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Interprofessional collaboration in a transitional care management clinic: A qualitative analysis of health professionals experiences

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ABSTRACT

Background: Given the relative newness of primary care interprofessional collaboration, exploration of team members perspectives about their team experience can provide insights about the benefits and detractions of interprofessional collaboration in primary care delivery.
Purpose: The purpose of this study was to examine the perceptions of a small interprofessional primary care team.
Method: A conventional content analysis was used to examine semi-structured interviews examining the benefits and barriers of interprofessional team work among 10 health professionals on an outpatient care team.
Results: Three separate themes emerged from the data: Barriers to Collaboration, Social Support, and Access to Human Capital.
Conclusions: Although barriers to interprofessional team work exist within this particular team dynamic, social support emerged as a mediator that buffered negativity, reduced burnout and stress, increased overall work satisfication, provided access to human capital and increased perceptions of improved patient care.

Recommendations for interprofessional collaborative care to improve health care delivery and patient experiences have been made at global and national levels.[1–3] Thought to improve fragmented delivery systems and address patient safety and medical errors, interprofessional collaborative care seeks for health professionals to deliberatively work together to deliver the highest quality of care.[2,3] Interprofessional collaboration can be defined "as an integrative cooperation of different health professionals, blending complementary competences and skills, making possible the best use of resources".[4] Patient and system-based outcomes associated with interprofessional care point to the need for continued research and rigorous study.[6,7] Significant challenges in examining outcomes of interprofessional collaborative care include the uniqueness of health care settings, team members and tasks.[1,7] Nonetheless, evidence to demonstrate where and how interprofessional care teams are effective will advance health care delivery by informing system design and health professions education to leverage elements conducive for success. Furthermore, given the recognition of stress and burnout as salient factors for health care professionals[8–12] and association with increased medical errors,[12,13] the potential role of interprofessional collaborative care as a positive source of support and job satisfaction for providers has been reported in the literature,[14] but not extensively researched.

Primary care settings are one of several health care contexts for interprofessional collaboration. Chronic disease coordination and management of high-risk patients are identified as particular areas in primary care where an interprofessional care approach can be beneficial.[3,15] Research regarding primary care practitioners' perceptions of interprofessional collaboration indicate positive views of interprofessional collaborative care models[15,16] and reviews examining interprofessional collaboration in primary care have identified several elements relevant to its effective practice, including issues associated with effective teamwork processes (i.e., communication, shared decision-making) and structural factors (i.e., space and organization).[5,17] Given the current emphasis on primary care interprofessional collaboration, exploration of team members perspectives about their team experience, particularly vis a vis work satisfaction, can provide further insights about the benefits and detractions of interprofessional collaborative primary care delivery. The purpose of this study was to examine the

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perceptions of a small interprofessional primary care team about their experience as an interprofessional care team, including job satisfaction.

1. Methods

In 2015, in response to concerns about high rates of patient readmissions to inpatient care within 30 days, a weekly interprofessional transitions of care clinic at a primary care internal medicine practice was developed. Patients that are cared for come from a diverse population, many of whom have complex chronic medical conditions and struggle with tenous social situations, limited access to care, transportation, and mental illness. Earlier research, within the clinic, demonstrated that patients were not being seen by their primary care providers promptly after discharge and that patient's medication regimens were often unclear following dicharge. In response, a protocol was developed for ensuring that patients were seen within two weeks of discharge, or sooner if possible. Two attending internists, nurse, pharmacist, psychologist, social worker, home care specialist and several trainees were brought together to try to help the patient as a team to prevent readmission. For one half hour prior to patient appointments the team huddles to review the nine patients scheduled that afternoon to discuss issues that arose during the hospitalization and to anticipate potential medical and psychosocial challenges that put them at risk for readmission.

