. Comme l'affirme le D^r Louise Samson, présidente du Collège royal des médecins et chirurgiens du Canada, le nouveau paradigme «ne consiste pas simplement à travailler côte à côte. Il s'agit vraiment de travailler ensemble. (...) Il

faut entretenir une très bonne communication (...) pour apprendre ce que les autres professionnels ont à offrir et les types de soins qu'ils fournissent.» Comme le nombre de médecins qui pratiquent seuls diminue (il est passé de 32 % en 2004 à 27 % selon le récent sondage) et que le nombre de ceux qui travaillent dans des pratiques en collaboration augmente, il est réjouissant de constater que les répondants au SNM croient presque à l'unanimité que la collaboration améliore la qualité des soins dispensés aux patients.

The graph below lists the professionals that survey respondents said they collaborate with most often — usually by telephone.

Among physicians, the most frequent collaborations are between FP/GPs, then with surgical specialists, followed (in descending order) by internal medicine and obstetrics/gynecology specialists and psychiatrists.

However, although most physicians say they collaborate in providing patient care, fewer than a quarter do so within a formal arrangement.

Medical students expect to work collaboratively. Some 70% of 2007 NPS survey respondents said collaborative/interdisciplinary case care was of interest. In addition, more than three-quarters of residents said they have been exposed to collaborative care — or assume they'll be working this way at some point.

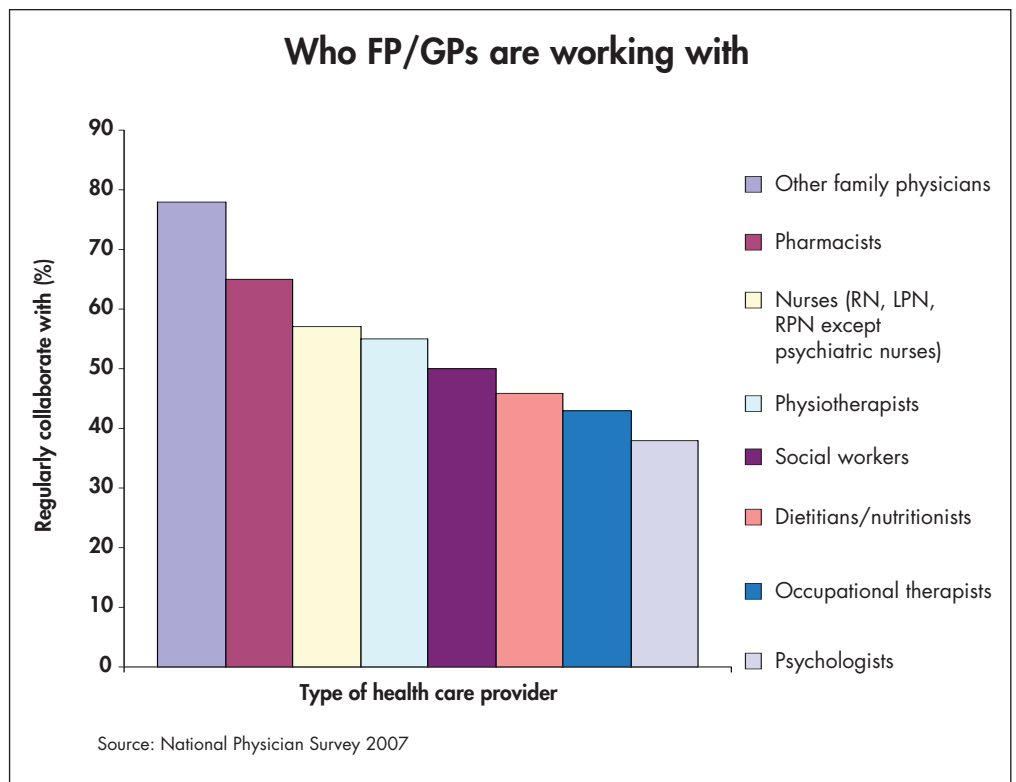
While many other models for collaborative health care exist, this model may resonate best with those involved in new primary care arrangements.