This study was approved by the Institutional Review Board at the study institution. The study consisted of semi-structured interviews with members of an interprofessional outpatient care team. The interprofessional care team consists of physicians, internal medical residents, medical students, pharmacy students, pharmacists, nurses, homecare representatives, social workers and a psychologist (a range of 8–15 members). Members of the interprofessional care team were recruited via email and consisted of physicians (n = 2), a clinical pharmacist (n = 1), homecare representatives (n = 2), a registered nurse (n = 1), social workers (n = 2) and a clinical psychologist (n = 1), for a total of 9 interviews. Given that medical and pharmacy students are not consistent team members, it was determined not to include them within the study. Thus, the majority of the interprofessional team was interviewed. The interviewer was a social behavioral scientist not connected to the team or health care delivery. After obtaining informed consent, each interview followed a semi-structured guide comprised of 14 questions that sought to assess the benefits and barriers associated with working as part of an interprofessional team (Fig. 1). Interviews were audio recorded and then transcribed verbatim. Interviews ranged from 25 to 60 min.

1.1. Data analysis

Interviews were coded using conventional content analysis by one of the researchers (NS).[18] Conventional content analysis was employed as the study was not based on previous theory.[18] With no theoretical foundation guiding the interview questions all themes and subthemes were derived solely from the data.[18] Each interview was analyzed independently and coded for emergent themes until saturation (no new themes could be identified) was reached. Emerging and final themes were then examined by two members of the research team (AB & EB), to provide confirmation of the emerging and final themes.

2. Results

Analysis revealed three separate themes associated with team members' perspectives on their work as an interprofessional team and job satisfaction: 1) Barriers to Collaboration, 2) Social Support, and 3) Access to Human Capital. Within Barriers to Collaboration were several subthemes: Time, Space, Financial, and Assumptions of Hierarchy. Social Support included a single subtheme, Increased Work Satisfaction. Access to Human Capital included two subthemes: Enhanced Communication and Perceived Improved Delivery of Care. Themes and subthemes are depicted in Table 1.

3. Barriers to collaboration

Participants perceived that 1) time, 2) space, 3 financial, and 4 Assumptions of hierarchy were the significant barriers towards a more effective interprofessional collaboration.

3.1. Time

Participants stated that team meetings and associated activities took some additional time, but quickly expressed that working together was worth the extra time, as they could provide better patient care through interprofessional collaboration.

> “We have our own patients as well, so I wish that on Wednesdays when the TCM clinic is happening that I didn't have to do the other stuff and could just do TCM. Because then I could focus more on TCM, which is what I really enjoy.”

> “I don't have enough time in the day, so anything I have extra I do, it's less time I have for other things.”

> “Barrier wise, I think getting peoples time, I feel like their time's kind of more valuable than what everybody else is apparently. So, trying to get someone else to sit through even to see the benefit of it I think would be a pretty big barrier.”

3.2. Space

Most participants perceived that there were spatial limitations in the clinic setting that hindered their effectiveness as an Interprofessional team. Participants described a lack of space to conduct interprofessional pre-clinic conferences. “We're in crowded conditions. There's really nothing that can be done. I think we are just doing the best we can.” Lack of space has led to the conclusion that there is no opportunity to expand the existing team or to incorporate other professions, as one participant noted, “We're all smooshed together like a sardine can.”

3.3. Financial

Participants perceived financial barriers as barriers and that these derive from two causal factors. First, members of the team are compensated in different ways and have different methods of billing for their services. Some health professionals on the team concluded that to participate as a part of the team they have to “volunteer” their time, while others are compensated for their efforts.

> “I think the biggest [issue is] probably payment. We get paid when a doctor sees a patient. … I mean that's the major way that we get revenue. I don't think the social workers are billing. I know our pharmacists can't bill unless it's coordinated with a physician. So obviously, this being a giant business and things having to run, we have to keep the lights on.”

The second causal factor that emerged was related to manpower. Health professionals, regardless of profession, are expensive to hire and maintain at any institution. In a fee-for-service environment, the fixed costs to build and maintain successful interprofessional health team may inhibit the incentives associated with an increased quality of care. “[Cost] … is a huge barrier to us being able to have these interprofessional teams … it's expensive to hire these people.”

3.4. Assumptions of hierarchy

Participants described how their past professional education and training effect team communcation, explaining how assumed