When doctors reflect on how they collaborate, the words that surface again and again are “respect,” “trust” and “communication.” As the survey indicates that most physicians who collaborate do so on an informal basis, it stands to reason that building great relationships with care providers in other professions is critical.

“I think it's the development of the team that's important,” observes Dr. Janice Willett, who works in an interprofessional group health association that has operated successfully for more than 20 years in Sault Ste. Marie, Ontario. Willett thinks it's good news that “collaboration in community-based medicine is in a renewal phase” because care can then be seamless and more timely.

How collaboration unfolds

Picture this example of a collaborative care model: a dot in the centre of a circle is the patient surrounded by a ring of what Cloutier calls “the care continuum.” Members of this continuum include the primary care physician and his or her administrative support staff, plus other members of a collaborative care team that is set up according to the patient's current medical condition. Other non-physician consultants — such as dietitians/nutritionists and social workers — are drawn in as the care plan and the patient's situation evolve. The team must fit into the local care community and be flexible, ready to change and adapt according to the patient's needs.



Dr. Louise Samson, a Montréal radiologist who is president of The Royal College of Physicians and Surgeons of Canada (RCPSC), adds, “It’s not just working side by side. It’s about *really* working together — so we need to communicate very well. ... We need to learn what other professionals can bring and the kind of care they provide.”

Both The College of Family Physicians of Canada (CFPC) and The Royal College have long acknowledged that the relationship between FP/GPs and other specialists is a vital one that must be nurtured. In 2006, the 2 organizations met to discuss how to improve the working and learning relationship between the 2 groups to enhance patient care and physician satisfaction.

This colloquium yielded a conjoint discussion paper and a collaborative action committee on intraprofessionalism (CACI) that has been meeting on an ongoing basis to discuss various issues involved in collaborative care and the referral/consultation process.

“Members (of the profession) need to be aware that their national medical organizations are concerned about and interested in drawing more attention to this issue,” says Samson, who co-chairs CACI along with her CFPC counterpart Dr. Louise Nasmith.

How patients benefit from collaboration

Doctors are enthusiastic about the potential for improved access to care, more broadly based diagnoses, better coordination of care — especially for chronic care patients who have ongoing special needs — and improved tracking using shared electronic medical records (EMRs).

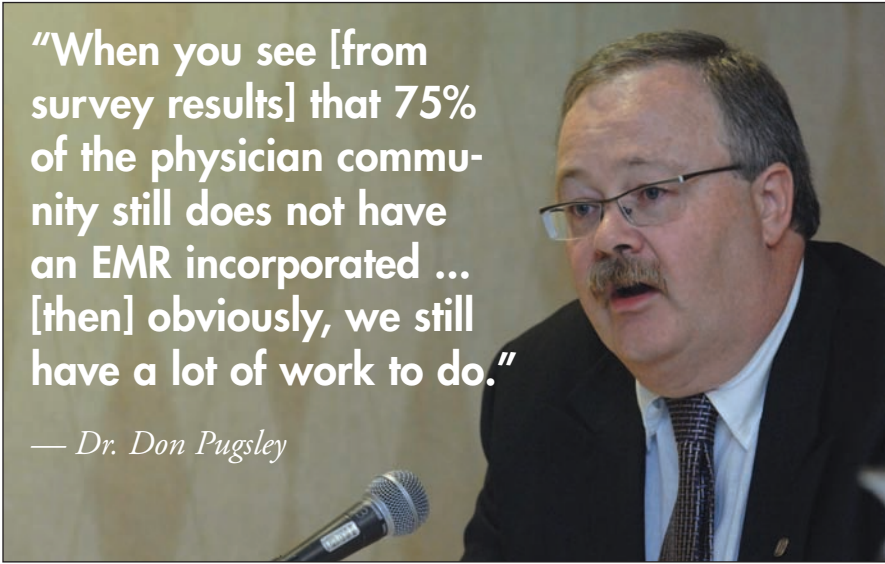
“It’s about the patient. It’s patient-centred for sure,” states Dr. Susan Fair of Winnipeg. Fair is a family physician, who was co-chair of the CMA working group on collaborative care. “Patients are getting older, much more complex and they need more care.”

When several members of a collaborative care team can share that care burden and coordinate all the various facets, it’s far less time-consuming and draining for the individual primary care physician.

Patients enjoy peace of mind when a collaborative care team is in place, says Cloutier, because they know they will be taken care of. Someone is there to answer each health need as it arises, and the overall care plan is being reviewed regularly by all team members, including the patient.

Boundaries and barriers

Although collaborative care gets great press and wide acceptance in policy documents, physicians are often frustrated by the lack of



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collaboration between specialists, subspecialists and FP/GPs. This was made clear in a 2006 CMA consultation on specialty care that involved close to 4 000 physicians across the country. Among issues cited were inadequate (or non-existent) consultation letters, inappropriate referral, a general breakdown in communications and physician shortages in all areas, which extend wait times and, thus, limit or deny patients access to specialty care.

The CFPC includes “collaborating as team members or team leaders” in its 4 principles of family medicine. It also articulated in a 2007 joint vision statement with the Canadian Nurses Association, a patient-centred approach that advocates full access to a family care/primary care setting, where each patient can receive care from a personal family doctor and a registered nurse or nurse practitioner.

The RCPSC noted — in its CanMEDS framework published in 2005 — that 1 of the 7 competencies a specialist with the college must demonstrate is that of “collaborator.”

The CMA’s recently approved policy document sets out guiding principles for effective collaborative care.

Then there’s the legal liability. As an anonymous correspondent in the 12 Feb. 2008, *The Medical Post* lamented in the “Your Voice” opinion column, “No one else wants to assume it; they talk about teams but will not take responsibility for outcomes.” Physicians we interviewed said the most successful and effective collaborative care teams have a formal agreement where the roles, governance structure and responsibilities of each team member are clearly spelled out, with corresponding legal provisos discussing their various levels of responsibility.

Funding picture needs clarification

In the end, said our informants, for collaborative care arrangements to work effectively in the health care system the funding must follow the patient.

“Doctors need to know what costs are being covered by the

[health] district [or other administrative authority] and what they are personally responsible for,” states Dr. Don Pugsley, president of Doctors Nova Scotia and the other co-chair of the CMA working group. He says financial arrangements need to be clearly defined for collaborative care teams, with built-in funding for the development and support of team members in their distinct roles as well as for required patient care.

Both health care administrators and collaborative care team members are seeking creative solutions to address the compensation issue. In rural and remote areas, for example, virtual networks might serve the collaborative function if the necessary technology is in place and team members are paid for the time they spend as collaborators.

One Nova Scotia pilot project has helped to establish nurse practitioners as collaborators with local physicians to improve care in underserved areas. Critical to the project’s success is the precondition for a negotiated collaborative agreement among all participants and an alternative payment method for participating physicians, with designated funding coming from provincial and federal levels.

The electronic role

One point repeatedly made by the physicians interviewed for this article is the requirement for an electronic communication system that is available to members of a collaborative team, making up-to-date communications and shared patient records possible.

As Pugsley notes, “When you see [from survey results] that 75% of the physician community still does not have an EMR incorporated ... [then] obviously, we still have a lot of work to do.” He believes that having the necessary information technology and EMR structure in place will also help with physician recruitment and retention, especially in rural and remote areas.

Special interest groups on the Internet may also provide support and encouragement to emerging collaborative care arrangements and, ultimately, “change and improve the way we collaborate,” says Samson.

Marla Fletcher is a staff writer for MD Pulse.